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Evaluating an Art Therapy Program in an Outpatient Psychiatric Hospital Setting for Individuals With Mood Disorders

Évaluation d'un programme d'art-thérapie offert dans un hôpital psychiatrique à des personnes non-hospitalisées souffrant de troubles de l'humeur

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ABSTRACT

The aim of this program evaluation was to assess the impact of an 8-week art therapy intervention for adults in a hospital-based outpatient mood disorders clinic on depressive symptoms and overall quality of life and to examine how these symptoms may change over time by primary psychiatric diagnosis. Following a convergent mixed-methods approach, data collection included quantitative and qualitative patient feedback regarding program implementation to improve delivery. Pre- and post-treatment results from this evaluation are presented (n = 88), including patient feedback on the program (n = 34). Independent of primary diagnosis, patients experienced improvements in depressive symptoms (p < .001, ηp^2 = .33), anxiety symptoms (p < .001, ηp^2 = .16), and stress symptoms (p < 0.01, ηp^2 = 15), as measured by the Depression Anxiety Stress Scales-21. In addition, patients experienced improvement in scores on the Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form (p < .001, ηp^2 = .37). Findings suggest that structured group art therapy can reduce symptoms of depression, anxiety, and stress and can improve quality of life in a Canadian outpatient psychiatric setting. Participants were generally satisfied with the quality of this service delivery and provided constructive qualitative feedback to help improve the service.

RÉSUMÉ
Cette évaluation de programme vise à évaluer l'incidence sur les symptômes dépressifs et la qualité de vie générale d'une intervention de 8 semaines en art-thérapie pour adultes dans un service hospitalier de consultation externe spécialisé dans les troubles de l'humeur, tout en examinant l'évolution de ces symptômes dans le temps par diagnostic psychiatrique primaire. La collecte de données, qui suivait une approche fondée sur des méthodes mixtes convergentes, comprenait les commentaires quantitatifs et qualitatifs des patients sur la mise en œuvre du programme afin d'en améliorer la prestation. Les résultats de cette évaluation avant et après traitement sont présentés (n = 88) et comprennent les commentaires de patients sur le programme (n = 34). Indépendamment du diagnostic primaire, les patients ont vu s'améliorer leurs symptômes dépressifs (p < 0,001, ηp^2 = 0,33), leurs symptômes anxieux (p < 0,001, ηp^2 = 0,16), et leurs symptômes de stress (p < 0,01, ηp^2 = 15), mesurés sur les échelles de dépression, d'anxiété, et de stress (EDAS-21). De plus, les scores des patients se sont améliorés au *Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form* [Questionnaire sur la qualité de vie, le plaisir et la satisfaction—version courte] (p < .001, ηp^2 = 0,37). Les conclusions donnent à penser que l'art-thérapie en groupe structuré peut réduire les symptômes de dépression, d'anxiété, et de stress et peut améliorer la qualité de vie dans un cadre psychiatrique ambulatoire canadien. Les participants étaient généralement satisfaits de la qualité de cette prestation de service et ont fourni des commentaires qualitatifs constructifs pour aider à l'améliorer.

It is estimated that 12.6% of Canadians will, at some point in their lives, experience a mood disorder and 8.7% will experience generalized anxiety disorder, both of which are mental health concerns that are commonly comorbid (Statistics Canada, 2015). As a result of the COVID-19 pandemic, these rates are increasing (Angus Reid Institute, 2020). Art therapy is a psychotherapeutic treatment that has been used as an adjunctive treatment with a variety of populations, including those diagnosed with mood and anxiety disorders (Chandraiah et al., 2012; Gussak, 2007; Nan & Ho, 2017; Thyme et al., 2007).

Art Therapy

Art therapy utilizes a combination of the creative process and psychotherapy to explore thoughts and feelings while promoting self-expression and self-reflection (Malchiodi, 2012). This type of intervention can support the improvement of a person's physical, mental, and emotional well-being (Kongkasuwan et al., 2016; Schouten et al., 2015). Specifically, the benefits of art therapy are derived from a number of factors, including the skills and strategies that this therapeutic approach targets. These include self-acceptance (Laranjeira et al., 2019), self-efficacy, identity development (Mauro, 1998), mindfulness, and flow (Warren, 2006). Art therapy interventions can also help individuals build social resources and social skills in a group therapy setting (Öster et al., 2006). Additionally, findings from group art therapy interventions indicate that this treatment may

be effective in reducing anxiety in groups for those with a traumatic brain injury (Briks et al., 2020).

Program Evaluation of Group Art Therapy as an Adjunctive Treatment for Mood Disorders in a Hospital-Based Outpatient Centre

Overall, controlled trials examining the efficacy of art therapy in psychiatric populations are limited, but some quasi-experimental investigations have deemed art therapy to be effective when delivered to patients who have been diagnosed with bipolar disorders and anxiety disorders (Chandraiah et al., 2012). In addition to controlled trials, there is a lack of literature on quality assurance regarding the delivery of art therapy in psychiatric settings, despite the fact that this would provide valuable information regarding the real-world application of such programming. Program evaluation provides the opportunity to assess a number of aspects of intervention delivery to support evidence-based practice. Such evaluations help to examine the effectiveness of programs in a naturalistic setting, beyond the evidence provided by randomized controlled trials, while improving the quality of service delivery.

Art therapy is currently offered through the Mood Disorders Treatment and Research Clinic at St. Joseph's Healthcare Hamilton in Hamilton, Ontario, as an adjunctive treatment to first-line psychotherapy, including Cognitive Behavioural Therapy (CBT), that is also offered through the clinic. Art therapy is a psychotherapeutic option for patients once they have completed CBT and their depressive or comorbid symptoms have not yet decreased to a functional level. In order to receive services at the Mood Disorders Treatment and Research Clinic, patients must have a diagnosis of a mood disorder. Other comorbid psychiatric illnesses such as anxiety disorders are often present as well.

In the present evaluation, we present pre- and post-treatment quantitative findings (n = 88) as well as treatment satisfaction feedback (quantitative and qualitative; n = 34) from a program evaluation of an 8-week art therapy group, administered repeatedly over the course of 6 years in an outpatient psychiatric setting, targeting patients who have been diagnosed with a mood disorder. While they access this group, participants are directed to create various forms of art using different modalities. They are directed by their art therapist in this artmaking and encouraged to reflect on how this practice impacts their depressive symptoms. It was also important to include in our evaluation the qualitative feedback that was collected through a treatment satisfaction questionnaire to aid in improving services (Berger et al., 2020). Using quantitative measures as well as quantitative and qualitative patient feedback to evaluate programs and services is common (Newcomer et al., 2015).

Statement of the Problem

Given the high prevalence of mood and anxiety disorders in Canada and given the available resources through the Mood Disorders Treatment and Research

Clinic to offer art therapy as an adjunctive treatment, we aimed to fill the current gap in the literature by examining art therapy as applied to this psychiatric population in the area of quality assurance for art therapy programming. Specifically, we aimed to evaluate this program's impact on depressive symptoms as well as on overall quality of life, while also looking at how these symptoms may change over time by primary psychiatric diagnosis. We also collected quantitative and qualitative patient feedback regarding the program's implementation to improve its delivery. We integrated the quantitative and qualitative data for the purpose of quality improvement, since by including both, we can examine not only symptom changes over time and self-rated satisfaction but also qualitative feedback from patients who accessed the program.

Methods

Clinical Setting and Interdisciplinary Team

At St. Joseph's Healthcare Hamilton's Mood Disorders Treatment and Research Clinic, group art therapy was offered to outpatient individuals who had been referred by members of their primary mental health team, which could include a registered nurse, a psychiatrist, and/or a psychologist. The Mood Disorders Treatment and Research Clinic is a service that uses a combination of psychotherapeutic and pharmacology-based interventions. Patients are seen in this clinic for consultations, medication management, and psychotherapy groups. As a result, most patients were taking psychotropic medications—including but not limited to antidepressants, mood stabilizers, and/or benzodiazepines—at the time of their enrolment in the group. The results of this program evaluation, therefore, reflect the implementation of an art therapy intervention in a naturalistic setting at an outpatient psychiatric clinic, where patients are receiving concurrent pharmacologic and psychotherapeutic interventions.

Participants

The criteria to attend the art therapy group included being a registered patient in the clinic, making a commitment to attend all sessions, and having a willingness to try a new type of therapy. Exclusion criteria from the group included unstable mood symptoms associated with mania. Patients attending the art therapy group ranged from having little to no experience creating or making art to patients who had skills related to art and/or had experience through art classes and community art programs.

Program Evaluation and Overview

We examined the effectiveness of art therapy for the population served through our clinic with the goal of reflecting on and improving services. We assessed

whether this intervention was sufficient to achieve therapeutic outcomes under a number of naturalistic conditions: a short-term intervention (i.e., 8 weeks) and the fact that patients receiving the intervention had a complex presentation of illness, including multiple concerns and diagnoses. Unlike many art therapy approaches, this intervention was standardized in terms of consistency in weekly art directives, time allotted to the intervention, materials available, a workbook that included reflection questions and space to create art, standardized homework assignments, and an integrated behavioural activation component that was specific to this intervention. Standardizing these elements provided consistency in care and allowed us to assess the effects of the therapeutic intervention in a more structured way than would have been possible otherwise. Our primary outcomes assessed whether this group art therapy intervention was effective in improving symptoms of depression, anxiety, and stress, in addition to improving quality of life. Importantly, we assessed whether this intervention was effective for several primary diagnoses that are commonly encountered in an outpatient mood disorder clinic, including depression, bipolar disorder, and anxiety disorders.

We also examined quantitative and qualitative patient feedback for further quality assurance reflections. We used a convergent mixed-methods design to collect quantitative and qualitative patient feedback at the same time and integrated all quantitative and qualitative data collected to understand different themes of the program: symptom change, satisfaction, and suggestions for improvement. We used a postpositivist approach to inquiry, which assumes a "real" reality that is only imperfectly and probabilistically apprehensible (Guba & Lincoln, 2005). Such an approach to inquiry may include qualitative methods and assumes that a hypothesis can be falsified (Guba & Lincoln, 2005). Although this evaluation was exploratory, with a post-hoc hypothesis, postpositivism best represents our approach.

Art Therapy Procedure

Each art therapy group was composed of five to 10 patients who met once a week for 8 weeks. The group was led by two therapists: a clinical art therapist and a registered nurse. Both group therapists used art materials, participated in group directives, and discussed their artwork in a therapeutic manner as part of the development of the group to support sharing and therapeutic rapport.

All art therapy groups took place in one of the outpatient clinic's central group therapy rooms. The group room had large windows that allowed natural light in and a central table with chairs arranged so that patients were able to sit and face each other. The group session was structured around several components.

1. The beginning of each session (i.e., approximately 15 minutes) was devoted to a check-in during which patients would take turns sharing their artwork and reflections on the art directive they had completed as homework between group

sessions. Reflections would include verbalizing the process, articulating thoughts related to the process, and conducting a mood check before the start of the session.

2. After the check-in, the art therapist introduced the directive for the week's session, to which 45 to 60 minutes would be devoted to artmaking. The group process involved creating art within a circular template that was provided to patients through art therapy booklets. The circle was referred to as a mandala, which references the symbolism from a Sanskrit word for "sacred circle." Mandalas are associated with feelings of wholeness, growth, change, containment, and expressions of the self, and the circle provided a contained space within which to create art. During the artmaking process, instrumental music was played quietly in the room through a small speaker.

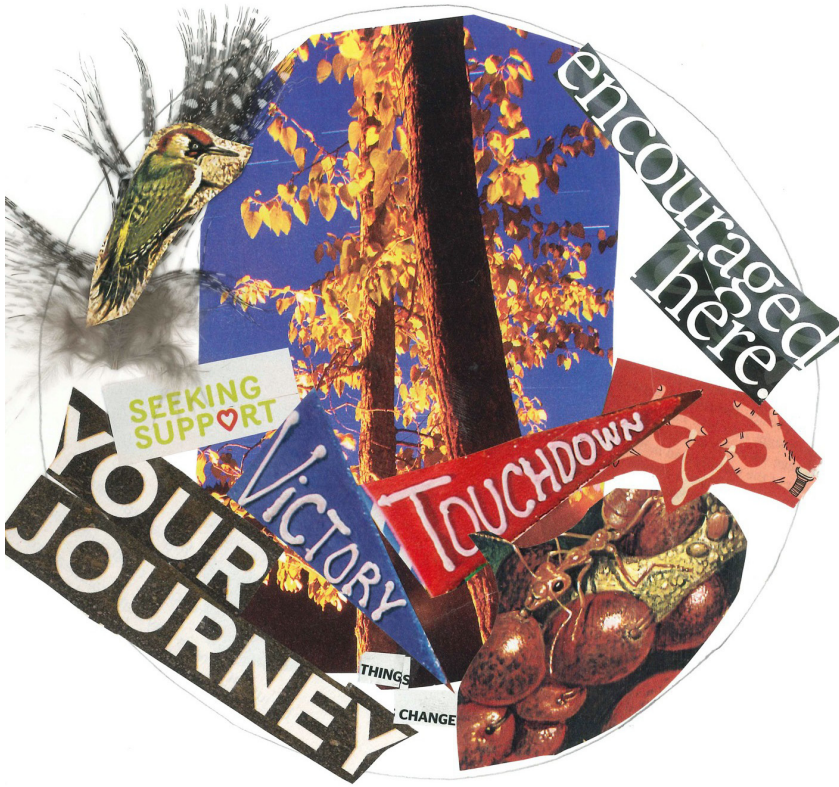
3. Upon completion of the artmaking, the last 15 minutes of each session were reserved for discussion, at which point patients recorded the date, the title, and the patients' reflection on the artwork they made, including descriptions and adjectives associated with the work. Patients reviewed and recorded the homework directive and took their art therapy books home to complete homework after each group session.

4. In addition, prior to and following each artmaking process, patients self-rated their mood and anxiety. A scale from one to 10 was used for mood (where one indicated lowest mood and 10 indicated highest mood) and 10 to zero for anxiety (where 10 indicated highest anxiety and zero indicated lowest anxiety). This information was collected for patients' own self-reflection process and allowed for immediate reflection on the effectiveness of the directive in that moment. This information was collected as part of patients' own self-reflection as well as therapeutic process but was at times inconsistently reported, so it was not included in the analysis.

The themes of the selected art therapy directives were aligned with establishing group goals to support steady integration in learning skills through expressive artmaking. Throughout the 8-week group, the art therapy directives focused on themes of comfort, acceptance, acknowledgement, self-representation, and self-soothing. The established goals of the group included (a) utilizing art as a tool for self-expression and the development of coping skills, (b) facilitating opportunities for patients to gain personal insight, (c) enhancing patients' social skills through group facilitation, (d) supporting patients in the re-establishment of self-identity and self-confidence, and (e) utilizing art as a tool for mood improvement and anxiety reduction as well as for long-term improvement of quality of life.

As part of the final group session, patients were prompted to create a card with a personal mandala on the front representing their thoughts and feelings regarding their personal experience in the art therapy group. Patients then wrote a letter to themselves inside the card to support the continuation of using the art therapy mandala book independently as they transitioned out of the group. Patients wrote their addresses on the envelope and mailed their cards to themselves. As the

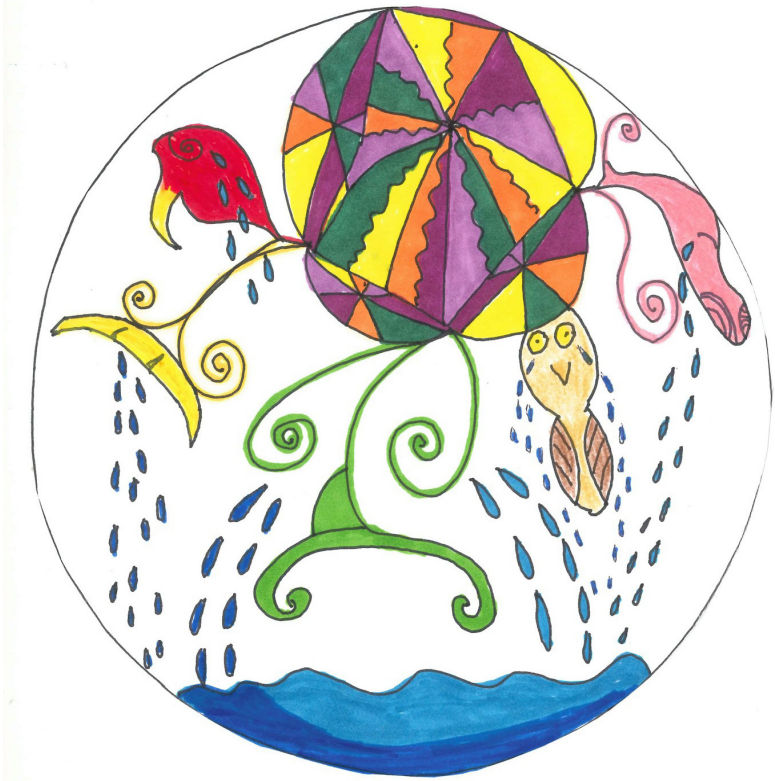
Figure 1
"Supportive Journey"



Note. This figure is an example of artwork completed in session by a participant following the directive "In the moment I hope … ," which the patient illustrated through a mandala entitled "Supportive Journey" using images and words to express growth, change, ability, and support. Each session provided additional opportunities to identify thoughts and emotions and to utilize the art's therapeutic directives to express emotion, process emotion, and cope with their emotions more effectively. In addition, art directives offered opportunities for meaningful engagement through artmaking, which supported mood improvement.

group finished, patients were encouraged to continue to create, using the skills developed during group sessions in combination with their art therapy books. In a wrap-up discussion, patients also shared and identified which directives they found most helpful and which directives they planned to continue to use to support self-expression, meaningful engagement, activation, and improvement in mood and anxiety (see Figures 1 and 2).

Figure 2
"Raining Tears"



Note. This figure is an example of artwork completed in session by a participant following the directive "In the moment I feel … ," which the patient explored using symbolism and colour through a mandala entitled "Raining Tears." The patient used colour to express outward feelings that they portray to family and friends, while the symbolism and the content of the drawing express their inner thoughts related to symptoms of depression, including sadness and suicidal ideation. The last session offers patients the opportunity to reflect on their time in the art therapy group and to review skills and tools they have learned throughout the 8 weeks.

Materials

A range of materials was offered and utilized, including resistive materials (markers, pencil crayons, gel pens, stamps, and collage materials) and fluid materials (acrylic paints, watercolour paints, oil pastels, and chalk pastels). Some materials were pre-selected by the art therapist based on the directive used for a particular session, while in other sessions, all materials were available for patients

to choose from independently. The art therapist discussed the use and steps of the art therapy book that each patient used for the group and reviewed these steps at each session as a guide to practise and develop independence in completing the artmaking steps.

The art therapy book used for the group was designed by the art therapist and included pages for patients to utilize throughout the eight group sessions and directives for them to follow during and after those sessions. Additional pages had been placed purposefully in the book so that patients could create independently after the group sessions had ended. There was no monetary charge to attend the art therapy group; all art materials were provided.

Data Collection Measures

Patients were formally assessed and given psychiatric diagnoses while being seen at the Mood Disorders Treatment and Research Clinic by a clinician prior to being referred to the art therapy group. The following self-report measures were collected prior to initiation of the art therapy group and during discharge following the final art therapy group session. Patients completed measures and handed them in to one of the group facilitators or at the clinic reception desk.

The Depression Anxiety Stress Scale-21 (DASS-21) is a short form of the original 42-item DASS scale (Henry & Crawford, 2005). The DASS-21 is used in clinical and non-clinical populations and consists of 21 self-report items evaluating three domains: depression, anxiety, and stress. The DASS-21 was developed to assess and to discriminate between symptoms of depression, anxiety, and stress (Lovibond & Lovibond, 1995). The DASS-21 has demonstrated good internal consistency, test-retest reliability, and convergent and discriminant validity (Brown et al., 1997; Crawford & Henry, 2003; Henry & Crawford, 2005; Lovibond & Lovibond, 1995; Sinclair et al., 2012).

The Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form (Q-LES-Q-SF; Endicott et al., 1993; Stevanovic, 2011) is used to assess quality of life. The Q-LES-Q-SF is a 16-item self-report questionnaire that evaluates satisfaction and enjoyment of different aspects of daily living, including physical health, mood, work, social relationships, family functioning, household activities, leisure, sexual life, economic status, medication use, and functioning (Endicott et al., 1993; Stevanovic, 2011). This questionnaire is a short form of the original 93-item Q-LES-Q. The Q-LES-Q-SF has demonstrated good internal consistency, test-retest reliability, and convergent and discriminant validity (Stevanovic, 2011). It has also been shown to be comparable in its psychometric properties to the long form (Stevanovic, 2011).

At the end of the group sessions, participants were given a treatment satisfaction questionnaire, with both qualitative and quantitative components, that was developed specifically for the Mood Disorders Treatment and Research Clinic. Participants rated their treatment satisfaction on a scale from 1 (low satisfaction)

to 7 (high satisfaction). They also rated their perceived improvement as a result of treatment on a scale from 1 (low improvement) to 7 (high improvement). Open-ended items on the questionnaire were used to collect qualitative feedback regarding the following topics: feedback on the time of day the group was offered, participants' hopes for the group, what was helpful about the group, and what could be improved regarding the group (see Table 1).

Quantitative Data Analysis

We compared pre- and post-group total and subscale scores on the DASS-21 as well as pre– and post–Q-LES-Q-SF scores to determine the effectiveness of the art therapy intervention on stress, depression, anxiety, and quality of life. Additionally, we aimed to assess whether patients' primary diagnosis influenced the outcomes of patients participating in the art therapy group.

In order to assess whether there was an effect of treatment and whether patients' primary diagnosis impacted depressive, anxiety, and stress symptoms as well as quality of life, we completed a series of 2x3 mixed-design ANOVAs, with DASS-21, its subscales, and Q-LES-Q-SF as the outcome variables. As the between-group factor, we split primary diagnoses into three categories: bipolar disorder (Type 1 and 2), unipolar depression (major depressive disorder and persistent depressive disorder), and anxiety disorders (post-traumatic stress disorder, generalized anxiety disorder, and social anxiety disorder). As the within-group factor, we compared pre- to post-treatment. Additionally, an interaction of pre- and post-treatment with diagnosis was included to assess whether there was an influence of any specific diagnosis on treatment effectiveness.

Prior to conducting the mixed-design ANOVAs, we examined variables for violation of assumptions. Notably, we excluded two participants in the "other" diagnosis category from the ANOVA due to the small sample size. Outliers were identified using boxplots, resulting in the removal of data concerning an additional three participants from the analysis.

The normality assumption for the mixed-design ANOVA (as tested through the Shapiro-Wilks test) was not met for the anxiety and depression subscale of the DASS-21. Although the mixed-design ANOVA is a relatively robust test of normality assumptions, additional tests were performed for the anxiety and depression subscales of the DASS-21 to confirm whether the effects of time and diagnosis could be observed through an approach that did not violate any assumptions of the relevant statistical tests. In order to test for the presence of the main treatment effect from pre- to post-treatment, we used paired t-tests or the Wilcoxon signed-rank test. The latter of these was used for the DASS-21 depression subscale since the assumption of normality was violated for this scale. We also tested for differences between diagnostic groups in pre- and post-measures using the Kruskal-Wallis test. Bonferroni corrections were applied for all tests conducted for the subscales of the DASS-21 to protect against familywise error.

Table 1
Quantitative and Qualitative Questionnaires

Measure	Description
Depression Anxiety Stress Scales-21 (DASS-21)	Developed to assess and discriminate between symptoms of depression, anxiety, and stress (Lovibond & Lovibond, 1995). Self-report scale that consists of 21 items, evaluates three domains (depression, anxiety, and stress), and is used with clinical and non-clinical populations.
Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form (Q-LES-Q-SF)	Self-report scale consisting of 16 items. Evaluates satisfaction and enjoyment of different aspects of quality of life, including physical health, mood, work, social relationships, family functioning, household activities, leisure, sexual life, economic status, medication use, and functioning. Short form of the original, 93-item Q-LES-Q (Endicott et al., 1993; Stevanovic, 2011).
Treatment Satisfaction Questionnaire	Questionnaire consisting of qualitative and quantitative components. Participants rated their treatment satisfaction and perceived improvement as a result of treatment on a Likert Scale from 1 (low) to 7 (high). Qualitative feedback was collected regarding several themes, including the time of day the group was offered, participants' hopes for the group, what was helpful about the group, and what could be improved regarding the group. This questionnaire was developed specifically for the MTRC.

The significance threshold used was $p < .05$. Effect sizes were calculated using partial eta squared, which is the recommended effect size when using an ANOVA (Cohen, 1973; Field, 2009). When it comes to effect sizes, .01 is considered small, .06 is considered medium, and .14 is considered large (Cohen, 1988). Statistical analyses were performed using SPSS Version 25. Participants' ratings of treatment satisfaction and perceived treatment improvements were examined using descriptive statistics.

Qualitative Data Analysis

We examined the qualitative feedback that participants provided using a thematic analysis (Braun & Clarke, 2006) and organized feedback into common themes. We followed Braun and Clarke's (2006) six-step process for conducting a thematic analysis, including familiarizing oneself with the data, generating codes from the data, searching for themes (i.e., organizing data into themes via codes), reviewing each theme, defining and naming each theme, and reporting findings.

Integration of Quantitative and Qualitative Components

Quantitative and qualitative data from the treatment satisfaction questionnaire were collected at the same time, so such data were merged during the data analysis stage of the study as part of the convergent mixed-methods design. Quantitative and qualitative data informed each other, since we wanted to know whether symptoms changed as a result of the group and whether patients subjectively found the group helpful and what their feedback was, in order to improve the group program. Each piece of information (qualitative and quantitative) was important in evaluating and improving the program.

Researcher Description

Reflexivity refers to the acknowledgement of personal values and perspectives that will inform the data collection, the qualitative analysis, and the interpretation of findings. It can include the social location of the authors to give context to the process (Burr, 2003). Reflexivity has been embedded throughout as we noted our approach to qualitative data collection as well as the context in which this program evaluation was completed (e.g., the MTRC). Personal and interpersonal reflexivity will be outlined below. Personal reflexivity involves reflecting on unique perspectives and how they may influence the project (Olmos-Vega et al., 2023). Interpersonal reflexivity involves reflecting on the relationships (including power dynamics) that existed during the project and how they impacted the program evaluation (Olmos-Vega et al., 2023). C. D. completed the qualitative analysis and A. S. completed the quantitative analysis, and therefore both C. D. and A. S. engaged in a reflexive process to acknowledge their personal and interpersonal locations in the program evaluation process.

At the time of the program evaluation, C. D. and A. S. were both connected to the MTRC in some capacity. They had interest in showing that the art therapy program was helpful to patients and were invested in providing high-quality services through the MTRC. C. D. was working as a clinical psychologist, whereas A. S. filled several roles during the study—including Ph.D. student, post-doctoral fellow, and research associate—and was a volunteer at the hospital's in-patient units. The fact that the qualitative and quantitative data were collected anonymously may have mitigated any influence C. D. and A. S.'s academic/professional backgrounds may have had on participant responses (e.g., power dynamic); however, they certainly acknowledge that their academic backgrounds may have had an impact on their analysis and interpretation of the findings, since this would be through a psychological or biological psychiatry perspective. C. D. and A. S. did not co-facilitate the art therapy groups.

C. D. has experience with qualitative data collection, analysis, and interpretation and has used various approaches and methodologies through community-based participatory action research in Indigenous communities in Canada. A. S.

gained experience with quantitative data collection throughout her Ph.D. work, dissertation, and post-doctoral work.

C. D. is a mixed Indigenous (Haudenosaunee, Cayuga nation), Polish, and Scottish woman. C. D. sees the world in both a circular and linear way, wholistic and siloed due to her mixed cultural background, and these ways of knowing and doing can at times become mutually exclusive. The qualitative analysis and interpretations are influenced by C. D.'s mixed cultural background, psychological training, and investment in the MTRC's program success. A. S. immigrated to Canada from Ukraine at a young age and has mixed Eastern European heritage. A. S. sees the world as complex and ineffable, with a postmodern understanding of the ineffability of "the whole truth," where people can be aware of only some aspects of an entity or experience and be ignorant of other equally valid and important perspectives. Her academic background had a strong influence on her world view as this project progressed, and it influenced her quantitative approach to the project, with the understanding that there are no perfect methods and no perfect understanding of a phenomenon.

Ethics

It should be noted that the authors of this project consulted with the local research ethics board (the Hamilton Integrated Research Ethics Board, affiliated with St Joseph's Healthcare Hamilton and McMaster University). From this consultation, it was decided that applying for and obtaining formal research ethics board approval was not necessary, since this is a program evaluation project, with the main goal to inform co-facilitators of the art therapy program as well as the clinic's management of the findings.

Results

Patient Characteristics

From 2014 to 2020, 88 patients participated in the art therapy program and completed pre– and post–DASS-21 questionnaires. Of these, 63 completed pre– and post–Q-LSES-Q-SF questionnaires during this time period and 34 patients completed the treatment satisfaction questionnaire. On average, eight patients attended an art therapy group at a time. In total, 17 art therapy groups were run between these dates and were included as part of this program evaluation. Patient demographics and primary diagnoses are summarized in Table 2 (quantitative) and in Table 3 (qualitative). Patients enrolled in the group ranged in age from 20 to 80 years old and were 45.85 years old on average. The majority of patients enrolled in the group were female (94.32%), and most had at least some post-secondary education. Due to data collection methods, some data were missing for education, marital status, and age at the time of enrolment. The majority of patients were single, divorced, or separated (52.27%). The majority of patients had

Table 2
Patient Demographics and Diagnoses (n = 88)

	Mean ± *SD* ***N*(%)**		***N*(%)**
Age	45.85 ± 13.35	***Education***	
Sex		Less than high school	1 (1.14%)
Male	5 (5.68%)	High school	11 (12.50%)
Female	83 (94.32%)	Some post-secondary	9 (10.23%)
		College or university	50 (56.82%)
Primary Diagnosis		Missing data	17 (19.32%)
Bipolar disorder (Type 1, 2, or NOS)	19 (21.59%)		
Unipolar depression[1]	58 (65.91%)	***Marital Status***	
Anxiety disorder[2]	7 (7.95%)		
Post-traumatic stress disorder	2 (2.27%)	Single, divorced, separated, or widowed	46 (52.27%)
Borderline personality disorder	1 (1.14%)	Partnered or married	40 (45.45%)
Schizoaffective disorder	1 (1.14%)	Missing data	2 (2.27%)

[1] Consisting of major depressive and persistent depressive disorders.
[2] Consisting of generalized anxiety disorder and social anxiety disorder.

a primary diagnosis of unipolar depression (65.91%), while others had a primary diagnosis of bipolar disorder (21.59%), anxiety disorders (7.95%), borderline personality disorder (1.14%), and schizoaffective disorder (1.14%).

Dropouts

Of the patients who participated in the art therapy program, 28% did not complete the post-treatment measures. Independent t-tests demonstrated that there were no statistically significant differences in the pre-group DASS-21 scores and its subscales or in the pre-group Q-LSES-Q-SF scores for those who completed post-group measures in comparison to those who did not complete post-group measures. Patients who missed a session and did not provide notification of their absence were contacted by the art therapist or the group co-lead to request the reason for their absence and to encourage continued participation. Patient feedback regarding group absences included transportation issues, conflicting appointments, discomfort with the therapeutic process, and illness, but

Table 3
Patient Demographics and Diagnoses (n = 34)

	Mean ± *SD* ***N*(%)**		***N*(%)**
Age	45.60 ± 11.00	***Education***	
Sex		Less than high school	1 (2.94%)
Male	4 (11.8%)	High school	1 (2.94%)
Female	30 (88.2%)	Some post-secondary	3 (8.82%)
		College or university	21 (61.76%)
Primary Diagnosis		Missing data	8 (23.53%)
Bipolar disorder (Type 1, 2, or NOS)	5 (14.71%)		
Unipolar depression[1]	26 (76.47%)	***Marital Status***	
Anxiety disorder[2]	3 (8.82%)	Single, divorced, separated, or widowed	18 (52.94%)
		Partnered or married	15 (44.12%)
		Missing data	1 (2.94%)

[1] Consisting of major depressive and persistent depressive disorders.
[2] Consisting of generalized anxiety disorder and social anxiety disorder.

statistics on reasons for drop-outs/missed sessions were not collected systemically and therefore were not included.

Primary Diagnosis by DASS-21 and Q-LSES-Q-SF Score Effects

The results from the mixed-design ANOVAs describe the effects of treatment, primary diagnosis, and the interaction of primary diagnosis with treatment on changes in DASS-21 scores (see Table 4). A main treatment (pre-/post-) effect was found for the DASS-21 total $F(1, 80) = 32.77$, $p < .001$ with a large effect size of $\eta p^2 = .29$. All three DASS-21 subscales (i.e., depression, anxiety, and stress) showed a significant decrease from pre- to post-treatment (all ps $< .001$) with large effect sizes (i.e., the depression, anxiety, and stress subscales had effect sizes of $\eta p^2 = .33$, $\eta p^2 = .16$, and $\eta p^2 = .15$, respectively). A significant main effect was found for group differences in primary diagnosis on the DASS-21 depression subscale, $F(2, 80) = 4.00$, $p = .02$, where individuals with unipolar depression had higher scores on the DASS-21 than individuals with bipolar disorder. This indicates that individuals with unipolar depression had higher depressive symptoms throughout the group than other members.

Table 4
Effect of Primary Diagnosis on Changes in DASS-21 and Q-LES-Q-SF Scores

Measures (pre- and post-treatment)	**Unipolar depression** [a]	**Bipolar disorders** [b]	**Anxiety disorders** [c]	***F* statistic:** diagnosis	***p***	***F* statistic: timepoint**	***p***	***F* statistic: treatment × diagnosis**	***p***
DASS-21 (pre-)	32.36 ± 13.14	27.76 ± 15.80	30.90 ± 9.31	2.24	n.s.	32.77	< .001	8.98	n.s.
DASS-21 (post-)	24.81 ± 10.21	21.43 ± 12.00	18.00 ± 7.80						
DASS-21-Depression Subscale (pre-)	28.59 ± 11.51	21.52 ± 13.56	25.78 ± 7.51	4.00	0.022	38.81	< .001	0.72	n.s.
DASS-21-Depression Subscale (post-)	21.17 ± 11.60	15.14 ± 9.52	14.90 ± 7.42						
DASS-21-Anxiety Subscale (pre-)	13.93 ± 9.18	14.67 ± 8.61	12.90 ± 8.70	0.62	n.s.	14.91	< .001	0.57	n.s.
DASS-21-Anxiety Subscale (post-)	10.91 ± 6.43	11.62 ± 8.33	7.11 ± 5.21						
DASS-21-Stress Subscale (pre-)	21.21 ± 10.45	19.33 ± 12.50	23.11 ± 6.41	0.32	n.s.	13.84	< .001	0.72	n.s.
DASS-21-Stress Subscale (post-)	17.55 ± 7.63	16.10 ± 9.40	15.78 ± 5.95						
Q-LSES-Q-SF (pre-)	34.13 ± 5.39	39.81 ± 6.85	36.57 ± 3.69	6.39	0.003	33.26	< .001	0.36	n.s.
Q-LSES-Q-SF (post-)	39.28 ± 6.46	44.69 ± 7.35	43.72 ± 4.86						

[a] For DASS-21, $n = 53$; for Q-LSES-Q-SF, $n = 36$.
[b] For DASS-21, $n = 21$; for Q-LSES-Q-SF, $n = 16$.
[c] For DASS-21, $n = 9$; for Q-LSES-Q-SF, $n = 7$.

There were no interaction effects of treatment (i.e., pre- vs. post-treatment) with primary diagnosis (e.g., bipolar disorder, unipolar depression, and anxiety disorders) on DASS-21 total score and subscale scores (depression, anxiety, and stress scales), indicating that the treatment effect was not significantly different between diagnostic groups.

Due to the normality assumption not being met for the DASS-21 depression and anxiety subscales for the ANOVA, we aimed to verify the effect of treatment and diagnosis on DASS-21 depression and anxiety subscales through an additional set of analyses, utilizing Wilcoxon Signed Rank tests to assess the effect of treatment. We also used the Kruskal-Wallis test to assess the effect of diagnosis. Both the depression and anxiety subscales showed statistically significant reductions across treatment (W_s = 122, z = -4.36, p < .001 and W_s = 192, z = -3.27, p = .001, respectively). The effect of diagnosis on the depression subscale was also found to be significant ($H(2) = 7.41$, p = .025), which corroborated results found in the mixed ANOVA described above. Therefore, we are confident in using the mixed-design ANOVA since, upon checking whether this assumption violation might have impacted results, we concluded that such findings did not differ from what was found in the ANOVA.

A main treatment (pre-/post-) effect was found for the Q-LES-Q-SF**,** $F(1, 56) = 33.26$, p < .001 with a large effect size of ηp^2 = .37. A significant between-group main effect was found for primary diagnosis on the Q-LES-Q-SF, $F(2, 56) = 6.40$, p = .003, where individuals with unipolar depression had lower scores on the Q-LES-Q-SF than individuals with bipolar disorder, which indicated that they had worse quality of life throughout their enrolment in the study. There were also no interaction effects from pre- to post-treatment and primary diagnosis on Q-LES-Q-SF scores, which indicated that the treatment was just as effective for all diagnoses with regard to quality of life.

Treatment Satisfaction

Participants' treatment satisfaction was rated as 6.38 out of 7 on average (SD = .58). Participants' perceived improvement from the treatment was rated as 4.85 out of 7 on average (SD = 1.12). Qualitative feedback was collected, coded, and organized into the following themes:

Time of Day. Most participants would have preferred that the program be offered in the afternoon.

Hopes for the Program. Several themes emerged regarding what participants hoped to gain from the program, including meeting people and being with others; making art; increased well-being through increased self-esteem, self-discovery, and improved mood; and building skills to cope (e.g., finding alternative ways to express emotions). One participant noted that they expected "to feel more content and at peace, a reduction in my depressive symptoms and low mood." Some participants had no expectations.

Helpful Parts. Several themes emerged regarding what participants found helpful about the program, including the length of the group as well as its open-ended structure, the co-facilitators, feeling connected to the group in a safe space, the topics of artmaking (e.g., comfort-related art, zentangle), available materials and tools for artmaking, finding different ways for participants to express themselves, self-discovery, and learning new coping strategies through art. As one participant put it, "Learning techniques that I can do at home, anxiety relieving art techniques, and directives that focused on positive and supportive parts of life."

Program Improvements. Several themes emerged regarding what participants thought should be improved about the program, including longer/more sessions, smaller groups, more skills covered, more facilitated interaction between group members, more discussion about emotions. As one participant stated, "I enjoyed the art I participated in, but I would add more sessions and like to learn more techniques and art projects." Some participants stated that there were no improvements needed.

Qualitative findings from the treatment satisfaction questionnaire paralleled reductions in psychiatric symptoms. As depressive symptoms were reduced over the course of treatment, participants noted that helpful topics included the therapeutic content of the directives and aspects of the program such as socializing, getting out of bed, and being creative. This reflects the behavioural activation component of art therapy. Alongside a reduction in anxiety, patients reported helpful parts of the program to include learning techniques that can be done at home, art techniques that relieved anxiety, and directives that focused on positive and supportive parts of life. In parallel to reports of stress being reduced over the course of the program, one of the participants reported that they "overcame my stress of being in a group activity. I found it not bad. A little stressful, but ended up being enjoyable." This view was representative of the larger group. Quality of life improved across the course of the program, and patients reported that participating in art therapy had helped their well-being and enabled them to have a quiet, calm space to do art for self-care.

Discussion

In this program evaluation, we examined the effect of attending a structured group art therapy program that was offered to adults who are registered with a mood disorders outpatient clinic within a public psychiatric hospital in Hamilton, Ontario, due to symptoms of depression, anxiety, and stress as well as a person's overall quality of life. We also aimed to identify whether primary diagnoses impacted the outcomes of this art therapy intervention, and we collected treatment satisfaction from participants.

The main findings from this project demonstrated a decrease in overall negative affect according to the DASS-21, including depressive symptoms, anxiety, and

stress from pre- to post-treatment in the art therapy group. Moreover, quality of life was improved from pre- to post-treatment. The qualitative feedback regarding what was helpful about this program supports these findings, and patients noted subjective symptom improvements. Patients' primary diagnosis (i.e., unipolar depression, bipolar disorder, or an anxiety disorder) did not impact the effect of treatment, which suggests that individuals with any of these primary mental health diagnoses can benefit from art therapy. Individuals with unipolar depression appeared to have significantly higher scores on the depression subscale of the DASS-21 and worse quality of life according to the Q-LES-Q-SF in comparison to those with a bipolar diagnosis throughout the group, but even so, there was no interaction of diagnostic group by time. This indicates that art therapy may have a transdiagnostic effect regarding its therapeutic benefits. We also found that participants expressed good treatment satisfaction and subjective improvements (as is in line with our quantitative findings) and provided helpful feedback for improving service delivery (e.g., longer sessions and more facilitated group interactions). We attribute the success of this art therapy program to its holistic approach through the incorporation of psychotherapeutic components that can assist patients in developing valuable skills and coping resources.

The results of this program evaluation fit within existing literature examining art therapy interventions, which demonstrates that art therapy has been shown to improve symptoms of depression (Chandraiah et al., 2012; Ponteri, 2001), anxiety, and stress (Chambala, 2008; Rowe et al., 2017) and to improve quality of life (Maujean et al., 2014). Our program evaluation demonstrates that such outcomes can be found among psychiatric populations accessing art therapy in a real-world outpatient mental health setting. Importantly, our findings suggest that a structured, group-based art therapy intervention is effective in reducing depressive and anxiety symptoms, in addition to stress, while improving the quality of life for patients involved in these groups. Our qualitative findings provide direction for ways to improve this program through the MTRC. Implementing a structured group art therapy intervention may be a cost-effective way to achieve positive therapeutic outcomes and to provide outcomes such as learning new coping skills and engaging in self-discovery, as reported by the patients.

Additionally, it is not surprising that no significant interaction of treatment effect and diagnosis was found for overall negative affect, anxiety, depression, stress, and quality of life by primary psychiatric diagnosis. The relevant literature has cited art therapy as an effective intervention in diverse populations, including individuals experiencing various mood and anxiety disorders, incarcerated individuals, patients with Alzheimer's disease, and those with stress-related disorders (e.g., Chambala, 2008; Chandraiah et al., 2012; Maujean et al., 2014; Ponteri, 2001; Rowe et al., 2017).

Limitations and Future Directions

Some limitations of this evaluation include the fact that plans for analysis were completed after the program had ended as part of a program evaluation. No *ad hoc* plans were made to examine the effect of primary psychiatric diagnosis prior to data collection; therefore, this analysis should be considered exploratory. Other limitations relate to the study design, given that this evaluation took place in a naturalistic setting without strict inclusion or exclusion criteria. Therefore, it is possible that changes from pre- to post-treatment in negative affect, depressive symptoms, anxiety, stress, and quality of life could have occurred due to a variable that is extraneous to the art therapy intervention, such as changes in medication. Since data concerning other interventions such as medication were not collected, we are unable to evaluate whether these factors were involved in the changes found. We also aimed to be systematic in collecting statistics on reasons for drop-outs/missed sessions to better address the needs of our participants (e.g., any barriers to service access). We did not conduct an a priori power analysis to estimate the required sample size for our analyses prior to data collection, and this indicates the possibility that our sample size may not have had sufficient power to detect the effects we investigated in this study.

Finally, we acknowledge that men and non-binary individuals were not well represented in our sample, and so we are limited in making conclusions regarding how well this art therapy intervention may work for males as well as for those with gender-diverse identities. A strength of our study is that primary diagnosis was obtained by clinicians in a specialized mood disorders outpatient clinic, but we were not able to extrapolate the exact year/time point of diagnosis, which we acknowledge is a corresponding limitation.

Future work should examine the mechanisms of change during the implementation of an art therapy program. Additional outcome variables of interest that could be relevant to examining this type of intervention include measures tapping into general functioning and adherence to homework completion. Future work should include individuals with additional primary diagnoses that were not included in our sample, such as substance abuse and eating disorders, to determine if art therapy may be beneficial for individuals with such diagnoses and whether treatment adherence may differ. Finally, future research/program evaluation work should examine outcomes at various follow-up time points in order to evaluate whether symptom improvement, quality of life, and use of the skills acquired are maintained after patients complete the group (e.g., 3-, 6-, and 12-month follow-ups). It should be noted that, since the COVID-19 pandemic, this art therapy program has become virtual, and therefore we aim in the near future to compare the findings presented in this article to those found through virtual programming. Such data collection is currently taking place.

In conclusion, a substantial proportion of Canadians will experience a mood and/or anxiety disorder at some point in their lives. Art therapy presents a unique

and exciting opportunity for individuals with various psychiatric difficulties to move toward recovery and provides another or an additional option to evidence-based programming such as cognitive behavioural therapy. This evaluation supports the use of art therapy as a helpful psychotherapeutic service for outpatient psychiatric populations with the following primary diagnoses: unipolar depression, bipolar disorder, and various anxiety disorders. With the added impact of the COVID-19 pandemic, investigating programs that can be delivered remotely, while maintaining engagement with their participants, has become especially pertinent. It is imperative that we continue to examine art therapy through high-quality program evaluation tasks as well as rigorous research activities in order to validate and disseminate the contribution that this form of psychotherapy has toward the mental health and well-being of psychiatric outpatients as well as various other populations with mental health concerns.

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