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Health Psychology, the Arts and Creative Approaches to Health Care

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Abstract

Health psychologists' use of the arts is an emerging area for research and practice. This article examines recent research findings and suggests strategies for incorporating the arts in health care across a wide range of clinical and community settings. Ethological theories support the evolutionary significance of the arts in human development and help form a foundation to understand the biopsychosocial processes involved in arts participation. This article builds upon this foundation and presents a wide range of arts and health interventions in the areas of health promotion and prevention, illness management, clinical assessment and improvement of the health care system.

Keywords

- *arts and health*
- *community arts*
- *health promotion*
- *health psychology*
- *public health*

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Introduction

CONSIDERING that the arts have been around for millennia, it is rather surprising that applied psychology has, for the most part, ignored the arts as part of an intervention strategy. This is particularly noticeable when one considers that nearly all psychological interventions involve altering behaviour, changing thought processes and/or transforming emotions. Similarly, the arts challenge people to think differently, engage in different behavioural experiences and experience different emotions. Ignoring the arts limits psychological practice to a mostly verbal discourse of persuading, coaching, encouraging and moderating (Wiener, 1999). For many people this verbal discourse works well; yet for others, with a variety of problems, it does not.

Using the arts in health care is not a new idea. Art (Collie, Bottoroff, & Long, 2006; McNiff, 1998), dance (Chodorow, 1991; Goodill, 2005), drama (Jennings, Cattanach, Mitchell, Chesner, & Meldrum, 1994), music (Aldridge, 1996) and poetry therapists (Mazza, 2003) have been working with clients and patients for several decades in Europe and North America (Jones, 2005; Levine & Levine, 1988; McNiff, 1981; Rogers, 1993). These approaches, while making important contributions that health psychologists can draw upon, use the arts as the central component of therapy. The arts therapies tend not to make use of community-based arts interventions nor consider non-clinical aspects of health care. Health psychologists, when using the arts, have the opportunity to develop a broader approach to health care. Often referred to as *arts and health*, this approach encompasses health promotion, disease prevention, policy development, illness management and aesthetics of the health care environment.

It seems to this writer that the majority of applied psychologists tend to adhere to conventional notions about what constitutes an appropriate intervention or treatment, thus limiting what evidence is allowed to be considered in evidence-based practice. As the title of this article implies, working with the arts in health care is not a precise and orderly process. The work can get messy as can the ontological, epistemological and methodological issues that are addressed along the way. But it can also be stimulating, motivating—often enjoyable—and is part of a wider creative process that is important to human development and health (Runco, 1996; Sternberg, 2006; Winnicott, 1971). Using the arts also calls upon one to consider what kind of transformation or translation might be involved in documenting our experience of the world in an art form, and the role psychological aesthetics plays in this documentation (Maclagan, 2001). Rather than depending solely on a linear narrative between healthcare professional and client the arts allows access to our 'imaginative life, and the aesthetic responses that are part of it' (Maclagan, 2001, p. 21). These aesthetic responses rely on an interaction between inner and outer reality and are, arguably, formed by a range of psychological constructs (e.g. cognition, emotion, the unconscious) interacting with the environment.

Arts and health

For many people the term *arts* conjures up an association to concert halls, theatres, museums and highbrow art galleries. This association can contain several elements: the arts are something that occur in a specific place, at a specified time, by those professionally trained and available for consumption by a select few. While these venues do showcase well-known artists at scheduled times who attract a particular audience, the arts are more than this. For the purpose of this article the arts are seen as offering participatory possibilities to create as well as to view. The venues are diverse and can include an intensive-care hospital bed, a community housing estate, a church basement and an elder care home among many other locations that offer formal and informal arts possibilities (Wali, Severson, & Longoni, 2002); and nearly everyone, regardless of training or qualifications and physical or intellectual abilities can potentially participate.

The emerging and interdisciplinary field of arts and health has developed in response to international interest in how the arts can contribute to health care. It has become an umbrella for those concerned with practice, research and policy initiatives and involves artists, health care professionals, community workers and researchers in the public, private and voluntary sectors (Kaye & Blee, 1997) and would seem an ideal place for health psychology to play a key role. The arts and health field takes a broad-based perspective in examining the uses of the arts in health care. It includes the work of arts therapists in clinical practice but also involves developing governmental policy, organizing community health interventions, enhancing health promotion strategies, improving the aesthetic environment of health care settings and undertaking research that examines a range of biopsychosocial factors that are impacted by arts participation. A brief list of arts and health projects include:

- artist participation in the design of health care facilities (Kirklin & Richardson, 2001);
- arts programming in hospitals (Baron, 1995; Breslow, 1997; Graham-Pole & Rockwood Lane, 1997; Staricoff & Duncan, 2003; Staricoff, Duncan, Wright, Loppert, & Scott, 2001);
- using music to improve social cohesion, self-esteem and cognitive functioning in older adults (Hays & Minichiello, 2005);[1]
- investigating the relationship between the aesthetic environment of hospitals and health outcome (Eades, 1997; Lawson & Phiri, 2003; Staricoff, 2004);
- the arts impact on clinical outcomes (Staricoff & Loppert, 2003);
- enhancing intergenerational learning and co-operation and decreasing social isolation through photography (Wang, Morrel-Samules, Hutchison, Bell, & Pestronk, 2004);
- investigating the relationship between patient recovery and perception of physical setting (Radley & Taylor, 2003);
- using photo-voice with teachers and community health workers to address HIV/AIDS issues in youth (Mitchell, DeLange, Moletsane, Stuart, & Buthelezi, 2005) and in issues related to women's health (Wang, 1999);
- impact of environmental arts projects on hospitalized adolescents (Issacs, 1994).

Making a case for involving the arts

There is a strong case to be made for psychology to pay more attention to the arts. The arts—in various forms—have been an essential part of the cultural and social evolution of human beings. Understanding the evolutionary role played by the arts in the social and emotional development of humans provides a foundation from which to gain a better appreciation of how and why the arts stimulate psychological mechanisms during an art experience, and how these different experiences might be used to enhance health.

Evolutionary utility

Although not agreed upon by all ethologists or evolutionary psychologists (Bradshaw, 2001) there is significant evidence that the arts have ethological utility (Aiken, 1998, 2001; Dissanayake, 1988, 1992, 2000). The arts have existed in various forms using different materials for perhaps 800,000 years but certainly for the last 200,000 years during the time of *homo erectus* (Bahn, 1998) and well before modern *homo sapiens* appeared. In every prehistoric, ancient and contemporary culture there is evidence of what we have come to call 'the arts' (Bahn, 1998; Dissanayake, 1992; Marshack, 1991). The evolutionary utility of the arts has, however, differed throughout history. Using Dissanayake's (1988, 1992) hypothesis that suggests the arts came about to make the ordinary special, it is possible to trace the development of the arts as an important component of human evolution. The need to make the ordinary special can be seen developmentally across time and cultures through synchronizing movements into dance, combining sounds in such a way as to create music and song, putting words together to create poetic meaning and stories, making marks on trees, cave walls and tools to create visually pleasing images and integrating sound, movement, words and visual images into rituals and ceremonies (Laderman & Roseman, 1996). Dissanayake's theory of making the ordinary special provides a conceptual foundation of the evolutionary mechanisms and processes involved in art making and observing, which can in turn assist in the understanding of how the arts can contribute to physical and mental health.

If the arts are seen ethologically as complex patterns of behaviours that involve participating, creating, observing and responding, the evolutionary function of this set of visual, kinaesthetic and auditory behaviours needs to be psychologically considered in relation to the importance of the arts for health and well-being. According to Dissanayake (1988) the arts have continued to exist because they are an aspect of culture that allows humans to create feelings of mutuality between each other and facilitate the need for belonging, finding and making meaning, as well as gaining physical competence, all of which are evolutionarily important. This evolutionarily important set of behaviours supports a biobehavioural basis for the arts as health enhancing, and offers health psychologists a range of intervention opportunities that include improving social networking (Greaves, 2006), enhancing positive affect (Pressman & Cohen, 2005), increasing life expectancy (Bygren, Konlaan, & Johansson, 1996), developing self-esteem and self-reliance (Matarasso, 1997), exploring the interrelationship between creativity and health (Runco & Richards, 1997), lessening social inequality and increasing access to health care (Blears, 2003), aesthetically altering the health care environment (Froggett, 2004; Lawson & Phiri, 2003; Staricoff, 2004) and contributing to treatment regimens to improve health outcomes for medical conditions (Camic, 1999a; Chapman, Morabito,

Ladakakos, Schrier, & Knudson, 2001; Long, 2003; Schorr, 1993; Serlin, 2000; Zimmerman, Nieveen, Barnason, & Schmader, 1996).

Although it is impossible to establish exactly what emotional responses humans living thousands of years ago encountered as they created art work, it is likely that art-making served at least two purposes: the need to understand the unknown and the elaboration of the ordinary and usual into something special. Emotions are involved in both of these purposes. The tension and anxiety associated with the unknown may have been reduced through movement and sound making, which in time became ritualized by virtue of the strong emotional responses that these activities triggered for participants. Likewise, the ordinary things of day to day life such as tools and living spaces invited visual elaboration with markings, design and colour, which enhanced their emotional-aesthetic appeal through evoking ethological releasers (Coss, 1968). Using the arts to reduce tension, increase mastery and familiarity and develop aesthetic solutions in response to the uncertainties of medical illness are all areas in which health psychology and the arts can partner.

Psychological mechanisms

As health psychology seeks effectively to work in partnership with the arts explanatory models need to be identified in order to advance further theoretical and empirical explanations about the role of psychological factors in arts-based interventions. Doing so will help contribute to an operationalized definition of the mechanisms and processes involved in the arts; three such mechanisms, motivation, cognition and affect, are briefly addressed here. A fourth, that of the unconscious, has been well documented elsewhere (e.g. Ehrenzweig, 1967; Schneider Adams, 1993).

The model of homeostatic motivation (Kreitler & Kreitler, 1972) is one such mechanism. It proposes that observing art initially creates tension and then offers relief from that tension before bringing about a restoration of emotional balance. In describing this as a motivational model the authors contend that 'the art experience is motivated by tensions which exist prior to its onset, but (is further) triggered through the productions of new tensions by the work of art' (Kreitler & Kreitler, 1972, p. 16). The initial tensions are:

> a major motivation for art … which exist in the spectator of art prior to his exposure to the work of art. The work of art mediates the relief of these pre-existing (diffuse) tensions by generating new tensions which are specific (to the art work). (1972, p. 19)

This model proposes that moderate rises in tension, which occur in art observing behaviour, are regarded as pleasant and that very high or very low levels of stimulation are unpleasant. Thus, according to this model, depending on an individual's prior experience, cultural background and knowledge of art, certain art experiences will be under- or over-stimulating and not likely to be found pleasant or desirable while others will provide the 'right amount' of challenge, engagement and interest.

The process of creating tension and then offering relief from it when viewing art, also occurs and is likely intensified when making art; the tension and relief caused by participating in arts experiences as an observer or creator can also be employed therapeutically (Camic, 1999a). For example, in clinical work, as a person creates a visual piece, participates in movement, uses performance or produces sounds through voice and music, new tensions are triggered by the art-making experience. These new tensions caused by art making paradoxically help to diminish the initial tension and contribute to aspects of illness management. In therapeutic activity that uses the arts, attending to the optimal level of activation (Fiske & Maddi, 1961) and stimulation (Schultz, 1965) are key tasks of the health professional and help create an environment in which the most productive work occurs. In planning clinical or community interventions the type of art media, as well as its motivating qualities, are essential to consider; consulting with artists about different art media beforehand can increase the likelihood of its acceptance and enhance its effectiveness as an intervention (Wilson, 2001).

In addition to the homeostatic model, which addresses basic motivational principles, the theory of cognitive orientation brings an additional cognitive dimension to our understanding about the possible role of the arts within health psychology. Briefly, this theory stipulates that 'the major motive underlying the tendency toward voluntary exposure to dissonant views and information in art and elsewhere is the motive to expand, elaborate, and deepen cognitive orientation … novelty, variety, and optimal complexity stimulate orientative tendencies' (Kreitler & Kreitler, 1972, p. 331). For a stimulus to become a cue (e.g. a song evoking past memories) it must be subjected to a series of (cognitive) processes

designed to determine its meaning and how this meaning relates to other concomitant internal and external stimuli. Every stimulus of significant magnitude to be noticed not only disrupts homeostasis but also evokes an orientating response—this is the physiological manifestation of the question: What is it? (Kreitler & Kreitler, 1972, p. 23). The theory of cognitive orientation assumes that 'behaviour is directed by what a person knows and believes, by judgements and evaluations, by views about himself, others and the world' (1972, p. 23).

In a programme at the Museum of Modern Art in New York people with mid-stage Alzheimer's disease were taken to the museum to view modern representational visual art. The art did not produce the emotional distress and cognitive chaos one might anticipate from such an experience. Quite the opposite occurred—these individuals responded with increased cognitive clarity and positive affect (Kennedy, 2005). Initially, but briefly, the art caused an increase in tension. The new tension appears to have been resolved through cognitive and affective engagement with the art. It appears that the tension created by the art was reduced, in part, by a cognitive process that triggered an orientating response, something quite unexpected given their diagnosis and previously observed behaviour in care homes.

A third psychological mechanism involved in observing and making art is affect. When observing art, whether it be a painting, musical composition, dramatic production or literary work, the author of the work is not necessarily communicating his/her own feelings nor does the viewer, responding with tension and release, necessarily know the author's own emotions (Rose, 1996). Rather than art being perceived as holding a truth to be interpreted, something akin to the Rorschach Inkblot Technique, art can be used to invite an interaction to occur between the created object and an individual's own conscious and unconscious patterns of responding. This active and socially constructed interaction has an affective element, what Rose refers to as 'emotional resonances, which draw on embedded reactions to shapes of stimulation; affective signalling; and the interplay of imagination and knowledge' (1996, p. 83). All art experiences, whether as a creator or viewer, possess these affective elements and as seen from the previous example using modern art in the care of people with Alzheimer's disease, can help trigger cognitive cues and increase orientation.

Any art form 'can potentially produce emotional responses that are compelling, insidious and expressive because they elude the usual verbal explanations and set up resonances among … nonverbal sensory/affective representations' (Dissanayake, 1992, p. 157). The emotional impact of art on the general public, such as Picasso's painting *Guernica*, has been well documented. What is less known, however, is the positive emotional impact art may have on people with medical and neurological problems. It is in working with these populations that the affective intensity triggered by the arts can be therapeutically engaged. Problems such as these are ideal for multidisciplinary collaborations between health psychologists, physicians, artists and health educators.

Opportunities for health psychology

Promotion and maintenance of health

Within the area of health promotion there are two pressing health-related problems facing industrialized countries that the arts might play a role. The first is a growing sense of alienation within the workplace and in community life. As the focus of society has drifted from the community to the family as the primary unit of concern, there are fewer experiences of community social support. The second problem is a marked decrease in daily physical activity, which has led to an increase in a range of medical problems. As a growing percentage of the population in many western societies become obese there is a noticeable increase in adolescent and young adult health problems. Physically active children, while not a rarity, are less likely to be engaged in sustained calorie burning activities. As the Internet, video games, television and automobile transport come to dominate the lives of children there are fewer opportunities to take daily walks, develop muscle tone, increase physical endurance, acquire new physical skills and enjoy the engagement of playing with others. Likewise, adults in many industrially developed countries also engage in fewer physical activities while at the same time consuming foods high in fat; this has led to an increase in cardiovascular disease, cancer and diabetes.

Public health officials in most countries are in competition with large corporations to capture the attention of increasingly sedentary and individualistic

western societies. There is far less profit to be made in promoting healthy behaviours than in marketing foods high in saturated fats while sitting and watching a wide-screen television. Antismoking campaigns, however, have been relatively successful in reducing tobacco use in North America and more recently in the European Union. What are needed are new approaches to increase physical and community-based activities in developed countries. It is in such an endeavour that the arts can play a role.

Between 2001 and 2003 the Office of National Statistics interviewed 12,262 people across England to explore their engagement with the arts (Fenn et al., 2004). This survey was the largest reported investigation of its kind to look at arts participation in any national sample. Of particular relevance for our discussion is the self-reported general health and engagement in the arts data. Over three-quarters of all respondents reported that their health was good or very good while only 5 per cent reported that it was bad or very bad. Of those respondents who reported good or very good health status, 85 per cent engaged in art activities over the past 12 months. Allowing for age and other personal characteristics, better health was more likely to be reported by those who:

- attended performing arts *and* attended non-performing arts and cultural events;
- participated in dance;
- accessed art forms through CDs, tapes or records, through the radio, television, videos or DVDs.

There were no differences in self-reported general health by participation in creative or sociable activities, or by access to arts through the Internet. For those who reported longstanding illnesses, however, there was a positive association between self-reported general health and engagement in creative and sociable arts activities (Windsor, 2005).

These survey results point towards interesting possibilities in regards to involving the arts in health promotion and maintenance. They suggest that health psychologists working in health promotion and education need to familiarize themselves with the range of cultural expressions in a given community or nation (Minkler, 1990) and to build on already popular arts activities to strengthen interest in health-oriented actions; simply stated, the arts can act as a catalyst to make health education (and promotion) memorable and enjoyable (McDonald, Antunez, & Gottemoeller, 1999, p. 273) and more likely to engage a target population. For example, in 2002 the California Adolescent Nutrition and Fitness Program launched Promoting Health Activities Together (PHAT, 2002), a programme that uses aspects of hip-hop culture to help build health awareness among 10–14-year-old African-American youth. Utilizing dance, music and emceeing in after-school programmes and community centres, a study involving 80 youth demonstrated at one-year follow-up that 67 per cent were still engaged in health-enhancing behaviours and retained skills and knowledge of nutrition and physical activity learned in the programme. PHAT has built on this success and now also offers culture-specific programmes to American Indian, Latino and Asian youth in the San Francisco Bay area as well as consultation services to other communities wanting to use hip-hop culture to improve the health of young people.

Art-infused health promotion and illness prevention programmes using the assessment tool of intervention mapping (Kick, Schaalma, Ruiter, & van Empelen, 2004) can help better integrate health psychology theory with targeted interventions to increase awareness, shape a community's consciousness and impact on health and well-being (Health Development Agency, 2000). For example, a song that encourages condom use in an amusing and friendly way, *Ponte El Sombrero* (*Put on Your Hat*), is heard on radio stations in Spanish-speaking communities in the Americas (McDonald et al., 1999). The song's title and lyrics become a humorous metaphor for safe sex. Likewise, witty adverts on London Public Transport have shown colourful dancing condoms as an encouragement to safely enjoy sex, and in the mid-1980s near the entrance to the Eisenhower expressway in Chicago, a 20-foot-tall quartet of blinking neon flaccid-to-erect penises stood greeting drivers on their way to the western suburbs. For several years these blinking penises, sponsored by a group of artists and a neighbourhood health coalition, encouraged, in a colourful and playful way, responsible and enjoyable sexual behaviour.

Prevention and management of illness

Although health psychologists can draw upon work in the management of illness from within the arts therapy professions of music, poetry, drama, dance and art (Camic, 1999a; Long, 2003; Serlin, 2000), much of this research can appear somewhat unfamiliar to the language, style and structure typical of psychology. Another problem for some psychologists is the lack of familiarity, knowledge, or skill in the

requisite art media. These issues are not insurmountable and can be addressed through elective coursework in doctoral training programmes (Camic, 1999b, 2000, 2001, 2007; Gaugh, 2001; Wilson, 2001) and in continuing professional development after qualifications and licensing have been obtained.

Strategies to help the prevention of illness occur on multiple levels and often involve large-scale government campaigns aimed at changing certain problematic behaviours such as tobacco use, illicit drug use, unhealthy eating patterns and low exercise levels; other public health interventions strive to increase life-enhancing behaviours such as breast and testicular self-examination, use of condoms to control sexually transmitted disease and, more recently, appropriate seat belt use for child passengers. Prevention also occurs on an individual level within patient–physician and patient–health psychologist relationships. In these relationships the health care professional may offer advice, warnings and alternative behavioural strategies to increase a health-enhancing lifestyle. Involvement in the arts within North America or Europe has rarely been considered as part of large-scale public health intervention projects, and it is equally rare to see the arts being recommended or prescribed by health care professionals,[2] yet the possibilities for such interventions seem nearly endless.

In 2004 Arts Council England commissioned a landmark study (Staricoff, 2004), which included a review of 385 references from the medical literature related to the effect of the arts in health care. This publication effectively launched Arts Council England's first national arts and health care strategy (Arts Council England, 2005). The report offers important evidence of the influence of the arts in achieving effective approaches to patient management and to the education and training of health practitioners. It also identifies the relative contributions that different art media could have in creating therapeutic health care environments. The report concludes by highlighting the importance of the arts in health care in the following areas, all of which hold relevance to health psychology (Staricoff, 2004, p. 47):

- inducing positive physiological and psychological changes in clinical outcomes;
- reducing drug consumption;
- shortening length of stay in hospital;
- increasing job satisfaction of health care workers;
- promoting better doctor–patient relationships;
- improving mental health care;
- developing health practitioners' empathy across gender and cultural diversity.

In the world's largest reported survey of arts projects and their role of helping people manage mental health problems, a recent report issued jointly by the United Kingdom's Department of Culture, Media and Sport and Department of Health (DCMS & DoH, 2005) sought to determine the extent of the relationship between participatory arts and people with mental health problems. Phase one of the project was an exploratory study to determine the range of activities and types of evaluation practices currently being used across England. The aim of phase two, which is currently in process, is to develop benchmark indices and measures to assess future community-based programmes that use participatory arts activities with people who have mental health problems. The significance of this project for health psychology is great indeed as it helps form the groundwork of an interdisciplinary public health approach that utilizes community arts services for mental health problems, which, with some modification, will likely be applicable to populations served by health psychologists. Community-based partnerships between health psychologists and artists can be considered within the broader remit of public health and have the potential of impacting large numbers of people across different ethnic groups, gender, sexual orientation and socioeconomic status; partnerships also have the potential of being able to develop innovative interventions by integrating the arts in ways that increase motivation, encourage social inclusion, provide job-based skills and make the work enjoyable, stimulating and even, entertaining.[3]

Identification of psychological factors contributing to physical illness

As a specialty area health psychology has never endorsed the perspective, once common in clinical psychology and psychiatry, that some physical illnesses are the sole manifestation of psychosomatic processes. Health psychology assessment takes into consideration a wide range of factors, which are included within the overarching biopsychosocial approach to health and illness.

The arts have the potential to contribute to health psychology in several areas: as a means of informal communication that could enhance clinical assessment, increase emotional capacity, expand effectiveness of social networking interventions and promote creative activity. A few examples follow of how the

arts might be used in assessment by clinical health psychologists:

- Drawing can be used as an information-gathering tool to complement the initial assessment interview (Burkitt, 2004). Asking the client to draw what their illness or injury looks like can further discussion and information gathering.
- Drawing as a tool to assist memory. This can help an adult client recall a particular event or life period through drawing a floor plan of a significant location in her/his past (Jacobson, 1995).
- Assemblage (Elderfield, 1992), collage (Brommer, 1994) and photo collage (Landgarten, 1993) are art forms that are readily accessible in an office or hospital setting and can be used in multicultural environments. These visual art forms share ease of accessibility, are generally seen to be non-threatening by clients and can be used in a range of settings.
- The short story is a well-known medium to most children and adults. Beginning with 'Once upon a time …' A client is asked to write or dictate a one to two paragraph story with a beginning, middle and end about an issue in their life. This tool is valuable to help develop a creative narrative that can add a playful, yet useful, element to the assessment process (Vygotsky, 1942/1971, pp. 89–117).
- Through the use of movement a client is invited to expand on any feeling or image she/he has at the time of assessment (Rogers, 1993). Although this may not be appropriate for all clients, it can provide the clinician with important information about how a client feels about and perceives her/his body.

Improvement of the health care system

In the early 1960s, American president John F. Kennedy (1963) spoke of the richness of the arts and the diversity of experience they can provide: 'For art establishes the basic human truths which must serve as the touchstones of our judgement. The artist becomes the last champion of the individual mind and sensibility against an intrusive society and an offensive state.' Although Kennedy was referring to the importance of artists and the arts as key elements in a democratic society this quotation is also relevant to our discussion about how the arts might improve the health care system. The World Health Organization's (WHO, 1992) definition of health as complete physical, mental and emotional well-being acknowledges that there is more to health than the absence of physical illness. For the WHO, health also has to do with innovation, adaptation and acceptance. While access to good medical care is vitally important, being healthy is not solely about having access to care. We will all face challenging times in our lives, through being sick, hurting from pain and grieving over losses that cannot be healed by medicine or surgery. Health is not an absence of these experiences, yet the health care systems of many countries support an unspoken belief that to be healthy is to be without illness, disease or pain. Health psychologists are ideally positioned between psychology and medicine to help bring about a change in perspective that could enhance our thinking about health and health care.

A recent editorial in the *British Medical Journal* called for diverting 0.5 per cent of the entire health care budget to the arts as a way to improve further the health of the country. The editorial calls for re-evaluating how industrialized societies respond to many of 'life's processes and difficulties such as birth, death, sexuality, ageing, unhappiness, tiredness, loneliness, perceived imperfections in our bodies (and to consider that) the arts may be more potent than anything medicine has to offer' (Smith, 2002, p. 1432) in helping people adapt and accept changes in health. Perhaps more in the United States than in other countries these common life challenges have become medicalized and, by extension, pathologized by the prevailing diagnostic classification (American Psychiatric Association, 1994). The structure of diagnosis, treatment and payment for health care in this type of system clearly leaves little room for innovative practices that focus on adaptation and acceptance as part of what it means to be healthy. In keeping many of life's processes and difficulties within the realm of medical practice, and thus often detached from the social and cultural fundamentals of a society, we are discouraged from drawing upon basic human activities, such as those offered by the arts, in times of distress.

An alternative approach is the development of community-based health care initiatives that involve the arts as part of public health interventions anchored in a cultural milieu (White, 2006) where a sense of personal and social identity, human worth, communication, participation in the making of political decisions, celebration and responsibility are key factors (Wilson, 1975). Rather than remaining focused on an illness model of health care where patients seek out physicians and mental health professions, the arts can help people engage in creative production, develop new skills, regenerate local traditions and encourage health-themed

events where people can support each other and foster better lifestyle choices (White, 2006, p. 132). Health psychologists can help develop, co-ordinate and assess community-based projects as they work closely with artists and community residents to develop a shared vision of community engagement and health. Research has shown that it is not the arts alone that provide health gain; rather it is how the project is delivered, the environment around the project and the conversations that took place during the planning and implementation stages that predict success (Everitt & Hamilton, 2003).

Conclusion

Health psychologists in North America and Europe have taken a lead role in clinical research to help improve the health care system. This has included developing new treatment approaches for people with a wide range of medical disorders and illnesses (Knight & Camic, 2004). In addition to direct patient care and research, health psychologists are involved in consultation, health promotion and disease prevention, developing health policy and teaching. Over the past decade health psychologists have cautiously begun looking at how the arts might be used in a variety of ways to heal emotional injuries, increase understanding of self and others, develop a capacity for self-reflection, reduce symptoms, change behaviour, alter thinking patterns, inhibit maladaptive responses and encourage adaptive ones. Recent developments in evolutionary theory lend support for the ethological utility of art making as a series of behaviours with emotional and cognitive benefits for the maker and observer of the art. Although the function of art making may have changed over millennia from ceremonial ritual to present-day professional art production, art making remains something that is accessible to all, regardless of training or skill.

The goals of health psychology can be enhanced through the arts. Through partnerships with artists, physicians and health educators psychologists can develop pioneering research projects and new clinical protocols to understand better the psychological, physiological, neurological, biological and aesthetic components of how the arts can improve health care (Guillochon, 2006). Developing where possible, graduate school classes and postdoctoral curricula that incorporate the arts in health psychology training is an important step towards the achievement of this goal. Another step is to move beyond only using verbal-based therapies and consider kinesthetic, visual and auditory elements as important sources of information for assessment and therapy. Likewise, in public health arenas health psychologists can forge new relationships with artists and community groups to address a range of issues of local concern. For this author working with the arts in health care has been a bit like playing in the mud; it is messy at times, the outcome is not certain and one feels personally challenged in different ways, but it can be greatly enjoyable, and for many clients and community members the experience adds innumerable (evidenced-based) benefits.

Notes

1. Additional examples of ongoing multidisciplinary research projects examining the psychophysiological effects of choral music on the elderly are being carried out by the Sidney DeHaan Research Centre for Arts and Health, Canterbury Christ Church University (UK), which can be found at http://www.canterbury.ac.uk/centres/sidney-de-haan-research/index.asp
2. An exception to this is the Bromley-by-Bow Health Centre project in east London where physicians prescribe art and horticultural activities to their patients. A research report can be found at http://www.uclan.ac.uk/facs/health/socialwork/bromleybybow/index.htm. The web site for the health centre is: http://www.bbbc.org.uk/html/homepage.htm
3. One such project is the Express Yourself Gallery located in Hailsham, East Sussex (UK). The gallery was developed as a partnership between the local community trust, the county's vocational and mental health services, local artists and service users. The gallery provides opportunities for service users that include a place to make and to sell visual art and to learn different skills associated with gallery management. Additional information can be found at http://www.expressyourself-gallery-uk.com

References

Aiken, N. (1998). *The biological origins of art.* Westport, CT & London: Praeger.

Aiken, N. E. (2001). An evolutionary perspective on the nature of art. *Bulletin of Psychology and the Arts*, *2,* 3–7.

Aldridge, D. (1996). *Music therapy research: From out of the silence*. London & Philadelphia, PA: Jessica Kingsley.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders—IV*. Washington, DC: APA.

Arts Council England. (2005). *National arts and health strategy*. Available at http://www.artscouncil.org.uk/aboutus/project_detail.php?rid=10&id=268 (accessed 4 December 2006).

Bahn, P. G. (1998). *Cambridge illustrated history of prehistoric art*. Cambridge: Cambridge University Press.

Baron, J. (1995). Art in hospitals. *Journal of the Royal College of Physicians of London*, *29*, 131–143.

Blears, H. (2003). *Capital investment in the arts, regeneration and health*. London: Department of Health. http://www.dh.gov.uk/NewsHome/Speeches/SpeechesList/SpeechesArticle/fs/en?CONTENT_ID=4031624&chk=MkC5rT (accessed 23 November 2006).

Bradshaw, J. L. (2001). Arts brevis, vita longa: The possible evolutionary antecedents of art and aesthetics. *Bulletin of Psychology and the Arts*, *2,* 7–11.

Breslow, D. M. (1997). Creative arts opportunities for hospitals: The UCLA experiment. In C. Kaye & T. Blee (Eds.), *The arts in health care: A palatte of possibilities* (pp. 125–135). London & Philadelphia, PA: Jessica Kingsley.

Brommer, G. (1994). *Collage techniques*. New York: Watson-Guptill.

Burkitt, E. (2004). Drawing conclusions from children's art. *The Psychologist*, *17,* 566–568.

Bygren, L. O., Konlaan, B. B., & Johansson, S. E. (1996). Attendance at cultural events, reading books or periodicals, and making music or singing in a choir as determinants for survival: Swedish interview survey of living conditions. *British Medical Journal*, *313*, 1577–1580.

Camic, P. M. (1999a). Expanding treatment possibilities for chronic pain through expressive arts therapies. In C. Malchioti (Ed.), *Medical art therapy with adults* (pp. 43–62). London: Jessica Kingsley.

Camic, P. M. (1999b). Arts-based academic and clinical training in the curriculum of professional psychology. Paper presented at the American Psychological Association annual convention, Boston, MA, August.

Camic, P. M. (2000). Incorporating the arts into graduate training programs in clinical psychology and medicine. In *Liberal arts and the education of artists: Conference proceedings* (pp. 29–35). New York: School of the Visual Arts Press.

Camic, P. M. (2001). Creating images, sound, movement, enactment, word: The arts in clinical training. *Bulletin of Psychology and the Arts*, *2*, 59–65.

Camic, P. M. (2007). More than words: Making use of the arts in clinical and counseling psychology training. In I. A. Serlin (Ed.), *Whole person psychology: Creative and expressive arts therapies* (pp. 259–282). Westport, CT: Praeger.

Chapman, L. M., Morabito, D., Ladakakos, C., Schrier, H., & Knudson, M. (2001). The effectiveness of art therapy interventions in reducing PTSD symptoms in pediatric trauma patients. *Art Therapy*, *18*, 101–104.

Chodorow, J. (1991). *Dance therapy and depth psychology*. London: Routledge.

Collie, K., Bottoroff, J. L., & Long, B. C. (2006). A narrative view of art therapy and art making by women with breast cancer. *Journal of Health Psychology*, *11*, 761–775.

Coss, R. G. (1968). The ethological command in art. *Leonardo*, *1*, 273–287.

DCMS, & DoH. (2005). *Mental health, social inclusion and the arts: Developing an evidence base: Final report from phase I: The state of the art in England*. Available at http://www.socialinclusion.org.uk/publications/Phase%201%20report.pdf (accessed 5 December 2006).

Dissanayake, E. (1988). *What is art for?* Seattle, WA: University of Washington Press.

Dissanayake, E. (1992). *Homoaestheticus: Where art comes from and why*. New York: The Free Press.

Dissanayake, E. (2000). *Art and intimacy: How the arts begin*. Seattle, WA: University of Washington Press.

Eades, G. (1997). Healing arts: Isle of Wight-arts for the hospital and community. In C. Kaye & T. Blee (Eds.), *The arts in health care: A palette of possibilities* (pp. 105–109). London & Philadelphia, PA: Jessica Kingsley.

Ehrenzweig, A. (1967). *The hidden order of art: A study in the psychology of artistic imagination*. Berkeley, CA: University of California Press.

Elderfield, J. (Ed.). (1992). *Essays on assemblage*. New York: Abrams.

Everitt, A., & Hamilton, R. (2003). *Arts, health and community*. Durham, UK: Centre for Arts and Humanities in Health and Medicine.

Fenn, C., Bridgwood, A., Dust, K., Hutton, L., Jobson, M., & Skinner, M. (2004). *Arts in England: Attendance, participation and attitudes in 2003*. London: Arts Council England.

Fiske, D. W., & Maddi, S. R. (1961). A conceptual framework. In D. W. Fiske & S. R. Maddi (Eds.), *Functions of varied experience* (pp. 11–56). Homewood, IL: Dorsey.

Froggett, L. (2004). Boundary management, learning and the organisational aesthetic: A case study from a community development setting. Paper presented at the European Society for Research into the Education of Adults, University of Roskilde, Denmark, 4–7 March.

Gaugh, L. (2001). What will we do today? A clinical psychology graduate student's experience of the creative arts in therapy. *Bulletin of Psychology and the Arts*, *2*, 67–69.

Goodill, S. (2005). *An introduction to medical dance movement therapy*. London & Philadelphia, PA: Jessica Kingsley.

Graham-Pole, J., & Rockwood Lane, M. T. (1997). Building arts in medicine. In C. Kaye & T. Blee (Eds.), *The arts in health care: A palette of possibilities* (pp. 136–147). London & Philadelphia, PA: Jessica Kingsley.

Greaves, C. J. (2006). Effects of creative and social activity on the health and wellbeing of socially isolated older people: Outcomes from a multi-method observational study. *Journal of the Royal Society for the Promotion of Health*, *126*, 134–142.

Guillochon, R. (2006). What's so special about Sam Everington's Bromley-by-Bow health centre? *British Medical Journal Careers*, 9 December, 218–219.

Hays, T., & Minchiello, V. (2005). The meaning of music in the lives of older people: A qualitative study. *Psychology of Music*, *33*, 437–451.

Health Development Agency. (2000). *Art for health: A review of good practice in community-based projects and initiatives which impact on health and well-being.* Available at http://www.nice.org.uk/page.aspx?o=502343 (accessed 1 December 2006).

Issacs, D. (1994). Art injection: Youth arts in hospital. *British Medical Journal*, *309*, 1170.

Jacobson, K. (1995). Drawing households and other living spaces in the process of assessment and psychotherapy. *Clinical Social Work Journal*, *23*, 305–325.

Jennings, S., Cattanach, A., Mitchell, S., Chesner, A., & Meldrum, B. (1994). *The handbook of dramatherapy*. London & New York: Routledge.

Jones, P. (2005). *The arts therapies: A revolution in healthcare.* Hove, E. Sussex & New York: Brunner-Routledge.

Kaye, C., & Blee, T. (Eds.). (1997). *The arts in health care: A palette of possibilities*. London & Philadelphia, PA: Jessica Kingsley.

Kennedy, J. F. (1963). Speech given at Amherst College, Amherst, Massachusetts in honour of the poet Robert Frost, 26 October. Available at http://www.arts.gov/about/Kennedy.html (accessed 12 June 2007).

Kennedy, R. (2005). The Pablo Picasso Alzheimer's therapy. *New York Times*, 30 October. Available at http://www.nytimes.com/2005/10/30/arts/design/30kenn.html?pagewanted=2&ei=5088&en=64357afcaecded1c&ex=1288328400&partner=rssnyt&emc=rss (accessed 1 April 2007).

Kick, G., Schaalma, H., Ruiter, R. A. C., & van Empelen, P. (2004). Intervention mapping: Protocol for applying health psychology theory to prevention programmes. *Journal of Health Psychology*, *9*, 85–98.

Kirklin, D., & Richardson, R. (2001). *The healing environment without and within*. London: Royal College of Physicians.

Knight, S. J., & Camic, P. M. (2004). Health psychology and medicine: The art and science of healing. In P. M. Camic & S. J. Knight (Eds.), *Clinical handbook of health psychology: A practical guide to effective interventions* (2nd edn, pp. 3–10). Seattle, Toronto, & Gottingen: Hogrefe & Huber.

Kreitler, H., & Kreitler, S. (1972). *Psychology of the arts*. Durham, NC: Duke University Press.

Laderman, C., & Roseman, M. (1996). Introduction. In *The performance of healing* (pp. 1–16). New York & London: Routlege.

Landgarten, H. B. (1993). *Magazine photo collage: A multicultural assessment and treatment tool*. New York: Brunner/Mazel.

Lawson, B., & Phiri, M. (2003). *The architectural environment and its effects on patient health outcomes*. London: TSO for National Health Service Estates.

Levine, S. K., & Levine, E. G. (1988). *Foundations of expressive arts therapy: Theoretical and clinical perspectives*. London & Philadelphia, PA: Jessica Kingsley.

Long, J. (2003). Medical art therapy: Using imagery and visual expression in healing. In P. M. Camic & S. J. Knight (Eds.), *Clinical handbook of health psychology: A practical guide to effective interventions* (2nd edn, pp. 315–341). Seattle, Toronto, & Gottingen: Hogrefe & Huber.

Maclagan, D. (2001). *Psychological aesthetics: Painting, feeling, and making sense*. London & Philadelphia, PA: Jessica Kinsley.

Marshack, A. (1991). *The roots of civilization: The cognitive beginnings of man's first art, symbol and notation* (2nd edn). New York: Moyer Bell.

Matarasso, F. (1997). *Use or ornament? The social implications of participating in the arts*. Stroud: Comedia Publications.

Mazza, N. (2003). *Poetry therapy: Theory and practice*. London & New York: Routledge.

McDonald, M., Antunez, G., & Gottemoeller, M. (1999). Using the arts and literature in health education. *International Quarterly of Community Health Education*, *18*, 269–282.

McNiff, S. (1981). *The arts and psychotherapy*. Springfield, IL: Charles C. Thomas.

McNiff, S. (1998). *Art-based research*. London & Philadelphia, PA: Jessica Kingsley.

Minkler, M. (1990). Improving health through community organisation. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), *Health behaviour and health education* (pp. 257–287). San Francisco, CA: Jossey-Bass.

Mitchell, C., DeLange, N., Moletsane, R., Stuart, J., & Buthelezi, T. (2005). Giving a face to HIV and AIDS: On the uses of photo-voice by teachers and community health care workers working with youth in rural South Africa. *Qualitative Research in Psychology*, *2*, 257–270.

PHAT. (2002). *Promoting health activities together*. Available at http://www.canfit.org/phat/about.html (accessed 12 December 2006).

Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin*, *131*, 925–971.

Radley, A., & Taylor, D. (2003). Images of a photo-elicitation study on the hospital ward. *Qualitative Health Research*, *13*, 77–99.

Rogers, N. (1993). *The creative connection: Expressive arts as healing*. Palo Alto, CA: Science & Behavior Books.

Rose, G. J. (1996). *Necessary illusion: Art as witness*. Madison, CT: International Universities Press.

Runco, M. A. (Ed.). (1996). *The creativity research handbook, volume 1*. Cresskill, NJ: Hampton Press.

Runco, M. A., & Richards, R. (Eds.). (1997). *Eminent creativity, everyday creativity, and health*. Greenwich, CT: Ablex.

Schneider Adams, L. (1993). *Art and psychoanalysis*. Boulder, CO: Westview Press.

Schorr, J. A. (1993). Music and pattern change in chronic pain. *Advances in Nursing Science*, *15*, 27–36.

Schultz, D. P. (1965). *Sensory restriction: Effects on behavior*. New York: Academic Press.

Serlin, I. (2000). Supportive/expressive psychotherapy groups for women with breast cancer: Incorporating imagery and movement as arts medicine. *California Psychologist*, *5–6*, 26.

Smith, R. (2002). Spend (slightly) less on health and more on the arts. *British Medical Journal*, *325*, 1432–1433.

Staricoff, R. (2004). *Arts in health: A review of the medical literature*. London: Arts Council England.

Staricoff, R., & Duncan, J. (2003). *A study of the effects of visual and performing arts in healthcare.* Available at http://www.chelwest.nhs.uk (accessed 11 April 2007).

Staricoff, R., Duncan, J., Wright, M., Loppert, S., & Scott, J. (2001). A study of the effects of visual and performing arts in healthcare. *Hospital Development*, *32*, 25–28.

Staricoff, R., & Loppert, S. (2003). Integrating the arts into health care: Can we affect clinical outcomes? In D. Kirklin & R. Richardson (Eds.), *The healing environment without and within*. London: Royal College of Physicians.

Sternberg, R. J. (2006). Creating a vision of creativity: The first 25 years. *Psychology of Aesthetics, Creativity and the Arts*, *1*, 2–12.

Vygotsky, L. (1942/1971). *The psychology of art*. Cambridge, MA & London: MIT Press.

Wali, A., Severson, R., & Longoni, M. (2002). *Informal arts: Finding cohesion, capacity and other cultural benefits in unexpected places*. Chicago, IL: Center for Arts Policy. Available at http://artspolicy.colum.edu/publications.html (last accessed 14 April 2007).

Wang, C. C. (1999). Photovoice: A participatory action research strategy applied to women's health. *Journal of Women's Health*, *8*, 185–192.

Wang, C. C., Morrel-Samules, S., Hutchison, P., Bell, L., & Pestronk, R. M. (2004). Flint photovoice: Community building among youth, adults, and policy makers. *American Journal of Public Health*, *94*, 911–913.

White, M. (2006). Establishing common ground in community-based arts in health. *Journal of the Royal Society for the Promotion of Health*, *126*, 128–133.

Wiener, D. J. (Ed.). (1999). *Beyond talk therapy: Using movement and expressive techniques in clinical practice*. Washington, DC: American Psychological Association.

Wilson, L. E. (2001). Erasing the gridlines: An interdisciplinary studio course for therapists who use art. *Bulletin of Psychology and the Arts*, *2*, 65–67.

Wilson, M. (1975). *Health is for people*. London: Darton, Longmen, & Todd.

Windsor, J. (2005). *Your health and the arts: A study of the association between arts engagement and health*. Research report 37. London: Arts Council England. Available at http://www.artscouncil.org.uk/documents/publications/yourhealth_phpfUVFl8.pdf (accessed 11 December 2006).

Winnicott, D. (1971). *Playing and reality.* London: Tavistock Books.

World Health Organization. (1992). *Basic documents* (39th edn). Geneva: WHO.

Zimmerman, L., Nieveen, J., Barnason, S., & Schmader, M. (1996). The effects of music interventions on postoperative pain and sleep in coronary bypass grafts patients. *School Inquest Nursing Practice*, *10*, 171–174.

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