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Abbreviations:

PV-ART: Pain-to-Vitamin Framework;
WHO: World Health Organization;
NICE: National Institute for Health and
Care Excellence;
PHQ-9: Patient Health Questionnaire-9;
GAD-7: Generalized Anxiety Disorder-7;
CD-RISC: Connor-Davidson Resilience
Scale;
WEMWBS: Warwick-Edinburgh Scale.

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From Emotional Pain to Psychological Nutrients: An Art-Based, Meaning-Centered Framework for Preventive Psychiatry and Mental Health Promotion

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Abstract

Background: Contemporary psychiatry faces a double challenge: the global burden of depression, anxiety, loneliness, trauma-related distress and functional impairment continues to grow, while many people remain unable or unwilling to access conventional mental health services. Preventive, community-based and recovery-oriented approaches are therefore needed as complements—not substitutes—to diagnosis, psychotherapy and pharmacological care.

Objective: This article proposes the Pain-to-Vitamin Art-Based Mental Health Framework (PV-ART), a structured, meaning-centered and arts-informed model designed to transform emotional pain into psychological nutrients through expression, narrative reorganization, social connection and habit formation.

Methods: A conceptual and translational review was conducted by integrating evidence from psychiatry, psychology, behavioral science, salutogenesis, resilience research, arts-and-health literature, music therapy, visual art therapy, behavioral activation and validated mental health measurement.

Results: PV-ART is organized around four sequential clinical-educational movements: Naming pain, expressing pain through symbolic creation, converting pain into meaning and consolidating change through micro-habits. The model is intended for adults with mild to moderate psychological distress, subclinical symptoms, recovery needs or relapse-prevention goals, and should be delivered under appropriate ethical and clinical safeguards. The article presents an eight-session protocol, outcome measures, implementation criteria, risk management procedures and research recommendations for pilot feasibility studies and randomized controlled trials.

Conclusions: Art-based and meaning-centered interventions may offer a promising adjunctive route to enhance emotional literacy, agency, social belonging and recovery-oriented well-being. PV-ART requires empirical validation but provides a clinically cautious, culturally adaptable and measurable framework for preventive psychiatry and mental health promotion.

Keywords: psychiatry; mental health promotion; art therapy; meaning-centered care; depression; anxiety; resilience; behavioral activation; well-being; recovery.

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1. Introduction: Why Psychiatry Needs Complementary Pathways of Meaning, Expression, and Habit

Mental health has become one of the central public health and ethical challenges of the twenty-first century. The World Health Organization has emphasized that mental health is essential to human development, social participation and collective prosperity, while also warning that needs remain high and responses are often insufficient, fragmented or inequitable [1, 2]. The Global Burden of Disease 2019 analysis confirmed that mental disorders remain among the leading causes of years lived with disability worldwide, without evidence of a global reduction in burden across recent decades [3]. The COVID-19 pandemic further intensified depressive and anxiety symptoms across many populations, revealing the vulnerability of mental health systems and the importance of accessible preventive interventions [4]. The WHO Mental Health Atlas and mhGAP programme both call for stronger community-based, evidence-informed and scalable approaches that can narrow the treatment gap and complement specialist care [5, 6]. Clinical guidelines such as NICE NG222 also stress shared decision-making, patient preference, psychological interventions, active monitoring and tailored care pathways for depression [7].

This article begins from a simple clinical observation: people do not only suffer from symptoms; they also suffer from unexpressed narratives, broken meanings, social disconnection, loss of agency and habits that gradually shrink life. Psychiatry has made extraordinary progress in diagnosis, pharmacotherapy, psychotherapy and neuroscience. Yet the lived experience of distress often exceeds the language of diagnostic categories. A person may meet criteria for a depressive episode, an anxiety disorder or trauma-related distress, but he or she may also be asking a deeper human question: What can I do with this pain? How can I prevent it from becoming identity, bitterness, isolation or resignation?

The proposed Pain-to-Vitamin Art-Based Mental Health Framework (PV-ART) addresses that question. The metaphor of transforming pain into a psychological nutrient does not deny suffering, romanticize trauma or replace clinical treatment. Rather, it proposes that, under safe conditions, emotional pain can be named, externalized, symbolized, shared, metabolized and converted into sources of self-knowledge, compassion, purpose and constructive action. The framework integrates art-based expression, meaning-centered reflection and behavioral habit formation into a structured intervention for mental health promotion and relapse prevention.

PV-ART is not presented as a psychotherapy brand, a diagnostic instrument or a stand-alone psychiatric treatment. It is a translational model for adults with mild to moderate psychological distress, people in recovery after a crisis, caregivers, professionals exposed to burnout, older adults at risk of loneliness and communities seeking mental health literacy. It can be used as an adjunct to clinical care when supervised by qualified professionals, or as a preventive psychoeducational programme when appropriate screening and referral pathways are in place. Its central hypothesis is that creative expression can help people move from emotional flooding to symbolic distance, from symbolic distance to meaning, and from meaning to daily habits that protect well-being.

2. Conceptual Positioning Within Contemporary Psychiatry

Modern psychiatry is increasingly pluralistic. Diagnostic systems such as DSM-5-TR provide shared clinical language and criteria, but psychiatric suffering cannot be understood only through categorical diagnosis [8]. The biopsychosocial model emphasized that health and illness emerge through the interaction of biological, psychological and social factors [9]. Explanatory pluralism in psychiatry also argues that no single level of explanation—molecular, cognitive, developmental, social or existential—is sufficient on its own [10].

PV-ART follows this pluralistic orientation. It does not compete with biological psychiatry, cognitive-behavioral therapy or pharmacological care; it complements them by addressing symbolic, relational and habit-based dimensions of mental health. The model also draws from meaning-centered traditions. Frankl's work on meaning under conditions of suffering remains clinically relevant because many people experience distress not only as pain but as a collapse of orientation [11]. Acceptance and commitment therapy similarly emphasizes values, acceptance and committed action rather than the mere elimination of uncomfortable internal experiences [12]. Cognitive therapy highlighted the role of beliefs and interpretations in depression [13], while behavioral activation demonstrated that engagement in meaningful activity can be a direct pathway to mood improvement [14]. Psychotherapy outcome research continues to show that psychological treatments are effective for depression and anxiety, while also showing the need for personalized, acceptable and scalable interventions [15].

PV-ART is therefore located at the intersection of four traditions: psychiatry, psychotherapy, arts-and-health practice and behavioral science. Its originality lies in sequencing them into a single practical pathway: pain is first recognized, then externalized through artistic form,

then reorganized through meaning, and finally translated into protective habits. This sequence avoids two common errors. The first is premature positivity, in which people are urged to “be strong” before their suffering has been heard. The second is endless rumination, in which pain is

repeatedly narrated without being converted into action. PV-ART proposes a middle route: truth, expression, meaning and movement.

Table 1. Overview of the Pain-to-Vitamin Art-Based Mental Health Framework (PV-ART) Movements.

Movement	Operational Definition	Expected Mechanism
1. Naming pain	The participant identifies the emotional experience without judgment and differentiates sadness, fear, anger, shame, guilt, loneliness, grief or exhaustion.	Emotional literacy; reduction of avoidance; initial containment.
2. Giving pain a form	The participant externalizes the experience through drawing, music, movement, collage, metaphor, object work or narrative fragments.	Symbolic distance; affect regulation; increased self-observation.
3. Extracting the vitamin	The participant asks what constructive learning, boundary, value, relationship, compassion or purpose may emerge from the experience.	Meaning-making; cognitive reappraisal; identity reconstruction.
4. Turning meaning into habit	The participant converts the learning into micro-habits repeated in everyday life.	Behavioral activation; self-efficacy; relapse prevention.

3. Theoretical Foundations of PV-ART

3.1 Emotion Regulation, Symbolic Distance, and Psychological Flexibility

Emotion regulation research has shown that mental health depends not merely on the presence or absence of emotion, but on the capacity to identify, tolerate, modulate and use emotional information adaptively [16, 17, 18]. Art-based expression can support this process because it gives emotion a form without forcing immediate verbal explanation. A drawing, a musical fragment, a movement, a metaphor or a poem can make distress visible and shareable. This symbolic distance matters clinically: when pain becomes an object of attention rather than an undifferentiated internal storm, the person can begin to relate to it with curiosity, self-compassion and agency.

Psychological flexibility is also central. PV-ART does not invite people to erase pain, but to change their relationship

with pain. The question becomes: Can this experience be placed in a wider story? Can it teach me something about boundaries, values, relationships, vulnerability, courage or care? Can it be transformed into a small act of reconstruction today? These questions connect art-based expression with committed action, avoiding both emotional avoidance and passive self-absorption.

3.2 Resilience, ordinary magic and recovery

Resilience research has moved away from heroic interpretations of invulnerability. It is now more accurately understood as dynamic adaptation in the context of adversity, supported by internal resources, relational protection and social conditions [19-21]. PV-ART uses the language of “vitamin” precisely to avoid the false idea that pain is good in itself. Pain is not good; what can become valuable is the learning, connection, humility, strength or purpose that may emerge when pain is metabolized through safe processes.

The framework is also aligned with recovery-oriented mental health care. Recovery is not reducible to symptom remission; it includes hope, identity, meaning, empowerment and social connection. Creative practices can help people recover authorship over their lives. A person who creates an image of anxiety, writes a letter to grief, composes a soundscape of anger or builds a symbolic map of future actions is not only expressing symptoms. He or she is rehearsing agency.

3.3 Well-Being, Self-Determination, and Salutogenesis

Well-being science contributes a further foundation. Psychological well-being includes autonomy, environmental mastery, purpose in life, positive relations, personal growth and self-acceptance [22]. Positive psychology introduced practical language for flourishing, including positive emotion, engagement, relationships, meaning and accomplishment [23]. The mental health continuum reminds us that the absence of mental illness is not identical with the presence of mental health [24]. Self-determination theory shows that autonomy, competence and relatedness are basic psychological needs [25]. Bandura's concept of self-efficacy explains why people need experiences of mastery to change behavior [26]. Antonovsky's salutogenic model adds the importance of comprehensibility, manageability and meaningfulness [27], while conservation of resources theory clarifies how stress can deplete personal, social and material resources [28]. PV-ART translates these constructs into practice. It seeks to make suffering comprehensible by naming it, manageable by externalizing it, meaningful by reinterpreting it, and actionable by connecting it to habits. In this sense, the framework is not a merely expressive intervention; it is a structured salutogenic process.

4. Evidence Base for Arts, Music, and Creative Expression in Mental Health

The arts-and-health field has grown substantially. A WHO scoping review synthesized a broad body of evidence on the role of the arts in improving health and well-being, highlighting preventive, promotional, management and treatment-related pathways [29]. Population research has also linked cultural engagement with lower risk of depression among older adults, suggesting that arts participation may contribute to social, cognitive and emotional protection [30]. Public health approaches increasingly recognize creative engagement as a potential resource for mental health promotion, social prescribing and community well-being [31].

Evidence from visual art therapy and music therapy is promising but still heterogeneous. A 2024 systematic review and meta-analysis in JAMA Network Open found that active visual art therapy was associated with therapeutic benefits for some outcomes, although the overall quality of evidence remained limited and heterogeneous [32]. A Cochrane review reported that music therapy plus treatment as usual was more effective than treatment as usual alone for depression, with possible benefits for depressive symptoms, anxiety and functioning, while also noting uncertainty and the need for further research [33]. Meta-analytic work on music interventions has found reductions in depressive symptoms, and broader reviews have associated music interventions with improvements in health-related quality of life [34, 35]. Creative arts therapies have long been used in clinical and community settings to support expression, containment, relational engagement and identity reconstruction [36, 37, 38]. Systematic reviews of art therapy in mental health have examined depression, anxiety and mixed psychiatric or psychosocial outcomes, often finding potentially positive effects but emphasizing methodological limitations such as small samples, heterogeneous protocols and variable control conditions [39, 40, 41, 42]. This evidence supports a cautious conclusion: arts-based mental health interventions are not magic, but neither are they merely decorative. They can be clinically relevant when they are structured, ethically delivered, carefully measured and integrated with existing care pathways.

5.1 Movement 1: Naming Pain

Many people arrive in distress with global language: "I am bad", "I cannot cope", "everything is wrong". The first movement transforms global distress into differentiated experience. The facilitator invites participants to name the dominant emotion, its body location, its triggering context, its intensity and its unmet need. This is not diagnosis; it is emotional literacy. Naming reduces chaos. It also protects against the risk of converting one painful episode into a totalizing identity.

5.2 Movement 2: Giving Pain a Form

The second movement uses artistic creation to externalize what is difficult to say directly. The aim is not aesthetic quality but symbolic truth. Participants may draw the shape of anxiety, choose a color for grief, build a collage of pressure, write a dialogue with fear, improvise a rhythm of anger or create a visual bridge between the present self and a future self. The facilitator does not interpret the work as an expert decoding hidden

meanings; instead, the participant remains the primary interpreter of his or her creation.

5.3 Movement 3: Extracting the Vitamin

The third movement introduces meaning. The facilitator asks: What does this pain reveal about something that matters? What boundary was crossed? What value needs protection? What relationship needs care? What habit must change? What strength has been underestimated? In PV-ART, a “vitamin” is any constructive psychological nutrient extracted from pain: self-knowledge, courage, humility, compassion, forgiveness, assertiveness, gratitude, responsibility, purpose or solidarity. The concept must be handled carefully: the facilitator never tells the participant what the vitamin is. The participant discovers it.

5.4 Movement 4: Turning Meaning into Habit

Insight without habit is fragile. PV-ART therefore ends every session with a micro-action. The action must be small, observable and repeatable: a five-minute walk, a message to a trusted person, a sleep boundary, a gratitude note, a breathing exercise, a creative diary entry, a request for help, a reduction in digital exposure or a scheduled pleasurable activity. The objective is not to solve a life problem instantly but to restore agency through repeated behavior. The artistic product becomes a cue for action.

6. Target Population, Clinical Boundaries, and Contraindications

PV-ART is designed primarily for adults with mild to moderate psychological distress, subthreshold depressive or anxiety symptoms, work-related exhaustion, loneliness, grief processes, post-crisis recovery needs, caregiver burden or relapse-prevention goals. It may also be useful in educational, organizational and community settings as a mental health literacy programme. However, it should not be used as a substitute for psychiatric assessment, psychotherapy or medication when these are clinically indicated.

Exclusion or referral criteria should include acute suicidal intent, active psychosis, uncontrolled mania, severe substance withdrawal, severe eating disorder risk, acute trauma destabilization, cognitive impairment that prevents informed participation, or any condition requiring urgent specialist care. Participants with moderate to severe symptoms may participate only when the programme is integrated into a broader clinical plan and risk monitoring is available. Facilitators must be trained to recognize deterioration, dissociation, self-harm risk, safeguarding concerns and the need for referral.

7. Proposed Eight-Session PV-ART Protocol

The following protocol is proposed for a pilot feasibility study. Sessions are weekly, 90 minutes each, in groups of 6 to 10 participants. Each session follows the same safe structure: arrival check-in, creative exercise, reflective dialogue, meaning extraction, micro-habit commitment and closing grounding exercise.

8. Mechanisms of Change

8.1 Emotional Labeling and Affect Tolerance

PV-ART begins with emotional labeling because undifferentiated distress tends to amplify helplessness. Naming emotions increases psychological clarity and prepares the person for regulation. Art supports affect tolerance because it allows emotion to be approached indirectly. A participant can look at an image of fear before being ready to speak fully about fear.

8.2 Externalization and Narrative Reorganization

Externalization reduces fusion between self and symptom. “I am anxiety” becomes “I am looking at the form my anxiety has taken today”. This distinction is clinically relevant because it restores an observing self. Narrative reorganization then helps the participant move from a fragmented story of injury to a more coherent story of survival, learning and future action.

8.3 Social Connection and Shame Reduction

Group-based creative work can reduce shame because participants discover that pain is not a private defect but a human experience. Shared artistic processes create low-pressure connection: people can participate before they have perfect words. This may be especially valuable for participants who experience loneliness, emotional inhibition or stigma.

8.4 Behavioral Activation and Habit Formation

Lifestyle and behavioral interventions are increasingly recognized as relevant to mental health, including physical activity, sleep, social participation and meaningful daily routines [43, 44, 45, 46]. Habit research shows that repetition in stable contexts gradually increases automaticity [47, 48]. Models of behavior change also emphasize readiness, capability, opportunity and motivation [49, 50]. PV-ART therefore connects each insight to a micro-habit, making the programme more than expressive catharsis. The artistic product becomes a cue for action.

Table 2. Detailed Eight-Session PV-ART Protocol Structure.

Session	Theme	Artistic Exercise	Clinical-Educational Objective	Micro-habit
1	Mapping the emotional landscape	Mood map with colors and body sensations	Identify dominant emotions and create baseline self-awareness	Daily two-minute emotion naming
2	The shape of anxiety or sadness	Drawing or clay form of distress	Externalize symptoms and create symbolic distance	One grounding practice per day
3	The biography of a wound	Narrative fragment or collage	Connect pain with context without over-identification	Write one compassionate sentence to self
4	Values under the pain	Image of a protected value	Discover what the pain is trying to defend	One action aligned with a chosen value
5	From isolation to belonging	Group rhythm, shared image or collective poem	Reduce shame and enhance social connection	Contact one supportive person
6	The vitamin inventory	Symbolic container of strengths and learnings	Transform pain into resources and language of agency	Practice one selected strength
7	Future self rehearsal	Letter, drawing or soundscape from future self	Build hope, direction and identity continuity	Schedule one meaningful activity
8	Personal relapse-prevention artwork	Personal manifesto or visual plan	Integrate warning signs, resources and habits	Thirty-day PV-ART habit plan

9. Outcomes and Measurement Strategy

A future pilot study should combine symptom, well-being, functioning, meaning, loneliness and qualitative outcomes. Measurement must be proportionate, non-burdensome and clinically useful. The proposed battery includes validated tools commonly used in mental health research and practice.

Primary feasibility outcomes should include recruitment rate, retention, attendance, adverse events, acceptability, facilitator fidelity and completion of micro-habit practice.

Secondary clinical outcomes may include changes in PHQ-9 and GAD-7 scores. Exploratory outcomes may include changes in meaning, loneliness, well-being and qualitative accounts of perceived transformation.

10. Implementation Model

10.1 Settings

PV-ART can be implemented in community mental health centers, primary care wellness groups, university counseling services, corporate well-being programmes, older adult centers, recovery colleges and nonprofit organizations. In clinical settings, it should be

coordinated with mental health professionals. In nonclinical settings, it should include screening, informed consent, boundaries of scope and referral procedures.

10.2 Facilitator profile

The ideal facilitator team includes a mental health professional or clinically trained supervisor and an arts-based practitioner trained in trauma-informed group facilitation. Facilitators should understand depression, anxiety, suicide risk, trauma triggers, safeguarding, confidentiality, cultural humility, group dynamics and the limits of nonclinical intervention. The art component should never be reduced to entertainment; the clinical component should never colonize the participant's creative meaning.

10.3 Fidelity and flexibility

A manualized structure is necessary for research, but rigid delivery can harm creative authenticity. PV-ART therefore uses “structured flexibility”: the four movements remain stable, while artistic media can be adapted to culture, age, literacy, physical ability and preference. Fidelity should assess whether each session includes emotional naming, creative externalization, meaning extraction, micro-habit planning and safe closure.

10.4 Safety protocol

Every PV-ART group should begin with explicit boundaries: the programme is not emergency care; participants may pass on any exercise; confidentiality is expected but cannot be absolutely guaranteed in groups; facilitators may need to act if safety concerns arise; and distress can temporarily increase when difficult material is approached. Sessions should end with grounding and stabilization. Written referral pathways should be available for participants needing individual assessment.

11. Ethical Considerations

Art-based mental health work involves ethical complexity. Participants may reveal traumatic memories, relationship violence, self-harm thoughts or severe despair through images or metaphors. Facilitators must avoid amateur interpretation, voyeuristic curiosity and pressure to disclose. The participant owns the meaning of the artwork. Consent must cover the creation, storage and optional sharing of artistic materials. No artwork should be photographed,

exhibited or used for teaching without explicit written permission.

The ethical use of the metaphor is empowering only when it respects the reality of harm and preserves the participant's right not to find meaning immediately. Sometimes the first vitamin is simply survival.

12. Discussion

PV-ART responds to a practical gap between clinical treatment and everyday life. Many people need more than information about symptoms but less than intensive specialist treatment. They need a safe language for pain, a method for emotional expression, a community experience that reduces shame and a behavioral bridge toward daily functioning. The framework offers this bridge by integrating art, meaning and micro-habits.

The model also reframes prevention. Preventive psychiatry should not be limited to risk detection; it should also build protective capacities: emotional literacy, self-compassion, connection, purpose, creativity and constructive routines. These capacities are not peripheral to mental health. They are part of how people remain alive inside their own lives.

A key strength of PV-ART is its compatibility with stepped care. For low-risk participants, it may function as psychoeducation and mental health promotion. For participants receiving therapy or medication, it may serve as an adjunctive group intervention. For organizations, universities or community centers, it may strengthen emotional culture and referral awareness. For research, it provides a manualizable intervention with measurable outcomes.

Nevertheless, the model must be tested empirically. Enthusiasm for the arts should not outrun evidence. Future studies should begin with feasibility and acceptability trials, followed by controlled studies comparing PV-ART plus usual care with usual care alone or with active control conditions. Studies should report intervention fidelity, facilitator qualifications, adverse events, participant characteristics, cultural adaptations and follow-up outcomes. Mixed-methods designs would be particularly appropriate because symptom scales alone may miss changes in meaning, identity and agency.

Table 3. Proposed Measurement Battery for PV-ART Evaluation.

Domain	Measure	Timing	Purpose
Depressive symptoms	PHQ-9	Baseline, week 4, week 8, follow-up	Screening and change in depressive symptom severity [51].
Anxiety symptoms	GAD-7	Baseline, week 4, week 8, follow-up	Change in generalized anxiety symptom severity [52].
Well-being	WEMWBS and/or WHO-5	Baseline, week 8, follow-up	Positive mental health and subjective well-being [53, 54].
Perceived stress	PSS	Baseline, week 8, follow-up	Global stress appraisal [55].
Resilience	CD-RISC	Baseline, week 8, follow-up	Perceived adaptive capacity [56].
Meaning	Meaning in Life Questionnaire	Baseline, week 8, follow-up	Presence and search for meaning [57].
Loneliness	UCLA Loneliness Scale	Baseline, week 8, follow-up	Social disconnection and perceived isolation [58].
Life satisfaction	SWLS	Baseline, week 8, follow-up	Cognitive evaluation of life satisfaction [59].
Recovery experience	Narrative/CHIME-informed interview	Week 8 and follow-up	Hope, identity, meaning, empowerment and connectedness [60].

13. Research Agenda

The following structured longitudinal research programme is recommended:

Phase 1: Development of a detailed PV-ART manual, facilitator training materials, fidelity checklist and risk protocol.

Phase 2: Qualitative acceptability study with participants and facilitators, including perceived safety, relevance, emotional impact and cultural fit.

Phase 3: Single-arm feasibility study assessing recruitment, attendance, retention, adverse events, completion of measures and preliminary outcome signals.

Phase 4: Pilot randomized controlled trial comparing PV-ART plus usual care with usual care or an active psychoeducation control.

Phase 5: Implementation study in community, university, organizational and primary care settings with attention to equity, scalability and cost-effectiveness.

Phase 6: Mechanism study testing whether changes in emotional clarity, meaning, loneliness and habit automaticity mediate symptom and well-being outcomes.

14. Limitations

This article proposes a conceptual and translational framework rather than reporting original empirical data. Therefore, no causal claims can be made regarding PV-ART efficacy. The supporting evidence comes from adjacent literatures—arts and health, music therapy, visual art therapy, behavioral activation, resilience and well-being—which vary in quality and applicability. The framework may be less suitable for participants with acute psychiatric risk, severe trauma activation or significant cognitive impairment unless embedded in specialist care.

Another limitation concerns cultural transferability. The metaphor of transforming pain into vitamin may be powerful in some contexts and unsuitable in others; it should be translated, adapted or replaced when necessary. Finally, because creative interventions depend heavily on facilitator skill, future research must distinguish the effect of the protocol from the effect of charismatic delivery.

Declarations

Ethics approval and consent to participate:

Not applicable. This manuscript is a conceptual review and translational framework and does not report data from human participants.

Consent for publication:

Not applicable.

Availability of data and materials:

Data sharing is not applicable to this article because no datasets were generated or analyzed.

Competing interests:

The author declares no competing interests directly related to this manuscript. The proposed framework is connected to the author's broader educational and well-being work; future empirical studies should use independent evaluation procedures.

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Dr. Ignacio Bonasa Alzuria conceived the framework, developed the conceptual structure and prepared the manuscript.

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15. Conclusions

Psychiatry needs scientifically responsible ways to address not only symptoms but also meaning, expression, belonging and daily agency. PV-ART proposes one such pathway. It invites people to name pain without shame, give pain a symbolic form, discover possible psychological nutrients and consolidate them through small protective habits. The model is not a cure, not a substitute for clinical care and not a romanticization of suffering. It is a structured, ethically cautious and measurable framework for mental health promotion.

The central proposition is simple: when pain remains silent, it often becomes weight; when pain is expressed, witnessed, understood and converted into action, it may become wisdom, compassion, boundary, courage or purpose. In that movement from wound to meaning and from meaning to habit, art can become a clinical ally and a public health resource.

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