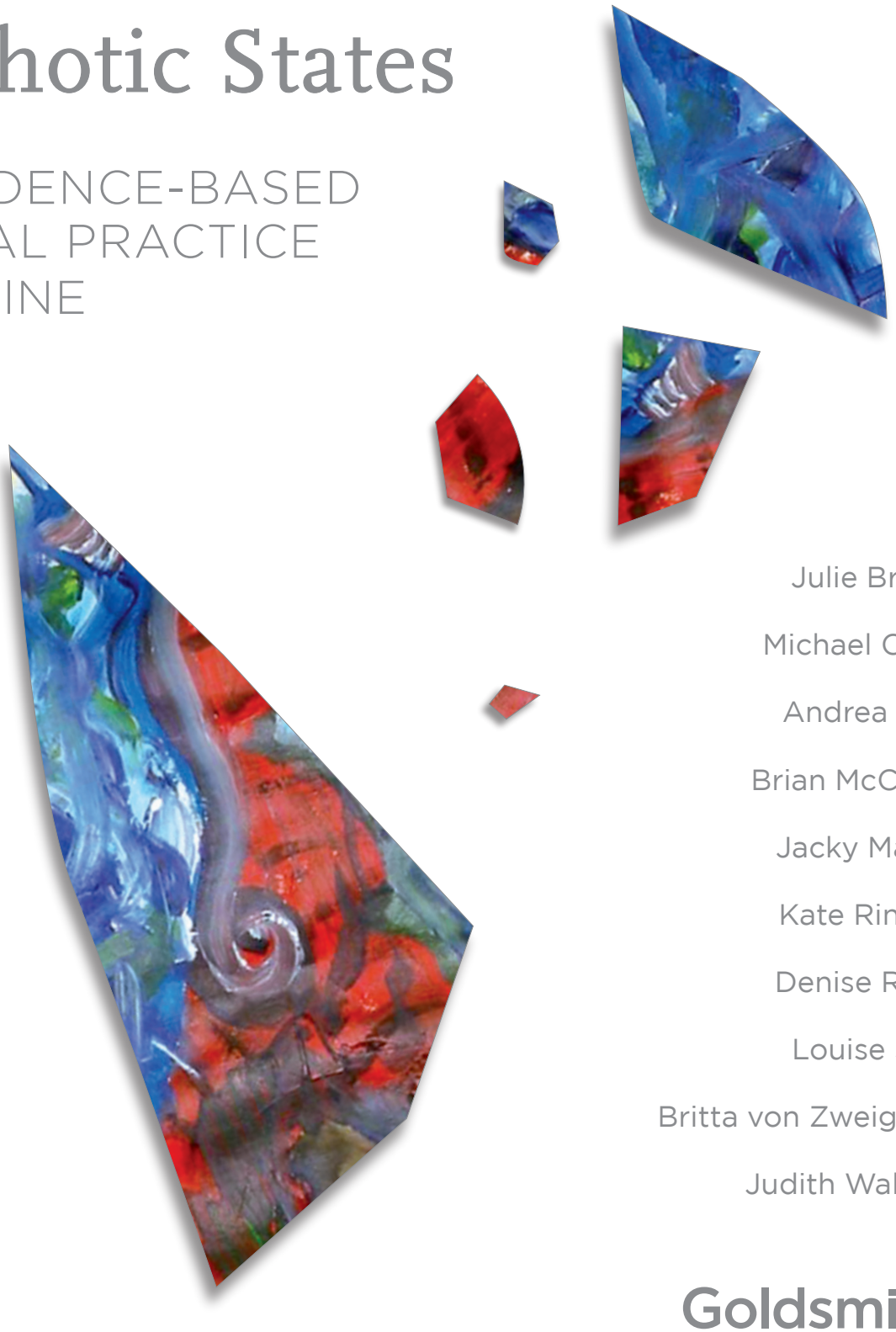
The Use of Art Work in Art Psychotherapy with People Who are Prone to Psychotic States

AN EVIDENCE-BASED CLINICAL PRACTICE GUIDELINE



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OXLEAS NHS FOUNDATION TRUST AND GOLDSMITHS, UNIVERSITY OF LONDON

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Acknowledgements

This Guideline was developed through the work and collaboration of a Guideline Development Group that, during its four years of meetings, comprised thirteen art therapists, all but one of whom worked in the Art Psychotherapy Service of Oxleas NHS Foundation Trust. The group began with eleven members; ten worked for the Trust and the Chair for Goldsmiths College. Our grateful thanks are due to the Trust and to the College: to the Trust for their direct financial support of the project during the first two years of its life and for their ongoing 'in kind' support in terms of group members' time, and to the College for the Chair's time and for the printing and publication of the final document.

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Introduction

This Clinical Guideline addresses the evidence base for the theory and practice of Art Psychotherapy for clients who have severe and complex problems. It draws on different types of evidence – from users, experienced practitioners, local custom and practice, research and other related literature. It addresses both in-patient and community care, and situates the profession and its practices in the context of National Service Frameworks.

The document begins with description of Art Psychotherapists' long-standing history of work with this client population and, in so doing, outlines something of the development of the discipline's theory and clinical practice. It describes the Guideline's development, the aims and objectives of the project and the overall scope of the Guideline. The processes of generating evidence through consultation with two expert panels – one comprising Art Psychotherapists experienced in this area of work and another comprising service users – are also described. The identification and critical appraisal of research and other texts relevant to the Guideline's topic, and the development of evidence weightings appropriate to the discipline, are also explained.

The Guideline then moves on to an extensive Evidence Review. This narrative describes the evidence the Guideline Development Group gleaned from all possible sources - textual, oral and practical. This includes research-based literature, other academically rigorous and descriptive literature and the opinions of expert practitioners, local practitioners and local expert users. The findings from the review process are described in the narrative and each is assigned to an evidence level. The evidence is reviewed thematically, for example regarding the contexts and settings of Art Psychotherapy practice, the referral process, assessment and clinical approaches. The theory that underpins clinical work is described first, followed by practice itself; the former (theory) derives almost entirely from the literature, but the latter (practice) is significantly informed by the opinions of our two expert panels and by the custom and practice of Art Psychotherapists at Oxleas NHS Foundation Trust. In so doing, the Guideline addresses some of the gaps in the current Art Psychotherapy literature.

The Evidence Review is followed by Recommendations. These distil the findings of the Review into General Principles and specific Recommendations for Art Psychotherapy practice with users who are prone to psychotic states. Each Principle and Recommendation is accompanied by a brief statement that refers to the evidence it has been derived from; like the evidence in the review, it too is assigned to a level. The highest level (1a and 1b) should be afforded the most significance.

The document concludes with discussion of the implementation of the guideline and audit criteria.

The Context and Development of the Guideline

INTRODUCTION

Art Therapy, or Art Psychotherapy as it is also known and described in this Guideline, has been offered within the NHS for sixty years. It originated through the work of artists and art teachers who, during the 1940s and 1950s, developed art studios in psychiatric hospitals and in other services for people with mental health problems and disabilities. A combination of social and cultural factors during these times enabled Art Therapy to develop: through the interest of psychiatrists and psychoanalysts in the art works of their patients; the consequent employment of artists and art teachers to work in different kinds of psychiatric and social care settings; and the interest of these artists and pioneer art therapists in the role of the unconscious in the making of art. In 1964 the professional association – the British Association of Art Therapists (BAAT) - was formed and in 1982 the discipline was recognised by the Department of Health. In 1997 Art Therapy was one of three Arts Therapies (the others were Music Therapy and Drama Therapy) to become a State Registered profession with the (then) Council of Professions Supplementary to Medicine (CPSM), now the Health Professions Council (HPC). Art Psychotherapy is a postgraduate profession, the qualification to practise being a Postgraduate Diploma or MA in Art Psychotherapy that follows an undergraduate degree, usually in the visual arts.

The discipline encompasses a range of practices but all focus on a reflective, experiential process that has at its heart the making of art. This occurs within a dynamically-oriented relationship between a client, their art and an Art Psychotherapist. Clients are encouraged to use art materials to articulate their concerns and, if appropriate, to view and discuss the resulting art works in order to clarify and explore their meaning and relationship to their current problems and earlier life experiences. This enables clients to regain self-esteem and a creative sense of agency in their lives, increases well-being and enhances their ability to cope with life's difficulties. The emphasis is on an alternative form of discourse that draws upon and supports clients' own resources in understanding and finding meaning in their lives.

Throughout the profession's history Art Psychotherapists have worked with clients who experience psychotic states, often offering the only psychotherapeutically-oriented service to these clients, both in the community and during acute phases of in-patient care. Art Psychotherapists may be one of several healthcare professionals offering treatment to this client population as part of a standard package of care, or they may be the sole mental health professional offering 'stand alone' treatment (Parry & Richardson, 1996). In the last few years strategic policy documents by the Department of Health (DoH) have recognised the important role of Art Psychotherapy in the UK's mental health services (e.g. 'Meeting the Challenge: a Strategy for the Allied Health Professions', DoH, 2000),

situating the Arts Therapies as one of the effective psychological therapies that make a valuable contribution to service provision ('Organising and Delivering Psychological Therapies', 2004). The DoH has made clear that these services make a "highly significant contribution to outcome and user satisfaction" and "should no longer be regarded as optional .. nor .. constrained by the vagaries of local geography and history" (DoH, 2004, p. 3). Services should provide for different levels of need across a person's life and for a range of problems - from short-term, acute reactions to life events to caring for people with psychosis and long-term, complex mental health problems (ibid, p.4).

The DoH states that users consistently place access to psychological services at the top of their list of unmet needs (ibid, p. 6). They cite MIND's 'My Choice' campaign (2003) that surveyed the extent of user choice in their treatment. The campaign found that over half of the respondents felt they had not been given enough choice, listing art, music and drama therapy amongst their top five alternatives to medication. The DoH has recognised that involving users in choosing the most appropriate therapy, providing information and improving access to services, attending to the differing needs of different user groups and situations and delivering evidence-based treatments, are all part of developing co-ordinated, appropriate and effective services (DoH, 2004, p. 1 - 2). This document is situated within this context and has drawn extensively on the advice and guidance of user representatives during the final stages of its development.

This Guideline is also situated in the context of the full national NICE Guidelines (2002/2006) on interventions in schizophrenia in primary and secondary care. In these documents, psychological interventions with people diagnosed as schizophrenic are described as aiming to decrease an individual's distress and vulnerability, reduce symptoms and risk, and improve communication and their quality of life (p. 114). The evidence presented in this document suggests that Art Psychotherapy addresses and achieves all these aims, not least the "supportive and empathic relationships" that NICE recommends (ibid) and does so within the 'step model' of treatment, i.e. steps 2 and 3 (as part of early intervention and prevention) and steps 4 and 5 (as part of treatment from mental health specialists). However, neither Art Psychotherapy, nor any other arts therapy, is identified in NICE's list of contemporary therapeutic approaches. NICE acknowledges the absence of evidence "to suggest that counselling or supportive psychotherapy is superior to 'standard care' or 'other active treatments'" (ibid) but recommends that user preferences are taken into account in their routine care.

The National Service Framework spells out five standards necessary for the improvement of patient care in the mental health services of the NHS (DoH, 1999). The NSF requires that the definition of standards and service models for all treatments be evidence-based, specifically targeting "effective services for people with severe mental illness" (Standards four and five) and "individuals who care for people with mental health problems" (Standard six). It states that planning and implementation are necessary at local level, not only in order to address service users' access to psychological and rehabilitation services but also to ensure the implementation of best clinical practice through the development of Clinical Guidelines and Clinical Audit. Indeed Parry & Richardson (1996) suggest that an evidence base to clinical practice in all psychotherapy-based services can be demonstrated through:

- The adoption of Clinical Guidelines for standard practice
- Clinical Guidelines being informed by research & service evaluation
- Appropriate services being specified for particular patient groups
- Outcomes for innovative treatments being monitored
- Key elements of standard practice being audited. (p.47)

The development of Evidence-Based Practice in Art Psychotherapy overall is in its early stages (Gilroy 1996, 2006; Wood 1999), although there has been a significant growth in research activity in recent years that has seen the completion and publication of a number of inductive and empirical research studies (e.g. Jones, forthcoming; Killick & Greenwood, 1995; Richardson et al, 2007). Alongside this is a growing body of academically rigorous Art Psychotherapy literature that, together with recent and ongoing research, comprises a sufficient critical mass to enable a rigorous critical appraisal of the literature and so the development of Clinical Guidelines. This is particularly so for the treatment of adult clients who are prone to psychotic states (vis Standards four and five), this being a client group with whom Art Psychotherapists have a long history of practice as exemplified, for example, in the work of Killick (1991, 1993, 2000), Wood (1992, 1997, 2000) and Greenwood & Layton (1987, 1991). This too is the context in which this Clinical Guideline has been developed.

HISTORY OF THE PROJECT

The project began in 2002 and followed several Clinical Governance initiatives undertaken by the Art Psychotherapy Service at Oxleas NHS Foundation Trust. These sought to develop a demonstrably clinically effective service, for example through setting standards in preparation for audit, reviewing supervision, developing Continuing Professional Development (CPD, including art practice), team-building, enhancing the knowledge and skills base of the service and developing research. The Head of the Art Psychotherapy Service at Oxleas NHS Foundation Trust at that time, Jacky Mahony, invited Dr. Andrea Gilroy of Goldsmiths College to write a proposal for the development of an Art Psychotherapy Clinical Guideline; this was submitted to the Trust and approved, and a small grant awarded that covered the consultation costs of the Chair for the first 2 – 3 years of the project. The Guideline Development Group that was subsequently formed comprised Art Psychotherapists who worked with adult clients at Oxleas NHS Foundation Trust between 2002 – 2006 and the Chair of the Group (Dr. Andrea Gilroy). The Group met 30 times over this 4 year period.

Choosing the topic for the Guideline was guided by the priorities of the Trust and of the Service, and also by Oxleas' Art Psychotherapists' wish to do a project that was of immediate and practical relevance to their day-to-day clinical work. Members of this client population were usually seen in either group or individual Art Psychotherapy by all members of the Service who worked with adult clients, albeit in a variety of in-patient and out-patient care services. It was anticipated that the project would enable clinicians to ensure that their practice with these particular service users was in accord with the best available evidence.

The Guideline was thus commissioned and supported throughout by Oxleas NHS Foundation Trust. During its development the first Randomised Controlled Trial (RCT) of group art therapy for people diagnosed as schizophrenic was completed (Richardson et al 2007, Jones forthcoming). Following this, in 2005 the DoH's Health Technology

Assessment Centre commissioned a further RCT examining the effectiveness of group interactive art therapy for this client population. This is currently being undertaken by Imperial College, University of London.

AIMS AND OBJECTIVES

The aim of this project was to improve the clinical effectiveness in clinical practice with adult mental health clients attending Art Psychotherapy at Oxleas NHS Foundation Trust through the development of a Clinical Guideline for practice with adults who are prone to psychotic states. This adheres to Government policy with regard to local implementation of the National Service Frameworks, in this instance in Art Psychotherapy. The objective was that the Guideline Development Group (the staff of the Art Psychotherapy Service of Oxleas NHS Foundation Trust and Dr. Andrea Gilroy of Goldsmiths College) initiate, develop and implement an Art Psychotherapy Clinical Guideline for adults with psychotic and related conditions that could subsequently be audited. We hope that the Guideline will be a significant contribution at a national level to the construction of an evidence base for Art Psychotherapy with these particular service users.

SCOPE OF THE GUIDELINE

This Clinical Guideline refers specifically to the use of art work in Art Psychotherapy with adult service users who have severe and complex problems and who are prone to psychotic and borderline psychotic states. It recognises that these clients are usually seen within the NHS but may also be encountered by Art Psychotherapists working with adult clients in the Social Services and in prison/offender institutions. The Guideline is thus an inclusive document that refers to the theory and practice of Art Psychotherapy across the range of services for users who are prone to psychotic conditions. This includes adults who have been diagnosed as schizophrenic, who may experience acute psychotic states and who are amongst the most severe and long-term users of mental health services seen in both in-patient and out-patient settings.

The Guideline refers to and has been developed by Art Psychotherapists working within the psychiatric mainstream of the NHS. The Guideline therefore acknowledges and works with the definitions of severe and complex illnesses described by DSM IV and ICD 10. However the theory and practice of Art Psychotherapy is embedded in a psychodynamic approach to therapy that has its origins in psychoanalysis, offering alternative ways of thinking about the lives and experiences of these service users to those of the medical model of psychiatry. The definitions of 'schizophrenia' and 'psychosis' used in this Guideline therefore have to encompass a tension between different philosophies of causation and care.

Both psychiatry and psychoanalysis use the terms 'psychotic states' to describe particular mental health problems, namely schizophrenia, manic depressive psychosis and paranoia. The term 'psychotic' has historically been associated with a number of different definitions, none of which are universally accepted. The narrowest definition is restricted to people who have delusions or prominent hallucinations without insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the person realises are hallucinatory experiences. Broader still is a definition that includes symptoms of schizophrenia, i.e. disorganised speech, disorganised behaviour and catatonic behaviour. The term also refers to a loss of ego boundaries and an impairment in reality testing.

According to ICD 10, schizophrenic disorders are characterised by distortions of thinking and perception and by inappropriate or blunted affect. Hallucinations, especially auditory, are common and may comment on the person's thoughts or behaviour. Intimate thoughts or feelings can be felt to be known or shared by others and explanatory delusions may develop that effect the person's thoughts and actions. Everyday situations can possess a special, sometimes sinister meaning intended uniquely for the individual, peripheral and irrelevant factors replacing those that are relevant and appropriate to a situation. Thinking can become vague, elliptical or obscure and speech incomprehensible. Clear consciousness and intellectual capacity are usually maintained, although over time there may be cognitive deficits. There may be inertia, negativism, stupor or catatonia. These problems influence the basic human functions that give a person feelings of individuality, uniqueness and self-direction (ICD 10, 1992, p. 86)

The Guideline addresses Art Psychotherapy practice with adult service users who have long-term and severe problems, who have been diagnosed as schizophrenic and/or are prone to psychotic states. This is a client population with whom Art Psychotherapists have a long history, about which there was known to be a (relatively) substantial literature, and which had immediate relevance to the Guideline Development Group. The Guideline does not address practice with the following client populations who have, for practical reasons alone, been excluded, namely: children, adolescents and families; clients diagnosed with personality disorders; who are depressed or anxious; who have panic disorders, social anxieties and phobias; who have eating disorders, addictions, learning disabilities, post-traumatic problems, obsessive compulsive disorders, organic brain syndromes and acquired brain injury. This does not infer that Art Psychotherapy is unhelpful or inappropriate for other client populations. Art Psychotherapy can benefit most users. It has a developing evidence base that addresses practice with a wide range of different client populations who use different kinds of Art Psychotherapy services in the public sector (Gilroy, 2006). Separate guidelines need to be developed for different user groups and across the range of services as the evidence base for the discipline develops, i.e. apart from those already completed (Waller, 2006, on art therapy and dementia; Pratt, 2004, on art therapy in palliative care, Teasdale, 2002, on art therapy in prisons).

USER CONSULTATION

User consultation was key to the development of this Guideline. It was facilitated through the User Council of Oxleas NHS Foundation Trust. Initially the Chair of the Guideline Development Group contacted the headquarters of MIND and the UK Advocacy Network seeking user representation. This was because local user representation seemed likely to encounter problems with boundaries and confidentiality. Unfortunately national organisations were unable to help and so we decided to explore the possibilities of user consultation locally, through the Trust. Consultation with the Research and Development Department at Oxleas confirmed that, as the project was 'secondary research', approval for local user consultation was not required from Oxleas Research Ethics Committee or from COREC (Central Office for Research Ethics Committees). The Group were also advised that local funds were available for users to take part in the project, according to Trust guidelines, and that a direct approach could be made to the local User Council. Two members of the Guideline Development Group therefore attended one of the User Council's monthly meetings to present the project and seek the Council's advice and assistance with finding user volunteers. The Council were supportive of the project and suggested advertising through various venues in and beyond the Trust.

A poster and accompanying leaflet were designed and distributed to day centres, community centres, MIND centres and related venues in the London boroughs of Bexley, Bromley and Greenwich, i.e. the areas covered by Oxleas NHS Foundation Trust (see Appendix 1). Volunteers were asked to contact the Art Psychotherapy Service; those who did were sent a letter describing the project and what was entailed in the user consultation process (see Appendix 2). This emphasised that the consultation process would not involve actually doing Art Psychotherapy or being in a therapy group but would require volunteers to read a document about Art Psychotherapy and attend three meetings to discuss and give feedback about it. One of the Guideline Group then liased with the six volunteers over the telephone and organised their travel to and from each of the three, two-hour meetings; phone calls prior to each meeting confirmed the arrangements. People were paid for their time, for reading the document and for coming to the meetings. The meetings took place at the Trust's Headquarters, Pinewood House; refreshments were provided. Oxleas NHS Foundation Trust supported and funded the entirety of the user consultation process.

Three members of the Guideline Group were nominated to meet with the User Consultation Group: the Chair of the Guideline Group (Dr. Andrea Gilroy); the Deputy Head of the Art Psychotherapy Service at Oxleas (Louise Smart) and Art Psychotherapist (Kate Ringrose). They met for an hour before and an hour after each consultation meeting to ensure that all travel and hospitality arrangements were in place and to prepare for the meeting, and then to feedback, process and check that discussions had been accurately recorded. Each representative of the Guideline Group had a role: Louise chaired the meetings; Andy acted as scribe; and Kate took responsibility for liaison in and between the meetings and for organising users' travel.

The meetings with the User Consultation Group were a pivotal part of the whole process of developing the Guideline and brought new energy and commitment to the project as it was nearing the end. At the first meeting the members of the Guideline Group described what a Clinical Guideline was, how this Guideline in particular had been developed so far, how the consultation process would work and who this Guideline was for. The first meeting generated lively discussion about the media used in Art Psychotherapy, how frightening it could be to be faced with a blank sheet of paper and art materials that were unfamiliar, and that Art Psychotherapy offered clients an important place to go – somewhere to escape to. Art Psychotherapy was, according to the user experts, preferable to taking medication. However, for some, medication was essential and could not be entirely dispensed with as it helped with the management of problems, although it could be reduced over time. Taking medication whilst also attending Art Psychotherapy was thought to be a good and effective option. Further conversation about the nature and benefits of Art Psychotherapy ensued that have been incorporated into the narrative (that follows) of evidence arising from user consultation. This first meeting also addressed publication of the document and confidentiality.

The second meeting with the User Consultation Group, 5 weeks later, involved the circulation of minutes from the first meeting and both general and detailed feedback on the draft guideline. Users agreed that initially they had resisted reading the document and had found it hard to get into; it had been a bit difficult to read, a bit 'dry', but once they were into it everyone found it logical, sequential, well written and positive. It was

straightforward, concise, easy to digest and the recommendations were good. There had been nothing new or surprising, although there were some concerns about language and who the document was written for. In draft the Guideline seemed to be 'written by Art Psychotherapists, for Art Psychotherapists', and users felt that the importance of the two-person relationship between client and therapist was not highlighted enough. It was felt very strongly that the document should include the users' voices and that it should emphasise Art Psychotherapy's usefulness to the client: that the purpose of Art Psychotherapy was to help the client understand what was happening, rather than (or as well as) the Art Psychotherapist. Nonetheless user representatives felt they had learned about Art Psychotherapy through reading the guideline because it explained the clinical approach in a way that had not quite been understood before.

Users' feedback about the document was both detailed and constructive and included significant proposals about the kind of treatment and services that they wanted. A key recommendation was about having speedy access to Art Psychotherapy and their wish for readily available, community-based, drop-in Art Psychotherapy studios that would enable users to be pro-active in the management of their problems. These and other points are incorporated into the narrative, principles and recommendations.

Following the second user consultation meeting the document was revised and sent to users again, together with minutes from the second meeting. At the third and final meeting, two months after the second meeting, users agreed that they had found the document much clearer and easier to read. They felt that they now had a voice in the document and that it was more accessible and flowed from one section to another in a way that it had not done before. Users also thought that the guideline gave a sense of how Art Psychotherapy had developed over the years – one of their suggestions was that some of the historical material should be explained a bit more – and they liked the way the Recommendations had been expanded.

Users offered a number of helpful suggestions for improving the document still further, for example including a Table of Contents so that readers could dip in and out of the document and adding a glossary of terms or a list of abbreviations as there were many acronyms and technical terms. Users also queried description of the changes in psychiatric practice over the years and wondered what 'anti-psychiatry' meant and suggested that this be explained more clearly. They reiterated their view that Art Psychotherapy can work effectively alongside medication and suggested that the Guideline Development Group state how long sessions – and treatment - should usually last, adding that Art Psychotherapists should be clear about when the assessment process ends and therapy begins. Users were however troubled by a part of the Theory section on Context that referred to misogyny, patriarchy and ethnic minorities and felt that this was too academic and could be misinterpreted; they suggested that the Group revise these paragraphs. These and other detailed changes suggested by users have been incorporated into the document.

At this last meeting we also discussed how user representatives would like to be acknowledged in the final text. We agreed that two 'expert panels' would be cited, namely the professional experts and the user experts, with some user's names listed and others acknowledged anonymously. We also discussed various possibilities for publication and agreed to send everyone a copy of the final document once it was completed. The meeting concluded with

members of the Guideline Group thanking users for their valuable contributions and for taking part. We all agreed that it had been a very useful and interesting process for everyone involved. After the meetings had ended we stayed in touch with users by letter (Appendix 3) and phone and checked two issues with them. One sought confirmation about how they would like to be acknowledged in the document, the other concerned a suggestion from a member of our Expert Practitioner Panel. This was that we use the term 'patient' throughout the document, given that its readership could extend beyond our own discipline into other professions and organisations. We asked users which was their preferred term. They unanimously opposed 'patient' because of the associated stigma, saying that the terms 'patient', 'service user' and 'client' reflected different stages of illness and health, in and out of hospital. 'Service user' was thought to be empowering and, like 'client', implied a voluntary status. Therefore the terms 'service user' and 'client' are used interchangeably throughout the document. We also checked how service users would like to be acknowledged in the final document and have followed the wishes of each individual.

EXPERT PANEL

Throughout the development of the Guideline the Development Group also consulted with a Panel of professional expert advisors. The Development Group wrote to the Chair of the British Association of Art Therapists and requested that BAAT Council nominate five 'expert' Art Psychotherapists according to the criteria outlined by Parry (2001). These were practitioners who:

- Were recognised by peers as having expertise in the topic
- Had clinical experience in the NHS
- One should have service management experience in the NHS
- All should wish to achieve consensus on best practice

The resulting Expert Practitioner Panel (see Appendix 4) existed only 'virtually' and never met either each other, members of the User Consultation Group or the Guideline Development Group. The Chair of the Guideline Group communicated with the Experts individually and by post/email. Their tasks were to:

- Check that all the relevant literature had been included in the Bibliography.
- Review the research evidence/literature once it had been appraised
- Assist in the development of recommendations arising from the literature
- Assist in the development of recommendations where literature was either absent or where it differed from the Group's view
- Confirm the 'clinical appropriateness' of the final recommendations

The Expert Practitioner Panel were sent the document, in draft, on three occasions and returned their comments to the Chair. The final version of the document sent to the Expert Panel included comments and revisions from the User Consultation Group. All suggestions and comments from the Expert Practitioner Panel were discussed, point by point, by the Guideline Development Group and adjustments made to the document accordingly.

SEARCH STRATEGY AND THE DEVELOPMENT OF THE BIBLIOGRAPHY

The literature consulted during the development of this Guideline was identified in the first instance by the Guideline Development Group and expanded following consultation with the Expert Practitioner Panel.

The Group generated a wide-ranging, international draft Bibliography that described Art Therapy/Art Psychotherapy with this client population, firstly through brainstorming and then through hand-searching national and international Art Therapy/Art Psychotherapy journals from 1990 to date. These included 'Inscape' (journal of the British Association of Art Therapists); the 'Arts in Psychotherapy'; the 'American Journal of Art Therapy'; 'Art Therapy' (journal of the American Association of Art Therapists); and the 'Canadian Journal of Art Therapy'. We also consulted conference and professional associations' websites, namely those of the American Association of Art Therapists (www.aata.org), the British Association of Art Therapists (www.baat.org) and 'Theoretical Advances in Art Therapy' (www.taoat.org), and checked the MA theses held in the Libraries of the University of Hertfordshire and Goldsmiths College. Time, funding and geography prevented library searches at other university libraries likely to hold research-based theses from post-qualification Art Therapy/Art Psychotherapy programmes across the UK

We also conducted online searches for relevant texts via Psychinfo, Clin Lit and Medline. Keywords used were 'art and therapy and borderline and patients' which retrieved 34 records, and 'art and therapy and psychosis' that identified 89 records. These included texts from all over the world: from Turkey, Norway, Hungary, France, Italy, Switzerland and the United States of America which referred sometimes to other arts therapies, to psychotherapy and to work with children and adolescents. Most UK texts cited in these searches had already been identified. The size of the Bibliography being generated, the differing languages, cultural differences and the variability of theory and practice described in these texts required that the literature be limited to only that which was strictly relevant to the work of the Art Psychotherapists at Oxleas, i.e. to the British Art Therapy/Art Psychotherapy literature. This resulted in a Bibliography of 50 texts. This was sent to the Expert Practitioner Panel who identified a further 21 texts, resulting in an initial Bibliography of 71 texts.

APPRAISAL OF THE LITERATURE

The Guideline Development Group then divided into three reading groups located at each of the three boroughs covered by Oxleas NHS Foundation Trust, namely Bexley, Bromley and Greenwich. The Chair randomly assigned the literature to each reading group for an initial appraisal in order to evaluate the relevance of each text to the Guideline's topic: 'The use of art work in Art Psychotherapy with people who are prone to psychotic states.' The initial appraisal process piloted an 'Initial Appraisal Checklist' (Appendix 5) that had been developed by the Chair, drawing on the work of Bury and Jerosch-Herold (1998). This examined whether or not a text was research-based, academically rigorous, credible, clinically relevant and relevant to the Guideline topic (no changes were made to the Initial Appraisal Checklist as a result of the pilot). Members of the Guideline Development Group read the texts independently, scoring them on the Initial Appraisal Checklist and taking this to their local reading group for discussion and decision (Gilbody & Sowden, 2000) regarding the inclusion or exclusion of each text from the Bibliography. The initial appraisal excluded 30 texts from the initial Bibliography of 71, leaving a Bibliography of 41 texts to be critically appraised.

Texts to be critically appraised were also assigned to the three reading groups by the Chair. However, this allocation was not random, texts being assigned to a different reading

group from that which had done the initial appraisal. The critical appraisal of the literature also piloted a Critical Appraisal Checklist developed by the Chair (Appendix 6; no changes were made as a result of the pilot). This Checklist appraised the content and method of each text in depth. For example, if a text was research-based the methodology was noted and its appropriateness to the research question was appraised. If texts were not research-based they were appraised in terms of their academic rigour and whether or not they were situated in a critical context. Descriptive case studies were considered in terms of the adequacy and sufficiency of description, its situating within a theoretical and critical context, the adequacy of visual illustration and its congruence with the description and analysis in the text. All texts were appraised again for the credibility, applicability and relevance to the Guideline topic.

After the main evidence review, three supplementary texts were identified by members of the Guideline Development Group and by the Expert Practitioner Panel that were not yet published. These were appraised following the same procedure as with the main review, resulting in a Bibliography of 44 texts that have informed the Guideline.

The appraisal process included identification of key issues arising from each text. These were collated and clustered by the Chair of the Group as themes emerged. Members of the Group then wrote sections of narrative describing the key issues and weighting the evidence throughout. These were collated and edited into the document by the Chair.

EVIDENCE WEIGHTINGS

The evidence hierarchies of medicine and the psychological therapies usually weight texts according to the rigour and nature of quantitative research methodology. These routinely exclude qualitative research and theoretical and descriptive studies. The Guideline Development Group deemed these standard structures to be inequitous methodologically and inappropriate for the current knowledge and evidence base of Art Psychotherapy. The Chair and the Guideline Development Group therefore devised an evidence hierarchy that, whilst staying within the framework of orthodox Evidence-Based Practice, enabled an inclusive, realistic and critical assessment of Art Psychotherapy's current evidence base. The 'Art Psychotherapy Levels of Evidence' are based on the 'Psychotherapy Levels of Evidence' (Parry 2001), but give equal weighting to quantitative and qualitative research methodology and values academically rigorous texts.

Each critically appraised text was assigned to one of four levels within the 'Art Psychotherapy Levels of Evidence' by the reading groups, following the process outlined by Bury and Jerosch-Herold (1998), Bury & Mead (1998), Cape (1998), Cape & Parry (2000) and Parry (2001), i.e. according to whether or not it was research-based (Level I), considering its research methodology (Level Ia or Ib) and academic rigour (Level II), and if it was from an expert or 'respected authority' (Level III).

Following an initial development of General Principles and Recommendations (drawing on Parry's 'Treatment Choice in Psychological Therapies', 2001), the Guideline Development Group identified certain aspects of their clinical work with clients who have severe and complex problems and are prone to psychotic states that were not addressed in the literature. Inclusion of descriptive narrative and General Principles and Recommendations arising from local custom and practice, developed through clinical consensus procedures

and group discussion, required the inclusion of a further level of evidence: Level IVa

Similarly, during the process of user consultation, it was clear that important feedback about Art Psychotherapy services and practices should be represented in the Guideline. A further evidence level was therefore added, Level IVb, representing evidence derived from the User Consultation Group. Thus there are six levels of Art Psychotherapy Evidence in all.

The evidence for this Guideline overall has therefore been interpreted and weighted as follows:

Art Psychotherapy Levels of Evidence	
Ia	Evidence from at least one randomised controlled trial or from at least one controlled, experimental or quasi-experimental study
Ib	Evidence from other research e.g. case studies, phenomenological, ethnographic, anthropological, art-based & collaborative studies
II	Evidence from other academically rigorous texts
III	Evidence from expert committee reports or opinions, or clinical experience of respected authority, or both
IVa	Evidence from local clinical consensus
IVb	Evidence from user consultation

The General Principles and Recommendations represent a distillation of the evidence, each having been being weighted for strength of evidence and assigned to a level. All are based on the best available evidence; for example if a recommendation could be based on high quality research-based evidence, other evidence (e.g. from expert opinion or local clinical consensus) was not used.

Evidence underpinning the General Principles and Recommendations that comprise this Clinical Guideline has therefore been drawn from the British Art Psychotherapy literature, derived from local custom and practice within the Art Psychotherapy Service of Oxleas NHS Foundation Trust, developed through feedback, clarification and the development of ideas from two Expert Panels: of expert practitioners and expert users.

Evidence Review

The following narratives summarise the Art Psychotherapy literature relating to the use of art work in Art Psychotherapy with people who are prone to psychotic states. This literature refers to clients diagnosed as schizophrenic or psychotic whose difficulties are long-term, i.e. who have periods of stability interspersed with psychotic episodes, as well as those in acute psychotic states.

This review, and the General Principles and Recommendations that follow, refer to generic Art Psychotherapy practice with these users unless specified otherwise, i.e. to work with individuals, individuals in groups, open studio groups and closed (slow, open) groups.

INTRODUCTION

The theory and practice of Art Psychotherapy with clients prone to psychotic conditions has developed significantly over the last 70+ years, there being three main periods in its history. Initially, working in the large psychiatric institutions in the 1940s through to the 1950s, there was an emphasis on people being encouraged to engage in the art-making process and on empathic 'containment'. Widespread tension between older psychiatric forms of practice for these clients, i.e. containment in institutions coupled with medication and occupation, and the anti-psychiatry movement of the 1960s that sought to understand symptoms and behaviour rather than contain and medicate them, led to the development of a social psychiatry perspective. Art Psychotherapy mirrored the anti-psychiatry movement with practitioners, the art therapy room or studio offering an 'asylum within an asylum'. However in the 1980s through to the 1990s, as clients were moved out of the large asylums to live in the community, Art Psychotherapists have had to develop different models of practice. The profession has been facilitated by these developments in psychiatry (Ib) (Wood 2000, 1997).

The Sainsbury Review (1998) acknowledges that clients with severe, complex and enduring problems can be hard to engage with mental health services. They refer to 15,000 people who are concentrated in deprived areas, often in inner cities, who have mostly never lived in psychiatric hospitals but who may have experienced repeated in-patient stays and unsatisfactory community placements. In this context it is important to note the work of Warner (1985) who demonstrates the increasing incidence of psychosis in relation to poverty. The Sainsbury Review supports the use of assertive outreach methods that enables these users to access mental health services. This suggests that practitioners should develop active methods and strategies that ensure that users know about, and are facilitated in their ability to make use of, the services that are available to them.

Thus it is now widely recognised that assertive outreach is effective in improving the engagement of this client population with the services provided for them (NICE 2006). This was supported in the first randomised controlled trial (RCT) of group Art Psychotherapy with people diagnosed as schizophrenic. Richardson et al (2007) and Jones (forthcoming)

demonstrated that a higher percentage of black and ethnic minority clients took part in the trial than would usually be the case for Art Psychotherapy services in the same geographical area. It was clear that the highly active recruitment process necessary for the trial resulted in improved access to Art Psychotherapy for ethnic minorities amongst these users (Ia).

Art Psychotherapy practice has been continuous with this client population since WW2, working in open studio settings, with closed groups and with individuals. The profession has made, and continues to make, a positive contribution to service provision for these users who can be hard to engage in the standard services of mental health care. This was demonstrated by Richardson et al (2007) (1a) and Jones' (forthcoming) RCT (Ia), and by Wood's (2000, 1997) historical research (Ib). Art Psychotherapy can be part of multi-disciplinary teams' packages of care or be a 'stand alone' treatment (Parry & Richardson, 1996). For example, Richardson et al's and Jones' RCT of 12 sessions of group Art Psychotherapy demonstrated that people diagnosed as schizophrenic experienced significant benefits on a scale that assessed negative symptoms. Overall the experimental group who took part in the Art Psychotherapy groups improved when compared with the control group, who did not. This was encouraging, given practitioners' view that the model of brief Art Psychotherapy used in the trial (12 weekly sessions) would not usually be expected to bring about change in such a short period of time, treatment usually occurring over a longer period of 18 months to 2 years (IVa; Gilroy and Jones, 2005). The trial's treatment model was based on group interactive art therapy (Waller, 1993), allowing time and space for art making and for sharing and talking about the images.

THEORY

Aims

Theory that underpins the use of art work in Art Psychotherapy with people prone to psychotic states has developed alongside clinical practice and, in recent years, has been informed by psychoanalytic theory. It can facilitate a living relationship with another (II) (Killick, 1995) and enable communication (III) (Skailes, 1997). More recently, research has shown that Art Psychotherapy offers a stepping-stone from isolation to the outer world for people who have experienced, and are experiencing, psychosis (Ib) (Wood, 2000). Making art in Art Psychotherapy provides a form of engagement that enables the maker – the client - to become absorbed, this being one of the tasks of therapy (Ib) (Wood, 2000). The Art Psychotherapist fosters the evolution of the client's language through their artwork; this enables a mediation to occur between the client's concrete and symbolic thinking and helps him or her to develop symbolic functioning. These symbolising ego functions enable the development of communication and relationship that are severely impaired in psychotic and borderline psychotic states (Ib) (Killick & Greenwood, 1995).

The art activity implicit in Art Psychotherapy strengthens the client's psychological experience (II) (Greenwood & Layton, 1987) and gives people a feeling of control and autonomy in their lives (III) (Molloy, 1997). Gradual, continuous and concrete progress can therefore be made with and through the making of art in Art Psychotherapy, providing a form of inner, creative reconstruction for the individual. Some authors see acceptance and growth being achieved through the art work's capacity to safely address a person's underlying emotional conflicts (III) (Molloy, 1997; Lydiatt, 1971). The art object the client has made informs the Art Psychotherapy process (II) (Killick, 1995) and can help link their unconscious to conscious thought (III) (Lydiatt 1971). These creative and symbolic

processes in Art Psychotherapy enable clients to shift from pathological to benign regression in their behaviour and artwork, creating the potential for ego functions (II) (Killick 1991) and for the maturation of the ego (II) (Greenwood, 1997). Consistent work over time in Art Psychotherapy can enable a client to see the events of his/her childhood in the context of their current life (III) (Molloy, 1997). Additionally, it has been found that clients who have an artistic identity benefit from recognition of their work by others, which may help to increase their self-esteem (III) (Crane 1996). For some clients, the showing of their art works can be seen as a substitute for giving (II) (Mann, 1991).

One author has identified three interactive fields in the Art Psychotherapy process with this client group:

- the intrapersonal (the client and their art-making)
- the intermediary (established by the images existing as objects in a setting)
- the interpersonal (the triangular relationship between the art work, the client and the Art Psychotherapist)
  (II) (Killick, 1991)

Another has identified a fourth field that places the Art Psychotherapy process in a wider context. This requires consideration of:

- the socio-political/socio-cultural contexts of poverty, race, class, culture and gender and the influence of contemporary art and popular culture
  (1b) (Wood, 2000, forthcoming)

Context

Research has shown that consideration of the socio-political and socio-cultural context of Art Psychotherapy is of primary importance to clinical practice (Ib) (Wood, 2000, forthcoming). This is because users make their art works in the context of cultural and social difference, particularly with regard to class and poverty; these have been found to be determinants in the therapeutic relationship (III) (Wood, 1999). This was reinforced when the sometimes stark reality of clients' lives was made clear during the recruitment process for the RCT of group Art Psychotherapy with people diagnosed as schizophrenic (Ia) (Jones, forthcoming). The trial involved the Art Psychotherapist and the Research Assistant making many home visits through which they gained first hand experience of the social and economic deprivation embodied in the living circumstances of many clients.

With regard to equity the accessibility of services for ethnic minority clients Richardson et al (Ia) (2007) and Jones (Ia) (forthcoming), in their RCT of short-term group Art Psychotherapy with users from this client population, demonstrated that a higher percentage of black and ethnic minority users took part than was usually the case in Art Psychotherapy services in the same area. This raised questions about assessment and referral procedures to Art Psychotherapy and CMHT services at that time. Although not designed to investigate ethnicity, the trial improved access to Art Psychotherapy for these users. However, the random allocation of clients to groups raised ethical questions about the potential for racism between group members. In this context it is interesting to note that, in another context, an author describes her ethnicity as a black Art Psychotherapist as impacting positively and being a catalyst for issues of difference in a mixed race client group, although this could also provoke scapegoating and attack (III) (Henry, 1999).

Two other authors suggest that the Art Psychotherapist's cultural roots can impact on the therapy in a positive way. Exploration of the context of clients' artworks and comparison of their and the therapist's cultural perceptions can assist both user and therapist in their view of each other (III) (Mottram, 1999; Henry, 1999). With these socio-political and socio-cultural matters in mind, it can sometimes be helpful for clients to be supported to include references and allusions to contemporary art, visual and popular culture in the artworks they make in Art Psychotherapy (Ib & III) (Wood, 2000, forthcoming, 1999).

Art Psychotherapists also need to be aware of the patriarchal context of their clinical practice and not impose reductive psychoanalytic meanings onto clients' behaviour and artworks. Misogynistic visual representations of women can be internalised and may, for example, be represented in a female client's work. The Art Psychotherapy relationship can encourage the questioning and challenging of the social and cultural conditioning of gender that both clients and therapists have internalised (II) (Hogan, 1997)

Further, the uncritical endorsement of psychotherapeutic, psychoanalytic and psychiatric principles can influence Art Psychotherapists to be heterosexually biased and prejudicial towards gay men, bisexuals, lesbians and transgendered clients. It is therefore important that Art Psychotherapists are aware of the impact that internalised homophobia has both on experiences of being pathologised and/or rendered invisible in the mental health system. This includes both client and therapist, and can influence the Art Psychotherapy relationship (II) (Dudley,2001; Fraser & Waldman 2003).

Setting

Research has shown that the organisational setting of Art Psychotherapy is of primary importance to clinical practice. Art Psychotherapists working in the public sector have to adapt the therapeutic frame to the socio-political context in which they are working (Ib & III) (Wood, 2000, forthcoming, 1999), changes within the public sector for example influencing the viability of long-term work (Ib, II, III) (Wood, 2000, forthcoming, 1997, 1999). It is therefore important that clinical work occurs within a time scale adequate to assimilate the therapy (II & III) (Wood, 1997, 1999). Local custom and practice suggests that continuity of care in the longer term can be maintained through the provision of three monthly follow-up meetings for users once discharged from weekly group or individual Art Psychotherapy (IVa). User feedback supported this view and added that it was useful when Art Psychotherapists encouraged users to look back at their artwork. They suggested that this could be part of ongoing, follow-up meetings provided by Art Psychotherapy services (IVb).

Art Psychotherapists work with members of this client population both individually and in different kinds of groups and do so in a variety of settings, for example in acute in-patient units, in the voluntary sector or community day centres (e.g. Greenwood & Layton, 1987) (II). However, users felt that Art Psychotherapy should be more accessible and easily available than it is at present, especially in the community. They emphasised that long-term problems have acute phases and that quick and easy access to Art Psychotherapy when health is deteriorating would provide a useful preventative intervention (IVb). Further, the relatively lengthy process of referral and assessment (described later on in this guideline) was, users felt, unhelpful when seeking access from the community, especially when people were unwell, or becoming unwell, and were least able to deal with

procedures and paperwork. Users said that the absence of Art Psychotherapy open studio groups in community settings, for example in 'drop in' centres, was disappointing. In their experience, such groups were usually only available in in-patient settings. They proposed that 'drop in' Art Psychotherapy services should therefore be readily available in the community. Users could then have direct access to Art Psychotherapy and would receive a quick and efficient service when it was needed. This would provide a major resource that would be very much welcomed (IVb).

The rooms in which Art Psychotherapists work are also critical to professional practice and effective clinical work (Ib & III) (Wood 2000, forthcoming, 1999). Practitioners thought that Art Psychotherapy groups should usually be conducted in designated Art Psychotherapy rooms and/or studios. These should be well-equipped and offer a wide range of art materials (IVa); users added that this should include photography and other digital/IT media (IVb). In order to facilitate clients working with a range of art materials Art Psychotherapists should have a wide knowledge of techniques and materials (III) (Lyddiatt, 1971). Also, Art Psychotherapy rooms and studios should be planned in a way that allows the physical space to be one where the relationship between the Art Psychotherapist and the client can develop and where therapeutic work can be both physically and psychologically contained (IVa). The physical space should allow for both 'action' and 'privacy' (III) (Lyddiatt, 1971; Case & Dalley, 1992).

However, as local practitioners pointed out, group and individual Art Psychotherapy can and does occur in other, non-designated spaces such as shared, multi-functional rooms that vary in their degree of appropriateness for making artwork, for example dining rooms on acute, in-patient wards. Art Psychotherapists do not work in such spaces from choice but are able to adapt and make the best use of circumstances and physical spaces that are far from ideal, providing a service for clients, and taking it directly to them, during the most acute stages of illness when they would otherwise be unable to access either Art Psychotherapy or any other form of psychological and/or dynamically-based therapy (IVa).

Users remarked that the settings of Art Psychotherapy could sometimes be intimidating, and felt that, whatever the physical location of Art Psychotherapy, clinicians should ensure that the room or space should be inviting and friendly, for example through consideration of matters such as the positioning of furniture (IVb). However, members of the expert practitioner panel queried whether Art Psychotherapy rooms should be 'friendly', and suggested that practitioners should maintain their awareness of the physical space being one that will be projected onto and into, and that this process will include users' responses to the art materials (III).

The role and function of the art work

As will by now be clear, the art-making process in and of itself plays a central role in Art Psychotherapy with people prone to psychotic states. The artwork functions in a number of different ways: angry feelings and ambivalence can be safely contained by the image-making process (II & III) (Wood, 1992; Schaverien, 1982; Morter, 1997); artwork can be a vehicle for interaction between elements in an image that embody different and/or conflicting aspects of a personality (II) (Seth-Smith, 1997); and art works can act as a transactional object, show evidence of transference and function as a talisman (II) (Schaverien, 1992) or fetishistic object (II) (Mann, 1997). Art works facilitate

communication between client and therapist (II) (Sarra, 1998), particularly when there are difficulties in this area (II & III) (Seth-Smith, 1997; Charlton, 1984), and can provide a common language in multi-racial/cultural groups (III) (Cooper, 1999). References and allusions to the visual arts in clients' art works might mean that the Art Psychotherapist can usefully refer to, and help clients to become aware of, art and visual culture in general. This can help to counter the social exclusion that some users experience and mitigate against some of the effects of alienation caused by long-term and recurring problems (Ib & II) (Wood 2000, forthcoming, 1997).

But, crucially, making art in Art Psychotherapy can enable the client to develop their sense of self. Users thought that Art Psychotherapy can continue to be helpful to people when they make images when alone and living in the community (IVb). This, as service users suggested, could be enhanced by directly accessible, 'drop in' Art Psychotherapy studios, based in the community, where people could take their art work for discussion. However, users also felt it was important that Art Psychotherapists emphasise that their clients do not have to talk about the work they make, whether it has been made inside a therapy session or outside and brought to it (IVb). They added that the Art Psychotherapist's keeping of their (i.e. the clients') artworks and ensuring that they were safe, was an important aspect of the Art Psychotherapy process, an issue echoed in the research literature which states that that it is important that clients' artwork a) usually stays in the Art Psychotherapy room and b) that the client should have a choice about where it is kept (Ib) (Killick, 1996). Users said that practitioners' keeping and storing their art work in a safe place enabled a subsequent looking back, remembering, and thinking about how things used to be: this, in turn, enabled people to think about putting strategies in place for dealing with their difficulties in the future (IVb). Service users said that making art in Art Psychotherapy was terribly important and preferable to taking medication, although Art Psychotherapy and medication worked together well, alongside one another (IVb).

Defences

Mechanisms of defence with people prone to psychotic states range from the pathological to the adaptive. Several authors describe Art Psychotherapy with people who are in extreme psychotic states, one describing how the art object can absorb the violence of the client's intrusive identification without damage to either client or therapist (Ib) (Killick, 1996). Here art-making can facilitate a person's symbolic functioning and thinking and enable a shift in the client from evacuative projective identification to projective identification as communication (II) (Killick, 1995). Another author, using Fairbairn (1986), describes how Art Psychotherapy is especially likely to activate schizoid processes in some people as the painting process engages the client with their introjective and projective mechanisms (II) (Mann 1991).

For example, when clients destroy their art work it can be seen as a schizoid process, as an evacuation of split off parts and a way of preserving the inner self when too much has been exposed (II) (Mann 1991). This author describes how such clients experience Art Psychotherapy as a threat to the self. Another considers it important that a facility be made to keep artworks that clients want to destroy (Ib) (Killick, 1996). However users pointed out that a person's destruction of their art is a process that should be negotiated between client and therapist. They agreed, however, that, where possible, such works should be kept in a folder that they could throw away later, if they still wished to do so

(IVb). Service users reiterated that that they had found it useful to revisit their artwork when they felt more settled and/or after they had been discharged. They therefore suggested that it would be useful if the Art Psychotherapist was proactive in this process, for example through inviting the client back for follow-up after the therapy had ended where the art works made in Art Psychotherapy could be reviewed (IVb).

The literature suggests (as previously described) that destroying the artwork can be a way of keeping the Art Psychotherapist at a distance so that the client and maker of the art can preserve the 'good inner object'; however this author also says that this can be experienced by the Art Psychotherapist with negative countertransference. (II) (Mann, 1991). He also describes how art making can be used defensively as a resistance against change and creativity, and suggests that an exploration of this defence is essential to look at the tension between regression and progression (II) (Mann 1997). Another author indicates how Art Psychotherapy can be helpful to women who develop psychosomatic illnesses stemming from 'intolerable predicaments', the art object containing expressions of split off and dissociated aspects of self (III) (Cooper, 1999).

Greenwood (2000) (II) draws on Rosenfeld's concept of destructive narcissism (1971) to explore how the deadly force inside the patient becomes more threatening when he or she turns towards life and begins to rely more on the help of the therapist. Here counter-transference is useful as it enables the Art Psychotherapist to gain some understanding of the terror of the client's experience and their feelings of being powerless and in a state of fright. In such extreme cases the intermediate area of play and creativity are lacking and communication in Art Psychotherapy is experienced as potentially life-threatening; the art-making process can therefore be used defensively (II). Clients who have suffered extreme, prolonged and repeated trauma can experience the Art Psychotherapy setting, the use of the art-making process and the therapeutic relationship as a re-enactment of those experiences; this can lead to heightened levels of disturbance that are defended against. It is clear that care must be taken with clients in such circumstances (II) (Greenwood, 2000).

However, more conscious, adaptive defences such as sublimation and humour can appear alongside pathological defences in Art Psychotherapy. Users felt that expression in words as well as images is important in the Art Psychotherapy process (IVb). The creativity and play that are implicit in the Art Psychotherapy process enables sublimation and humour to become more readily available and to grow as valuable and mature defences (II) (Greenwood & Layton 1987, Greenwood 1991). Maturation of the ego can thus be facilitated through Art Psychotherapy (II) (Greenwood, 1997). Working in this way with the defences of psychotic clients, allowing humour to emerge, can make the unbearable seem bearable, making it easier for both client and therapist to show their vulnerabilities (II) (Greenwood & Layton, 1991).

PRACTICE

Referrals

Practitioner experience suggests that, generally speaking, referrals to differing kinds of Art Psychotherapy groups and to individual Art Psychotherapy come through multi-disciplinary team meetings and from different teams within and outside NHS Trusts. This includes referrals from community mental health teams, long-term care teams, assertive outreach community treatment teams, from other psychological therapists

and community services and from GPs (IVa). Referrals are usually made via a letter or an Art Psychotherapy referral form sent to the Art Psychotherapy Service, not to individual clinicians. This gives details of the client's family background, social situation, medication and presenting problems and should routinely include a risk assessment (III), the reason/s for the referral to Art Psychotherapy and why it is the treatment of choice (II) (Dudley, 2004). Each client is then met and formally assessed prior to commencing Art Psychotherapy, the referrer receiving regular feedback either in ward rounds or through written reports (II) (Deco 1998). Local practitioners pointed out that self-referrals from the community may come to an Art Psychotherapy Service following a client's experience of Art Psychotherapy as an in-patient (IVa) but, as users said, referral systems are not always accessible, equal or effective. Jones (forthcoming) raised questions about the assessment and referral procedures of the Art Psychotherapy and CMHT services during a RCT of group Art Psychotherapy for people diagnosed as schizophrenic. He suggests that more assertive outreach methods are needed to enable access to Art Psychotherapy services for all members of this client population, particularly those from black and ethnic minority groups (Ia).

Local experience has found that, in an acute, in-patient setting, a 'formal' referral system may not always be possible. In this situation, including that on wards, Art Psychotherapy is usually offered as an 'open group', i.e. one that has a changing and fluid membership where the focus is on the making of art. Such groups are not open to everyone on a ward (IVa). In this situation it is useful, where possible, to set up a referral system that parallels the usual referral system to Art Psychotherapy, addressing the same issues and giving feedback in the same way (II) (Deco, 1998), but the changeable and sometimes volatile nature of an acute ward can make formal, written referrals difficult to achieve and manage. In this situation local practitioners have found that they can take note of nursing staff's referrals and recommendations for a group immediately before it is due to begin, where possible attending ward handovers (IVa). Self-referrals can also be taken (IVa). This requires the Art Psychotherapist to conduct a brief, informal risk assessment prior to each group, being mindful of both the group's and the therapist's safety and excluding clients who may be disruptive through physical violence, verbal abuse and hostile or chaotic behaviour (IVa). Art Psychotherapists usually speak to clients immediately before a group and informally monitor attendance (II) (Deco, 1998).

Local practitioners have found it useful to circulate information about an Art Psychotherapy Service, in the form of a leaflet, to all staff and potential clients in all settings; specific information about ward-based Art Psychotherapy groups can be made available through leaving leaflets on wards (IVa). This enables all clients to give informed consent to treatment (IVa). An open Art Psychotherapy group on a ward can serve as a source of referrals and act as an informal assessment period for longer-term group or individual work in the community (IVa). A yearly audit of referral sources and waiting list times can demonstrate and develop the use of Art Psychotherapy services (II) (Dudley, 2004).

Open, studio-based groups may also be offered for longer-term clients, either in residential settings or in the community, although again it should be noted that service users' experience was that such groups were not available in the community and they fervently wished that they were! Local practitioners thought that these kinds of community-based, open studio groups should also have a formal referral and feedback system (IVa), although some practitioners keep such groups open to all who are

interested and accept informal referrals (II) (Saotome, 1998). Service users felt that Art Psychotherapy studios in the community should be 'open access' with little or no referral system, and should operate in ways that enabled swift, equitable access (IVb).

Users were keen to emphasise their rights regarding choice about their treatment and thus the importance of giving informed consent to Art Psychotherapy, whatever form it may take (IVb). They said that the need for informed consent should therefore be made explicit at the outset of Art Psychotherapy and, if clients were not able to give informed consent themselves, then their next of kin or other family members' views and opinions should be sought (IVb). This highlights the importance of potential clients receiving clear information, including written information, about Art Psychotherapy, and that practitioners should explain the treatment process and what they do in a suitable, client-friendly way (IVb).

Assessment

The assessment of clients for Art Psychotherapy usually entails more than one meeting between prospective client and therapist. Users felt that Art Psychotherapists should explain exactly what the client can expect to gain from engaging with Art Psychotherapy and be transparent about the practicalities of the treatment and the therapeutic process – about exactly what Art Psychotherapy entailed (IVb). Written information about Art Psychotherapy should therefore be made available before an initial meeting between client and a member of the Art Psychotherapy Service (IVa)

This first meeting is a forum in which client and therapist can ascertain if Art Psychotherapy could be helpful and, if so, whether individual or group therapy should be offered, and what type of group. This first meeting should emphasise the mutuality of the assessment process (II) (Dudley, 2004). Users were in agreement, making clear that they wished to be given real choices about the treatment they received (IVb). This first meeting, which occurs prior to a formal Art Psychotherapy assessment, is also an opportunity for client and therapist to think carefully about material that may be touched upon, not only in this meeting but also in the forthcoming assessment and subsequent therapy (II) (Dudley, 2004). Issues of difference need to be considered and attention needs to be given to allocation of the client to an Art Psychotherapist within the team, considering for example the various skills, interests and approaches available (II) (Dudley, 2004).

Local custom and practice suggests that the physical setting of an Art Psychotherapy assessment can influence how it is conducted. This refers to whether or not an assessment takes place in a designated Art Psychotherapy studio-based space, a room where art materials are accessible and may be used, or in a room where art materials are unavailable and their use would be inappropriate (IVa). The assessment should take place, where possible, in the room where the therapy is to take place, were it to be offered. This provides consistency and the potential for the client to relate to and use the art materials (II) (Dudley, 2004). Where this is not possible the client should be shown where Art Psychotherapy will occur; this introduces him or her to the space and to the art materials. This is an important part of the assessment process that assists clients in the making of an informed choice and either declining or giving informed consent to Art Psychotherapy (IVa), a point with which users emphatically agreed. They added, however, that their right to decline or withdraw from Art Psychotherapy at any point should also be respected (IVb) and suggested that the appropriateness of the therapy, and the approach being used, should be reviewed during treatment.

Art Psychotherapists should consider the initial meeting, and the assessment that follows, as the beginning of a relationship (II) (Dudley, 2004). The literature suggests that practitioners should consider offering an assessment period (i.e. more than one session) as this enables time for reflection between sessions before the client is asked to consent to, or decline, Art Psychotherapy. The literature states that during the initial meeting and the assessment Art Psychotherapists should be careful to learn their client's language and to describe his or her experiences as they emerge in terms of the influence of the person's background, history and current situation, considering the function and meaning of distress in the client's life. This is achieved through linking actual experience with here and now material, whilst thinking about the images that are evoked in both the client's and the Art Psychotherapist's minds and how these might relate to the client's art-making (II) (Dudley, 2004). Academically rigorous literature suggests that using descriptive rather than diagnostic language enables the particularity of Art Psychotherapy to be maintained within the psychiatric system and helps preserve a focus on the social inequalities and contexts that foster distress (II) (Dudley, 2004). However, user feedback suggested that using diagnostic language could also be acceptable. They felt that it was important that Art Psychotherapists were both clear and transparent about any diagnosis that they, or anyone else, had made about an individual's problems and mental health issues (IVb).

Local practitioners considered that the assessment process may, at some point, incorporate the use of art materials. Circumstances and the nature of the client's difficulties might make it appropriate to use art materials in the first assessment. This is because the focus is on building a therapeutic relationship, reducing the client's anxiety and, for users who have been particularly isolated, establishing a low-key, supportive approach (IVa). In this context it may be appropriate to address how the client views art and to consider her/his response to the art materials and the nature of their engagement with the art-making process (IVa). Users felt that any initial discomfort they might feel about using the art materials could be alleviated by the Art Psychotherapist assisting and advising how they might use the various media available (IVb).

Specific issues can arise for Art Psychotherapists working with clients who have an artistic identity. Users like these are not inhibited from discussing feelings in relation to their artwork. Equally, an individual's artistic identity does not interfere with group Art Psychotherapy processes when other group members do not have this identity (III) (Crane, 1996).

Thus the assessment process for Art Psychotherapy needs to be thorough, to emphasise the mutuality of the process and respect the client's right to choose their treatment. This does not mean that assessment should be unduly lengthy; users said that, in their experience, assessment can take far too long and needs to be quick and efficient (IVb). Further, users stated that it is important that practitioners are clear about when the assessment process ends and therapy begins (IVb). Similarly, it is important that practitioners make it clear how long each session will last (IVb) and discuss with their clients the likely length of treatment (IVa).

Individual or group?

The experience of local practitioners is that Art Psychotherapy is offered to people prone to psychotic states both individually and in different kinds of groups. People can be seen

individually if they are considered to be too fragile, damaged, vulnerable or seriously at risk to be seen in a group. Clients who have the potential for disruptive or hostile behaviour may also be considered appropriate for individual work (IVa).

A 'closed' Art Psychotherapy group is a group with a stable membership that can change slowly over time as clients leave and new clients join. Practitioners thought that these groups are suitable for clients who are isolated and need to develop confidence. These users may feel too exposed and vulnerable in individual Art Psychotherapy but a group can encourage them to share and explore their difficulties with others as relationships, artwork and interactions develop. However, practical issues, for example waiting lists, may influence referral to group rather than individual therapy when time and space for individual work is limited (IVa).

Other factors that need consideration when referring clients to Art Psychotherapy groups include the constellation of an existing or new group in terms of gender, age, ethnicity and social and cultural background (1a) (Jones, forthcoming). Similarly the nature of clients' problems – those of existing members and a new member, or the homogeneity/ heterogeneity of an entirely new group – and the relative degrees of 'illness' and 'wellness' of the group members, all need to be considered in terms of group cohesion (IVa).

'Open' or 'open studio' Art Psychotherapy groups are usually offered in residential or semi-residential settings and, according to local practitioners, are usually accessed through a clinical referral. These offer a low-key, art-based approach for situations such as wards (which have both in- and day-patients) where attendance is likely to be inconsistent and unpredictable and where verbal and social interaction may be limited. These groups can be suitable for different users who may, for example, be in an acute phase of their illness and be very isolated and/or potentially hostile and who therefore need flexible and moderate levels of verbal, social and visual interaction (IVa). However, as stated earlier, service users suggested that direct access to 'open' or 'open studio' groups in the community would be hugely helpful to their ability to maintain good mental health and to prevent relapses, and so be pro-active in the management of their problems (IVb).

Users felt that they should be given a real choice about the kind of intervention they would prefer and be enabled to have an open discussion with the Art Psychotherapist about the benefits of each modality (IVb). They also drew attention to the confusion that can arise about the different kinds of art-based activities that are offered to them. Users said that they sometimes experienced pressure to attend a particular activity or therapy, and that this could mean that they were not really able to choose what they wanted to do. Art Psychotherapists should therefore make sure that clients are not pressurised into attending therapy, or any other art-based activity, and are offered real choice about their treatment (Level IVb).

Clinical approach

Generally speaking a supportive Art Psychotherapy approach is thought appropriate for clients who are in the midst of or who have had a history of psychosis (II) (Greenwood 1997, Wood, 1997). Users were clear that the Art Psychotherapist's consistent and reliable presence, and their continuing interest in the person and their artwork, were all very important. They also felt that the regularity of sessions was important as Art Psychotherapy

offered something to look forward to and brought structure into the week; it was therefore hugely disappointing when a session was missed, whatever the reason (IVb). This is echoed in the literature that emphasises the importance of paying careful attention to, and being respectful towards, the service user and their artwork (Ib & II) (Wood 2000, 1997).

Clients' initial engagement with Art Psychotherapy can occur through the art materials, then with the room and then with the client's 'self' (III) (Case & Dalley, 1992), but it can also occur firstly through the relationship with the Art Psychotherapist, then with art-making and then with the self (IVb). This suggests that the focus of therapy can change; for example it might be on concrete aspects of the environment and on the artwork rather than on psychological relating (Ib & III) (Wood 2000; Case & Dalley, 1992).

This is supported by the literature when it suggests that opportunities for experimentation, exploration and creative play should be maximised as this not only facilitates clients' engagement with Art Psychotherapy but is also ego strengthening (Ib) (Killick & Greenwood, 1995). Through adopting this approach the Art Psychotherapist can foster the evolution of the client's language in the artwork that enables them to mediate between concrete and symbolic thinking (Ib) (Killick & Greenwood, 1995).

However, users felt that it should always be made clear that the use of art media is encouraged, not enforced, there being, as they pointed out, a fine line between being encouraged and being pushed into using art materials (IVb). Some art materials may be particularly beneficial; clay, for example, is thought to lead to positive outcomes for clients (II) (Greenwood, 1994; Seth-Smith, 1997). However, users' experience was that the art materials in Art Psychotherapy were limited and tended to focus on drawing. They said that a wide range of art materials should be available and that this should include photographic and other digital/IT media that went beyond the usual art materials offered in Art Psychotherapy for painting, drawing, sculpting and modelling (IVb). Any discomfort a user might feel when faced with unfamiliar media, or with a blank page could, they suggested, be alleviated by Art Psychotherapists initially showing clients how to use the art materials (IVb). Users added that sometimes they simply wanted to make a good picture and found that this was helpful, but they thought that Art Psychotherapists discouraged this and tended to interpret too much (IVb). Users felt that Art Psychotherapists should listen carefully to their clients' ideas and aspirations about their artwork and support any wish to experiment with new and different art materials (IVb).

The literature suggests that clients who find it hard to stay in the Art Psychotherapy room can sometimes be helped to stay if the Art Psychotherapist also engages with art-making (III) (Morter, 1997). Indeed the Art Psychotherapist's art activity is thought to reduce the transference and therefore to increase equity in Art Psychotherapy groups (II) (Greenwood & Layton, 1987) and in work with individuals too (IVa). This view was not entirely supported by users who said that the Art Psychotherapist's art-making was not always helpful and indeed could be distracting, intimidating and alienating. They suggested that the Art Psychotherapist's art activity should be thought about and negotiated with each client (IVb).

Local practitioner experience is that some clients report relief from some of the distress caused by visual hallucinations after spontaneously making images of these in an Art Psychotherapy group. In subsequent work with people troubled by visual hallucinations,

practitioners have suggested to their clients that they might depict the hallucinations in their artwork. Feedback from users suggested that this was helpful and could cause the hallucinations to lose some of their intrusive intensity (IVb).

The literature suggests that attempts to remove art work from the Art Psychotherapy setting can be experienced by its maker as an attempt to evacuate the material held in the art object from the client's mind (1b) (Killick, 1996). Art Psychotherapists should therefore refrain from removing art works and not take up invitations to engage with the client while they are working on their art object (Ib) (Killick, 1996) as clients may also experience such interventions as concrete intrusions. However, engaging with the art work, for example through non-interpretive conversation about it, can enable the client to take a good object from the therapist in a concrete, external way (III) (Morter, 1997). In this situation practitioners thought that a client's wish to take their art work out of the setting can be a recognition of the work's worth that can enhance self-esteem and affirm identity (IVa)

The literatures states that humour is creative and adaptive and therefore useful in Art Psychotherapy with clients who have severe and complex problems and who are, or have been, severely disturbed (Ib & II) (Killick & Greenwood, 1995; Greenwood & Layton, 1991). As described earlier, when humour emerges in an Art Psychotherapy group it should be valued rather than be seen as inappropriate because it can deflate tension, indicate the development of mature defences and may also lead to new discoveries for the client. Like art (such as the Dada movement), humour can hold conflicting ideas (II) (Greenwood & Layton, 1991)

'Containment', or an emotionally safe place

The use of the word 'containment' provoked concern and strong, negative reactions from service users because of associations with confinement and locked wards. They suggested that the phrase 'emotionally safe place' was a more accurate description of what was offered in Art Psychotherapy. They also felt that when the term 'containment' was used in this document, that it should have quotation marks around it so as to differentiate it from its more negative connotations.

Several authors draw on Bion's concept of 'containment' (1962) to inform their clinical practice (e.g. Greenwood & Layton, 1987, 1991; Killick 1997, Seth-Smith 1997), that is the creation of a space where clients can feel they are emotionally safe. In summary this refers to a process whereby intolerable, unacceptable and disowned feelings are assigned to or projected into another, usually the therapist. These feelings are modified and 'held' by the therapist until they become tolerable and can be owned, managed and understood by the client. In Art Psychotherapy the artwork has a particular function that provides three phases of 'containment': thoughts and feelings are projected into the artwork, digested through the art-making process and re-introjected through subsequent discussion (II) (Greenwood & Layton, 1987). The creation of an emotionally safe place is thus made possible by the relationship between the different elements of Art Psychotherapy, the formation of a containing relationship within a containing environment being thought to make integration possible.

Thus, before creative and symbolic processes can be used therapeutically, a containing relationship has to be developed between the client and the Art Psychotherapist (II)

(Greenwood, 1994; Killick, 1991). The therapist's attention to dynamically structured and maintained boundaries enables the client's projected material to be contained within the therapeutic relationship. This requires a time scale that enables the client to develop sufficient ego strength so that they can assimilate what has been projected (Ib and II) (Killick & Greenwood, 1995; Wood, 1997). The literature suggests that many experiences of 'containment' may be necessary to hold a client's core anxieties before change is possible (II) (Killick, 2000).

The creation of a safe emotional space for people with severe and complex problems is therefore extremely important. Various aspects of Art Psychotherapy contribute to the quality and function of 'containment', i.e. the physical environment of the space and the materials (Ib) (Wood 2000; Greenwood, 2000) and the relationship with the therapist who uses all the transactions that occur within the setting to hold and manage the client's thoughts and feelings (II) (Killick, 1991). The continuity of the physical space is especially important and is provided by a safe and undisturbed area in which to work where staff and clients can feel secure. Sessions should be at a regular time and place without interruption, the Art Psychotherapist maintaining a quiet presence and a respectful manner (Ib & III) (Wood 1997, 2000, 1999).

The literature states that a client's capacity to face frightening feelings can be facilitated by the provision of this particular kind of safe emotional and physical space that offers art materials which can be worked with in the presence of others (II) (Greenwood, 2000). Fear and persecution can be ventilated through the artwork within the safety of the studio (Ib & II) (Wood 2000, 1997), the image acting as a receptacle for non-verbal aspects of the maker and enabling the client to express and embody meaning in their art work (II) (Seth-Smith, 1997). Such 'evacuative' processes are thought to acquire symbolic meaning over time (II) (Killick, 2000). Having this kind of experience of 'containment' can help clients to retain and/or regain a sense of self (II) (Killick, 2000).

The literature suggests that the well-contained, long-term work that was possible in the large psychiatric institutions of the NHS may no longer be possible due to the changes in provision and moves towards community care. This raises questions of therapeutic technique and the management of treatments, especially when the therapeutic frame is not well supported and Art Psychotherapists experience difficulty in providing 'containment' for clients living in the community. The need for therapists and other staff to feel contained themselves is therefore crucial so that they may continue to offer containing work to their clients (Ib & II) (Wood 2000, forthcoming, 1997).

Boundaries

Boundaries are considered particularly important and helpful with this client group. A boundaried Art Psychotherapy group facilitates the strengthening of psychological boundaries (II) (Greenwood & Layton, 1987) through fostering the experience of 'containment', giving structure to the setting and enabling the client to relate concretely to the use of space, time, equipment and materials as well as to the person of the therapist (II) (Killick, 1995). The literature recommends that boundaries are clear and dynamically structured.

Boundaries need to be maintained, but their negotiation within the Art Psychotherapy setting can offer significant points of contact between client and Art Psychotherapist

within the therapeutic relationship (Ib & II) (Killick and Greenwood, 1995; Wood, 1997, 2000). This can be a way of establishing inner and outer reality for the client (Ib) Killick, 1996). In Art Psychotherapy groups the therapist, by holding boundaries that can be permeable, allows the group to survive and transform destructive attacks and other anti-group phenomena (II) (Sarra, 1998). As previously described, a boundary that preserves artwork, and ensures its survival following attempts at its destruction, can also be useful (II) (Killick, 1997).

Groups and 'Open Studio' Groups

Art Psychotherapy within a group setting offers a safe emotional place to be for clients who are in extreme distress and are feeling very vulnerable. In acute settings, for example on a ward, an open studio approach offers a reliable and constant structure, a flexibility of interaction and withdrawal, as well as 'containment' or a safe emotional place (Ib & II) (Wood 2000; Deco, l998). An ongoing, ward-based Art Psychotherapy group can be a facilitating culture that survives rapidly changing in-patient populations (II) (Sarra (l998), its structure providing a boundaried backdrop that can help foster the ability to be an individual amongst others (II) (Deco, l998), albeit in a physical environment that is far from ideal. Interaction can develop slowly between the client and their images according to the client's needs, the therapist being active and involved as a 'real person' (II) (Deco, l998). This approach is appropriate if the Art Psychotherapist controls referral, assessment and selection (II) (Deco, l998) although, as previously described, users thought that studio-based 'drop in' Art Psychotherapy groups in the community should be directly accessible.

One author describes providing individual sessions for people with severe and complex problems in an open studio in a designated Art Psychotherapy space. The boundaries of such a setting, the use of an art folder and the physical environment of a studio-like art room can provide an environment in which the user can experiment with the connection between themselves and the Art Psychotherapist (II) Killick, l995, 2000).

Some Art Psychotherapists work directly with themes that emerge during the initial, conversational stage of an Art Psychotherapy group as it begins (II) (Greenwood & Layton, 1987) and as they develop through resonances in the artwork (IVa). This provides 'containment', the artwork and the group itself modifying anxieties and providing a focus for the group's projections (II) (Greenwood & Layton, l987, l991).

Interpretation and meaning

In the literature the Art Psychotherapist's and the client's understanding of the client's inner world are said to be informed by observations of different aspects of the therapeutic relationship and by both parties' responses to the art work (II) (Schaverien, 1982). Positive transference to the therapist may keep the client attending sessions and help promote self-growth (II) (Schaverien, 1982). However, the literature states that it is important for the Art Psychotherapist to refrain from making interpretations with clients who are psychotic (Ib, II and III) (Killick, 1996; Wood, 1997, 2000; Lydiatt, 1971). In this situation research suggests that the Art Psychotherapist should suspend comment on both the content and the meaning of a client's behaviour and artworks, and that the attention of both client and therapist should instead focus on the formal elements of the therapeutic relationship (Ib) (Killick & Greenwood, 1995). One author suggests that, at such times, clients may experience their artwork in a concrete rather than symbolic way (II) (Mann, 1997), another

that clients in a psychotic state are not able to relate to their artwork as an object (Ib) (Killick, 1996). The Art Psychotherapist may thus shift the emphasis away from the content and meaning of an image and on to its form, focusing instead on the client's methods of expression in the Art Psychotherapy space (Ib) (Killick & Greenwood, 1995). However, users remarked that they had found it helpful when the Art Psychotherapist interpreted their artwork as they wanted to know what the therapist was thinking about it, although this needed to be done in a way that was useful to the client. That is to say that it should be clear that interpretation occurs within the context of a relationship between client and therapist where they work together on reaching an understanding about what an image might mean (IVb).

Art works made in Art Psychotherapy should therefore be experienced as a safe arena in which to explore, communicate and relate non-verbally to another within the context of a therapeutic relationship and in the physical space of a studio or other kind of Art Psychotherapy room (II) (Schaverien, 1982). This is particularly important at times when verbal comments made by the therapist are experienced as intrusive and potentially disruptive of the client's creative expression (III) (Lyddiatt, 1971). In such situations the art object can hold the transference in a concrete way rather than symbolically, and function as a transitional object (II) (Schaverien, 1997). The client's artwork may therefore contain split off, projected aspects of the client's self that can, over time, become integrated within the art object without the need for interpretation (II) (Schaverien, 1982). As users said, Art Psychotherapists can over-interpret, it being neither necessary nor desirable to always discuss and/or interpret the artworks that have been made (IVb). Indeed the meaning of an artwork may only be fully experienced by the person who made it – the client. An image may be experienced by its maker as an anchor for chaotic feelings while the therapist may feel alienated from it, and from its maker (II) (Schaverien, 1997).

The literature also suggests that for clients who suffer psychosis but who are not in an actively psychotic state, transference can be acknowledged, although not when it will threaten the person's ego strength (Ib) (Wood, 2000, forthcoming). However, the client will need to reclaim projected transference when they feel able to (II) (Schaverien, 1982).

Countertransference

Significant countertransference responses, including destructive ones, can, as indicated earlier, be engendered in practitioners who work with members of this client population. Countertransference to clients in psychotic and borderline psychotic states is primitive and often unconscious. Supervision is therefore essential to effective work with this client group (Level III) (Killick, 1995). It is also essential that this kind of work is not undertaken in isolation (II) (Greenwood, 2000).

Some authors suggest that the making of artwork by the Art Psychotherapist in sessions can provide containment through holding countertransference feedback (II) (Greenwood & Layton, 1987); it can also serve as a useful mirror for the client's experience (III) (Morter, 1997). However, as previously described, service users experienced this as their therapist not being fully present and there for them in the session. They added that they were sometimes distracted from their own process by thinking about the Art Psychotherapist's image (IVb). Once again, this needs to be discussed between client and therapist.

This review of the evidence about the use of art work in Art Psychotherapy with people prone to psychotic states has drawn on quantitative and qualitative research (Ia and Ib), on academically rigorous literature (II), on the experience and knowledge of expert practitioners (III), on the local custom and practice of members of the Guideline Development Group (IVa) and on the experiences and feedback of local expert users (IVb). The General Principles and Recommendations that follow distil the narrative into a series of statements that summarise the evidence and offer guidance for Art Psychotherapy practice with this client population.

Recommendations

The Recommendations that follow are of two kinds:

1. **General Principles that the Guideline Development Group recommend should be taken into account when offering Art Psychotherapy with people prone to psychotic states.**

2. **Specific recommendations about Art Psychotherapy services and practices**

These two types of recommendation reflect the evidence, each guiding principle and recommendation having been weighted and linked to the evidence described in the preceding narrative. This evidence is briefly summarised and related to each recommendation. The strength of each recommendation depends on the quality of the evidence that supports it and is graded from Ia to IVb, as described on pages 17 and 18.

1. GENERAL PRINCIPLES

1. **Art-making in Art Psychotherapy is a language with which to communicate. Level Ib**

There is strong evidence that making art in Art Psychotherapy offers people prone to psychotic states a language that can mediate between inner and outer worlds which enables relationships to be developed. This is particularly so for those who are socially isolated and whose verbal communication is impaired. Art Psychotherapy can be offered alongside medication; neither contraindicates the other. This was confirmed by service users; their experience was that medication and Art Psychotherapy worked well together.

2. **Art Psychotherapy is a form of engagement that offers the potential for clients to become absorbed in the making of art. Level Ib**

Research has shown that making art in Art Psychotherapy engages the maker in a process that enables an immersion in the activity and an associated thoughtfulness. Making art in the context of a relationship with an Art Psychotherapist can mediate between concrete and symbolic thinking and allow symbolic functioning to be restored.

3. **Art-making in Art Psychotherapy can facilitate relationship with the self and another/ others and reduce isolation. Level Ib**

The capacity to relate to others can be severely impaired in psychotic states but there is strong evidence that making art in Art Psychotherapy can enable a person

experiencing psychosis to develop a visual language and hence enter relationship through art – first with themselves and then with others.

4. **The organisational setting of Art Psychotherapy is of primary importance to clinical practice. Level 1b**

There is strong evidence that the organisational contexts in which Art Psychotherapists work have a major impact on their clinical work. This refers to matters such as the duration of therapy, the availability (or lack) of resources such as studio or other appropriate rooms, art materials and equipment, all of which can influence Art Psychotherapists' clinical approach. Research in allied areas of Art Psychotherapy practice has also produced strong evidence that demonstrates the influence organisational support has on the effectiveness of art therapy, its absence having been shown to lead to less positive client outcomes (Sheppard et al 1998, Waller 2002).

5. **Art Psychotherapists are able to work with hard-to-engage clients who usually do not have access to, or engage with, dynamically-based therapies. Level IVa**

Art Psychotherapists have a long history of working with people prone to psychotic states who, traditionally, neither access nor are able to make use of dynamically-based therapies. This is particularly so for those experiencing acute psychotic states. Local custom and practice suggests that Art Psychotherapists continue their work with members of this client population, both in the community and on acute wards.

6. **Art Psychotherapy offers the potential for the safe 'containment' of the most troubling of emotions experienced by clients. This can occur in acute, in-patient, day-patient and community settings. Levels IVa**

Evidence from local practitioners and users suggests that Art Psychotherapy offers clients physical, psychological and emotional safety because feelings and problems can be articulated in, and communicated through, art making. Visual expression may, or may not, be accompanied and/or followed by verbal discussion, the choice remaining with the maker of the artwork. Local practitioners and service users propose not only that Art Psychotherapy can occur at all levels or 'steps' of care, but that it should.

7. **There are three interactive fields in the Art Psychotherapy process with this client group:**
   - **the intrapersonal (the client/s and their art-making)**
   - **the intermediary (established by the images existing as objects in a setting)**
   - **the interpersonal (the triangular relationship between the art work, the client/s and the Art Psychotherapist). Level II**

Good evidence from theoretical literature has identified and articulated three ways in which people prone to psychotic states interact with their inner world through art-making, the physical environment and the person of the Art Psychotherapist during the treatment process. This informs the nature and type of interventions practitioners make with their clients.

8. **The interactive fields unique to the Art Psychotherapy process provide the potential for the 'containment' of core anxieties. This can facilitate fundamental change. Level II**

Similarly, academically rigorous literature by expert practitioners has provided good evidence that articulates how the particularities of the studio environment in Art Psychotherapy – the room, the art materials and the interactions the client has with them and with the therapist – provides a contained space for people who have experienced or are experiencing psychotic states. Users confirmed their experience of Art Psychotherapy as a physically and emotionally safe place to be. The continuing and repeated safety of place, interaction and relationship can enable change at a deep and profound level.

9. **A fourth interactive field places Art Psychotherapy practice within the socio-political and socio-cultural contexts of family, poverty, race, class, culture and gender, and of contemporary art and popular culture. Level Ib**

There is also strong evidence that the social, cultural and political contexts of practice, beyond the immediate environment of the Art Psychotherapy room and the organisation offering the service, play a part in treatment. Therefore issues concerning clients' and therapists' backgrounds and present circumstances merit consideration in the treatment, as does the visual culture that surrounds contemporary life.

10. **Different elements in an image and the use of different art materials can embody diverse and/or conflicting aspects of self and/or a group. Level II**

There is good evidence in the academically rigorous literature to show how artworks function in different ways. Different parts of an artwork can represent and/or embody a variety of feelings or conflicts about the maker, the therapist or, in a group, about the group and other group members. A visual interaction may also be enabled between the differing elements of a 2D or 3D image. An art object can function as a talisman, as an 'empowered object' that has magical qualities and represents good power. It can become a scapegoat, an object invested with meaning that can, along with its associated feelings, be disposed of. It may also become a fetishistic object that holds a variety of symbolic meanings that are gradually relinquished and assimilated by the maker (Schaverien, 1992).

11. **The art work in Art Psychotherapy and the way it is related to by the client can help the client and the Art Psychotherapist to understand the client's defensive strategies. Level II**

Good evidence from academically rigorous literature has described the different ways in which the artworks made in Art Psychotherapy can be used as a defence. As art objects are made they can incorporate the violence of clients' intrusive thoughts and feelings, without damage to either client or therapist. As time goes on this can change from a process where feelings are evacuated into an art object to one where they are communicated through an art object.

However, making art in Art Psychotherapy can also be a means through which clients can maintain the status quo and resist change. It can be a way of keeping the Art Psychotherapist at arms length, particularly with extremely traumatised people who may experience the treatment as a re-enactment of the trauma and consequently feel very frightened.

12. Coping strategies such as humour and sublimation can be promoted through making art in Art Psychotherapy. Level II

There is sound evidence that the creativity and play that are, usually, implicit in the Art Psychotherapy process can enable the development of mature defences such as sublimation and humour. Expert, experienced practitioners have described how these can be directly supported, when appropriate, in Art Psychotherapy.

13. Using art materials in Art Psychotherapy can provide a safe and contained way of expressing difficult, destructive and potentially unsafe feelings. Level II

Good evidence from academically rigorous literature explains how making art in the safe, emotional space offered by Art Psychotherapy enables clients to articulate painful and distressing feelings. This is a fundamental principle underlying the theory and practice of Art Psychotherapy.

14 The client's engagement with Art Psychotherapy can be through their relationship with the room and/or the art materials as well as through their relationship with the Art Psychotherapist. Levels III & IVa

Evidence from expert opinion and local practitioners suggests that service users' engagement with all forms of Art Psychotherapy begins with relationship. This can occur in different ways: through a relationship with the physical spaces and facilities of an Art Psychotherapy service, or through a relationship with the therapist. This initial engagement, whatever its nature, enables clients to enter the triangular relationship that characterises Art Psychotherapy, that is the relationship between the artist/client, the art that they make and the Art Psychotherapist. Academically rigorous literature has described how the nature of clients' engagement with Art Psychotherapy can change as therapy progresses, the emphasis shifting between the three axes of the Art Psychotherapy triangle, according to the needs and preferences of the client.

15. The creation of a safe, emotional and creative space through the relationship with the Art Psychotherapist is a critical factor in the therapy overall. Level IVa

Evidence from local practitioners suggests that the establishment and maintenance of a physical, psychological and emotionally safe place to be in Art Psychotherapy occurs primarily through the relationship with the therapist. It is this that enables clients to be creative and to begin, sustain and achieve positive outcomes in Art Psychotherapy.

16. Empathic visual attunement by the Art Psychotherapist to the client and their art work is an important element in the therapy. Level IVa

Evidence from local practitioners also suggests that Art Psychotherapists' acute sensitivity to and understanding of the aesthetic and other visual properties of their clients' artworks, for example the facture (a work's physical properties), are significant and influential factors in Art Psychotherapy.

2. RECOMMENDATIONS

Context

1. **The therapeutic frame of Art Psychotherapy should be seen in the context of the socio-political circumstances of client and therapist. Level 1b**

2. **Difference, diversity, poverty and deprivation need to be considered and their impact on the therapeutic relationship explored. Level III**

   There is strong evidence, supported by expert opinion, that practitioners should pay heed to the race, class, gender, sexual orientation and material circumstances of both client and therapist and consider their influence on the process and content of Art Psychotherapy. Difference can give rise to a variety of responses, positive and negative: it can be a means through which otherwise difficult issues can be addressed but it can also be a source of conflict and tension.

3. **Contemporary art and popular culture can, on occasions, be usefully explored in relationship to artworks made in Art Psychotherapy. Level 1b**

   Strong evidence suggests that it is helpful when practitioners encourage their clients to consider the artworks made in Art Psychotherapy within the wider context of contemporary visual art and culture. This can enhance and enrich clients' engagement with making, thinking, and looking at art in Art Psychotherapy.

Setting

4. **Art Psychotherapy should take place in a dedicated Art Psychotherapy space. Ideally this should be in an art room that is well-planned and equipped and which allows for privacy and art-making. Level Ib**

   There is strong evidence to suggest that the rooms in which Art Psychotherapy takes place are critical to effective practice. Equally strong evidence suggests that appropriate, dedicated, studio-based spaces provide the optimum conditions for effective clinical practice. Such rooms should allow for the use and storage of a full range of wet and dry art materials, including digital, photographic and other media such as ceramics and sculpture.

5. **It is essential that the Art Psychotherapy space should be respected and free from interruptions. Level II**

   Academically sound literature provides good evidence to suggest that Art Psychotherapy spaces should be quiet and away from any likelihood of physical intrusion. This enables the creation of a physical space that is emotionally and psychologically safe in which the necessary immersion in making art can occur and a consequent thoughtfulness can develop.

6. **Art Psychotherapy sessions should take place at a regular time and place. Level II**

   There is good evidence that therapy should be consistent, reliable and regular in terms of time and place. This is fundamental to good practice and was emphatically supported by service users. They spoke strongly to the importance of Art Psychotherapy, and the therapist him or herself, being a dependable, ongoing presence.

Service users described how a therapy session offered structure to what would otherwise be empty time and how devastating it could therefore be when a session did not occur.

Local practitioners noted that, notwithstanding Recommendations 4, 5 and 6, their practice often occurs in non-designated spaces. Although this meant working in physical spaces that were often far from ideal (for example, ward dining rooms), it nonetheless resulted in practice being taken to clients, enabling access to a psychological therapy for very distressed and vulnerable people. In such circumstances local practitioners propose that as many recommendations as possible be maintained. For example, Art Psychotherapy should, where possible, be offered in environments that are in some way set apart so that a sense of privacy, confidentiality and safety can be offered that is free from intrusion and matters such as ward routines. There should also be regularity of time and a consistency of place, therapist and art materials.

7. **The Art Psychotherapy room should be inviting and friendly. Level IVb**

Evidence from service users suggests that Art Psychotherapy rooms can be intimidating with furniture and art materials arranged in uninviting ways; they therefore felt that therapy rooms should be friendly and inviting. This view was tempered by expert opinion that queried whether Art Psychotherapy rooms should be 'friendly' and were mindful that, whatever the nature of the physical space, it would always be the object of clients' projections. Local practitioners' view was that Art Psychotherapy rooms should, where possible, be welcoming and stimulating.

8. **The client should have choice regarding where their artwork is kept, within the constraints of the Art Psychotherapy setting. A folder should always be offered. Level Ib**

9. **The storage of art works must be in a safe and confidential place. Level IVa**

10. **For some clients it can be helpful to provide a folder in which art work that is 'thrown away' can be stored. Level IVa.**

The storage of art works made in Art Psychotherapy has, generally speaking, merited little attention in the literature. This may be because the safe storage of clients' work is an underlying assumption of practice, it being one of the professional association's Principles of Professional Practice, i.e. that clients' art is stored safely for the duration of therapy. For many years an allied Principle stated that clients' artworks should be stored for a period of three years post-therapy. However, the keeping (and indeed archiving) of material and/or data nowadays is sometimes considered in parallel with the keeping of clinical notes and in the context of the Data Protection Act. The storage of clients' art is therefore increasingly a matter of local custom and practice, determined by the policies and practices of the different organisations that offer Art Psychotherapy.

The storage of artworks made by clients prone to psychotic states has, however, benefited from particular attention in the Art Psychotherapy literature with regard to the part it plays in treatment. There is strong evidence to suggest that client choice with regard to the storage of their art is critical. This was supported by service users. There is also strong evidence to suggest that the concrete 'containment' (or, in this instance, the physical and symbolic safety) offered by the provision of an art folder for service users' artworks is helpful. Local custom and practice adds that clients' artworks should be stored not only safely but also in a place that is confidential, that is not accessible to others, for example in a day centre or on a ward.

Strong evidence further suggests that the artworks clients wish to throw away should be kept. A person's wish to destroy their art can be managed productively in Art Psychotherapy through the provision of a particular art folder for such works so that they are preserved. Such artworks can, as users pointed out, provide a useful vehicle for later reflection, when their health had improved, as they can inform ways in which future health could be maintained. However, local practitioners thought that, on occasion, it was helpful for clients to discard or destroy artworks. Service users concurred, saying that their wishes about their art should be respected and its eventual fate negotiated between client and therapist.

11. **The storage of art materials must be in a safe place and in accordance with Health and Safety regulations and with the Control of Substances Hazardous to Health (COSHH). Level IVa**

Local practitioners noted the absence of discussion in the literature about the hazardous substances and equipment that are often in Art Psychotherapy rooms, for example different types of paint, scissors, ceramic glazes and kilns. While practitioners ensure that non-toxic materials are used as much as possible there are occasions when art materials and equipment are not absolutely safe. Thus Art Psychotherapists should ensure that all materials and equipment are stored and used safely, in accordance with appropriate legislation.

12. **Art Psychotherapists and other staff need to feel contained themselves in order to offer a safe emotional space to their clients. Professional support, clinical supervision, reading, research and Art Psychotherapists' own art work are all vital. This is particularly important when the Art Psychotherapist is the only health professional working with a client. Level Ib**

13. **Good liaison should be established with other members of the multi-disciplinary team. Level III**

There is strong evidence that describes the importance of ongoing professional support for practitioners working with clients prone to psychotic states. This can take several forms, including different aspects of practitioners' CPD, but ongoing and local support of practice is critical to Art Psychotherapists' ability to work with the distressing material that their clients bring. Expert practitioner opinion adds that it is important that Art Psychotherapists build and maintain good relationships and effective liaison with their colleagues in the multi-disciplinary team.

14. **Art Psychotherapists should routinely offer ongoing, follow-up services e.g. at annual, six or three monthly intervals. These sessions could include inviting clients to review their artworks. Level IVa**

Evidence from local practitioners, supported by users, suggests that regular, follow-up meetings with Art Psychotherapists are helpful. Service users added that these can usefully include an opportunity to review their artwork. As previously described this enables clients to look back at times when their health has not been good, a process that can assist with the development and maintenance of strategies for good mental health in the future. Users proposed that such meetings would be a useful preventative intervention.

15. **Community-based, 'open' Art Psychotherapy studios, with Art Psychotherapists available, should be directly accessible to clients living in the community. Level IVb.**

Evidence from service users suggests that the provision of Art Psychotherapy services in the community is inadequate. Further, service users had found that current provision of community-based Art Psychotherapy services was difficult to access, especially in times of crisis. They suggested that increased and improved Art Psychotherapy services that were directly accessible would have an important preventative function. Users reported that they were well aware when their health was deteriorating and thought that, when this occurred, accessing Art Psychotherapy quickly would prevent further deterioration and eventual admission to hospital.

Users also said that they had found making art when they were alone a helpful thing to do. They added that sometimes they would like to discuss their work with an Art Psychotherapist and reiterated the need for easily accessible, 'drop in' Art Psychotherapy services in the community.

Referrals and Assesment

16. **Art Psychotherapists should develop active outreach strategies that increase the participation of ethnic minorities and other clients who usually find it hard to engage with standard mental health care services. They should ensure that these potential clients are aware of, and can easily access, the Art Psychotherapy services that are available to them. Level Ia**

There is strong evidence that active outreach improves the access and use of all the psychological services for service users who have severe and complex problems. Equally strong evidence suggests that Art Psychotherapists should enhance their outreach strategies, ensuring that their services are known about and that people prone to psychotic states are enabled to access the services they need.

17. **Written information about Art Psychotherapy services, e.g. in the form of a leaflet, should be circulated to all staff and potential clients in all settings, and be made available to all clients before the first meeting with an Art Psychotherapist. Level II**

18. **Written information specific to ward-based Art Psychotherapy should be made available to clients and staff on acute and other wards. Level IVa**

There is good evidence to suggest that written information about Art Psychotherapy services should be widely available to all clients and staff in primary and secondary care. This enables clients to give their informed consent to referral to Art Psychotherapy, to assessment and to treatment. Leaflets and other forms of written information also serve to inform colleagues in multi-disciplinary teams about the aims, objectives and treatment approaches offered by Art Psychotherapists at all levels or 'steps' of care.

Local practitioners emphasised the importance of ensuring the availability of such information about Art Psychotherapy in in-patient settings. This was so that clients could give informed consent to ward-based Art Psychotherapy and be aware that this can function as a route into ongoing group and/or individual Art Psychotherapy.

19. The Art Psychotherapist should evaluate and select appropriate referrals for assessment. Level II

20. Referrals to group and individual Art Psychotherapy in out-patient and community services should be in writing and made to an Art Psychotherapy service. Level IVa

21. Referrals should include details of a client's family background, social situation, medication, presenting problems, and the reasons why the referral has been made and why Art Psychotherapy is the treatment of choice. Level II

22. All information in a referral letter or other document concerning the client's family, social situation, medication, presenting problems and the reason for referral to Art Psychotherapy, should be verified and discussed with the client during the Art Psychotherapy assessment. Level IVb

Evidence from local practice suggests that referrals to Art Psychotherapy come from colleagues working at all levels and in all types and 'steps' of care. Given the range of referral sources, local practitioners advise that all referrals should be put in writing to an Art Psychotherapy service (not to an individual practitioner). Good evidence also suggests that all referrals should be evaluated prior to a formal Art Psychotherapy assessment.

Good evidence from academically rigorous literature, supported by expert opinion, also suggests that referrals should include full details of a client's background, presenting problems and a risk assessment as well as a clear statement about why Art Psychotherapy is considered by the referrer to be the treatment of choice for the individual. Users added that the referral process should be transparent and that all the information in a referral, including any diagnosis, should be openly discussed during the assessment. This, they said, was a helpful and informative process.

23. In an acute setting referrals should, where possible, parallel the usual referral system to an Art Psychotherapy service. Level II

24. Client participation in ward-based, open Art Psychotherapy groups can serve as part of the initial, informal discussion and assessment for longer-term group or individual Art Psychotherapy. Level IVa

25. When a written referral is not possible, and/or when a client self-refers, Art Psychotherapists should ensure that they are cognisant of their client's background and legal status. Level IVa

There is good evidence to suggest that it is best practice to maintain a written referral system to Art Psychotherapy in all treatment settings. However, the literature acknowledges, and local custom and practice confirms, that there are situations where a written referral is not received and, as local practitioners pointed out, there are others where a written referral is not possible, for example when a service user self-refers or when an Art Psychotherapist is working on an acute, in-patient ward. In such circumstances evidence from local custom and practice suggests that best practice is that Art Psychotherapists work closely with ward and other staff to ensure they are aware of their clients' background and legal status. They should also conduct a brief, informal risk assessment to ensure clients' suitability for Art Psychotherapy.

26. The assessment should include an initial meeting between client and Art Psychotherapist where both can begin to ascertain whether Art Psychotherapy might be helpful, identify and discuss the issues to be addressed, and begin thinking about which Art Psychotherapy approach might suit the client best. Level II

There is good evidence from academically rigorous literature to suggest that it is helpful for clients to have an initial meeting with an Art Psychotherapist prior to a formal assessment. This first meeting should emphasise the mutuality of the assessment process and enable both to ascertain whether or not Art Psychotherapy would be an appropriate intervention and, if it is, to begin thinking together about what approach would be best. Users added that this first meeting enables the therapist to explain to the client exactly what Art Psychotherapy entailed, how it worked, what the different approaches were and how they might expect to benefit from them. This first meeting, together with written information about Art Psychotherapy, enables clients to make an informed choice about beginning their treatment and which approach to choose.

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27. The assessment process should extend over two or more meetings, giving client and therapist time to reflect and enabling the client to give fully informed consent, or to decline, Art Psychotherapy. Level II

There is good evidence to suggest that, generally speaking, the Art Psychotherapy assessment process should not entail just one meeting. Extending the assessment to two or more sessions enables both client and therapist to have time between sessions to reflect before a decision is made about whether or not to proceed with the therapy.

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28. Clients must always give their informed and voluntary consent to Art Psychotherapy. Their right to decline should be respected. Level IVb

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29. If clients are not able to make informed choices about their treatment, their next-of-kin should be consulted. Level IVb

Evidence from user consultation emphasises the importance of clients giving truly informed consent and, in particular, their right to decline Art Psychotherapy. Users also suggested that, when their health prevented them from making a fully informed decision about whether or not to begin Art Psychotherapy, their families' views should, where appropriate, be sought.

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30. Art Psychotherapists should ensure that assessments are done quickly and efficiently. Level IVb

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31. If a client is returning to an Art Psychotherapy service and has been fully assessed on a previous occasion, a shorter assessment of the person's current situation could suffice. Level IVb

Service users reported that the referral and assessment process in Art Psychotherapy could be too long. Evidence from user consultation therefore suggests that Art Psychotherapists should ensure that their referral and assessment systems are as efficient as possible. Users also suggested that, when a service user wanted to return to Art Psychotherapy, the assessment process could usefully be shortened in order that they might have speedy access to a therapist. This was especially important when users were living in the community and their health was deteriorating.

32. Art Psychotherapists should openly discuss the goals and aims of therapy with their potential client during the assessment process. Practitioners should explain what they do, what Art Psychotherapy involves and indicate a likely timeframe for the treatment. Level IVb

33. Where possible, assessment for Art Psychotherapy should occur in the place where the therapy is to take place so that the client may relate to the physical space and to the art materials. When this is not possible, the client should be shown where the sessions will be. Level II

Evidence from service users emphasised the importance of Art Psychotherapists conveying all possible information about the Art Psychotherapy process - in terms of its aims, likely length, the different treatment approaches and the therapist's expectations of the client - all so that the potential client could accept or decline the treatment in full knowledge of exactly what Art Psychotherapy entailed. Good evidence from academically rigorous literature adds that conducting the assessment in the physical space where the therapy will occur enhances clients' knowledge and experience of the overall treatment approach in Art Psychotherapy and so aids their informed consent.

34. Art Psychotherapists should use descriptive rather than diagnostic language in the assessment and ensure that clients' experiences and circumstances are articulated in the client's language. Level II

35. Diagnostic language need not be entirely excluded from an assessment as it may be useful for the client. Art Psychotherapists should be transparent about any diagnosis they, or anyone else, has given. Level IVb

Good evidence from the academically rigorous literature suggests that Art Psychotherapists should, during the assessment process, endeavour to learn their client's language in order to describe and understand the person's problems. It is further suggested that this ensures a focus on the social contexts and origins of distress that, in turn, maintains the particularity of Art Psychotherapy within psychiatric systems. Whilst users were in broad agreement with this recommendation they thought that the language of diagnosis could also be helpful. However, they stressed that Art Psychotherapists should be transparent about any diagnosis they, or any other member of the referring multi-disciplinary team, had given.

36. Engaging with the art materials and discussing the responses of both client and therapist during the assessment process can demonstrate the Art Psychotherapy process and enables both client and therapist to make a fully informed choice about its suitability. Level IVa

37. Images evoked or made during the assessment can be related to the client's history and experiences and to their future art-making in the therapy. Level II

There is good evidence to suggest that a potential client's use of art materials during an Art Psychotherapy assessment can be helpful to both client and therapist in making decisions about whether or not it is a suitable treatment option for the individual and, if it is, which approach would be best. Using art materials enables users to begin to relate to them and for the resultant artworks to be associated, along with other images or metaphors that emerge in the assessment, to the person's background and history and to their past, present and future art-making.

Evidence from local practitioner and user experience elaborated this recommendation. Practitioners thought that engaging with art materials could reduce clients' anxiety levels in an assessment and assist in the establishment of a low-key, supportive approach. They also thought it could assist the discussion of a potential client's views and previous experiences of art and demonstrate the nature of Art Psychotherapy through exploration of his or her engagement with the art materials in the moment. Users echoed this view, but added that any hesitation or worry a person might have about using art materials should be alleviated by the Art Psychotherapist giving advice and guidance about how they can be used. They also drew attention to the fine line between being encouraged and being pressurised to use art materials in Art Psychotherapy.

38. Individual Art Psychotherapy can be offered to clients who are particularly vulnerable and/or seriously at risk. Level IVa

39. Individual Art Psychotherapy can be offered to clients whose disruptive or hostile behaviour makes group Art Psychotherapy inappropriate for their needs. Level IVa

Evidence from local practitioners' custom and practice suggests that individual Art Psychotherapy is usually offered to those clients who are either particularly vulnerable and at risk, or those whose behaviour makes them potentially disruptive, and therefore unsuitable, for different kinds of group Art Psychotherapy.

40. Group Art Psychotherapy can be offered to clients who are isolated and lacking in confidence and who would benefit from exploring their difficulties through interaction with others. Level IVa

Evidence from local custom and practice suggests that group Art Psychotherapy is particularly suitable for members of this client group who are socially isolated and who would benefit from developing their self-confidence and interactive skills.

41. Selection of clients for Art Psychotherapy groups should be considered in terms of the group's constellation, i.e. with regard to gender, age, ethnicity and social and cultural background. Level Ia

42. Selection for group Art Psychotherapy should consider a group's heterogeneity/homogeneity and cohesion in terms of its members' health. Level IVa

Strong evidence suggests that Art Psychotherapists should pay attention to social, ethnic, cultural, age and gender issues when selecting clients for a closed or slow, open Art Psychotherapy group. Evidence from local practitioners adds that clients' relative degrees of illness and wellness should also be considered during the selection and referral process for a group.

43. 'Open' or 'open studio' Art Psychotherapy can be offered to clients in the acute phase of their difficulties during in-patient care, to those who need a flexible approach with moderate levels of verbal, social and visual interaction, and to clients living in the community. Level IVa and IVb

Local practitioner and user-based evidence suggests that 'open' Art Psychotherapy groups (with a fluid membership and sometimes permeable or negotiable boundaries) and/or 'open studio' Art Psychotherapy groups (where the focus is on art-making) are suitable for service users in different phases of health and ill health. Such groups offer moderate and flexible levels of verbal and visual communication and social interaction that can proceed at individual clients' and/or a group's pace. Such groups can be offered on acute, in patient wards when people are at their most vulnerable and distressed, or in dedicated Art Psychotherapy rooms in hospital, community or residential settings when clients are recovering and/or living in the community. Users reiterated the inadequate provision of Art Psychotherapy services like these in the community and that increases in, and improved access to, such services would provide an invaluable resource that would enable them to be pro-active in managing their mental health.

44.Clients who consider themselves artists may or may not find Art Psychotherapy helpful and need to be carefully assessed. An artistic identity may not disrupt an individual's therapeutic process, or that of a group of which they are a member, but it may not be useful for these clients to have their artistic identity challenged. Level III

Some service users identify themselves as artists. Evidence from expert opinion suggests that, although Art Psychotherapy is not contra-indicated for these clients and indeed that it may be useful, that their needs require careful assessment. The presence of service users who identify themselves as artists does not have a disruptive effect on an Art Psychotherapy group.

45.The mutuality of the Art Psychotherapy assessment process should be emphasised at all times. Clients should be made fully aware of the range of possible approaches from which they can choose (group, open studio, individual). Level II

Good evidence from academically rigorous literature suggests that the mutuality of the process should be emphasised throughout the assessment. Users' right to choose their treatment should be enhanced through practitioners ensuring that potential clients are fully informed about all aspects of the assessment and the possible benefits of the different treatment approaches in Art Psychotherapy. Users emphatically supported this view, but added that they sometimes felt pressured to engage with a particular therapy or art-based activity. This negated their ability to make real choices about their treatment.

46. When considering which therapeutic approach might be suitable for a client the Art Psychotherapist should be aware of issues of difference, preferred approach, skills and interests of the staff of the Art Psychotherapy service. Level II

Good evidence from academically rigorous literature suggests that care should be given when matching client to Art Psychotherapist with regard to issues of difference and the availability of staff with particular skills and interests.

47.Art Psychotherapy should begin as soon as possible after the assessment. Level IVb

Evidence from users proposed that any gap between completing an assessment and beginning Art Psychotherapy should be as short as possible.

48. The appropriateness of Art Psychotherapy, and the particular approach being used, should be regularly reviewed throughout the therapy to ensure that it meets changing client needs. Level IVb

Evidence from users suggested that the general suitability of Art Psychotherapy, and of the particular approach being used, should be the subject of regular review in light of its continuing suitability for the individual as their health changed and their needs altered.

49.Regular audits should be undertaken e.g. of referrals, including their sources, the treatment offered and received, and of waiting lists for different therapeutic approaches. Level II

Good evidence from academically rigorous literature suggests that regular audits of Art Psychotherapy services' referral and related systems can identify problems that require review and remedy and monitor whether a service is meeting the needs of the client population it serves.

Therapeutic Approach

50. It is important to establish boundaries which relate to the use of space, time, equipment, materials and interactions with others. This helps foster the experience of a safe and contained space. Level II.

51.Boundaries should be stated at the outset of Art Psychotherapy but, in certain studio-based and/or acute, in-patient settings, boundaries can be negotiated to allow both interaction and withdrawal. This can offer significant points of therapeutic contact in the relationship through which the strengthening of psychological boundaries can be facilitated. Level Ib

There is strong evidence that suggests that Art Psychotherapy offers clients a particular kind of 'containment' through a series of expectations with regard to time, interaction, relationship and the use of physical space, art materials and equipment. The evidence suggests that the structured and real, tangible boundaries in the physical setting of Art Psychotherapy enables people prone to psychotic states to experience 'containment': that is the particular boundaries with regard to the physical space and place, art materials and made objects enables clients' feelings to be projected onto things as well as onto the therapist until the feelings can be known, understood and reclaimed. Thus repeated experiences of the different elements that constitute Art Psychotherapy - physical, material, emotional and psychological - create 'containment' or an emotionally safe place. It is important to reiterate service users' negative associations with 'containment' and the consequent use of inverted commas around the term throughout this guideline.

Strong evidence suggests that boundaries should be stated at the commencement of Art Psychotherapy. In an ongoing closed or slow/open group, the maintenance of boundaries enables individual clients to develop their ego strength. However, in some settings, for example in an open studio or ward-based open session, boundaries can be negotiated so that service users' engagement with the room, the materials and the person of the therapist can proceed at the individual client's pace. This enables users who are extremely vulnerable and distressed to enter relationship with the space, the

art materials and the therapist, and to manage their inner and outer realities. In other circumstances, such as a closed group on a ward or in the community, there is good evidence to suggest that boundaries need to be maintained so that a group can survive destructive attacks.

52.Opportunities for experimentation, exploration and creative use of art materials by the client should be encouraged and supported by the Art Psychotherapist. Level Ib

53.Clients should be offered a wide range of materials including photography, IT and other media and equipment that facilitate and support the client's full engagement with the creative process. Level IVb

54.Art Psychotherapists should facilitate their clients' use of new and unfamiliar art media, especially at the beginning of therapy, giving guidance and advice when needed. Level IVb

55.Art Psychotherapists should be clear that clients' use of art materials is encouraged, but not always required, in Art Psychotherapy. Level IVb

There is strong evidence to suggest that Art Psychotherapists should ensure that every opportunity for creative and playful use of art materials is maximised. Supporting clients to develop an experimental and exploratory approach to art materials and art making can enable the discovery of an individual client's visual language that can, in turn, mediate between concrete and symbolic thinking.

However, evidence from service users drew attention to two important corollaries. Their experience was that the range of materials on offer in Art Psychotherapy was often limited and focused on drawing, painting and modelling. They suggested that there should be a much greater variety of art materials available that included photographic and digital media. They added, however, that such media would be unfamiliar to many people and would require the Art Psychotherapist to demonstrate, initially, how they could be used. Indeed they suggested that users new to Art Psychotherapy would, generally speaking, benefit from advice and guidance about how art materials might be used. Service users went on to emphasise that, while it was important that clients were encouraged and supported in their explorations of differing media, it was equally important that a person was not compelled to make art in Art Psychotherapy.

56. Art Psychotherapists must have a good knowledge of a range of art techniques and materials. Level III

Evidence from expert opinion, coupled with users' feedback about their needs and wishes regarding the exploration of a wide range of art materials, suggests that Art Psychotherapists need to maintain a current knowledge of, and skills base with, an extensive range of art materials and equipment.

57.An active and empathic approach can foster the therapeutic relationship in Art Psychotherapy. Level II

58. The Art Psychotherapist should ensure their verbal input is non-intrusive so that clients are not pressurised to speak, can become absorbed in the silent process of making art and relate non-verbally to their image. Level II

59. Art Psychotherapists should ensure that they listen carefully and attend to their clients' ideas and aspirations about their art work. Level IVb

There is good evidence from academically rigorous literature that an understanding and sympathetic approach supports the development of the therapeutic relationship in Art Psychotherapy. Practitioners should ensure that, generally speaking, their verbal interventions are non-intrusive so that service users can immerse themselves in making and thinking about their art and looking at what they have made. Service users added that practitioners should pay attention to their clients' aims and ambitions for their artwork. They stated that this sometimes included the desire to make a 'good picture' and suggested that this should be respected and supported by clinicians. Users added that Art Psychotherapists had a tendency to over-interpret and emphasised the importance of Art Psychotherapists' respecting a client's wish to not speak about their artwork, whether it had been made in an Art Psychotherapy session or when the person had been alone.

60. When the client appears unable to make use of symbolic expression, communication can focus on formal elements of the art work and the client's interaction with the environment. Level Ib

There is strong evidence to suggest that when clients are actively psychotic, that conversation in Art Psychotherapy should not focus on content, meaning and interpretation of service users' art but on matters to do with visual method, such as form, line, colour and materials. Concrete, reality-based conversation about boundaries and interactions in and with the physical space, the equipment and the person of the therapist, have also been found to be helpful.

61. In working with the transference practitioners should consider whether it will be helpful for the client if they explicitly observe and interpret the transference. Level Ib

62. Art Psychotherapists should be sensitive to potential responses to their comments about the content and meaning of a client's artwork while remaining aware that their understanding of their client's art work may be valuable to him or her. Level 1b

There is strong evidence to suggest that Art Psychotherapists need to think carefully about whether or not to offer an interpretation about the transference relationship and about clients' artworks, interactions and behaviours. Such comments can be experienced as intrusive and therefore be detrimental to the therapeutic process, but equally they can be experienced as valuable and constructive.

63. Interpretation should come from a mutual exploration, between client and Art Psychotherapist, about their understanding of what an art work might mean. Level IVb

65.The Art Psychotherapist should respect all the art works made by clients in Art Psychotherapy but should acknowledge the client's, sometimes different, experience of it as well. Level IVa

Evidence from user consultation emphasised the importance of an understanding of the content and meaning of clients' artworks being explored and achieved in a collaborative way. However, the view of local practitioners was that, while it was desirable that interpretations should develop from mutual understandings of artworks, it was not always possible as the artist – the service user - and his or her audience – the Art Psychotherapist – might have quite different experiences of, and views about, an art work.

66.The emergence of humour should be supported when it deflates tension, expresses and contains conflictual feelings and promotes creative growth. Level Ib

There is strong evidence to suggest that, when humour emerges in Art Psychotherapy, it can be a productive avenue for the expression and ventilation of thoughts and feelings. This can enhance the development of playful, inventive and imaginative processes in the art-making and social interactions that occur in the therapeutic arena.

67.When working with someone who has hallucinations it can be helpful to invite them to represent the hallucinations with the art materials. Level IVa

Evidence from local practitioners suggests that the depiction of hallucinatory material can be of benefit to people prone to psychotic states. This was confirmed and supported by service users.

68.The making of art work by the Art Psychotherapist within sessions can, at times, provide a useful mirror of the therapy and countertransference feedback. Level II

69.Art Psychotherapists may or may not use art materials in sessions. The rationale for and impact of this needs to be considered in open discussion between therapist and client as it can be experienced as either helpful or distracting. Level IVa

There is good evidence to suggest that an Art Psychotherapist's engagement in art making in sessions with service users can be a useful way to reflect on the therapy and give feedback to clients; it can also assist practitioners with the management of their countertransference responses. However, evidence from service users suggested that this was not always helpful as the activity could infer that the therapist was unavailable to the client. Service users also reported that thinking about the therapist's art could disrupt their making and thinking about their own artwork.

70. Art Psychotherapists should encourage their clients to look back at and review their art work so that they can remember how things were and consider strategies for the future management of their problems. This may be during therapy, at the end and at follow-up after the therapy has ended. Level IVb

Evidence from user consultation suggested that regular reviews of clients' artworks can provide a useful means of reflection about the process and outcomes of Art Psychotherapy. Users were of the view that this could occur at different stages during therapy and that it should continue at regular intervals once therapy had ended. They added that this was a particularly helpful intervention that Art Psychotherapists could make as it enabled a collaborative, constructive and purposeful reflection about artworks that had been made during difficult times which enabled service users to think and plan about how they might better manage their mental health in the future.

Implementation Issues and Audit Criteria

Limitation and uses of the Guideline

This Guideline is based on the best available evidence pertaining to Art Psychotherapy with people prone to psychotic states and has used a robust development process. Readers should be aware, however, that a degree of uncertainty underlies the recommendations because of gaps in the evidence and because of the methodological limitations of research and other forms of evidence that the Guideline has drawn upon.

The Guideline is situated within the parameters of Evidence-Based Practice in Art Psychotherapy that, in recent years, has seen an increase in the completion and publication of inductive and empirical research. Alongside this there is a growing body of academically rigorous Art Psychotherapy literature that, together with the research-based literature, comprises a sufficient critical mass of literature from which to develop Clinical Guidelines (Gilroy, 2006). However, there remain significant gaps in the specific literature that refers to Art Psychotherapy with adult service users who have long-term, severe and complex mental health problems, who are diagnosed as schizophrenic and/or who are prone to psychotic states. This Guideline has addressed some of these gaps through consultation with two panels of Experts - of practitioners recognised as experts in the care and treatment of members of this particular client group, nominated by the Council of the professional association (the British Association of Art Therapists), and of local service users – and through the custom and practice of Oxleas' Art Psychotherapists.

Within the parameters of orthodox EBP this guideline has methodological limitations, not only because of the lack of data from RCTs and other research for the Guideline Group to draw upon but also because of the range of approaches Art Psychotherapists use with members of this client population that are tailored to the needs of individual service users. Researching the effectiveness of any psychodynamically-based approach to care and treatment using a RCT is reliant on the manner in which the intervention is delivered. This difficulty does not pertain to other interventions in medicine and psychiatry, for example a drugs trial, where a medication's effectiveness can be studied in isolation from external and other factors that may confound the treatment and invalidate the results of the trial. Nonetheless an Art Psychotherapy RCT has informed this Guideline (Jones, forthcoming; Richardson et al, 2007). It should also be noted that the commissioning of good quality research in Art Psychotherapy as a whole, as well as with this particular client population, is minimal. Thus for Art Psychotherapy, like many other therapies, an "absence of evidence is not evidence of ineffectiveness" (Parry, 2001, p. 40).

There are other difficulties in researching Art Psychotherapy. Throughout the profession's history Art Psychotherapists have rarely used standard diagnostic criteria to define

their client population. Further, researchers have tended to prefer the methodologies of qualitative investigation. Also, the pool of literature to draw on may be limited due to a variety of factors, including publisher and profession bias. These methodological problems are not unique to Art Psychotherapy, or to other psychological therapies.

The recommendations represent generalisations based on research, academically rigorous literature, expert clinical opinion, service user experience and local Art Psychotherapy custom and practice. They are not a substitute for practitioners' professional judgement about practice in local contexts and settings and clinical decisions about individual clients.

Implementation issues

This Guideline presents a series of General Principles and Recommendations to guide the services and practices of Art Psychotherapists who work with people who are prone to psychotic states. It aims to contribute to the process of developing the evidence base to Art Psychotherapy practice and service delivery. It should be emphasised that this Guideline is not prescriptive. Its intention is to inform practice and act as an 'aide memoire' to Art Psychotherapists normal, routine clinical work. The implementation of the recommendations and the development of local standards may be influenced by local practice in different NHS trusts, voluntary services and by service user expectations and needs.

We suggest that the Guideline will be of primary interest to Art Psychotherapists and recommend that it be used as an aid to clear, effective and transparent practice. It can also be a means through which practitioners can ensure the receipt of appropriate referrals, enabling referrers and service users to make informed decisions about Art Psychotherapy as the treatment of choice. It will enable practitioners to ensure that their practice conforms to standards derived from the best available evidence.

As Parry (2001) states, local service users should be involved in the implementation and audit of this Guideline wherever possible to ensure that their needs are met and that service provision is evidence-based and acceptable to them. A key issue in auditing the implementation of the recommendations is establishing that service users have adequate access to the services that the Guideline recommends. One of the main concerns that arose during the user consultation process was the lack of readily accessible Art Psychotherapy services in the community. Service users stated that they needed to be able to access Art Psychotherapy services easily, without an extended referral process through their consultant or care coordinator. The cost implication of implementing this recommendation could be considerable if purpose built spaces were required. However this could be minimised if existing NHS community service spaces, and others in allied social, educational and voluntary organisation services, were refurbished and transformed into Art Psychotherapy studios. Staffing these spaces would also have a cost implication. Cost implications for other areas of the Guideline should be minimal, for example the provision of a wide variety of art materials that included digital and photographic media and lockable, secure spaces for the storage of service users' artworks. However, it is the view of the Guideline Development Group that long-term savings may be made as a result of investment that enables services to meet the recommendations in this document. This is because service users' admissions will be reduced if they are able to access and engage with community-based Art Psychotherapy. This would be the subject of audit, and of research.

Audit criteria and concordance with the guideline

The following review criteria are suggested for audit when the recommendations in this guideline are being implemented. Local service users should be involved in such audits to ensure that Art Psychotherapy services are acceptable, accessible and equitable. The Guideline Development Group suggest that practitioners audit:

- The availability of Art Psychotherapy services in in-patient, out-patient and community-based care.
- The relevance, accessibility, equity and acceptability of existing in-patient, out-patient and community-based Art Psychotherapy services.
- The art materials, equipment and physical spaces used for Art Psychotherapy to establish whether or not they meet the required standards.
- The Art Psychotherapy treatment approaches on offer in in-patient, out-patient and community care, i.e. within the 'step model' of treatments.
- The extent to which Art Psychotherapists are working with members of this client population, particularly members of black and ethnic minorities.
- That Art Psychotherapy has been considered as part of the treatment plan for members of this client population and if not, why not.
- Referrals to an Art Psychotherapy service to ensure equity and accessibility for those for whom Art Psychotherapy would be the treatment of choice.
- That service users preferences have been taken into account and that their informed consent to treatment has been given.
- That users' cultural and ethnic identity has been considered in the processes of assessment and treatment.
- Times between referral and first meeting, and assessment and beginning Art Psychotherapy in all settings.
- That adequate lengths of Art Psychotherapy are offered.
- That service users are followed up to monitor the outcomes of Art Psychotherapy, for example through reviews, hospital admission and symptoms.

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List of Abbreviations

BAAT	-	British Association of Art Therapists
CMHT	-	Community Mental Health Team
CPD	-	Continuing Professional Development
COREC	-	Central Office for Research Ethics Committee
CPSM	-	Council for Professions Supplementary to Medicine
DoH	-	Department of Health
DSM IV	-	Diagnostic and Statistical Manual for Mental Disorders
HPC	-	Health Professions Council
ICD 10	-	International Statistical Classification of Disease
MIND	-	National Association for Mental Health in the United Kingdom
NICE	-	National Institute for Clinical Efectiveness
NHS	-	National Health Service
NSF	-	National Service Framework
RCT	-	Randomised Controlled Trial

Appendix 1: Poster

Appendix 2:
First Letter to Service Users

Dear

Thank you for your interest in our Art Therapy project which we hope will help us to improve the Art Therapy service.

We are arranging an initial meeting for Friday 3rd February 2006.This will be a discussion meeting where we will go through the document with you. Then we will give you the document to take away with you to read and bring back to the next meeting with your comments. There will be one more meeting after that.

The document has been developed by a group of Art Therapists in Oxleas Trust in conjunction with Goldsmiths University. Three of the Art Therapists involved in the project will be meeting with you. These are Andy Gilroy, Kate Ringrose and Louise Smart.

The first meeting will be held at Pinewood House and transport will be arranged for you.

Please bring your diary with you to arrange further meetings.

Can you please contact the Art Therapy Department at ..... to confirm that time, date and place are ok for you and to raise any queries.

I have enclosed an Art Therapy leaflet.

Appendix 3:
Second Letter to Service Users

Dear

RE: CLINICAL GUIDELINES PROJECT

Following a meeting recently about the Clinical Guidelines document we would very much appreciate your opinion on two important points which were discussed.

The first question is, whether we should use the term client, service user or patient in the document? This could be varied if you feel different terms would be more relevant in different circumstances, for example, using the term 'patient' when talking about someone who was in hospital. We would welcome your thoughts on this.

Secondly, for those of you who would like your names acknowledged, please could you let us know on the enclosed sheet how you would like your name to appear. I have enclosed an S.A.E for replies to be returned. Thank you very much.

Appendix 4: Expert Practicioners Panel

Jane Dudley	RMN, Postgraduate Diploma in Art Psychotherapy, Postgraduate Diploma in Group Psychotherapy, MA Women's Studies. State Registered Art Therapist Vice Chair, British Association of Art Therapists Co-Head, Art Psychotherapist Service, Sutton Hospital, South London and St. George's NHS Trust. Visiting Lecturer, Goldsmiths College
Helen Greenwood	BA Hons Art History, Postgraduate Certificate in Education. State Registered Art Therapist Art Psychotherapist, Specialist Psychotherapy Team, South West Yorkshire Mental Health Trust. Visiting Lecturer, Northern Training Programme for Art Psychotherapy
Kathy Killick	BA Hons, Postgraduate Diploma in Art Therapy, MA Art Therapy, State Registered Art Therapist BPC Registered Psychotherapist Professional Member of the Society of Analytical Psychology Jungian Analyst and Art Psychotherapist in private practice
Roger Wilks	BA Visual Art, Postgraduate Diploma in Art Psychotherapy, Postgraduate Diploma in Group Psychotherapy. State Registered Art Therapist Art Psychotherapist, Henderson Hospital, South London and St. George's NHS Trust.
Chris Wood	BA, Postgraduate Diploma in Art Therapy, PhD State Registered Art Therapist Director, Northern Training Programme for Art Psychotherapy, Sheffield NHS Trust. Art Psychotherapist, Sheffield NHS Trust.

Appendix 5: Initial Appraisal Checklist

Please tick Yes/No/Don't know for each question

1	**Is the text research-based?**		Yes	No	Don't know
	1.1	If yes: is there an explicit research methodology?			
	1.2	Are the methods of data collection and data analysis fully described?			
2	**Is the text academically rigorous?**		Yes	No	Don't know
	2.1	Are the ideas, theories, facts and other information adequately described, referenced and properly presented in a Bibliography?			
3	**Does the text seem truthful and believable?**		Yes	No	Don't know
	3.1	Is the material sufficiently well-described for you to believe it?			
	3.2	Is the material sufficiently well-described for you, potentially, to replicate the author's processes of thought and action?			
4	**Is the text helpful?**		Yes	No	Don't know
	4.1	Does it make sense in terms of your own experience?			
	4.2	Does it contribute to your thinking about your own clinical practice?			
5	**What are the key findings?**		Yes	No	Don't know
	1				
	2				
	3				
6	**Is the paper/chapter relevant to .....?**		Yes	No	Don't know

Appendix 6: Critical Appraisal Checklist

Check for validity:

1	**Is the text research-based?**		Yes	No	Don't know
	1.1	If yes: does it address a clear research question?			
	1.2	Was there ample description of the context and the respondents/ patients?			
	1.3	Is the intervention under investigation clearly defined?			
	1.4	Was the method appropriate to the research question?			
	1.5	Were the methods of data collection and analysis clearly described?			
	1.6	Were the respondents appropriate to the topic being investigated?			
	1.7	Was the setting(s) appropriate to the topic being investigated?			
	1.8	Are the outcomes/findings of the research clearly described?			
	1.9	Did the authors make their role in the research clear?			
	1.10	Was the data independently assessed?			
	1.11	Are the findings replicable?			
2	**If the text is NOT, research-based, is it 'academically rigorous'?**		Yes	No	Don't know
	2.1	Does the text have clearly stated aims and objectives?			
	2.2	Are the ideas, theories, facts and other information adequately described and referenced in a properly presented bibliography?			
3	**Is the text contextualised within the existing literature?**		Yes	No	Don't know
	3.1	Is the literature review appropriate to the topic?			
	3.2	Is the literature review comprehensive and up-to-date?			
	3.3	Does it draw on a range of sources, i.e. does it present more than one point of view?			
4	**If a case study, was the process and content of the work adequately described?**		Yes	No	Don't know
	4.1	Was there adequate description of the institutional context?			
	4.2	Was there sufficient description of the patient's background?			

	4.3	Was there sufficient description of the referral process to Art Therapy?			
	4.4	Was practice appropriately integrated with theoretical discussion of the case?			
5	**Were ethical issues considered?**		Yes	No	Don't know
	5.1	Was ethical consent sought from appropriate bodies and/or individuals?			
	5.2	Has confidentiality and anonymity been respected?			
6	**Were illustrations of art work included?**		Yes	No	Don't know
	6.1	Were the illustrations adequately discussed?			
	6.2	Did the illustrations make sense in relation to the text?			
Check for applicability					
7	**What are the key findings of the text?**				
	1				
	2				
	3		Yes	No	Don't know
	7.1	Do the results/findings address the research questions/aims and objectives of the text?			
	7.2	Are the results/findings discussed in the context of the literature review?			
8	**Is there enough detail to assess the credibility of the results/findings?**		Yes	No	Don't know
	8.1	Is there enough detail for you to believe that what the author says is true?			
	8.2	Is there enough detail for you to assess the author's interpretation of the results/findings?			
	8.3	Were all the clinically important outcomes considered?			
	8.4	Were there any other outcomes or findings that you would expect the author to have addressed?			
	8.5	If yes, does this affect your view of the applicability research/paper?			
9	**Are the findings/results likely to be clinically important?**		Yes	No	Don't know
	9.1	Can the findings be applied to your clinical work?			
	9.2	Do they help you gain insights into your work?			
	9.3	Are your patients comparable to those in the study/paper?			
	9.4	Is your setting comparable to that in the study/paper?			
	9.5	Do you have the skills to deliver the intervention investigated/described?			

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