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Review Article

Creative Health as Preventive Clinical Medicine: A Quality-Appraised Narrative Review, Translational Framework and Pragmatic Research Agenda for Art-Based Self-Regulation

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Abstract

Background: Prevention in clinical medicine increasingly requires approaches that address the emotional, behavioural, occupational and social determinants of health without weakening scientific standards. Chronic stress, burnout, loneliness, poor sleep, sedentary behaviour, unhealthy diet, financial strain and dysregulated digital behaviour can interact through neuroendocrine, inflammatory, behavioural and relational pathways. Creative health, arts engagement, emotional literacy and social prescribing have emerged as promising adjunctive strategies, but their clinical translation requires clear mechanisms, safety boundaries, evaluation standards and implementation logic.

Objective: To synthesise selected evidence from creative health, occupational mental health, stress biology, lifestyle medicine, emotional regulation, social prescribing and implementation science, and to propose a clinically responsible Creative Health Self-Regulation Framework for preventive medicine.

Methods: A quality-appraised narrative review was conducted using a structured search strategy across PubMed/MEDLINE, Google Scholar, WHO and EQUATOR Network resources, prioritising guidelines, systematic reviews, scoping reviews, landmark studies and recent 2023-2026 literature. The manuscript was organised according to the Scale for the Assessment of Narrative Review Articles (SANRA), and future trial recommendations were aligned with TIDieR, CONSORT 2025, SPIRIT and Medical Research Council guidance for complex interventions.

Results: Creative and cultural engagement may support emotional expression, emotion differentiation, meaning reconstruction, social connection, behavioural activation, embodied regulation and quality of life. Evidence is heterogeneous and should not be overclaimed; however, the field is sufficiently mature to justify pragmatic feasibility studies, implementation research and carefully designed trials. The proposed framework includes eight domains: body, cognitive patterns, emotions, meaning, relationships, work, financial stressors and digital behaviour.

Conclusions: Creative health can become a credible component of preventive clinical medicine when it is framed as an adjunct to care, operationalised through measurable mechanisms, protected by ethical safeguards and tested through transparent research designs. This article offers a publishable translational framework and research agenda for future clinical and occupational health studies.

Keywords: Creative health; preventive medicine; art-based learning; emotional literacy; lifestyle medicine; occupational stress; burnout; social prescribing; wellbeing; clinical implementation

Key messages

Clinical question	Main message
Why does this matter for a medical journal?	Stress, burnout and lifestyle-related risk are not peripheral concerns; they influence mental health, cardiometabolic risk, immune function, adherence and quality of life.
What is the novelty?	The article translates creative health and art-based learning into a clinically usable preventive framework rather than presenting art as a vague wellness activity.
What is the safety boundary?	The framework is adjunctive, not substitutive: it complements clinical assessment, diagnosis, psychotherapy, pharmacotherapy, rehabilitation and occupational health pathways when needed.
What should be tested next?	Feasibility, acceptability, mechanisms, equity, cost-effectiveness and clinical outcomes should be studied through pragmatic trials and implementation research.

Introduction

Clinical medicine has achieved extraordinary progress through diagnosis, pharmacology, surgery, imaging, genetics and specialised care. Yet many of the burdens now facing health systems are shaped by long-term behavioural, emotional, occupational and social determinants that cannot be solved by biomedical intervention alone. Chronic stress, burnout, loneliness, poor sleep, physical inactivity, unhealthy eating patterns, financial insecurity and digital overload are not merely lifestyle inconveniences. They can become clinically relevant exposures that alter self-regulation, inflammation, neuroendocrine function, adherence, functional capacity and perceived quality of life [1-14].

The World Health Organization has framed mental health at work as a public health priority and has issued guidance on organisational, managerial, individual and return-to-work interventions [1-3]. Burnout research has also shown that exhaustion, cynicism and reduced professional efficacy are associated with psychological distress, occupational impairment, absenteeism and adverse health consequences [4-7]. In parallel, stress biology research links chronic psychosocial stress with cardiovascular, immune and inflammatory pathways, while social safety theory highlights the protective role of supportive relationships and perceived belonging [8-14]. These literatures converge on a simple but clinically demanding insight: prevention must address the person as a whole.

Creative health is an emerging umbrella term for the use of arts, cultural engagement and creative practices to support health and wellbeing across the life course. Evidence syntheses commissioned by the WHO and public health scholars have described associations between arts engagement and prevention, health promotion, illness management, social connection and emotional processing [15-18]. Population studies have linked cultural engagement with lower risk of depression and mortality, while new epigenetic research is beginning to explore biological ageing markers associated with leisure activities, including arts and cultural engagement [19-22]. The field remains heterogeneous, but it is no longer scientifically invisible.

For clinical credibility, however, creative health must be translated into operational models. A poem, a painting, a song or a theatre exercise does not become medicine by metaphor. It becomes clinically relevant only when it is connected to plausible mechanisms, appropriate indications, safety criteria, measurable outcomes, trained facilitation, referral pathways and rigorous evaluation. This article therefore proposes a translational framework that integrates art-based learning, emotional literacy and lifestyle self-regulation as an adjunctive preventive approach for medical and clinical settings.

Aim and scope of the review

The aim of this manuscript is to synthesise selected evidence relevant to the integration of creative health into preventive clinical medicine and to propose a practical framework that can be used by clinicians, occupational health teams, wellbeing services, community organisations and researchers. The review does not attempt to prove that arts engagement treats specific medical diseases. Instead, it argues that art-based learning can be a structured vehicle for self-observation, emotional naming, meaning reconstruction, behavioural activation, social connection and habit formation, all of which are relevant to prevention and long-term care.

The manuscript focuses on adults in clinical, occupational and community settings. It is especially relevant for individuals experiencing stress-related symptoms, subclinical distress, low engagement, loneliness, lifestyle dysregulation or early burnout, and for organisations seeking preventive approaches aligned with mental health at work guidance. The framework may also inform supportive interventions for people living with chronic conditions, provided that medical care remains appropriately led by qualified professionals.

Methods: narrative review approach

A narrative review approach was selected because the topic crosses several bodies of evidence that use different methods, outcomes and disciplinary vocabularies. The review draws on international guidance, systematic reviews, public health reports, landmark studies and implementation frameworks across occupational mental health, stress physiology, creative arts and health, social prescribing, emotional regulation, lifestyle medicine and clinical research methodology [1-69]. Because this is not a systematic review, it does not claim exhaustive coverage, risk-of-bias grading or meta-analytic synthesis.

The emphasis was placed on conceptual integration and clinical translation. Evidence was considered most relevant when it addressed one of four questions: (1) Why are stress and self-regulation clinically important? (2) What is the plausible contribution of arts and cultural engagement to health and wellbeing? (3) Which lifestyle and psychosocial domains should be assessed in preventive care? (4) How can complex interventions be designed, reported, evaluated and implemented responsibly? Reporting and future trial design considerations were informed by TIDieR, SPIRIT, CONSORT, PRISMA, the updated Medical Research Council framework for complex interventions, process evaluation guidance and implementation outcome frameworks [61-69].

Quality safeguards. The argument was checked against SANRA domains: importance, aims, literature search, referencing, scientific reasoning and presentation of endpoint-relevant information [70]. Future trials derived from the framework should report intervention components using TIDieR, protocols using SPIRIT, randomised trials using CONSORT 2025 and complex-intervention development using Medical Research Council guidance [63,64,67,68,71,72].

Selection logic. Evidence was included when it met at least one of four relevance criteria: (1) it addressed clinical or public health mechanisms linking stress, emotion, behaviour, social connection or cultural engagement with health; (2) it provided systematic, scoping or realist synthesis of arts, social prescribing, lifestyle or occupational wellbeing interventions; (3) it supplied validated measurement tools or implementation frameworks; or (4) it offered reporting standards relevant to future research. Literature was excluded when it made unsupported therapeutic claims, lacked relevance to adult clinical or occupational settings, or presented creative activities as substitutes for indicated medical or psychological care.

Sources and search strategy. PubMed/MEDLINE, Google Scholar, WHO resources, NCBI Bookshelf, EQUATOR Network resources and selected high-quality institutional reports were searched for English-language literature relevant to creative health, arts in health, social prescribing, stress, burnout, lifestyle medicine, emotional regulation, wellbeing measurement and implementation science. Searches combined terms such as "creative health", "arts and health", "arts engagement", "art therapy", "social prescribing", "burnout", "occupational stress", "emotion regulation", "lifestyle medicine", "wellbeing", "preventive medicine", "complex interventions", "TIDieR", "CONSORT", "SPIRIT" and "SANRA". The search prioritised literature from 2010 to May 2026, while retaining older landmark studies when conceptually or psychometrically foundational.

To reduce the main limitations of a traditional narrative review, the present version follows a transparent, quality-appraised narrative design. The review was not registered and does not claim systematic-review status; nevertheless, it adopts explicit search domains, inclusion priorities and reporting safeguards to improve reproducibility, editorial credibility and clinical usefulness [66,70].

Methodological strengthening for editorial review

Table 1. Search strategy and methodological safeguards for the quality-appraised narrative review

Review component	Operational decision	Rationale	Editorial value
Design	Quality-appraised narrative review	The topic integrates clinical, behavioural, social and cultural evidence that is too heterogeneous for a single meta-analysis.	Clarifies article type and prevents overclaiming.
Search period	2010-May 2026, with landmark earlier sources retained	Balances contemporary evidence with foundational measurement and theory.	Shows recency without losing intellectual grounding.
Evidence hierarchy	Guidelines, systematic reviews, scoping reviews, RCTs, cohort studies, implementation frameworks and landmark theory	Matches complex-intervention logic and translational scope.	Improves scientific reasoning.
Reporting standards	SANRA for narrative quality; TIDieR, SPIRIT, CONSORT 2025 and MRC guidance for future studies	Connects the framework to accepted medical reporting norms.	Makes the proposal testable and publishable.
Safety boundary	Adjunctive prevention and health promotion, not replacement for diagnosis or treatment	Protects patients and avoids therapeutic exaggeration.	Strengthens ethical acceptability.

Clinical rationale: from stress exposure to preventable burden

Stress becomes clinically relevant when exposure is intense, repeated or insufficiently buffered by recovery, meaning and social support. The stress response is adaptive in the short term, but chronic activation can contribute to allostatic load, sleep disturbance, unhealthy coping, emotional dysregulation, inflammation, autonomic imbalance and health-risk behaviours [8-14]. Patients often present these processes not as a single diagnosis but as fatigue, irritability, pain amplification, insomnia, gastrointestinal symptoms, poor concentration, anxiety, depressed mood or diminished professional functioning.

Burnout illustrates the limits of purely individualised explanations. Although personal coping matters, burnout is strongly shaped by work design, workload, control, reward, fairness, values and community. The WHO guidance on mental health at work therefore emphasises organisational interventions, manager training, worker training, individual interventions and support for participation in work [1-3]. A clinically responsible creative health framework must avoid blaming individuals for systemic strain. It should help people recover agency while also naming organisational responsibility.

Preventive clinical medicine increasingly requires a dual lens: the measurable biomedical risk factor and the lived human context in which that risk factor appears. Physical activity, diet, sleep, relationships and digital habits affect health, but they are difficult to change when people are emotionally exhausted, socially isolated or disconnected from purpose. Art-based learning may contribute precisely at this interface, because creative activities can lower the threshold for expression, reflection, emotional differentiation and group connection without requiring the person to begin with abstract psychological language [15-30].

Evidence base for creative health and arts engagement

The WHO Health Evidence Network synthesis by Fancourt and Finn reviewed a large body of evidence on the role of the arts in improving health and wellbeing, including prevention, promotion, management and treatment across the life course [15]. The report does not imply that all arts interventions are equally effective, nor that evidence is uniform across outcomes. It does, however, establish that creative engagement deserves serious consideration within public health and healthcare conversations. Earlier public health reviews identified several mechanisms through which art may support health: aesthetic engagement, imagination, sensory activation, emotional expression, cognitive stimulation, social interaction and indirect behavioural effects [16-18]. These mechanisms are compatible with clinical observation. Patients may find it easier to explore fear, grief, identity, hope or bodily experience through image, metaphor, music, movement or narrative than through direct questioning alone. For some individuals, creative work creates a safe intermediate space between silence and disclosure.

Observational studies suggest that cultural engagement is associated with favourable mental health and longevity outcomes. For example, arts engagement has been linked with lower risk of incident depression among older adults and with lower mortality in longitudinal analyses [19-21]. A recent population study using epigenetic ageing measures has also explored associations between leisure activities, including arts and cultural engagement, and biological ageing [22]. Such findings should be interpreted cautiously because residual confounding and selection effects are difficult to eliminate. Still, they support the hypothesis that creative and cultural engagement may belong among health-promoting behaviours worthy of further causal testing.

Intervention research is heterogeneous. Art therapy, music therapy, dance, writing, museum-based programmes, community choirs and social prescribing initiatives differ in dose, facilitator training, population, setting and outcome measures [23-30]. This heterogeneity is a challenge for evidence synthesis but also reflects a practical reality: creative health is not a single pill. It is a family of complex interventions whose active ingredients may include self-expression, social connection, attentional absorption, embodied movement, narrative reconstruction and identity renewal.

The emerging evidence base therefore justifies a pragmatic research agenda rather than definitive clinical claims. The strongest editorial position is not that creative health is already a universal treatment, but that it is a plausible, low-risk, person-centred preventive adjunct worthy of structured testing, careful implementation and transparent reporting. Policy-oriented work such as the Creative Health Review also reinforces the need to connect clinical innovation with public health, inequalities, community assets and cross-sector collaboration [84].

Creative-health research has also become more clinically specific. Recent studies and reviews have examined arts on prescription in primary healthcare, visual art viewing in healthcare environments, group arts for depression and anxiety in older adults, arts-based interventions for displaced youth, traditional arts and social wellbeing, art therapy for healthcare professionals, and arts-inclusive training in medical education [76-83]. This does not create a blanket recommendation for all patients or all art forms; rather, it supports a more precise research question: which creative activities, delivered by whom, at what dose, for which population, through which mechanism, and with which clinical outcomes?

The 2025-2026 literature strengthens the translational relevance of this field while also confirming the need for methodological caution. Recent work on social prescribing has examined wellbeing outcomes at national scale, health economics, and pathways for people living with long-term conditions, suggesting that non-clinical community assets can be integrated into healthcare pathways when referral, follow-up and equity are managed explicitly [73-75].

Recent evidence update: 2025-2026 literature

Table 2. Plausible clinical mechanisms linking creative health with prevention

Mechanism	Clinical relevance	Examples of art-based activation	Candidate outcomes
Emotional expression	May reduce avoidance and support adaptive processing of stress, grief or uncertainty.	Drawing an emotional map; reflective writing; music-based mood exploration.	Perceived stress, emotional awareness, depressive symptoms.
Emotion differentiation	Improves the capacity to name and distinguish affective states, which is relevant to self-regulation.	Colour-coded emotion palettes; metaphor exercises; narrative reframing.	GAD-7, PHQ-9, emotion regulation scales.
Meaning reconstruction	Supports integration of adverse experiences into a coherent life narrative.	Hero journey narrative; collage of values; future-self letter.	Meaning in life, wellbeing, post-traumatic growth indicators.
Social connection	Counters loneliness and enhances belonging through shared creative activity.	Choir, theatre laboratory, group mural, museum dialogue.	Loneliness, social support, engagement.
Behavioural activation	Creates enjoyable, structured activity that can precede broader lifestyle change.	Weekly creative micro-habit; dance or movement-based session.	Activity frequency, adherence, sleep quality, vitality.
Embodied regulation	Links breath, posture, rhythm and movement with autonomic settling.	Rhythmic movement, percussion, mindful sketching.	Heart-rate variability, sleep, subjective calm.

Emotional literacy as a clinical bridge

Emotional literacy can be understood as the capacity to identify, name, communicate and regulate emotional states in ways that support health, relationships and decision-making. It is conceptually related to emotion regulation, emotional awareness, emotion differentiation and emotional intelligence [31-38]. In clinical practice, low emotional literacy may appear as somatisation, impulsive coping, conflict, avoidance, sleep disruption, poor adherence or difficulty asking for help.

Art-based learning offers a practical bridge because it allows emotions to be externalised before they are verbalised. A patient who struggles to say "I am afraid" may be able to choose an image, a colour, a sound or a metaphor. This externalisation reduces the threat of direct disclosure and creates a shared object for reflection. In group contexts, it also normalises vulnerability without forcing premature intimacy.

The clinical value of emotional literacy is not sentimental. Emotion regulation strategies are transdiagnostic processes implicated across anxiety, depression, trauma-related symptoms, addictive behaviours and interpersonal difficulties [31-34]. Emotional awareness and differentiation are associated with adaptive coping and psychological flexibility [35-36]. Emotional intelligence research further supports the relevance of perceiving, understanding and managing emotions in personal and social functioning [37-38]. Creative health programmes should therefore treat emotional literacy as a measurable competence, not as a decorative slogan.

Meaning, identity and the human dimension of prevention

Many preventive interventions fail not because patients do not understand advice, but because the advice does not connect with identity, meaning and the realities of daily life. Meaning-making research shows that people interpret stressful events through global beliefs, goals and situational appraisals [39]. Psychological wellbeing models emphasise autonomy, environmental mastery, purpose, personal growth, positive relations and self-acceptance [40-42]. These constructs are clinically relevant because they influence motivation, persistence and resilience.

Art can help transform prevention from instruction into appropriation. A person may know that walking, sleeping, eating better or reducing screen time is beneficial, but knowledge alone rarely sustains change. When behaviour change is connected to a valued identity - a parent who wants to be present, a professional who wants to lead without self-destruction, a patient who wants to recover dignity after illness - the intervention becomes more durable. Creative exercises can reveal these identities and translate them into micro-commitments.

Meaning must also be handled ethically. Clinicians and facilitators should not impose interpretations, spiritual frameworks or moral expectations. The role of the intervention is to help participants discover, name and test their own sources of meaning, while respecting cultural, religious, secular and personal diversity. This is particularly important in medical contexts where illness, suffering and mortality can make meaning both clinically powerful and emotionally delicate.

Lifestyle self-regulation: from advice to micro-habits

Lifestyle medicine has strong evidence for the importance of physical activity, nutrition, sleep and social connection. WHO guidelines recommend regular physical activity and reduced sedentary behaviour for adults, with health benefits accruing even when individuals move from inactivity to modest activity [43-44]. Diet quality is associated with mental and physical health, and dietary improvement has been tested as an adjunctive intervention in depression [45-47]. Sleep duration and quality are funda-

mental to cognitive, metabolic and emotional functioning [48-49]. Social relationships are associated with mortality and physical health outcomes [50-51]. Digital health and digital behaviour have become additional determinants of attention, sleep, mental health and access to care [52-53].

The difficulty is not the absence of advice; it is the gap between advice and adherence. Patients frequently receive recommendations without a method for integrating them into emotionally complex lives. Art-based learning can support lifestyle self-regulation by converting abstract goals into symbolic, visible and emotionally meaningful commitments. A "sleep hygiene plan" may become a drawing of an evening boundary. A "nutrition goal" may become a values-based ritual of care. A "physical activity prescription" may become a music-linked walking practice.

The proposed framework uses micro-habits because small, repeated behaviours are more feasible than dramatic transformations. In clinical settings, the focus should be on realistic changes: a ten-minute walk, a two-minute breathing sketch, a weekly cultural activity, a shared meal, a digital sunset routine, a brief gratitude note or a scheduled conversation with a supportive person. These behaviours are not trivial when they are repeated, measured and connected to clinical goals.

The Creative Health Self-Regulation Framework

The Creative Health Self-Regulation Framework proposed here is an eight-domain model for preventive clinical use. It is designed to be brief enough for real-world settings and broad enough to capture the interaction between body, mind, relationships and environment. The eight domains are: (1) body, (2) cognitive patterns, (3) emotions, (4) meaning, (5) relationships, (6) work and role functioning, (7) financial stressors and (8) digital behaviour. Each domain can be explored through a clinical question, a creative prompt and a micro-habit.

The framework does not replace standard assessment. In primary care, occupational health, psychiatry, rehabilitation or chronic disease management, it should be used after appropriate screening and risk assessment. Red flags such as suicidality, severe depression, psychosis, substance dependence, domestic violence, acute trauma, uncontrolled medical symptoms or safeguarding concerns require referral and evidence-based clinical management. Creative health is suitable as a supportive adjunct when risk is appropriately managed.

The framework can be implemented at three intensities. Level 1 is a brief clinical conversation lasting five to ten minutes, using one creative prompt to identify a self-regulation micro-habit. Level 2 is a structured group programme of four to eight sessions facilitated by trained professionals. Level 3 is an integrated care pathway combining clinical screening, creative group work, lifestyle counselling, social prescribing and follow-up measurement. This stepped model protects proportionality and allows services to match intensity to need.

Table 3. Eight-domain clinical map for creative health self-regulation

Domain	Clinical question	Creative prompt	Micro-habit example	Possible measure
Body	How is the body signalling overload or recovery?	Draw a body map of tension and energy.	Ten-minute walk after lunch three days per week.	Activity log, sleep diary, SF-36.
Cognitive patterns	Which thoughts amplify or soften stress?	Create two columns: inner critic and inner coach.	One cognitive pause before responding to conflict.	Perceived Stress Scale.
Emotions	Which emotions are present but unnamed?	Choose three colours for the week and name them.	Two-minute emotion naming practice each evening.	GAD-7, PHQ-9, emotion awareness.
Meaning	What makes change worth the effort?	Create a collage of values and future identity.	One weekly action aligned with a core value.	Flourishing Scale, meaning scales.
Relationships	Who nourishes or drains recovery?	Map the support network as circles of proximity.	One intentional connection per week.	Loneliness, social support.
Work/role	Which role demands exceed current resources?	Theatre exercise: role, mask and authentic voice.	One boundary conversation or workload clarification.	Burnout inventory, engagement scale.
Financial stressors	How does money stress affect health behaviour?	Draw a stress-to-decision chain.	One practical financial micro-action.	Stress score, self-efficacy.
Digital behaviour	How does technology affect attention and sleep?	Sketch the daily digital curve.	Digital sunset 30 minutes before sleep.	Screen-time log, sleep quality.

The framework is summarised in Figure 1. Its purpose is not to medicalise art, but to make creative health clinically accountable: each domain is linked to plausible mechanisms, each activity requires safety boundaries, and each implementation pathway should define screening, referral, fidelity and outcome measurement.

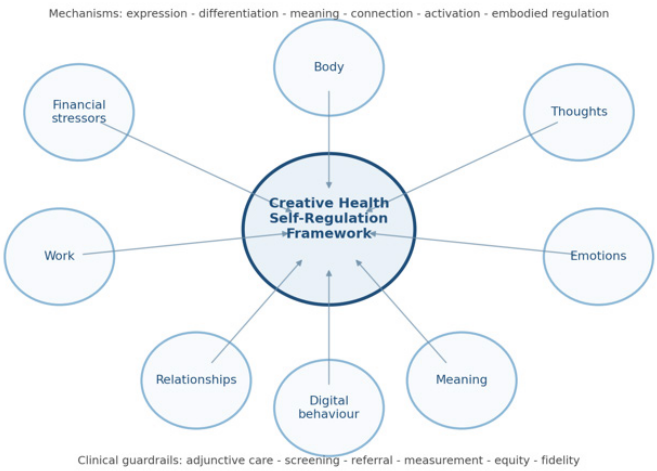

Figure 1. Creative Health Self-Regulation Framework: domains, mechanisms and clinical guardrails

Clinical indications and contraindications

The framework is most appropriate for prevention, early support, recovery maintenance and adjunctive wellbeing care. Potential indications include occupational stress, early burnout symptoms, mild to moderate stress-related distress, loneliness, adjustment challenges, chronic disease self-management support, caregiver strain, post-treatment survivorship support and health promotion groups. The intervention may also be useful for healthcare professionals because it creates a non-stigmatising language for exhaustion, moral distress and meaning loss.

Contraindications are relative rather than absolute. Individuals with acute psychiatric risk, severe cognitive impairment, active psychosis, severe trauma activation, uncontrolled addiction, safeguarding concerns or medical instability should receive specialised assessment and treatment before participating in open creative groups. Some people may find expressive exercises triggering; facilitators must be trained to titrate depth, offer opt-out options, avoid forced disclosure and maintain clear referral pathways.

Cultural safety is essential. Art is not a universal language in a simplistic sense; it is shaped by culture, class, education, disability, religion, gender, age and personal history. Programmes should include accessible materials, multiple forms of expression, trauma-informed facilitation, respect for silence, confidentiality and sensitivity to stigma. The goal is not artistic performance, but health-supporting expression and self-regulation.

Outcome measurement and clinical evaluation

For clinical adoption, outcomes must be measurable. The framework can use brief validated instruments depending on the setting and target population. Depression and anxiety symptoms can be screened with PHQ-9 and GAD-7 [54-55]. Perceived stress can be assessed with the Perceived Stress Scale [56]. Burnout and engagement can be measured with validated occupational instruments [57-58]. General quality of life and wellbeing can be assessed through SF-36 and flourishing measures [59-60].

Measurement should not be excessive. A pragmatic programme might assess three levels: (1) safety and acceptability, (2) proximal mechanisms such as emotional literacy, perceived stress and social connection, and (3) distal outcomes such as burnout, sleep quality, quality of life, healthcare utilisation or sickness absence. Qualitative data are also important because creative interventions may produce changes in language, identity, meaning and relational confidence that are not fully captured by symptom scales.

Equity should be evaluated explicitly. If creative health programmes mainly reach educated, affluent or culturally confident participants, they may widen inequalities. Studies should report who participates, who declines, who drops out and which adaptations are needed for different groups. Accessibility, cost, language, disability accommodations, digital inclusion and geographic availability should be considered implementation outcomes, not administrative details.

Table 4. Measurement strategy for future clinical studies

Level	Question	Example outcomes	Suggested tools
Feasibility	Can the programme be delivered as planned?	Recruitment, attendance, completion, facilitator fidelity.	Administrative data, fidelity checklist.
Acceptability	Do participants and clinicians consider it useful and safe?	Satisfaction, perceived relevance, adverse experiences.	Surveys, interviews, adverse-event logs.
Mechanisms	Does it change proposed pathways?	Emotional naming, perceived stress, social connection, self-efficacy.	PSS, qualitative interviews, social support measures.
Clinical outcomes	Does it improve health-relevant endpoints?	Anxiety, depression, burnout, sleep, quality of life, work functioning.	GAD-7, PHQ-9, burnout tools, SF-36.
Implementation	Can it be sustained and scaled equitably?	Reach, adoption, fidelity, cost, equity, maintenance.	RE-AIM, implementation outcome measures.

Implementation in clinical and occupational settings

Implementation should begin with the question: where does this intervention add value without overburdening the system? In primary care, it may function as a referral option for patients with stress-related complaints who do not require specialist mental health care but need structured support. In occupational health, it may complement organisational interventions by helping workers develop emotional language, recovery practices and social connection. In rehabilitation or chronic disease services, it may support motivation, identity reconstruction and adherence.

The intervention should be described using TIDieR principles: who provides it, what materials are used, what procedures are followed, where it occurs, how often it is delivered, how it is tailored and how fidelity is assessed [63]. Future protocols should follow SPIRIT, and trials should be reported using CONSORT or appropriate extensions [64-65]. Systematic reviews should follow PRISMA, and complex intervention development should align with updated Medical Research Council guidance [66-67]. Process evaluation is necessary to understand not only whether the programme works, but how, for whom, under what conditions and at what cost [68-69].

Training is a critical issue. Facilitators need more than artistic talent. They

require basic knowledge of mental health boundaries, trauma-informed practice, group dynamics, confidentiality, safeguarding, cultural humility, referral processes and outcome documentation. Conversely, clinicians do not need to become artists; they need enough creative literacy to refer appropriately, interpret participant feedback and integrate creative work into care planning.

Table 5. Implementation checklist for services

Component	Minimum requirement	Reason
Screening	Brief assessment of distress, risk, expectations and accessibility needs.	Prevents inappropriate inclusion and supports safe tailoring.
Facilitator competence	Training in creative facilitation, boundaries, safeguarding and referral.	Protects participants and improves fidelity.
Manualisation	Clear session structure with flexible adaptation.	Allows replication without reducing human responsiveness.
Clinical pathway	Defined referral routes for risk, deterioration or specialist needs.	Maintains medical responsibility and safety.
Measurement	Small set of validated outcomes plus qualitative feedback.	Creates evidence without excessive burden.
Equity plan	Accessibility, cost, language, disability and cultural adaptations.	Prevents creative health from becoming a privilege.
Sustainability	Budget, governance, supervision and quality improvement.	Supports long-term integration rather than isolated events.

Ethical safeguards

Creative health can be emotionally powerful. That power creates ethical responsibilities. Programmes should clearly state that participation is voluntary, that artistic quality is irrelevant, that no one is required to disclose personal trauma, and that participants may pause or stop at any time. Confidentiality rules should be explicit, especially in workplace groups where participants may fear professional consequences.

Medical claims must remain proportionate. It would be unethical to suggest that painting, music, theatre or writing can replace evidence-based treatment for depression, cancer, cardiovascular disease, diabetes, psychosis or other clinical conditions. The appropriate claim is narrower and stronger: structured creative engagement may support self-regulation, meaning, connection and health-promoting behaviour as part of preventive, supportive or rehabilitative care.

Data protection is also important. Creative outputs may contain sensitive personal information. Services should decide whether participants keep their own works, whether images are photographed, how consent is obtained, how data are stored and whether works can be used for teaching or dissemination. In research settings, ethics approval should address the emotional and symbolic nature of creative materials.

Research agenda

The next stage of creative health research should move from broad enthusiasm to precise questions. Feasibility studies should test recruitment, retention, fidelity, safety, acceptability and outcome burden. Pilot trials should refine effect-size estimates and identify plausible mechanisms. Pragmatic randomised trials should compare creative health programmes with usual care, social prescribing alone, lifestyle counselling alone or active control groups, depending on the setting.

Mechanistic studies are needed. Potential mediators include perceived stress, emotion differentiation, social connection, behavioural activation, sleep quality, meaning in life, self-efficacy and autonomic regulation. Biological outcomes such as inflammatory markers, cortisol rhythms or epigenetic ageing measures may be explored in carefully designed studies, but should not be used prematurely as marketing claims. The field should welcome biological curiosity while resisting biological sensationalism.

Economic evaluation is also necessary. Health systems and employers need to know whether creative health interventions reduce healthcare utilisation, sickness absence, turnover, loneliness, medication escalation or relapse risk, and whether benefits justify costs. Implementation research should examine adoption, reach, fidelity, adaptation and maintenance across diverse populations. Without this evidence, creative health may remain inspiring but marginal.

A publishable next step is a staged programme of feasibility, pilot and pragmatic effectiveness research. The proposed sequence is intentionally conservative: before claiming clinical impact, the intervention should establish acceptability, fidelity, safety, mechanism plausibility, equity and reproducibility.

Table 6. Staged research roadmap for testing the framework

Stage	Primary question	Recommended design	Core outcomes	Reporting standard
1. Manualisation	Can the programme be described and replicated?	Intervention manual, facilitator guide, fidelity checklist	Completeness of intervention description, fidelity domains	TIDieR [63]
2. Feasibility	Can participants be recruited, retained and safely supported?	Single-arm feasibility study	Recruitment, retention, adherence, adverse events, acceptability	MRC complex interventions [67]
3. Pilot trial	Are procedures and candidate outcomes workable?	Assessor-blinded pilot RCT	PHQ-9, GAD-7, PSS, WHO-5 or SF-36, sleep, work engagement	CONSORT 2025/SPIRIT [64,71]

4. Process evaluation	How and why does the intervention work or fail?	Mixed-methods process evaluation	Dose, fidelity, participant experience, context, mechanisms	MRC process evaluation [68]
5. Pragmatic evaluation	Does it improve clinically relevant outcomes under real-world conditions?	Cluster or individually randomised pragmatic trial	Symptoms, wellbeing, utilisation, work outcomes, cost-effectiveness	CONSORT 2025 [71]

Practical programme architecture: from session to pathway

A clinically credible creative health programme should be simple enough to deliver and specific enough to evaluate. A suggested eight-session group pathway begins with orientation and safety, then progresses through body awareness, emotional naming, cognitive reframing, meaning reconstruction, relationship mapping, work-role boundaries, digital recovery and consolidation. Each session should contain four stable components: a brief check-in, a creative exercise, a reflective dialogue and a micro-habit commitment. This repeated architecture creates psychological safety while allowing individualisation.

Session 1, orientation and baseline self-regulation, introduces the idea that prevention is not a moral test but a practice of care. Participants complete baseline measures, agree confidentiality rules and create a simple personal symbol of recovery. Session 2, the body as messenger, uses body mapping to distinguish signals of overload from signals of restoration. Session 3, naming emotions, uses colour, image and metaphor to increase emotional vocabulary. Session 4, thoughts and inner dialogue, uses writing or theatre techniques to identify the difference between the inner critic and the inner coach.

Session 5, meaning and values, invites participants to create a visual representation of what makes change worthwhile. Session 6, relationships and belonging, maps sources of support, conflict and nourishment. Session 7, work, money and digital boundaries, examines the modern stressors that often remain hidden in clinical conversations. Session 8, integration, converts learning into a personalised preventive plan with three micro-habits, one support action and one red-flag plan. This structure allows the programme to be manualised without becoming mechanical.

In individual care, the same architecture can be compressed into brief encounters. A clinician might ask: "If your stress had a colour, shape or sound today, what would it be?" The answer is not interpreted as art therapy; it is used as a doorway to self-observation. The clinician can then ask: "What is one small action that would help your body, mind or relationship system recover before tomorrow?" In five minutes, the consultation moves from symptom description to self-regulation planning.

In organisational settings, the pathway should be paired with structural review. Creative workshops can help workers express strain, but they should not become a substitute for workload redesign, fair management, psychological safety or adequate staffing. A responsible employer uses creative health both as support for individuals and as listening architecture for the organisation. Anonymous thematic findings may guide leadership action, provided confidentiality is protected.

Table 7. Example eight-session creative health pathway

Session	Theme	Creative method	Clinical target	Home micro-habit
1	Safety and self-regulation baseline	Personal symbol of recovery	Engagement and expectations	One daily observation of energy.
2	Body as messenger	Body map of tension and vitality	Somatic awareness	Ten minutes of restorative movement.
3	Emotional literacy	Colour and metaphor palette	Emotion naming	Name three emotions each evening.
4	Cognitive patterns	Inner critic / inner coach dialogue	Cognitive distancing	One pause before automatic reaction.
5	Meaning and values	Values collage or future-self letter	Motivation and purpose	One values-aligned action.
6	Relationships	Support network map	Belonging and help-seeking	One nourishing contact.
7	Boundaries and digital recovery	Digital curve and role masks	Sleep, attention and role strain	Thirty-minute digital sunset.
8	Integration	Personal prevention canvas	Maintenance planning	Three-week self-regulation plan.

Hypothetical clinical applications

The following vignettes are illustrative and do not describe real patients. They are included to clarify how the framework could be applied without making unsupported claims of efficacy. In primary care, a 52-year-old professional with insomnia, irritability and mild hypertension may receive standard medical assessment, blood pressure management and lifestyle advice. A creative health referral could then focus on body mapping, evening digital boundaries and values-based walking. The aim would not be to treat hypertension through art, but to support adherence, recovery routines and stress awareness while biomedical care continues.

In occupational health, a healthcare worker with emotional exhaustion and reduced meaning might participate in a group programme after risk screening. Theatre-based exercises could help distinguish professional role, organisational pressure and personal identity. Reflective writing could identify moments of moral distress and sources of meaning. Outcomes could include perceived stress, burnout dimensions, work engagement and qualitative accounts of boundary-setting. Organisational leaders would also need to review workload and team climate, because individual recovery cannot compensate indefinitely for structural harm.

In chronic disease management, a patient living with diabetes may un-

derstand dietary and physical activity advice but feel defeated by repeated failure. A creative exercise can externalise the "story of failure" and replace it with a micro-habit plan linked to dignity and self-care. The clinical team would still monitor glycaemic control, medication, diet and complications. The creative component would support motivation, identity and adherence rather than making metabolic claims on its own.

In community mental health prevention, a group of older adults experiencing loneliness may benefit from museum-based dialogue, choir participation or shared creative workshops. The active ingredient may be less the art object itself than the combination of cultural stimulation, routine, conversation, belonging and renewed identity. Outcomes should therefore include loneliness, mood, social participation and qualitative experience, not only symptom reduction.

Discussion: why creative health belongs in medical and clinical research

The strongest argument for creative health in medical research is not that art is magical. It is that human beings are symbolic, relational and embodied. They do not change behaviour only because they receive information. They change when they can feel, name, imagine, practise and sustain a different relationship with themselves and their environment. Clinical prevention often fails at this human translation point. Creative health can help fill that gap.

The second argument is that many health problems are now problems of regulation. People need to regulate attention in a digital environment, emotions under pressure, sleep in overstimulated evenings, food choices under stress, work boundaries in permanent connectivity, loneliness in fragmented communities and meaning in times of uncertainty. The arts can train attention, rhythm, expression, empathy, perspective-taking and shared presence. These are not soft luxuries; they are human capacities with clinical consequences.

The third argument is pragmatic. Health systems face rising demand and limited professional capacity. Low-risk group interventions, community partnerships and social prescribing pathways may extend the preventive reach of care when they are well governed. Creative health programmes can be delivered in clinics, workplaces, libraries, museums, community centres and digital or hybrid formats. The challenge is to maintain quality, equity and evidence rather than multiplying attractive but untested activities.

The fourth argument is ethical. A purely biomedical model may unintentionally reduce people to diagnoses, risk scores or treatment plans. Creative health reintroduces personhood without rejecting science. It creates space for biography, dignity, agency and relationship. In this sense, it aligns with person-centred care, public health, rehabilitation, occupational well-being and palliative humanism. The scientific task is to evaluate this contribution rigorously, not to dismiss it because it is difficult to measure.

The framework proposed in this article also helps avoid two common errors. The first error is romanticism: claiming too much for art and ignoring methodological weakness. The second error is reductionism: dismissing art because it does not behave like a drug. Complex interventions require different evaluation logics. Mechanisms, context, adaptation, implementation and participant meaning are not noise; they are part of the intervention. The updated guidance for complex interventions supports this broader but disciplined research perspective [67-69].

Limitations of this review

This manuscript is a narrative review and conceptual framework, not a systematic review. The evidence base was selected for relevance and integration rather than exhaustive retrieval. The field of creative health is heterogeneous, and findings vary by population, intervention, facilitator, dose and outcome. Many studies are observational, small, context-dependent or vulnerable to selection bias. Strong causal claims are therefore inappropriate.

Another limitation is that the proposed framework has not yet been tested as a full clinical package. Its components are evidence-informed, but the integrated model requires feasibility testing, manualisation, fidelity assessment, cultural adaptation and controlled evaluation. The article should therefore be read as a translational proposal for research and practice, not as proof of clinical efficacy.

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Declarations
Conclusion

Preventive medicine needs methods that are biologically informed, behaviourally realistic and humanly meaningful. Risk calculators, screening protocols and lifestyle advice remain essential, but they often fail when patients lack emotional language, social support, hope, identity, agency or a practical way to translate recommendations into daily life. Creative health can help fill that translational gap when it is structured, measured and ethically integrated into clinical pathways.

The Creative Health Self-Regulation Framework offers a clinically responsible bridge between medical prevention, emotional literacy, lifestyle medicine, social prescribing and implementation science. Its strength lies in disciplined humility: it does not claim that art replaces treatment, nor that all creative activities are clinically effective. It proposes that art-based self-regulation can become a credible adjunct to preventive care when delivered with screening, referral criteria, fidelity, equity, measurable outcomes and transparent research standards. The next scientific task is clear: manualise it, test it, refine it and evaluate it through pragmatic, patient-centred and ethically robust studies.

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