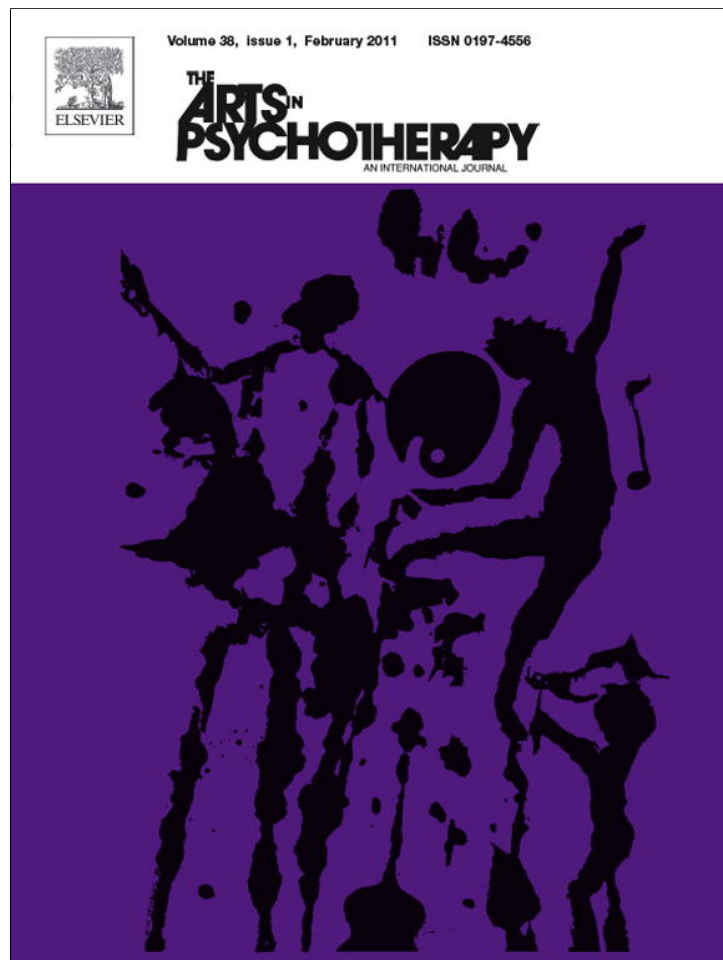


Provided for non-commercial research and education use.
Not for reproduction, distribution or commercial use.



This article appeared in a journal published by Elsevier. The attached copy is furnished to the author for internal non-commercial research and education use, including for instruction at the authors institution and sharing with colleagues.

Other uses, including reproduction and distribution, or selling or licensing copies, or posting to personal, institutional or third party websites are prohibited.

In most cases authors are permitted to post their version of the article (e.g. in Word or Tex form) to their personal website or institutional repository. Authors requiring further information regarding Elsevier's archiving and manuscript policies are encouraged to visit:

<http://www.elsevier.com/copyright>



Contents lists available at ScienceDirect

The Arts in Psychotherapy



Arts therapies for young offenders in secure care—A practice-based research

Henk Smeijsters, PhD*, Julie Kil, MSc, MDATH, SRDATH, Han Kurstjens, MA, Jaap Welten, MDTh, SRDTh, CP, ECP, Gemmy Willemars, MATH, SRATH

KenVaK Research Centre, Zuyd University of Applied Sciences, P.O. Box 550, 6400 AN Heerlen, The Netherlands

ARTICLE INFO

Keywords:

Drama therapy
 Music therapy
 Art therapy
 Dance-movement therapy
 Young offenders
 Constructivistic research
 Practice-based evidence

ABSTRACT

This article describes the results of the first phase of a research project to develop, implement, evaluate, and improve arts therapies interventions for young offenders in secure care. By means of a naturalistic/constructivistic research methodology in combination with grounded therapy methodology, practice-based evidence has been generated. Core problems of young offenders that are connected to delinquency have been described and arts therapies interventions have been developed that can be used to change these core problems. Core problems are problems with self-image, with expressing and discharging emotions, the inability to resolve interpersonal problems and finally, negative cognitions. In co-creation with practitioners, interventions have been developed for drama therapy, music therapy, art therapy and dance-movement therapy. A treatment theory has been developed that explains the working of arts therapies by means of the first author's theory of analogy. This theory explains arts therapies by means of the equality between forms of expression in art and the core self consciousness as described by Damasio and the vitality affects within the core self as described by Stern.

© 2010 Elsevier Inc. All rights reserved.

Literature review

Characteristics of young offenders in secure care

In her dissertation, Boendermaker (1999) notes that the problems of young offenders in secure care are often multiple (oppositional defiant disorder, conduct disorder, antisocial personality disorder, and attention-deficit/hyperactivity disorder). Almost all youngsters have severe problems in their contact with parents at home, at school, and elsewhere. Boendermaker gives the following figures for youngsters in the Netherlands: behavior problems (99%), oppositional behavior (86%), delinquent behavior (83%), disturbed social and emotional bonding, combined with severe mood fluctuations (73%), addiction (68%), and hyperactivity (35%).

The young people concerned come from an unstable family situation and often have a long history of fragmented schooling and interventions by the social services. Research from different countries shows that in many cases traumatic events at home are the basis of delinquent behavior. In the United States, 90% of adult male delinquents have been the victim of incidental or continuing trauma (McMackin, Leisen, Sattler, Krinsley, & Riggs, 2002). Research with young offenders shows that they are often the vic-

tim of violence or sexual abuse (Wood, Foy, Layne, Pynoos, & James, 2002).

Arts therapies are used with young people who have been committed by a juvenile court to an institution. Arts therapies are also used with young people who have serious educational or maturation problems that impede their development into adulthood and who require a secure setting so as to prevent their absconding from care or being removed by others.

Assessment

The SAVRY (Structured Assessment of Violence Risk in Youth) has been developed to assess the chance of recidivism (Duits, van Casteren, van den Brink, & Dorelijers, 2005; Lodewijks, 2008; Lodewijks, Dorelijers, De Ruiters, & de Wit-Grouls, 2003). The SAVRY contains static risk factors that cannot be changed (such as previous number of crimes) and dynamic risk factors that can be changed. Dynamic factors can be contextual (such as the neighborhood of residence) or individual (personal characteristics). In the pilot research study (Smeijsters, van den Braak, Helmich, Reumers, & van der Wekken, 2009), arts therapists agreed that they should focus on several individual dynamic factors as described in the SAVRY, such as experience of stress and low coping capabilities, difficulty in regulating anger, impulsivity and risky behavior, disturbed contact with peers, lack of empathy, negative thoughts about self and others, and lack of attention.

Besides risk factors, the SAVRY also describes protective factors such as involvement (working together), exploring behavioral

* Corresponding author. Tel.: +31 0 45 400 6483.

E-mail address: h.smeijsters@hszuyd.nl (H. Smeijsters).

URLs: <http://kenvak.hszuyd.nl> (H. Smeijsters), <http://www.smeijsters.nl> (H. Smeijsters).

alternatives, emotional bonding, a positive relationship with intervention and authority, and, last but not least, a flexible personality (self-esteem, being able to adjust to the environment, finding good solutions, being able to respond to others, self-calming). The pilot research showed that arts therapies can be very helpful in strengthening these protective factors.

Treatment goals

Beginning in 2010, all institutions for young offenders in the Netherlands have used the YOUTURN method as a basic treatment. YOUTURN is a combination of the (social) competence model (Palmer & Hollin, 1999) and the cognitive-behavior method called EQUIP (Gibbs, Potter, & Goldstein, 1995). The (social) competence model seeks to improve the capability to fulfill developmental tasks by reinforcing adequate behavior. EQUIP focuses on the cognitive interpretation of information and the resulting choice of behavior.

There is criticism that focusing only on changing criminal behavior is not successful if self-esteem is not addressed. An improved self-esteem increases learning ability, empowerment, and the competence to change life (IPPR, 2003; OJJDP, 1998). The goal of YOUTURN is a mix of improving self-esteem, regulating anger, and developing social and responsible behavior.

Treatment goals of arts therapies

Research in forensic psychiatry (Smeijsters & Cleven, 2006) had shown that in their actual clinical treatment, arts therapists do not focus on the DSM-IV disturbances as such, but instead on so-called “problem areas.” Problem areas are problematic feelings, behaviors, and cognitions that are linked to disturbances on the one hand and offensive behaviors on the other. Examples of problem areas are the lack of emotional expression and empathy, high emotional tension, impulsivity, lack of interpersonal boundaries, and destructive aggression.

In the pilot research on young offenders (Smeijsters et al., 2009), it became clear that in their work, arts therapists focus on problematic feelings, behaviors, and cognitions. These were called “core problems” (which in essence are equal to “problem areas”). By means of qualitative research with the arts therapists, these problems/areas were explored until consensus was reached (to conform with grounded theory). Core problems are closely linked to the dynamic individual risk factors of young offenders.

Different from EQUIP, the arts therapies focus strongly not on cognitive interpretations but on noncognitive emotional and behavioral patterns that are embodied. This explains why during the past decade the arts therapies have become affiliated with the third generation of cognitive-behavior therapies, such as schema-focused therapy (Young, Klosko, & Weishaar, 2003), dialectical therapy (Linehan, 1993), and mentalization (Bateman & Fonagy, 2004). Psychiatrists, psychotherapists, and arts therapists working with these therapies agree that the arts therapies are needed as an important supplement to EQUIP and YOUTURN (Bernstein, Arntz, & de Vos, 2007; Smeijsters, 2007). However, research was needed to precisely describe this contribution.

Effects of arts therapies

The systematic review of research studies shows that effects of the arts therapies are often expressed in terms of reduced aggression, anger, tension, stress, and cognitive distortion and of improvements in impulse control, emotional expression, coping skills, compliance with rules, and social skills. A lot of the research involves qualitative studies of a restricted number of participants. Research designs and case studies focusing specifically on arts therapies for young offenders with disturbances are summarized here.

The findings are categorized along with the core problems that have been identified.

Drama therapy

For drama therapy, one meta-analysis and many case studies are available (Haen & Brannon, 2002; Hanna & Hunt, 1999; Kipper & Ritchie, 2003; Trower, 1978). These show that there are no research findings available on self-image, interaction, and cognition. Case studies show the importance of drama therapy in working with anger and violent impulses. The meta-analysis shows a large effect size for “Role reversal” (ES = 0.93) and “Doubling” (ES = 1.29).

Music therapy

Effects of music therapy have been analyzed by one meta-analysis (Gold, Voracek, & Wigram, 2004), two mixed designs (quantitative and qualitative; Gardstrom, 1999; Tyson, 2002), one pre-test–post-test design (DeCarlo & Hockman, 2003), and one qualitative study (Baker & Homan, 2007). In the qualitative research, youngsters report that rap music lessons increase their self-esteem and pride, friendships, and respect for others; organizing capabilities; reflection; and ability to work on a product. Questionnaires for self-evaluation show that youngsters use rap music as a tool to decrease emotional and physical outbursts of anger and hostility. Compared to psycho-education and group therapy, rap therapy leads to significant positive differences in relaxation, arousal, joy, regulation of anger, control of impulsivity, avoidance of delinquent behavior, and ethical thinking. Rap prevents offender behavior, increases social relations, and improves the relationship with daily life and the ability to take on decision-making.

The meta-analysis shows a small effect size on self-image (ES = 0.46), a small negative effect size for social capabilities (ES = -0.17), a large effect size for behavioral problems (ES = 0.96) and combined problems (ES = 0.82), and a medium effect size for developmental problems (ES = 0.76).

Art therapy

For art therapy, two research designs with case studies (Baillie, 1998; Bennink, Gussak, & Skowran, 2003) and one mixed design (quantitative and qualitative; Persons, 2009) are available. No research data were found for self-image. Case studies show results for emotions such as access, expression, catharsis, regulation, sublimation, and verbal access. Boys report that art therapy decreases their anger, depression, and anxiety. They report also that art therapy helps to build up positive relationships with others and that they learn to be tolerant and to accept others. Concerning cognition, they are convinced that art therapy structures their chaotic impressions and makes verbal and cognitive processing and the control of behavior possible. Also, self-injury and being in trouble seem to decrease.

Dance-movement therapy

Dance-movement therapy offers one meta-analysis that contains 14 studies with a control group (Ritter & Graff Low, 1996). There is a small effect size on self-image (ES = 0.27). There is a medium effect size on anxiety (ES = 0.70). There are no results available for interaction and cognition. The overall effect size for psychic disturbances (ES = 0.37) and developmental delay (ES = 0.43) is small.

All arts therapies

For all arts therapies together, there are results available for one qualitative multiple case studies research (Smeijsters, 2007). Clients reported experienced effects such as showing their vulnerable side, expressing anger, physical catharsis, exploring levels of tension, expressing different levels of tension, being aware of their

own level of aggression, detecting the beginning of the process that might end in an aggressive outburst, stopping aggression in time, and decreasing impulsivity. No data on interaction are available. On cognition, clients report that they become able to talk about conflicts and feelings instead of acting them out. They are able to reflect on emotions, give emotions a name, and detect and verbalize bodily signals.

Research phases

Although research in forensic psychiatry with adults has been conducted, research with young offenders is scarce. There is little evidence about methods used by arts therapists working with young offenders, whether it works, and why it works. Therefore, it was decided to do practice-based research with arts therapists working in clinical practice. This led to several research questions, which were divided into two phases. (This article focuses on the first research phase. The second phase will be presented in a second article.)

Phase 1 (2008–2009): development of consensus-based interventions

During the first phase (2008–2009), the development of consensus-based interventions took place through analyzing and integrating the tacit knowledge of experienced arts therapists. Also, a credible treatment theory was developed to explain why arts therapies work.

Phase 2 (2009–2010): application and evaluation of consensus-based interventions

In the second phase, actual practice was improved by utilizing the consensus-based interventions. An ongoing process evaluation determined how the consensus-based interventions that were used in clinical practice could be improved during treatment. Treatment effects were evaluated by means of a multiple case study design, with pre-test and post-test measurements and qualitative change process research.

Research questions of Phase 1

The research questions of this phase were: How do arts therapists describe the core problems of young offenders with whom they work? What is the content of their treatment interventions? Which theoretical model can explain how arts therapies work? What are characteristics that make them special, as compared with treatment theories and characteristics based on the cognitive-behavior model?

Respondents

In total, eight drama therapists, five music therapists, seven art therapists, and seven dance-movement therapists from six clinical institutions for young offenders were involved. In each modality (drama, music, art, dance-movement), a core research circle and an extended research circle were established. The core circle of persons worked very intensively together. Each core circle acted as a community of practice (Wenger, 1998) in which practitioners from different clinical institutions closely worked together. Their institutions allowed them to spend one day a week, for two years, on their research work. The members of the core circle precisely described their own work in practice, discussed it with the other members of the community of practice very critically, and then integrated their tacit and theoretical knowledge and developed a new treatment

draft on which they agreed. Each core research circle was led by a KenVaK researcher with theoretical and practical expertise in the same modality. To reach consensus, several treatment drafts from each core circle were discussed with the members of the extended research circle. The research design and results were discussed by the KenVaK research team and the KenVaK International Advisory Board.

Research methodology

The goal of this research was to develop practice-based evidence. Therefore, a research methodology was chosen that combines characteristics of action research methodology, naturalistic/constructivistic inquiry, and grounded theory. During the development of treatment drafts, techniques of evidence-based practice were also used.

Practice-based evidence (PBE)

Evidence-based practice (EBP) has become part of clinical work. This means that each clinician should be aware of and make use of treatments that have been evaluated by means of experimental research (RCT), so-called evidence-based treatments (EBT). However, research shows that putting evidence-based treatments into practice is not as easy as it may seem to be, because these treatments are different from what happens in clinical practice (see, e.g., Weisz & Weiss, 1993). Therefore research is needed that enables practitioners to find practical solutions for problems they encounter in their clinical practice. *Practice-based evidence* specifically emphasizes the clinical experiential knowledge of the therapist and the client (Barkham & Mellor-Clark, 2003; Barkham, Mellor-Clark, Connell, & Cahill, 2006; Hutschemaekers, 2009; Smeijsters, 2006, 2007, 2009a, 2009b; van Yperen & Veerman, 2008). Although PBE does make use of quantitative clinical outcomes in routine evaluation (CORE; Barkham et al., 2006), it also brings clinical practitioners and clients together to describe, discuss, evaluate, and develop what works in therapeutic practice. PBE is experiential knowledge built upon reflection on cases. Its aim is to describe and develop successful practices.

Practice-based evidence is based on actual practice and encourages therapists to make that practice and the observed effects explicit. Van Yperen and Veerman argue against utilizing top-down interventions derived from studies of effects and are in favor of adopting a bottom-up approach that starts from what actually exists and builds on that. PBE develops by designing, applying, evaluating, and improving. The great advantage of this approach is that it takes place in normal practice.

Practice-based evidence is not simply generating ideas from clinical practice. Tacit knowledge is made explicit, critically discussed, evaluated, compared with theory and research findings (here EBP comes in), put into practice, and evaluated again. It is evidence that is generated by means of a sound research methodology and leads to new treatments and changed practice.

Action research methodology

Many of the characteristics of action research (Greenwood & Levin, 2000) have been applied. There has been a co-generative inquiry in which arts therapists from clinical practice and researchers together collaborated to define core problems and gather relevant knowledge from clinical practice and theory, analyze the information, and design treatment manuals to change clinical practice. Arts therapists have learned research skills themselves, pooled knowledge, conducted the research, interpreted the results, and applied what has been learned.

As stated before, the research was divided into two phases. In Phase 1, treatment manuals were developed from of clinical tacit knowledge and combined with codified professional knowledge; in Phase 2, these treatment manuals were used in clinical practice and improved while in use.

In action research, it is possible to incorporate criteria of trustworthiness and research techniques as they have been described in naturalistic/constructivistic inquiry and to use techniques of analysis that have been developed within grounded theory. The next sections describe which research criteria and research techniques have been used.

Naturalistic/constructivistic inquiry

Action research stresses the willingness of practitioners to act on the results. To reach this willingness, it is important that there is participative democracy as both a method and a goal (Greenwood & Levin, 2000). This can be accomplished by using research criteria and research techniques from the naturalistic/constructivistic research methodology. Typical for this methodology is that it “constructs” knowledge by researchers and practitioners working together on an equal basis. Practitioners become scientist-practitioners who define and solve practical problems (Hayes, Barlow, & Nelson-Grey, 1999; Hutschemaekers, 2009).

In this project, the arts therapists acted as co-researchers (Lincoln & Guba, 1985, 2000). This meant that they not only supplied data but also played a highly active role in all phases of the project. The arts therapists reflected on and clarified for themselves the practices that they use, and when, how, why, and with whom. This enabled them to learn from and with one another and to compare their experiential knowledge, evaluate it, and integrate it into best practices. It also enabled them to integrate new knowledge into their process of reflection and development.

The research focused on actual practice and produced a result that could be utilized in practice without much further ado. From the point of view of learning, we are dealing with reflection on action and reflection in action. The collaboration between arts therapists themselves, arts therapists as co-researchers, and researchers is in the nature of a *community of practice* in which people with the same experiential background who deal with the same issues join together to describe interventions and to systematize, innovate with, apply, and evaluate them. The research enabled the clinical institution to develop into a learning organization and the profession, into a learning profession.

Research techniques

The research techniques were taken from naturalistic/constructivistic inquiry (Lincoln & Guba, 1985, 2000) and grounded theory (Strauss & Corbin, 1998).

Data collection techniques, such as open interviews, group techniques, Delphi techniques, and participatory observation, were used.

Data analysis techniques were taken from grounded theory methodology. By means of *coding*, issues in a transcript were developed into a topic structure. Next, by means of *categorizing*, similar codes from several interviews were grouped together into a single category (e.g., the category “self-image”). Within a category, subcategories were developed (e.g., “properties” of and “goals” and “play forms” for self-image). Separate subcategories were integrated into *themes* (e.g., “expressing in art who you are”). In data analysis, use was made of techniques such as *scrapping*, *selecting*, *paraphrasing*, and *integrating*. Finally, themes from a number of categories/subcategories were related to one another. For example, in “a play form that provides space to make a personal contribution leads to cheerfulness,” two themes were related to one another:

“space to make a personal contribution” and the ensuing result, “cheerfulness.”

In the context of qualitative research, “trustworthiness” is a general criterion for good research. This quality can be divided into *credibility* (whether the analyses are accepted by the respondents), *dependability* (whether any important information is missing), *confirmability* (whether external assessors can confirm the conclusions), *transferability* (whether people operating within a different context can derive what is usable), and, finally, *authenticity* (whether the respondents have had a fair chance to express their personal views).

To fulfil these quality criteria, techniques such as *triangulation* (making use of various different people, data collection techniques, and theories), *member checking* (repeatedly checking with respondents as to whether the results are in line with what they actually mean), and *peer debriefing* (presenting results to peers at the workplace and to independent experts elsewhere) have been used.

Consensus was reached by discussing over and over again the drafts of the treatment manual and treatment theory until saturation had been reached (to conform to grounded theory). Consensus means that all participants agree that what has been written down can be defined as “best practice.” Saturation means that in their opinion, no new data can be found. Yet this process cannot be seen as finished, because the use of these treatment manuals by other arts therapists might lead to adjustments. The criterion of transferability allows that when the treatment manuals are diffused to other contexts, they might be changed because of contextual conditions in the new setting (Greenwood & Levin, 2000).

Results

The research resulted in the description of core problems; consensus-based treatment manuals for drama therapy, music therapy, art therapy, and dance-movement therapy; and a treatment theory that explains why arts therapies work.

Description of core problems on which arts therapists focus

Arts therapists focus on the following four core problems because these are closely related to risk factors and protective factors. This section describes the four core problems. Later, we describe how they relate to risk factors and protective factors. These core problems were identified during a preliminary research study (Smeijsters et al., 2009). They were arrived at by means of focus interviews with arts therapists.

Self-image

Young people with a weak identity often do not really know who they are. They also have negative convictions about themselves and/or a lack of self-confidence. Underestimating oneself and a lack of self-respect can lead to a misunderstanding of what one can and cannot influence. Such young people often fail to develop sufficient behavioral alternatives or considered solutions; they display little positive responsiveness to others, find it difficult to adapt to their environment, and are unable to deal with problems or calm themselves down. Conversely, unrealistic ideas about oneself can give rise to an artificial, inflated feeling of self-worth. Negative judgments and feedback are then quickly interpreted as threats to one's self-image, which can result in aggressive behavior.

Emotions

These young people are unable to recognize the emotions of others and adjust their behavior accordingly, and/or they are unaware of their own explosive emotions and/or are unable to express and discharge these emotions in an appropriate manner. As a result, they may experience excessive stress and quickly become frustrated. There is often moderate or serious loss, with the young person having insufficient coping skills to deal with this. There may be fluctuations in mood, impulsiveness, or high-risk behavior. Such young people do things without thinking and respond suddenly with intense emotions, without taking account of the consequences. They find it a major problem to regulate their moods and to control their anger and impulses (including aggressive impulses); they may have outbursts during which they threaten, frighten, or injure other people or do serious damage to property. Their lack of coping skills may also lead to internalization problems.

Interaction

Juveniles with this core problem often lack social skills and are unable to resolve interpersonal problems. They are unable to recognize or observe other people's limits. This lack of social skills and/or inability to resolve interpersonal problems and/or disturbed autonomy increases the likelihood of their being rejected by other juveniles in the same age group, leading to their becoming involved with other delinquents and/or gangs. They frequently lack empathy and feelings of regret. They are unmoved by the pain or misfortunes of others and indifferent to their feelings. They callously ignore the negative effects of their own behavior on others and/or do not recognize the fact that their own actions are wrong. Their attitude toward authority is often negative, and they are therefore not open to treatment or guidance.

Cognitions

Juveniles with problems in the area of cognitions have negative cognitions regarding themselves, their own abilities, and their own skills. This may lead to internalization problems. They also often have negative cognitions regarding other people. They perceive and interpret the behavior of others incorrectly. As a result, they have negative attitudes toward others and the world around them, and they tend to wrongly assume aggressive intentions on the part of others. They generalize incorrectly and fail to test the validity of negative views. These young people regularly endorse views and values that justify crime or violence.

Rejection by others of the same age may be both the cause and the effect of incorrect perception of aggressive intentions on the part of other people. It may be the cause because rejection can lead to their assuming that others are being aggressive toward them, and it may be the effect because assuming aggressive intentions can lead to behavior that itself incites rejection.

Consensus-based treatment manuals

The following section presents the outcomes of the first phase of research, which resulted in the development of an intervention for each of the arts therapies that applies to the four core problems. Consensus regarding these interventions was reached by the arts therapists participating as members of the research group or as reviewers. The arts therapists in the research group first described their own treatment manual and then discussed what they thought would be the most effective treatment; they then presented this draft best practice to the reviewers, who provided comments. All of the examples were generated by means of the practice-oriented

research method already described. Because of the limited space available, this article deals only with examples from one or two core problems.

Drama therapy treatment

Core problem: emotion

Using drama is an extremely appropriate way of learning to recognize and play out emotions. For the young people with whom we are dealing, it is extremely important to explore a variety of emotions – and different gradations of those emotions – and to learn how to control them. A range of play forms can be applied. These include both *prestructured performance* and options such as *improvisation* directly with other group members or the therapist. In the course of the performance, the therapist can “confront” the young people concerned with a variety of emotions. This allows them to investigate how they deal with emotions during the performance and what they want and need to learn by doing so.

Example 1

The *play form* is that of a “ring the doorbell” game using emotion cards. Actor A rings the doorbell and actor B opens the door. The actor who rings portrays a different emotion each time. The actor who opens the door is neutral and responds to the emotion that the first actor displays. As a *technique*, one can utilize *role reversal*. This allows each young person to experience both roles, thus giving him/her an understanding of the other person's situation.

The *method* used is open or closed improvisation (Spolin, 1999). This can be categorized in Phase 2, *scenework*, of *Emunah's five-phase model* (1994).

The rationale behind this play form is that it trains young people in recognizing, properly and spontaneously, the emotion displayed and in interpreting it and responding to it. Another important factor is recognizing one's own impulsive responses to the emotion displayed: A too intense and uncontrolled response immediately disrupts the realism of the performance. The young person sees which emotions he/she is able to portray and which emotions he/she finds difficult to adopt or portray appropriately. In this type of performance, it is important for the young person to realize that one can restrict the other person within the performance and retain control of the situation by closing the door. This play form contributes to increasing the young person's confidence in his/her own spontaneity. One can compare this with the view proposed by Moreno (1977): Spontaneity is a new response to a familiar situation and an appropriate response to a new situation.

Example 2

The *play form* is that of the “emotion letter.” The young person writes a letter to a fictitious person. The letter contains a specific question or contains information that arouses a particular emotion in the recipient. A scene is then played out between the recipient and the writer of the letter. The young person selects the role that he/she plays first. The *technique* of *role reversal* can later be used, but interventions during the scene – for example *enlarging*, *lift your mask*, and *transformation to the here and now* – may also be used to give greater depth to the scene.

This play form fits in with such *methods* as *storymaking/storytelling* (Gersie, 1997) and *closed improvisation* (Spolin). If one uses a fixed drama text as a variant, it can also be related to *supervised drama* (te Kieffe, Van Rhijn, & Haans, 1994). These methods can be categorised in *Emunah's* Phase 2, *scenework*, and Phase 4, *culminating enactment*.

The rationale behind this play form is that it allows young people to experiment with how to deal with emotional situations that they have chosen themselves. Depending on the amount of realism, the letter may have a more personal significance for the young per-

son concerned and consequently make greater demands on his/her personal involvement. The right amount of *discrepancy* (Johnson, 2005) will guarantee the containment of this play form that is so necessary for the young person.

Music therapy treatment

Core problems

The core problems presented above apply, although they are not all given equal prominence; they are not independent entities but are interwoven with one another. This means that treatment more frequently focuses on a combination of the four core problems. A particular core problem is given greater prominence than others during the various phases.

The *self-image* core problem is felt to be more of an “umbrella” core problem. Self-image and self-esteem are the sum total of experience within the core problems of *emotion* and *interaction*.

The *cognition* core problem is the least explicitly applied. The approach is often not directed by a focus on dysfunctional cognitions. It is nevertheless the case that, quite apart from what is given the greatest prominence (emotion, self-image, or interaction), the music therapist – throughout the whole course of treatment – explicitly asks the young person about his/her recognition of the experience gained in patterns from everyday life. This more cognitive intervention is actually a request that the young person recognize the *analogy* between the musical event and everyday life (i.e., recognize/acknowledge problem behavior and the request for assistance).

Play forms

The *play forms* can basically be described as *receptive* and *active*. The preference is for active play forms. The receptive play forms are frequently supplementary, serve to create conditions, or are important during the intake as a stepping-stone to an active and interactive therapy situation that contains elements of improvisation (Kurstjens & Baerends, 2006). This is not to say, however, that improvisation is merely a basic play form; rather, it means that experimentation and free “tryouts” have an important place within more closely defined play forms.

“Always the same but always different”

What is always very significant within the play forms used is the element of working on or toward a music product. This may be a composition, song, or rap, or learning to play an instrument. It can take the form of a presentation, performance, CD, or DVD. It can take place for the young person him/herself, for family/friends, or for the residential care group. At first sight, this would appear to be a rather one-sided approach. Looked at more closely, however, it turns out that this play form has numerous variants and also a deliberate focus on the various objectives and help requirements. It falls into many variants specifically relating to the young person concerned. The attitude and function of the music therapist is also variable and flexible in this context, but deliberately related to the specific objectives. Working toward a product focuses on the core problems concerned. Some examples can illustrate this.

For the core problem of *emotion*, the play form will focus on the quality of the musical expression – for example, by encouraging the young person to pay greater attention to the use of dynamics or to making the timbre more suitable by changing the instrumentation. For the core problem of *interaction*, the therapist can curb too rapid or too superficial successes and ensure that the product is created by means of a process of consultation. For the core problem of *cognition*, there can be more verbal consultation regarding the significance of the content and structure of the work as it relates to the pattern of day-to-day action. For the core problem of

self-image, a link will be made to pride in one's own identity in the design.

The therapist plays a number of different roles in all of this. As a *musician*, he/she plays along, comments on his/her role in the collaboration, adopts a position of his/her own, or makes him-/herself dependent on the young person. As the *composer* (or rap producer), he/she gives structure to the form and keeps a record of things so as to be able to continue and create an overview. In the role of *recording engineer*, he/she helps with intermediate products and refinements in the recording, provides the necessary technical know-how, and gives instruction in the use of the equipment. The *critical listener* comments on the quality and expressiveness of the product, responding from the perspective of the person at whom the product is targeted.

In all of these roles, there are elements that refer to the core problems. These roles will receive more or less emphasis depending on the objectives that have been set.

Art therapy treatment

Therapists in secure care environments find that art therapy is most utilized for the core problems of *self-image* and *emotion*. Because art therapy often involves more individual work with the client, the core problem of interaction is mainly relevant between the therapist and the young person concerned. If group work is involved, the core problem of interaction can be developed effectively within the context of art therapy. The core problem of cognition is primarily addressed in the case of dysfunctional habits of thought that become apparent when reflecting on the action during the therapy session.

Core problem: self-image

Young people who are confined to a secure clinic for young offenders often have a negative self-image and a great fear of failure. Art therapy is creative and consequently constructive by nature. An art product is created, which has a strengthening effect. Art therapy gives the young person the opportunity to work on the basis of his/her own needs, to occupy space in a positive manner, to be proud of him/herself, and to get to know him/herself. The creative nature of art therapy – creating a product, showing something of oneself – can reinforce someone's ego and help them to discover their capabilities (Budde, 1989). Developing one's individuality increases one's resilience. Art therapy is to a large extent an activity that calls on one's individuality (Schweizer et al., 2009).

Play forms

The emphasis of the play forms for this core problem is on developing one's own identity and a positive self-image by, for example, using one's imagination, picturing one's wishes, representing and reinforcing qualities, and working constructively with the artistic materials.

One play form is “making choices.” Here, in no more than 10 min, the client chooses from magazines pictures (not texts) that mean something to him, affect him, or interest him. Then he cuts or tears away everything that is unimportant. He is asked to lay out the pictures in front of him and select three. Then a small cardboard frame is used to reduce his final choice to only a single image (or part of an image) (see Fig. 1).

Another play form is modeling an imaginary animal in clay.

There is also the play form of drawing a self-outline on a large piece of paper and filling in the outline with personal characteristics. For example: “You can draw well with your hands, so put a pencil in your hand; in your head, you have memories, so draw these in symbolic form; with your feet, you can play football, so draw a football, etc.”



Fig. 1. Collage technique in art therapy.

Another play form is expressing one's name in wood, plaster, clay, or graffiti.

It also is possible to model three figures in clay, with the titles "This Is Who I Was," "This Is Who I Am," and "This Is Who I Want to Be."

Core problem: emotion

Artistic materials provide something to hold on to when one's feelings are unstable. They create a bridge between feeling the material and what the young person feels inside. The way a young person works with artistic materials is seen as *analogous* to what he/she feels and how he/she behaves outside the context of the therapy (Smeijsters, 2008a, 2008b, 2008c). Expressing feelings with artistic materials is indirect because the feeling is "named," although not in words. The indirect means of reflection creates a safe situation in which the client can admit the feeling.

Working with artistic materials helps to distance the emotion and to integrate it. Controlled sensory work of this kind allows the young person to call up emotions and experience them artistically so as to get a grip on them. Artistic materials contain numerous experiential qualities that trigger those emotions.

Play forms

The emphasis of the play forms for this core problem is on expressing emotions and getting a grip on them by, among other things, experimenting with different-feeling materials, using one's imagination, and representing emotions on the basis of dynamics.

In one play form, two clients select an emotion and express it on paper in the clearest possible manner. Halfway through, they swap drawings and finish each other's drawing without knowing what emotion the other has attempted to express. They link up with what has already been drawn and continue with it. They then say which emotion it is.

In another play form, they look for pictures of people or faces in newspapers and allocate to them a number of different pieces of paper. Each piece of paper stands for an emotion. They are asked to work out that emotion with artistic materials.

In another play form, they are asked to make an angry animal, a frightened animal, a sad animal, and a happy animal. They examine and discuss the similarities and differences and are asked to show each emotion clearly in the relevant animal. Then they discuss which animal they often behave like and which animal they then feel like.

Dance-movement therapy treatment

Dance-movement therapy is used for the four core problems; it is striking that objectives in the area of *self-image* and *emotions* are mentioned most frequently. The *emotion* core problem will be dealt with here.



Fig. 2. Dancing with sticks. Photo: J. Kil.

Core problem: emotion

After a trauma, *mirroring* can reduce the feeling of loneliness and help to get rid of some of the pain by means of movement rituals (Levy, Ranjbar, & Hearn Dean, 2006). In cases of aggression, dance-movement therapy can also teach the client, in a structured form, how to express feelings in a controllable manner (Koshland, Wilson, & Wittaker, 2004). Appropriate play forms include:

Expressing and dealing with emotions

We find play forms based on authentic movement in which mirroring one another creates a movement, from stasis, that comes more from within. When creating a dance, young people can express their feelings in static form. These forms can be placed one after the other and combined with music. There can be an investigation of what your body does – or wants to do – with various feelings or memories. If you are angry, for example, you tend to clench your fists. Clients are asked to investigate what movements correspond with clenched fists.

Discharging and regulating anger and aggression

Here we have play forms in which the young person is required to be still – for example, to move to music but to stop moving when the music stops. You can use, for instance, the game of "Statues" or similar games, such as pushing one another away and holding the position you end up in.

There are play forms based on a Laban element – for example, strength, where you can vary the strength of a movement from soft to strong/powerful, with the movement remaining controlled. Keep the movement controllable by supporting it with breathing or noises, for instance.

Other play forms are the stick dance (see Fig. 2), boxing, or movements such as kicking or hitting, as in African dance.

Apply the pressure gauge or variations of the pressure gauge such as the pan, the volcano, the car with gears, and the remote

control. Play forms are offered in which the tension increases, and the young person can become aware of this. If the tension increases too much, the therapist works with the young person to find ways of calming down again. This can be done by offering tips, e.g., relaxation exercises or a more energetic activity such as jogging.

Treatment theory

A treatment theory is a theory that explains which problems (“mediators”) of a client a therapy affects and how and why it does this, based on valid theoretical principles and pre-existing research results (“circumstantial evidence”) (van Yperen & Veerman, 2008). In our case, this involves explaining the risk factors and protective factors for delinquency that are affected by arts therapies and how and why these therapies do this.

Today there is a strong trend to link the arts therapies to cognitive-behavior therapy and its third-generation therapies (such as schema-focused therapy and dialectical behavior therapy). There is a good reason for this, because research shows that cognitive-behavior therapies are successful. However, when making this link, a fundamental question arises as to what is typical for the arts therapies. Working together with cognitive-behavior therapies can be from the top down or from the bottom up. “Top down” means using cognitive-behavior techniques in the arts therapies. “Bottom up” means working “arts-based” and from there finding a connection with cognitive-behavior therapies.

Cognitive-behavior therapy is effective in reducing recidivism (Aos, Miller, & Drake, 2006), but it is not always effective (Chu & Harrison, 2007; Elliott & Greenberg, 2001; Institute of Medicine, 2007; Ross & Hilborn, 2008; Weisz, McCarthy, & Valeri, 2006; www.scienceblog.com). With several populations, such as clients with personality disorders, there is a need to work with experiential techniques that focus on the so-called “embodied cognition.” This has led to the development of the third generation of cognitive-behavior therapies, where therapists work with, for instance, schema modes (in schema-focused therapy) and the emotional mind (in dialectical behavior therapy). Based on research findings, the Dutch neurologist Lamme (2010) makes the statement that we have a false image of the influence of the rational on our behavior. We suggest cognitions and decisions in the pre-frontal cortex that do not precede our emotion and behavior at all.

In forensic psychiatry and institutions for young offenders, we see a growing connection between schema-focused therapy, dialectic behavior therapy, and the arts therapies because these therapies address the noncognitive parts. But still the question remains: What is typical for the arts therapies? In other words: Where is the art?

We need a theoretical model that gives us not only the embodied cognition but also the art. Stern (2010) describes the psychic forms as art forms, and Malloch and Trevarthen (2008) describe the psychotherapeutic process as a process of art. In our belief, these theories can offer a theoretical basis for the arts therapies that is bottom-up and can both use the essence of art forms and link it to the noncognitive parts of the psyche. In the next sections, this theory is presented.

Noncognitive

As stated before, when working with specific client groups, the cognitive approaches require non-verbal and noncognitive supplementation (Bernstein et al., 2007). That supplementation often focuses on “internal working models” of clients (Zevalkink & van Dam, 2007). Internal working models are implicit, nonverbal and noncognitive patterns that have developed in the past, have been

embodied, and in the present determine perception, feeling, action, and thinking. In our view, arts therapies can provide this necessary supplementation because they call not so much on verbal or cognitive abilities but on noncognitive experience. This is possible because arts therapists encourage the client to act in a manner that is unprepared, intuitive, experiential, improvisatory, experimental, playful, active, and exploratory.

The playful atmosphere enables the client to relax and be him/herself, invites him/her to be active, and gives him/her the opportunity to be able to do something. In the experience of psychotherapists and psychiatrists – in this and previous research (Smeijsters, 2007) – because of the play space, arts therapies are suitable for gaining access, breaking through resistance, and dealing with a lack of motivation. As a result, there is increased attention to what is happening and motivation for making use of the event.

Vitality affects in the core self

Neuropsychologists refer to implicit, nonverbal, noncognitive, felt knowledge as being essential for the “core self” (Damasio, 1999). Although vitality affects are not limited to the domain of feeling, shifts of feeling in the core self are “vitality affects” (Stern, 2000, 2010). Vitality affects are characterized by a pattern in time that arises from the combination of such parameters as force, speed, flow, and timing. These parameters characterize how we feel and how we experience relationships. A spoken phrase, a smile, a gesture, or a facial expression by someone else is made up of a combination of these parameters. As we shall see below, these parameters are also essential for forms of art.

Vitality affects are experiences in the “present moment” on the basis of intuition, without prior consideration (Stern, 2004). Working in the arts means surrendering oneself unthinkingly but actively to the present moment. While acting in the present moment of arts therapies, the client can feel what is happening in his/her core self without too many thoughts and interpretations. The subjective world is experienced as it is lived, pre-theoretically and pre-reflectively (Stern, 2010).

Analogy

The patterns of the vitality affects within the core self are very similar to the design processes in the media that are used in arts therapies. Vitality affects of the core self are expressed in the arts by means of analogy (Smeijsters, 2003, 2005, 2008a, 2008b, 2008c). “Analogy” means that there is an equality between the processes in which shifts of feeling occur within the core self (the vitality affects) and media processes. Core self experiences are reflected in media processes, and media processes are able to call up old and new core self experiences. In analogy, there is a fictitious situation – the event in the arts – that is able to call up actual core self experiences. There is a middle ground between “in vivo” and “in vitro” (cf. Johnson, 2009). It is precisely this combination that is safe and is consequently able to break down barriers.

The client can experience the same vitality affects in activities in the arts that have occurred with events in the past and that have since become established as patterns (the internal working models) in the present. Expressing, recognizing, feeling intensely, and influencing the vitality affects that lie at the basis of the patterns during activities in the arts are essential for the arts therapies.

Risk factors and protective factors

Risk factors are factors that increase the risk of delinquency – for instance, lack of emotion regulation. Protective factors are factors that decrease the risk of delinquency – for example, feeling stable. Research by Rutter (1987) and Lodewijks (2008) shows that

risk factors and protective factors of the SAVRY are good predictors of “desistance” (McNeill, 2006), i.e., refraining from violent recidivism. Protective factors lead to a significant increase in the statistically explained variance through the risk factors. Protective factors also create a buffer effect, in the sense that few protective factors are present in subgroups with a high risk of recidivism, while there are numerous protective factors in subgroups where the risk of recidivism is low. Lodewijks’s conclusion is that greater attention should be given to protective factors during treatment aimed at reducing recidivism. Studies by researchers, including Hubble et al. (1999) and Duncan, Miller, and Sparks (2004), show that it is above all the client him/herself and his/her environment that determines the effect of the therapy. Therapy would appear to work primarily by activating the sources of strength within the client.

Arts therapies involve a combined influence on risk factors and protective factors. Arts therapies can primarily serve to reduce impulsiveness, regulate anger, and increase empathy and compliance. However, arts therapies also make a contribution to the outcome by influencing the protective factors. The relaxed, playful, and safe nature of arts therapies creates a protective situation with strong social support and strong attachment in which a positive attitude to the intervention can develop. Arts therapies work in particular with such protective factors as setting one’s own goals, acting for oneself, trying out new roles, providing reciprocal positive reinforcement, working on the basis of one’s strong points, experiencing positive emotions, acquiring new chances, trusting in one’s own actorship, increasing one’s problem-solving ability, and directing situations.

Discussion

An important issue for the arts therapies is whether they should strive for “silver bullets” (Duncan et al., 2004). We think that it is impossible to standardize arts therapies treatments in a way that the same intervention can be used with different clients in different contexts. Such a medical model takes the heart out of the creative and experimental play space of the arts therapies. This view has implications for research, too. Findings that have been generated by this practice-based research cannot easily fulfill the positivistic criterion of generalization. However, this does not mean that transferability is impossible. It is important to test the treatment manuals in each new context and to adjust them if necessary. Because clients and context are many and different, we cannot find the “silver bullets” of arts therapies.

Another issue is the relationship of arts therapies’ treatments with the DSM classification. This practice-based research shows that the arts therapists who were involved do indeed work with so-called “core problems.” These are linked to the DSM disturbances as well as to the risk factors of delinquency, but are not the same thing. Arts therapists focus on self-image, emotions, interaction, and cognitions that can be part of the dynamic individual risk factors, like impulsiveness and anger, but they also strongly empower their clients to increase their self-experience, identity, confidence, and pride. By not focusing directly on the delinquent behavior but instead working in an experimental play space and focusing on the art process and art product, arts therapists address a deeper personal level that lies at the basis of disturbances, dynamic risk factors, and delinquent behavior.

Comparing the arts therapies to other therapies, such as cognitive-behavior therapies, makes clear that arts therapists on the one hand search for a connection with those therapies that focus on embodied cognition, but on the other hand stress the characteristics of the arts with which they are working. In the present moment of the arts therapies, clients experience the art process pre-theoretically and pre-reflectively. Proceeding in the art pro-

cess is analogous to experiencing vitality affects in the core self. In the art process, the clients can express the shifts of feelings in the core self and explore new ways of feeling and behaving.

The interventions that have been developed in this research do not yet have the status of a generally applicable best practice. They have been developed bottom-up on the basis of the experiential knowledge built up by the arts therapists at the participating institutions and a number of reviewers, and they have also been supported by theoretical and practical information taken from the relevant literature. In this way, a fruitful combination of *practice-based evidence* and *evidence-based practice* has been created.

The next step will be to increase the size of the group of arts therapists who provide feedback and also the potential approaches with regard to methodology. There is also not yet a best practice because the interventions developed thus far still need to be utilized and evaluated. Both actions – utilization at the participating institutions, with evaluation, improvement, and presentation to a larger group of arts therapists, and more methodological approaches – are on the program in the second phase of research (2009–2010). The current status of the interventions is that the participating arts therapists have reached consensus within the research groups on a draft best practice that can be implemented in their own work.

One valuable aspect of this study is that it has led to arts therapists from different institutions and with different backgrounds talking to one another and developing their work. Because so much knowledge taken from practice, theory, and research is integrated by the professionals themselves, there is strong commitment to actual application of the interventions. It is also important that independent experts are involved in discussion of the usefulness and the effect of arts therapies. Arts therapists and experts with a variety of theoretical perspectives exchange views and assist one another in developing the intervention and accounting for its effect.

One difficulty with the study is that in actual practice there are three parallel interests: (1) the development of arts therapies interventions by the arts therapists themselves; (2) the need to comply with evidence-based research criteria; and (3) the necessary accreditation of interventions by the Ministry of Justice. Arts therapists want to have interventions available that represent the core of their discipline and that are properly substantiated, applicable, and flexible, so that they can tailor them to their clients. Some researchers wish to carry out experimental research (an RCT) in order to demonstrate that a given intervention is effective in treating a particular problem; other researchers wish to remain close to standard practice and primarily carry out research that follows what is done in practice and assists the arts therapists in treating and evaluating. For clinic directors who consider arts therapies to be valuable, it is important – with a view to acquiring financing – to have the interventions assessed by the accreditation committee of the Ministry of Justice.

The strength of this research lies in the discussions that took place between arts therapists, managers, and researchers to find the “happy medium” amidst development, research, and accreditation. In this way, practice, research, and accreditation by the Ministry of Justice can coalesce. The research thus becomes a good example of how professionals can develop their action in actual practice while at the same time complying with the criteria that apply to research and to official accreditation. Seeking the happy medium that combines those three interests is a pioneering challenge for arts therapists. This question is high on the agenda for arts therapists and will be to a great extent decisive for recognition of their profession. One successful aspect of this project is that professionals play a decisive role.

The differences in training and professional background among the participating therapists means that a great deal of time is necessary for everyone to explain how he/she works and why. Nevertheless, it is precisely this exchange of different points of view

that is so very fruitful for the profession and for therapy in actual practice. Moreover, in this way, arts therapists are developing competencies that will enable them to put what they have learned into practice even after the project is over.

The interventions and the treatment theory will be made available to all arts therapists who wish to apply them to their work, regardless of whether in the context of this research. After all, it will only be after we apply externally what we have learned in this internal research that we can effectuate a serious reduction in juvenile delinquency.

Acknowledgements

The study involves research groups for each of the different arts therapies. The groups were coordinated by Julie Kil (dance-movement therapy), Han Kurstjens (music therapy), Jaap Welten (drama therapy), and Gemmy Willemars (art therapy), all of whom are researchers at KenVaK. The following arts therapists were involved in the initial phase as members of the research group or out of personal interest as reviewers: DRAMA THERAPY: Hilde Augustejn, Sanne van der Kolm, Jorg de Man, Josefien van der Wekken (project group members) and Elsa van den Broek, Tessa Bruggeman, Judith Hollands, and Annemieke Hahné (reviewers). MUSIC THERAPY: Frederik Esbach, Victor Macaré, Heinz Reumers (project group members) and Rob van Alphen and Nan van Leeuwen (reviewers). ART THERAPY: Marjan Helmich and Eline Godts (project group members) and Marie-Joze van Drie, Charlotte Evers, Digna van Roemburg-Tack, Hans Hoog Stoevenbelt, and Beatrix Verhofstad-Swinkels (reviewers). DANCE-MOVEMENT THERAPY: Eefje Prins (project group member) and Eva van den Boom, Mady de Jongh, Silke Loenen, Robbert Otte, and Monique Peters (reviewers). In the Netherlands there is a difference between dance-movement therapy and psychomotor therapy which is not based on an art form. In this article psychomotor therapy is not included.

Appendix A. Participants in the research project

The project is directed by the lead author (Smeijsters), director of research at the KenVaK Research Centre for the Arts Therapies. The centre is a joint venture of the Zuyd, Utrecht, ArtEZ and Stenden Universities of Applied Sciences. The project involves groups for drama therapy, music therapy, art therapy, and dance-movement therapy; these are coordinated by the KenVaK researchers Kil (dance-movement therapy), Kurstjens (music therapy), Welten (drama therapy), and Willemars (art therapy). Highly experienced arts therapists at six Dutch clinics for young offenders in secure care participate as a member of a research group or as a reviewer. The clinics concerned are Stichting Jeugdzorg St. Joseph (JJI Het Keerpunt and Icarus Jeugdzorg Plus), O.G. Heldring, Rentray, Den Hey-Acker, Avenier (Jongerenhuis Harreveld and De Sprengen).

References

- Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not*. Olympia, WA: Washington State Institute for Public Policy.
- Baillie, C. (1998). Art as therapy in a young offender institution. In M. Liebmann (Ed.), *Art therapy with offenders*. London: Jessica Kingsley Publishers.
- Baker, S., & Homan, S. (2007). RAP, recidivism, and the creative self: A popular music programme for young offenders in detention. *Journal of Youth Studies*, 10(4), 459–476.
- Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology and Therapy*, 10, 319–327.
- Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice-based evidence. A brief history of the origins and applications of CORE-OM and CORE System. *Counseling & Psychotherapy Research*, 6, 3–13.
- Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. Oxford: Oxford University Press.
- Bennink, J., Gussak, D. E., & Skowran, M. (2003). The role of the art therapist in a Juvenile Justice Setting. *The Arts in Psychotherapy*, 30(3), 163–173.
- Bernstein, D. P., Arntz, A., & de Vos, M. E. (2007). Schemagerichte therapie in de forensische setting. Theoretisch model en voorstellen voor best clinical practice [Schema-focused therapy in the forensic setting. Theoretical model and proposals for best clinical practice]. *Tijdschrift voor Psychotherapie*, 33, 120–139.
- Budde, E. (1989). *(Creative therapy in practice: Assignments and working models for creative art therapy) Creatieve therapie in praktijk: opdrachten en werkwijzen voor beeldende creatieve therapie*. Deventer, The Netherlands: Van Loghum Slaterus.
- Boendermaker, L. (1999). *Judicial treatment institutions for youth. Population and working method) Justitiële behandelingsrichtingen voor jongeren. Populatie en werkwijze*. Leuven–Apeldoorn, The Netherlands: Garant.
- Chu, B. C., & Harrison, T. L. (2007). Disorder-specific effects of CBT for anxious and depressed youth. A meta-analysis of candidate mediators of change. *Clinical Child & Family Psychology Review*, 10(4), 352–372.
- Damasio, A. R. (1999). *The feeling of what happens. Body and emotion in the making of consciousness*. London: Heinemann.
- DeCarlo, A., & Hockman, E. (2003). RAP therapy: A group work intervention method for urban adolescents. *Social work with Groups*, 26(3), 45–59.
- Duits, N., van Casteren, M., van den Brink, W., & Dorelijers, Th. A. H. (2005). Risicotaxatie van geweldsrecidive bij jeugdigen [Risk taxation of violence recidivism by youngsters]. *Tijdschrift voor psychiatrie*, 47, 511–518.
- Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client. A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass.
- Elliott, R., & Greenberg, L. S. (2001). *Essential research findings in counseling and psychotherapy*. London: Sage Publications.
- Emunah, R. (1994). *Acting for Real*. Florence: Brunner/Mazel.
- Gardstrom, S. C. (1999). Music exposure and criminal behavior: Perceptions of juvenile offenders. *Journal of Music Therapy*, 36(3), 207–221.
- Gersie, A. (1997). *Reflections on therapeutic storymaking*. London: Jessica Kingsley Publishers.
- Gibbs, J., Potter, G., & Goldstein, A. (1995). *The Equip Program. Teaching youth to think and act responsibly through a peer-helping approach*. Champaign, IL: Research Press.
- Gold, C., Voracek, M., & Wigram, T. (2004). Effects of music therapy for children and adolescents with psychopathology: A meta-analysis. *Journal of Child Psychology and Psychiatry*, 45, 1054–1063.
- Greenwood, D. J., & Levin, M. (2000). Reconstructing the relationship between universities and society through action research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.
- Haen, C., & Brannon, K. H. (2002). Superheroes, monsters, and babies: Role of strength, destruction, and vulnerability for emotionally disturbed boys. *The Arts in Psychotherapy*, 29(1), 31–40.
- Hanna, F. D., & Hunt, W. P. (1999). Techniques for psychotherapy with defiant, aggressive adolescents. *Psychotherapy*, 36(1), 56–68.
- Hayes, S. C., Barlow, D. H., & Nelson-Grey, R. (1999). *The scientist practitioner. Research and accountability in the age of managed care*. Boston: Allyn and Bacon.
- Hubble, M. A., Hubble, M. A., et al. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington: American Psychological Association.
- Hutschmaekers, G. (2009). *(Rules on your way and practical objections) Wetten in de weg en praktische bezwaren*. Nijmegen, The Netherlands: Radboud Universiteit.
- Institute of Medicine. (2007). *Treatment of PTSD: An assessment of the evidence*. Washington: Institute of Medicine.
- IPPR. (2003). *Offender rehabilitation and the arts: IPPR Seminar Summary*. London: Institute for Public Policy Research. Available at www.ippr.org.uk.
- Johnson, D. R. (2005). *Developmental transformations. Text for practitioners*. New York: Institute for the Arts in Psychotherapy.
- Johnson, D. R. (2009). *Examining underlying paradigms in the creative arts therapies of trauma* (first draft). artspsychotherapy@sbcglobal.net.
- te Kieft, J., Van Rhijn, N., & Haans, T. (1994). Begeleid toneel: keuzes maken en spelen [Coached theater: To make choices and to play]. *Tijdschrift voor Creatieve Therapie*, 13(1), 2–6.
- Kipper, D. A., & Ritchie, T. D. (2003). The effectiveness of psychodramatic techniques: A meta-analysis. *Group Dynamics: Theory, Research and Practice*, 7, 13–25.
- Koshland, L., Wilson, J., & Wittaker, B. (2004). PEACE through Dance/Movement: Evaluating a violence prevention program. *American Journal of Dance Therapy*, 26(2), 69–91.
- Kurstjens, H., & Baerends, A. (2006). Actieve muziektherapie. In H. Smeijsters (Ed.), *Handboek muziektherapie. Evidence-based practice voor de behandeling van psychische stoornissen, problemen en beperkingen* (Handbook of music therapy. Evidence-based practice for the treatment of psychic disturbances, problems and limitations). Houten, The Netherlands: Bohn Stafleu Van Loghum.
- Lamme, V. (2010). *(The free will does not exist. About who is really the boss in the brain) De vrije wil bestaat niet. Over wie er echt de baas is in het brein*. Amsterdam: Bert Bakker.
- Levy, F. J., Ranjbar, A., & Hearn Dean, C. (2006). Dance/Movement as a way to help children affected by war. *Journal of Physical Education, Recreation, & Dance (JOPERD)*, 77, 5, 6, 9, 12.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.

- Linehan, M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Lodewijks, H. (2008). *Violence risk assessment in adolescents in the Dutch juvenile justice system. Studies on the reliability and predictive accuracy of the SAVRY*. Amsterdam: Rozenberg Publishers.
- Lodewijks, H. P. B., Doreleijers, Th. A. H., De Ruiter, C. De, & de Wit-Grouls, H. (2003). *(Structured taxation of violence recidivism by youngsters) Gestructureerde taxatie van geweldsrisico bij jongeren*. Eefde, The Netherlands: Rentray.
- Malloch, S., & Trevarthen, C. (Eds.). (2008) *Communicative musicality: Exploring the basis of human companionship*. Oxford: Oxford University Press.
- McMackin, R. A., Leisen, M. B., Sattler, L., Krinsley, K., & Riggs, D. S. (2002). Preliminary development of trauma-focused treatment groups for incarcerated juvenile offenders. In R. Greenwald (Ed.), *Trauma and juvenile delinquency: Theory, research, and interventions*. Binghamton, NY: Haworth.
- McNeill, F. (2006). A desistance paradigm for offender management. *Criminology and Criminal Justice*, 6, 39–62.
- Moreno, J. L. (1977). *Psychodrama. First volume*. Beacon, NY: Beacon House.
- OJJDP, Office of Juvenile Justice and Delinquency Prevention. (1998). *Arts programs for juvenile offenders in detention and correction*. Available at <http://ojjdp.ncjrs.org>.
- Palmer, E. J., & Hollin, C. R. (1999). Social competence and sociomoral reasoning in young offenders. *Applied Cognitive Psychology*, 13(1), 79–87.
- Persons, R. W. (2009). Art therapy with serious juvenile offenders: A phenomenological analysis. *International Journal of Offender Therapy and Comparative Criminology*, 53, 433–453.
- Ritter, M., & Graff Low, K. (1996). Effects of dance/movement therapy: A meta-analysis. *The Arts in Psychotherapy*, 23, 249–260.
- Ross, R. R., & Hilborn, J. (2008). *Rehabilitating rehabilitation: Neurocriminology for treatment of antisocial behavior*. Ottawa: Cognitive Centre of Canada.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57, 316–331.
- Schweizer, C., de Bruyn, J., Haeyen, S., Henskens, B., Rutten-Saris, M., & Visser, H. (Eds.). (2009). *Uit de verf. Handboek beeldende therapie* (Out of the paint. Handbook of art therapy). Houten, The Netherlands: Bohn Stafleu van Loghum.
- Smeijsters, H. (2003). Forms of feeling and forms of perception. The fundamentals of analogy in music therapy. *Nordic Journal of Music Therapy: Theory Building in Music Therapy. An International Archive*, 12(1), 71–85.
- Smeijsters, H. (2005). *Sounding the self. Analogy in improvisational music therapy*. Gilsum, NH: Barcelona Publishers.
- Smeijsters, H. (Ed.). (2006). *Handboek muziektherapie. Evidence-based practice voor de behandeling van psychische stoornissen, problemen en beperkingen* (Handbook of music therapy. Evidence-based practice for the treatment of psychic disturbances, problems and limitations). Houten, The Netherlands: Bohn Stafleu van Loghum.
- Smeijsters, H. (2007). *(Aggression regulation in forensic psychiatry) Agressieregulatie in de forensische psychiatrie*. Heerlen, The Netherlands: Hogeschool Zuyd–KenVaK.
- Smeijsters, H. (2008a). *(The arts of life. How the arts contribute to an emotional healthy life) De kunsten van het leven. Hoe kunst bijdraagt aan een emotioneel gezond leven*. Diemen, The Netherlands: Veen Magazines.
- Smeijsters, H. (2008b). *(The arts of life. Examples form the creative arts therapies) De kunsten van het leven. Voorbeelden uit de creatieve therapie*. Diemen, The Netherlands: Veen Magazines.
- Smeijsters, H. (2008c). *(Handbook of arts therapies) Handboek creatieve therapie*. Bussum, The Netherlands: Coutinho.
- Smeijsters, H. (2009a). Onderzoek in en door de praktijk en practice based evidence in de lerende organisatie. Voorbeelden van onderzoek door kenniskringen van hogescholen [Research in and by practice and practice-based evidence in the learning organization. Examples of research by research centers at the universities of applied sciences]. *THEMA–Tijdschrift voor Hoger Onderwijs en Management*, 1, 4–13.
- Smeijsters, H. (Ed.). (2009b). *Research in practice in the arts therapies*. Heerlen, The Netherlands: KenVaK/Melos.
- Smeijsters, H., van den Braak, J., Helmich, M., Reumers, H., & van der Wekken, J. (2009). *(Arts therapies in judicial institutions and locked care for youth) Vaktherapie in de Justitiële Jeugdinrichtingen en de Gesloten Jeugdzorg. Kaderdocument voor alle vaktherapieën*. Heerlen/Cadier & Keer, The Netherlands: KenVaK/Het Keerpunt.
- Smeijsters, H., & Cleven, G. (2006). The treatment of aggression using arts therapies in forensic psychiatry: Results of a qualitative inquiry. *The Arts in Psychotherapy*, 33(1), 37–58.
- Spolin, V. (1999). *Improvisation for the theater*. Evanston, IL: Northwestern University Press.
- Stern, D. N. (2000). *The interpersonal world of the infant. A view from psychoanalysis and development psychology*. New York: Basic Books.
- Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton.
- Stern, D. N. (2010). *Forms of vitality. Exploring dynamic experience in psychology, the arts, psychotherapy, and development*. Oxford: Oxford University Press.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.
- Trower, P. (1978). Skills training for adolescent social problems. A viable treatment alternative? *Journal of Adolescence*, 1, 319–329.
- Tyson, E. H. (2002). Hip-Hop Therapy: An exploratory study of a rap music intervention with at-risk and delinquent youth. *Journal of Poetry Therapy*, 15(3), 131–144.
- Weisz, J. R., McCarthy, C., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents. A meta-analysis. *Psychological Bulletin*, 132(1), 132–149.
- Weisz, J. R., & Weiss, A. L. (1993). *Effects of psychotherapy with children and adolescents*. Newbury Park, CA: Sage Publications.
- Wenger, E. (1998). *Communities of practice. Learning, meaning and identity*. Cambridge: Cambridge University Press.
- Wood, J., Foy, D., Layne, C., Pynoos, R., & James, C. B. (2002). An examination of the relationship between violence exposure, posttraumatic stress symptomatology, and delinquent activity. In R. Greenwald (Ed.), *Trauma and Juvenile Delinquency: Theory, Research, and Interventions*. Binghamton, NY: Haworth.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy. A practitioner's guide*. New York: Guilford Press.
- van Yperen, T., & Veerman, J. W. (Eds.). (2008). *Zicht op effectiviteit. Handboek voor praktijkgestuurd effectonderzoek in de jeugdzorg* (A view on effectiveness. Handbook of practice driven effect research in youth care). Delft, The Netherlands: Eburon.
- Zevalkink, J., & van Dam, Q. D. (2007). *(Presence of mind. The actual moment in a psychoanalytic treatment) Tegenwoordigheid van geest. Het actuele moment in een psychoanalytische behandeling*. Assen, The Netherlands: Van Gorcum.