

Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study



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ABSTRACT

Art therapy (AT) is frequently used in the treatment of patients diagnosed with cluster B/C personality disorders, but there is little evidence for its efficacy. This study aimed to provide insight into the perceived effects of AT. We interviewed 29 adult patients in individual and focus-group in-depth interviews, including a 'negative case', starting with a topic list coming from the literature study. Data were gathered and analysed using the Grounded Theory Approach in order to generate concepts and inter-related categories. The constructed theoretical model of effects of AT consisted of five core categories: improved sensory perception; personal integration; improved emotion/impulse regulation; behaviour change; and insight/comprehension. Compared to verbal therapy (VT), patients experienced AT as an experiential therapeutic entry with a complementary quality next to VT and a more direct way to access emotions, which they attributed to the appeal of art materials and art making to bodily sensations and emotional responses. AT was found to fit well the core problems of patients with personality disorders, to offer a specific pathway to more emotional awareness and constructive emotion regulation. The perceived effects give input for further development and research and the development of an assessment tool to examine the efficacy of AT and within clinical practice.

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Introduction

Art therapy (AT) can be described as the therapeutic use of art making within a professional relationship by people who experience illness, trauma or challenges in living, or by people who seek personal development. The purpose of AT is to improve or maintain mental health and emotional well-being. Art therapy utilises drawing, painting, sculpture, photography and other forms of visual art expression (Malchiodi, 2005).

AT is frequently used to treat people with personality disorders (PDs) who are struggling with serious emotional and self-regulation problems (APA, 2007). Therapists believe AT is a powerful intervention in the treatment of PDs, and patients report

that AT has beneficial effects in daily clinical practice. Nevertheless, AT is not usually the first-choice treatment according to the basic principles of evidence-based medicine. This is because there is little empirical evidence for its efficacy, and the available evidence is not focused on the unique value of AT itself but on multidisciplinary treatment programmes, in which AT is important but plays only a secondary role. The specific effects of AT have not been isolated in these studies (e.g. Bateman & Fonagy, 1999; Bateman & Fonagy, 2004; Gatta, Gallo, & Vianello, 2014; Karterud & Urnes, 2004; Wilberg, Karterud, Urnes, Pedersen, & Friis, 1998). There seems to be a discrepancy between the limited evidence for AT and the fact that AT is considered to be promising in practice. Since that is the case, why is AT used so often?

Until now, we have relied on the clinical expertise of art therapists and their collective sense of profession. Experts describe a large variety of effects that AT can have on the recovery process of a patient with PD. First, they have noted that AT improves emotion and impulse regulation (Eren et al., 2014; Haeyen, 2005, 2007;

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Morgan, Knight, Bagwash, & Thompson, 2012). AT seems to stimulate the regulation of overwhelming and poorly adapted emotional experiences by allowing the patient to express emotional themes in the artwork and to handle materials that appeal to different emotional responses. AT uses experiential techniques and effectively provokes mental states connected with 'child modes' and improves the 'healthy adult mode' known from Schema Focused Therapy (Van den Broek, Keulen-de Vos, & Berstein, 2011). In addition, experts stated that patients learn to reduce their tension and/or stop when their emotions become too overwhelming, to structure chaotic behaviour and to rethink behaviour before acting on it. This results in strengthened control, improved self-structuring skills and more positive behaviour (Eren et al., 2014; Haeyen, 2005, 2007; Zigmund, 1986). Lack of self-control and structuring skills are typical behavioural problems for many patients with PD, especially Borderline PD (Linehan, 1996).

The second effect mentioned by experts concerns stabilising and strengthening identity. Many art therapists and a few researchers have described the effect of strengthening identity: a more positive self-image (Chrispijn, 2001; Haeyen, 2007; Johns & Karterud, 2004; Morgan et al., 2012; Neumann, 2001) and an increase in 'self-cohesion' (Levens, 1990; Robbins, 1984). According to researchers and art therapists with many years of clinical experience, AT leads to increased self-awareness, improved self-perception, improved reflective abilities and self-insight (Bateman & Fonagy, 2004; Haeyen & Henskens, 2009; Haeyen, 2007; Jádi & Trixler, 1980; Levens, 1990; Ouwens et al., 2007; Waller, 1992). Many patients with PD experience serious identity problems, also known as self-regulation problems. They suffer from a damaged or poor self-image, which consists of polarities. Various experts have stated that AT increases contact with one's own emotions, body and experience. In other words, intra-psychological integration is stimulated through artwork and the art-making processes, possibly resulting in a corrective emotional experience (Bateman & Fonagy, 1999; Goodwin, 1999; Gunther, Blokland-Vos, van Mook, & Molenaar, 2009; Haeyen & Henskens, 2009; Haeyen, 2007; Lefevre, 2004; Lev-Wiesel & Doron, 2004; Van Vreeswijk et al., 2012). As Bateman and Fonagy (2004) described, in AT, experience and feeling are placed outside the mind and into the world, a process that facilitates explicit mentalising. They further stated that AT creates transitional objects and that the therapist needs to work at developing a transitional space. The created objects can be used to facilitate expression while building stability of the self (Bateman & Fonagy, 2004). By creating playful safe transitional objects and space, identity may be strengthened and stabilised by the patients' investigation of their own basic preferences and needs.

The third effect mentioned by literature is about learning to express emotions more effectively. Many art therapists and a few researchers have mentioned that, by moving from images to words, patients learn to express themselves in a more implicit way through which explicit expression and mentalization can emerge. During AT, patients examine feelings without words, pre-verbally and sometimes less consciously (Eisdell, 2005; Haeyen, 2005; Johns & Karterud, 2004; McMurray & Schwarz-Mirman, 2001; Milia, 1998; Springham, Findlay, Woods, & Harris, 2012). In this way, AT is said to contribute to the process of gaining insight and understanding about the patient's problem. AT potentially offers a different therapeutic entry than regular verbal therapies. Art therapists emphasise that, since this entry is indirect, AT breaks down barriers (Haeyen, 2005; Hartwich & Brandecker, 1997; Robbins, 1994). Through AT, expression is used to improve communication and initiate contact (Daszkowski, 2004; Gatta et al., 2014; Haeyen & Henskens, 2009; Johns & Karterud, 2004; Karterud & Pedersen, 2004; Springham et al., 2012; Zigmund, 1986). Expression of intra-psychological conflicts and traumatic experience during AT gives the patient the opportunity to experience (instead of avoid) and reframe these

conflicts, which art therapists believe may be highly effective for trauma processing (Eastwood, 2012; Engle, 1997; Hitchcock Scott, 1999; Jádi & Trixler, 1980; Lyshak-Stelzer, Singer, St John, & Chemtob, 2007; Morgan et al., 2012; Moschini, 2005; Pifalo, 2006; Van der Gijp & Kramers, 2005). Karterud and Pedersen (2004) also mentioned that the effect of learning to express emotions more effectively could explain the results of a quantitative study among 319 patients with PD. That study found that patients valued AT more highly than other treatment elements, such as verbal therapy (VT) and other therapy groups. The authors explained the high value assigned to AT as related to the 'as-if situation' that offers patients a safe way to explore their perception of feelings and emotions, express them and give them meaning by means of self-objects in the shape of works of art. As described by Fonagy, Gergely, Jurist, and Target (2002), AT adheres to a 'pretend mode' by using fantasy and imagination.

The fourth effect to consider is about dealing with limitations and vulnerability by accepting limitations and using more effective coping skills. Experts have mentioned that acceptance, support and recognition are some of the effects of AT related to learning to deal with and accept one's own expression or artwork and that of others (Haeyen, 2007; Gunther et al., 2009; Springham et al., 2012; Van Vreeswijk et al., 2008). Dealing with personal expressions validates vulnerabilities that are present in the AT process and product, and challenges coping skills. Entering new experiences in AT and having indirect experiences by working together on artistic assignments lead patients with PD to experience positive effects on self-acceptance, higher self-esteem and improved social functioning. Long-term psychodynamic art psychotherapy decreased symptoms of self-mutilation, suicidal attempts, self-harm behaviours (Eren et al., 2014).

The expert opinions and evidence from multidisciplinary treatment studies suggest that AT may be promising. Coordinating treatment modalities may offer patients more therapeutic possibilities than one treatment modality may offer alone (Heckwolf, Bergland, & Mouratidis, 2014; Springham et al., 2012). This is also stated in recent publications on AT that describe contemporary PD treatment modalities combined with AT. Examples are: AT combined with Dialectical Behaviour Therapy, Mentalization-based treatment or with Schema Focused Therapy (Haeyen, 2007; Heckwolf et al., 2014; Springham et al., 2012; Van den Broek et al., 2011; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2012).

However, we do not know the differential effects of AT compared to VT and to what degree patients recognise the supposed effects of AT. Literature provides us with many patient testimonies, most of which describe positive experiences with AT (Eisdell, 2005; Gatta et al., 2014; Haeyen & Henskens, 2009; Moschini, 2005). Patients bring their own personal and unique concerns, expectations and values to AT. However, in those testimonials, little attention is paid to the difference between AT and VT. In addition, they do not provide a systematic view of the uniqueness and added value of AT.

This study aimed to provide a systematic investigation of the patients' experience of the benefits of AT. In addition to existing expert literature, this study could give a complete image of the effects of AT in treatment of adult patients with PD cluster B/C and develop a theoretical framework that is grounded in patients' daily AT experiences. This framework would contribute to the theoretical formation of AT and also lead to a clarification of the possible specific qualities of AT compared to VT.

Method

This qualitative study was performed with the Grounded Theory Approach (GTA) (Corbin & Strauss, 2008). In-depth interviews

were used to collect the data, because we wanted to focus on what patients report when absorbed in genuine AT experiences in the context of a natural setting, in order to examine the experience without preconceived notions or expectations. GTA was used to gather and analyse the data to generate concepts and interrelated categories, because there has been little research into the effects of AT experienced by patients with PD and because the GTA focuses on the experience processes of PD patients in AT.

Procedure

We conducted participant sampling according to the principles of theoretical sampling, in which new cases were chosen in each step to compare with those that had already been studied (Corbin & Strauss, 2008). Step 1 was an individual interview phase that started with interviews of three patients who were just finishing their treatment. Next, we interviewed five more patients of different ages, sex, settings and modes of treatment. This process is a form of theoretical sampling (Strauss & Corbin, 1998). Then we included three more patients who had ended their treatment between one month and six years ago (time sampling); they were added because they might evaluate AT differently than patients who were still involved with the treatment and therapists. Finally, we also interviewed a patient who might not approve of the results so far, a so-called 'negative case' (Corbin & Strauss, 2008). We analysed all the interviews by open coding, resulting in a code tree. This process of data gathering came to a point of information saturation when no new codes emerged (155 codes).

In Step 2, we conducted three focus-group interviews in order to focus more specifically on the added value of AT and for additional dialogue to deepen the developed concepts. The respondents were given the opportunity to interact and discuss things with each other. We interviewed 17 more patients in these focus groups; the results of these interviews were analysed by axial coding. This process reduced the number of codes to 54 and resulted in main and subcategories (five main categories and 28 subcategories).

In Step 3, we performed selective coding based on the main and subcategories found in the axial coding. All interviewed patients were asked to read the summaries that emerged from the data analysis and to give feedback. This feedback confirmed the analysis, so no new content was added to conceptualise the categories.

The continuation of these three steps was an iterative process of data gathering and data analysis. In this process, new data were compared with previous data and previous data were repeatedly compared with new data. The iterative process and 'constant comparison' are key aspects of Grounded Theory methodology (Corbin & Strauss, 2008). Fig. 1 outlines the three main steps of data collection and data analysis in this study. The dotted lines represent the constant comparison.

Participants

Participants were recruited through departments of a mental-health-care centre that focused exclusively on PD. We interviewed 29 patients about the effects of AT that they had experienced. Participants were adult patients (27 female and two male) with at least one Axis II PD, cluster B/C diagnosis. The most frequent diagnosis was a 'personality disorder not otherwise specified'. Other participants were diagnosed with evasive, borderline, dependent, obsessive-compulsive and narcissistic personality disorders and/or traits. The largest group had a GAF score of 55, meaning moderate symptoms or moderate difficulty in social, occupational or school functioning. The participants received AT as part of a multidisciplinary treatment programme or were specifically referred for AT by a psychologist or psychiatrist.

An inclusion criterion for this study required that participants had received at least 15 sessions of AT. All respondents received VT in addition to AT. We interviewed 25 participants during or at the end of their treatment process and four some time after receiving AT (varying from one month to six years after AT). We individually interviewed 12 patients; 17 more were interviewed in a focus group.

Interviews

The group of 29 respondents was interviewed in 12 individual ($n = 12$) and three focus groups ($n = 17$). These interviews were open in-depth interviews, proceeding inductively and using an unstructured format and a topic list coming from the literature study. The starting point for both the individual interviews and the focus groups was a general instruction that determined the sequence of the conversation: to talk about what they experienced (emotions, interactions and consequences) as an effect or benefit of AT and what they experienced as helping or obstructing conditions relating to the art therapist, the circumstances and their own basic needs in AT. The topic list was used to prevent important topics from being neglected and to bring fluency to the conversation if necessary. Participants were also asked to articulate the characteristics of AT as compared to VT and the specific effect of the art-making process based on their 'most important' art product. These 'most important' art products chosen by the respondents were present at the time of the interview, which helped the conversation remain concrete and specific. Each interview lasted about 1 h and each respondent was interviewed once.

Data analysis

As already mentioned, we used GTA to analyse the data and to generate concepts that could then be integrated into a theoretical framework about the effects of AT with interrelated categories and their properties. The data were analysed using Kwalitan, a computer programme for qualitative data analysis (Peters, 2000). Consistent with the principles of the Grounded Theory method, we applied three coding steps (i.e. open, axial and selective coding) to the interview analysis (Fig. 1) (Corbin & Strauss, 2008). First, we prepared all the interviews by fully transcribing the audio recordings. In the open-coding phase, concepts were identified and their initial properties and dimensions were discovered. In this study, the open coding in Step 1 started after the first three interviews. In this step, we used 'in vivo codes' as much as possible, which means that the text fragments were labelled using the words of the respondents themselves (Corbin & Strauss, 2008). In vivo codes included 'conflict with myself', 'to get out of the "thinking" mode' and 'symbols'. All the codes were summed up in a code tree (i.e. a list of codes). All the text fragments from the following interviews that shared the same characteristics were given the same code. Through comparative analysis, we renamed existing codes to develop them more fully. Consequently, the code tree expanded as the open coding progressed and until no new codes emerged. At the end of this process, the code tree contained 155 codes.

In Step 2, the axial coding phase, it became clear that codes could be grouped together into categories based on their more overarching similarities. The number of codes was then reduced to 54. Similar codes were grouped by making connections between categories at the property and dimension levels (Corbin & Strauss, 2008). For example, we grouped several codes ('to show myself', 'metaphors (used to symbolise oneself)', 'identity' and 'express/portray feelings from the past') into the category 'self-expression'.

Through this process, it became possible to determine main and subcategories. This was guided by the number of patients who

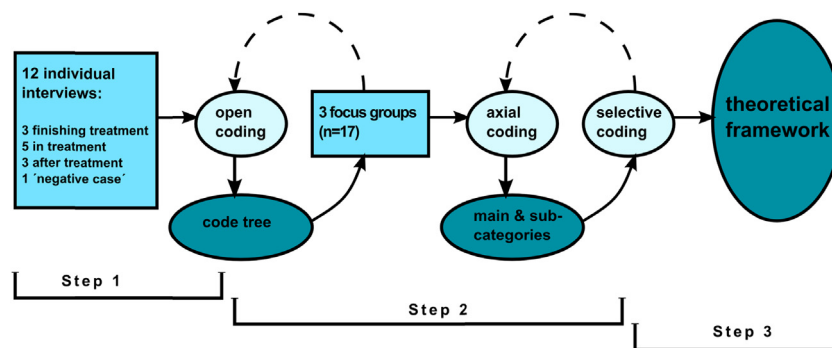


Fig. 1. Steps in the iterative process of the study.

talked about a category, the frequency with which a category was mentioned and the importance it was given. This process resulted in five core categories and 28 subcategories.

In Step 3, selective coding connected the categories in order to create and refine an integrating theory (Corbin & Strauss, 2008). In this process, five core categories of effect emerged to which all subcategories could be linked. Although these steps seem to be sequential, this process of analysis required constant comparison of all the interviews (see Fig. 1).

Quality criteria

Several techniques were used to meet the quality criteria of 'trustworthiness' to ensure the rigour of this research (Guba, 1981; Krefting, 1991; Lincoln & Guba, 1985). Credibility strategies to establish trustworthiness were 'prolonged engagement' in which informants were accustomed to the researcher. The threat of responds based on social desirability rather than on personal experience was countered by the facts that numerous interviews were held, in different social contexts and by talking in the presence of their own artwork in order to stay close to the actual experience. Other strategies were time sampling and triangulation of data methods and data sources (different social settings for data collection – individual and focus groups, theoretical sampling of respondents on gender, age, diagnosis and from different wards). Reflexivity was used to satisfy the criteria of credibility, dependability (i.e. the findings can be repeated) and conformability (i.e. the findings are grounded in data and not biased by the investigator's motivation or interest). A field journal was kept to be sensitive of our own subjectivity, for auditability and self-reflection. Writing memos was used to document considerations and insights, and to make constant comparisons during the process of data collection and analysis. Another way of looking for truth value of the findings that we performed was including a disconfirming or 'negative case' (Corbin & Strauss, 2008). A negative case is a respondent who would not approve previous findings, i.e. the positive results of AT we found so far. We selected a respondent, who showed resistance to AT and avoidance of experiences in AT. Member checking was performed on two occasions to ensure that the researcher accurately represented the respondents' opinion. All respondents mentioned that they recognised not only their experiences but also those of others. Peer examination was performed with other researchers and field experts to ensure the honesty of the researcher and deeper reflexive analysis by checking coding and categories developed from the data, for reaction and to discuss hypothesis. The whole process was audited/coached by research experts and a senior lecturer in art therapy for inspection and verification. These last two strategies and the description about informants and setting to identify whether data are typical contribute to the dependability and transferability of this study. Transferability is also strengthened by

the fact that this study is conducted in a naturalistic setting, i.e. a mental health care expert centre for specialised treatment of PD with different treatment programmes.

Results

Core categories

We found five core categories related to the effects of AT (see Table 1).

Core category 1: perception and self-perception

Perception concerns the base of the experienced effects of AT. It is defined as discovering materials, feeling the accompanying physical effects and exploring possibilities and choices, which results in more self-awareness and a sense of individuality. Patients stated that working with art is an experience that one can enter into and that this experience leads to experiencing the present moment, to emotional responses and to more emotional and body awareness. Patients also indicated that, at first, they sometimes felt worse when they gained full perception of all their mutable, often negative, emotions and feelings and the accompanying destructive behaviour. They noted that this process consisted of starting to experience and recognise the actual burden of negative feelings, while simultaneously experiencing that they had so far made little progress in dealing with these feelings. Avoidance of negative feelings came forward in the interviews as a core problem for people with PD. Perception was the first step in this process of experiencing, recognising and validating emotions, as can be seen in the following quote:

'I start with a heavy, big piece of clay . . . I am an analyser in my profession, but this I do by intuition . . . and I need to use my force to get it in the first rough shape. I like to beat the clay . . . I feel it's actually about power and aggression for me . . . but as the art process progresses, I need to be more careful, more refined and vulnerable in my actions.' (Respondent 8, a 60-year-old male)

This perception was a base for further therapeutic exploration and actions and for exploring changes in patterns of feelings, behaviour and thoughts.

Core category 2: personal integration

'Personal integration' is defined as the ongoing self-definition in which the integration of contradictive polarities in oneself leads to more self-coherence and self-acceptance. The patients mentioned that they could express and portray their personal issues, emotional experiences and identity or self-image in AT. They felt that their identities became visible, which led to an ongoing self-definition in which identity and self-image could be strengthened and become more positive. The patients noticed that another characteristic of

AT is that the artwork confirms what is already there and that their development in the therapy process became visible in the work of art. They spoke of how a more coherent, more stable self-image and more self-acceptance arose. By expressing emotions through their artwork, they could further investigate and unravel their thoughts, patterns and inner conflicts. The following quote emphasises how art work can contribute to becoming aware and more accepting of oneself.

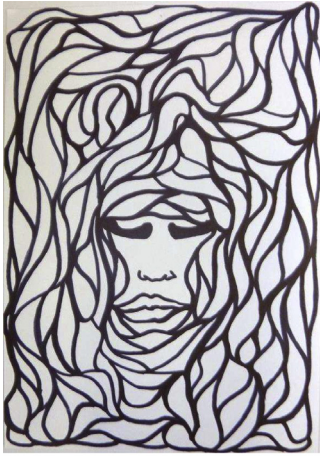


Image 1: 'I am scared stiff every time I see what I draw. I do tend to play down things I look at it and I often get a bit of shock, because how trapped or how unsafe I felt comes to the surface.... Really intense emotions are revealed. ... Through becoming conscious, feelings can be integrated.' (Respondent 27, a 21-year-old female)

The patients also stated in the interviews that, in the artwork, they examined, expressed and processed inner struggles closely connected to traumatic experiences from the past by giving them form. This investigational art process helped patients differentiate between emotions, thoughts, patterns and inner conflicts or contradictory feelings. Personal integration and more self-coherence were facilitated by bringing conflicting emotions, thoughts and behaviours into one coherent image. The following quote illustrates this integration process.



Image 2: '... the two emotions are integrated in such a way that they exist beside each other and that they can become unified ... by working with contrast and material such as chicken wire and sheep wool, symbolising contrasting emotions ... together in one work of art. ... Both are possible; at the same time, it was such an eye-opener for me ... as if things have come together. Before, I was such a mess; my feelings were rushing through each other. ... I got more of a grip on myself.' (Respondent 2, a 44-year-old female)

Core category 3: emotion and impulse regulation

Regulation of emotion involves modifying the emotion after it is felt. Patients got in touch with or really experienced their emotions by means of works of art. They learned to allow these emotions and

to let them go or turn them off as well. Patients who were able to do this during AT experienced more freedom and developed more grip on the intensity of their emotions. The next quote shows how a tendency for self-harm can be countered in the art work:

'It is also good to be able to draw feelings of self-destruction. Because then you are dealing with it, with the emotion itself, but not by putting the knife in your body That is the difference.' (Respondent 16, a 27-year-old female)

Patients basically learned to dose and regulate their emotions. The artwork and the art-making process offered an experiential space in which patients could experiment, act out, experience and portray. Before AT, their emotions were more uncontrolled or over-controlled, which resulted in feeling unsafe. The patients learned to cope with their emotions instead of being overwhelmed and unable to reframe or intervene effectively, as can be seen in the quote accompanying Image 3. Patients could organise feelings and thoughts during AT because the process of creating art demands structure of perception and thoughts. As a result of the improvement in their emotion-regulation skills, they felt more confident that they could guard their own sense of security.

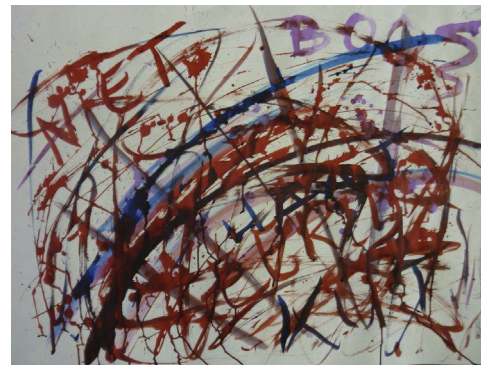


Image 3: 'And I'm thinking, "oh well, I will see what comes", and I was splashing around with some ink, and the red was like blood for me, and everything was boiling inside, I just got really cross, I felt really anxious and I had to distance myself, it was so important to me, because I usually push away the anger inside of me ...; it became clear to me how angry I actually am, that is something I really had to face here. ... My husband said: "You will get through the rest, but this had to be brought up". For me, it was a real turning point. I also realised that by being in contact with the group about this, a lot of emotion could break loose. ... at that moment I realised that I do have control of it.' (Respondent 9, a 54-year-old female)

Core category 4: behaviour change

Behaviour changes consist of two aspects: the behaviour of the patients towards themselves and their behaviour towards or in cooperation with others. A number of patients stated that they learned to change their behaviour patterns. Patients mentioned that creating requires the ability to be self-directed, because they have to make a number of choices about what to do and how to do it. The product and process trigger different emotional states and reactions. Therefore, experiments in AT can help patients practice alternative behaviour.

During the interviews, we found ample indications that the patients learned to find social support from others. Even though they often found teamwork exercises to be unpleasant and difficult, the patients often stated that these exercises ultimately resulted in important experiences. In the AT group, they learned to develop self-respect and to balance this with reaching their goals and managing their relationships by looking for solutions together with others. During art exercises in which social behaviour was studied and challenged, patients learned to know the behaviour patterns that they used in contact with others.

Table 1
Core categories and subcategories of AT effects.

Core categories	Subcategories
1 Improved sensory perception and self-perception	<ul style="list-style-type: none"> – discovering/experiencing materials and possibilities – discovering new opportunities and gaining consciousness of individuality/authenticity – emotional reaction to materials – perception/awareness of one's own feelings – experiencing the present moment – body awareness/perceiving the body/physical signals
2 More personal integration	<ul style="list-style-type: none"> – seeing one's emotional experience through visual images/design – exploring, recognising and acknowledging feelings – portraying identity/self-image – portraying feelings of past and present – differentiating and clarifying feelings and thoughts – differentiating one's own patterns concerning feelings, thoughts and behaviours – differentiating between inner conflicts/themes
3 Improved emotion and impulse regulation	<ul style="list-style-type: none"> – emotionally expressing personal themes – improving regulation skills – acting out and 'living through' emotions/feelings and directing this process – anchoring feelings/experiences
4 Behaviour change	<ul style="list-style-type: none"> – applying alternative behaviour in dealing with oneself and one's own emotions – experiencing emotional contact with others – advancing social cooperation skills – adequately coping with social conflicts – giving/receiving social recognition and emotional support – improving feedback skills (giving and receiving)
5 Stronger insight and comprehension	<ul style="list-style-type: none"> – improving the verbal expression of experiences – improving transcending thinking on the product/process – ameliorating understanding of one's own patterns regarding intra-psychic functioning – ameliorating reflection on one's own patterns in relation to others – drawing, transcending and connecting conclusions about this

'I still remember that one time we all had to draw on one piece of paper. I didn't like it at all. I wasn't going to use the whole paper so to say, you don't want to begrudge the others their space, but you notice that someone else is going over what you drew (uh...). I couldn't really deal with that so well. ... I have been giving myself more space ... , let others see more of who I am and if someone crosses my boundaries, then I let them know.' (Respondent 3, a 35-year-old female)

Core category 5: insight and comprehension

Insight and comprehension is defined as the ability to understand oneself and others, which underlies overt behaviour by perceiving and interpreting behaviour. This leads to insight about oneself and others. The patients often talked about how they learned to put into words their non-verbal experiences in AT. They mentioned that they experienced an inner dialogue that guided their choices while working on the art product. This dialogue was also present after the art-making process, by distancing themselves from the artistic process and the artwork and by transcending thinking on the product/process by naming and giving meaning. They developed insight and comprehension by looking at their emotions, thoughts and behaviour through artistic means. They also developed a better level of understanding or insight into their own patterns on an intra-psychological level and in relation to others. Through this, they came to a more generalised self-insight and reflection by naming their own processes and drawing transcending and connecting conclusions about them. Self-reflection and self-insight were established in a judgement-free atmosphere,

helped by the therapist and the group. The next two quotes show how AT stimulated insight and comprehension:

'I was not aware of how much of a perfectionist I was, and that it was limiting me so much. This is something I realised in art therapy.' (Respondent 21, a 23-year-old female)

'... an art work confirms things and it helps to work towards things. To realise what you've got ... I have a really good foundation ... while I was making this artwork, that is when I really woke up.' (Respondent 28, a 56-year-old female)

Towards a model of the core categories of AT effects

On the basis of the above data, we constructed a model (Fig. 2) consisting of five core categories: one as a base and four categories on top of it that show a certain overlap. Core category 1, 'Perception', formed the base upon which intensely felt experiences can lead to what the patients reported to be therapeutic effects. Improved perception of physiological reactions to external or internal stimuli was the first step towards experiencing the present moment, recognising emotions, naming and validating them, and taking steps to express them constructively or change them. Patients stated that they experienced perception as a basis for experiencing other effects.

The four other categories can be summarised as follows. Core category 2, 'personal integration', is important for patients with PD because it concerns the effect of experiencing oneself as more of a whole person, more balanced and less divided, conflicted, unstable and/or dependent. Core category 3, 'emotion and impulse regulation', concerns the effect of handling one's own emotions/impulses and not being the victim of these emotions/impulses. Core category 4, 'behaviour change', concerns the effect of handling the way a patient deals with him/herself and/or others, by learning to accept or by developing different behaviour. Core category 5, 'insight and comprehension', concerns the effects of being able to better understand yourself and others, and of being able to make yourself understood by others, instead of isolating yourself and feeling misunderstood and alienated.

This theoretical framework contributes to the theoretical formation of AT in the treatment of patients with PD. Categories 2 through 5 showed overlap; they did not appear to have a particular order and concerned more or less autonomous concepts. They also influenced each other: an effect on one concept influenced the development of another effect, as can be seen in the following quote, which mentions effects on perception, self-insight and personal integration.

'... a lot of short-tempered rage was bothering me I have really learned to stand still, examine it and name it, and see what it does with you. ... That is something I really did in AT ... examining my feelings, becoming conscious. ... and if I act effectively, I will not get this wrath anymore and the feelings can be integrated into my thoughts and my actions.' (Respondent 1, a 39-year-old female)

The importance of each category depended on the individual patient, on his or her personal therapeutic process and the focus of this process. A satisfactory result could be based upon the presence of one or more effects with their own degree(s) of intensity. In order to deliver the right conditions for the development of therapeutic effects, patients mentioned that the therapy should be well attuned to the patient's basic needs to be seen and heard, and should establish a good balance between feelings of controlled safety and freedom.

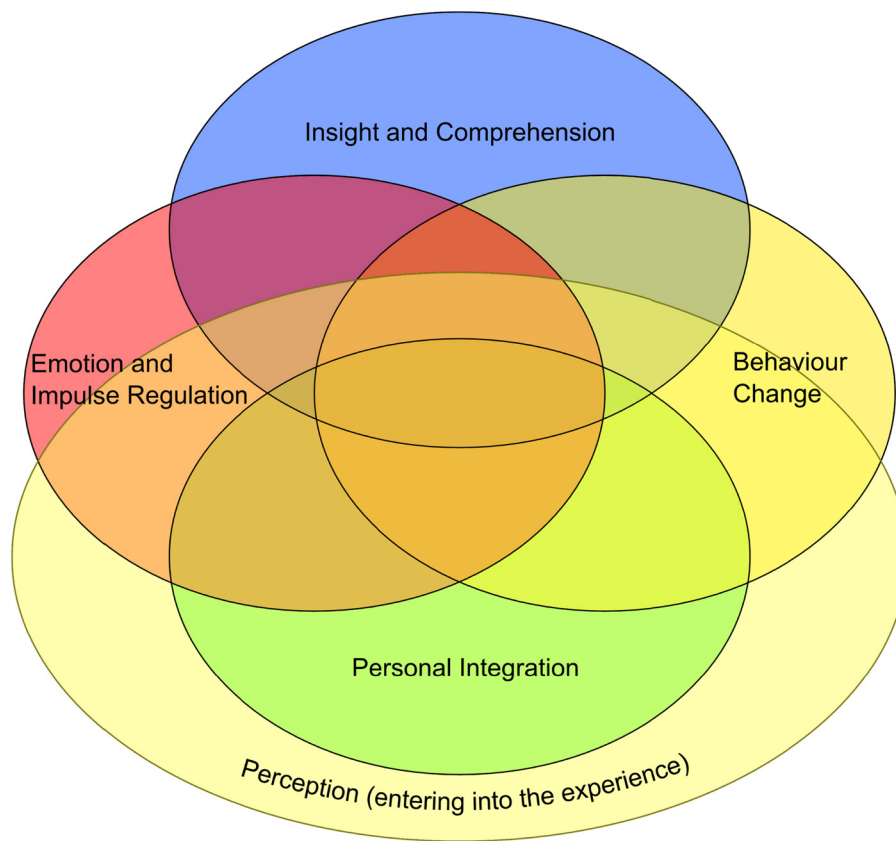


Fig. 2. Model of core categories of AT effects.

The perceived core of AT in comparison to VT

According to many of the patients, AT was, mainly, a more direct way to access less-conscious, less-aware or non-framed emotions through a working method that was essentially based on experience. AT confronted them with themselves and their own patterns of feelings, thoughts and actions within a fairly safe situation. Many patients even stated that for them, compared to VT, AT was the better, safer and better-paced way to explore their emotions in their therapeutic development. However, some patients find AT more difficult than VT because they fear emotions and loss of control, as was seen in the negative case. This case showed explicitly that, whenever the course of AT becomes difficult, the patient might experience resistance against feeling what is going on. Patients also indicated that, in AT more than in VT, one could really find out and practice how to act differently. The following quote shows how different emotional levels can be reached in AT:

'Yes, words are in a manner of speaking my survival position, that talking and that thinking . . . usually it is because I want to stay away from something emotional that I don't want to feel or experience . . . in AT, you do come closer to yourself. Verbally, things need to be faster, . . . in art you have more time and possibility to work within your boundaries and to really think or feel . . . that is the difference; because of this, it becomes calmer and . . . you reach the emotional levels easier that you simply pass over in talking. It is all so fast . . . from your head more into your body.' (Respondent 3, a 35-year-old female)

Patients often mentioned that they experienced a different dynamic in AT compared to VT: AT was more gradual, less rapid

and more concentrated on the self. More gradual because in VT interactions follow each other rapidly and thoughts about the communication itself can take up concentration. More concentration on the self and the possibility of more 'undisturbed' inner dialogue were also mentioned as characteristics of AT. Because of this, patients stated that they felt to have more overview and control. They were able to perceive less-conscious processes and to allow less-conscious feelings to become more conscious. Patients sometimes feared emotions and loss of control exactly because of this experiential emotion-focused appeal. The positive effect of having improved contact with less-conscious feelings was a more stable self-image and 'an improved felt contact with the self and others', as was stated often.

The patients often associated talking in VT with being rational, with cognitions being in the foreground and also with avoiding emotions and sometimes with 'whining'. The patients sometimes found words to be too direct. The alternative therapeutic entry of AT felt like a less controlled and a more lived-through experience. Many of the patients stated that they found it characteristic as well as safe that, in AT, communication happens via the image, as a result of the work of art. AT offers a situation that is aimed at experiencing and that also has a playful character, a combination of pleasant and serious, which was found to be characteristic of AT. According to the patients, images were revealing, direct and confrontational as well as concealing, protective and grounding. Many patients mentioned that characteristics of AT and VT complemented each other. Processes that started in one therapy could be continued in the other. The next quote shows how a therapeutic process that was avoided in VT came to development in AT:



Image 4: 'AT has really helped me to work on things or to get things going. This project was actually a starting point of me facing a lot deeper problem that I had been avoiding in verbal therapy until then ... about the (um...) sexual abuse in my past. ... I made photos of symbols that stand for me and for a part of my life. ... I put them in cigar boxes, they each represent a certain moment in my life ... and I wrote a poem to go with each part.' (Respondent 18, a 27-year-old female)

Discussion

In this study, we developed an integrated theoretical model of the effects of AT based on the PD patients' experiences. This model consists of five core categories: (1) perception; (2) personal integration; (3) emotion and impulse regulation; (4) behaviour change; and (5) insight and comprehension. Improved perception (1) is the first step towards experiencing the present moment and seems to be the basis upon which other therapeutic effect categories lean: to experience oneself more as a whole person and be more balanced (2), to handle one's own emotions/impulses (3), to accept or develop different behaviour towards oneself and others (4) and to better understand oneself and others (5). Categories 2 through 5 appear to have no particular order and to influence each other. Core problems for many patients with PD—managing emotions, adequately processing information about experienced emotions, lower emotional awareness, having problems identifying their own and others' emotions (Levine, Marziali, & Hood, 1997; Linehan & Heard, 1992; Westen, 1991) – are all addressed in AT, as was stated by the PD patients. According to them, the added value of AT in relation to VT is that they experience AT mainly as a more direct way to access more unconscious emotions because art materials and art making appeal to bodily sensations and emotional responses.

To a large degree, the patients' experiences were in line with the expert knowledge. Experienced art therapists describe the effects of AT as improving emotion- and impulse-regulation skills, stabilising and strengthening identity, learning to express emotions and dealing with limitations. The patients mentioned almost all the effects mentioned by experts. Experts and patients agree that the artwork facilitates personal integration by bringing together conflicting emotions, thoughts and/or behaviours into one coherent image. Both also emphasise the specific possibility in AT to fall back on the visual process that is visible in the single art product, in traces of actions and in the chronological line of the different artworks made over time. As a result, personal changes become visible in the artwork and self-reflection is challenged. Finally, experts and patients agree that AT improves emotion-regulation skills. Some patients in AT experienced a change from overly controlled to more

spontaneous handling of emotions, while other patients experienced a change from impulsive to more felt control.

So experts and patients agree to a large extent. However, there are some nuances. Some differences between expert knowledge and patients' opinions were also brought forward by this study. Experts emphasise more than patients that it is important in AT treatment to come to verbal expression and they emphasise more the importance of trauma processing. This could be explained by the fact that most respondents had group therapy focused on general psychological PD problems and that these themes were not the focus point of the interviews. The most important difference seems to be that experts define the therapeutic entry of AT as indirect, as a playful 'as-if situation', and they emphasise that AT breaks down barriers because of this. Patients, however, noted that AT is not always 'a safe way to explore the perception of feelings and emotions'. Because of the indirect emotion-focused therapeutic appeal of AT, this entry is sometimes even more threatening to patients than entry through VT. Art therapists in practice should be very aware of this aspect and not easily assume that AT is always accessible and playful. To counteract this fear of loss of control, it is important that art therapists focus on the specific needs of the client by arranging a safe balance between the offered structure, in order to provide direction, and the offered freedom, in order to meet the need for autonomy.

The added value of AT in PD treatment as comes forward in our findings is that AT not only fits well the core problems of PD and the goals to go with them, it also offers a specific experiential level with different aspects that provides therapeutic access to these problem areas. The added value of the specific experiential level of AT comes forward in the findings of this study, because PD patients explicitly experience AT as a more direct way than VT to access more unconscious emotions; this is because AT appeals to bodily sensations and emotional responses. Patients stated that AT confronted them with themselves and their own patterns of feelings, thoughts and behaviours, going further than a conscious, rational level and leading to more emotional awareness. Looking further into the different aspects concerning this experiential level of AT, patients state that in AT they practice alternative coping behaviour more directly and actively than in VT and that AT also has a different dynamic than VT: it is more gradual, with relatively more concentration on the self and more 'undisturbed' inner dialogue. This may result in a psychological overview and a feeling of control. Because of the experience-based approach, in which patients can come to development using their internal dialogue, tempo, expression and self-reflection, AT can be especially useful for people who tend to rationalise, avoiding emotional inputs, and for people who are weak on the personal integration level. However, although AT matches well the goals that go with the core problems of AT, it is essential that the art therapist should tune in soundly on the core problems of PD with AT interventions in a way that offers a balance between emphasis on emotional expression, on experience and at the same time with an eye on the personal integration.

The AT effect of increasing emotional awareness by providing experiential situations may be an answer for the 'experiential avoidance' phenomenon described in literature about PD (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), which refers to a broad range of potentially problematic behaviours that are used to avoid aversion/unpleasant experiences. Experiential avoidance is a way of acting to avoid painful experiences that can cause different kinds of acting out or self-destructive behaviour. Decreasing experiential avoidance is an important aim in the treatment of PD (Berking, Neacsiu, Comtois, & Linehan, 2009). This study shows that experiential avoidance could be linked with AT, because AT provides stimulating experiential situations that result in more felt emotional awareness. Improved awareness in AT stimulates 'affect tolerance' or experiential acceptance (i.e. differentiation of mixed

valenced feelings and constructive emotion regulation). This may yield a more stable self-image and can improve contact with the self and others. In clinical practice, art therapists should focus in on this strong side of AT by developing AT interventions specifically directed on emotion-regulation skills and by developing specific AT emotion-regulation treatment modules with a strong link to experiential awareness and acceptance. Furthermore, this should also have implications for future research, by including experiential awareness and acceptance as an outcome measure in future studies on the effectiveness of AT.

AT could also be effective for patients who struggle with integration on an intra-psychic level, who are sometimes considered to be therapy resistant. The concept of 'personal integration' has also been articulated in this study. Patients with PD have difficulties with personal integration, and AT seems to have potency in making therapeutic progress with it. Patients with PD are often able to use language, metaphors and/or visual symbols in art and poetry, but they are unable to connect this expression to their experience. Being able to connect and integrate this expression to their affective, physical and relational experiences is necessary for developing a coherent self-image and continuity of experience (Gregory & Remen, 2008). This study shows that AT utilises the ability of patients with PD to express themselves in images, symbols and metaphors and that AT helps them link this expression to affective experiences, thoughts and words. The art therapist is the guiding coach in this process, and he or she prevents that a patient is only at a symbolic or cognitive level, not making connection with the experiential, sensory level.

Several techniques were used to meet the criteria of "trustworthiness" during the course of this research (see Methods section). There are limitations of this study despite these efforts to enhance quality. A limitation of this study is that we did not take into account the treatment phase of the interviewed patients. Interviewed patients had had at least 15 sessions of AT, in different phases of treatment and also post-treatment. It may be that patients beginning treatment experience different effects than patients who have finished AT treatment. Although peer review showed recognisability of the findings, another limitation could be that the group of respondents may be selective in terms of motivation/willingness, self-insight and treatment access. The respondents felt some need for treatment and were willing for specialised treatment. The group of PD patients in practice is broader than that, often having self-destructive, impulsive behaviour or often having difficulties in the therapeutic alliance. Further exploration and development of the theoretical framework may require the inclusion of a wider range of PD patients. Several techniques were applied to focus on reflexivity to counter subjectivity. Besides the review of peers and expert auditors, the interviewer also practiced skills to keep the neutral role which is necessary for the interviews to ensure that respondents felt free to say what they wanted to say, being aware of the possible bias coming from her profession, i.e. art therapist (S.H.). Intervention also helped to prevent possible bias.

A strength of this study is its systematic way of examining the effects of AT according to a representative number of patients in a naturalistic setting, which led to a transferable and practice-based overview of AT effects. In addition, it included a 'negative case' which is a respondent who would not approve the previous findings (Corbin & Strauss, 2008). Because this negative case could be explained, the general interpretation was strengthened. The concepts that we found are integrated into a theory with interrelated categories. Because of the rich information and the point of saturation that we reached, we assume that these findings are applicable, usable and transferable.

This study gives also rise to examination of whether it is possible to quantify the effects of AT. The effects found may form the basis for developing a tool to make these effects measurable

during AT. Future research could include monitoring AT processes or randomised controlled trials with pre- and post-measurements. In addition, future studies could investigate if and how the effects that we found show up in the formal aspects in the visual art work during AT. For example, can we see personal integration be developed and on what level, in the formal aspects of art work, in the images and/or in symbols? Formal aspects and changes in the art work could be connected to the levels as mentioned by Hinz (2009) in the Expressive Therapies Continuum. Specific AT modules with AT interventions or methods that specifically fit the effects that we found could also be tested in further research on the effectiveness of AT with outcome measures as experiential awareness and acceptance. In this way, AT can be developed to a higher quality standard.

Our final conclusion is that this study provides a systematic overview of AT effects in the treatment of PD. The framework that we developed contributes to the theoretical substantiation of AT. The main finding of this study about the added value of AT seems to be the direct way to emotions, and the possible potency of AT on active improvement of emotion regulation, experiential acceptance and integration on an intra-psychic level. Through this direct, active experience and its outcomes in the form of art products, different goals that are directly addressed by specific AT methods can be achieved: more emotional awareness; constructive emotion regulation; a more stable self-image; contact with the self and others; psychological overview and a feeling of control; integration of emotions/feelings; and possible insight (into self and others) and comprehension. Practitioners should realise the strength of the fact that AT is an experiential therapeutic entry that offers opportunities to gain more emotional awareness and that has a complementary quality next to the relatively more cognitive quality of VTs. A strong recommendation for clinical practice is that practitioners should be aware of and make full use of the experiential aspect of AT and make a fruitful therapeutic combination with VTs in PD treatment.

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References

- APA. (2007). *Beknopte handleiding bij de diagnostische criteria van de DSM-IV-TR (Diagnostic and statistical manual of mental disorders), (4th version, revised text)*. Washington, DC: American Psychiatric Association.
- Bateman, A. W., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychotherapy*, 156, 1563–1569.
- Bateman, A. W., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization based treatment*. New York: Oxford University Press.
- Berking, M., Neacsiu, A., Comtois, K. A., & Linehan, M. M. (2009). The impact of experiential avoidance on the reduction of depression in treatment for borderline personality disorder. *Behaviour Research and Therapy*, 47, 663–670. <http://dx.doi.org/10.1016/j.brat.2009.04.011>
- Chrispijn, J. (2001). Een kasteel van klei. Behandeling van cliënten met stemmingsstoornissen gecombineerd met persoonlijkheidsstoornissen. In C. Schweizer (Ed.), *In beeld, doelgroepgerichte behandelmethoden van beeldend therapeuten* (pp. 85–101). Houten/Diegem: Bohn Stafleu van Loghum.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research. Techniques and procedures for developing grounded theory*. London: Sage Publications.
- Daszkowski, A. (2004). Alles unter einem Dach: Die integrative Funktion der Kunsttherapien der stationären Borderlinebehandlung. *Persönlichkeitsstörungen Theorie und Therapie*, 8(3), 143–153.
- Eastwood, C. (2012). Art therapy with women with borderline personality disorder: A feminist perspective. *International Journal of Art Therapy*, 17(3), 98–114.
- Eisdell, N. (2005). A conversational model of art therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 1–19.
- Engle, P. (1997). Art therapy and dissociative disorders. *Art Therapy*, 14(4), 126–131. <http://dx.doi.org/10.1080/07421656.1987.10759293>
- Eren, N., Ögünç, N. E., Keser, V., Bıkmaz, S., Sahin, D., & Saydam, B. (2014). Psychosocial, symptomatic and diagnostic changes with long-term psychodynamic art psychotherapy for personality disorders. *Arts in Psychotherapy*, 41(4), 375–385.

- Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.
- Gatta, M., Gallo, C., & Vianello, M. (2014). Art therapy groups for adolescents with personality disorders. *Arts in Psychotherapy*, 41(1), 1–6.
- Goodwin, J. M. (1999). *Splintered reflexions, images of the body in trauma*. New York: Basic Books.
- Gregory, R. J., & Remen, A. L. (2008). A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. *Psychotherapy: Theory, Research and Practice*, 45(1), 15–27. <http://dx.doi.org/10.1037/0033-3204.45.1.15>
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, 29(2), 75–91.
- Gunther, G., Blokland-Vos, J., van Mook, C., & Molenaar, J. P. (2009). Vaktherapie binnen klinische schematherapie. In E. Muste, A. Weertman, & A. M. Claassen (Eds.), *Handboek klinische schematherapie* (pp. 99–130). Houten: Bohn Stafleu van Loghum.
- Haeyen, S. (2005). *Panel discussion for experienced arts therapist about arts therapies in the treatment of personality disorders. Internal document on behalf of the development of the National multi-disciplinary guideline for the treatment of personalities disorders*. Utrecht: Trimbo Institute.
- Haeyen, S. (2007). *Niet uitleven maar beleven, beeldende therapie bij persoonlijkheidsproblematiek*. Houten: Bohn Stafleu van Loghum.
- Haeyen, S., & Henskens, B. (2009). Methoden, methodieken en diagnostische instrumenten. In C. Schweizer, C. Schweizer, et al. (Eds.), *Uit de verf, handboek beeldende therapie* (pp. 222–430). Houten: Bohn Stafleu van Loghum.
- Hartwich, P., & Brandecker, R. (1997). Computer-based art therapy with inpatients: Acute and chronic schizophrenics and borderline cases. *Arts in Psychotherapy*, 24(4), 367–373. [http://dx.doi.org/10.1016/S0197-4556\(97\)00042-7](http://dx.doi.org/10.1016/S0197-4556(97)00042-7)
- Hayes, S. C., Wilson, K. W., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64(6), 1152–1168. <http://dx.doi.org/10.1037/0022-006X.64.6.1152>
- Heckwolf, J. I., Bergland, C., & Mouratidis, M. (2014). Coordinating principles of art therapy and DBT. *Arts in Psychotherapy*, 41(4), 329–335.
- Hinz, L. D. (2009). *Expressive therapies continuum: A framework for using art in therapy*. London: Taylor & Francis.
- Hitchcock Scott, E. (1999). The body as testament: A phenomenological case study of an adult woman who self-mutilates. *Arts in Psychotherapy*, 26(3), 149–164. [http://dx.doi.org/10.1016/S0197-4556\(99\)00008-8](http://dx.doi.org/10.1016/S0197-4556(99)00008-8)
- Jádi, F., & Trixler, M. (1980). The use of focal conflict model in art therapy. *Confinia Psychiatry*, 23, 93–102.
- Johns, S., & Karterud, S. (2004). Guidelines for art group therapy as part of a day treatment program for patients with personality disorders. *Group Analysis*, 37(3), 419–432. <http://dx.doi.org/10.1177/533316404045532>
- Karterud, S., & Pedersen, G. (2004). Short-term day hospital treatment for personality disorders: Benefits of the therapeutic components. *Therapeutic Communities: International Journal for Therapeutic & Supportive Organisations*, 25(1), 43–54.
- Karterud, S., & Urnes, O. (2004). Short-term day treatment programmes for patients with personality disorders. What is the optimal composition? *Nordic Journal of Psychiatry*, 58(3), 243–249.
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, 45(3), 214–223.
- Lefevre, M. (2004). Finding the key: Containing and processing traumatic sexual abuse. *Arts in Psychotherapy*, 31, 137–152. <http://dx.doi.org/10.1016/j.aip.2004.05.001>
- Levens, M. (1990). Borderline aspects in eating disorders: Art therapy's contribution. *Group Analysis*, 23(3), 277–284. <http://dx.doi.org/10.1177/0533316490233008>
- Levine, D., Marziali, E., & Hood, J. (1997). Emotion processing in borderline personality disorders. *Journal of Nervous and Mental Disease*, 185, 240–246.
- Lev-Wiesel, R., & Doron, H. (2004). Allowing clients to choose their preferable non-verbal therapeutic modality. *Arts in Psychotherapy*, 31, 261–269. <http://dx.doi.org/10.1016/j.aip.2004.05.004>
- Lincoln, Y. S., & Guba, E. A. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Linehan, M. M. (1996). *Borderline Persoonlijkheidsstoornisstoornis. Handleiding voor training en therapie*. Lisse: Swets & Zeitlinger Publishers.
- Linehan, M. M., & Heard, H. (1992). Dialectical behaviour therapy for borderline personality disorder. In J. Clarkin, E. Marziali, & H. Munroe-Blum (Eds.), *Borderline personality disorder: Clinical and empirical perspectives* (pp. 248–268). New York, NY: Guilford Press.
- Lyshak-Stelzer, F., Singer, P., St John, P., & Chemtob, C. M. (2007). Art therapy for adolescents with posttraumatic stress disorder symptoms: A pilot study? *Art Therapy*, 24(4), 163–169.
- Malchiodi, C. A. (Ed.). (2005). *Expressive therapies*. New York, NY: Guilford Press.
- McMurray, M., & Schwarz-Mirman, O. (2001). Integration and working through in art therapy. *Arts in Psychotherapy*, 28, 311–318.
- Milia, D. (1998). Art therapy with a self-mutilating adolescent girl. *American Journal of Art Therapy*, 34(4), 98–106.
- Morgan, L., Knight, C., Bagwash, J., & Thompson, F. (2012). Art therapy and personality disorder: A discussion of its utility from the perspective of those with lived experience. *International Journal of Art Therapy*, 17(3), 91–98.
- Moschini, L. B. (2005). *Drawing the line: Art therapy with the difficult client*. Hoboken, NJ: John Wiley & Sons.
- Neumann, E. (2001). Forschungsperspektiven integrativer klinischer Kunsttherapie am Beispiel einer Borderlineproblematik. *Musik-, tanz und Kunsttherapie*, 12(4), 171–187. <http://dx.doi.org/10.1026/0933-6885.12.4.171>
- Ouwens, M., Vroling, M., Haeyen, S., Faassen, L., Kranendonk, H., Metzemaekers, R., et al. (2007). Gluren bij de burens. Inventariserend onderzoek naar de interventievormen door vaktherapeuten. *Tijdschrift voor Vaktherapie*, 4, 17–22.
- Peters, V. (2000). *Kwaliteit 5.0. Gebruikershandleiding. Afdeling methoden*. Nijmegen: Katholieke Universiteit Nijmegen.
- Pifalo, T. (2006). Art therapy with sexually abused children and adolescents: Extended research study. *Art Therapy*, 23(4), 181–185.
- Robbins, A. (1984). The struggle for self-cohesion: An analytically oriented art therapy case study. *Art Therapy*, 1(3), 107–118. <http://dx.doi.org/10.1080/07421656.1984.10758763>
- Robbins, A. (1994). *A multi-modal approach to creative art therapy*. London: Jessica Kingsley Publishers.
- Springham, N., Findlay, D., Woods, A., & Harris, J. (2012). How can art therapy contribute to mentalization in borderline personality disorder? *International Journal of Art Therapy*, 17(3), 115–129. <http://dx.doi.org/10.1080/17454832.2012.734835>
- Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage Publications.
- Van den Broek, E., Keulen-de Vos, M., & Berstein, D. (2011). Arts therapies and schema focused therapy: A pilot study. *Arts in Psychotherapy*, 38(1), 325–332.
- Van der Gijp, H., & Kramers, M. (2005). De kunst van het verwerken, beeldende creatieve therapie voor vrouwen met seksueel misbruik en geweld in hun geschiedenis. *Tijdschrift voor Creatieve Therapie*, 2, 4–11.
- Van Vreeswijk, M., Broersen, J., Bloo, J., & Haeyen, S. (2012). Techniques within schema therapy. In M. van Vreeswijk, J. Broersen, & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice* (pp. 185–197). West-Sussex: John Wiley.
- Waller, C. S. (1992). Art therapy with female incest survivors. *Art Therapy*, 9(3), 135–138.
- Westen, D. (1991). Cognitive-behavioral interventions in the psychoanalytic psychotherapy of borderline personality disorders. *Clinical Psychology Review*, 11, 211–230. [http://dx.doi.org/10.1016/0272-7358\(91\)90101-Y](http://dx.doi.org/10.1016/0272-7358(91)90101-Y)
- Wilberg, T., Karterud, S., Urnes, O., Pedersen, G., & Friis, S. (1998). Outcomes of poorly functioning patients with personality disorders in a day treatment program. *Psychiatric Services*, 49(11), 1462–1467.
- Zigmond, J. (1986). Relating developmental level to art materials in work with paranoid and schizoid personalities. *Pratt Institute Creative Arts Therapy Review*, 7, 1–12.