The Arts in Psychotherapy 69 (2020) 101663

Contents lists available at ScienceDirect

The Arts in Psychotherapy

journal homepage: www.elsevier.com/locate/artspsycho

Research Article

Compassion Focused Art Therapy for people diagnosed with a cluster B/C personality disorder: An intervention mapping study

Suzanne Haeyen[a,b,c,*,1], Jackie Heijman[b]

[a] GGNet, Centre for Mental Health, Scelta, Expert Centre for Personality Disorders Apeldoorn, PO Box 2003, 7230 GC, Warnsveld, the Netherlands
[b] HAN University of Applied Sciences, Department Arts & Psychomotor Therapies, PO Box 6960, 6503 GL, Nijmegen, the Netherlands
[c] KenVaK, Research Centre for the Arts Therapies, PO Box 550, 6400 AN, Heerlen, the Netherlands

ARTICLE INFO

Keywords:
Compassion focused therapy
Art therapy
Personality disorders
Intervention mapping
Emotion regulation
Compassion

ABSTRACT

A key concern of Compassion Focused Therapy (CFT) is to develop inner warmth, safeness and soothing. The aim of the current study was to develop a compassion focused art therapy programme for clients diagnosed with Personality Disorders (PDs), the goal being to strengthen compassion skills and achieve more adaptive emotion regulation.

The Intervention Mapping Method was used for this purpose, based on: 1) determining needs, 2) goals for behavioural change, 3) theoretical art therapy methods and practical applications, 4) translation into an art therapy intervention, 5) planning adaption, implementation and durability, and 6) an evaluation plan. Use was made of a number of literature studies, focus groups with clients and occupational group professionals, questionnaires and a feasibility study.

The study resulted in the development of a Compassion Focused Art Therapy (CFAT) intervention for clients diagnosed with PDs, in which the most important goal was strengthening their compassion for themselves and for others. Key topics of CFT are found here as well, such as mindfulness, imagery and emotion regulation systems. The programme is based on a number of potentially effective methods that were specifically combined and tailored for this client population. Further research with a larger sample is needed to substantiate the intervention.

Introduction

Buddhism defines the concept of compassion as “a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it” (Lama, 1995). According to K.D. Neff (2003), K. Neff (2003), one of the researchers of compassion, important components of compassion are being mindful and being open to your own suffering, being friendly and non-judgmental and aware that you have your experiences with suffering in common with other people. Compassion is a universal human characteristic, one that is potentially present in all of us. However, developing these aspects does not come naturally to everyone. Clinical psychologist and professor Paul Gilbert designed Compassion Focused Therapy (CFT) for this purpose. It is aimed at clients with chronic and complex mental problems, often with an intricate and challenging background involving excessive self-criticism and shame (Gilbert, 2005, 2009, 2018a, Gilbert & Procter, 2006).

A relatively new treatment in psychology, CFT comprises a number of starting points such as cognitive behavioural therapy, mindfulness and the biological theory of evolution (Gilbert, 2018a). One of the key concerns of CFT is to use compassionate mind training to help people develop and work with experiences of inner warmth, safeness and soothing through compassion and self-compassion (Gilbert, 2009). Gilbert drew up a protocol of 12 psychotherapy sessions with CFT as their starting point. The protocol focuses on aspects such as the theory of evolution, emotion regulation, mindfulness, and compassion for self and others (Gilbert, 2018b). Although conventional behavioural therapy treatments can effectively help alter their patterns of thought, clients often continue to experience the same deeply rooted negative feeling about themselves (Gilbert, 2018a). CFT is explicitly focused on changing this feeling through compassion, thus allowing clients to be gentler and more sympathetic toward themselves (Gilbert, 2018a). Compassionate mind training helps transform problematic patterns of cognition and emotion related to anxiety, anger, shame and self-criticism. More and more, compassion is the object of study, and has proved

* Corresponding author at: GGNet, Centrum Voor Geestelijke Gezondheid, Apeldoorn, the Netherlands.
E-mail addresses: s.haeyen@ggnet.nl (S. Haeyen), jackieheijman@gmail.com (J. Heijman).
[1] Postal address: PO Box 2003, 7230 GC, Warnsveld, the Netherlands.

https://doi.org/10.1016/j.aip.2020.101663
Received 11 December 2019; Received in revised form 22 April 2020; Accepted 22 April 2020
Available online 28 April 2020

to have a positive influence on complex mental health problems such as stress, anxiety, depression and emotion regulation (e.g. Braehler et al., 2012; Gilbert, 2009; Kirby, 2017; MacBeth & Gumley, 2012; K. Neff, 2003; Seppala et al., 2013), and improving interpersonal and social relationships (e.g. Crocker & Canevello, 2012). The limitation in these empirical studies is the small number of participants involved in each case.

A target group with chronic and complex mental problems is that of clients with a cluster B/C personality disorder. Personality disorders are one of the most frequent psychiatric disorders treated by healthcare professionals. More than 45 % of psychiatric clients meet the criteria for one or more personality disorders (Akwa, 2017; Zimmerman, Rothschild, & Chelminski, 2005). A personality disorder is a lasting pattern of inner experiences and behaviour that clearly deviates from expectations in the person's culture, is present in many different situations and is persistent, emerges during adolescence or young adulthood, is stable over time, and leads to constraints or causes suffering (American Psychiatric Association [APA], 2013). These clients are often troubled by unpleasant experiences from their past, disturbed representations of self (excessive self-criticism) and of the other, and impaired emotion regulation (American Psychiatric Association [APA], 2013; Eurelings-Bontekoe et al., 2017). These negative experiences from the past relate to a deficiency in mentalization, e.g. the ability to understand one's own, and others' mental states (Bateman & Fonagy, 2012). Clients with a personality disorder are generally given psychotherapy such as Mentalization Based Therapy, Schema Therapy, Dialectical Behavioural Therapy and/or medication.

Another therapeutic approach used for clients diagnosed with a personality disorder and which is also aimed at changing feelings, behaviour and thoughts is art therapy (van den Broek, Keulen-de Vos, & Bernstein, 2011; Eren et al., 2014; Franks & Whitaker, 2007; Gatta, Gallo, & Vianello, 2014; Green, Wehling, & Talsky, 1987; Haeyen, 2018; Haeyen, 2019; Haeyen, Chakhssi, & Van Hooren, 2020; Haeyen, Dehue, van Hooren, van der veld, & Hutschemaekers, 2018; Haeyen, van Hooren, van der veld, & Hutschemaekers, 2018; Springham, Findlay, Woods, & Harris, 2012). The target group generally follows a multidisciplinary treatment and art therapy is often part of it. In art therapy, clients work methodically and experientially on individual therapeutic goals by working with various art materials such as paints, clay, pencil, and so on, and assignments in which experiences are evoked and people can practise different forms of behaviour. The therapy works on developing emotional, cognitive, social or physical skills that can be applied in daily life (Nederlandse Vereniging voor Beeldende Therapie, 2018). There is emerging evidence indicating the effectiveness for art therapy. A recent study showed that art therapy is effective for clients diagnosed with a B/C cluster personality disorder, as recent research has shown (N = 74) (Haeyen, Dehue et al., 2018; Haeyen, 2018; Haeyen, van Hooren et al., 2018). It reduces general mental dysfunctioning and symptoms such as early maladaptive behaviour or emotional states (impulsiveness, detachment, vulnerability and punitive behaviour). It also promotes adaptive modes (pleasant feelings, spontaneity and self-regulation) and positive mental health, strengthens well-being and other positive outcome measures. Unpleasant inner thoughts, feelings and physical sensations are more readily accepted (Haeyen, Dehue et al., 2018, 2018b). van den Broek et al. (2011) found that (inter alia) art therapy could trigger early emotional states. Despite the fact that not much research has been done in this field, art therapy is viewed by professionals and clients in the practice of mental healthcare as a valuable treatment for clients with a personality disorder (Karterud & Pedersen, 2004). Through art therapy, clients experience improvements in perception, emotion regulation, personal integration, behaviour and gaining insight into and an understanding of their problems (Haeyen, van Hooren, & Hutschemaekers, 2015; Springham et al., 2012). Specific symptoms of clients with a cluster B/C personality disorder such as the instability of self-image respond to art therapy, and it can be of help in improving interpersonal functioning (Green et al., 1987). It also makes patterns, feelings and behaviour visible and tangible in the artwork produced (Schweizer et al., 2009). On the basis of the foregoing, CFT and art therapy would seem to be closely connected, and the combination could well be a form of added value.

Art therapy could complement CFT, since actions and perceptions are regarded as important components of CFT (Gilbert, 2018a). CFT is focused on direct sensory experience, for example in using guided imagery. It is also suggested that art therapy is essential in developing higher mentalization capacity. By visualizing inner mental content in a tangible form, the process of explicit mentalization is slowed down and made manageable (Springham et al., 2012). Moreover, mindfulness, a major aspect of CFT, is inextricably bound up with art therapy thanks to the tactile quality of working with a variety of art materials, experiences in the moment and making changes to artworks (Davis, 2015). Various forms of art therapy are often combined with mindfulness (e.g. Mindfulness Based Art Therapy, Monti et al., 2006) or focusing (e.g. Focusing Oriented Art Therapy, Rappaport, 2009). A number of compassion-based therapies have been developed, such as Compassion Oriented Art Therapy (COAT), which aims to create a supportive therapeutic environment for gender-variant clients (Beaumont, 2012), and the ONEBird model, which integrates mindfulness, compassion, and creative expression (Williams, 2018). However, these therapies do not link directly to the target group of people diagnosed with a personality disorder, nor to the CFT protocol developed by Gilbert (2018b).

The CFT protocol developed by Gilbert was specifically designed for talk therapy (2018b). Because in practice, therapists often work together on a multidisciplinary basis, it is important that they work on the basis of the same framework in other forms of therapy, such as art therapy. After all, for the effectiveness of psychotherapeutic treatment of personality disorders, it is important that it is based on a clear, coherent and unambiguous therapy model that is applied consistently (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ [National Advisory Committee Regarding Multidisciplinary Guidelines for Development in Mental Healthcare], 2008).

This calls for a translation of Gilbert (2018b) CFT protocol into an art therapy treatment. The aim of the current study is to develop a compassion focused art therapy programme for clients diagnosed with PDs with the object of strengthening compassion skills and more adaptive emotion regulation.

Method

Intervention Mapping (IM) is a systematic method for developing, implementing and evaluating healthcare interventions (Bartholomew, 2016). According to IM, experiential knowledge (empirical knowledge) and theory are used to arrive at an intervention that promotes health. IM can be used in politics, education or the healthcare sector. It is composed of the following steps: Step 1. Needs assessment by reviewing scientific literature on the target group, the environmental factors and determinants that promote healthy, compassionate behaviour in the target group. Step 2: The determinants of healthy, compassionate behaviour are used to define targets for behavioural change, aimed at compassionate behaviour in the target group. Step 3: Assessment of theoretical methods and their practical application for the goals aimed at developing compassion. Step 4: Translating existing methods into an organised art therapy intervention. Stap 5: Planning the adaption, implementation and durability of the intervention thus designed. Step 6: Drawing up an evaluation plan (Bartholomew, 2016).

Steps 1 and 2 were conducted by means of a literature review of the target group and by means of a multidisciplinary focus group consisting of 11 healthcare professionals (psychiatrist, psychotherapists, art therapist, music therapist, psychomotor therapist, sociotherapists, system therapist), all of them specialised in the treatment of clients with a cluster B/C personality disorder, on the use of compassion in therapy

Table 1
Specific determinants of ineffective personality disorder behaviour per diagnostic group (American Psychiatric Association [APA], 2013) (Haeyen, Dehue et al., 2018, 2018b).

Diagnostic group (prevalence in general population)		Specific determinant
Cluster B	Antisocial personality disorder (0.2–3.3 % [a])	Pervasive pattern of disregard for and violation of the rights of others, lack of empathy, bloated self-image, manipulative and impulsive behaviour
	Borderline personality disorder (1.6–5.9 % [b])	Pervasive pattern of instability in relationships, self-image, identity, behaviour, and affects often leading to self-harm and impulsivity
	Histrionic personality disorder (1.84 %)	Pervasive pattern of attention-seeking behaviour and excessive emotions
	Narcissistic personality disorder (0–6.2 %)	Pervasive pattern of grandiosity, need for admiration, and a lack of empathy
Cluster C	Avoidant personality disorder (2.4 %)	Pervasive feelings of social inhibition and inadequacy, extreme sensitivity to negative evaluation
	Dependent personality disorder (0.49 %/0.6 %)	Pervasive psychological need to be cared for by other people
	Obsessive-compulsive personality disorder (2.1–7.9 %)	Characterised by rigid conformity to rules, perfectionism, and control to the point of satisfaction and exclusion of leisurely activities and friendships (not the same as and quite different from obsessive-compulsive disorder)

[a] In rehabilitation clinics, jails, and forensic institutes > 70 % [b] In mental health institutions up to. 20 %

and the needs of the target group. The following databases for literature were consulted (date October 2, 2019): psychINFO, Academic Search Complee, MEDLINE, NARCIS, Psychology and Behavioral Sciences Collection (EBSCO). Keywords were: “personality disorder*” or “personality pathology”, “health determinants AND personality disorder*”, “emotion dysregulation AND personality disorder*”, “emotion regulation AND personality disorder*, “compassion focused therapy”. The information from the focus group was subjected to open and to axial coding and linked to the literature review.

Step 3 included a sub-study of the usefulness of art therapy assignments aimed at compassion. Part of this focused on conducting trial sessions. Service users completed self-report questionnaires, two focus groups were held with a total of nine clients and the sessions offered were evaluated with the two implementing therapists. A focus group was also held with three art therapists with ample experience in working with clients diagnosed with a personality disorder. This focus group discussed potentially workable art therapy interventions for this target group aimed at strengthening compassion. The theoretical methods, assignments, techniques and practical applications thereof, as inventarised and analysed in this step, were assessed for usability. A literature study was also carried out with the theme of key elements in the CFT module and their possible application in art therapy. The following databases for literature were consulted (date February 22, 2019): psychINFO, Academic Search Complete, MEDLINE, CINAHL, NARCIS, ERIC en Psychology and Behavioral Sciences Collection (EBSCO), Social Sciences Citation Index, ScienceDirect en Science Citation Index. Keywords were "personality disorder*" or “personality patholog*”, "art therap*" or "arts therap*" or "creative therap*" in all fields, and “compassion”, “mindfulness”, “soothing rhythm breathing”, “shame”, “self-criticism”, “emotion regulation” and “guided imagery” in Dutch and English. An additional search was based on the key words “positive art(s) interventions”. The search was delimited by the term “age 18 up”. This peer-reviewed research literature was supplemented by descriptive literature – handbooks and descriptions of expert opinions.

In step 4 the results were combined into an organised intervention. The intervention was implemented and supervised **in step 5**, and an evaluation plan was written to promote retention of the intervention **in step 6**.

Results

Outcomes of the IM process will be described according to the six steps.

Step 1: Needs assessment

As stated in the preface, personality disorders are frequent in healthcare. Cluster B is also called the impulsive, dramatic or emotional cluster. Cluster C has a more anxiety-based character (van der Molen et al., 2015). Because in practice, these two diagnostic clusters are often seen in similar treatment programmes, this study is limited to these two groups. A central characteristic of personality disorders is a lack of emotion regulation (Dimaggio et al., 2017). The forms this can assume in each diagnostic group are shown in Table 1, listing the specific determinants per personality disorder according to the American Psychiatric Association [APA] (2013). These determinants are egosyntonic, that is, they are seen as a fundamental part of the person and his or her character.

Emotion dysregulation, or the inability to effectively respond to and manage emotions, has been established as a core symptom in clients with personality disorders (PDs), impairing well-being and causing considerable distress. Emotion dysregulation in individuals with PDs refers to harm of self or others, affective lability, anxiousness, cognitive dysregulation, avoidance, oppositionality and suspiciousness (American Psychiatric Association [APA], 2013). Effective treatment of emotion dysregulation may significantly reduce the burden and improve the quality of life of clients with personality disorders. Unfortunately, conventional treatments are only moderately successful in attenuating emotion regulation difficulties (Cristea et al., 2017). An alternative form of treatment which may offer a helpful strategy for improving emotion regulation in this specific group of clients is CFT. CFT elicits a decrease in shame and self-criticism in clients with a personality disorder, and is regarded as valuable in the process of emotion regulation (Lucre & Corten, 2013). A meta-analysis by Wilson, Mackintosh, Power, and Chan (2019)) showed that compassion-related therapies increase self-compassion and decrease symptoms of anxiety and depression.

In CFT, compassion is related to an evolutionary functional analysis of emotions, distinguishing between three major emotion regulation systems (see Fig. 1): (1) the threat protection system, which provides abilities to detect and respond to threat; (2) the drive-seeking and resource-seeking system, which provides information on the availability of resources and rewards; and (3) the soothing and affiliation system, which enables individuals to reassure and soothe themselves (2014, Gilbert, 2009). CFT is aimed at people who find experiences of soothing positive affect difficult or frightening. This may particularly suit clients diagnosed with personality disorders whose threat system seems overactivated (e.g. anxiety, sadness, guilt, anger, shame) and whose soothing system seems poorly accessible. CFT may contribute to more effective emotion regulation through (1) strengthening an individual’s capacity for experiencing and tolerating affiliative/soothing emotions in the face of setbacks; and (2) strengthening the capacity for regulating and engaging with unpleasant or feared emotions such as anger, anxiety or guilt (which are characteristic of the threat system) (Chakhssi, 2015).

Emotion regulation difficulties in personality disorders are associated with an impaired bonding process, as well as maladaptive interpersonal patterns of behaviour (Lewis, 2018). If babies don’t experience any bonding with their parents in their first years (love, trust

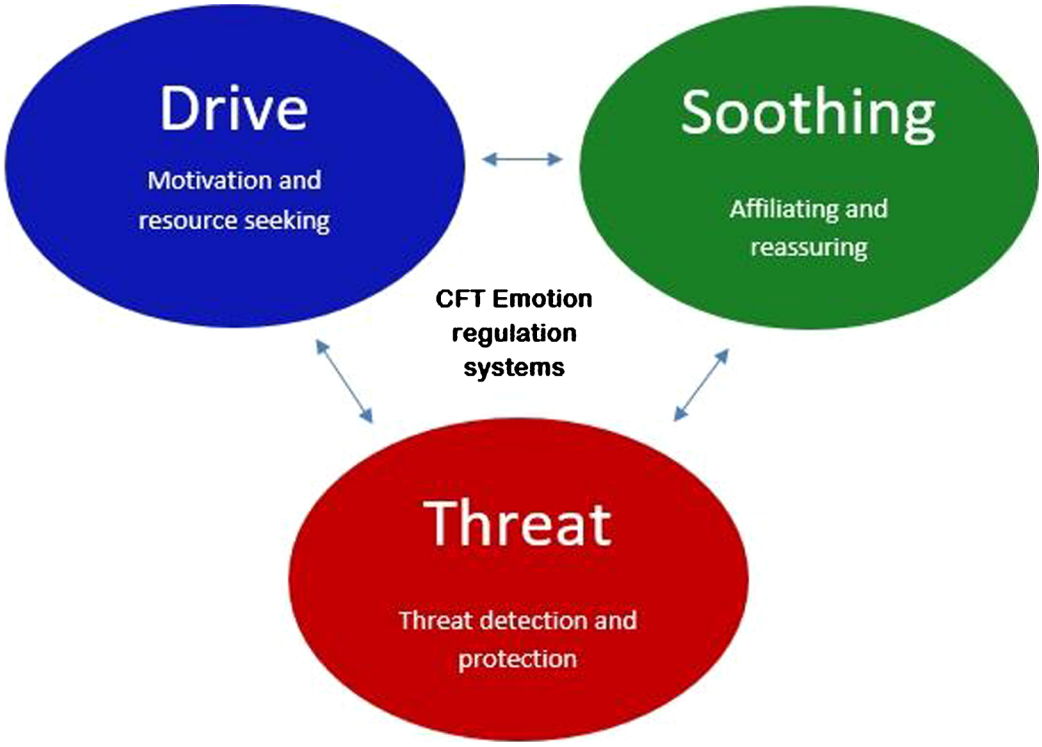

Fig. 1. Major emotion regulation systems.

and calming by means of soothing), it can result in anxiety for relationships and love, which are avoided as a form of self-protection (Mikulincer & Shaver, 2007). CFT makes use of the bonding relationship and the importance of affection and positive affirmation for a healthy mental condition and effective emotion regulation (Gilbert, 2018a).

The multidisciplinary focus group of specialised healthcare professionals stressed the importance of developing compassion in the target group. It emerged that clients in this target group have a great deal of self-criticism; they are not accustomed to positive validation and have difficulty in making contact with others. They have difficulty in bonding and often push people away to protect themselves from pain and emotions. CFT is appropriate for clients who have been diagnosed with personality disorders and whose threat system is overactivated (by e.g. anxiety, sadness, guilt, anger, shame) and whose soothing system seems poorly accessible (Gilbert, 2018a). Invalidation, lack of warmth in bonding, and abuse show distinct relationships with self-criticism and self-compassion (Naismith, Zarate Guerrero, & Feigenbaum, 2019). The focus group showed that compassion can teach clients to be less strict and unforgiving for themselves, that guilt feelings can be downplayed and clients can develop healthier emotions by means of the calming system. The professionals saw that, in learning about compassion, clients became milder towards themselves and showed higher mentalization capacity; they showed more understanding of and insight into themselves and others. They also undertook to experiment more with new behaviour and exploration of emotions.

Step 2: Matrix of change objectives

Next, important and changeable objectives of behaviour were chosen. For personality disorder clients of both cluster B and C, determinants taken from Table 1 were summarised and translated into general therapeutic change objectives focused on emotion regulation systems and compassion skills. These general change objectives were translated into more concrete performance objectives to be identified in art therapy (see Table 2). The general change objectives can be described as follows.

1 **Is able to experience emotions in the present moment.** The person actively uses mindfulness skills to fully experience emotions, and has a focused attention for feelings, actions and thoughts.
2 **Recognises and distinguishes their major emotion regulation systems: (1) threat protection, (2) drive- and resource-seeking; and (3) soothing and affiliation**. The person has the ability to recognise, validate, and regulate their emotion regulation systems. The capacity for emotion regulation is stronger when a person has learned how to label and regulate emotional arousal, how to tolerate emotional distress, or when to trust their emotional responses as reflections of valid interpretations of events (Linehan, 1996). This is a change objective because of determinants such as emotion dysregulation, excessive emotions, emotional vulnerability, extreme sensitivity, and impulsive, avoidant, or attention-seeking behaviours (Haeyen, Dehue et al., 2018, 2018b). The person understands when and how their emotion regulation systems are activated.
3 **Is able to express and regulate emotions constructively.** The person is able to show how they feel by expressing emotions and is able to handle these in a direction that is constructive/helping, reassuring and soothing.
4 **Uses improved compassion and self-compassion skills.** This means that the person uses compassion skills to protect, to use resources, to reassure and soothe themselves and others. Instead of being overly self-critical, the person can be self-observing, mild, accepting and self-accepting.

Step 3: Theoretical methods and practical strategies

In Step 3, general change objectives from Step 2 were translated into practical strategies by selecting theory-based intervention methods. Theoretical foundations and empirically evaluated methods and strategies for these change objectives were obtained by literature review. Practice-based intervention methods were selected from the results of: 1) a feasibility study based on experiences of users in 4 pilot CFAT

Table 2
Matrix of general change objectives and performance objectives in art therapy for cluster B/C personality disorder patients.

Target group and determinant (selected)	General change objectives	Performance objectives in Compassion Focused Art Therapy
Cluster B - Lack of empathy - Instability in relationships - Instability of self-image, identity - Instability of behaviour (impulsivity) and affects (excessive emotions) Cluster C - Feelings of social inhibition and inadequacy - Dependent or avoidant behaviour and anxiousness (suppressed/avoided emotions) - Extreme sensitivity to negative evaluation - Psychological need to be cared for by other people - Rigid conformity to rules, perfectionism, and excessive control	1 Is able to experience emotions in the present moment. 2 Recognises and distinguishes the own major emotion regulation systems: (1) threat protection, (2) drive- and resource-seeking; and (3) soothing and affiliation. 3 Is able to express and regulate emotions constructively. 4 Uses improved compassion and self-compassion skills.	1 The client is able to experience emotions in the present moment mindfully, with focused attention, during the art process and reflective verbalisation based on own and others' expressions in art work. 2 The client expresses and structures emotion in the art processes focused on regulating emotions, improving the calming systems. 3 The client investigates own patterns concerning emotion regulation systems in the art work and the reflection afterwards. 4 Patient develops compassion skills and compassionate thinking about own and others' actions, emotions and art products. 5 Patient develops a more compassionate sense of self by observing, being mild and accepting own creative expression (instead of being overly self-critical) and by being open to experiment and spontaneous actions in the art processes.

sessions; 2) two focus groups with nine clients and two executive art therapists; 3) an inventory focus group with three senior art therapists, with many years of experience in working with this target group. The usefulness of the theoretical methods, assignments, techniques and their practical application, as inventarised and analysed in this step, were assessed.

Objective 1: experiencing emotions in the present moment mindfully and with focused attention. This can be achieved by learning mindfulness skills. Practising focused attention and using sensory stimulation in art therapy provides grounding of bodily experience, it gives access to the client's inner wisdom, resulting in more compassion, and it increases skills to stay in the moment in the experiential process (Rappaport, 2014, p. 193). Mindfulness in art therapy can be used to increase self-compassion because its non-judgmental nature is emphasised and self-criticism decreases (Hogan, 2016; Rappaport, 2014). Mindfulness-Based Art Therapy (MBAT) also provides for a significant decrease in stress (Monti et al., 2006; Jalambadani & Borji, 2019) and characteristics of depression and anxiety (Jang, Lee, Lee, & Lee, 2018) in medical healthcare clients.

Objective 2: recognising and distinguishing own emotion regulation systems. Emotion regulation systems become visible and recognisable in artwork based on the analogue process model (Pénzes, van Hooren, Dokter, Smeijsters, & Hutschemaekers, 2014). This strategy analyses the analogy between the artwork and the client's daily life. The various sytems literally become visible to the client. Strategies emphasised by the focus groups include literally working out the emotion regulation system of Gilbert (2018a), where size and distance between systems can be analysed and compared with daily life. Ineffective emotion strategies not only can be recognised but can also be removed in the artwork or adapted to effective strategies, thus creating space to practice healthy behaviour (Haeyen et al., 2015; Verfaille, 2016).

Objective 3: expressing and regulating emotions constructively. Expressing and regulating these emotion systems can be achieved in practice by placing emphasis on the persons own feelings and needs (Gilbert, 2018a; Haeyen et al., 2015) to strengthen a healthy calming system. Guided imagery is used in art therapy to weaken symptoms, change the mood and activate healing (Malchiodi, 2011). Mental images evoke the same brain activity as 'real' images. In this way, the senses can be stimulated by guided imagery. Making artwork after a guided imagery session can more deeply anchor the calming feeling and make visible what is necessary for this (Malchiodi, 2011). Franklin (2010) pointed out that creating art helps to modulate emotions that arise concomitantly with attachment relationships. In addition, the distraction strategy is effective in art therapy to regulate emotion (Gruber & Oepen, 2018), thanks to its indirect operation.

Objective 4: Using improved self-compassion skills. Art therapy proves to be excellently suited to improving and practising self-compassion skills (Williams, 2018). Suffering literally becomes visible on paper and can then be regulated. Practical strategies are an unassuming approach in looking at artwork, with attention to image characteristics, and playful exploration, so that the self-critical side is silenced and self-compassion is increased (Withrow, 2004). Making artwork can lead to many critical thoughts (Haeyen, 2015). Clients with a personality disorder can be extremely strict with themselves in this regard, even throwing away their own work, for example. In art therapy, they learn to look non-judgmentally and to become aware of persistent patterns of self-criticism (Haeyen, 2015). The strength of the group in art therapy also ensures that people can respond with compassion to another's work. The focus groups stress that self-criticism can be visualised, and the use of materials can be likened to a compassionate image, to compassionate surroundings. One consideration here: it has proved that the therapy should not only focus on the warmth of compassion; such a one-sided approach could cause clients to adopt a negative attitude to compassion. Compassion can also mean being honest with yourself, taking yourself seriously and facing your self-criticism.

Step 4: Intervention

In Step 4, the theoretical models and methods of Step 3 are translated into a manual for the intervention. The manual is based on information from Steps 1–3, the literature review, the pilot sessions, the focus group with art therapists and a group with a specialised treatment team for clients with a personality disorder. In making decisions, use was made of the number of years of experience of the first author (SH) with art therapy assignments developed and used in practice for PD treatment by many art therapists, taking assignments from a larger workbook (Haeyen, 2018). Gilbert's CFT protocol was used as a framework for designing the CFAT programme. Final decisions for this 10-session intervention protocol were made in the research group. We concluded that an intervention programme should focus on: (1) a clear generic treatment structure; (2) the change objectives that fit the client's goals; (3) a therapeutic style that fits these objectives; (4) monitoring of progress in art therapy; and (5) support for art therapy professionals.

Inclusion criteria are: adults (18+ years) with a diagnosis of a cluster B and/or C Personality Disorder or a personality disorder not otherwise specified (American Psychiatric Association [APA], 2013), an IQ > 80, experiencing difficulties on account of being overly self-critical, readily feeling threatened. Exclusion criteria are acute crisis, psychosis, actual and serious suicidal behaviour and/or thoughts, and/

Table 3
Compassion Focused Art Therapy protocol (10 sessions) based on theoretical models and empirically validated methods.

Session	Title & Art assignments	Change objectives	Performance objectives
1	**Awareness of compassion** Clients check in, discussion of basic rules, warm-up: Soothing rhythm breathing exercise focused on mindfulness via movement of chalk on paper. Assignment: Becoming aware of compassion through guided imagery and later imagining it. Evaluation: reflection.	1, 4	1, 4, 5
2	**The tree of origins** Clients check in, warm-up: Soothing rhythm breathing exercise focused on mindfulness, using a crayon, focused on recognising their own needs. Assignment: 'the tree of origins' showing roots (family of origin), trunk (development) and branches (what clients worry about). Evaluation: reflection and homework.	1, 3, 4	1, 3, 4, 5
3	**Emotion regulation** Clients check in, discussion of homework. Introduction to the emotion regulation systems: protection, drive and calming systems. Assignment: 'a picture of your three circles', imagining how the emotion regulation systems are recognised by your self. Evaluation: reflection.	2, 3	2, 3
4	**Compassionate self-image** Clients check in, warm-up: Soothing rhythm breathing exercise focused on mindfulness, drawing a bowl shape and sensory experience. Assignment: 'welcome yourself – self-image in safe surroundings'. Shaping own silhouette and the environs using shapes and colours suited to your most compassionate self. Evaluation: reflection.	1, 2, 4	1, 2, 4, 5
5	**Safety vs security** Clients check in, warm-up: Soothing rhythm breathing exercise focused on mindfulness by becoming sensorily aware of clay. Assignment: 'a fragile moment'. Guided imagery, shaping themselves as a clay figure with background/surroundings. Then they add what the clay figure needs in order to feel better. Evaluation: reflection.	1, 2, 3, 4	1, 2, 3, 4, 5
6	**Inner Critic** Clients check in, warm-up: Soothing rhythm breathing exercise focused on mindfulness by following ecoline dribbled on paper. Assignment: 'inner critic', exhibit of inner critic's statements, read this out loud to each other and make a visual reply that comes from your compassionate self. Evaluation: reflection and homework.	2, 3, 4	2, 3, 4
7	**Shame** Clients check in, discuss homework. Warm-up Soothing rhythm breathing exercise focused on mindfulness of the sensory experience of tearing paper. Assignment: 'mask of shame', how you present yourself to others (outside of mask) and the anxiety and shame (inside of mask). Evaluation: reflection.	2, 3, 4	2, 3, 4
8	**The compassionate self** Clients check in, warm-up: Soothing rhythm breathing exercise focused on mindfulness (tearing flypaper). Assignment: 'a meeting in the woods', imaging the compassionate self after guided imagery. Evaluation: reflection.	1, 4	1, 4, 5
9	**Compassion for the other** Clients check in, warm-up: represent the emotion of the moment and its physical perception. Assignment: 'Showing compassion for the other', interaction between group members by responding to each others' troublesome situation in the form of an image. Evaluation: reflection.	2, 3, 4	2, 3, 4
10	**Wrapping up** Clients check in. Assignment: After reviewing all artworks, write a letter to yourself. This is followed by a 'compassionate wish' for the future, in clay. Evaluation: extensive reflection on the process of each group member.	4	4, 5

or severe brain pathology. Clients participate on a voluntary basis.

Generic structure: 10-session CFAT programme

This CFAT programme has a structure of 10 weekly 90-minute sessions of group art therapy, each based on the change objectives (see Table 3). The therapy setting should be transparent and safe (e.g. with a warm and respecting attitude towards each other), and it should be possible to rely on professional crisis intervention when needed. The therapeutic group situation should be feasible, meaning that the client can benefit from the therapy group and can also collaborate constructively with others. It is an open rolling group. The sessions end with discussion and reflection based on the art process and art product. The atmosphere of the sessions should be one of respect, validation, empathy and understanding, with the main emphasis on the need to sustain communication, to keep the channels of communication open (Fonagy, Luyten, & Allison, 2015). This is of utmost importance to re-establish epistemic trust in the patient with PDs. Epistemic trust is defined as openness to the reception of social knowledge that is regarded as personally relevant and of generalizable significance (Fonagy et al., 2015), which gives a sense that human communication can be trusted and relied on. This appears to be a key element in therapy for severe psychiatric patients (Buck & Havsteen-Franklin, 2013). Art therapy creates opportunities of contingency and joint engagement. The patient creates an art work which resonates with his/her inner feelings, which could enlarge the opportunity for the therapist and other patients to respond in a contingent manner and could promote mentalization (Buck & Havsteen-Franklin, 2013). For the patients to better understand one's inner thoughts and those of others, an atmosphere of trust, validation and contingency should therefore be promoted.

Description of the CFAT programme

Firstly, we describe how each change objective is addressed in the protocol as a whole. Secondly, we describe the content of each session separately. The art therapy content fits the personality disorder clients' goals based on the change objectives in step 2 and the theoretical methods and practical strategies in step 3.

Targeting change objective 1: Is able to experience emotions in the present moment. The client develops mindfulness and self-awareness skills by means of mindfulness-based warm-ups for grounding and arriving in the present moment. Self-awareness is stimulated in all art assignments by focusing on the experience in the here and now and promoting greater sensory and affective perception of the art materials used. Greater exploration of the qualities of various expressive materials (such as pastels, clay, and paint) are incouraged by the art therapist. Using guided imagery, clients are asked to yield to inner images and emotional perception. The reflective discussion focuses on non-judgmental questions and characteristics of the artwork.

Targeting change objective 2: Recognises and distinguishes own major emotion regulation systems: (1) threat protection, (2) drive-seeking and resource-seeking; and (3) soothing and affiliation. The client gives content and form to the various emotion regulation systems (threat, drive and calming) and charts the response to threatening situations. The difference between safety and security is studied and the effectiveness of the client's response system is discussed. In the reflective verbalisation at the end of each assignment, the therapist asks the clients specific questions, with the object of their becoming aware of emotions, behaviour and thoughts.

Targeting change objective 3: Is able to express and regulate emotions constructively. A variety of art assignments are provided, aimed at constructive behaviour, feelings and emotion. Clients investigate their calming system and practice utilising and enhancing it. They define their threat system and their self-critical thoughts, and active practising is encouraged, e.g. clients make changes to their artworks and regulate their emotions.

Targeting change objective 4: Uses improved compassion/self-compassion skills. The sessions focus on self-compassion and compassion for others. This is achieved by means of guided imagery assignments with the theme of compassion, giving compassionate responses (in image form) to artwork of other clients and depicting the ideal 'compassionate self'. We work with positive reinforcement, and questions aimed at compassion are asked in the discussion.

Qualifications of the therapist. It is required that this intervention is carried out by an officially trained and registered art therapist with specific expertise in the understanding and management of people diagnosed with cluster B or C personality disorders. It is of great importance that the therapist exhibits non-judgmental and respectful behaviour and continuoually encourages clients to do so as well. The therapist invites them to discuss their own and other people's work in non-judgmental terms.

The sessions

Session 1. Awareness of compassion

The group starts with brief introductions, clients check in ('how is everyone feeling today?'), followed by a discussion of the group's basic rules. Next is a warm-up in the form of a soothing rhythm breathing exercise (mindfulness breathing exercise). Clients move a piece of chalk on paper in time to the rhythm of their breathing. The assignment of the first session is about 'being aware of compassion'. Using guided imagery, a situation is defined in which clients become aware of compassion towards themselves or towards group members. The materials provided are A2 paper, crayons, pastels, charcoal, conté crayons, and coloured paper. In the evaluation at the end of this session, compassion skills are actively practised by stimulating non-judgmental responses to their own and each other's artwork and by noticing compassion and its qualities as translated in the artwork.

Session 2. The tree of origins

We briefly check in, followed by a soothing rhythm breathing exercise as a warm-up during which clients move a crayon to the rhythm of their breathing; after this, the movements of the crayon are adjusted to the client's wishes. The assignment that follows is designing a 'tree of origins'. Participants are encouraged to think about how you are formed by your background, your growth and your concerns in the course of time, where the roots symbolise the family of origin, the trunk represents personal development and the branches what people ponder or worry about. The materials provided here are A2 paper, drawing and painting materials (acrylic paints/gouache). In the evaluation at the end of this session, rigid behavioural patterns are discussed and the sense of guilt is actively mitigated by encouraging participants to recognise the influence of their background on emotions and behaviour. At the end of the session, they are assigned homework: watching a video on emotion regulation systems.

Session 3. Emotion regulation

To start, we briefly check in and then discuss the homework. This is followed by an explanation of the three central emotion regulation systems, symbolised by three circles: red (protection system), blue (drive system) and green (calming system). The assignment is to produce 'a picture of your three circles'. Each person depicts the three emotion regulation systems based on the three circles, while their actual design is determined by how a person recognises himself or herself in each of these systems. The size of the circles and their distance from the others may also differ per individual. The materials provided for this are A2 paper, drawing and painting materials, and collage material. In the evaluation at the end of this session, questions about behaviour, feelings and thoughts are actively asked, based on the way clients designed their systems and how they are related. The group could also briefly consider the interaction of the systems in general and their link to each client's personal design.

Session 4. Compassionate self-image

We briefly check in, followed by a warm-up, a soothing rhythm breathing exercise: drawing a bowl shape to the rhythm of their breathing, with the sensory experience of pastels. The bowl shape is suggestive of receiving and security. This is followed by 'welcome yourself', an assignment in which clients produce a compassionate self-image. Clients welcome themselves in the form of the silhouette that has been drawn of them standing in front of a large sheet of white paper on the wall. The next step is to shape it more clearly in a way suited to each person's most compassionate self. Compassionate, safe surroundings are then added to the silhouette (variation: to another person's silhouette). The materials provided here are pastels, ecoline, watercolours, paint, A1 paper, pencil. In the evaluation at the end of this session we focus on the expressive characteristics of the compassionate self and the impediments or obstructions that stand in the way of achieving this ideal image. At the end of the session homework is assigned: take a picture of yourself with your mobile phone and look at your compassionate self every day. Think about how you can take a compassionate moment for yourself every day.

Session 5. Safety vs security

After briefly checking in, the warm-up is a soothing rhythm breathing exercise focused on becoming sensorially aware of working with clay and the slower breathing. The subsequent assignment depicts 'a fragile moment'. Using guided imagery, we focus our attention on a time when clients felt vulnerable. Then they set to work on an art product consisting of three parts. In the first part, the client is a clay figure in a vulnerable position. In the second part a background made of cardboard is folded to stand behind the clay figure. A threatening environment is created on the cardboard using expressive colours, shapes and images. In the third part, clients are asked to make and to add to the art product what each person's clay figure needs in this situation to

make him or her feel better. The materials provided are chamotte in various colours, coarse and fine, cardboard, drawing and painting materials. In the evaluation at the end of this session, safety and security are discussed based on the appearance and characteristics of the surroundings in the art product. We dicuss questions about response patterns, with a focus on their effectiveness.

Session 6. Inner critic

After we check in, the warm-up is focused on mindfully following drops of ecoline on paper and looking at the shape thus created. In this session we work on the theme of 'the inner critic' in order to make people aware of the effect it has. For the assignment, first texts from the negative internal dialogue appropriate to the inner critic are written in expressive terms on a large sheet of paper. Then this text is read out to group members, so that each of them can feel what they actually do to themselves by being so extremely critical. After this, everyone has plenty of time to make a visual reply to their own text, coming from their compassionate self. The materials provided are A2 paper, marker, various types of chalk, painting materials and coloured paper. During the evaluation at the end of this session, clients are asked about the effect of the inner critic on thoughts, feelings and behaviour, and the visual answer from the compassionate self, the constructive dissent, is discussed. At the end of the session homework is assigned: watching a meditation on youtube called "f*ck you meditation", e.g. a humorous and easily excessible meditation.

Session 7. Shame

After checking in, we discuss the homework, then go on to the warm-up: a soothing rhythm breathing exercise focused on the sensory experience of tearing white drawing paper, and the "f*ck you meditation". During this session the theme of shame is investigated using the 'mask of shame' assignment, in which each client paints a mask. The outer surface shows how clients present themselves to others and the inside represents the shame, which only the client can feel. Lastly, a compassionate reply to this mask is given by a card showing a statement or symbol. The materials provided are acrylic paint/gouache and masks. In the evaluation at the end of this session we discuss differences between the inner and the outside world (as seen in the mask) and in a compassionate manner, we explore the influence of shame on emotions and behaviour.

Session 8. The compassionate self

We check in and then go on to the warm-up: a soothing rhythm breathing exercise focused on the sensory experience of tearing green flypaper. This is followed by an assignment called 'a meeting in the woods', guided imagery focused on a meeting with the compassionate self, who has a message for the client and gives something to him or her. After this, based on the imagery, clients make an artwork. The bits and pieces of flypaper may be used for this; there is a free choice of materials. In evaluating this session, clients focus their attention on their experiences during the guided imagery, which they then work out into a picture. We discuss what it was that their compassionate self gave them, how this is linked to the client's needs and how these needs can be fulfilled. Compassion skills are encouraged by stimulating group members to give each other unprejudiced responses.

Session 9. Compassion for the other

After checking in, a mindfulness warm-up is focused on the emotion of the moment and its physical perception. The emotion is then shown in colour in a body silhouette on paper.

This is followed by the assignment: 'Showing compassion for the other', interaction between group members by responding to each others' troublesome situation in the form of an image. Through guided imagery, the group thinks of a specific emotional moment: what this was like, how it was physically perceived. They represent the image on paper inside a circle, and then the participants change places and look at someone else's artwork. Transparent paper is taped over the image and on it, clients give an empathic answer to the emotional moment of the other.The materials provided are paper, transparent paper, tape and drawing materials. The evaluation of this session is focused on patterns of behaviour in receiving and offering compassion in the artwork and in 'real life', and on the effectiveness of these patterns.

Session 10. Wrapping up

After checking in, we set out on the assignment titled 'compassionate wish'. In the first part of the assignment, all of the artworks made by the clients are displayed. Each client looks at his or her process and then writes a brief letter to self with at least three positive points about his or her learning process. The letters are read aloud. In the second part a compassionate wish is chosen for the future relating to the process and the letter they just wrote. The wish is worked out in clay. During the final, extensive evaluation we focus on each client's process, on transfer of this process to the future, and on the wish clients have created for themselves. The group members are actively involved and are encouraged to respond to each client's process in a compassionate manner.

Steps 5 and 6: implementation and evaluation

The manual was written and first used at a mental health care institution. Scientific evaluation of the intervention was part of the implementation process. In an outpatient treatment setting, the intervention described was studied as a trial for clients with a cluster B/C personality disorder. Clients completed the entire intervention and three case studies were measured using the instruments Positive and Negative Affect Scale (PANAS; Watson, Clark, & Tellegen, 1988; Dutch: Peeters, Ponds, & Vermeeren, 1996), Self-Compassion Scale short form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011), Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004; Dutch: Neumann, van Lier, Gratz, & Koot, 2010) and Forms of Self-Critisising/Attacking and Self-Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Dutch: Sommers-Spijkerman et al., 2017). The scores were analysed using the Reliable Change Index (RCI) to determine whether the differences in the pre- and post-measurements were clinically relevant. The respondents were also interviewed and the transcripts analysed. This showed that the general picture in relation to feasibility was positive. A few adjustments in the information provided, session protocol and duration of the sessions are desirable. All measuring instruments showed clinically relevant differences. These differences show both progress and decline in emotion regulation and compassion. From the results it is concluded that the CFAT module intervenes in both emotion regulation and compassion. The total score on the compassion scale, the SCS-SF, increased from 47 to 59 points (RCI = 2.03) for case one. This total score is higher than the non-clinical normal values ($\mu = 48.12$, SD = 11.61). Case two showed a clinically relevant improvement on 'inadequate self' on the FSCRS (RCI = 2.70). In the emotion regulation scale, the DERS, augmentations were demonstrated for 'emotional clarity' in case two (RCI = 2.26 > 1.65) and 'emotional awareness' for case one (RCI = 1.96 > 1.65). Positive affect, measured by the PANAS scale, significantly increased in case two (RCI = 2.27 > 1.65). In case one an increase in negative affect was found (RCI = 2.27 > 1.65). The general experiences of the respondents were positive. The clients were in various phases of their treatment; this, in conjunction with the results, indicates that we must look closely at exactly where and when this module is enlisted and for what purpose. For example, clients in the middle phase of treatment showed the best results. The protocol imparted a sense of realization for clients in the startup phase; sensitivity and awareness of complaints increased. Considering the small sample in this study, it is of great importance to conduct further research of the effectiveness and the timing of compassion focused art therapy so as to give the results more conclusive force.

Discussion

In this paper, we have described the systematic development of a compassion-focused art therapy programme aimed at people with cluster B/C personality disorders and carried out by art therapists. We followed the steps of the IM process and developed a tailored intervention programme. The recommended attitude of the therapist is described, as well as boundary conditions and advice for use. It was implemented on the basis of a written manual and we performed a feasibility study based on three case studies. This is the first time that Gilbert's compassion-focused workbook has been translated into an art therapy programme based on a number of potentially effective methods that were combined into one ready-to-use programme tailored to the client population. This is important, because a key instruction for a compassion intervention is to develop programme manuals that are easy to use and have a lighter touch; this could more readily facilitate the use of this intervention in different contexts (Kirby, 2017). Further research is needed to substantiate this idea.

A number of methodological considerations can be put foward about this study. One limitation of the study is that most of the sources cited relating to art therapy are based on opinions of experts or on small studies. Considering the growth in the number of studies of art therapy, this knowledge base could be further strengthened in the coming years. Secondly, a robust evaluation of the intervention with a larger sample is lacking; this could help to empirically substantiate the protocol. The use of qualitative data on a larger scale is recommended; this can cover aspects such as experiences of clients and therapists, barriers, and implementability (Kirby, 2017). Lastly, on the basis of these initial pilot studies, the point when this intervention can best be utilised is still undetermined; the timing seems to be important, but further study of its effectiveness will have to demonstrate this. In addition to timing, Kirby (2017) names as an important focus of attention the dosage of compassion-focused interventions. Further study could include both dosage and timing.

The strengths of this research include, firstly, that development and testing of the protocol was directly focused on the target group: clients with a cluster B/C personality disorder. This is in line with a recommendation of Kirby (2017) – the use of specific clinical populations in studies for research of compassion-focused interventions. Secondly, a number of closely involved parties took part – referrers, art therapists and other professionals with whom we work in practice. It is expected that these two strong points together form a reasonably complete reflection of the wish to strengthen compassion in the target group through art therapy and the alternatives by which to achieve this. The PANAS, SCF-SF, DERS and FSCRS questionnaires proved to be useful in the present study. As to content, the questionnaires are suited to client self-reports, and RCI scores were calculated on this basis. The use of these questionnaires provides for simpler comparison and communal understanding of the usability of different compassion-focused interventions.

A final, not unimportant, recommendation for further research is a specific investigation of what 'active ingredients' the intervention comprises. This is in line with the recommendations of Kirby (2017) and with focus points of studies of the arts therapies (FVB – Federatie Vaktherapeutische Beroepen, 2017). The CFAT intervention developed here consists of several components such as mindfulness, guided imagery and the combination with art therapy. It would be interesting to find an answer to the question of what specific 'ingredients' work in the intervention, and which do not, or less so. Further research is in any case important because regular forms of psychotherapy prove to be only moderately effective for many clients, including clients with a Borderline Personality Disorder (Budge et al., 2013; Cristea et al., 2017; Stoffers et al., 2012). Gilbert also points out that existing therapies are only moderately effective, and a great many clients do not respond to therapy. CFT could well ensure that the deeply rooted negative feeling experienced by clients is addressed (Gilbert, 2018b).

To conclude, compassion is a relevant theme in today's society and and in healthcare, and the specific elements of art therapy may offer an effective route to strengthening compassion. Clients' own emotional expression always requires positioning, so that they can immediately practise adopting a compassionate attitude towards themselves and towards others. The artwork created by a client is an authentic product that is concretely visible and tangibly present. These characteristics of art therapy seem to be important to people who have been diagnosed with personality disorders and who suffer from problems with compassion for themselves and for others. The CFAT intervention we have developed offers a suitable answer.

Acknowledgements

The authors would like to thank the participating clients and professionals for their willingness to share their views, opinions and experiences. Thanks are also due to Timea Kehr and Sandra van Leeuwen for their sub-studies in this project, Arjan Doolaar for the APA-check and Carol Stennes for the translation.

References

Akwa, G. G. Z. (2017). *Zorgstandaard persoonlijkheidsstoornissen: Kwaliteitsontwikkeling GGZ.* Utrecht: Auteur.

American Psychiatric Association [APA] (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Bartholomew, L. K. (2016). *Planning health promotion programs: An intervention mapping approach.* San Francisco, CA: Jossey-Bass.

Bateman, A., & Fonagy, P. (Eds.). (2012). *Handbook of mentalizing in mental health practice.* Arlington, VA: American Psychiatric Publishing Inc.

Beaumont, S. L. (2012). Art therapy for gender-variant individuals: A compassion-oriented approach. *Canadian Art Therapy Association Journal, 25*(2), 1–6. https://doi.org/10.1080/08322473.2012.11415565.

Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2012). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *Clinical Psychology, 52*, 199–214. https://doi.org/10.1111/bjc.12009 PMID 24215148.

Buck, E. T., & Havsteen-Franklin, D. (2013). Connecting with the image: How art psychotherapy can help to re-establish a sense of epistemic trust. *Art Therapy Online, 4*(1), https://doi.org/10.25602/GOLD.atol.v4i1.310.

Budge, S. L., Moore, J. T., Del Re, A. C., Wampold, B. E., Baardseth, T. P., & Nienhuis, J. B. (2013). The effectiveness of evidence-based treatments for personality disorders when comparing treatment-as-usual and bona fide treatments. *Clinical Psychology Review, 33*, 1057–1066. https://doi.org/10.1016/j.cpr.2013.08.003.

Chakhssi, F. (2015). *Effects of a brief compassion induction on emotion regulation in patients with personality disorder.* Unpublished research protocol.

Crocker, J., & Canevello, A. (2012). Consequences of self-image and compassionate goals. *Advances in experimental social psychology, 45*, 229–277. https://doi.org/10.1016/B978-0-12-394286-9.00005-6.

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry, 74*, 319–328. https://doi.org/10.1001/jamapsychiatry.2016.4287.

Davis, B. J. (2015). *Mindful art therapy: A foundation for practice.* London, United Kingdom: Jessica Kingsley.

Dimaggio, G., Popolo, R., Montano, A., Velotti, P., Perrini, F., Buonocore, L., ... Salvatore, G. (2017). Emotion dysregulation, symptoms, and interpersonal problems as independent predictors of a broad range of personality disorders in an outpatient sample. *Psychology and Psychotherapy, 90*, 586–599. https://doi.org/10.1111/papt.12126.

Eren, N., Öğünç, N. E., Keser, V., Bıkmaz, S., Şahin, D., & Saydam, B. (2014). Psychosocial, symptomatic and diagnostic changes with long-term psychodynamic art psychotherapy for personality disorders. *The Arts in Psychotherapy, 41*, 375–385. https://doi.org/10.1016/j.aip.2014.06.004.

Eurelings-Bontekoe, E. H. M., Verheul, R., & Snellen, W. M. (Eds.). (2017). *Handboek persoonlijkheidspathologie: Voor opleiding, onderzoek en klinische praktijk [Handbook personality pathology: For training, research and clinical practice]*(3rd rev. ed.). Houten, The Netherlands: Bohn Stafleu van Loghum.

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders, 29*, 575–609. https://doi.org/10.1521/pedi.2015.29.5.575.

Franklin, M. (2010). Affect regulation, mirror neurons, and the third hand: Formulating mindful empathic art intervention. *Art Therapy, 27*, 160–167. https://doi.org/10.1080/07421656.2010.10129385.

Franks, M., & Whitaker, R. (2007). The image, mentalisation and group art psychotherapy. *International Journal of Art Therapy Inscape, 12*, 3–16. https://doi.org/10.1080/17454830701265188.

FVB – Federatie Vaktherapeutische Beroepen (2017). *Strategische Onderzoeksagenda voor de Vaktherapeutische beroepen [Strategic research agenda for the expressive therapies professions].* Retrieved fromhttps://fvb.vaktherapie.nl/strategische-onderzoeksagenda.

Gatta, M., Gallo, C., & Vianello, M. (2014). Art therapy groups for adolescents with personality disorders. *The Arts in Psychotherapy, 41*, 1–6. https://doi.org/10.1016/j.

aip.2013.11.001.
Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy.* Londen, United Kingdom: Routledge.
Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264.
Gilbert, P. (2014). The origins and nature of compassion focused therapy. *The British Journal of Clinical Psychology, 53*, 6–41. https://doi.org/10.1111/bjc.12043.
Gilbert, P. (2018a). *Compassion focused therapy: De toepassing binnen CGT [Compassion focused therapy: Application within cognitive behavioral therapy] (L. Berkhuizen, Trans.).* Amsterdam, The Netherlands: Boom.
Gilbert, P. (2018b). *Protocol CFT-behandeling. Unpublished treatment protocol.*
Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13*, 353–379. https://doi.org/10.1002/cpp.507.
Gilbert, P., Clarke, M., Hempel, S., Miles, J. N. V., & Irons, C. (2004). Criticizing and reassuring oneself: An exploration of forms, styles and reasons in female students. *The British Journal of Clinical Psychology, 43*, 31–50. https://doi.org/10.1348/014466504772812959.
Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor Structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41–53. https://doi.org/10.1023/B:JOBA.0000007455.08539.94.
Green, B. L., Wehling, C., & Talsky, G. J. (1987). Group art therapy as an adjunct to treatment for chronic outpatients. *Hospital & Community Psychiatry, 38*, 988–991. https://doi.org/10.1176/ps.38.9.988.
Gruber, H., & Oepen, R. (2018). Emotion regulation strategies and effects in art-making: A narrative synthesis. *The Arts in Psychotherapy, 59*, 65–74. https://doi.org/10.1016/j.aip.2017.12.006.
Haeyen, S. (2015). De Gezonde Volwassene verstevigen in beeldende therapie: Meer een gevoeld dan gedacht proces [strengthen the healthy adult in art therapy: More a felt than imagined process]. In A.–M. Claassen, & S. Pol (Eds.). *schematherapie en de Gezonde Volwassene: Positieve technieken uit de praktijk [Schema therapy and the healthy adult: Positive techniques from practice]* (pp. 157–174). . https://doi.org/10.1007/978-90-368-0951-1_11.
Haeyen, S. (2018). *Effects of art therapy: The case of personality disorders clusters B/C (Doctoral dissertation).* Nijmegen, The Netherlands: Radboud Universiteit.
Haeyen, S. (2019). Strengthening the Healthy Adult Self in Art Therapy. Using Schema Therapy as a positive psychological intervention for people diagnosed with personality disorders. *Frontiers in Psychology-Clinical and Health Psychology, 10*, 644. https://doi.org/10.3389/fpsyg.2019.00644.
Haeyen, S., van Hooren, S., & Hutschemaekers, G. (2015). Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study. *The Arts in Psychotherapy, 45*, 1–10. https://doi.org/10.1016/j.aip.2015.04.005.
Haeyen, S., Dehue, F., van Hooren, S., van der veld, W., & Hutschemaekers, G. (2018). Development of an art therapy intervention for patients with Personality Disorders: An intervention mapping study. *International Journal of Art Therapy Inscape, 23*, 125–135. https://doi.org/10.1080/17454832.2017.1403458.
Haeyen, S., van Hooren, S., van der veld, W., & Hutschemaekers, G. (2018). Efficacy of art therapy in individuals with personality disorders cluster B/C: A randomized controlled trial. *Journal of Personality Disorders, 32*, 527–542. https://doi.org/10.1521/pedi_2017_31_312.
Haeyen, S., Chakhssi, F., & Van Hooren, S. (2020). Benefits of Art Therapy in people diagnosed with Personality Disorders: A quantitative survey. *Frontiers in Psychology, 4*(11), 686. https://doi.org/10.3389/fpsyg.2020.00686.
Hogan, S. (2016). *Art therapy theories: A critical introduction.* London, United Kingdom: Routledge.
Jalambadani, Z., & Borji, A. (2019). Effectiveness of mindfulness-based art therapy on healthy quality of life in women with breast cancer. *Asia-Pacific Journal of Oncology Nursing, 6*, 193–197 https://doi.org/193.10.4103/apjon.apjon_36_18.
Jang, S. H., Lee, J. H., Lee, H. J., & Lee, S. Y. (2018). Effects of mindfulness-based art therapy on psychological symptoms in patients with coronary artery Disease. *Journal of Korean Medical Science, 33*, e88. https://doi.org/10.3346/jkms.2018.33.e88.
Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity: the Journal of the International Society for Self and Identity, 2*, 85–101. https://doi.org/10.1080/15298860309032.
Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity: the Journal of the International Society for Self and Identity, 2*, 223–250. https://doi.org/10.1080/15298860309027.
Karterud, S., & Pedersen, G. (2004). Short-term day hospital treatment for personality disorders: Benefits of the therapeutic components. *Therapeutic Communities, 25*, 43–54.
Kirby, J. N. (2017). Compassion interventions: The programmes, the evidence, and implications for research and practice. *Psychology and Psychotherapy, 90*, 432–455. https://doi.org/10.1111/papt.12104.
Lama, D. (1995). *The power of compassion: A collection of lectures by his Holiness the XIV Dalai Lama (G. Thupten Jinpa, Trans.).* New Delhi, India: HarperCollins.
Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ [National Advisory Committee Regarding Multidisciplinary Guidelines for Development in Mental Healthcare] (2008). *Multidisciplinaire Richtlijn Persoonlijkheidsstoornissen. Richtlijn voor de diagnostiek en behandeling van volwassen patiënten met een persoonlijkheidsstoornis [Multidisciplinary Guideline for Personality Disorders. Guideline for the Diagnosis and Treatment of Adult Clients With Personality Disorder].* Utrecht, The Netherlands: Trimbos-instituut.
Lewis, J. J. (2018). *Attachment insecurity, emotion regulation difficulties, and mindfulness deficits in personality pathology. Dissertation Abstracts International: Section B: The Sciences and Engineering.* Retrieved fromhttps://digital.library.unt.edu/ark:/67531/metadc862767/.
Linehan, M. M. (1996). *Borderline persoonlijkheidsstoornis: Handboek voor training en therapie [Borderline personality disorder: Manual for training and therapy].* Lisse, The Netherlands: Swets & Zeitlinger.
Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy for personality disorder. *Psychology and Psychotherapy, 86*, 387–400. https://doi.org/10.1111/j.2044-8341.2012.02068.x.
MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*, 545–552. https://doi.org/10.1016/j.cpr.2012.06.003.
Malchiodi, C. A. (2011). *Handbook of art therapy* (2nd ed.). New York, NY: Guilford Press.
Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* https://doi.org/10.1521/pedi_2017_31_312.
Monti, D., Peterson, C., Kunkel, E., Hauck, W., Pequignot, E., Rhodes, L., et al. (2006). A randomized, controlled trial of mindfulness-based art therapy (MBAT) for women with cancer. *Psycho-Oncology, 15*, 363–373. https://doi.org/10.1002/pon.988.
Naismith, I., Zarate Guerrero, S., & Feigenbaum, J. (2019). Abuse, invalidation, and lack of early warmth show distinct relationships with self-criticism, self-compassion, and fear of self-compassion in personality disorder. *Clinical Psychology & Psychotherapy, 26*, 350–361. https://doi.org/10.1002/cpp.2357.
Nederlandse Vereniging voor Beeldende Therapie (2018). *Nederlandse vereniging voor beeldende therapie [Dutch association for art therapy]. Voor wie is vaktherapie beeldend? [Art therapy, for whom?].* Retrieved on November 28, 2018, from https://nvbt.vaktherapie.nl/?page=54069.
Neumann, A., van Lier, P. A. C., Gratz, K. L., & Koot, H. M. (2010). Multidimensional assessment of emotion regulation difficulties in adolescents using the Difficulties in Emotion Regulation Scale. *Assessment, 17*, 138–149. https://doi.org/10.1177/1073191109349579.
Peeters, F. P. M. L., Ponds, R. W. H. M., & Vermeeren, M. T. G. (1996). Affectiviteit en zelfbeoordeling van depressie en angst. *Tijdschrift voor Psychiatrie, 38*, 240–250.
Pénzes, I., van Hooren, S., Dokter, D., Smeijsters, H., & Hutschemaekers, G. (2014). Material interaction in art therapy assessment. *The Arts in Psychotherapy, 41*, 484–492. https://doi.org/10.1016/j.aip.2014.08.003.
Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical Psychology & Psychotherapy, 18*(3), 250–255. https://doi.org/10.1002/cpp.702.
Rappaport, L. (2009). *Focusing-oriented art therapy: Accessing the body's wisdom and creative intelligence.* London, United Kingdom: Jessica Kingsley.
Rappaport, L. (2014). *Mindfulness and the arts therapies: Theory and practice.* London, United Kingdom: Jessica Kingsley.
Schweizer, C., Bruyn, J., Haeyen, S., Henskens, B., Rutten-Saris, M., & Visser, H. (2009). *Handboek beeldende therapie: Uit de verf [Handbook of art therapy: Express yourself].* Houten, The Netherlands: Bohn Stafleu van Loghum.
Seppala, E., Rossomando, T., & Doty, J. R. (2013). Social connection and compassion: important predictors of health and well-being. *Social Research, 80*(2), 411–430.
Sommers-Spijkerman, M. P. J., Trompetter, H. R., ten Klooster, P. M., Schreurs, K. M. G., Gilbert, P., & Bohlmeijer, E. T. (2017). Development and validation of the forms of Self-Criticising/Attacking and self-reassuring scale – Short form. *Psychological Assessment, 30*(6), 729–743. https://doi.org/10.1037/pas0000514.
Springham, N., Findlay, D., Woods, A., & Harris, J. (2012). How can art therapy contribute to mentalization in borderline personality disorder? *International Journal of Art Therapy Inscape, 17*, 115–129. https://doi.org/10.1080/17454832.2012.734835.
Stoffers, J., Vollm, B., Rucker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *The Cochrane Database of Systematic Reviews, 2012*(8), https://doi.org/10.1002/14651858.CD005652.pub2.
van den Broek, E., Keulen-de Vos, M., & Bernstein, D. P. (2011). Arts therapies and schema focused therapy: A pilot study. *The Arts in Psychotherapy, 38*, 325–332. https://doi.org/10.1016/j.aip.2011.09.005.
van der Molen, H. T., Simon, E., & van Lankveld, J. (Eds.). (2015). *Klinische psychologie: Theorieën en psychopathologie [Clinical psychology: Theories and psychopathology]*(3rd ed.). Groningen, The Netherlands: Noordhoff.
Verfaille, M. (2016). *Mentalizing in arts therapies (C. Stennes, Trans.).* London, United Kingdom: Karnac.
Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*(6), 1063–1070. Geraadpleegd op 24-02-2019 van http://pascal-francis.inist.fr/vibad/index.php?action=search&terms=7759587.
Williams, P. R. (2018). ONEBird: Integrating mindfulness, self-compassion, and art therapy (ONEBird: intégration de la pleine conscience, de l'autocompassion et de l'art-thérapie). *Canadian Art Therapy Association Journal, 31*, 23–32. https://doi.org/10.1080/08322473.2018.1454687.
Wilson, A. C., Mackintosh, K., Power, K., & Chan, S. W. Y. (2019). Effectiveness of self-compassion related therapies: A systematic review and meta-analysis. *Mindfulness, 10*, 979–995. https://doi.org/10.1007/s12671-018-1037-6.
Withrow, R. L. (2004). The use of color in art therapy. *The Journal of Humanistic Counseling, 43*, 33–40. https://doi.org/10.1002/j.2164-490X.2004.tb00040.x.
Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *The American Journal of Psychiatry, 162*, 1911–1918. https://doi.org/10.1176/appi.ajp.162.10.1911.