SARAH LYNCH BA Hons

ART THERAPY FOR PEOPLE EXPERIENCING PSYCHOSIS.

Section A: What does art therapy offer as an intervention for adults with diagnoses of psychotic disorders?

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Summary of the MRP Portfolio

Section A

This review aimed to explore what art therapy offers as an intervention to adults with diagnoses of psychotic disorders. Three online databases were searched; yielding a final sample of 21 papers. The research reviewed showed a mixed picture, with findings from some quantitative studies showing positive effects of art therapy and others finding no evidence of a positive impact. Papers reporting qualitative research highlighted a number of perceived positive effects of art therapy. However, a number of methodological problems were identified and the quality of the papers was variable. Clinical implications and recommendations for further research are discussed.

Section B

This study used grounded theory to explore how service users experience art therapy following a first diagnosis of a psychotic disorder, and the possible mechanisms through which art therapy might be helpful. Ten interviews were conducted with eight participants. A preliminary theory was created and seven categories were constructed: unpressured atmosphere, pleasure and engagement in art-making, expression and communication, connecting with others, changing emotional experience and experience of self, supporting recovery and continuation of art, and barriers. The findings are considered together with limitations and alongside existing research and theoretical perspectives. Implications and recommendations for future research are also highlighted.

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Section A: Literature review paper

What does art therapy offer as an intervention for adults with diagnoses of psychotic disorders?

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Abstract

National UK guidelines state that art therapies should be considered for people with psychosis. Whilst art therapy has a long history of working with this population, provision is inconsistent and the efficacy of this approach has been challenged recently. This review aimed to explore what art therapy offers as an intervention to adults with diagnoses of psychotic disorders. Three online databases were searched – PsycInfo, PubMed and Social Policy and Practice; yielding a final sample of 21 papers. The research reviewed showed a mixed picture, with findings from some quantitative studies showing positive effects of art therapy and others finding no evidence of a positive impact. Papers reporting qualitative research highlighted a number of perceived positive effects of art therapy: enabling expression and exploration of experiences, increasing confidence and self-esteem, enhancing sense of self, contributing to awareness and a sense of being grounded, and development of skills. However, sample sizes in these papers were small, with many being single case studies. Overall, the quality of the papers was variable, with 11 of the 21 papers being judged as 'poor' according to quality criteria, and a number of methodological problems were identified. Clinical implications and recommendations for further research are discussed.

Keywords: Art therapy, art psychotherapy, psychosis, schizophrenia

Introduction

Psychosis – What Is It?

Psychosis[1] is a term commonly used to describe a state in which an individual perceives and interprets things differently to those around them (British Psychological Society, 2014) (BPS). The Diagnostic and Statistical Manual for Mental Disorders (5th ed.; American Psychiatric Association, 2013) (DSM-5) distinguishes between positive and negative symptoms of psychotic disorders. Positive symptoms are considered those which are identified by their presence or addition, such as hallucinations, delusions, disorganised speech and disorganised behaviour (American Psychiatric Association, 2013) (APA). Negative symptoms conversely are suggested to be identified by their absence or reduction such as lack of motivation, social withdrawal, low energy and apathy (Rethink, 2014).

The DSM-5 (5th ed.; APA, 2013) lists diagnoses of schizophrenia, schizoaffective disorder and delusional disorder within the chapter on psychotic disorders. Individuals with a diagnosis of depression or bipolar affective disorder may also experience psychotic states. Psychosis can often be used as a broader term encompassing different diagnoses and is also commonly used to describe particular experiences irrespective of diagnosis.

Whilst the DSM-5 describes psychosis as a mental disorder, an alternative perspective is offered in a recent report entitled ‘Understanding psychosis and schizophrenia’ by the BPS (2014). This publication asserts that thinking about experiences such as hearing voices and paranoia as part of a mental disorder is just one way of conceptualising them and that there are other ways of considering and trying to understand these experiences. They also challenge the dichotomous nature of diagnoses and argue for a continuum approach. The BPS’s (2014)

[1] This report uses terms such as ‘psychosis’, ‘psychotic states’, ‘diagnoses of psychotic disorder’, and ‘symptoms’ for ease of understanding as this is in line with the research papers reviewed. However, it is acknowledged that these terms are not used by all and that there are many different ways of understanding and conceptualising these experiences.

report also chooses to use the term ‘psychosis’ more frequently, alongside more neutral terms such as ‘experiences’, rather than ‘schizophrenia’, in line with moving away from a medical conceptualisation.

Regardless of the debate on diagnosis, there is evidence that for some, experiencing psychosis can be associated with distress and difficulties with social and occupational functioning (Kelleher et al., 2015). However, it is important to note that experiences, such as hearing voices or unusual beliefs, are understood differently in different cultures, with some valuing and appreciating them (Bidois, 2006; Heriot-Maitland, Knight & Peters, 2012; Lawrence, Jones & Cooper, 2010).

Incidence and Prevalence of Psychosis

Recent research by Kirkbride et al. (2012) has suggested that the annual incidence for psychotic disorders in England is 32 cases per 100,000 people. They report that incidence is much greater in Black and minority ethnic (BME) groups and higher in men compared to women before the age of 45, with rates levelling after. In the same study, the authors report a prevalence of four in 1000 for active psychosis in the past year. However, other research has yielded different estimates with the commonly cited prevalence of 1 in 100 having been reported (BPS, 2014). There has also been some research to suggest that urban environments are associated with higher incidence rates for psychosis compared to rural environments (Sundquist, Frank & Sundquist, 2004).

Theories about Psychosis

There is a plethora of theories on psychosis ranging from those focusing on neurotransmitters and brain anatomy to those suggesting the importance of life events, social factors and cognitive and affective processes. One particular psychological model that has

received much attention is Garety, Kuipers, Fowler, Freeman and Bebbington's (2001) cognitive model of the positive symptoms of psychosis. This model theorises that positive symptoms are fundamentally the result of experiences, such as internal thoughts, being appraised as external. This appraisal is the result of biopsychosocial vulnerabilities, emotional responses, dysfunctional schemas and reasoning and attributional biases. Garety et al.'s (2001) model allows for consideration and inclusion of a range of factors which could be seen to contribute to experiencing psychosis whilst placing individual psychological factors centrally within the theory. This model has formed part of the theoretical basis for cognitive behavioural therapy for psychosis (CBTp).

However, alternative theoretical perspectives on psychosis are offered by the psychodynamic tradition. Martindale and Summers (2013) argue that psychosis can be thought of as "a response to unbearable aspects of reality" (p.124). They argue that a task for all individuals is to "integrate different aspects of reality, to tolerate conflict between them, to make compromises and to find ways of managing these multiple realities, often at the same time" (p.124). They suggest that for some individuals there are experiences which they find unmanageable, and that as a result, aspects or experiences of reality are altered or dispensed with through the use of psychological defences, leading to psychotic symptoms. Martindale and Summers (2013) posit this understanding of psychosis whilst positioning it within a broader stress-vulnerability model, acknowledging factors such as early attachment relationships, biological factors and life stressors, which may contribute to an individual experiencing psychosis.

Both the cognitive-behavioural and the psychodynamic models appear consistent with evidence of trauma and abuse in the lives of a majority of people who receive diagnoses of psychotic disorders (Read, Fosse, Moskowitz & Perry, 2014).

Services for Psychosis

Under government policy in the past decade there has been a growth in specialist services for psychosis, in particular early intervention for psychosis, assertive outreach and crisis resolution services (Department of Health, 2001; Department of Health, 2011). Policies (Department of Health, 2011) and National Institute for Health and Care Excellence (NICE) guidance (NICE, 2014) has stressed the importance of intervening early, with evidence suggesting that following an early intervention model can improve outcomes for individuals with psychosis and be cost-effective (Singh, 2010). Policies have also encouraged service user involvement, asserting the importance of service users having choice around their treatment and having their preferences taken into account (NICE, 2011).

Interventions for Psychosis

NICE guidance for psychosis (NICE, 2014) recommends primarily oral antipsychotic medication, CBTp and family interventions for the treatment of psychosis. Although there is some evidence for the utility of these interventions, there is also contention.

Whilst the use of antipsychotic medication is almost universal in the care and support of individuals experiencing psychosis (Royal College of Psychiatrists, 2012), research evaluating its efficacy shows far from dramatic improvements in symptoms. A review (Leucht, Arbter, Engle, Kissling & Davis, 2009) has shown that antipsychotics can have an effect on symptoms but that many will see no improvement. Attention has also increasingly been paid to the side effects of these medications, which include weight gain, drowsiness, and increased risk of diabetes, hypertension and sexual problems (Royal College of Psychiatrists, 2014).

Regarding the efficacy of CBT in the treatment of psychosis, there are also mixed findings and ambiguity. One systematic review (Jauhar et al., 2014) of the evidence for CBTp suggested that it has a small therapeutic effect on symptoms. However, a Cochrane review (Jones, Hacker, Cormac, Meaden & Irving, 2012) comparing CBT to other psychological therapies found no clear or convincing evidence that CBT resulted in superior outcomes.

Interestingly, a study (Moritz, Berna, Jaeger, Westermann & Nagel, 2016) exploring service users' views on interventions for psychosis identified that they considered the treatment of memory, attentional and affective problems more important than treatment of their positive symptoms. The results from this research highlight the importance of interventions being tailored to identified needs rather than purely diagnosis driven.

Art Therapy for Psychosis

In addition to the previously discussed interventions, NICE guidance for psychosis and schizophrenia (NICE, 2014) also recommends considering arts therapies for all individuals experiencing psychosis, particularly to alleviate negative symptoms. The NICE guidance (2014) states that arts therapies for psychosis should have several aims:

- "enabling people with psychosis or schizophrenia to experience themselves differently and to develop new ways of relating to others",
- "helping people to express themselves and to organise their experience into a satisfying aesthetic form"
- "helping people to accept and understand feelings that may have emerged during the creative process (including, in some cases, how they came to have these feelings) at a pace suited to the person." (NICE, 2014)

The British Association for Art Therapists (BAAT) define art therapy as "a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as a diagnostic tool but as a medium to address emotional issues which may be confusing and distressing" (BAAT, n.d.). In order to differentiate between occupational or activity art groups which may be run in mental health and community settings, BAAT also states that art therapy is "not a recreational activity or an art lesson".

Whilst art therapy is in the NICE guidance, a survey of art therapists working in mental health trusts by Patterson, Debate, Anju, Waller and Crawford (2011) revealed that the provision of art therapy was not consistent. Some trusts had no provision, whilst ones that did typically employed art therapists to work over a range of services and settings. The majority of respondents also reported that art therapy was not well integrated with other services and was not well understood by colleagues. Despite the problems identified by responding art therapists, the study by Moritz et al. (2016) reported that participating service users identified art therapy as one of the most helpful interventions for psychosis.

Art therapy has long been associated with psychodynamic theories, ideas and practice. A survey of art therapists (Patterson, Debate, et al., 2011) stated that the majority described themselves as having a psychodynamic theoretical orientation. Art therapists in this study also reported typically using a 'non-directive' approach in their therapy and aimed to encourage service users to use art making as a means of expression, communication and in developing self-understanding. Holttum, Huet and Wright (2016) conducted a Delphi survey of art therapists working with people diagnosed with psychotic disorders. They reported that key areas of knowledge and skill for art therapists include understanding the role of trauma, socio-political awareness, and service-user-defined recovery, as well as skills such as working collaboratively, working sensitively with fear and distress, and helping people

understand their psychotic experiences. However, art therapy is not a manualised intervention or approach and currently there is not an established and universally agreed set of practice elements which art therapists follow.

Theories of Art Therapy for Psychosis

Art therapists informed by the psychodynamic tradition have argued that art making within art therapy enables concrete and symbolic communication between the service user and therapist, externalising of emotions and thoughts which may not otherwise have been expressed, processing of experiences and a strengthening of an individual's ego boundaries (Killick & Schaverien, 1997). Psychodynamic therapy is often focused on exploring and bringing to awareness the dynamic conflicts and tensions taking place for an individual. In art therapy, such conflicts may be revealed, explored and processed through art-making rather than verbally (Hogan, 2015). Czamanski-Cohen and Weihs (2016) have also used psychoanalytic theory as a basis for a 'bodymind model' of art therapy suggesting that art therapy offers a unique therapeutic process due to the use of the body, senses and imagery, which is different to that experienced in traditional verbal therapies.

It has also been suggested that a piece of artwork created within art therapy can act as a transitional object (Malchiodi, 2003). Winnicott (1971) theorised that infants use transitional objects, often soft toys or blankets, during separation from their mothers to soothe and comfort them. Winnicott (1971) argued that these objects are symbolic and serve to represent the mother or caregiver rather than replacing them, as well as describing that infants will project their feelings onto the objects. Malchiodi (2003) discussed in art therapy, "art products can become transitional objects which may become imbued with meaning beyond what they are in reality". They may be used to express, explore and process feelings and experiences, and also to encourage a connection with the art therapist (Malchiodi, 2003).

More recently, art therapists have suggested that art therapy can increase mentalisation by "promoting the formation of mental representations of thoughts and feelings" (Montag et al., 2014, p.2) and to develop a language which supports mentalisation. Although mentalisation difficulties have been mostly discussed in relation to borderline personality disorder (Bateman & Fonagy, 2012), there is also research suggesting that these difficulties are present in those with psychosis (Versmissena et al., 2008). Frith and Cocoran (1996) argue that deficits in mentalisation or theory of mind may underlie experiences such as delusions and paranoia. As such, if art therapy can affect theory of mind or mentalisation, this may in turn improve psychotic symptoms.

There is also a branch of art therapy which sees art as therapy rather than the notion of art in therapy (McNiff, 2004). This perspective considers art-making in itself intrinsically restorative, reparative and beneficial. Therefore, it may not suggest a psychosis-specific process, theory or intervention; rather that it can offer benefits to any who engage in it.

Rationale and Aims of the Review

Whilst there are a number of different interventions and treatments recommended for individuals experiencing psychosis, there is uncertainty and ambiguity surrounding the efficacy of these options. Art therapy, whilst having a long-standing history of working with psychosis is also not universally provided and a recent large scale study (Crawford et al., 2012) has questioned the usefulness of the approach. In the current NHS climate, there is a growing pressure and requirement for interventions and services to be evidence based and cost effective (The Kings Fund, 2015). As such, it is important, for both the art therapy profession and clinical psychology, that interventions for individuals experiencing psychosis are researched and evaluated, in order to understand what different interventions can offer to

this population. This review focuses on the potential contribution of art therapy, and therefore aims to consider the following question:

- What does research suggest that art therapy can offer or contribute as an intervention for adults with diagnoses of psychotic disorders?

Methodology

The papers reviewed in this report were obtained by searching several online databases – PsycInfo, PubMed and Social Policy and Practice. A preliminary review of the literature identified that both 'art therapy' and 'art psychotherapy' were used, in addition to some papers focusing on 'schizophrenia' whereas others used the broader term of 'psychosis' or 'psychotic disorders'. As such, the literature was searched using all these terms. No date range was used as due to the review question and number of results it was not deemed necessary. Papers were excluded from this review if they were not written in English, were book chapters or book reviews, were theoretical or focussed on drama or music therapy. Papers were also restricted to those involving only adults (defined as 18 years and above) and those with diagnoses of psychotic disorders. Figure 1 shows the search strategy used and how the final sample of papers were reached. Duplicates were firstly removed automatically using an automated database function, however this did not successfully remove all duplicates. Further duplicates, such as the same research published in more than one publication, were removed manually when reviewing abstracts and full articles. Table 1 provides a summary of the papers included.

This review is based on Grant and Booth's (2009) systematic review type, as such seeking to "systematically search for, appraise, and synthesise research evidence" (p. 95), identifying what is known and unknown in a research area and highlighting recommendations for practice and future research. The papers were assessed for quality using Kmet, Lee and

Cook's (2004) quality assessment criteria with associated interpretation and categorisation of these scores based on those used by Ghannouchi, Speyer, Doma, Cordier and Verin (2016). Studies which achieved a 'good' or 'strong' quality rating are discussed in greater detail than those rated as 'poor' or 'adequate' in the following section.

Search terms: [art therapy OR art psychotherapy] AND [psycho* OR schizophren*]

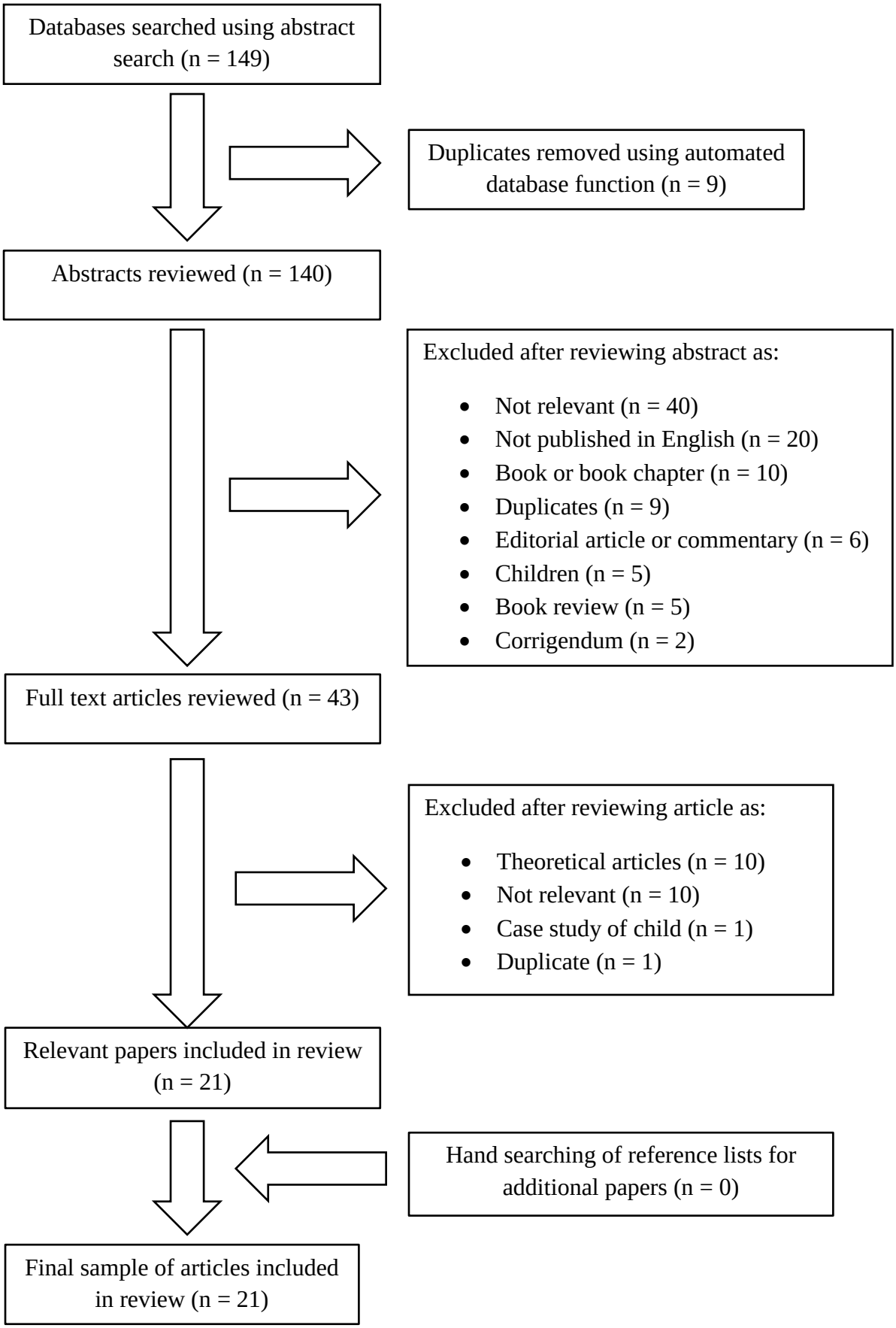

Figure 1. Prisma diagram showing literature search.

Table 1.

Summary of papers included in review.

Study	Country / Quality score	Intervention	Sample	Methodology	Findings
Alter-Muri (1994)	USA Quality score: 5/20 (25% - poor)	3 years of art therapy, both group and individual	44 year old man with diagnosis of schizophrenia	Case study	Developed identity of artist, was able to express experiences through art therapy, increased verbal communication, enjoyment of art making, acknowledgement of his strengths.
Brown (1975)	USA Quality score: 2/20 (10% - poor)	4 months of individual art therapy, 2-3 times a week.	55 year old man with diagnosis of schizophrenia	Case study	Art therapy served as a means for expression, exploration and processing of emotions and experiences.
Carabell (1982)	USA Quality score: 4/20 (20% - poor)	Individual art therapy, unspecified duration.	38 year old man with diagnosis of paranoid schizophrenia	Case study	Art therapy enabled processing and exploration of thoughts, feelings and conflicts.
Crawford et al. (2012)	UK Quality score: 24/26 (92% - strong)	12 months of weekly 90 minutes group art therapy sessions	417, aged 18 and over with diagnosis of schizophrenia	Three arm, rater blinded randomised controlled trial (RCT). Art therapy plus standard care compared to activity groups plus standard care and standard care alone. Measures of global functioning, mental health symptoms, social functioning, medication adherence, satisfaction with care, mental wellbeing and health-related quality of life taken at 12 and 24 months after randomisation.	Mental health measures and global functioning were similar across art therapy and activity group conditions with activity group showing a greater reduction in positive symptoms of schizophrenia at 24 months.
Doughtery (1974)	USA Quality score: 4/20 (20% - poor)	Group art therapy over 6 month period	5 women aged 18-55, with diagnoses of schizophrenic reactions	Case study	Participants were able to use art therapy to express themselves and communicate. Also appeared to help develop social skills, ability to be in a group and consideration of others.

Gajic (2013)	Serbia Quality score: 16/46 (35% - poor)	Group art therapy, weekly sessions for 2 months	2 patients with diagnoses of schizophrenia	Comparison of pre and post scores on clinical global impression (CGI) and global assessment of functioning (GAF), and use of observations and interpretations of drawings	Minimal improvement shown on CGI and GAF. Observations and drawings suggest art therapy contributed to improvement in social inclusion and self-esteem.
Gotthold (1983)	USA Quality score: 5/20 (25% - poor)	Individual art therapy over nine months	25 year old man with diagnosis of paranoid schizophrenia	Case study	Suggests art therapy enabled expression, transformation of energy, sense of achievement, increased ability to express verbally.
Hanevik, Hestat, Lien, Telgjaerg & Danbolt (2013)	Norway Quality score: 15/20 (75% - good)	Expressive art therapy delivered in a group. Weekly sessions, 2.5 hours long for 10 months.	5 women suffering from psychotic disorder, aged between 31 and 58	Multiple single case study, using three sources of information - participants' artwork, therapists' notes of the sessions and interviews with participants.	Participants were able to explore their psychotic experiences through art therapy. All reported some beneficial effect on their ability to cope with psychosis and an increase in feeling valued. Two participants reported that they were able to cognitively reinterpret their psychotic experience and this in turn helped them to cope with it.
Killick (1996)	UK Quality score: 6/20 (30% - poor)	Individual art therapy over six years.	Man in early twenties with diagnosis of schizophrenia.	Case study	Art therapy gave way of expressing and processing experience, developing ability to express verbally. Author suggests contributed to growth in ego strength.
Leurent et al. (2014)	UK Quality score: 19/26 (73% - good)	Same as Crawford et al. (2012) MATISSE study (two out of three conditions)	Secondary analysis of MATISSE data using two of the three conditions, art therapy (n=140) and treatment as usual (TAU) (n=137)	Secondary analysis of MATISSE data.	No significant difference in effectiveness of art therapy between those with more severe negative symptoms compared to those with less severe symptoms, or between those who expressed a preference for art therapy and those who did not. No other significant moderating effects found.
Lowe (1984)	USA Quality score: 2/20 (10% - poor)	Individual weekly art therapy over six month period	71 year old woman with a diagnosis of paranoid schizophrenia	Case study	Author suggests art therapy helped processing and reintegration of memories and experiences, and was a method of expression and communication
Montag et al.	Germany	12 sessions of 90	58 - 29 allocated to	Single-blind, parallel group RCT	Greater mean reduction of positive

(2014)	Quality score: 22/26 (85% - strong)	minutes group art therapy over 6 weeks delivered in inpatient setting. Non-directive approach.	art therapy, 29 to TAU. Aged between 18 and 64, diagnosed with schizophrenia.	comparing art therapy and TAU to TAU. Outcome measures included those exploring positive and negative symptoms, depression, functioning, mentalising function, self-efficacy, quality of life and satisfaction with care.	symptoms in art therapy group at post-treatment and follow up. Lower negative symptoms in art therapy group at follow up. Significantly higher GAF scores in art therapy group at post-treatment and follow up. No difference in depression, self-efficacy, quality of life or satisfaction of care scores.
Patterson, Crawford, Ainsworth & Waller (2011)	UK Quality score: 18/20 (90% - strong)	None	24 art therapists	Grounded theory study exploring art therapists view through interviews and focus groups, and written material	Art therapists reported belief that art therapy is valuable and beneficial and that it can enable engagement with another and with therapy, offer an alternative to medical model/system, help communication, enable exploration of their experiences and change how individuals see themselves.
Patterson, Borschmann & Waller (2013)	UK Quality score: 17/20 (85% - strong)	Same as Crawford et al. (2012)	23 MATISSE participants	Grounded theory study using range of data sources: MATISSE investigators' accounts, participants, therapists and trial documents, participant accounts (interviews, focus groups), researcher observations	Art therapy can have benefits for those who engage in it. Some participants reported changes in self-esteem, sense of agency and confidence.
Pendleton (1999)	USA Quality score: 4/20 (20% - poor)	Group art therapy, weekly sessions	Case study on a 36 year old man with diagnosis of schizophrenia	Case study	Reported enjoyment of art therapy, increased confidence in art making and ability to use art therapy to express feelings. Also described increase in confidence, interpersonal ability and self-esteem.
Potocky (1993)	USA Quality score: 7/20 (35% - poor)	Group art therapy using Gestalt approach, one hour weekly sessions	Aged early 20s to late 60s, diagnosed with chronic schizophrenia. Group was open ranging from 6-10 clients a week.	Case study	Group contributed to increases in self-esteem, confidence, expression, awareness and ability to adopt identity of 'nurturer'.
Richardson, Jones, Evans, Stevens &	UK	12 sessions of group interactive art	43 (in art therapy condition) and 47 in	RCT comparing art therapy plus standard psychiatric care to standard	The art therapy group had significantly better scores on SANS

Rowe (2007)	Quality score: 20/26 (77% - good)	therapy, sessions 1.5 hours	standard care, participants with chronic schizophrenia	psychiatric care alone. Measures include brief psychiatric rating scale, social functioning scale, inventory of interpersonal problems, scale for assessment of negative symptoms (SANS), Lancashire QoL profile, brief symptom inventory	than the control group. No significant differences on any of the other measures.
Smith, Macht & Refsnes (1967)	USA Quality score: 4/20 (20% - poor)	Twice weekly individual art therapy and weekly group art therapy over approximately two months.	30 year old man diagnosed with schizophrenic reaction, acute paranoid type.	Case study	Art therapy gave relief from symptoms, opportunity for engagement, expression and increased understanding of the individual.
Teglbjaerg (2011)	Denmark Quality score: 16/20 (80% - strong)	Formative group art therapy for 1 year, weekly 2 hour sessions, inspired by expressive arts therapy	5 patients who had suffered with severe schizophrenia for over 5 years compared to group of 5 patients with nonpsychotic diagnosis	Interviews and written evaluations before and after therapy and at one year follow-up.	Art therapy increased participants' sense of self, self-esteem and sense of connectedness with others
Williams (1976)	USA Quality score: 6/20 (30% - poor)	Individual art therapy	25 year old man with diagnosis of paranoid schizophrenia	Case study	Art therapy enabled expression of thoughts and feelings unable to express with words, and provided way of exploring, processing and integrating experiences.
Young (1975)	USA Quality score: 11/20 (55% - adequate)	Twice weekly art therapy sessions for 3 weeks.	30 individuals with diagnoses of chronic paranoid schizophrenia or chronic schizophrenia undifferentiated.	Comparison of supportive art therapy, insight art therapy and control group on draw-a-person test. Observations and interpretations from these test used.	Most participants in the insight group were not able to engage actively with this approach. Authors argue patients could use the supportive art therapy more helpfully and may have contributed to increase in self-esteem.

Literature Review

Overview of Studies

The search strategy described yielded 21 papers that satisfied the inclusion criteria. Of these papers, 11 were from America, six were from the UK and the remaining four from other European countries. Regarding research design and methodology, 11 were case studies, four were qualitative, three papers reported randomised controlled trials (RCTs), one used a pre-post quantitative design, one employed a multiple single case study design and one was a secondary analysis of one of the RCTs. The papers explored different art therapy interventions, with six of the papers involving individual art therapy, 12 of the papers focusing on group art therapy, and two exploring both individual and group art therapy. There was variety in frequency, duration of the sessions and the approach taken by the art therapist. Based on Kmet, Lee and Cook's (2004) quality appraisal tool, five papers were considered 'strong' in terms of quality, three 'good', one 'adequate' and 12 were judged to be 'poor'.

Of the papers, one paper used data solely from art therapists, 17 focused on participants with diagnoses of 'schizophrenia', two reported case studies of individuals with diagnoses of 'schizophrenic reactions' and one paper included individuals with diagnoses of 'psychotic disorder'. Given this review is considering what art therapy can offer or contribute to individuals with such experiences, the broader term of psychosis will be used rather than focusing on specific psychiatric diagnosis, in line with the BPS (2014).

Impact on Positive Symptoms of Psychosis

Three studies specifically explored the effect of art therapy on positive symptoms of psychosis – Montag et al. (2014), Crawford et al. (2012) and Richardson et al. (2007). Of these studies (all randomised trials), only Montag et al. (2014) reported a significant

reduction on outcome measure scores measuring positive symptoms compared with a control group. Studies by Crawford et al. (2012) and Richardson et al. (2007) described no significant differences.

Montag et al.'s (2014) study compared art therapy as well as treatment as usual (TAU) to TAU only. This study measured positive symptoms using the scale for assessment of positive symptoms (SAPS) and suggested that there was a greater reduction in SAPS scores for those receiving art therapy at post-treatment and 12 week follow up compared to those receiving TAU. However, this study suffered from several limitations including a small sample size, high attrition rates and a lack of an active control intervention. Significant differences were also found in baseline characteristics, with those who completed the art therapy intervention being more likely to be female and have a higher IQ. Although the authors note that these were statistically controlled for, they acknowledge that this finding may have reflected important differences of this group compared to the wider group of those experiencing psychosis and may affect the validity of the results.

Crawford et al.'s (2012) multicentre study of art therapy in schizophrenia: systematic evaluation (MATISSE) used the positive and negative syndrome scale and reported that art therapy was not associated with differences in positive symptoms. This study involved comparing art therapy to an activity group and to standard care. The authors, in fact, describe that participants allocated to the activity group showed fewer positive symptoms at 12 and 24 months compared to those receiving art therapy. This study involved a large sample, 417 participants and, as such, is the largest piece of research exploring art therapy for individuals experiencing schizophrenia. It also compared art therapy to an active control, as well as TAU, which is a strength of the study design. Despite this, a significant problem in the study was the engagement of participants in the interventions. Of those allocated to art therapy 39% did not attend any sessions, with those attending regularly reported to be few, with similarly low

attendance of the activity control condition. Therefore, as Holttum and Huet (2014) suggest, it seems arguable that this study did not adequately test the benefits of art therapy as so few engaged with the intervention.

Crawford et al. (2012) also state that the mean duration of experiencing schizophrenia was 17 years with 96% of participants being prescribed antipsychotic medication. These are important factors to take into account when considering if an intervention has anything to offer. It is potentially much more difficult for an intervention to have a significant impact on positive symptoms if participants have experienced them and been in mental health services for such a long duration, and as such, may not be a fair reflection of what art therapy is able to offer. Further criticisms of the study have discussed that there was variability and confusion in the type of art therapy which therapists participating in the trial were advised to follow (Wood, 2013), and that the therapy as delivered in the trial, being an inpatient model, was not suitably adapted and tailored to the needs of the community-based participants (Holttum & Huet, 2014). The version of 'usual care' these service users typically receive has been reported as poor (Schizophrenia Commission, 2012), and assistance in attending a new weekly therapy group would have been unlikely without special arrangements, none of which were mentioned by Crawford et al. (2012).

Richardson et al.'s (2007) study used another outcome measure to explore psychotic symptoms, the brief psychiatric rating scale (BPRS). This research was a RCT comparing group interactive art therapy to standard care. The authors report that no significant differences on this measure were found. However, in this study the art therapy intervention involved 12 weekly sessions of art therapy, lasting one and a half hours. Richardson et al. (2007) comment that this was considered the absolute minimum necessary and acknowledge that this would be deemed "sub optimal by many art therapists" (p. 484). Therefore, this

research could be criticised for not comparing a 'sufficient therapeutic dose' of art therapy, which could therefore make the results unsurprising. Furthermore, Richardson et al. (2007) cite problems with recruitment which led to a small sample size and insufficient power in the trial. This undermines the confidence that can be had in the reported findings and associated conclusion that art therapy does not contribute to a change in positive symptoms, as it is plausible that given a sufficient sample size favourable results may have been found.

Impact on Negative Symptoms of Psychosis

Montag et al.'s (2014), Crawford et al.'s (2012) and Richardson et al.'s (2007) studies also explored art therapy's effect on negative symptoms. Montag et al. (2014) and Richardson et al. (2007) found some evidence that art therapy may improve negative symptoms, whereas findings from Crawford et al.'s (2012) trial suggest that art therapy did not offer any benefit compared to activity groups and standard care.

The study by Montag et al. (2014) reported that there was a significantly greater reduction of negative symptoms at 12 week follow up (as measured by the scale for assessment of negative symptoms) (SANS) in the art therapy group compared to those receiving TAU. However, no significant difference was found when comparing scores directly after treatment. This is an intriguing finding and may suggest that the benefits of art therapy as an intervention take time to manifest. However, as discussed in the previous section, this study has several weaknesses which should be considered and which may affect the reliability and validity of the results.

Richardson et al.'s (2007) study reported a small significant difference between conditions at post-treatment and follow-up for negative symptoms as measured by the SANS. They assert that participants in the art therapy arm of the study showed a greater improvement in negative symptoms compared to those receiving standard care. However,

Richardson et al. (2007) are cautious about the result, noting that the art therapy group had lower SANS scores at baseline compared to the standard care group and that this difference was “narrowly significant” (p.486) making interpretation more difficult.

The MATISSE study (Crawford et al., 2012) found no significant difference in scores of negative symptoms across the art therapy, activity group and TAU conditions. A study by Leurent et al. (2014) conducting a secondary analysis of the MATISSE data exploring moderating factors also found that there was no difference in effectiveness of art therapy for those who had more severe negative symptoms compared to those with less severe. However, these secondary analyses may have been underpowered as a result of the trial not planning on testing for interactions between variables. Leurent et al. (2014) acknowledge that, as such, a non-significant result does not necessarily mean that the interaction does not exist.

Impact on Global Functioning

Four studies (Montag et al., 2014; Crawford et al., 2012; Richardson et al., 2007; Gajic, 2013) explored the effect of art therapy on measures of global functioning. All four studies used the global assessment of functioning scale (GAF). Similarly to the effect on positive symptoms, Montag et al. (2012) reported that the art therapy group showed significantly higher GAF scores compared to the standard care group at post-intervention and follow up. Conversely, studies by Crawford et al. (2012) and Richardson et al. (2007) reported no significant difference between conditions.

Gajic’s (2013) uncontrolled study supported Montag et al.’s (2012) results and reported improvement, albeit minimal, on the GAF when comparing pre and post-intervention scores. However, Gajic (2013) only reported on two of the art therapy group’s participants and with such a small sample size it prevents any reliable conclusions from being drawn. This study did not use a control group but was rather seeking to present observations

from a group art therapy intervention. The paper was also characterised by the quality appraisal standards (Kmet, Lee & Cook, 2004) as being 'poor'. Gajic (2013) offered little information on the selection of participants, the other interventions which they were receiving concurrently and did not control for confounding variables.

Impact on Self-Esteem and Confidence

In addition to research on symptoms and functioning, some qualitative studies (Patterson et al., 2013; Teglbjaerg, 2011; Pendleton, 1999; Potocky, 1993; Young, 1975) have suggested that art therapy can lead to increases in service users' confidence and self-esteem. Patterson et al.'s (2013) study interviewed 23 of the MATISSE trial participants in addition to other data sources such as trial investigators' accounts, observations and trial documents. Despite the MATISSE trial (Crawford et al., 2012) finding no evidence for the effectiveness of art therapy for individuals suffering from psychosis, Patterson et al. (2013) conclude that art therapy can be helpful for those who engage with it. Specifically, they report findings from six participants who engaged in art therapy and described increases in self-confidence and self-esteem. Although qualitative data are useful, it is important to consider that the authors' conclusions relate to a very small number of participants and percentage of those who took part in the larger study. It is also unclear from the paper just how the participants for this study were selected. Despite this, the paper is helpful in further elucidating the potential of art therapy.

This finding was supported by Teglbjaerg's (2011) research. Teglbjaerg's (2011) paper reports a qualitative study exploring five participants' experience of a one-year expressive art therapy group through interviews and written evaluations. Teglbjaerg (2011) asserted that participants expressed increases in their self-esteem as a result of engaging in art therapy. It is suggested that this was a result of art therapy strengthening participants' sense

of self. This study suffers limitations associated with the small sample size as with many of the papers reviewed. Teglbjaerg (2011) provides a thorough description of the findings and themes and sets a useful theoretical context for the research. However, there is a lack of reflexivity in the account which is an identified weakness of the paper.

Gajic's (2013) study also reported that group art therapy appeared to increase individuals' confidence and self-esteem. This assertion was based on Gajic's observations and consideration of participants' artwork, rather than rooted in the participants' own reports. Although the views of therapists and researchers are not to be discounted, they may not necessarily accurately reflect the participants' experiences and should be considered with a certain level of caution. This is particularly as the findings appeared to be unsystematic observations and impressions pertaining specifically to the researcher rather than views collected and analysed using an identified qualitative methodology.

Pendleton (1999), Potocky (1993) and Young (1975) also document observations that art therapy appeared to contribute to increases in confidence and self-esteem. Pendleton (1999) noted that through art therapy, the client "showed increased confidence in his interactions with others" (p.33-34) and Potocky (1993) discussed how praise from other group members helped to foster individuals' self-esteem in group art therapy. However, Pendleton's (1999) paper focuses on one individual case study and the findings reported are the subjective views and interpretations of the therapist. Potocky's (1993) and Young's (1975) papers, whilst reporting on slightly larger samples, have limitations in not using verification procedures to establish the credibility of the results, a lack of reflexivity and insufficient information regarding data collection and data analysis methods.

Enabling Expression and Exploration of Experience

All of the qualitative papers reviewed reported that service users were able to use art therapy as a method of expressing their thoughts, feelings and experiences. In particular, Hanevik et al.'s (2013) study used a qualitative multiple case study design and explored an expressive art therapy group intervention. All five service users who were engaged in the group took part in the study. The paper gave a good description of the intervention and methodology. Interestingly, the art therapist was also a psychiatrist and Hanevik et al. (2013) note that the participants reported a "great confidence" (p. 315) in her and that open discussion around medication and symptoms occurred during the therapy. It seems that this intervention may not be reflective of art therapy in general, and the therapist being also a psychiatrist may have had unconsidered effects. Hanevik et al. (2013) reported that all the participants were able to use art to express and explore their experiences of psychosis. Hanevik et al. (2013) accept the subjectivity which is part of their methodology and acknowledge the potential bias of the first author also being the therapist.

Hanevik et al.'s (2013) reported findings of art therapy enabling and facilitating expression and exploration of experiences are consistent with Patterson, Crawford, et al.'s (2011) research. Patterson, Crawford, et al. (2011) interviewed art therapists (both those who had taken part in the MATISSE trial and those who had not) about the nature of art therapy and how it can be helpful for individuals with a diagnosis of schizophrenia. The authors describe how art therapists reported that art therapy is a safe space in which service users can openly discuss their experiences and "speak the otherwise unspeakable" (p.76). Whilst there is a clear account of the methodology and process of analysis, there is a lack of information regarding how participants were selected and recruited. However, strengths of the paper are the acknowledgement of its limitations, the awareness and discussion of the subjectivity of qualitative research and the useful positioning of the results within a chosen epistemological position.

Several papers (Lowe, 1984; Killick, 1996; Smith, Macht & Refsnes, 1967; Williams, 1976) particularly suggested that such individuals were able to express themselves and their experiences in a way which they would have found difficult in talking therapies. As such, these papers argue that art therapy offers an intervention in which individuals are able to engage and in which they can express things which they are not able to verbalise. Several papers (Alter-Muri, 1994; Killick, 1996; Lowe, 1984; Williams, 1976) also reported that through art therapy and communicating and expressing nonverbally, verbal expression slowly developed and increased. The inference from some papers was that communication through art acted as a scaffold for verbal communication and may then serve as preparation for a more verbal form of therapy.

This finding that service users were able to express themselves in art therapy seemed universal across all the papers and may suggest that art therapy offers a unique intervention for a client group which is otherwise not adequately catered for by other psychological approaches. Such expression and communication by service users reportedly contributes to both the client's and professional's understanding of them and their experiences (Williams, 1976). However, a bias in publication and write up is also likely to exist, with only those cases for which art therapy has been felt to be useful being chosen. Therefore, the papers may constitute an unrepresentative sample and there may be individuals who participate in art therapy for whom this is not the case.

In addition, some papers (Alter-Muri, 1994; Carabell, 1982; Gotthold, 1983; Lowe, 1984; Killick, 1996; Williams, 1976) also argued that art therapy facilitated a processing of thoughts, feelings and experiences. The suggestion from these papers is that through art therapy service users were able to explore, process, integrate and make sense of their experiences in a way which was helpful to them and which in some cases contributed to an improvement in symptoms. Despite the commonality with which the papers discussed this, it

is important to hold in mind that most of these articles were referring to only one individual and as such, even taken together, represent a small and potentially biased sample.

Effect on Sense of Self

Several papers (Alter-Muri, 1994; Patterson, Crawford, et al., 2011; Patterson et al., 2013; Pendleton, 1999; Potocky, 1993; Teglbaerg, 2011) made reference to art therapy having an impact on the service user's sense of self. Patterson, Crawford, et al. (2011) describe art therapy contributing to enhancing self-esteem and discuss that participants are able to move away from having an identity associated with mental ill-health and to that of an artist. Alter-Muri (1994) also made this assertion. The paper describes a case study of art therapy with a man with a diagnosis of schizophrenia, and that during the course of the therapy he "came to view himself as an artist" (p.221). This change was reportedly associated with gaining a feeling of importance and a reduction in delusional beliefs. A paper by Pendleton (1999) similarly described a case study of art therapy with a man with a diagnosis of schizophrenia. Alter-Muri (1994) and Pendleton (1999) in their reports both describe that artworks produced in art therapy are exhibited and that this has positive effects on service users' self-esteem, perhaps strengthening their identity as an artist rather than mental health patient. Potocky (1993), instead, reports that group art therapy allowed service users the opportunity to adopt an alternative identity as that of a nurturer to other members of the group.

Teglbjaerg (2011) reported that the most consistent finding for participants was a change in how they experienced themselves. This was identified by a range of experiences such as feelings of increased confidence, self-awareness and strength. Teglbjaerg (2011) posited an understanding of these changes, suggesting that individuals with a diagnosis of schizophrenia have a "very primary preverbal sense of self (minimal self)" (p.316) and that

art therapy strengthened participants' sense of self. Teglbjaerg (2011) suggests that this occurs due to art-making resulting in an increased level of presence-being, allowing for expression and integration of experiences and for improved social relatedness, connectedness and emotional capacity. The paper also echoes art therapists' observations of allowing a change in identity, with Teglbjaerg (2011) discussing that art therapy facilitates exploration of one's identity and allows an individual to experience being a creator of something and to experience feelings of pride associated with this. Service users in Patterson et al.'s (2013) study also reported a sense of achievement and competence through the art-making and participation in the therapy.

Grounding

Patterson, Crawford, et al. (2011), Potocky (1993) and Teglbaerg (2011) discuss in their papers the observation that art therapy can increase an individual's awareness or sense of grounding. Teglbjaerg (2011) refers to 'presence-being', and how art-making demands participants to shift their awareness from a more internal focus to external reality. The author noted that this process was associated with a reduction in anxiety and paranoid ideation. Similarly, Patterson, Crawford, et al. (2011) described "a sense of being grounded" (p.77) which was created by having an image which was "a concrete and symbolic anchor within and across sessions" (p.77). Some of the participants in Patterson, Crawford et al.'s (2011) study described the art-making slightly differently, in terms of serving as a distraction from psychotic experiences and distress. Potocky (1993) described that art therapy enhanced "group members' here-and-now awareness of themselves and others" (p.77).

Development of Skills

Several of the papers described that through art therapy service users developed skills. Some (Pendleton, 1999; Young, 1975) commented specifically about the development of

skills in art and art-making. Others highlighted the development of social skills and the ability to interact and relate to others (Alter-Muri, 1994; Doughtery, 1974; Potocky, 1993). This seemed particularly apparent in papers which described art therapy as delivered in a group. Alongside these developments in particular skills was also a theme of an emergence or increase in service users' sense of competence and a reported sense of achievement (Gotthold, 1983). This could be seen as being related to a change in sense of self and identity as previously discussed.

However, there are a number of problems and limitations with using material from the case studies reviewed. Firstly, given that generally the service users presented were receiving a number of different interventions, it is not possible to attribute the changes or improvements in the service user to art therapy specifically. As such, many of the effects or outcomes noted may not be due to the art therapy intervention. There is also the issue of the subjectivity and veracity of the accounts presented. Are they accurate? Are the views shared by other professionals and the service user or supported by other information? Some of the reported changes or developments reported were also based on interpretations of the client's artwork. This raises further questions regarding the subjectivity and validity of these interpretations. Another issue is, assuming the changes were observed in art therapy, did they generalise to outside of the therapy and did they equate to changes in functioning?

General Methodological Issues

As evident from the information in Table 1, the papers considered in this review explore different types of art therapy. As a result, the interventions being compared are heterogeneous and may have importantly different components, orientations and effects. Although research has shown that the majority of art therapists identify as working psychodynamically (Patterson, Debate, et al., 2011), there may still be a difficulty within the

profession in terms of operationalising and defining what art therapy is. Tailoring and adapting interventions to the client has also been described as a feature of art therapy which, whilst appropriate and useful clinically, can make it difficult to accurately and reliably evaluate it. Holttum, Huet & Wright (2016) have suggested that their Delphi survey is the start of creating an agreed list of practice elements for art therapy with people diagnosed with psychotic disorders. This characterisation has yet to be drawn upon in controlled trials.

Considered together, the papers reviewed in this report use a varied range of designs, outcomes, effects and use both quantitative and qualitative methodologies. However, many of the studies have relatively small samples which makes it difficult to be confident about their findings and associated conclusions and implications. Four of the studies (Crawford et al., 2012; Leurent et al., 2014; Patterson, Crawford, et al., 2011; Patterson et al., 2013) have also arisen from the same trial (MATISSE) and therefore share many of the same limitations whilst also reporting on the same research data and intervention. Furthermore, only six of the studies reviewed were from the UK which may limit the applicability of the results to UK services, although similar reported findings across a range of countries and contexts may give credence to some suggested impacts.

Whilst most of the quantitative studies reviewed included some follow up of participants, most of the qualitative studies did not. Given that there is research suggesting that it can take some time for the benefits of therapy to fully manifest, it could be considered a limitation that those studies did not seek to follow up participants to explore whether and how the effects of art therapy are continuing and if new effects have arisen.

Finally, many of the papers included in this review were highlighted by the use of the criteria of Kmet, Lee and Cook (2004) as having poor methodological quality. These pieces of research were accounts focusing on single individuals or groups and detailing the course of

art therapy. Although case studies can offer important information, they have particular limitations. Specifically, for many, there was no information regarding sampling or why the individual cases were chosen. There was also no evidence or description of any systematic data collection or data analysis methods, or the use of verification procedures. Whilst some of the reports demonstrated reflexivity clinically, they did not do so with regards specifically to the research. This suggests that the findings from such papers should be used and interpreted with caution.

Discussion

Summary of Findings from Review

This review discussed and appraised the research exploring art therapy for adults with diagnoses of psychotic disorders. The search revealed 21 papers that met the inclusion criteria. The quality of the research papers included was variable with approximately half of the papers being judged as 'poor' (Kmet, Cook & Lee, 2004).

Quantitative research which has explored the efficacy of art therapy for psychosis has shown a mixed picture. Whilst the large scale MATISSE study (Crawford et al., 2012) found no evidence of significant effects of art therapy on a range of outcome measures, it suffered from low engagement and practice was unclear and possibly sub-optimal. However, the findings from other studies (e.g. Montag et al., 2014; Richardson et al., 2007) challenged those posited by Crawford et al (2012). Montag et al. (2014) reported results that art therapy had a beneficial effect on outcome measure scores of positive and negative symptoms and global functioning compared to a control group. Richardson et al. (2007) also reported some evidence that art therapy may improve negative symptoms. However, these studies also suffered from limitations such as small sample sizes, insufficient power, high attrition rates and a lack of an active control intervention. As such, the findings taken together do not

provide convincing, consistent evidence for the efficacy of art therapy on psychotic symptoms or functioning.

Papers reporting qualitative research and case studies provided often rich descriptions of the art therapy process, and changes reported and observed by the participants and by the art therapists. This body of research suggests that art therapy may have other effects, including: enabling expression and exploration of experiences, increasing confidence and self-esteem, enhancing sense of self, contributing to awareness and a sense of being grounded and development of skills. These papers showed varying levels of quality according to Kmet, Cook & Lee (2004) with some using systematic and clearly reported methods of analysis, whereas others were based solely on the therapist's observations and interpretations. Although this research highlights the range of potential positive and beneficial effects, they are largely subjective reports of single participants or small groups, and particularly may not be representative of the general population of individuals accessing art therapy for psychosis. The papers could be argued to offer evidence for what art therapy can offer to this group of individuals, rather than any information on how likely it is that an individual will experience these effects, or how these potential benefits compare to those from other interventions.

Limitations of the Review

This review focused on empirical research into art therapy for psychosis and schizophrenia. As such, it excluded papers that were purely theoretical or descriptive which may have resulted in possible outcomes, mechanisms and processes being neglected and overlooked. There is also a larger body of research which has investigated art therapy for personality disorder. Whilst there are differences between these mental health diagnoses as defined, the research in this area may have much to offer in the way of understanding what art therapy offers as an intervention for individuals in distress. Furthermore, given the

constraints of this review it was not possible to cover all of the described outcomes and examples of art therapy, and instead has offered an account of the most dominant and pertinent features. It is also likely that, whilst seeking to provide an objective overview of the research area, the narrative offered within this review is subject to the bias and subjectivity of the author.

Clinical Implications

The papers considered in this review do not provide a clear understanding of the usefulness or not of art therapy for individuals experiencing psychosis. Whilst some research, particularly qualitative studies and to some extent Montag et al.'s (2014) and Richardson et al.'s (2007) smaller scale RCTs found some support for the efficacy of art therapy, larger studies such as Crawford et al.'s (2012) found no evidence for effectiveness. Considered together, this body of research does not offer sufficient consistent and convincing evidence of art therapy's utility with this population. As such, this prevents robust conclusions from being drawn and makes it difficult to offer clinical recommendations for the use of art therapy with individuals with diagnoses of psychotic disorders.

However, the research suggests that there may be potential contributions offered by art therapy. In particular, there may be a potential therapeutic role for non-verbal expression of experiences, emotions and trauma. Using art-making or activity may also be useful for facilitating engagement and as part of a therapeutic intervention. Finally, there may be a role for interventions and therapy to enable and develop a different narrative or identity for the individual.

Whilst there is uncertainty regarding what art therapy can offer, the potential contributions discussed in this paper are relevant not only to the art therapy profession but also to clinical psychology. Clinical psychology is interested in understanding experiences of

distress and how best to support individuals. The findings of this review highlight the importance for those working with individuals experiencing distress, including clinical psychologists and art therapists, to consider the role of engagement, non-verbal expression, narratives and how an individual may experience different therapeutic modalities.

Research Recommendations

Given the relatively small body of literature on art therapy and psychosis and the criticisms of the reviewed studies, there are a number of research recommendations that can be made.

The samples that many of these studies have used have had a long duration of experiencing psychosis, with Crawford et al. (2012) reporting a mean duration of 17 years and Montag et al. (2014) citing a mean of between 12 and 15 years depending on condition. Research has suggested that the likelihood of recovery from psychosis decreases the longer the duration of symptoms. As such, interventions with this population may be unlikely to have a large significant effect compared to those who have suffered with psychosis for a much shorter period of time. Therefore, a useful recommendation for further research is for studies to explore the efficacy and experience of art therapy for first episode psychosis, or for those under the care of early intervention services.

Most of the studies reviewed centred on art therapy being delivered as a group intervention rather than individually. A further recommendation for future research is to compare these two modalities to investigate whether they have any different effects and how they are experienced by service users. Similarly, it may be useful to compare different types of art therapy, such as psychodynamically rooted art therapy and expressive or formative art therapy to gain a better understanding of the effects of different types of art therapy intervention.

Perhaps the most significant criticism of the MATISSE trial (Crawford et al., 2012) is the lack of attendance and engagement in art therapy for those allocated to it. Therefore, further large scale research is needed which compares individuals who have engaged in a reasonable number of art therapy sessions to an active control to more accurately explore effectiveness. An additional avenue for further research is the comparison of art therapy to other psychological interventions, such as CBT or psychotherapy.

As previously discussed, the papers included in this review were critiqued in terms of their quality and there have been a number of limitations which have been highlighted as a result of this. Therefore, a clear recommendation for further research is for additional studies, both quantitative and qualitative, of higher quality to be conducted, such that greater confidence can be had in their findings and conclusions.

Whilst further research in this area is necessary for the field of art therapy, it also has implications for clinical psychology. Gaining a better understanding of interventions and what is helpful for people experiencing psychosis is of high importance to clinical psychology, and may also improve understanding and theories of psychosis and other interventions and approaches commonly offered by clinical psychologists. Increasing this research and knowledge base may also suggest ways of adapting and tailoring psychological interventions to be most effective for individuals, in addition to helping to identify the 'active ingredients' which are helpful for people experiencing psychosis. Identifying what interventions are helpful, for whom, and at what time, is particularly relevant given the increasing need for interventions to be cost-effective and evidence-based given limited resources (The Kings Fund, 2015). Furthermore, given the notable and widely discussed findings from Crawford et al.'s (2012) MATISSE study, these research recommendations are important in order to gain a more robust and comprehensive understanding of art therapy for psychosis, on which decisions regarding the provision of art therapy can be made.

Conclusion

This review aimed to explore what art therapy offers as an intervention for adults with diagnoses of psychotic disorders. From the 21 papers reviewed, a mixed and inconsistent picture has emerged. Whilst some positive effects have been noted, there is a lack of robust and convincing evidence for art therapy's effectiveness. The review also highlighted that much of the research was of poor methodological quality and had a number of limitations leading to important recommendations for further research.

Despite its long history of work with people with severe mental health conditions, art therapy as a profession could be argued to have struggled to evaluate and evidence its utility, much as psychodynamic therapy until recently, and as such its position in the current mental health system may be in jeopardy. If some service users can benefit from it, this would be a loss to them as well as the profession itself. A key recommendation for both clinicians and researchers alike is to continue to develop innovative and acceptable ways of defining, measuring and evaluating art therapy practice.

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Section B: Empirical paper

The experience of art therapy for individuals following a first diagnosis of a psychotic disorder: A grounded theory study.

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Research on art therapy and psychosis has typically focused on individuals who have experienced psychotic symptoms for many years. This study used a grounded theory methodology to explore how service users experience art therapy following their first diagnosis of a psychotic disorder, and the possible mechanisms through which art therapy might be helpful for such individuals. Eight participants were interviewed, with two participants being interviewed twice. A preliminary theory was created and seven categories were constructed from the data, namely unpressured atmosphere, pleasure and engagement in art-making, expression and communication, connecting with others, changing emotional experience and experience of self, supporting recovery and continuation of art and barriers. Participants reported that through the atmosphere of art therapy, art-making, and communication, they were able to build relationships, connect with others, experience a sense of commonality, absorption, sense of freedom and discover alternative perspectives and different understandings. Whilst this study suffered from some limitations, the results build on the current research base by suggesting possible processes and mechanisms through which art therapy is helpful, and focusing on a previously under-represented population. The findings are considered alongside existing research and theoretical perspectives. Clinical implications and recommendations for future research are also highlighted.

Keywords: Art therapy, art psychotherapy, psychosis, schizophrenia, early intervention

Introduction

Psychosis

There are different ways of conceptualising what can be called ‘psychosis’ or ‘psychotic symptoms’ (British Psychological Society, 2014) (BPS), which includes experiences such as hearing voices and having unusual beliefs. Whether adopting a perspective in line with a medical model or using an alternative way of understanding these experiences, many individuals experience distress and seek support from mental health services (Kelleher et al., 2015).

Early Intervention Services

Government policy has stressed the importance of timely access to mental health services and in particular early intervention for psychosis services (Department of Health, 2011). Early intervention services are intended to have smaller caseloads than community mental health teams, such that professionals can work more intensively with service users, with a particular emphasis on holistic recovery (French, Smith, Shiers, Reed & Rayne, 2010). Research has suggested that a long duration of ‘untreated psychosis’ is associated with poorer social, occupational and economic outcomes, higher rates of hospital admission and detentions under the Mental Health Act, and reduced personal recovery (Marshall et al., 2005; NHS England, 2016).

Bird et al. (2010) reported that individuals receiving care from early intervention services have fewer hospital admissions, lower relapse rates, less severe symptoms and improved access and engagement with treatment. As a consequence, it has been argued that early intervention services are cost-effective and result in significant cost savings long term (Singh, 2010; McCrone, Craig, Power & Garety, 2010). Unsurprisingly, recent government

policies have advocated for the continuation of these services (Department of Health, 2011; NHS England, 2016).

The latest revision of the National Institute for Health and Care Excellence (NICE) guidance for psychosis and schizophrenia (NICE, 2014) made an amendment stating that early intervention services should be available for first episode and first presentation psychosis regardless of an individual's age or the duration of untreated psychosis. The guidance states that early intervention services should "aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis" (NICE, 2014, p.17). Within this guidance, NICE (2014) recommend the use of antipsychotic medication and psychological therapy, namely cognitive behavioural therapy (CBT) and family interventions. The guideline also states that arts therapies should be offered.

Art Therapy for Psychosis

Whilst the NICE guidance (2014) recommends that art therapy should be considered, there is ambiguity regarding evidence of its efficacy. A recent large scale randomised controlled trial (RCT) (Crawford et al., 2012) compared art therapy to activity groups and to a control group. The study concluded that art therapy produced no significant improvements on mental health symptoms or functioning compared to attending an activity group. This study, however, has been criticised for very low engagement in the intervention conditions. As such, it could be argued that participants did not receive a sufficient amount of art therapy, and the results may not accurately reflect the possible impact or effects of art therapy.

Other studies, such as Montag et al. (2014) and Richardson, Jones, Evans, Stevens and Rowe (2007), have reported some positive effects of art therapy compared to a control group, including improvements on measures of positive and negative symptoms and global

functioning. Qualitative research has also suggested that art therapy may be useful to individuals experiencing psychosis by increasing self-esteem, enabling expression, communication and processing of experiences, developing skills and impacting on individuals' sense of self (Hanevik, Hestat, Lien, Telgjaerg & Danbolt, 2013; Patterson, Borschmann & Waller, 2013; Potocky, 1993; Teglbjaerg, 2011).

However, much of the research which has explored art therapy for psychosis has involved participants who have experienced symptoms for many years or who are referred to as having 'chronic' diagnoses. Participants in Crawford et al.'s (2012) study had a mean duration of illness of 17 years, which brings into question whether the effectiveness and potential benefits which can be gained from an intervention differ depending on when an individual accesses the intervention. The focus on timely access to psychological support for individuals and improved outcomes for those who receive help early suggest that the effectiveness of interventions (including art therapy) may differ depending on how long an individual has been experiencing psychotic symptoms. Holttum and Huet (2014) also questioned whether the Crawford et al. (2012) trial was based on a clear model of change.

Relevant Theoretical Perspectives

The art therapy tradition has been historically largely influenced by psychodynamic and psychoanalytic thinking, including Jungian analytic theory (Hogan, 2015). From this theoretical perspective, art-making and in particular pictorial symbolism, is suggested to emerge from the unconscious. Through the process of art-making, individuals are thought to be able to bring previously unaware aspects of themselves into focus. This process of bringing previously unconscious material further into consciousness is considered intrinsically beneficial and therapeutic (Hogan, 2015).

Another theoretical perspective which has more recently been considered in relation to art therapy is the theory of mentalisation, particularly for individuals with diagnoses of personality disorder. Bateman and Fonagy (2006) state that mentalising concerns "a focus on mental states in oneself and in others, particularly in explanations of behaviour" (p. 1). Springham, Findlay, Woods and Harris (2012) have suggested that art therapy increases mentalisation by "allowing a slow, manageable pace to the organization of thoughts and feelings through art-making and a stepwise process of converting these into words" (p.11). There is also research suggesting that mentalising difficulties are present in those experiencing psychotic symptoms (Versmissena et al, 2008), and as such this may be a relevant theoretical perspective.

Yalom's (2005) work also provides a useful and relevant insight into the understanding of art therapy which is often delivered in groups. Yalom (2005) argued that interactions between group members in psychotherapy provide the catalyst for change and suggested 11 therapeutic factors which influence this, including universality, group cohesiveness, instillation of hope and catharsis. These factors may be relevant and reflective of some of what happens within group art therapy (Waller, 1993), but this has not been documented empirically.

Rationale for study

Whilst a number of relevant theoretical perspectives and recent research relating to art therapy have been discussed, overall there is a lack of theory and research on the specific mechanisms and processes of art therapy for psychosis. In particular, what happens in art therapy for those individuals who have recently begun experiencing psychosis or entered services has not been given much consideration.

Researching and evaluating art therapy as an intervention for people with psychosis is also of importance to clinical psychology for many reasons. Firstly, clinical psychology is concerned with how best to support individuals in distress, and as such, which interventions are most effective and for whom. Furthermore, research in this area will also add to and enhance the current theoretical and empirical understanding of psychosis, and will develop psychological knowledge about how interventions work and which specific components in interventions help to bring about positive changes.

Research Aims

This study aims to focus on the following research questions:

- How is art therapy experienced by service users?
- For those who describe art therapy being helpful, what appears to be the process of change and how can art therapy be helpful?

Regarding these research questions, this study aimed to explore and create a preliminary theory regarding the service user experience of art therapy following a first diagnosis of a psychotic disorder.

Method

Design

This study used grounded theory to explore experiences of art therapy as there was limited theory regarding how art therapy might be helpful for individuals and the processes and mechanisms involved (Urquhart, 2013). This methodology was chosen so that, in addition to identifying concepts and categories within the data, relationships between concepts could also be considered, in order to develop hypotheses about therapeutic processes as perceived by participants.

This study adopted a social constructionist epistemological stance which takes the perspective that both participants and the researcher co-construct the data and the interpretations of the data. This approach is congruent with grounded theory methodology as discussed and advocated by Charmaz (2006).

Participants

The project initially aimed to identify participants who engaged with art therapy following a first episode of psychosis in order to explore the experiences of individuals who had had art therapy following a shorter period of experiencing psychosis and contact with services, compared to much of the published research. However, through discussions with art therapists this proved very difficult to identify due to the problems with defining a 'first episode' and the changes to early intervention services being available to individuals with a 'first presentation' of psychosis. As such, it was decided that the inclusion criteria would be eligibility for an early intervention service and would focus on art therapy following a first diagnosis of a psychotic disorder. Eight participants took part in the study, with two participants (Jacob and Charlie) being interviewed twice. Demographic information for the participants is shown in Table 1.

Table 1.

Participant characteristics.

Pseudonym[1]	**Gender**	**Age**	**Ethnicity**	**Eligibility for EIS**[2]	**Type of art therapy**
Liam	Male	24	White British	Eligible	Group & individual[3]
Jacob	Male	24	White British	Eligible	Group
Isobel	Female	27	White British	Eligible	Group & individual

Charlie	Male	24	White British	Eligible	Group
Max	Male	30	Mixed White	Eligible	Group & individual[3]
Stephanie	Female	52	White European	Eligible	Group
Phillip	Male	46	White European	Not eligible	Group & individual
Laura	Female	51	White British	Not eligible	Group

[1] names have been changed

[2] at time of art therapy

[3] individual art therapy as at times no other service users attended group art therapy

Participants were recruited through art therapists working in NHS mental health trusts. Three NHS trusts were initially involved in this study, however despite expectations from the trusts that the projected sample size would be achievable, significant difficulties with recruitment were experienced. This was due to a number of factors including key staff leaving, recent introduction of CBT targets for this client group and lower numbers accessing art therapy than expected. Therefore a fourth NHS trust became involved.

Participants were initially eligible for the study if they had had or were currently having art therapy whilst under the care of, or eligible for, an early intervention for psychosis service. Inclusion criteria also included participants having sufficient use of English, not experiencing current significant risk issues and having capacity to consent to take part in the study. Participants were reimbursed travel expenses up to a maximum value of £10 if attending a face-to-face interview; however no other incentive was provided.

A key component of grounded theory is theoretical sampling, which was used in this study. Theoretical sampling refers to making decisions on where to sample from next based on analytical grounds (Urquhart, 2013) in order to develop the theory based on emerging concepts. As such, two participants (Jacob and Charlie) were interviewed a second time to

elaborate on emerging hypotheses on the continuation of art and to explore the relationships and theoretical links between concepts. Two further participants (Phillip and Laura) who had art therapy later (whilst not eligible for early intervention services) were interviewed to explore similarities and differences in experiences, and to consider whether there were things which got in the way of them accessing art therapy earlier and their views on whether this would have been helpful.

Procedure

Participants were approached about the study by an art therapist with whom they were familiar. They were given the participant information sheet (see appendix B) and asked if they would be willing to be contacted by the researcher. Participants were then contacted by the researcher to discuss the study in more detail, to answer any questions the participant had and to arrange an interview if the participant agreed to take part. Interviews took place either face-to-face or over the phone and were audio-recorded.

A semi-structured interview schedule was used to explore service users' experience of art therapy and how art therapy may have impacted on them. The interview schedule was developed in discussion with supervisors. Attention was given to formulating open and non-leading questions whilst covering the relevant material. Probes and follow up questions were also devised, and it was identified that it was important for the researcher to stay flexible, open and attentive to all possible meanings and experiences as expressed by participants (Warren, 2001). The interview schedule was adapted as the research progressed, in line with grounded theory methodology (Charmaz, 2008). The duration of the interviews was between 20 and 51 minutes.

Data Analysis

The audio recordings of the interviews were transcribed. Transcripts were initially coded using open coding, such that the researcher could stay open to new and emerging codes throughout the transcripts. Focused coding was then used to create conceptual categories and subcategories (Charmaz, 2008). Relationships between the categories were generated through theoretical coding. Memos (see appendix H for examples) were written throughout the data collection and analysis in order for reflections to be captured and theoretical and conceptual insights to be recorded (Charmaz, 2008). These memos were fundamental and intrinsic to the analysis, informing coding decisions. The transcribing of the interviews and analysis of the data occurred concurrently with conducting the interviews. Whilst the different stages of analysis have been described, it is important to acknowledge that grounded theory is an iterative and reflexive process, rather than a linear one. Due to the scale of this study, the concept of 'theoretical sufficiency' was used as opposed to 'theoretical saturation' (Dey, 1999). This refers to the point at which the preliminary theory is considered to have good explanatory power, rather than it be an exhaustive process whereby no new codes are emerging.

Quality assurance

In line with quality criteria for qualitative research set out by Yardley (2000) and Mays and Pope (2000), several measures were taken as part of the quality assurance process. A research diary (see appendix I for abridged version) was kept from the beginning of the project in order to capture the researcher's insights and reflections, document the course of the research and also as a way of illuminating and exploring potential biases and presumptions. In particular, prior to conducting the interviews, it was noted that the researcher felt a desire to advocate for art therapy and identified a potential bias towards positive experiences of art therapy. As such, the importance of paying attention to negative, difficult and different experiences of art therapy was noted.

Respondent validation interviews were also conducted with two participants, in which the preliminary concepts, categories and model were shared with the participants and feedback was obtained. Participants expressed agreement with the model and categories, commenting on particular elements which felt pertinent to them, e.g. feeling free. One participant stated, “I feel I have been heard by you”. In addition, one transcript was coded independently by the researcher and their supervisor, and the codes were then compared and discussed. A high consistency was found with focused codes and subcategories.

Whilst some research has advocated that face-to-face interviews yield richer data (Novick, 2008), other research has argued that interviews conducted over telephone have certain advantages, such as increased practicality, perceived anonymity, can be experienced as less intrusive and may mitigate power dynamics (Drabble, Trocki, Salcedo, Walker & Korcha, 2016; Vogl, 2013). Care was taken during telephone interviews to pay attention to tone of voice and hesitation in the absence of visual cues, and to demonstrate active listening and encouragement. Observations from the interviews are captured in the research diary and differences between interviews were not perceived to be the result of the mode of interviewing.

Ethical considerations

This research was given favourable opinion by the NHS Research Ethics Committee (see appendix D) and approved by each of the participating NHS trusts. Conduct and ethical practice throughout the research was in accordance with the BPS’s ethical code for research (BPS, 2010).

It was identified that participants may find it distressing to discuss their experiences of art therapy, or that the interview may evoke difficult memories. This was addressed by the researcher being sensitive and responsive when interviewing participants and offering breaks

if necessary. If a participant would have become distressed, the researcher would have stopped the interview and ensured they had appropriate support and contact details. If there had been any concerns regarding risk to self or others, participants were aware that confidentiality would have been broken and the art therapist who recruited the participant would have been contacted. The same measures were in place for interviews conducted over the phone, and further discussion was had at the end of the interview regarding how the participant found the interview and to ensure that they did not require support.

However, it was also considered that some participants may find it useful or enjoyable to share their experiences. The importance of gaining the perspectives of service users, as in this study, was also in line with the NHS values, in particular, 'working together for patients', 'respect and dignity' and 'commitment to quality of care' (Department of Health, 2015).

Results

This research sought to explore service users' experience of art therapy and create a preliminary theory or model for how art therapy can be helpful for individuals following a first diagnosis of a psychotic disorder. The grounded theory analysis resulted in seven categories and 19 subcategories (see Table 2). The overall model constructed is shown in Figure 1. Each category will be discussed alongside verbatim quotes from the interviews.

Table 2.

Categories and subcategories.

Category	**Subcategory**
Unpressured atmosphere	Accepting environment
	Relaxed environment
Pleasure and engagement in art-making	Enjoyment of art-making

	Experimentation and exploration
Expression and communication	Expression
	Communication
Connecting with others	Commonality
	Discovering other perspectives
Changing emotional experience and experience of self	Feeling free
	Absorption
	Enabling reflection on experiences
	Viewing self differently
Supporting recovery and continuation of art	Life vest
	Supporting recovery
	Ongoing art activity
Barriers	Impact of mental health
	Not the right fit
	Anxiety
	Access and availability

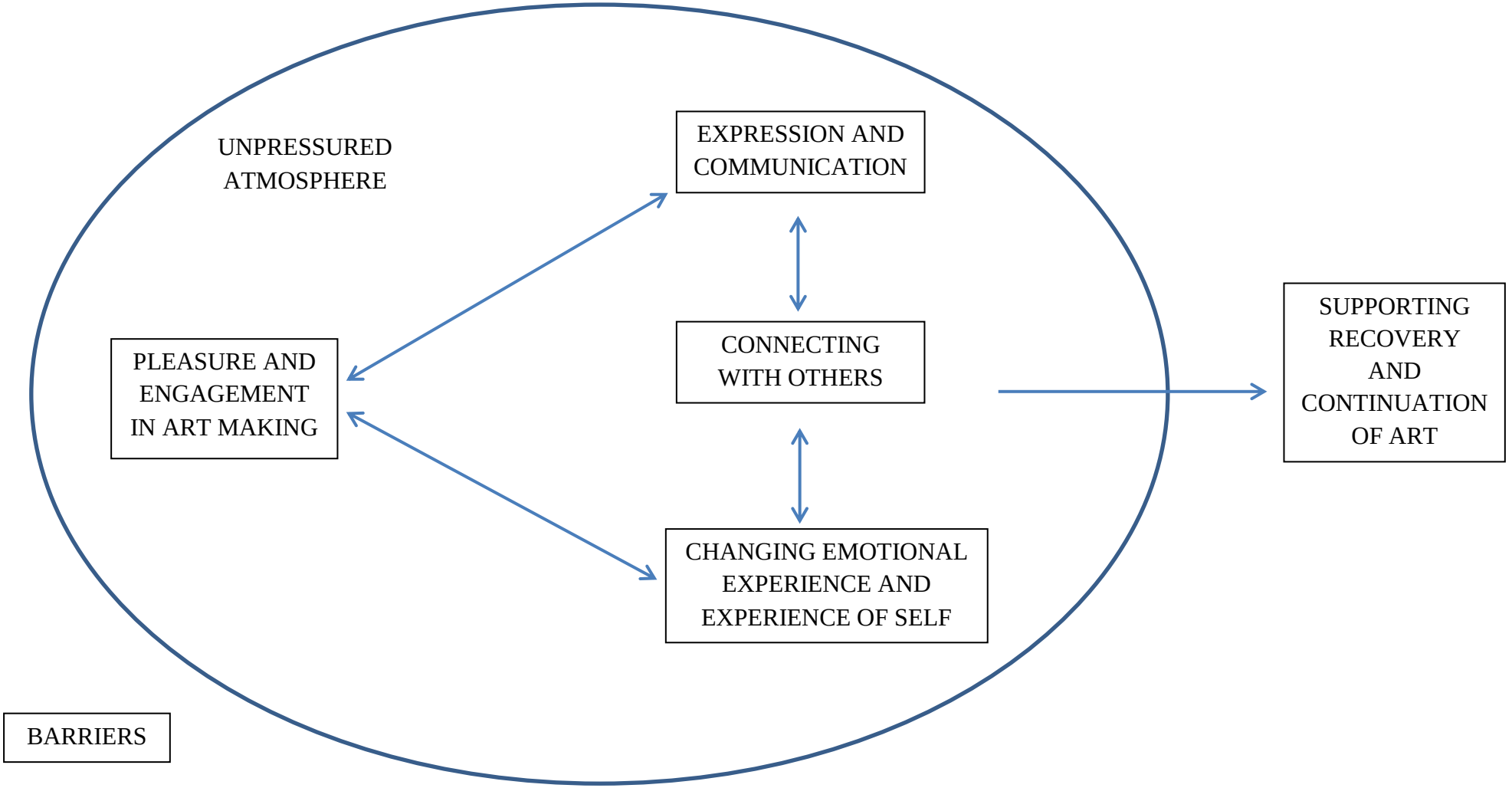

Figure 1. Preliminary model of service user experience of art therapy

Unpressured Atmosphere

A key category from participants' accounts was the unique atmosphere of art therapy which participants described experiencing. This atmosphere was typically described as being different to other environments e.g. other therapies, groups or activities; and discussed very positively. This is highlighted by Stephanie, who commented:

> Well I will do anything in my power to make these art therapists and drama therapists, music therapists work because just think of it if you are locked up. I mean you don't see the sky, you don't feel the wind, you don't feel the grass and then there is some, a place where you can just be yourself, without being judged.

Jacob also reported, "I mean for me I think it was probably unique. I can't really think of any other places that were like that."

In particular, art therapy was commonly spoken about as being an unpressured environment, in which there were no fixed goals or expectations. Jacob explained, "art therapy is just do what you want to do and what you feel like doing which is nice, just to get rid of social structure thing". This contrasted with how some participants spoke about talking therapies and feeling under pressure in these sessions to talk. Charlie commented, "we kind of had enough space to do our own thing, and it didn't feel that there was so much pressure because the group was small." Liam also spoke about this, noting "I think some of the times it was good because it meant there wasn't much pressure to talk about stuff if you didn't want to".

Accepting environment. Participants often highlighted the accepting, non-judgmental and inclusive feel of art therapy. For example, Jacob stated, "they were all like really accepting and it was quite nice, so my first session was just really nice". Stephanie also

commented, “even ideas I had that were manic…it was just a thing that was silly but they never um, never laughed about it, they were always quite um, inquisitive and that was all going on whilst I was drawing.”

Relaxed environment. Participants described the art therapy atmosphere as being relaxed, and feeling a sense of calm. Jacob described that “it was pretty calm which was nice….it was pretty relaxed” and Charlie reported that “it felt laid back…a peaceful environment”. Liam also commented, “art therapy was far more relaxed I’d say…compared to what I’ve heard about other therapies it’s far more informal”.

Pleasure and Engagement in Art-Making

Participants, unsurprisingly, discussed the art-making as an integral component and core feature of art therapy.

Enjoyment of art-making. In particular, participants frequently commented on their enjoyment of the art-making as an activity in itself. For example, Liam described, “I suppose a lot of it is I just enjoy drawing…I think largely it was just a pleasant activity”; and Stephanie commented, “I was happy uh painting, yeah I was happy painting there.” Jacob also noted, “I liked the art…it was nice trying to make certain pieces.” Charlie further explained, “just really doing it [art making] for the kind of joy, whereas when you are talking with people there is usually a question involved, but with art there’s not really a question, it’s more of a, just a, interpretation of something.”

Experimentation and exploration. Another theme which was evident was of art-making involving experimentation and exploration, creatively in terms of using different materials and exploring different ways of making art, and was described as interesting,

engaging and stimulating. For instance, Jacob commented, “It was really interesting to try and figure out how to do things and experimenting”. Max also highlighted this by explaining,

> the nice bit of actually just being able to go into the room…with all these lovely materials and just explore creatively…so by doing the art therapy, it has introduced me to loads of materials and techniques and it has also, in a, it has freed me up to go “I’m going to try something” rather than go “this is what I do, this is all I do.”

Expression and Communication

For many participants, art therapy enabled and supported them to be able to express their feelings and experiences, and communicate with the art therapist and group members.

Expression. It seemed that some participants were able to express themselves directly through their art-making. Jacob exemplified this by reporting, “I can remember a piece I did where I was just like throwing paint um from a couple of metres to the paper and that was quite expressive of what I felt at the time.” Stephanie also commented, “I had delusions and I had hallucinations…it takes a lot of energy out of you and then you know, it is impossible to write but you can go and make big movements on paper and express yourself like that.”

For some, this was experienced as “a release” and there was a cathartic quality to participants’ descriptions of “getting it out” and expressing oneself. Charlie, for example, said, “it is good to just get anything out; and I do feel that there is some kind of release from that, when you manage to put pen to paper.” It was also commented by some participants that art-making and art therapy enabled them to express themselves in a way which was not possible or they had found more difficult in talking therapies.

Communication. Participants also discussed that art-making facilitated communication between themselves, the therapist and others (if in group art therapy).

Specifically, the art-work and art-making acted almost as a buffer, such that participants could move between verbal communication and art-making in a way which served to manage anxiety and gave them control and autonomy over communicating. As such, talking seemed to feel more comfortable and less anxiety-provoking. This seemed connected to the experience of the atmosphere of art therapy being unpressured. This is highlighted by Jacob and Max:

> It's [art-making] just an extra thing so you're not always in therapy, you're not always talking and you don't always have to talk. You have something else that can take away from that instead if you're not feeling like it which is kind of like comforting and makes you talk more. (Jacob).

> We'd be talking while we were creating, which was, there was no eye contact or anything because we were all so busy but that freed up the space to be able to talk about things while you are actually doing it. (Max)

Connecting with others

The data from the interviews suggested that another important aspect of art therapy, and in particular group art therapy, is encouraging being with and relating to others, which went beyond simply communicating. For instance, participants spoke of the value of sharing experiences and connecting with others. Jacob explained, "things you wouldn't like tell anyone, well other people, but everyone was fine sharing it there", and Max stated "art therapy has also helped me to connect with people, which is quite good." Isobel also highlighted this by commenting, "I suppose with group therapy is what's important is the speaking afterwards because you, you learn a lot from other people and you bring your own story to a table of many stories." Participants also talked about building relationships with other group members and of developing friendships, some of which continued after the

therapy ended. Max, for instance stated, “with groups it was quite nice building up um, um a relationship with a couple of the other members of the group”; and Jacob noted, “I’ve got friends from it who I still see”.

Commonality. Several participants reported that being with, connecting and sharing with others contributed to experiencing a sense of commonality with others. This is exemplified by Max, who noticed, “thinking ok it’s not only me, it’s, there’s other people who are experiencing like negative things as well”, and Jacob who reported “It was nice having other people with the same sort of illnesses as me”.

Discovering other perspectives. Discovering other perspectives was also a theme which was evident in the data. Participants spoke of the interest, curiosity and value of hearing different views and opinions from other group members and therapists.

> It was interesting to see people’s feedback on the art that was produced I think, uh they often saw things in the art which I didn’t see myself and that was quite appealing, I don’t know, not appealing, but it was nice to see something else which you hadn’t noticed yourself…you can kind of see it from a different perspective when you hear what they have to say about it. Like stuff that you may not have noticed at first, like gets brought up or drawn out from the picture.” (Charlie)

Jacob also commented, “it was just interesting to see how people interpret what you had done…it would definitely make you think about what you had done differently”.

Changing Emotional Experience and Experience of Self

Several different and salient intrapersonal changes and processes seemed evident within the data collected.

Feeling free. There was a theme from the interviews that some participants experienced a feeling of freedom. This appeared to be partly related to the stance and approach of the art therapists, not imposing activities or directing the sessions heavily; and also related to the unpressured atmosphere. Stephanie, for example, commented that "nobody ever accorded [sic] me or said 'hey what are you doing now?'. Um, I think it was to be able to be free." This was supported by Jacob who stated that "it felt pretty good. It was quite freeing"; and Max who described "it was just being able to you know, you don't always have to be in adult professional mode…and it's just thinking about yourself rather than um trying to do something that everyone else likes. So that was quite good, quite liberating".

Absorption. Participants noted that creating art was a typically occupying, and engaging activity. As Jacob noted, "it sort of just takes your mind off everything which you need sometimes." Liam reiterated this by explaining, "I often didn't notice the other people there when I was drawing….I'd just get on with it and forget everyone….I think it's probably good really, quite a lot of absorption". Max commented,

> It helps you focus on, and not worry about other people, not worry about other people's body language and like facial movements and things so it sort of takes away the feeling that you might be getting judged or tested or things like that.

Many participants acknowledged that the absorption in something had a calming effect and could serve as a distraction. Isobel explained, "I definitely know that it helped in the moment just to have that time to focus on something different"; and Jacob commented "doing that sort of relaxed me a lot…you can zone out and you can get into it, it's really nice…that's really good for the mental health side".

Some participants identified that art therapy and art-making was not only a distraction from their current experiences but also an escape, as described by Stephanie: "And I just

could not stop doing art or claying, or whatever. I just wanted to occupy myself really, to be an escape from um, from um the horrible illness I had."

Enabling reflection on experiences. Art therapy also appeared to encourage participants to explore their understanding of, and reflect on, their experiences and for some for this to change.

> I think it brings to life, for me it's, it makes the abstract nature of thoughts a bit more apparent…I often just put pen to paper and see what comes out and I think the mind often does that with thoughts. It just randomly puts thoughts together into some combinations to see what comes out and I think that can be distressing sometimes when the mind conjures up some weird story or whatever, but I think it's just playing with its artistic abilities. (Charlie)

> Even though it's not like at the time, it's not very fun but to sit back and reflect on it [experience of psychosis], going it was fun in a personal exploration and it's made my life so much more interesting. I can sit and reflect and think. (Max)

Viewing self differently. This subcategory encompasses participants' experiences of viewing themselves differently through the process of art therapy. Most prominent from the data, was the sense that through art therapy, some participants saw themselves as individuals with skills, abilities and something to offer, rather than solely as people with mental health problems. Stephanie notes, "the point is I always felt so useless having a psychosis, not so last time because I was involved into art…I had something to show people." For a few, such as Max, art therapy encouraged an identity of an artist to develop - "so yeah, it's definitely helped me develop myself as, as an artist".

Supporting Recovery and Continuation of Art

For some participants the benefits of art therapy seemed to be largely in-the-moment, however others described longer term impacts, such as improving mental health, contributing to recovery and also leading to continued interest and engagement in art.

Life vest. Participants spoke of valuing art therapy and for many of having more than one 'course' or period of engaging with it. For some, it appeared to serve as a useful coping strategy at further difficult times. For example, Max commented:

> So it's given me a um, like a life vest where I know if it is getting really bad just go and do a bit of art therapy, explore it and do that so, it's just that, it's given that understanding of what works for me and what doesn't.

Liam also explained that, "when I was having another psychotic episode I found it [art therapy] was one of the things which calmed me down a lot."

Supporting recovery. As well as affecting how individuals feel and relate in the moment, some participants described that art therapy supported them in their recovery and in improving their mental health and wellbeing. For example, Jacob said, "I guess art therapy sort of got me out of a bad place", and Max described, "it did make a really big impact on how I develop myself and my thought patterns."

Ongoing art activity. It also seemed that accessing and engaging in art therapy contributed to an increased appreciation and interest in art, such that for some they continued to pursue other creative activities or art-making following finishing art therapy. Charlie explained that "recently I've just started another workshop, an art workshop." Whilst Jacob noted that "I appreciate art a bit more and I want to do it still, like I want to carry on doing it".

Barriers

Whilst the majority of participants reported experiences of art therapy were positive, the data suggested that there are also a number of barriers to art therapy and to experiencing positive change.

Impact of mental health. One of the themes which was discussed was the impact of participants' mental health on their ability to engage with art therapy. Phillip, for example, did not have art therapy when he was first unwell, saying "I was too frightened, too ill at the time… at that time I just couldn't, I was too freaked out and unwell by things". Laura commented about art therapy and explained:

> I think it can be a very interesting experience when you are in psychosis but I do think ideally you need to be at the end of, so you need to be hospitalised, you need to be in a state where the medication is really beginning to take effect, when um, because obviously the psychosis lasts a while.

Having art therapy at the right time for the participant seemed important and linked to how helpful it was experienced to be. This is further explained by Laura:

> I was offered art therapy at a better stage and moment in my recovery… when I was initially doing art therapy it was later on in the process, so I was much more back to being myself. And so I wasn't quite so delusional at that stage, and I was understanding one – that I was unwell and two – that this could help, and then I was open to seeing how it could help and then three – was no longer being so unwell.

Not the right 'fit'. Participants' accounts of art therapy highlighted variety and variability in many aspects of the intervention. For instance, group versus individual art therapy, the level of direction and approach of the art therapist, when participants had art therapy and the timing of the intervention. It seemed that if one of these was not the right 'fit'

for the individual then this could contribute to disengagement from art therapy or the feeling that it is not right for them. For example, Isobel commented that "I think the one-on-one sessions I found really intense and from where I was it was just very hard to engage and not sort of over-analyse."

It was acknowledged that this is a very difficult task for the art therapist, and that particularly in group art therapy there will need to be some compromising. Isobel explained this difficulty in the following:

> But that needs a lot of enthusiasm from the therapist really, to like engage you in to doing it and get you going sort of thing. It needs to be like quite a lot of energy involved in it. But then this is what I think 'cos someone else might need more of a like calmer approach and it would help to be a lot more peaceful and like make things in a slow way so it's tricky because it's completely personalised.

Anxiety. Anxiety about art therapy, both individual and group, was also a theme which was discussed in the interviews. Jacob explained this by saying:

> I felt quite anxious at the start because I didn't know what it was going to be like, and it was quite daunting, meeting a load of new people and they all knew each other because they'd been there before and so I was like the new person.

For some, such as Jacob, this dissipated after the initial few sessions or participants were able to manage and overcome it.

Access and availability. Some participants highlighted that it was difficult to access art therapy, or that the location or timing of the sessions were problematic.

> The sessions I go to now are, are in the hospital and that has a lot of um, well at first had a lot of negative…feelings about that. I've managed to sort of get through that but

> I think it would be easy for people to get put off by that, you know to have to go back through the hospital doors. (Phillip)

Model Summary

Figure 1 shows the model constructed with the categories. The relationship between art-making, expression and communication, connecting with others and changing emotional experience and experience of self are presented as taking place within the unique atmosphere of art therapy. This atmosphere was perceived as facilitating, encouraging and informing the context in which the processes occur. However, the atmosphere is also suggested to be created and affected by what happens in the art therapy. As discussed in the expression and communication subcategory, art-making helped enable participants to express themselves, communicate and connect with others and also for changes to their emotional experience and their experience of self to occur. For some participants, they described the usefulness and benefit of art therapy to be "in the moment", however for others there were ongoing effects resulting from their experience of art therapy. Whilst most of the model focuses on positive experiences and mechanisms for positive change, it is important to note that there are barriers and difficulties to engaging beneficially with art therapy which should not go unrecognised.

Discussion

Summary of Findings

This study offers a preliminary model of how service users experience and report being affected by art therapy following a first diagnosis of a psychotic disorder. This study suggests that for some individuals art therapy can contribute to or facilitate positive change, and that for some it offers an experience that is different to that had in other therapies and interventions. The findings also offer suggestions and hypotheses regarding what the

particularly helpful or 'active ingredients' of art therapy are. For example, the lack of pressure and freedom participants described in art therapy appeared important for continued participation and therapeutic engagement. Art-making as an occupying activity and a means of non-verbal expression, and the opening up of a plurality of perspectives could also be suggested to be key components of art therapy which contributed to therapeutic change.

The findings could be seen to counter Crawford et al.'s (2012) results which suggested that art therapy did not lead to any significant improvements in mental health symptoms or functioning, and to support those of Montag et el. (2014) and Richardson et al. (2007). This study, however, also indicates that some of the benefits or changes resulting from art therapy may not easily be captured by outcome measures focusing largely on symptom reduction, as are commonly used within quantitative research.

This study found that participants reported relating to themselves and others differently through art therapy, and art-making enabling expression and reflection on experiences. These results are in line with other qualitative research (Hanevik et al., 2013; Patterson et al., 2013; Potocky, 1993; Teglbjaerg, 2011) which has discussed a range of positive outcomes of art therapy. However, the results from this study build on this previous research by exploring the relationship between the different concepts and categories, and investigating the processes which occur in art therapy. This is a notable strength of this piece of research, and whilst offering only a preliminary model of service user experience and change, it is arguably a useful contribution to the research base.

The findings from this study also offer some support to the contention that art therapy can help increase mentalisation (Springham et al., 2012). In particular, the results suggest that for some participants art-making allowed and encouraged them to see and explore the

perspectives and views of others, and to acknowledge that multiple perspectives and interpretations exist amongst people.

However, the results did not offer particular support to Jungian analytic theory. Participants did comment on expressing their feelings and experiences through art-making, and of this process encouraging discovering of alternative perspectives and changing their understanding. However, they did not discuss being made aware of things which they previously were not and there was not particularly a sense from the data of unconscious material being brought more into consciousness. Whilst it could be argued that this study does not lend support for this theoretical perspective, neither does it offer evidence disproving it. It may be that participants did not discuss this as they were not aware of it, and it may be that the art therapists delivering the therapy would have different interpretations of whether this is a relevant and accurate way of explaining what happens in art therapy.

Support was also found for several of Yalom's (2005) group therapeutic factors and the role that these may have in facilitating change for individuals. The subcategory of commonality particularly relates to Yalom's (2005) therapeutic factor universality, which refers to the recognition that individuals are not alone in their difficulties and experiences. Another of Yalom's (2005) therapeutic factors – group cohesiveness, is argued to promote a group member's sense of belonging, acceptance and validation. This could be seen to have parallels with the category of atmosphere and the importance that participants placed on this being accepting and non-judgmental, and fostering an environment in which positive changes can occur.

A strength of this study was its focus on individuals most of whom engaged with art therapy following their first diagnosis of a psychotic disorder and in relatively short contact with services. As much of the research in this area has focused on individuals who have

experienced psychotic symptoms for many years, this study provides valuable insight into the experiences of people who have previously been particularly under-represented. However, interestingly, the study suffered significant difficulties with recruitment, which was unexpected by the heads of art therapies and those involved. This observation throws into question how widely this group of individuals are offered and engage with art therapy, and what underlies this.

Limitations

This study has offered useful insights, however it has also several notable limitations that need to be considered. Firstly, whilst the views and experiences of service users were the focus of this research and some were consulted in the analysis, they were not involved in the design. This input could have provided a valuable contribution to the shaping of the project.

Grounded theory research is not governed by the need for determined and specified sample sizes, however it is important to note the relatively small sample size in this study. Whilst theoretical sufficiency was achieved, it is possible that data from additional participants would have offered alternative experiences which would have changed the model presented in this paper.

Another notable limitation of the research was the reliance on art therapists to recruit participants which may have biased the sample taking part, such that those with more positive experiences were approached and encouraged to participate. In this study, it was considered necessary and more feasible to go through art therapists to recruit, partly as an ethical issue so that individuals were initially approached by someone they knew. However, it is acknowledged that alternative methods of recruitment may have yielded a potentially less biased sample that may have had experiences which were more heterogeneous. This particular criticism is one that is pertinent for much of the qualitative research in this field.

It is also necessary to note that whilst this study has attempted to focus on individuals who had shorter period of psychotic experiences and contact with services, this was difficult to define stringently. As psychotic symptoms can be considered on a continuum it is often difficult or impossible for service users and professionals to identify when they began. As such, being under or eligible for early intervention services was used, however it is acknowledged that there may have been differences in how long participants may have had certain experiences before engaging with art therapy.

It was also hoped that some participants at least would have been able and willing to bring a piece of their artwork to discuss in the interview. Unfortunately, nearly all participants reported that they had not or were not able to keep their work following art therapy. As such, this prevented some potentially rich discussions regarding the art work and the meaning or significance this may have had for participants.

Finally, several measures were put in place for quality assurance, such as the use of a research diary, memos, respondent validation and coding comparison, however the inherent subjectivity of the results should be born in mind. Specifically, it is important to acknowledge the potential bias by the researcher and their supervisors towards highlighting positive experiences of art therapy, particularly following the prominent results from Crawford et al.'s (2012) study and the anxiety concerning the position of art therapy in the current NHS and socio-political context.

Practice Implications

It is difficult to make confident recommendations for clinical practice and services given the small scale of this research. However, the results do suggest that for some individuals who engage in art therapy, it can be a positive experience which has beneficial effects. It also suggests that for these individuals art therapy offers something which other

therapies do not or for whom alternative psychological interventions are difficult to engage with. Several participants stated that verbal communication would have been difficult without the art-making. It may also be difficult for practitioners to create an unpressured atmosphere without the aid of something like art materials and the invitation to use them relatively freely. It seems possible that clients who struggle with purely verbal therapies should have the option of art therapy since it may help to increase their confidence to be with others and enable more verbal reflection to emerge.

Future Research

Recruitment difficulties which were experienced in this research have led to a questioning of whether art therapy is offered widely to individuals experiencing first episode psychosis. It would be interesting to examine this observation more robustly and to explore what leads art therapy to be offered and accessed by individuals, or whether it is only considered once other interventions have been unsuccessful. The findings from this research would have important implications for the discipline and for making sense of what may be contributing to difficulties with developing an evidence base for this intervention.

The experiences of those who accessed art therapy later on were useful in exploring barriers or some of the reasons underlying why an individual may or may not engage with art therapy initially following a first diagnosis of a psychotic disorder. However, there were also some similarities and commonalities in experiences of art therapy, and it may be interesting for research to investigate this further and whether different processes take place or whether there is a need for different art therapy approaches.

This study, alongside other qualitative research, has suggested that some of the positive changes and experiences that participants report in relation to art therapy are not those which are typically the focus of outcome measures. It would be interesting for future

research to develop outcome measures using service user-defined outcomes or those based on what art therapists theorise and expect as a result of someone engaging in art therapy, and to investigate how successful art therapy is at achieving these.

Another strand of research which would be useful is that focusing on whether individuals feel more able to engage in talking therapies after accessing art therapy, or if it has any impact on how individuals communicate longer term.

As this study offered a preliminary theory regarding the experience of art therapy, it would be useful for further research to develop and explore this further, investigating the applicability, validity and representativeness of this model. Participants in this study also did not particularly talk about what the art therapist did, which made it difficult to make connections between therapeutic actions and participants' experience of art therapy or its perceived effects. Studies using observational or video methods to obtain further insights into the detailed processes in art therapy and how they may lead to service users' experiences would be useful. In line with these recommendations, exploration of what the 'active ingredients' or key components which facilitate change are in art therapy would be useful. Such research may involve specifically focusing on some of the mechanisms and components which have been suggested by this piece of research.

Conclusion

This study explored service users' experiences of art therapy. The study found that within the unpressured atmosphere of art therapy, participants were able to engage in and express themselves through art-making, connect with others, experience absorption, a sense of freedom and reflect on their experiences and themselves differently. Whilst much of what participants spoke about was in-the-moment experiences, some also described being able to use art therapy as an on-going coping strategy, of it supporting their recovery and continuing

to enjoy and pursue art. However, important barriers to engaging with art therapy and experiencing positive changes were also identified.

Despite its limitations, this study has contributed to the field of research on art therapy and psychosis. It has focused on people who have been commonly under-represented in this area of research and has explored the potential processes involved in experiencing change. Whilst due to the size of the study and limitations it is difficult to advocate for particular clinical and practical recommendations, a number of important suggestions for future research have been made. Importantly, the findings from this study suggest that for some individuals art therapy can be experienced as unique, positive and personally significant.

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Section C: Appendix of supporting material

APRIL 2017

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A: Quality Checklist

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Appendix B: Participant Information Sheet

Study exploring the experience of art therapy for individuals suffering from psychosis

Information for participants

Hello. My name is Sarah Lynch and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study).

Part 1 of the information sheet
What is the purpose of the study?
The purpose of the study is to explore how service users who have experienced a first episode of psychosis experience art therapy, whether there are ways in which it has been helpful or unhelpful, and if it has affected the way you see yourself. The aim is to then develop a scientific theory about how art therapy can affect people.

Why have I been invited?
Participants are invited to take part in this study if have experienced a first episode of psychosis and if they are having or have had art therapy. The study is aiming to recruit between 12 and 16 participants to take part.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?
If you agree to be contacted regarding the study, I will contact you and discuss the study and answer any questions you might have. After this discussion if you agree to take part in the study, I will arrange an interview. The interviews can be done over the phone or face-to-face. The interview is likely to last approximately one hour and will be audio-recorded. In the interview I will ask you questions about your experience of art therapy and any impacts it may have had. I will also invite you to bring along to the interview or discuss one piece of your own art work which you found particularly significant in the art therapy process. You will also be offered a follow-up session to discuss the results of the study and to find out how well you feel the results fit with your experiences but this is optional. The results of this study will be written up as part of a PhD.

Expenses and payments
Participants will be reimbursed for their travel costs of attending the interview up to a maximum of £10.

What will I have to do?

During the interview I will ask you questions about your experience of art therapy, your understanding of yourself, the art work you have brought to the interview and any impact which art therapy may have had.

What are the possible disadvantages and risks of taking part?
Participants may find it difficult or distressing to discuss their experiences in the interview, particularly if these are negative. The interviews may also bring up upsetting memories of previous distress, however care will be taken to ensure that the interviews are conducted sensitively and considerately. If you become distressed then we would ensure your current care team would offer support.

What are the possible benefits of taking part?
Some participants may find it helpful or positive to talk about their experiences. Although there may not be any particular benefits to participating, it is hoped that this study will help to inform people whether and how art therapy can be helpful for people with psychosis.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet
What will happen if I don't want to carry on with the study?
You are free to withdraw from the study at any time and this will not affect the care that you receive. Anonymised data collected up to your withdrawal would still be used in the study.

What if there is a problem?
Complaints
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. To contact me please leave a message for me on a 24-hour voicemail phone line at [number removed] - please say that the message is for me [Sarah Lynch] and leave a contact number so that I can get back to you. If you remain unhappy and wish to complain formally, you can do this by writing to Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology [address removed].

Will my taking part in this study be kept confidential?
Data collected during the study will be kept anonymous, with participant numbers being used instead of names in both paper and electronic forms and no identifiable information being collected. Electronic data will nonetheless be stored password protected. Identifying names of people and places will be changed on transcribing of interviews and audio recordings will be erased after transcription. The only time I would pass on information would be if you said something that led me to be concerned that you or someone else may be at risk of harm. If possible I would discuss it with you first. Your taking part will be kept confidential, but this confidentiality may be breached if you indicate that you are likely to put yourself or others at risk or disclose any incidences of neglect or poor care.

What will happen to the results of the research study?
The results of the research study will be submitted to Canterbury Christ Church University and may be published in a scientific journal. Anonymised quotes from the interviews and photographs of participants' art work may also be used in final and published reports, however participants will not be identified in any report or publication.

Who is organising and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London – Camden and Kings Cross Research Ethics Committee.

Further information and contact details
1. General information about research.
If you are interested in finding out more about research in general, you may find the websites below helpful.

NHS choices overview on medical research
http://www.nhs.uk/conditions/clinical-trials/pages/introduction.aspx

NHS Health Research Authority
http://www.hra.nhs.uk/

National Institute for Health Research
http://www.nihr.ac.uk/research/

2. Specific information about this research project.
If you would like to speak to me and find out more about the study or have questions about it which you would like answered, you can leave a message for me on a 24-hour voicemail phone line at [number removed]. Please say that the message is for me [Sarah Lynch] and leave a contact number so that I can get back to you.

3. Advice as to whether you should participate.
If you are unsure about participating in this study, you can contact me on the above details and I would be happy to discuss any questions or queries you may have. It may also be helpful to discuss this with your care coordinator or health professional.

Appendix C: Participant Consent Form

Centre Number:
Study Number:
Participant Identification Number for this study:

CONSENT FORM

Title of Project: Impact of art therapy on sense of self in individuals with first episode psychosis
Name of Researcher: Sarah Lynch

Please initial box

1. I confirm that I have read and understand the information sheet dated 08/08/16 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree for the interview to be recorded and that anonymous quotes from my interview may be used in published reports of the study findings ☐

4. I agree that photographs of my art work may be used in published reports of the study findings ☐

5. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix D: Ethics Approval Letter

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Appendix E: Trust Research and Development Approval Letters

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Appendix F: Interview Schedules

Interview schedule (for interviews 1, 2, 3)

Thank you for agreeing to take part in this study.

Do you have any questions about the study? Is there anything that you are not sure of or want further information on?

If you are happy to participate, can I ask you to sign this consent form please?

Before we start the interview, is it okay to take some basic information from you?

How would you describe your gender and ethnicity? How old are you? Are you aware of having a diagnosis, and if so what is it? When would you say you first became unwell/started experiencing psychotic symptoms? At what point did you have art therapy?

What was it like having art therapy?

Are there any particular things about it that stand out for you?

What, if anything, have you got from art therapy?

What has it meant for your life in general – if you would say it has?

Did you find that art therapy had any impact on other areas of your life?

Thank you for bringing in a piece of your art work that you found particularly significant in the art therapy process. Can you tell me about this? What is it that makes this piece significant for you?

Now, this might be difficult to say, but when you think about other things that have been helpful to you, how would you compare art therapy to these other things? Has art therapy been more helpful than some other things, or less helpful?

- And can you say in what way, or how?
- What was different about it?
- Can you imagine not having had art therapy? What would that have been like?

Is there anything else you would like to say about your experience of art therapy? Maybe something we haven't covered?

If not mentioned in interview – Has art therapy had any impact on the way you see yourself?

Probes

Can you tell me more about that?

How did you find…? What was that like?

When you say…what does that mean to you?

Is that what you expected?

Is there anything else which you got from it? Has it meant anything else for your life? Has it had any other impact on your life?

Did that change over time or the course of art therapy? What was that like at the start/towards the end of the art therapy?

Thank you, that's all of my questions. Thank you for sharing your experiences and how you found art therapy.

How did you find the interview?

If it was difficult or distressing, make sure has support available, e.g. has contact details for care coordinator

Interview schedule (for interviews 4, 5)

Thank you for agreeing to take part in this study.

Do you have any questions about the study? Is there anything that you are not sure of or want further information on?

If you are happy to participate, can I ask you to sign this consent form please?

Is it ok to take some demographic information?

What's your gender?

What's your age?

How would you define your ethnicity?

Are you aware of having a diagnosis? Are you happy to share that with me?

When would you say you first became unwell?

At what point did you have art therapy?

Do you know roughly how many sessions of art therapy you had?

Was the art therapy in a group or one-to-one?

What was it like having art therapy?

Are there any particular things about it that stand out for you?

What did you hope to gain from art therapy? Did this happen?

How did you come to be referred and have art therapy?

What, if anything, have you got from art therapy?

What has it meant for your life in general – if you would say it has?

Did you find that art therapy had any impact on other areas of your life?

What would have been different, both at the time you were having art therapy and now if you hadn't had art therapy if anything?

How did you find the level of direction in the art therapy?

Do you think it would have been different having art therapy in a group/one-to-one?

Do you think it would have been different/had different effects if you had accessed art therapy at a different time? Was it different depending on how your mental health was?

If mentions good to talk about things – what was good about talking about it?

What would it have been like talking/sharing experiences with a group if no art making?

Thank you for bringing in a piece of your art work that you found particularly significant in the art therapy process. Can you tell me about this? What is it that makes this piece significant for you?

Could you tell me a little about the sorts of art work you created during art therapy?

Now, this might be difficult to say, but when you think about other things that have been helpful to you, how would you compare art therapy to these other things? Has art therapy been more helpful than some other things, or less helpful? Have you had other therapies or groups?

- And can you say in what way, or how?
- What was different about it?
- Can you imagine not having had art therapy? What would that have been like?

Is there anything else you would like to say about your experience of art therapy? Maybe something we haven't covered?

If not mentioned in interview – Has art therapy had any impact on the way you see yourself?

Probes

Can you tell me more about that?

How did you find…? What was that like?

When you say…what does that mean to you?

Is that what you expected?

Is there anything else which you got from it? Has it meant anything else for your life? Has it had any other impact on your life?

Did that change over time or the course of art therapy? What was that like at the start/towards the end of the art therapy?

Thank you, that's all of my questions. Thank you for sharing your experiences and how you found art therapy.

How did you find the interview?

If it was difficult or distressing, make sure has support available, e.g. has contact details for care coordinator

Travel expenses

Ask about willingness to be contacted for respondent validation interviews

Interview schedule – further questions for interviews 6, 7 and 8

- Have you continued with art/art-making?
    - If so, in what context?
    - What does it mean to continue with art?
    - Is it helpful?
    - Is this different to art therapy, and if so, how?
- What does it mean/how does it feel to have others view your art work?
- What is helpful about expressing yourself through art?
    - How did you feel before and after?
- Can you describe the atmosphere of art therapy?
    - Was this helpful or unhelpful?
    - How did this make you feel?
    - Were there other places you felt similarly?
- Would you have art therapy again?
    - Why?
- I wonder if you can remember a particular piece you created in art therapy? Would you be able to describe it?
    - What are your thoughts and feelings on it?
    - Can you tell me about how you came to create that piece?
    - Did it represent anything in particular?
- Were there any differences in how you felt or you experience when you were in art therapy compared to typically at that time?
    - What do you think led to those differences?

Interview schedule – further questions for interviews 9 and 10

- Can you describe the atmosphere of art therapy?
    - Was this helpful or unhelpful?
    - How did this make you feel?
    - Were there other places you felt similarly?
- How did you feel during the art therapy sessions?
- When did you have art therapy?
    - When was this in relation to when you first began experiencing 'psychosis'?
    - What contact had you had with mental health services before this?
- How did you come to have art therapy then?
- Would it have been different if you had had it earlier?
- Were you offered art therapy before?
    - If so, were there things which got in the way of you engaging with it?
- How would it have compared to other interventions/therapies you had at that time?

Appendix G: Sample Transcript with Focused Coding

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Appendix H: Example Memos

2nd September 2016

Conducted first three interviews. Initial thoughts:

- Art therapy as a way of grounding, being present, included
- Having choice, freedom, autonomy, choosing own direction
- Calming, relaxing space
- I am wondering about the intensity of one-to-one vs group art therapy, is there a change in pressure or intensity?
- Participants talked about their views on the level of direction given by the art therapist – what determines why someone wants a greater or lesser level of direction or autonomy/freedom?
- Participants seemed to be talking about it being beneficial 'in the moment' but does it help longer term or with management of symptoms or understanding of experiences?

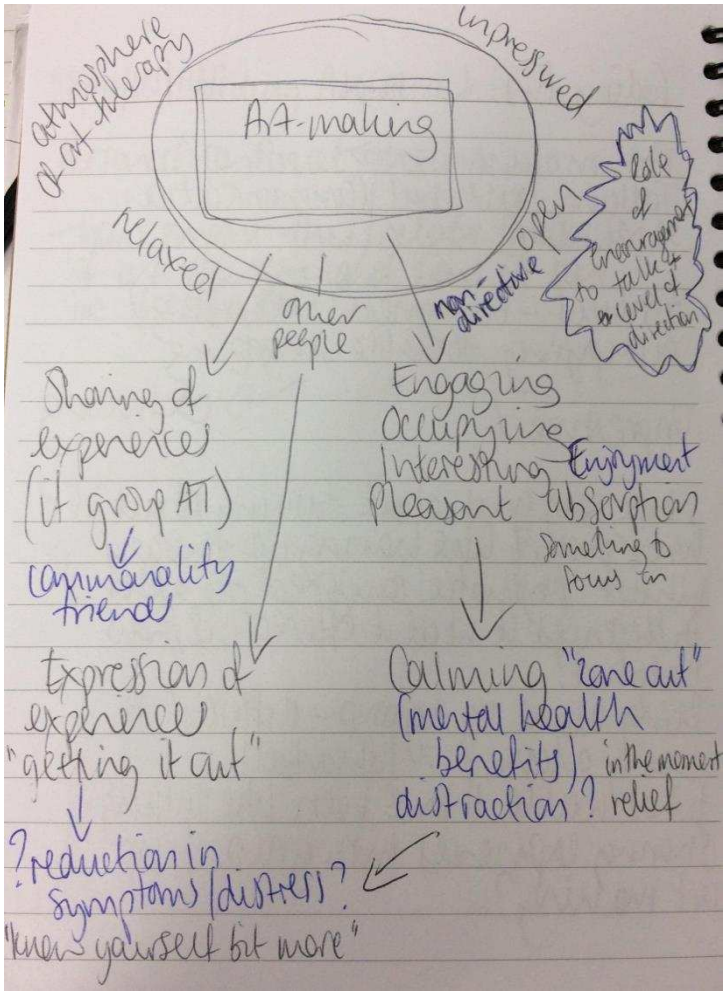
7th September 2016

Transcribing the first three interviews.

Participants seem to talk about art making as being a buffer between exposing nature of therapy – "safety net". Perhaps participants are using art and art making to control how much they say/expose, how vulnerable they are, how much to reveal? Also seems that being able to go between talking and art making enables the service user to be in control. Art work is almost being used to mediate contact and interaction with others and the art therapist.

Through transcribing, I am also noticing how I have asked questions about how art therapy compares to OT or activity groups – is this influenced by the results from the MATISSE trial?

4th November 2016



14th November 2016

Art therapy being calming – this then seems to offer a strategy (for managing symptoms?) which service users can use independently, outside of the sessions.

Atmosphere of art therapy seems really important and perhaps quite unique? Seems like this environment/atmosphere fosters and facilitates positive effects and experiences. The art work and art making is part of this.

6th January 2017

Further interviews – ask about relationships between potential categories/concepts. How does the atmosphere/environment relate to how participants felt and what they got from art therapy? How was the atmosphere helpful? Is this different for participants who had art therapy later, whilst not under EIS? Were there things which got in the way of them accessing and engaging in art therapy earlier?

I am interested in the 'fit' of art therapy for participants – they have talked about timing, interest in art, relationship with therapist and others, group vs individual, acceptability of intervention and level of direction. Seems like there has to be a reasonable 'fit' for participants to continue engaging and get something from it.

8th January 2017

Art work as focus for expression, communicating, coming together, sharing and relating. Art making used to express symptoms, thoughts, feelings, experiences → creating distance from experiences? Also art making as an activity is reported as something enjoyable to do, and is occupying. What is helpful about 'getting it out', expressing? Is there a change in experience in how someone feels before and after? If so, what is it?

Art making seems to have many functions.

20th January 2017

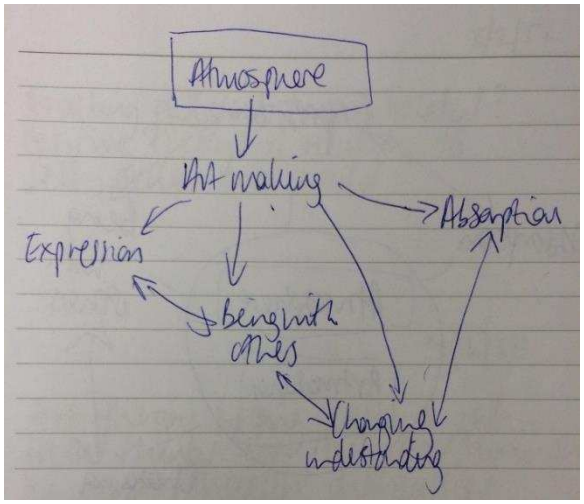
Does art therapy allow the person to experience themselves differently? Perhaps the space and atmosphere created in art therapy enables this?

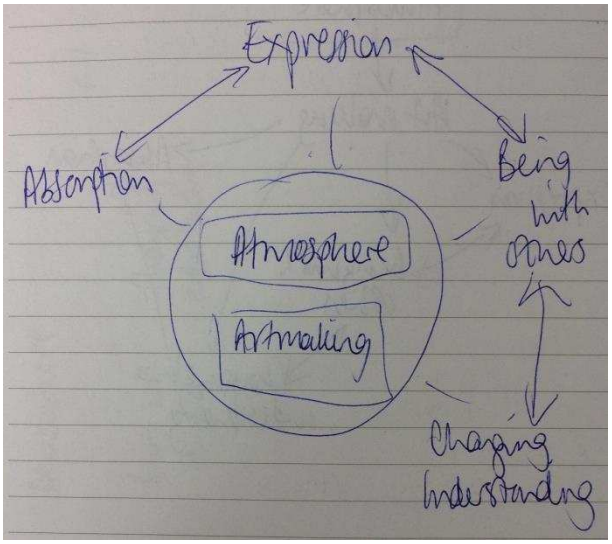
26th January 2017

Art therapy → being seen in a different way? Rather than in terms of distress, deficits, what they can't do, but someone with something to offer, with capability and competence. Is this related or resulting from being able to engage meaningfully with something and others?

30th January 2017

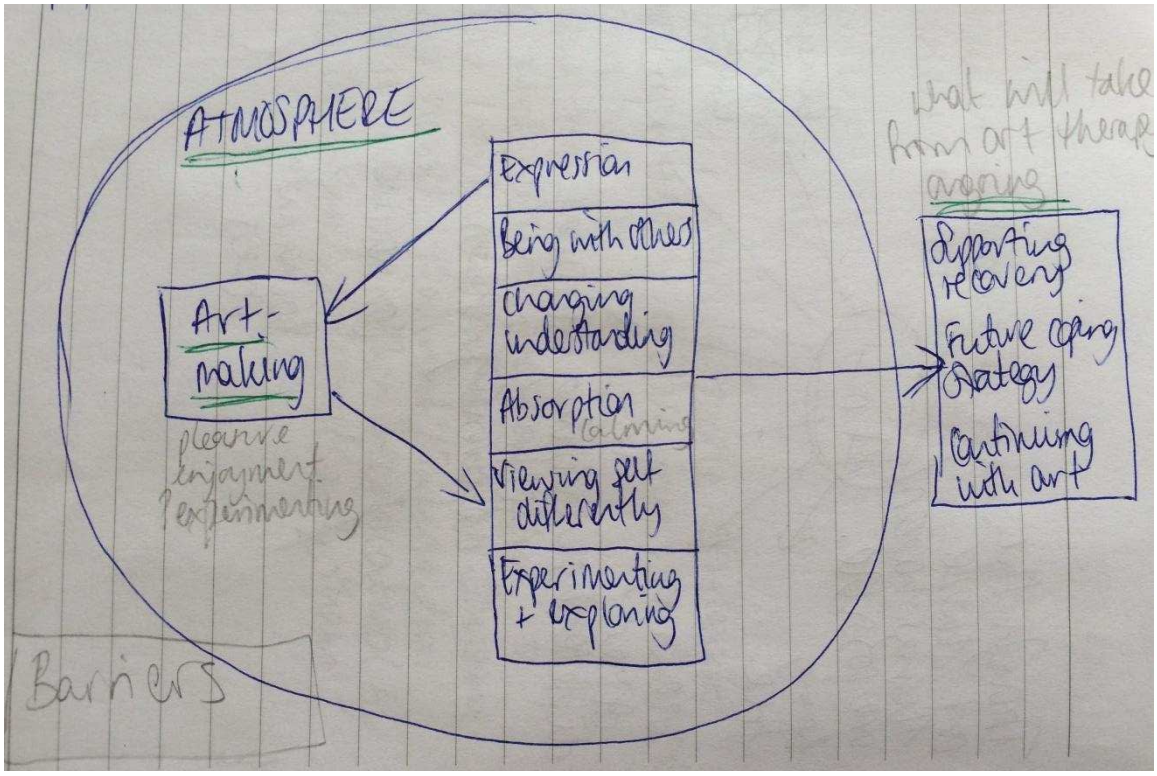
Have lots of thoughts from the data and have been trying to make sense of how categories fit together by drawing it out.





February 2017

Going back and forth between the data, focused codes and categories, and discussion with supervisors. Thinking about the atmosphere not just preceding the art-making and then what is experienced, but what is experienced happening within in and being shaped by it.


ATMOSPHERE
Art-making
pleasure
enjoyment
experimenting
Expression
Being with others
changing understanding
Absorption
calming
viewing self differently
Experimenting + exploring
Barriers
what will take from art therapy
ongoing
Supporting recovery
Future coping strategy
Continuing with art

Appendix I: Abridged Research Diary

28th November 2014

Salomons research fair – heard about numerous different projects, research ideas and interests. The range of research areas was impressive, however I feel overwhelmed by the choice and the uncertainty about what I would like to focus on. I plan on doing some reading around different subject areas and emailing potential supervisors over Christmas.

December 2014/January 2015

Interested in three different project areas – ecopsychology, a theory of mind project which is largely set up, and art therapy and psychosis. Have done reading in this area and been liaising with supervisors. I feel that the art therapy and psychosis one fits best with my interests and previous experience.

27th February 2015

Submitted research supervisor form and been discussing and developing ideas for my research project focusing on service user experience of art therapy for psychosis.

March/April 2015

Liaising with different heads of art therapy in different mental health trusts to try to get them to participate in the research and facilitate recruitment. It has been difficult getting in contact with them, however I have managed to get two trusts to commit to the study and they feel confident that the numbers will not be a problem.

29th May 2015

MRP proposal form submitted.

17th June 2015

MRP proposal review – the review meeting went well and the panel approved my project whilst also giving me some useful ideas to consider. In particular, they suggested it might be worthwhile getting a third NHS trust on board with the research project, just as a back-up in case there are difficulties in one of the others. I think this is a really good idea and will discuss with my supervisors about this.

September 2015

I have been struggling to get another trust to agree to help with the research. However, one of my supervisors has had a meeting with a head of art therapies for another trust and they are willing to support the study and help with recruitment.

20th November 2015

I attended the Art therapy and Psychosis Research Symposium at the British Association for Art Therapists. This was really interesting. I got the sense from art therapists that they feel art therapy is useful but hard to pin down and measure. There seems to be a difficulty describing, detailing and operationalising what art therapists actually do in the room. There also seems to be potential tension between art therapy and other disciplines e.g. the BPS document on psychosis did not mention art therapy. Historically art therapy was offered to people who were not offered other psychological therapies. However, art therapy is underpinned by psychological theories, particularly psychodynamic.

From discussions with art therapists and hearing the presentations, I wonder whether art therapists focus less on 'the psychosis' than other psychological therapies? I also wonder what the role of the art work is, and if it is necessary? Does the artwork provide a backdrop or context for other more general therapeutic processes to take place?

December 2015

NHS ethics application submitted.

January 2016

NHS research ethics committee – felt apprehensive about attending the committee and daunted by the number of panel members but it went well and was over very quickly!

February 2016

Received favourable opinion by NHS research ethics committee. Now need to continue with the process of getting the project approved by the trusts research and development departments. The required information has been sent to the trusts, however they would not process the applications until the project had received favourable opinion from the ethics committee.

18th February 2016

I attended an art therapy meeting at one of the trusts with aim of encouraging art therapists to recruit for the project. At this meeting, I was aware of the hesitation to be involved in research following the unfavourable outcome of the MATISSE study, and also reluctance as the research is being conducted by a psychologist rather than an art therapist. I also noticed that this may contribute to a bias in recruitment, such that art therapists may wish to cherry-pick participants who have experienced particularly positive changes or benefits to take part. However, the feedback was that they should definitely be able to help with recruitment and thought the numbers were easily achievable.

19th March 2016

I attended an Introduction to Profession of Art Therapy day at British Association of Art Therapists. Interesting responses and observations from the day about why offer art therapy –

- Not dependent on having to talk/ask questions, for those who don't know how to start talking or don't want to
- Choice of art materials → having choice, control
- Can be fun, playful
- Personal – art as our own language
- Can project things into our artwork → symbolism
- Art work as a space between two people
- Don't have to look directly at each other – comparison with Freud's use of a couch?
- Being seen, attunement, being held in mind, containment
- Place to think about relationships, attachment
- Art making as means for being in a room with someone

Also made me think about several things – what are the expectations of art therapists for what art therapy can do? What is the desired outcome, or is there one? Does this differ from psychology?

March 2016

The study has been approved by one trust R&D department but rejected by another which has sent a letter with a long list of questions and points that they want addressed. I feel frustrated by this, particularly given some of the questions and requests made show inexperience with my chosen design and methodology – e.g. asking me to provide a power calculation. I am also having difficulty getting R&D approval from the third trust who have contracted out their R&D. They need local authorisation to give the final go-ahead and are not being responded to by anyone in the trust.

April 2016

I have responded to the letter from the trust who have rejected by study. I am not feeling particularly optimistic about this as there were several points/recommendations which I explained I was not able to change.

I am also continuing to chase the third trust who are still waiting for local authorisation. This feels incredibly frustrating.

May 2016

R&D approval granted by second and third NHS trust. Emails sent to art therapists in trust with participant information sheets and information about the project.

June 2016

I attended the BAAT psychosis special interest group. Discussed difficulty of recruitment for the research study. Interesting discussion with group members including heads of art therapy for two of the trusts involved, in which they expressed that they were surprised and disappointed that I had not been able to recruit. They had thought that they would have had many potential participants but have discovered that they are not commonly working at the

early intervention end of the spectrum and rather service users are referred to art therapy when everything else has been tried. It was raised that targets around CBTp are taking away from referring to art therapy. However, a head of art therapy from another trust works particularly with early intervention as one of her special interests and has offered to help with the project and with recruitment. This is brilliant, although I will need to go back to ethics to add another site and go through their trust R&D.

The NHS ethics process has changed as of the new financial year. As such, in order to add another site to my study, I have to get my project moved under the new health research authority (HRA) approval. I have applied to do so but unfortunately have been informed that this may take some time as there is a large backlog. I have also had to submit an amendment to conduct the interviews off NHS property (at the independent studios where art therapy takes place in this trust) and over the phone (as potential participants have expressed they would prefer this).

8th July 2016

Attended an art therapy for children and adolescents workshop at Salomons as part of the course teaching. This was interesting to learn more about art therapy and the theoretical underpinnings.

July 2016

I have received confirmation that the study has been brought in line with the new HRA approval. I am continuing to chase them about my amendment as I have not heard back

August 2016

Amendment has been approved. It feels like such a long time since beginning the project and getting it through ethics, but pleased to be able to finally get going with recruiting and interviewing.

Before beginning the interviews I thought it would be a good time to stop and explore some of my own views, preconceptions and thoughts on this topic.

I was drawn to this project for several reasons – my background working in psychosis and early intervention for psychosis services and my interest and appreciation of art. Having worked in services where there is no psychology or other therapies for service users, I feel strongly that there should be this provision. I have also been in teams where there is only limited psychology (and no art therapy) and have experienced being told that some service users ‘are too unwell for psychology’, or need further support with engaging. Considering why I chose this area of research, I realise that I feel there should be a range of different psychological and therapeutic options available to people. However, I am aware this may not necessarily be in line with evidenced-based practice. I think that perhaps similarly to the art therapists that I have met with I also feel a desire to advocate for art therapy and I may have a potential bias towards positive experiences of art therapy. It will be really important for me to

make sure I pay attention and give time and space to individuals' negative, difficult and different experiences of art therapy, as well as the more positive ones.

I have also been reflecting on the meeting and contact I have been having with art therapists and feeling some pressure for the research to yield positive results, particularly in the light of the MATISSE study which was not in favour of art therapy. This is perhaps particularly apparent in the context of relying on them to do the initial stage of recruiting, and makes me think that I need to consider how results, if not what they may be expecting, are fed back to them and communicated.

September 2016

Finally begun interviews – it feels really good to have done the first three interviews, and they were really interesting. I was pleased that participants had lots to say about their experiences. I was intrigued that art therapy seemed to offer these individuals a different space to which they were used to. I also noticed that the art-making seemed to be very central to accounts and experiences of art therapy. Thinking about this has highlighted perhaps my own uncertainty and even scepticism about the actual role of the art and art-making. It also makes me remember a presentation I attended about an art therapist's phd into art therapy for individuals with diagnoses of borderline personality disorder and how the theory constructed did not centre around the art and was focused instead on the interpersonal processes which occurred. Perhaps this is also bringing up my biases as a trainee clinical psychologist (rather than being from the art therapy profession) about what parts of therapy I think or have been taught are the most important.

The third interview I conducted over the phone. I had been a bit apprehensive that this would make the interview shorter, or less rich in terms of the data, but actually it did not feel like that at all. In fact, I noticed that I felt freed up to concentrate and focus even more on what the participant was saying, and respond to this, as I wasn't having to also think about what I was doing non-verbally. I wonder if this is experienced similarly by the participant? I was interested having read some articles about the impact of the mode of interviewing and in particular how conducting interviews over the phone can serve to ameliorate some of the potential power differential between researcher and participant. It seemed that this participant voiced more negative or mixed experiences of art therapy and I wonder whether she felt more able to do so over the phone. I had initially wanted to do all the interviews face-to-face but being able to do phone interviews seems to be making it easier to recruit participants as it is more convenient for them and takes up less of their time. Doing both phone and face-to-face interviews is actually making me consider things about how I am conducting the interviews that I'm not sure I would have done if using just one modality.

October 2016

Finished first draft of part A – I found this tough and it has taken me quite a while to finish a first draft. However, I found it really interesting to read in more detail about art therapy and the research in this field. Having also been reading a lot about grounded theory to refresh my memory from when I initially wrote my research proposal, I am aware that having reviewed

the literature in this area before conducting the bulk of the interviews and analysis, I need to be mindful not to be influenced by this information. It will be important to consider the attention I am paying to certain ideas and themes during interviews and analysis.

November 2016

I have conducted a few more interviews, however it continues to be difficult to recruit and I feel pretty stressed about whether I will be able to get enough participants.

These interviews have been interesting and I feel that there are definitely some common ideas and themes coming out. It will be good to code these and look back on the codes from the previous interviews. Reflecting on these interviews, again I am feeling drawn to the idea of the atmosphere of art therapy being really important and being fundamental for positive experiences or positive changes to occur.

I've been making notes about things which I am interested in and would like to ask about in further interviews. I am thinking about the role that art and art-making continues to play in people's lives once art therapy has ended. Two of the participants I have interviewed discussed continuing to do art and I am interested in finding out more about this. I think I will discuss whether this is possible and a good idea with my supervisor. It could also be a way of asking further questions about how some of the emerging categories are related and exploring my hypotheses.

January 2017

Finished final interviews! I feel really relieved that I've managed to get to this point. I feel the last interviews went well and I'm looking forward to coding these and seeing all of the data together. Although at the moment all of my codes and preliminary ideas and hypotheses feel quite overwhelming and a bit hard to make sense of!

It was really interesting to hear the experiences of the two participants who had art therapy a bit later on. I think they gave a useful perspective on some of the things which might get in the way of accessing and engaging art therapy earlier on. However, I also noticed that there were some commonalities in some of the experiences and in how art therapy can be helpful. This makes me wonder whether my main focus on those engaging with art therapy whilst eligible for early intervention for psychosis services is helpful or necessary. I know I had a very clear rationale for wanting to focus on this but now it seems perhaps unnecessary. If I had lots more time I would be really keen to continue with this research and explore further. What is a useful and helpful intervention for someone and when is such an important question for our profession to think about.

February 2017

I have been going through the codes and categories that I have so far created from the data, and starting to feel overwhelmed looking at it all together. I have hundreds of initially line by line codes and it feels so hard to keep track of everything. I feel anxious that I am not doing

justice to all the participants' experiences and accounts and hope that they are all represented in the analysis.

I have been going between the data, codes and categories making changes and adjustments, and I'm starting to feel more satisfied with my analysis. However, it feels like there could be a number of interpretations, categories and theories constructed from the data, which makes me question how useful what I have created is. I feel I am falling a bit into the trap of a more positivist epistemology, feeling anxious to get the 'right' or 'correct' analysis; rather than acknowledging that my role in constructing the results is unavoidable.

6th March 2017

Draft of part B finished – I feel really pleased that I have been able to get to this stage, particularly given the big problems with recruitment. There were many times I thought I wasn't going to have enough data or it wasn't going to come together!

I met with my internal supervisor to discuss her comments. This was really helpful and we spent most of the time talking about the results section which needs the most work – mainly adding in more quotes and also trying to make the category names reflect the data within them a bit more. I think this is a really good point and will definitely make it come alive a bit more.

Late March 2017

I've been working on my part B, and oscillating between feeling proud of it and feeling anxious! It feels like I could carry on working on it for ever, and making little tweaks to the analysis.

Appendix J: Table of Categories, Focused Codes and Example Quotes

Category	Subcategory	Focused Codes	Example Quotes
Unpressured atmosphere		Unique space of art therapy	Well I will do anything in my power to make these art therapists and drama therapists, music therapists work because just think of it if you are locked up. I mean you don't see the sky, you don't feel the wind, you don't feel the grass and then there is some, a place where you can just be yourself, without being judged (Stephanie) I mean for me I think it was probably unique. I can't really think of any other places that were like that (Jacob)
		Non-directive approach of art therapists	when you get to do what you want in the art therapy like with the paint and the materials and everything (Jacob) no it was always left up to you (Liam) there wasn't a huge amount of direction given, er I didn't find. There was enough but not very much (Charlie)
		Feeling unpressured	So if you were like playing basketball or bowling they were like, there's an objective and you're trying to complete it but the art therapy is just do what you want to do and what you feel like doing which is nice, just to get rid of social structure thing. Because there's no like rule about what you have to do in art therapy. (Jacob) I think some of the times it was good because it meant there wasn't much pressure to talk about stuff if you didn't want to. (Liam) we kind of had enough space to do our own thing, and it didn't feel that there was so much pressure because the group was small. (Charlie)
	Accepting environment	Accepting of others	but they were all like really accepting and it was quite nice. So my first session was just really nice.(Jacob)
		Non-judgemental	it was just a thing that was silly but they never um, never laughed about it, they were always quite um, inquisitive and that was all going on whilst I was drawing (Stephanie) it's really in a non-confrontational environment. So um you're not having to, I'm not having to worry about whether I'm boring or not or whether you are bored listening to other people (Laura)

	Relaxed environment	Informal	I think compared to what I've heard about other therapies it's far more informal sort of. (Liam)
		Relaxed and calm atmosphere	art therapy was far more relaxed I'd say (Liam) it felt laid back…uh, a peaceful environment (Charlie)
Pleasure and engagement in art making	Enjoyment of art making	Enjoyment in art making	I mean we got to do the art as well, I liked the art (Jacob) well it was nice trying to make certain pieces. (Jacob) I suppose a lot of it is I just enjoy drawing (Liam)
		Interest in art making	it was just interesting (Jacob) it was quite interesting I'd say. It's mostly just drawing or painting, I mostly did drawings (Liam)
	Experimentation and exploration	Experimenting with art materials	yeah that was one of the good things, so it was a group thing and also just being able to do whatever you want with the materials was really good (Jacob) It was really interesting to try and figure out how to do things and experimenting (Jacob)
		Problem solving	like being able to…because I was trying to make a piece of work that like just paint risen from the page but we were just using paper so it kept soaking in so I was thinking for ages how to figure it out and I covered it in glue, and then the next week I did it and it worked. I like that. (Jacob)
		Exploring creatively	the nice bit of actually just being able to go into the room, and have your hour, or hour and a half, however long it is, with all these lovely materials and just explore creatively (Max) so by doing the art therapy, it has introduced me to loads of materials and techniques and it has also, in a, it has freed me up to go I'm going to try something rather than go this is what I do, this is all I do (Max)
Expression and communication	Expression	Expressing through art	I can remember a piece I did where I was just like throwing paint um from a couple of metres to the paper and that was quite expressive of what I felt at the time (Jacob) but it takes a lot of energy out of you and then you know, it is impossible to write but you can go and make big movements on paper and express yourself like that. (Stephanie)

			I remember painting, painting a big painting as big as a door. And I painted as well, very, very big, on big sheets as high, and as big as the wall to put my, because I had, I didn't have the feeling that I was at, my past and my future, it was all so muddled. So it gave me the opportunity to express that on a piece of paper, a very big piece of paper.(Stephanie)
		Expressing as a release	I don't know maybe just getting all that stuff out of your head. Even if it's just random shapes it is something for you to focus on. So just taking things out of your head and putting them down. (Jacob) I think it was helpful to just get it off your chest a bit (Liam)
		Difficulty expressing oneself in talking therapies	No, I was too ill. I was sectioned, I was too ill. I, I had, nothing normal came out of my mouth. And um, I was just too ill to have that. That was a step later. (Stephanie) You kind of have to think about and try to remember your problems and if you can't you just sit there and talk about the weather, which is quite bad (Jacob)
	Communication	Art enabling verbal communication	Yeah it's just, it's just an extra thing so you're not always in therapy, you're not always talking and you don't always have to talk. You have something else that can take away from that instead if you're not feeling like it which is kind of like comforting and make's you talk more. (Jacob) So we'd be talking while we were creating, which was, there was no eye contact or anything because we were all so busy but that freed up the space to be able to talk about things while you are actually doing it. So, I found you have that in both sides of, group and one-to-one so. (Max) Rather than being sat down in a chair opposite someone, and like now talking and explaining everything, it's, it's, nice, it's good to be able to, to be able to be creative and then conversation does or doesn't, you know, is possible or isn't at that time, you know. (Phillip)
		Art as way of communicating	and now and again someone would do something to do with their psychosis so towards the end I did do a few things I was thinking were going to happen (Liam) I mean I have had a creative background but obviously it could be that someone goes and they are opened up to a whole new world which helps them get a handle on the problems or find a different voice if they are not verbally

			communicating. (Phillip)
		Art as focus for communicating	And you could talk about the art as well so if you didn't have anything to say. (Jacob) the conversation was more open, so we might just talk about the art (Liam)
Connecting with others		Sharing with others	yeah we all spoke freely… like things you wouldn't like tell anyone, well other people but everyone was fine sharing it there (Jacob) I suppose with group therapy is what's important is the speaking afterwards because you, you learn a lot from other people and you bring your own story to a table of many stories." (Isobel) I remember like with the group one, a positive it was going around talking about each other's work was a positive experience because we were able to like talk to each other about like things. (Isobel)
		Building relationships and socialising	so I just made friends really and it was more of a social thing than art therapy sometimes (Jacob) and I've got friends from it who I still see. (Jacob) I think it was just the case of um getting back into a social environment if you know what I mean, interacting with people a bit more than I had been doing. (Charlie)
		Being with others	quite nice to be able to get along with a group (Charlie)
	Commonality	Feeling a sense of commonality with others	um at the start it was pretty good, actually it was pretty good the whole time for me but there were some other people as well and I quite like them. It was nice having other people with the same sort of illnesses as me (Jacob) and feeling comfortable and thinking ok it's not only me, it's, there's other people who are experiencing like negative things as well (Max) It's very nice actually because it makes you feel not alone with what you are doing. (Laura)
		Hearing others experiences	it was quite nice to see how they [experiences] were all different really. I mean one girl she had a lot of visual hallucinations so she painted what she saw. (Liam) I think the group ones were a lot more, in a way it was a lot more rewarding because you got to see what other people were doing and going through as well.

			(Isobel)
	Discovering other perspectives	Hearing the views of others	I preferred the group therapy because there were just more people to consider things with (Liam)
		Hearing others interpretations of art work	and we would all talk about it at the end that was quite funny because [art therapist] would try and find some meaning in these like meaningless things that we had done and then everyone else would try and find meaning in your work and you'd just agree with the best one. (Jacob) it was interesting to see people's feedback on the art that was produced I think. uh they often saw things in the art which I didn't see myself and that was quite appealing, I don't know not appealing but it was nice to see something else which you hadn't noticed yourself. (Charlie)
		Insight into others	it's interesting, I like seeing how other people's minds work so you give them like just a circle and they tell you loads of things (Jacob) nd so, in a learning process it was really good, to be able to learn about other people's issues with psychosis (Max)
Changing emotional experience and experience of self	Feeling free	Liberating	I guess it was just being able to you know, you don't always have to be in adult professional mode…and it's just thinking about yourself rather than um trying to do something that everyone else likes. so that was quite good, quite liberating (Max)
		Sense of freedom	nobody ever accorded me or said hey what are you doing now. Um, I think it was to be able to be free (Stephanie)
	Absorption	Art making as occupying activity	you can zone out and you can get into it, it's really nice. And like that's really good for the mental health side I think (Jacob) I definitely know that it helped in the moment just to have that time to focus on something different (Isobel)
		Calming effect	and doing that sort of relaxed me a lot, (Jacob) and um I think it was just really nice, and relaxing. (Jacob) It was nice, it was actually quite calming. (Liam)
		Art making serving as distraction and	It sort of just takes your mind of everything which you need sometimes. (Jacob) I often didn't notice the other people there when I was drawing… I'd just get on with it and forget everyone… I think it's probably good really, quite a lot of

		escape	absorption (Liam) And I just could not stop doing art or claying, or whatever. I just wanted to occupy myself really, to be an escape from um, from um the horrible illness I had (Stephanie)
	Enabling reflection on experiences	Enabling reflection	Even though it's not like at the time, it's not very fun but to sit back and reflect on it, going it was fun in a personal exploration and it's made my life so much more interesting. I can sit and reflect and think. (Max)
		Making sense of thoughts and experiences	yeah I think it brings to life, for me it's, it makes the abstract nature of thoughts a bit more apparent (Charlie)
		Helping process experiences	I was thinking like, um, um, I felt captured. I didn't know why I was captured so I had visions of being a commando. Or, I would feel like what I just make was loads of birds in clay and fishes in um, fishes on paper. I went back to er a space in my youth and I, I know flying fish in France, I saw them there. So I used to draw them, I used to draw the flying fish in the water and then put bars there. I didn't know why I was doing that but obviously I felt half free to be taken care of and half um, half um, captured because of the bars, in jail. (Stephanie)
		Giving meaning	like I think, ah I often just put pen to paper and see what comes out and I think the mind often does that with thoughts, it just randomly puts thoughts together into some combinations to see what comes out and I think that can be distressing sometimes when the mind conjures up some weird story or whatever but I think it's just playing with it's artistic abilities. (Charlie)
	Viewing self differently	Artistic identity	so yeah, its definitely helped me develop myself as, as an artist (Max) I definitely feel like it has opened up a side of myself that I wasn't, that I was dismissive of before, dismissive in that I didn't believe that I was at all artist…I now believe actually that anyone is an artist (Laura)
		As someone with something to offer	yeah I guess I take myself a bit more seriously. (Jacob) the point is I always felt so useless having a psychosis, not so last time because I was involved into art…yes, because I could not, I had something to show people, uh in the corridor. It is not the most beautiful um thing I made but um yeah (Stephanie)

			It's actually a creative environment, where the creativity is the centre of what you are doing rather than the illness (Laura)
Supporting recovery and continuation of art	Life vest	Art as a coping strategy	When I was having another psychotic episode I found it was one of the things which calmed me down a lot. (Liam) If I'm feeling low, or tired, or frustrated I get my art materials out and I don't do it in a professional way, I just draw, explore, and it helps me develop and explore and think (Max)
		Accessing art therapy again in the future	So it's given me a um, like a life vest where I know if it is getting really bad just go and do a bit of art therapy, explore it and do that so, it's just that, it's given that understanding of what works for me and what doesn't (Max)
	Supporting recovery	Benefit in facilitating recovery	I was in quite different places with both of them in my life. But I guess art therapy sort of got me out of a bad place (Jacob) now I'm really aware, it's definitely made me stronger in what I do. (Max) in a broader sense it did make a really big impact on how I develop myself and my thought patterns. (Max) I don't think I'd be doing as well…still not out of the woods yet but I don't think I'd be doing as well as I am if I hadn't had the opportunity (Phillip)
		Therapeutic effect of being creative	S: and is that something you've continued doing at all since those sessions? P: uh yeah quite a bit actually, I find it quite therapeutic (Charlie) if you're in the throes of depression or something, or everything's really dark it's hard to see out but, but the chance to be creative and that, if one is able still has a positive effect (Phillip)
		Limits to longer term impact	I think if I'm honest not that much really. I think um it was more of a in the moment thing for me really…but I think in terms of the ongoing like taking something away, it was more of a like in the moment relief.. (Isobel)
	Ongoing art activity	Continuing to pursue art	I ended up doing an exhibition with some of my work (Jacob) S: and is that something you've continued doing at all since those sessions? P: uh yeah quite a bit actually, I find it quite therapeutic…I have been doing it on my own and that has been quite nice, I've been…yeah….but recently I've just started another workshop, an art workshop. (Charlie)
		Development of	um, I appreciate art a bit more and I want to do it still, like I want to carry on

		interest or hobby	doing it (Jacob) well it got me into drawing (Liam)
		Development of art skills	I think I'm more comfortable with art itself after art therapy. I don't think I was quite as comfortable with art before. (Charlie)
Barriers	Impact of mental health	Difficulty engaging when unwell	depending how well or not well I've been, depends how much I've been able to um, to take part sort of thing. (Phillip) I mean I'm still able to produce stuff, pictures and that, but it might be that, I think, I can only manage 15 minutes, 10 minutes and then other times it can be…whereas now I can, you know I can, be in the hour session (Phillip)
		Impact of mental health on creativity	When I was ill more recently, it was, I was totally stripped of that [creativity]. (Phillip)
		Level of distress	I was too frightened, too ill at the time… at that time I just couldn't, I was too freaked out and unwell by things (Phillip)
		Having it at the right time	I think it can be a very interesting experience when you are in psychosis but I do think ideally you need to be at the end of, so you need to be hospitalised, you need to be in a state where the medication is really beginning to take effect, when um, because obviously the psychosis lasts a while. (Laura) I also think I was offered art therapy at a better stage and moment in my recovery so although I was usually suffering from psychosis before or when I was initially doing art therapy, it was later on in the process, so I was much more back to being myself. And so I wasn't quite so delusional at that stage, and I was understanding one – that I was unwell and two – that this could help, and then I was open to seeing how it could help and then three – was no longer being so unwell. (Laura)

	Not the right fit	Difficulties and frustrations with the approach	it was kind of annoying because I had a lot of ideas about what I wanted to do but just couldn't do it cos I like can't draw anything so I just went more abstract. (Jacob) he one-on-one I think I found it very um…like in a negative way I found it really hard to engage with the materials that we were using…everything became really meaningful so to choose what I was going to use was really difficult and that was quite a hard thing and knowing what to draw was quite hard. Um and I felt very, like I didn't like my work so much, as much with that. (Isobel)
		Intensity	I think the one-on-one sessions I found really intense and from where I was it was just very hard to engage and not sort of over-analyse (Isobel) well I think, like it was meant to be about 6, but generally it was 2 of us, um for a lot of the time it was just me, so it was just me that turned up…which was quite intense (Max)
		Challenge of meeting individual needs	But that needs a lot of enthusiasm from the therapist really, to like engage you in to doing it and get you going sort of thing. It needs to be like quite a lot of energy involved in it. But then this is what I think cos someone else might need more of a like calmer approach and it would help to be a lot more peaceful and like make things in a slow way so it's tricky because it's completely personalised (Isobel)
	Anxiety	Initial anxiety	it was quite daunting, meeting a load of new people and they all knew each other because they'd been there before and so I was like the new person (Jacob) initially I feel a bit apprehensive (Phillip)
		Uncertainty of what art therapy is	yeah I felt quite anxious at the start because I didn't know what it was going to be like, (Jacob) I think the understanding of it at the beginning was, I suppose wasn't really clear (Max)
	Access and availability	Availability of art therapy	…had some on the ward and also I had to, excuse me, really um put the thumb screws on my care coordinator who was in the early intervention team, to sort of go I enjoy art, why am I not doing art therapy. Like I find it something to connect with, so, yeah there was a gap but there seems to be, there always seems to be a gap between community therapies and ward therapies which I've

			never understood. (Max) eah, and to find the place, because um, I forgot about this, it was sectioned so you can't go anywhere unless somebody is with you. So if the nurses don't have time, you can't go to your art therapy (Stephanie)
		Impact of location and setting	The sessions I go to now are, are in the hospital and that has a lot of um, well at first had a lot of negative um…feelings about that. I've managed to sort of get through that but I think it would be easy for people to get put off by that, you know to have to go back through the hospital doors and that sort of thing (Phillip) I found it incredibly difficult to find the premises, the area. The area was so complicated, I never knew where to go. (Stephanie)
		Ability and motivation to attend	it impacted on my work so I couldn't work full time because I was coming to the art therapy (Max) The only problem was making myself go consistently to the meetings… I've not always been able to make myself go. (Laura)

Appendix K: NRES End of Study Form

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Appendix L Feedback Summary for Ethics, R&Ds and Participants

Service User Experience of Art Therapy: A Grounded Theory Study

Background

National UK guidelines state that art therapies should be considered for people with psychosis. Whilst art therapy has a long history of working with this population, provision is inconsistent and the efficacy of this approach has been challenged recently. Research on art therapy and psychosis has typically focused on individuals who have experienced psychotic symptoms for many years.

Aim

This study used a grounded theory methodology to explore how service users experience art therapy following a first diagnosis of a psychotic disorder, and the possible mechanisms through which art therapy might be helpful for such individuals. Regarding these research questions, this study aimed to explore and create a preliminary theory regarding the service user experience of art therapy following a first diagnosis of a psychotic disorder.

Method

Eight participants were interviewed, with two participants being interviewed twice. Interviews were audio-recorded and transcribed. Grounded theory was used to analyse the data, such that transcripts were coded and categories and subcategories were created from the data.

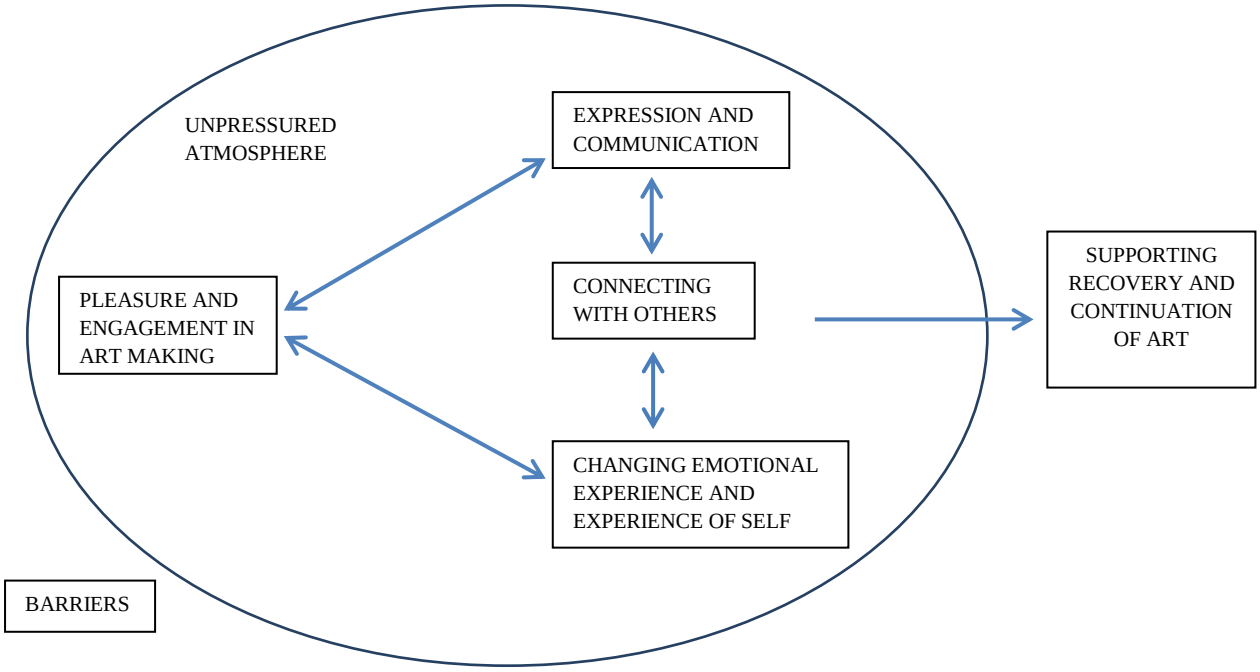
Findings

A preliminary theory was created and seven categories were constructed from the data, namely unpressured atmosphere, pleasure and engagement in art-making, expression and communication, connecting with others, changing emotional experience and experience of self, supporting recovery and continuation of art, and barriers (see figure below). Participants reported that through the atmosphere of art therapy, art-making, and communication, they were able to build relationships, connect with others, experience a sense of commonality, absorption, sense of freedom and discover alternative perspectives and different understandings. For some participants, art therapy supported them in their recovery, offered them a ‘life vest’ for the future and led to a continuation of art activity. However, some important barriers and difficulties to engaging beneficially with art therapy were also noted.

Implications and Recommendations

It is difficult to make confident recommendations for clinical practice and services given the small scale of this research. However, the results do suggest that for some individuals who engage in art therapy, it can be a positive experience which has beneficial effects, and it therefore seems appropriate that art therapy be available within mental health services.

Further research exploring how widely and universally art therapy is offered to individuals who have recently experienced psychosis or accessed mental health services would be useful. In addition, research developing and examining this model further, and exploring alternative ways of investigating and demonstrating art therapy outcomes, and when and who it can offer potential benefits to is needed.



Sarah Lynch
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University

Appendix M: Author Guideline Notes for Journal

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