Research Article **ISSN: 3065-5641**

Global Journal of Critical Care and Emergency Medicine

Art and Therapy Toward a Clinical Matrix of Artistic Indication by Disease, Symptom, and Therapeutic Mechanism

Dr. Ignacio Bonasa Alzuria*

Liderarte, Madrid, Spain.

ORCID: 0009-0001-3940-4278

***Correspondence:**
Dr. Ignacio Bonasa Alzuria, Liderarte, Madrid, Spain.

Received: 19 Apr 2026; **Accepted:** 21 May 2026; **Published:** 01 Jun 2026

Citation: Ignacio Bonasa Alzuria. Art and Therapy Toward a Clinical Matrix of Artistic Indication by Disease, Symptom, and Therapeutic Mechanism. Glob J Emerg Crit Care Med. 2026; 3(2); 1-9.

ABSTRACT

The relationship between art, health, and well-being has evolved from a humanistic intuition into an expanding clinical, psychosocial, and neuroscientific research field. The decisive question is no longer whether the arts may contribute to care, but which artistic modality may be more appropriate for which disease, symptom, clinical stage, patient profile, and therapeutic objective. This article proposes an orientative matrix for artistic indication based on a narrative review of secondary literature and recent studies on music therapy, therapeutic singing, dance/movement, visual arts, theatre/drama therapy, expressive writing, poetry therapy, bibliotherapy, and cultural participation. The central thesis is that the arts should not be presented as substitutes for medical, psychological, or rehabilitative treatment, but as complementary interventions able to address cross-cutting dimensions of suffering: anxiety, pain, depression, isolation, cognitive decline, communication, mobility, identity, adherence, meaning-making, and quality of life. The most consistent evidence is found in music therapy for oncology, dementia, prematurity, and neurological rehabilitation; dance for Parkinson disease and depressive symptoms; singing for COPD with limited but promising evidence; visual arts for mental health, trauma, cancer, autism, and cognitive impairment with heterogeneous results; theatre for social skills, mentalization, and child and adolescent mental health; and writing and bibliotherapy for mild depression, grief, coping, and narrative reconstruction. The article concludes that the future of the field requires a form of precision artistic prescription: selecting artistic practice not by fashion or generic preference, but by clinical target, biopsychosocial mechanism, safety, cultural context, professional availability, and measurable outcomes.

Keywords

Art therapy, Music therapy, Dance movement therapy, Drama therapy, Bibliotherapy, Mental health, Cancer, Dementia, Parkinson disease, Well-being, Artistic prescription.

Introduction

For decades, art entered healthcare settings mainly as accompaniment, entertainment, humanization, or emotional relief. However, the accumulation of studies in public health, psychology, neuroscience, rehabilitation, palliative care, and behavioural sciences has placed the arts within an emerging field of clinical and social relevance. The World Health Organization scoping review by Fancourt and Finn synthesized more than 3,000 studies and indicated that the arts may contribute both to health promotion and disease prevention and to the management of clinical conditions across the life course [1]. Earlier and complementary reviews in arts and health, public health and medical humanities also support the relevance of artistic engagement as a humanizing and potentially health-promoting resource [2-6].

The general statement that art is good for health is, however, insufficient for an indexed journal. A scientific formulation requires greater precision: which artistic modality, at what intensity, for which patient, with which objective, at which phase of disease, under which safety conditions, and with which evaluable outcomes. This article responds to that need through a matrix of artistic indication that differentiates among music, singing, dance, visual arts, theatre, writing, poetry, bibliotherapy, and cultural participation.

The core thesis is that art does not primarily act on disease as a closed biomedical entity, but on cross-cutting dimensions of human suffering: pain, anxiety, depression, fear, isolation, cognitive decline, loss of role, altered body image, communication difficulties, immobility, trauma, grief, lack of meaning, and reduced quality of life. Therefore, the clinically useful question is not which art cures which disease, but which artistic practice can best complement the treatment of a specific person according to his or her dominant symptom, functional status, life story, and therapeutic objective.

This precision is essential to avoid two opposite risks. The first is biomedical reductionism, which treats art as an irrelevant ornament with no therapeutic value. The second is pseudoscientific exaggeration, which attributes absolute curative properties to art without evidential support. Between these extremes lies a fertile space: complementary artistic interventions that are prudent, measurable, humanizing, and clinically meaningful.

Aim, Scope, and Research Question

The main aim of this article is to propose an orientative clinical matrix linking artistic modalities with diseases, symptoms, and plausible therapeutic mechanisms, integrating recent scientific evidence and criteria of clinical prudence.

The specific objectives are: (1) to differentiate the principal modalities of artistic intervention used in health; (2) to identify the clinical targets where evidence is more consistent or promising; (3) to organize indications by disease, symptom, and mechanism; (4) to identify limits, contraindications, and safety conditions; and (5) to offer an operational proposal for precision artistic prescription applicable to healthcare, social care, educational, and community contexts.

The research question is formulated as follows: which type of art may be most appropriate as a complementary intervention for selected diseases or clinical needs, and under which criteria of evidence, mechanism, and safety should it be recommended?

Narrative Review Methodology and Criteria for Grading Evidence

An integrative narrative review of scientific literature and reference documents published mainly between 2014 and 2026 was conducted, prioritizing systematic reviews, meta-analyses, Cochrane reviews, reports from international organizations, randomized clinical trials, and synthesis studies in arts and health. The review focused on artistic modalities with a recognizable presence in the literature: music therapy, music interventions, singing, dance/movement, visual art therapy, creative arts therapies, drama therapy, applied theatre, expressive writing, poetry therapy, bibliotherapy, and cultural participation [1-45].

The selection of sources was not intended to replace a systematic review with an exhaustive protocol. Rather, its purpose was to build a critical synthesis oriented toward practical transfer. Studies with methodological clarity, defined clinical populations, clinically relevant outcomes, and explicit discussion of limitations were prioritized, particularly when they addressed mechanisms of change, health communication, clinical arts therapy, arts-based public health, or wellbeing outcomes [1,5,6,14,22,36,38]. When the evidence was heterogeneous, strong indications were avoided and cautious language was used: may contribute, appears promising, limited evidence, or recommended only as a complement.

To facilitate interpretation, this article proposes an orientative scale of evidence strength. This scale does not replace GRADE or formal risk-of-bias tools, but it helps organize the clinical matrix in a way that is understandable for healthcare professionals, researchers, and decision-makers.

Table 1: Orientative scale of evidence strength used in the article.

Level	Operational description	Clinical implication
A	Consistent evidence from systematic reviews, meta-analyses, or Cochrane reviews with clinically relevant outcomes.	May be recommended as a structured complementary intervention, with individual adaptation and outcome evaluation.
B	Moderate or promising evidence with controlled studies, heterogeneous meta-analyses, or consistent results in subgroups.	May be used in supervised programs, informing the patient of limits and uncertainty.
C	Preliminary, heterogeneous, or small-sample evidence, including observational studies or studies with high risk of bias.	Use prudently, preferably as psychosocial or community support rather than as the main clinical intervention.
D	Insufficient evidence for a specific clinical indication, although cultural, educational, or well-being value may exist.	Avoid therapeutic promises; use only as a safe resource for well-being or humanization.

Conceptual Framework: From Art as Accompaniment to Art as Complementary Intervention

Art in health can take many forms. Listening to music in a waiting room is not the same as receiving music therapy from an accredited professional. Recreational painting is not equivalent to participating in art therapy within a psychological process. Attending a theatre performance is not the same as engaging in drama therapy with clinical objectives. Terminological confusion is one of the weaknesses of the field and must be addressed rigorously [2,5,6,14,23,36].

This article distinguishes four levels of intervention. The first is environmental or humanizing art: music, images, sensitive architecture, cultural spaces, or aesthetic resources that improve the care context. The second is participatory art for well-being: workshops, choirs, museums, reading, writing, or dance in community settings. The third corresponds to structured artistic interventions with health objectives, such as singing for COPD or adapted dance for Parkinson disease. The fourth level is clinical arts therapy, delivered by qualified professionals within an explicit therapeutic framework, such as music therapy, art therapy, drama therapy, or dance movement therapy.

The strength of art lies in its ability to act simultaneously across physiological, emotional, cognitive, behavioural, social, cultural, and existential domains. Music may modulate arousal and activate autobiographical memory; dance may improve mobility and belonging; visual arts may externalize emotions that are difficult to verbalize; theatre may rehearse roles and social skills; writing may reorganize biography; poetry may name the unsayable; and cultural participation may reduce loneliness and restore a sense of community [4,15,16,20,25,32,38,44].

Matrix of Artistic Indication by Modality, Mechanism, and Clinical Target

The following matrix is not intended as a closed clinical guideline, but as an orientative instrument. Its use should be integrated with medical diagnosis, psychological assessment, patient preferences, professional availability, culture, age, functionality, risks, and measurable objectives.

Music Therapy and Applied Sound Medicine

Music is one of the artistic modalities with the strongest scientific development in health. Its clinical advantage lies in the fact that it can be used receptively or actively, individually or in groups, with families, in hospitals, or in community settings. In addition, it has a particular capacity to modulate emotion, attention, memory, breathing, motor rhythm, and interpersonal connection [10,11,15,19,20,39].

Oncology

Anxiety, Pain, Fatigue, and Quality of Life

In patients with cancer, music interventions have been studied to reduce anxiety, depression, pain, fatigue, and procedure-related distress. The Cochrane review by Bradt et al. concluded that music interventions may have beneficial effects on anxiety, depression, hope, pain, and fatigue in adults with cancer [11]. Related arts-based evidence in oncology also supports cautious consideration of art therapy and creative arts approaches for anxiety, quality of life, palliative care, and body-image concerns [8,34,37]. This evidence does not mean that music affects tumour progression; rather, it may improve relevant dimensions of the oncological experience.

The most reasonable indication is found in four settings: before or during invasive procedures, during chemotherapy or radiotherapy, in prolonged hospitalization, and in palliative care. In these contexts, music may reduce perceived threat, promote relaxation, activate meaningful memories, improve sleep, and offer a non-intrusive sense of companionship.

The intervention must be personalized. Music perceived as relaxing by one patient may be indifferent or even aversive to another. Therefore, musical biography, cultural background, age, emotional state, clinical moment, and sensory tolerance should guide selection.

Dementia

Emotional Memory, Depression, and Social Behaviour

Dementia is a particularly relevant field for music because musical memory and emotional response may remain partially preserved even when verbal language deteriorates. The Cochrane review on music-based interventions for dementia reported that music-based therapy probably improves depressive symptoms and may improve overall behavioural problems compared with usual care; compared with other activities, it may improve social behaviour, although effects may not persist after treatment ends [39]. Participatory arts research in older adults and residential care also supports the relevance of artistic participation for wellbeing, connection, and dignity in later life [16,32].

The main recommendation is to use autobiographical music, group singing, personalized playlists, and sessions involving caregivers. Music should not be imposed as continuous background noise; it should be delivered sensitively, with attention to volume, duration, and behavioural response.

In advanced dementia, music may operate as a bridge of presence: it does not necessarily restore declarative memory, but it may open windows of emotion, gaze, smile, movement, affective recognition, and calm.

Table 2: Synthetic matrix of artistic indication by modality.

Modality	Priority clinical targets	Best-fitting conditions	Level
Music therapy / structured music	Anxiety, pain, depression, fatigue, autobiographical memory, communication, physiological regulation	Cancer, dementia, prematurity, post-stroke aphasia, palliative care, invasive procedures	A-B
Therapeutic singing	Breathing, expiratory control, posture, mood, belonging	Stable COPD, ageing, isolation, weakened voice, community well-being	B-C
Dance / movement	Balance, gait, coordination, behavioural activation, body self-esteem, social bonding	Parkinson disease, mild-moderate depression, chronic pain, ageing, mild frailty	A-B
Visual arts / art therapy	Non-verbal expression, trauma, identity, body image, emotional regulation, symbolization	PTSD, cancer, autism, dementia, chronic pain, anxiety, emotional disorders	B-C
Theatre / drama therapy	Role, empathy, social skills, mentalization, narrative, behaviour	Autism, adolescence, relational trauma, social anxiety, psychosocial rehabilitation	B-C
Writing / poetry / bibliotherapy	Narrative elaboration, grief, meaning, cognitive restructuring, testimony	Mild depression, mild anxiety, grief, chronic illness, palliative care, non-acute trauma	B-C
Cultural participation and museums	Loneliness, cognitive stimulation, belonging, subjective well-being, active ageing	Older adults, social frailty, community mental health, prevention	B-C

Prematurity and Neonatal Intensive Care

Physiological Regulation and Bonding

In premature infants, music and the human voice have been explored as interventions for physiological regulation and early bonding. Meta-analytic and Cochrane evidence suggests possible benefits in parameters such as heart rate, regulation during the intervention, and parent-infant interaction, although carefully supervised protocols are required [10,19].

This indication should not be interpreted as indiscriminately playing music in a neonatal intensive care unit. Sound intensity, duration, stress signs, clinical condition, parental involvement, and specialized staff must be controlled. Maternal or paternal voice, gentle singing, and structured sounds may support a containing auditory experience when applied rigorously.

Stroke and Aphasia

Melodic Intonation Therapy

Melodic intonation therapy illustrates a specific clinical use of music in neurorehabilitation. In post-stroke non-fluent aphasia, melody, rhythm, and repetition may support verbal production and functional communication. Systematic reviews and meta-analyses have found significant effects on functional communication and repetition, although larger trials and standardized protocols are still needed [18,45].

This indication must be integrated with speech and language therapy and neurological rehabilitation. It is not a matter of singing random songs, but of using melodic and rhythmic patterns with concrete linguistic objectives, therapeutic progression, and functional assessment.

Therapeutic Singing and Respiratory Health

Therapeutic singing combines breathing, vibration, posture, emotion, expression, and group belonging. In chronic respiratory diseases such as COPD, singing may improve respiratory awareness, expiratory control, bodily confidence, and social well-being. However, the evidence must be presented cautiously.

The Cochrane review by McNamara et al. concluded that there is low to very low quality evidence that singing is safe for people with COPD and may improve the physical component of the SF-36, but it did not show clear improvements in dyspnoea or respiratory-specific quality of life [30]. Singing can therefore be considered a promising complementary intervention, but not a substitute for pulmonary rehabilitation or medical treatment.

The most reasonable indication is stable COPD with low mood, isolation, fear of exertion, low adherence, or the need for more motivating breathing exercises. Sessions that are too demanding, poorly ventilated spaces, repertoires with excessively long phrases, or dynamics that generate excessive fatigue should be avoided.

Dance, Movement, and Bodily Rehabilitation

Dance is a complex intervention because it integrates physical activity, music, rhythm, coordination, memory, emotion, relationship, and pleasure. Unlike conventional exercise, it may generate adherence through its aesthetic and social dimensions. Its indication should distinguish motor, emotional, cognitive, ageing-related, and community objectives [21,24,26,31,35,42].

Parkinson Disease

Parkinson disease is one of the conditions that best fits dance-based interventions. The review and meta-analysis by Carapellotti et al. observed that dance may improve motor impairments, especially balance and motor symptom severity, in people with mild or moderate Parkinson disease [12]. Its clinical usefulness is related to external rhythm, motor anticipation, weight shifting, coordination, procedural memory, and social motivation.

Modalities such as adapted tango, ballroom dance, gentle contemporary dance, or seated dance may be used according to functional level. Dance offers something that many exercise programs fail to achieve: it transforms rehabilitation into an experience of identity, beauty, and belonging.

The main precaution is the risk of falls. The intervention should assess motor status, freezing, orthostatic hypotension, fatigue, medication, assistive devices, and the need for physiotherapy supervision.

Depression, Anhedonia, and Behavioural Activation

Dance movement therapy and other dance-based interventions show favourable results in depressive symptoms. Karkou et al. concluded that dance movement therapy may be effective in adults with depression, especially when combined with usual treatment [24]. Previous Cochrane evidence, later meta-analytic updates, older-adult dance reviews, and recent dance-related analyses support the hypothesis that dance interventions can reduce depressive symptoms, although there is heterogeneity in population, format, and intensity [26,31,35,42].

Its main mechanism may be understood as a combination of behavioural activation, bodily regulation, interpersonal synchrony, mastery, non-verbal expression, and recovery of the body as an inhabitable place. In mild or moderate depression, especially with isolation and sedentary behaviour, dance can be a highly motivating tool.

In severe depression, active suicidal ideation, or eating disorders with high body-image distortion, dance should be applied within a supervised clinical plan and not as an isolated intervention.

Visual Arts and Active Art Therapy

Visual arts include painting, drawing, collage, sculpture, clay work, therapeutic photography, mandalas, symbolic creation, and other practices of plastic expression. Their differential value appears when emotional experience cannot be expressed through verbal language or when the person needs to externalize, symbolize, and contemplate from a certain distance what is lived internally.

The systematic review and meta-analysis published in JAMA Network Open by Joschko et al. examined randomized clinical trials on active visual art therapy and found benefits in some health outcomes, although with high heterogeneity and a predominance of low-quality studies [22]. This conclusion is fundamental: visual arts are promising, but they do not allow absolute claims. Art therapy theory and expressive arts frameworks also underline the importance of adaptation, symbolic processing, and safety [23,29].

Trauma and PTSD

In trauma and post-traumatic stress disorder, art therapy may help externalize internal images, work with fragmented memories, reduce avoidance, and build a less threatening narrative. Creative therapies offer a non-verbal pathway that may be less intrusive than direct verbalization at the initial stages. Recent reviews and meta-analyses on creative arts interventions for PTSD and young populations suggest promising but not definitive effects because of methodological limitations and heterogeneous interventions [7,27,29,41].

Art therapy should not be used to open deep traumatic material without clinical containment. The principle of safety requires beginning with regulation, resources, boundaries, choice of materials, and control of pace. Creation may heal, but it may also reactivate if symbolic exposure is forced without preparation.

Oncology and Body Image

In cancer, visual arts may help elaborate fear, uncertainty, bodily changes, hair loss, scars, altered femininity or masculinity, grief for lost health, and the need for meaning. Plastic creation allows the patient to be not merely a passive recipient of treatments, but the author of a form, an image, and a personal narrative [8,34,37].

Its indication is especially interesting in patients with anxiety, sadness, verbal blockage, loss of control, or altered body image. It may be combined with writing, therapeutic photography, or legacy object creation in palliative care.

Autism and Non-verbal Communication

In autistic children and young people, creative therapies and visual art may support expression, sensory regulation, communication, social skills, and flexibility. Recent reviews report promising findings, although the field requires more robust studies and a neuroaffirmative approach that does not aim to normalize the person, but to expand channels of communication, well-being, and participation [28,40].

The intervention must be highly individualized: some materials may be regulating and others sensorially aversive; some people prefer structure and others exploration; some require augmentative visual communication and others a low-demand environment.

Dementia and Cognitive Impairment

In cognitive impairment, visual arts may promote participation, self-esteem, non-verbal communication, cognitive stimulation, fine motor skills, and social relationship. Their value is not measured only in memory scores or cognitive scales, but also in presence, enjoyment, interaction, and dignity [16,32,39].

Activities should be adapted to the stage of disease. In early stages, complex projects, photography, visual reminiscence, and adapted museum visits may be appropriate. In moderate or advanced stages, simple materials, tactility, colour, repetition, and absence of aesthetic judgement should be prioritized.

Theatre, Drama Therapy, and Psychodrama

Theatre provides a singular therapeutic mechanism: role. It allows the rehearsal of behaviours, exploration of identities, change of perspectives, practice of social skills, expression of conflict, work on boundaries, and construction of shared narratives. Drama therapy uses theatrical processes within a therapeutic relationship, including dramatic play, role-play, improvisation, puppets, masks, scenes, stories, and safe fictional reality [9,36].

Its indication is especially relevant in childhood and adolescence, autism, social anxiety, relational trauma, psychosocial rehabilitation, emotional education, and groups with communication difficulties. Fiction offers distance: it is not me, it is the character; precisely that distance allows an approach to what hurts with less threat.

Reviews on drama therapy and applied theatre show promising findings in mental health and social skills, but the evidence still requires greater standardization [9,36]. Therefore, the indication should be formulated as complementary, especially useful when the objectives are relationship, empathy, mentalization, expression, and rehearsal of behavioural alternatives.

Expressive Writing, Therapeutic Poetry, and Bibliotherapy

Writing transforms experience into narrative. In chronic illness, grief, trauma, or depression, the person may remain trapped in fragments of pain. Writing makes it possible to organize, name, resignify, bear witness, and recover biographical continuity. Writing does not eliminate disease, but it may prevent disease from monopolizing the whole identity.

Bibliotherapy has favourable evidence for depressive symptoms, especially in low-intensity formats and mild or moderate depression. Reviews and meta-analyses suggest that guided reading may reduce depressive and anxious symptoms, although its effectiveness depends on appropriate material selection, motivation, literacy, accompaniment, and clinical severity [13,17,33,43].

Therapeutic poetry has emerging evidence. Its value lies in condensing emotional experience into images, rhythm, and metaphor. It may be especially useful in grief, trauma, advanced illness, palliative care, mild depression, and support groups. Poetry makes it possible to name the unsayable without fully explaining it [25].

Artistic Prescription by Disease or Clinical Condition

The following matrix crosses disease or clinical condition with preferential artistic modalities. It should be interpreted as complementary guidance, never as a closed medical protocol.

Safety, Contraindications, and Ethical Criteria

The integration of the arts into health requires clear ethical criteria. The first criterion is non-substitution: no artistic intervention should replace indicated medical, psychological, pharmacological, surgical, rehabilitative, or psychotherapeutic treatments. The second criterion is informed consent: the patient should understand objectives, limits, alternatives, and possible emotional mobilization. The third criterion is professional competence: not every artistic activity is therapy, and not every artist is qualified to work with trauma, severe illness, or complex mental health [14,29,36].

Safety must be assessed by modality. In dance, the main risks are falls, fatigue, and pain. In music, overstimulation, painful memories, or sensory overload. In art therapy, traumatic reactivation or frustration linked to aesthetic judgement. In theatre, emotional exposure, shame, or group overflow. In writing, rumination or intensification of distress if trauma is addressed without containment. In singing, dyspnoea, respiratory fatigue, or excessive vocal demand [22,29,30,36,41].

The most important ethical criterion is that art should increase dignity, agency, and care, not impose performance, normative beauty, or compulsory positivity. A person who is ill does not need to demonstrate that he or she can cope with everything; the person needs safe spaces to express, rest, create, connect, and recover humanity.

Operational Proposal

From Clinical Diagnosis to Artistic Indication

For artistic prescription to be rigorous, it should not begin solely with diagnosis, but with a multidimensional assessment. Two people with the same cancer may need different interventions: one may require music for procedural anxiety, another art therapy for body image, another legacy writing, and another gentle dance to recover vitality. Diagnosis guides the process, but it is not enough [8,11,34,37].

A practical six-step algorithm is proposed: (1) identify disease and clinical stage; (2) determine the dominant symptom or need; (3) assess artistic preferences and the patient culture; (4) evaluate risks and contraindications; (5) select modality, intensity, frequency, and responsible professional; and (6) measure outcomes with simple indicators before and after the intervention.

Indicators may include validated clinical scales when possible - pain, anxiety, depression, quality of life, fatigue, functionality - and qualitative measures such as patient narrative, family observation, participation, satisfaction, sense of meaning, or perceived dignity. This dual evaluation is consistent with arts-and-health literature, which often requires quantitative outcomes and qualitative accounts of lived experience [1,5,6,38].

Table 3: Orientative artistic prescription by disease, dominant symptom, and therapeutic objective.

Condition	Preferred modality	Therapeutic objective	Main precaution
Cancer	Music therapy, visual arts, writing, poetry, gentle dance	Reduce anxiety, pain, and fatigue; elaborate body image; support meaning and quality of life	Do not promise effects on tumour progression; adapt to fatigue and immunosuppression
Dementia	Autobiographical music, singing, visual arts, adapted museums	Improve mood, social behaviour, bonding, non-verbal communication, and dignity	Avoid overstimulation; observe emotional and behavioural response
Parkinson disease	Adapted dance, rhythmic music, singing	Improve balance, gait, coordination, mood, and belonging	Assess fall risk, fatigue, and motor fluctuations
Stroke with aphasia	Melodic intonation, rhythm, therapeutic singing	Support functional communication and repetition	Integrate with speech therapy; do not apply without linguistic objectives
COPD	Therapeutic singing, adapted respiratory choir	Improve expiratory control, bodily confidence, and socialization	Do not replace pulmonary rehabilitation; monitor dyspnoea and effort
Chronic pain	Music, visual arts, gentle movement, writing	Modulate attention to pain; improve mood and sense of control	Avoid invalidating real pain or proposing unsafe movement
PTSD / trauma	Art therapy, regulating music, accompanied writing, gradual drama therapy	Regulate, symbolize, integrate narrative, and reduce avoidance	Do not force traumatic exposure without clinical containment
Autism	Visual arts, structured music, therapeutic theatre, movement	Support communication, regulation, social skills, and expression	Use a neuroaffirmative approach; attend to sensory sensitivity
Mild-moderate depression	Dance, music, bibliotherapy, writing, artistic group	Activation, bonding, expression, self-esteem, and meaning	Severe depression or suicidal ideation requires specialized clinical care
Palliative care	Music, poetry, legacy writing, visual arts, photography	Relief, dignity, farewell, family bonding, and legacy	Adapt to energy, pain, and patient will

Table 5: Algorithm for complementary artistic prescription.

Step	Guiding question	Decision
1	What is the disease, stage, and functional status?	Determine clinical limits and available energy
2	What is the main target: pain, anxiety, mobility, communication, meaning, or bonding?	Choose a measurable priority objective
3	Which art connects with the patient biography and preferences?	Avoid imposed or culturally alien interventions
4	What risks exist?	Adapt the modality or rule out the intervention
5	Who should facilitate it?	Healthcare professional, accredited arts therapist, community artist, or mixed team
6	How will outcomes be evaluated?	Scales, observation, testimony, adherence, and quality of life

Discussion

The proposal of a clinical matrix for artistic indication seeks to overcome generic discourse about art and health. The field needs a second conceptual generation: fewer inspirational claims and more methodological precision. The question is not whether art moves people emotionally, but when, how, for whom, and with which outcomes it can be integrated into care [1,5,6,14,22,36].

The evidence reviewed shows that the arts may contribute meaningfully in domains where traditional medicine, while essential, does not always reach on its own: emotional suffering, loneliness, identity, meaning, body image, communication, adherence, motivation, and dignity. These domains are not accessories. They determine how a person lives disease, relates to treatment, and preserves or loses a vital project.

Music therapy appears as one of the most mature modalities because of the volume of reviews and studies available [10,11,15,19,39]. Dance stands out for its potential in Parkinson disease, depression, and active ageing [12,21,24,26,31,35,42]. Visual arts have deep value in trauma, mental health, cancer, autism, and body image, although they require more high-quality studies [7,8,22,23,27-29,34,37,40,41]. Theatre and drama therapy are particularly relevant for social skills and role reconstruction [9,36]. Writing, poetry, and bibliotherapy provide a narrative and existential dimension that is essential in chronic illness, grief, and mild depression [13,17,25,33,43].

Real integration of the arts into health requires interdisciplinary teams. Physicians, psychologists, nurses, physiotherapists, occupational therapists, music therapists, art therapists, drama therapists, educators, community artists, and researchers should work with shared languages. Evidence should not kill beauty, but beauty should not replace evidence.

From a humanistic perspective, art reminds us that the patient is not merely an altered organism, but a wounded biography. Disease can reduce a person world to diagnosis, waiting, fear, and treatment. Art opens another door: it allows the person to become again an author, performer, creator, witness, and protagonist of part of his or her life.

Limitations

This article presents a narrative review and conceptual proposal, not a systematic review with a PRISMA protocol, exhaustive search, formal risk-of-bias assessment, or original meta-analysis. Its conclusions should therefore be interpreted as preliminary academic and clinical guidance, consistent with the caution recommended in heterogeneous arts-and-health and creative arts therapies literature [1,5,6,14,22,36].

The heterogeneity of the field is a central limitation. Labels such as art, art therapy, creative arts therapies, or artistic interventions group practices that differ substantially in duration, facilitator training, population, intensity, context, and objectives. This diversity makes it difficult to compare outcomes and formulate strong recommendations.

There is also a risk of publication bias, small sample sizes, limited longitudinal follow-up, and scarce reporting of adverse

Table 4: Risks and safety measures by artistic modality.

Modality	Possible risks	Safety measures
Music	Sensory overload, evocation of painful memories, auditory fatigue	Personalize repertoire, control volume, observe emotional response, allow pauses
Singing	Dyspnoea, fatigue, vocal pressure, frustration	Adapt phrases, intensity, and duration; coordinate with pulmonary rehabilitation when appropriate
Dance	Falls, pain, fatigue, body shame	Functional assessment, safe space, physical support, seated or adapted dance
Visual arts	Traumatic reactivation, aesthetic frustration, unsuitable materials	Emphasize process rather than result; use safe materials; provide therapeutic containment
Theatre	Emotional exposure, shame, group conflicts	Use role gradually, preserve fictional distance, establish group rules, ensure expert facilitation
Writing / poetry	Rumination, emotional intensification, traumatic opening	Use graded prompts, time limits, accompaniment, and regulatory closure
Bibliotherapy	Negative identification, abandonment due to difficulty, rigid literal interpretation	Individualize selection, guide reading, and provide safe discussion

events. In addition, some artistic interventions may produce important subjective benefits that are not always captured by traditional biomedical indicators, particularly in wellbeing, cultural participation, resilience, and community mental health [3,4,16,32,38,44].

Finally, applicability depends on context. An intervention feasible in a university hospital with accredited music therapists may not be available in primary care or rural settings. The matrix must be adapted to resources, culture, language, age, preferences, and health systems.

Conclusions

Art should not enter health as decoration or as a miraculous promise, but as a rigorous, prudent, and deeply human complementary intervention. The available evidence allows us to state that selected artistic modalities may contribute to improvements in symptoms, functionality, well-being, and quality of life across several clinical conditions, provided that they are applied with criteria, safety, and evaluation [11,12,22,24,30,39,43].

Music appears particularly indicated for anxiety, pain, cancer, dementia, prematurity, aphasia, and palliative care [10,11,18,19,34,39,45]. Singing may be useful as respiratory and community support in stable COPD [30]. Dance stands out in Parkinson disease, mild-moderate depression, and active ageing [12,21,24,26,35,42]. Visual arts offer a privileged language for trauma, cancer, autism, dementia, body image, and chronic pain [7,8,22,27-29,37,40,41]. Theatre and drama therapy make it possible to rehearse roles, empathy, and social skills [9,36]. Writing, poetry, and bibliotherapy support narrative elaboration, meaning, grief, and personal recovery [13,17,25,33,43].

The key to the future is to move toward precision artistic prescription. The goal is not to recommend art generically, but to choose the right modality for the right target, in the right person, at the right time, and with the right supervision. That is the leap that may turn art into a serious tool for humanization, health, and transformation.

When a person who is ill sings, paints, dances, writes, or performs, he or she is not escaping reality. The person is recovering a part of the self that disease should not have the right to take away. There, precisely, art becomes care.

References

1. Fancourt D, Finn S. What is the evidence on the role of the arts in improving health and well-being? A scoping review. World Health Organization Regional Office for Europe. 2019.
2. Clift S, Camic PM. Oxford textbook of creative arts, health, and wellbeing. Oxford University Press. 2016.
3. Fancourt D, Steptoe A. The art of life and death: 14-year follow-up analyses of associations between arts engagement and mortality in the English Longitudinal Study of Ageing. BMJ. 2019; 367: l6377.
4. Sharman LS. Arts and crafts engagement and subjective well-being in the general population. Frontiers in Public Health. 2024.
5. Staricoff RL. Arts in health: A review of the medical literature. Arts Council England. 2004.
6. Stuckey HL, Nobel J. The connection between art, healing, and public health: A review of current literature. Am J Health Promot. 2010; 100: 254-263.
7. Briana Applewhite, Brennan Delattre, Ilina Singh, et al. Creative arts-based interventions for reducing post-traumatic stress symptoms among youth: A meta-analysis with a focus on non-Western populations. Nature Mental Health. 2025.
8. Archambault K. The effectiveness of art therapy for anxiety, depression, and quality of life in cancer patients: A systematic review. Psycho-Oncology. 2019.
9. Marij Berghs, Anna-Eva J C Prick, Constance Vissers, et al. Drama Therapy for Children and Adolescents with Psychosocial Problems: A Systemic Review on Effects, Means, Therapeutic Attitude, and Supposed Mechanisms of Change. Children (Basel). 2022; 9:1358.
10. Bieleninik L, Ghetti C, Gold C. Music therapy for preterm infants and their parents: A meta-analysis. Pediatrics. 2016; 138: e20160971.
11. Bradt J, Dileo C, Myers-Coffman K, et al. Music interventions for improving psychological and physical outcomes in people with cancer. Cochrane Database Syst Rev. 2021; 10: CD006911.
12. Carapellotti AM, Stevenson R, Doumas M. The efficacy of dance for improving motor impairments, non-motor symptoms, and quality of life in Parkinson disease: A systematic review and meta-analysis. PLOS ONE. 2020; 15: e0236820.
13. Cuijpers P. Bibliotherapy in unipolar depression: A meta-analysis. J Behav Ther Exp Psychiatry. 1997; 28: 139-147.
14. De Witte M, Orkibi H, Zarate R, et al. From therapeutic factors to mechanisms of change in the creative arts therapies: A scoping review. Front Psychol. 2021; 12: 678397.
15. De Witte M, Pinho AS, Stams GJ, et al. Music therapy for stress reduction: A systematic review and meta-analysis. Health Psychol Rev. 2022; 16: 134-159.
16. Fraser KD, Bungay H, Munn-Giddings C. The value of the use of participatory arts activities in residential care settings to enhance the well-being and quality of life of older people: A rapid review of the literature. Arts & Health. 2014; 6: 266-278.
17. Gualano MR, Bert F, Martorana M, et al. The long-term effects of bibliotherapy in depression treatment: Systematic review of randomized clinical trials. Clin Psychol Rev. 2017; 58: 49-58.
18. Haro-Martinez A, Perez-Araujo CM, Sanchez-Caro JM, et al. Melodic intonation therapy for post-stroke non-fluent aphasia: Systematic review and meta-analysis. Front Neurol. 2021; 12: 700115.

19. Haslbeck FB, Jakab A, Held U, et al. Musical and vocal interventions to improve neurodevelopmental outcomes for preterm infants. Cochrane Database Syst Rev. 2023.
20. Horden P. Music as medicine: The history of music therapy since antiquity. Routledge. 2017.
21. Jaldin MA. Effects of formal and traditional dance on cognition, depression, and anxiety in older adults: A systematic review and meta-analysis. Journal of Aging and Physical Activity. 2025.
22. Joschko R, Klatte C, Grabowska WA, et al. Active visual art therapy and health outcomes: A systematic review and meta-analysis. JAMA Network Open. 2024; 7: e2428709.
23. Kaimal G. Adaptive response theory: An art therapy framework. Art Therapy. 2019; 36: 215-219.
24. Karkou V, Aithal S, Zubala A, et al. Effectiveness of dance movement therapy in the treatment of adults with depression: A systematic review with meta-analyses. Front Psychol. 2019; 10; 936.
25. Kassab A, Jayatunje R, Bou Khalil R. The therapeutic functions of poetry in mental health: A systematic review and meta-analysis. Psychiatry Research. 2025; 356: 116897.
26. Koch SC, Riege RFF, Tisborn K, et al. Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis update. Front Psychol. 2019; 10: 1806.
27. Zehui Li, Qiaoyu Cui, Xinyu Liu. Systematic review of the effectiveness of arts therapy for post-traumatic stress disorder in children and adolescents. Front Psychiatry. 2025. 11; 16: 1716481.
28. Lopez-Escribano C, Cristina Orío-Aparicio. Creative arts therapy for autistic children: A systematic review. The Arts in Psychotherapy. 2024.
29. Malchiodi CA. Trauma and expressive arts therapy: Brain, body, and imagination in the healing process. Guilford Press. 2020.
30. McNamara RJ, Epsley C, Coren E, et al. Singing for adults with chronic obstructive pulmonary disease. Cochrane Database Syst Rev. 2017: CD012296.
31. Meekums B, Karkou V, Nelson EA. Dance movement therapy for depression. Cochrane Database of Systematic Reviews. 2015: CD009895.
32. Noice T, Noice H, Kramer AF. Participatory arts for older adults: A review of benefits and challenges. The Gerontologist. 2014; 54: 741-753.
33. Pannu, A, Ramesh KG, Sharma K. The efficacy of bibliotherapy in depression management: A systematic review. Current Psychiatry Research and Reviews. 2025.
34. Perez-Cabral A. Art therapy in palliative care: A systematic review. Palliative & Supportive Care. 2020.
35. Rittiwong T, Reangsing C, Schneider JK. The effects of dance interventions on depression in older adults: A systematic review and meta-analysis. J Appl Gerontol. 2023; 42: 2009-2024.
36. Sajnani N, Marxen E, Zarate R. Critical perspectives in arts therapies: Response/ability across a continuum of practice. The Arts in Psychotherapy. 2021; 72: 101748.
37. Sanli ES, Bulguroğlu MM, Akın-Sarı B. et al. Effects of creative arts therapies on individuals with impaired body image: A systematic literature review. The Arts in Psychotherapy. 2025.
38. Sonke J, Sams K, Morgan-Daniel J, Schaefer N, et al. Health communication and the arts in the United States: A scoping review. Am J Health Promot. 2021; 35: 106-115.
39. van der Steen JT, Smaling HJA, van der Wouden JC, et al. Music-based therapeutic interventions for people with dementia. Cochrane Database Syst Rev. 2017; 5: CD003477.
40. Wei S, Yan Lai AH, Hong Ho HW. (2025). The effectiveness of art therapy on children and adolescents with autism spectrum disorder: A systematic review. Healthcare (Basel). 2025; 13: 2960.
41. Wang J, Bo Zhang, Rosliza Yahaya. Colors of the mind: A meta-analysis of creative arts therapy as an approach for post-traumatic stress disorder intervention. BMC Psychol. 2025; 13: 32.
42. Xing Z. Effects of dance movement therapy and other dance-related interventions on depression: A systematic review and meta-analysis. European Archives of Psychiatry and Clinical Neuroscience. 2026.
43. Yuan S, Zhou X, Zhang Y, et al. Comparative efficacy and acceptability of bibliotherapy for depression and anxiety disorders in children and adolescents: A meta-analysis. Neuropsychiatric Disease and Treatment. 2018; 14: 353-365.
44. Zarobe L, Bungay H. The role of arts activities in developing resilience and mental wellbeing in children and young people: A rapid review. Perspectives in Public Health. 2017; 137: 337-347.
45. Zhang X, Jianjun Li, Yi Du. Melodic intonation therapy on non-fluent aphasia after stroke: A systematic review. Front Neurosci. 2022; 15: 753356.