

# Reaching a UK consensus on art therapy for people with a diagnosis of a psychotic disorder using the Delphi method

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**Abstract**

Some authors have suggested there is low consensus about art therapy practice for people with a diagnosis of a psychotic disorder. This study used the Delphi survey method to seek consensus among UK art therapists. In the Round 1 online survey, 24 UK art therapists working with the client group provided statements describing their practice. These were analysed using content analysis along with statements from relevant art therapy literature and from 32 service users. The resulting list of 713 statements grouped into 13 themes were then sorted by a core group of five art therapists with extensive experience with the client group, producing 111 statements that were then rated by an augmented national UK panel of 30 art therapists in the Round 2 Delphi survey. Rating was according to perceived importance of each element of practice, and 80 items each reached 80% consensus as highly important. In Round 3, 11 items that reached high but not 80% consensus were re-rated by 26 of the panel of 30, and all but 2 reached 80% consensus. The final list of 89 statements is the first UK national consensus on art therapy practice with people with a diagnosis of a psychotic disorder.

**Key words**

Art therapy, psychosis, practice, consensus, Delphi method

**Introduction**

Art therapists have worked with people diagnosed with severe mental health problems for several decades (McNiff, 2004; Wood, 1997) and have built up considerable practice knowledge, but there is relatively little systematic research. The UK's National Institute for Health and Care Excellence (2009; 2013) recommends that arts therapies be offered to people with a diagnosis of schizophrenia or psychotic disorders on the basis of the few studies that existed up to 2009 and service users' testimony. Boyle (2002) and Bentall (2004) have questioned whether the concept of schizophrenia holds up scientifically, and it is likely that people given the diagnosis, or increasingly a diagnosis of a psychotic disorder, have a range of different difficulties that have come about through different combinations of circumstances. These can include childhood trauma and abuse (Read, Fosse, Moskowitz & Perry, 2014). However, people who experience auditory hallucinations or beliefs about being persecuted are especially likely to receive such a diagnosis, and they also often experience a lack of motivation or withdraw from social activities, which attracts the label 'negative symptoms'.

One UK community-based randomised trial suggested art therapy may be helpful for 'negative symptoms' of 'schizophrenia' (Richardson, Jones, Evans, Stevens & Rowe, 2007). However, a larger national UK trial (Crawford et al., 2012) suggested that art therapy did not have greater benefit than treatment as usual or activity groups. The latter trial suffered from a high level of non-attendance. Whilst this was argued to reflect routine practice in what was a 'pragmatic trial', there is the alternative argument that since most participants who were followed up at two years had experienced no or much less art therapy than intended (similarly for the activity groups), art therapy as such was not tested.

Difficulty attending community-based treatment is well documented for people with a diagnosis of schizophrenia (Fanning et al., 2012; Gooding, Saperstein, Mindt & Medalia, 2012; Startup, Wilding & Startup, 2006; Stewart, 2012). Psychotropic drugs given to people with the diagnosis can cause marked drowsiness and difficulty in concentration and movement (Moncrieff,

2013). In younger people, some medications cause significant weight gain within a few weeks (NICE, 2013), which may adversely affect their social confidence. Furthermore, usual care has been poor (The Schizophrenia Commission, 2012), with services fragmented, often poorly led, pessimism about recovery, and insufficient involvement of people's families. Unless provision of any psychological therapy is integrated into the system, it is unlikely that people would easily attend it. Moreover, art therapists tend to work part-time, often in more than one job, which may be why Patterson, Debate, Anju, Waller and Crawford (2011) reported their level of integration with services to be variable in a national survey. Part-time work can limit therapists' ability to attend team meetings, for example.

Brooker et al. (2007) published practice guidelines for art therapy with people with diagnoses of psychotic disorders, and one strength of these guidelines was that their authors engaged an expert panel of service users as well as art therapists. Issues cited by Brooker et al. (2007) included making the therapy room welcoming, making art therapy accessible, for example by assertive outreach (including to members of ethnic minority groups), and recognition of visual cultures within specific cultural groups. A supportive and respectful stance by the art therapist were important, as was highlighted by Hanevik, Hestad, Lien, Teglbjaerg and Danbolt (2013) in their qualitative study of group art therapy for women experiencing psychotic states. Both of these publications, the recommendations of Wood (1992; 1997), and the study by Patterson, Borschmann and Waller (2012) suggested the importance of the art therapist demonstrating valuing clients' artwork. Appreciation of the effect of long-standing difficulties and of childhood trauma was also a feature in Brooker et al. (2007), Wood (1992; 1997), and Molloy (1997). These publications and Hanevik et al. (2013) highlighted the importance of creating conditions in which clients could become absorbed in art-making and could feel and act in a playful manner.

Evidence has being growing in recent years that childhood trauma and abuse are often a feature of the lives of people who come to receive a diagnosis of psychotic disorder (Read et al., 2014). These childhood experiences mean that many with the diagnosis have difficulty in interpersonal relating. Brooker et al. (2007) therefore suggested the need for enabling clients to

gradually move from initial absorption in and indirect communication through artwork, to articulating difficulties in words. It can take time for clients to come to the point where they feel safe to make a connection with the therapist and trust him or her. Making this relationship, and being able to explore and come to understand oneself and one's life better, become a bridge to making more connections outside therapy. Brooker et al. (2007) drew on earlier theorising by Wood (1997), Killick (1997), Greenwood and Layton (1987), Molloy (1997) and others. However, it is also broadly consistent with the current theoretical basis for mentalization-based psychodynamic treatment of those experiencing psychotic states, as illustrated by Debbane et al. (2016). Whilst this latter theoretical approach does not require artwork as part of the process, both sets of theorising recognise the importance of understanding the effect of clients' early attachment experiences, the need for the gradual building of trust, and a welcoming therapist stance.

Wood (1997), Molloy (1997) and Brooker et al. (2007) all emphasized the importance of team working with other professionals, something also emphasized by NICE (2009; 2013) and The Schizophrenia Commission (2012). Active management of the referral process was a feature of Brooker et al. (2007), with emphasis on making art therapy accessible. Brooker et al. (2007) highlighted the need to adapt to the NHS socio-political context (especially pressure for shorter therapy), knowledge of different art techniques, willingness to demonstrate how to use particular materials, art therapy room requirements, thorough assessment in order to determine the type of art therapy (group, individual, which therapist etc) would be appropriate and to enable choice.

Brooker et al. (2007) used psychodynamic language in places, but recommended against using such language with clients. They also suggested art therapists need to be aware of how uncritical acceptance of some psychoanalytic or psychiatric principles may maintain prejudice against people who identify as LGBT. Hanevik et al. (2013) highlighted that their participants found it helpful to depict and then talk about and make sense of psychotic experiences, and that this helped them manage these experiences.

### Rationale and aims

Whilst these various sources place emphasis on different facets of art therapy for psychosis, there are significant areas of consensus, in contrast to the suggestion of a lack of consensus reported by Patterson, Crawford, Ainsworth and Waller (2011) following their UK survey of art therapists. However, any suggestion of a lack of clarity is of concern, because if art therapy is to be properly tested in future randomised trials it is vital that the practice is both clear and appropriate for the client group (Medical Research Council, 2008). Since the economic crisis of 2008, the social context within the UK's NHS has become even more subject to pressures for shorter therapy and efficient use of resources than previously. Therefore art therapy practice, along with that of other therapists, may have had to further adapt to new conditions since Brooker et al. (2007) produced their guidelines. Also they drew only on a small panel of art therapists.

The present authors set out to discover what UK art therapists who work with people with diagnoses of psychotic disorder in community-based services actually do, the current level of consensus, and if this was low, whether consensus could be reached. The Delphi survey method (Jones & Hunter, 1995), lends itself to seeking such consensus, and has been used previously in art therapy (Taylor Buck & Hendry, 2016). Another parallel study is on-going to investigate in depth what art therapists do and why they do it. That study's findings will be reported at a future time.

## Method

### Design.

The Delphi survey comprised three phases: (1) Generation of statements describing art therapy practice by a national UK expert panel of art therapists, and from relevant literature and service users, (2) UK expert panel rating of items as to level of importance for practice with people who have diagnoses of psychotic disorders or seen in Early Intervention for Psychosis (EIP) services, and (3) Re-rating those items that were rated very important or essential by less than 80% but more than

70% of UK panel participants. This process was similar to the method followed by Morrison and Barratt (2010) in seeking consensus on the practice of cognitive behaviour therapy with this client group, with the added input from consultations held earlier with service users.

**Participants.**

Out of 27 art therapists expressing interest initially, 24 completed the Round 1 online survey, generating statements describing practice. In Round 2, eight more art therapists expressed interest and three of these completed the survey in addition to the original 27, giving N = 30 participants who rated the items on importance for practice. In Round 3, 25 of these 30 re-rated 11 items. Table 1 shows the characteristics of the art therapists who took part in Round 2. Since BAAT does not have a record of the numbers of art therapists who work in a given speciality at any particular time, and art therapists tend to be mobile, it is not possible to give a response-rate. Input from service users was on the basis of a focus group (N = 11) and an earlier survey (N = 21) that had each been carried out for purposes other than the present study, but whose material was relevant and permission to use anonymous statements had been obtained. Only limited demographic data are available on these groups. Their mental health diagnoses included bipolar disorder, schizophrenia, severe depression and anxiety, eating disorder and personality disorder. Both men and women were represented, and those currently using mental health services as well as those who used them in the past.

**Questionnaires.**

The Round 1 online survey asked the UK panel to generate three statements describing their practice with the client group in question. They were asked to write in plain English, to try not to use more than about 15 words, and to think of the statement being preceded by the phrase, 'When working with this client group I believe the following is important.' They were further asked to begin their statements with words such as, 'Willingness to…', 'Knowledge of…', 'Skill in…', 'Ability to…', 'Awareness of…', 'Training in…', 'Experience of…', and 'Recognizing…'. The aim was to capture things

therapists did, and the specific knowledge, experience and skills on which they drew in a way that could be communicated widely and understood.

The list of practice items for the Round 2 survey was compiled by combining items generated in Round 1 with statements from the two service user data sets, and from relevant art therapy literature (Brooker et al., 2007; Hanevik et al., 2013; Molloy, 1997; Patterson et al., 2012; Wood, 1992; 1997).

**Procedure.**

The study proposal was submitted to the Salomons Ethics Panel at Canterbury Christ Church University for independent scrutiny. Following ethical approval, the chief executive officer of the British Association of Art Therapists (BAAT) sent an email to all 1560 full BAAT members (working with all client groups) inviting those who worked with people diagnosed with a psychotic disorder and saw them in a community setting to take part in the survey. Of 27 interested and sent the Round 1 survey, 24 completed it. Contextual data were also collected, such as number of years qualified. All statements describing practice were collected from the literature, and those that were similar eliminated. Content analysis (Krippendorff, 1980) was carried out on the items generated from Round 1 together with those from the literature and service users, resulting in 713 statements grouped into 75 themes. These were discussed and re-sorted by five members of the BAAT psychosis special interest group currently working with clients with psychotic disorders, and including two working in EIP services). All five were at least 16 years post-qualification and had all seen more than 20 clients with a psychosis diagnosis as outpatients. This produced a consolidated list of 10 main areas of practice (Table 3), incorporating 111 statements capturing key areas of practice, worded actively. Statements were preceded on the questionnaire by the phrase: ‘As an art therapist you need to…’. After all 27 of the national panel rated the 111 items in Round 2, a seminar was held on the interim findings, attended by 17 art therapists who had not responded to the previous call. A subsequent invitation to these 17 ascertained that 3 were ineligible (one worked abroad, one had

not yet completed training and one only had six months' experience with the client group). A further 11 did not respond, and 3 of the remaining 4 completed Round 2, giving N = 30. In Round 3, 26 of these 30 participants re-rated 11 items that reached consensus of 70-79%.

**Results**

**Table 1:** ***UK art therapist panel (N = 29 due to missing data for 1 participant)***

| | N participants | (% of responders) | Median | Range |
|---|---|---|---|---|
| Sex | 25 female | 83.3 | | |
| Ethnicity | 28 White British | 93.3 | | |
| Time since qualified | 16 for more than 20 years | 55.2 | More than 20 years | 'Less than 1 year' to 'Over 20 years' |
| Hours per week as art therapist | | | 26-30 hrs | '5 or fewer' to '36-40 hours' |
| When working in NHS | 23 now or within past year | 79.3 | | |
| N clients with psychotic disorder ever seen | 22 saw more than 20 | 75.9 | More than 20 | '1 to 5' to 'More than 20' |
| N with psychotic disorder ever seen as outpatients/ in community | 16 saw more than 20 | 57.1 | More than 20 | '0' to 'More than 20' |
| Time since last client with psychosis | 24 within past week | 82.8 | Less than 1 week | 'Less than 1 week' to '3-6 months ago' |
| N clients with psychosis seen per week | | | 3-5 | '1-2' to 'More than 10' |
| N sessions per client | | | 21-40 | 'Up to 10' to 'More than 40' |
| See clients one-to-one | 25 | 86.2 | | |
| Closed groups | 14 | 48.3 | | |
| Open groups | 17 | 58.6 | | |
| Level of integration into team | | | Quite a lot | 'A little' to 'Completely'* |

* Likert scale 'Not at all', 'A little', 'Partly', 'Quite a lot', 'Completely'

Table 1 indicates that participants mainly worked in the National Health Service, more than half had qualified at least 16 years previously, most had seen more than 20 clients with a diagnosis of psychotic disorder, the majority in a community setting, and the median number seen per week was 3-5 clients. Table 2 shows that over 80% of the art therapist sample worked in NHS outpatient or community settings. Art therapists often have more than one job, so other jobs are also shown in the table. Most participants had worked with clients at all stages following diagnosis, from less than six months to over five years.

**Table 2:** ***Settings in which participants had worked***

| Setting | N participants | % |
|---|---|---|
| EIP inpatients | 6 | 20.7 |
| EIP outpatients/ in community | 9 | 31.0 |
| NHS outpatients/ community | 24 | 82.8 |
| Community arts | 5 | 17.2 |
| Acute inpatient | 18 | 62.1 |
| Long-stay NHS | 10 | 34.5 |
| NHS therapeutic community | 1 | 3.4 |
| NHS crisis house | 1 | 3.4 |
| Assertive outreach | 4 | 13.8 |
| CAMHS | 3 | 10.3 |
| Primary care | 1 | 3.4 |
| Forensic | 5 | 17.2 |

Note: EIP = Early intervention for psychosis service; CAMHS = Child and adolescent mental health service

In Round 2, 80 of the 111 items were confirmed because there was at least 80% consensus that they were very important or essential, and 20 were eliminated due to consensus being lower than 70% that they were very important or essential. The remaining 11 statements were selected for re-rating in Round 3 due to reaching a consensus between 70 and 79%. All but 2 of these 11 reached at least 80% consensus in Round 3. Table 3 shows the 89 items retained, and whether they appeared only in Round 2 or in Round 2 and 3. The items are grouped according to the 10 major areas of practice arrived at in the consultation with the special interest group.

## Discussion

This UK national sample of 30 art therapists working with people with diagnoses of psychotic disorders converged on the majority of practice descriptors in ten areas of practice for art therapy with this client group. There was a high degree of respect for research and theory pertaining to the nature and social causes of psychotic states, in keeping with recent research evidence (Read et al., 2014). There was consensus on the need to be aware of discrimination and poor care, as well as respect different cultural backgrounds, as highlighted by Brooker et al. (2007). The lack of consensus on the importance of the NICE guidelines may relate to the relatively low evidence base to date in art therapy, so that respondents might not have expected it to feature there.

**Table 3:** ***Delphi items seen by 80% or more of sample to be very important or essential***

| Statement | Round included |
|---|---|
| **Relevant knowledge and awareness for working with clients with diagnoses of psychotic disorders** | |
| **The nature of psychotic states and experiences** | |
| Understand the nature of psychotic states and severe mental distress from the perspectives of multiple professionals, service users and carers | 2 |
| Understand the range of factors that may make it difficult for people with diagnoses of psychotic disorders to communicate their experiences at times | 2 |
| Recognise how some medication given for psychosis can affect alertness, ability to think, and affect people physically (e.g. metabolic and cardiovascular disorder) | 2 |
| **Research and theory** | |
| Be up to date on theories of attachment, mentalization and neuropsychology and of thinking on the role of social-economic life circumstances, and trauma as potential contributors to the development and maintenance of psychosis | 2, 3 |
| Be up to date on evidence from a range of research (including art therapy research) on therapy relating to psychotic states and experiences | 2 |
| **Socio-political awareness** | |
| Be aware of the prejudice and discrimination that can follow the diagnosis of a psychotic disorder | 2 |
| Know how oppression, abuse, deprivation and stress can contribute to the causes of psychotic states | 2 |
| Be aware of instances of poor care and negative attitudes towards people with psychosis diagnoses in the mental health system, and the detrimental effects these can have | 2 |
| Respect the importance to people of their ethnic, religious and cultural backgrounds - including art traditions | 2 |
| Be aware that people from ethnic minorities are over-represented in the mental health system and more likely to be diagnosed with schizophrenia | 2, 3 |
| Acknowledge power relations in the mental health system and in the therapeutic relationship and the possible emotional effects of these for the service user | 2 |
| **Service-user-defined recovery** | |
| Appreciate and appropriately use current developments in user-led support and services such as the Hearing Voices Network | 2, 3 |
| Show awareness of, respect for, and appropriate reference to the role of carers in the lives of service users, be they relatives, friends or other mental health workers | 2 |
| **Initial assessment process** | |
| Respond to new referrals swiftly in order to support engagement | 2 |
| Explain clearly art therapy and its purpose and potential benefits to service users who may be initially disabled by their mental distress, strong medication or situation | 2 |
| Know how to obtain informed consent to engage in art therapy and understand the fluctuating nature of capacity | 2 |
| Be able to accept the situation where art therapy is not right for someone | 2 |
| Enter into collaborative discussion with the service user about any potential barriers to engagement and how to address these | 2 |
| Conduct risk assessment and devise a management plan in collaboration with the service user and relevant others | 2 |
| Work collaboratively with the service user on setting initial aims of the therapy | 2, 3 |
| Recognise crisis as a window to engagement. E.g. be responsive to service users' needs on acute admission wards | 2 |
| **Engaging clients in art therapy** | |
| **Creating and holding a safe therapeutic space** | |
| Offer a calm, alert and responsive presence | 2 |
| Work appropriately with service users in response to fear and distress they may exhibit | 2 |
| Establish and hold boundaries around therapy and artwork without being overly rigid | 2 |
| Collaborate with service users in creating an appropriate therapeutic alliance using sensitive communication skills | 2 |
| Connect with people who experience psychotic states on an ordinary human level | 2 |
| Appreciate the importance of ordinary kindness towards people who have a diagnosis of a psychotic disorder | 2 |
| Be appropriately open and honest in sharing your thinking with service users | 2 |
| Demonstrate empathy even when a service user's experience is very different from your own | 2 |
| Be able to name differences between your own and a service user's experience or understanding while retaining an empathic stance | 2 |
| Be aware how small things you do and say that show your interest and encouragement can make a real difference to people's recovery | 2 |
| Be able to work side-by-side with the service user who has a diagnosis of psychotic disorder, in a collaborative alliance | 2 |
| **Acceptance and respect** | |
| Be aware of the effect your appearance or body language may have on service users | 2 |
| Remember that people have had a life before they got a diagnosis of psychotic disorder | 2 |
| Enable service users to feel that they are your equal as human beings | 2 |
| Demonstrate acceptance of the artwork of people who experience psychotic states | 2 |
| Acknowledge that people with diagnoses of psychotic disorders will have knowledge about their condition and some solutions for self-care that they have used in the past. | 2 |
| **Skills for therapeutic work** | |
| **Working within a framework of user-defined recovery** | |
| Show commitment to supporting service users' capacity for achieving aspirations as they define them | 2 |
| Convey the belief that recovery or an improved life is possible for people with diagnoses of psychotic disorders | 2 |
| Collaborate with service users to help them think about how to cope better with everyday difficulties | 2 |
| Be flexible in terms of communicating between sessions to promote engagement, using text, email, phone and letter as appropriate | 2, 3 |

**Table 3 continued:** ***Delphi items seen by 80% or more of sample to be very important or essential***

| Statement | Round included |
|---|---|
| **Use of artwork activities** | |
| Recognise and help people overcome difficulties in using art materials | 2 |
| Use joint attention / looking together while taking care not to intrude | 2 |
| Enable service users to play and enjoy the art materials where possible | 2 |
| Foster service users' expression of self, emotions or psychotic experiences through artwork and in words | 2 |
| Enable people to process disturbing thoughts and feelings using images and words | 2 |
| Accept that service users who experience psychotic states sometimes use artwork activity in the session for temporary relief from mental distress | 2 |
| Understand that making artwork can help a service user compose themselves and that although the effect may be short-lived, it can be cumulatively helpful | 2 |
| Collaborate with service users in order to make a range of art materials available that might suit them | 2, 3 |
| **Helping people understand and manage their psychotic experiences** | |
| Understand psychotic experiences and communications as potentially meaningful | 2 |
| Help service users to differentiate aspects of their experience that enhance their lives and identities (e.g. valued spiritual experiences) from those that undermine them | 2 |
| Collaborate with service users to make sense of their psychotic experiences as relating to events or circumstances in their lives – past or present | 2 |
| Collaborate with service users to enable them to manage distressing psychotic experiences more effectively | 2 |
| Be aware that exploring the meaning of service users' art work is not always helpful | 2 |
| Be able to work sensitively with people who have had very traumatic experiences | 2 |
| **Dealing with setbacks** | |
| Be creative, resourceful and flexible in adapting your approach to people's fluctuating needs | 2 |
| Take an interest in people's real-world social context that can help or harm their well-being and/or make it difficult to attend therapy | 2 |
| **Ending therapy** | |
| Understand the importance of giving service users enough time to prepare for the ending of therapy | 2 |
| Make effective links with community resources including arts-based resources as a way of helping service users have a way forward at the end of therapy. | 2 |
| Support service users to evaluate their experience of and use of therapy and to express feelings about ending | 2 |
| **Early intervention for psychosis** | |
| Appreciate how important education, work or training can be to young people, including young people with a diagnosis of a psychotic disorder | 2 |
| Convey an expectation of positive outcomes to young people and their families and the real possibilities for satisfying lives | 2 |
| Enable young people to experience art therapy as an accessible and enjoyable psychological intervention | 2 |
| Understand Early intervention Philosophy (e.g. Open Dialogue Approach, IRIS Guidelines.) | 2 |
| **Group art therapy** | |
| Establish a well-functioning art therapy group that is appropriately adapted to the needs of service users with a diagnosis | 2 |
| Facilitate a group culture in which group members feel able to make artwork at their own pace alongside others | 2 |
| Manage the group to minimise the likelihood of any person causing distress to others, either verbally or through artwork. | 2, 3 |
| Help service users to make connections with one another through their art making and facilitated discussion | 2 |
| Help service users to realise they are not alone in having had psychotic experiences | 2 |
| Acknowledge the ways in which service users contribute to the well-being of other group members. | 2 |
| **Organisational context** | |
| Work collaboratively with a range of other professionals | 2 |
| Explain art therapy clearly and simply to other professionals and negotiate and maintain the conditions it needs | 2 |
| Be prepared for and skilled in advocating clients' needs with other professionals where appropriate | 2 |
| Be able to explain to other staff why art therapy sometimes doesn't help | 2 |
| Know and understand the work setting and use this knowledge to propose the ways in which art therapy might make a contribution to the organisation. | 2 |
| Be able to contribute to multidisciplinary thinking, formulation and risk assessment | 2 |
| Know about other interventions available in your service (e.g. CBT for psychosis, family work for psychosis, hearing voices groups) | 2 |
| **Families and friends** | |
| Address the concerns or questions of service users' relatives or friends in an honest and open way, within the bounds of confidentiality | 2 |
| Recognise when a friend or relative of a service user is, or can be helpful | 2, 3 |
| Recognise when a service user is having difficulty with a relative or friend and support their efforts to improve the relationship | 2 |
| Be transparent around any barriers to communication with service users' friends or families | 2 |
| **Self-awareness, CPD, supervision and support** | |
| Be aware of your professional power and its potential to do damage as well as help service users | 2 |
| Keep your knowledge of therapeutic work in your area up to date | 2 |
| Find and use appropriate supervision to manage challenges in working with people with diagnoses of psychotic disorders | 2 |
| Practise in accordance with current statutory regulations and ethical guidelines | 2 |
| Recognise that therapeutic skill may involve appropriate reference to your own experience of distress | 2, 3 |
| Be able to judge when to share any personal experiences you may have that seem relevant and potentially helpful to a service user | 2 |
| Avoid over-identifying with a service user where you have a similar life experience | 2 |
| Appreciate that valuing your own difficult life experiences can help you value rather than devalue them in others | 2 |

**Table 4:** ***Excluded items***

| Item | Consensus |
|---|---|
| **Relevant knowledge and awareness –** | |
| **Research evidence and theory** | |
| Know the National Institute of Health and Clinical Excellence (NICE) guidelines relating to interventions and treatments for people diagnosed with psychotic disorders | 68.9% |
| **Socio-political awareness** | |
| Know about the research showing the impact of poverty, unemployment, housing problems, and benefit changes for people with a diagnosis | 69.0% |
| **Service-user-defined recovery** | |
| Be familiar with personal accounts of recovery of people who have had diagnoses of psychotic disorders, e.g. Jacqui Dillon, Romme and Escher's books on voice-hearers | 58.6% |
| Seek examples of art-making and artwork by people who experience severe mental distress but who have not been your client, and what the artists say about their work | 27.6% |
| **Initial assessment process** | |
| Be assertive in outreach to individuals who are newly referred, e.g. arrange first meetings in individual's home or cafe if appropriate | 55.5% |
| Consider meeting new individuals with their friends or family | 53.6% |
| Use art media as part of the initial assessment process | 55.1% |
| **Engaging clients in art therapy** | |
| **Creating and holding a safe therapeutic space** | |
| Be able to speak transparently about your own image making as appropriate | 57.2% |
| **Skills for therapeutic work** | |
| **Working within a framework of user-defined recovery** | |
| Set up group work in local community rather than clinical setting where possible | 40.7% |
| Help service users to empower themselves in relations to their treatment, including taking an advocate role with other people or agencies when appropriate. | 53.8% |
| **Use of artwork activities** | |
| Set themes for artwork when appropriate, and collaboratively when possible | 37.0% |
| Show appreciation of aesthetic qualities of service users' artwork as appropriate | 62.9% |
| Be willing to teach some art skills as part of art therapy if that is what service users want | 51.8% |
| When appropriate use existing artworks by established artists as a focus of discussion | 32.1% |
| **Ending therapy** | |
| Use Audio Image Recordings as part of the ending process when appropriate | 19.2% |
| **Group art therapy** | |
| Help group members engage in looking together at each other's artwork and reflecting on different perspectives. | 55.5% |
| Consider offering individual reviews to group members to allow individuals to mark progress or alter aims made at start of therapy | 66.7% |
| Set up group work in local community rather than clinical setting where possible | 44.4% |
| **Families and friends** | |
| Consider offering psycho-educational courses for friends and family on e.g. psychosis, support, treatment, therapy | 53.8% |
| **Self-awareness, CPD, supervision and support** | |
| Use your own art making as part of your reflective practice | 69.2% |

Regarding recovery as defined by service users, awareness of user-led support services and the role of carers was well recognised, but not personal accounts of recovery or artwork by service users other than one's clients. Service user involvement in the training of mental health

professionals has only recently become a requirement from the UK Health and Care Professions Council (2013), and most survey respondents would not have encountered it.

In the area of initial assessment, there was high consensus on the need to respond quickly, but not for assertive outreach, which may reflect the history of art therapists working in in-patient units and subsequently moving out into community settings (Wood, 1997). With the identified more general lack of outreach work and cohesive team working (The Schizophrenia Commission, 2012), art therapists would need specific training to address the need for outreach, though a few may be on placement in EIP services during their training now, or have moved into those settings since qualifying.

Since art therapy is based around artwork activity, it was surprising that only 55.1% of participants thought that the use of art media should be used as part of initial assessment. However, discussion of any barriers to engagement was seen as important by over 80%, and a barrier for some people could be use of art materials. It is possible that there was a range of interpretation about what constituted 'initial assessment', which might have meant only the first meeting for some respondents.

All but one of the items relating to creating and holding a safe therapeutic space received high consensus. The exception concerned speaking about one's own image-making, and the low consensus could be due to only a few art therapists making their own images in-session. Traditionally this was not part of art therapy, but increasingly is being discussed as valuable (e.g. Havsteen-Franklin, 2014). Skills to work within a framework of user-defined recovery were well-recognized, as was enabling a range of ways of communicating between sessions.

Various functions for artwork activities weresupported, including art as a safe way of sharing a focus of attention, playfulness, self-expression, emotion-processing, and soothing, all of which have been discussed in the literature (Brooker et al., 2007; Wood, 1997). However, there was low consensus on the use of themes, bringing in artworks by established artists, appreciating the aesthetics of service users' artworks, and on teaching art techniques. Themes and teaching art have

tended to be discouraged or explicitly criticised by some writers on psychodynamic art therapy (McNeilly, 1984; 1987; 1989; 1990), although others strongly favour their use for specified purposes as part of a range of therapeutic approaches (Brooker et al., 2007). Use of art-viewing has increasingly been reported as part of community arts interventions in museums and galleries (Hutchinson, 2012; Treadon, 2016), and its empirical and theoretical value is increasingly written about (Betts, Potash, Luke & Kelso, 2015).

All of the items on helping people to understand and manage their psychotic experiences reached high consensus, in keeping with the findings of Hanevik et al. (2013). The need to work with setbacks was also well recognized. Support and preparation for ending therapy was unproblematic for respondents except for the use of audio-image recordings. Although this item contained the caveat 'when appropriate', it is possible that despite promotion of this technique by BAAT and examples in the BAAT members' areas on the website, many members have not embraced this approach. It may relate to use of technology, or client or therapist fears about consent and confidentiality.

Important issues relating to safety and therapeutic functioning of groups were well supported, but respondents were less keen on helping members look together at each other's artwork. This could be due to more respondents running open than closed groups. Open groups tend to be less structured, and to allow all to work at their own pace and establish a space that will not be subject to intrusion. Individual reviews did not receive wide support, and it is not clear why, although it would entail an increase in workload that could have implications for a part-time therapist or for NHS resources.

All items within the area of working with the organisational context were supported, which is consistent with the fact that most participants reported feeling fairly well integrated into a team (though not all did). Although most respondents felt they should address concerns of clients' families or friends, the consensus was much lower on offering psychoeducation. The need for continuing

professional development (CPD), self-awareness, supervision and support was well recognized, but not so much the use of one's own art-making for reflective practice.

**Limitations.**

It is difficult to know how representative the sample was of art therapists nationally who work with people who have diagnoses of psychotic disorder. However, the sample contained a range of art therapists and included some working in EIP services. Although many statements were worded tentatively, including phrases such as 'where possible' and 'if appropriate', this did not prevent a number of them reaching only low consensus despite representing practice appreciated by art therapists, service users or both in the earlier phase of the study. However, comments on the Round 2 Delphi survey suggested that some valued practices were constrained by limitations of the practice context. It is difficult to construct succinct items each covering one aspect of practice. Whilst ideally one aims to keep items as focused as possible, discussion within the core group made it clear that this would result in hundreds of items. Therefore the decision was made to stay with more complex items, but the downside was that sometimes respondents wished to separate them out. For example, one respondent commented that judging when to disclose personal information was essential, but disclosing it was not. Against this, another respondent commented that the items were worded clearly and the questionnaire easy to do. Some participants said they rated an item low because it would be handled by a different multidisciplinary team member. This aspect would be difficult to cover fully in one listing of reasonable length. A further limitation was that an individual item cannot incorporate the range of mental states and stages of therapy. Perhaps what the list represents was a best compromise in attempting to cover the key elements of practice.

**Clinical implications.**

One of the immediate next steps planned by the authors of this paper is to circulate the findings widely within BAAT and promote discussion on BAAT's closed social media platforms and

special interest group forum on psychosis. We will also repeat an exercise already tried that promoted knowledge of the NICE guidelines. BAAT runs regular CPD for its members, and will consider the potential for psychosis-specific and more generic sessions, since some issues highlighted here go beyond working with psychosis. For example, use of one's own art within sessions, themed groups, use of established artwork, teaching an art technique, use of audio-image recording to enable clients to record their reflections near the end of therapy, and use of one's own artwork for reflective practice may all be activities that could have relevance for a wider pool of art therapists.

Where relevant, it may be fruitful for art therapists to attend CPD aimed at multidisciplinary teams, both to foster inter-professional understandings and capitalise upon knowledge and experience from other professional groups and from service user trainers.

**Future research.**

The British Psychological Society (BPS) is investigating alternatives to diagnosis (Division of Clinical Psychology, 2013), partly in recognition of Boyle's (2002) and Bentall's (2004) unpacking of the concept of 'schizophrenia' and questioning whether it holds up empirically. The BAAT is likely to align with this work given that it has the potential to support therapists in approaching each person as an individual. It is consistent with recognizing specific difficulties across diagnoses, whose amelioration may be facilitated by different art therapy approaches. Ongoing research into how art therapists have developed their practice with people who have a diagnosis of a psychotic disorder promises to be the start of identifying these different difficulties and needs, and what may help, and planned service user consultation will also feed into further research in this area. Therefore, the current report is simply a snapshot of what a national UK sample of experienced art therapists currently views as good practice. Further sets of guidelines for people with specific identified problems of living, and with input from both therapists and service users, will be forthcoming.

**Conclusions.**

This was the first attempt to find consensus in a national UK sample of art therapists who work with people who have diagnoses of psychotic disorders. A large number of statements representing different elements of practice was collated from the literature, from service users, and from an initial Delphi survey of 24 art therapists. These were then whittled down to 111 statements by a core group of five experienced art therapists working with the client group, and then two further Delphi rounds established a final list of 89 statements across ten areas of practice. The resulting list of good practice elements is broadly consistent with previous art therapy literature, and current thinking in psychological therapy, and represents an important clarification of current practice.

**References**

Bentall, R. P. (2004). *Madness explained.* London: Penguin

Betts, D. J., Potash, J. S., Luke, J. J. & Kelso, M. (2015). An art therapy study of visitor reactions to the United States Holocaust Memorial Museum. *Museum Management and Curatorship, 30* (1), 21-43.

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* (2nd edn.) Hove, New York: Routledge

Brooker, J., Cullum, M., Gilroy, A., McCombe, B., Mahoney, J., Ringrose, K.,… & Waldman, J. (2007). The use of artwork in art psychotherapy with people who are prone to psychotic states: An evidence-based clinical practice guideline. London: Goldsmiths. Available at http://research.gold.ac.uk/112/

Crawford, M.J, Killaspy, H., Barnes, T.R.E., Barrett, B., Byford, S., Clayton, K., … & Waller, D. (2012). Group art therapy as an adjunctive treatment for people with schizophrenia: Multicentre pragmatic controlled trial. *BMJ, 344,* e846. DOI: 1136/bmj.e846

Debbane, M., Benmiloud, J., Salaminios, G., Solida-Tozzi, A., Armando, M., Fonagy, P., & Bateman, A. (2016). Mentalization-based treatment in clinical high risk for psychosis: A rationale and clinical illustration. *Journal of Contemporary Psychotherapy,* June 1016, pp. 1-9.
DOI: 10.1007/s10879-016-9337-4

Division of Clinical Psychology. (2013). *Position statement on the classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift.* http://www.madinamerica.com/wp-content/uploads/2013/05/DCP-Position-Statement-on-Classification.pdf

Fanning, F., Foley, S., Lawlor, E., McWilliams, S., Jackson, D., Renwick, L., .. … & O'Callaghan, E. (2012). Group cognitive behavioural therapy for first episode psychosis: Who's referred, who attends and who completes it? *Early Intervention in Psychiatry,* **6,** 432-441. doi:10.1111/j.1751-7893.2011.00333.x

Gooding, A.L., Saperstein, A., Mindt, M.R., & Medalia, A. (2012). Predictors of treatment utilisation at cognitive remediation groups for schizophrenia: The roles of neuropsychological, psychological and clinical variables. *Neuropsychological Rehabilitation,* **22**, 516-531. DOI.10.1080/09602011.2012.665583

Greenwood, H. & Layton, G. (1987) An out patient art therapy group. *Inscape*. Summer: 12 – 19.

Hanevik, H., Hestad, K., Lien, L., Teglbjaerg, H.S., & Danbolt, L.J. (2013). Expressive art therapy for psychosis: A multiple case study. *The Arts in Psychotherapy*, 40, 312-321. DOI: 10.1016/j.aip.2013.05.011

Havsteen-Franlin, D. (2014). Consensus for using an arts-based response in art therapy. *International Journal of Art Therapy,* 19, 107-113. DOI: 10.1080/17454832.2014.968598

Health and Care Professions Council. (2013). *Standards for education and training programmes. Service user and carer involvement in education and training programmes.* http://hpc-uk.org/Assets/documents/10004167SUCstandardwebsiteinformation.pdf (accessed 27 November 2015).

Hutchinson, S. (2012). Art B. *British Association of Art Therapists Newsbriefing, December,* 20-22.

Jones J, & Hunter H. (1995). Consensus methods for medical and health services research. *BMJ*, 311, 376–380.

Killick, K. (1997). Unintegration and containment in acute psychosis. In K. Killick & J. Schaverien (Eds.), *Art, Psychotherapy and Psychosis* (pp. 38-51). London, England: Routledge

Krippendorff, K. (1980). *Content Analysis: An Introduction to its Methodology*. London: SAGE

McNeilly, G. (1984). Directive and non-directive approaches in art therapy, *Inscape, December,* 7-12 (Article first published in1983 in *The Arts in Psychotherapy*).

McNeilly, G. (1987). Further contributions to group analytic art therapy. *Inscape, Summer,* 8-11.

McNeilly, G. (1989). Group analytic art groups. In Gilroy, A. & Dalley, T. (Eds.), *Pictures at an exhibition: Selected essays on art and art therapy* (pp. 156-166). London & New York: Routledge.

McNeilly, G. (1990). Group analysis and art therapy: A personal perspective. *Group Analysis, 23* (3), 215-224.

McNiff, S. (2004). *Art heals: How creativity cures the soul*. London, England: Shambhala.

Medical Research Council. (2008). *Developing and evaluating complex interventions: New guidance*. Retrieved from www.mrc.ac.uk/complexinterventionsguidance

Molloy, T. (1997). Art psychotherapy and psychiatric rehabilitation. In In K. Killick & J. Schaverien (Eds.), *Art, psychotherapy and psychosis* (pp. 237-259). London, England: Routledge.

Moncrieff, J. (2013). *The Bitterest Pills: The Troubling Story of Antipsychotic Drugs.* Basingstoke: Palgrave Macmillan

Morrison, A.P., & Barratt, S. (2010). What are the components of CBT for psychosis: A Delphi study. *Schizoprhenia Bulletin,* 36, 136-142. DOI:10.1093/schbul/sbp118

National Institute for Health and Clinical Excellence. (2009). *NICE Clinical Guideline 82, Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*. London, England: Author.

National Institute for Health and Care Excellence. (2013). *Psychosis and schizophrenia in children and young people: Recognition and management*. London, England: Author. Retrieved from http://publications.nice.org.uk/psychosis-and-schizophreniain-children-and-young-people-cg155#close

Patterson, S., Crawford, M. J., Ainsworth, E., & Waller, D. (2011). Art therapy for people diagnosed with schizophrenia: Therapists' views about what changes, how and for whom. *International Journal of Art Therapy (Inscape)*, *16*, 70-80.

Patterson, S., Debate, J., Anju, S., Waller, D., & Crawford, M. J. (2011). Provision and practice of art therapy for people with schizophrenia: Results of a national survey. *Journal of Mental Health*, *20*, 328-335.

Patterson, S., Borschmann, R, & Waller, D.E. (2012). Considering referral to art therapy: Responses to referral and experiences of participants in a randomised controlled trial. *International Journal of Art Therapy, 18,* 2-9. DOI: 10.1080/17454832.2012.738425.

Read, J, Fosse, R, Moskowitz, A and Perry, B (2014). The traumagenic neurodevelopmental model of psychosis revisited, *Neuropsychiatry,* 4, 65-79

Richardson, P., Jones, K., Evans, C., Stevens, P., & Rowe, A. (2007). Exploratory RCT of art therapy as an adjunctive treatment in schizophrenia. *Journal of Mental Health*, *16*, 483-491.

Startup, M., Wilding, H., & Startup S. (2006). Patient treatment adherence in cognitive behaviour therapy for acute psychosis: the role of recovery style and working alliance. *Behavioral and Cognitive Psychotherapy,* **34:** 191–9.

Stewart, K. D. (2012). Factors contributing to engagement during the initial stages of treatment for psychosis. *Qualitative Health Research,* **23***,* 336-347. DOI: 10.1177/1049732312468337

The Schizophrenia Commission. (2012). *The Abandoned Illness.* London: Rethink Mental Illness, Accessed 27th June 2016 at https://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf

Taylor Buck, E., & Hendry, A. (2016). Developing principles of best practice for art therapists working with children and families. *International Journal of Art Therapy: Inscape,* 21, 56-65. DOI: 10.1080/17454832.2016.1170056.

Treadon, C. B. (2016). Bringing art therapy into museums. In D. Gussak & M. L. Rosal (Eds.), *The Wiley Handbook of Art Therapy* (pp. 487 - 497). West Sussex, UK: John Wiley & Sons, Ltd.

Wood, C. (1992). Using art therapy with "chronic" long-term psychiatric patients. In D. Waller & A. Gilroy (Eds.), *Art therapy: A handbook* (pp. 73-89). Buckingham, UK: Open University Press.

Wood, C. (1997). The history of art therapy and psychosis 1938-95. In K. Killick & J. Schaverien (Eds.), *Art, psychotherapy and psychosis* (pp. 144-175). London, England: Routledge.