Effectiveness of group arts therapies compared to group counselling for diagnostically heterogeneous psychiatric community patients: Randomised controlled trial in mental health services

Group Arts Therapies Manual

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Introduction

This manual has been developed to help to describe core features of group arts therapies practice in community mental health care for a randomised controlled trial. The manual development was led by a group of six arts therapists (2 each from art, dance movement and music therapy), and involved input, reflection and discussion in three workshops with wider arts therapists in East London NHS Foundation Trust and Avon and Wiltshire Partnership Trust.

Our hope is that the manual will be a supportive guide when reflecting upon practice in clinical supervision. It is not intended to be a recipe book, but rather a guide to best practice outlining core principles in group arts therapies. We have outlined a recovery and resource-oriented approach as these are both embedded in the ethos of the NHS Trusts participating in this study and we believe, important elements in mental health care. The manual is broadly informed by theories relating to affective neuroscience and developmental psychology with an emphasis on humanistic, resource-oriented and recovery-oriented practice. In line with the contextual model of psychotherapy, it does not rest or rely on any one single model of practice and we believe that this model accommodates wider psychoanalytic, psychodynamic and behavioural theories.

We encourage the arts therapists in this trial to use this manual as a springboard for discussing and exploring clinical work in supervision. As within the groups themselves, we encourage you to be curious, open-minded and inquisitive about the group's process, the art forms and to explore your roles within them.

Underpinning theory

One of the strengths of the arts therapies, is the diversity of ways the art-form can be used within relationships to bring about therapeutic change. Whilst there are many models of training, we have attempted to bring together some core principles that help to explain why and how group arts therapies can be helpful for different types of mental illness in community mental health services.

Mental illness may result from a combination of genetic, biological, social and environmental factors. Whilst no single model of mental illness exists, current theory suggests that across all psychiatric diagnoses, concepts of negative valence (e.g. acute threat/fear, loss), positive valence (eg. motivation and reward), cognition, social processes, arousal and regulation are of relevance to understanding shared features of mental illness. Within secondary mental health care, these concepts are seen in challenges faced by patients in terms of managing and regulating mood and anxiety, maintaining motivation in daily life and becoming stuck in patterns of thinking, feeling or relating, leading to emotional and relational distress. Relationships are further affected through difficulties communicating effectively making developing and sustaining relationships with others difficult. Through social isolation and associated stigmatisation, many lack confidence to socialise and be with others, with wider effects of disempowerment, loss of identity, role and self-esteem.

Contextual model of psychotherapy and common factors:

Whilst there are many forms of psychological and psychotherapeutic approaches, evidence suggests that features that are shared by all forms of therapy are most important in effecting change. The contextual model (Wampold, 2001) suggests that patient expectancy (what patients expect to

happen in therapy), patient and therapist belief in the therapy (commitment and conviction in the therapeutic model) and establishment of a therapeutic relationship play a greater part in determining outcomes than the unique and specific features of an individual model. In line with the contextual model, a meta-analysis showed that, across group therapies, common shared factors account for the greatest amount of change in therapy, rather than unique factors (Orfanos, Banks & Priebe, 2015). These factors, as suggested by Yalom and Leszcz (2005), include acceptance and cohesion, altruism, installation of hope, guidance, modelling, self-understanding, learning from interpersonal action, self-disclosure, imparting of information and development of social skills.

More recent research (Orfanos & Priebe, 2017) suggests that within closed community therapy groups, the first few sessions of the group are the most important in determining outcomes. Sessions where group members showed high cohesion in the first sessions predicted future engagement and greatest therapeutic gains. Reporting similar findings for different types of group psychotherapy, Tchuschke and Dies (1994) proposed that such early group integration promotes capacity for self-disclosure, which increases interpersonal feedback thus increasing opportunities for positive feedback from the group. The above suggests that important factors within group therapy are patient understanding and clear expectations of what will happen in therapy, patient and therapist shared commitment to working in a particular way and time to develop and establish a good working alliance and therapeutic relationship. Within groups this highlights the importance of patient preference, clear information on what to expect, fostering group cohesion in the initial phases and promoting active engagement quickly and early on in the therapeutic process.

Contribution of the arts in therapy:

Inclusion of an active and creative arts-based process provides opportunities for self-expression, creativity and a nonverbal means of relating with other people. The art-form brings a third object-concrete (such as a recording or piece of art work), or experienced (such as movement or heard sound)- into the matrix of relations within the group (Karkou & Sanderson, 2005). Each person brings their own unique creative and cultural identity. This can be explored as part of the therapy with the potential to link this and expand their personal relationship and use of the art-form as a 'helping resource' in their day-to-day lives (Ansdell & Meehan, 2010). Arts therapies are therefore well placed to help patients identify difficulties and strengths through the use of the art-form in the varying interactions in the group. Use of the art-form can facilitate exploration and expression of emotions and discovery of personal meaning in creative activities, allowing experiences and learning through non-verbal and verbal communication. Through creativity, imagination and play, patients are helped to explore new or different emotional and cognitive experiences with support of both the group and the therapist. The production of a piece of art is often cited as a means of strengthening self-esteem by clients (Grocke, Bloch, Castle et al., 2013; Taylor Buck & Havsteen Franklin, 2013) and can provide access to personal and interpersonal resources which may be continued into wider daily and creative life in the community (Ansdell & Meehan, 2010).

Arts therapies have historically been informed by a wide range of theories within psychotherapy as a means of understanding the underlying processes. A recent survey, circulated by the British Association of Art Therapy to all arts therapies professions identified that therapists drew upon a range of models, with expressive, psychodynamic, person-centred, attachment and group-interactive models most commonly cited. Principles from each of these have informed understanding of arts therapies interventions, along with wider principles of resource orientation (Mössler, Fuchs, Heldal et al., 2011; Priebe, Omer, Giacco & Slade, 2014) and recovery (McCaffrey,

2014; McCaffrey, Carr, Solli & Hense, 2017; McCaffrey & Edwards, 2016; McCaffrey, Edwards & Fannon, 2011; Rolvsjord, 2004;2010). The principles of person-centred therapy (Rogers, 1967) are especially relevant to how the therapist models and interacts with members of the group involving a non-directive, empathic stance. The psychodynamic model (Montgomery, 2002) provides a means of understanding patterns of relating and emotional responses across unconscious and conscious levels, which is particularly suited to understanding nonverbal and implicit levels of communication. Huet and Springham (2018) suggest art-work in art therapy may be considered a second order representation within psychological processes (representing alternative 'as if' scenarios, rather than reality). This provides a means of trying out different ways of relating to oneself and others in an imaginative and safe way. Resource and recovery-oriented approaches are informed by a move towards a contextual and health-promotion focus rather than a deficit or treatment-based one. Principles include a shared, equal, collaborative process; focus on patients' strengths and potentials; acknowledging the patients' creative identity; being emotionally involved in the creative process and fostering positive emotions (McCaffrey, Carr, Solli & Hense, 2017).

Implications for the different modalities:

Whilst we hypothesise that it is the shared, or common factors of therapy that are associated with eventual change of health outcomes, each arts modality has particular multi-sensory and aesthetic properties which can provide different and unique opportunities and experiences within a group context (Malchiodi, 2005). Whilst in simple terms a single sensory modality is implied (art, the eye; music, the ear; dance movement, the body), a range of senses are activated, offering a range of different sensory modes of expression (McNiff, 2981). Stern, Malloch and Trevarthen's studies of human communication show how timing, shape and intensity ("vitality affects") are used to communicate intention and regulate interaction from birth onwards (Stern, 2010; Malloch & Trevarthen, 2010). The multi-sensory and multi-modal features of arts-based work can therefore facilitate basic physical and behavioural experiences, such as facilitating a relaxation response, self-soothing, and building of healthy attachments (Huet & Springham, 2018; Malchiodi, 2005).

A model of group arts therapies

The proposed model of group arts therapies (Figure 1), emphasises the importance of the art form in its appeal to the patient, the facilitating of active participation and emotional engagement, the introduction of creativity, and the support of exchange and interactions. The final therapeutically effective processes however are non-specific to the art form and will rather benefit from the diagnostic heterogeneity of the group.

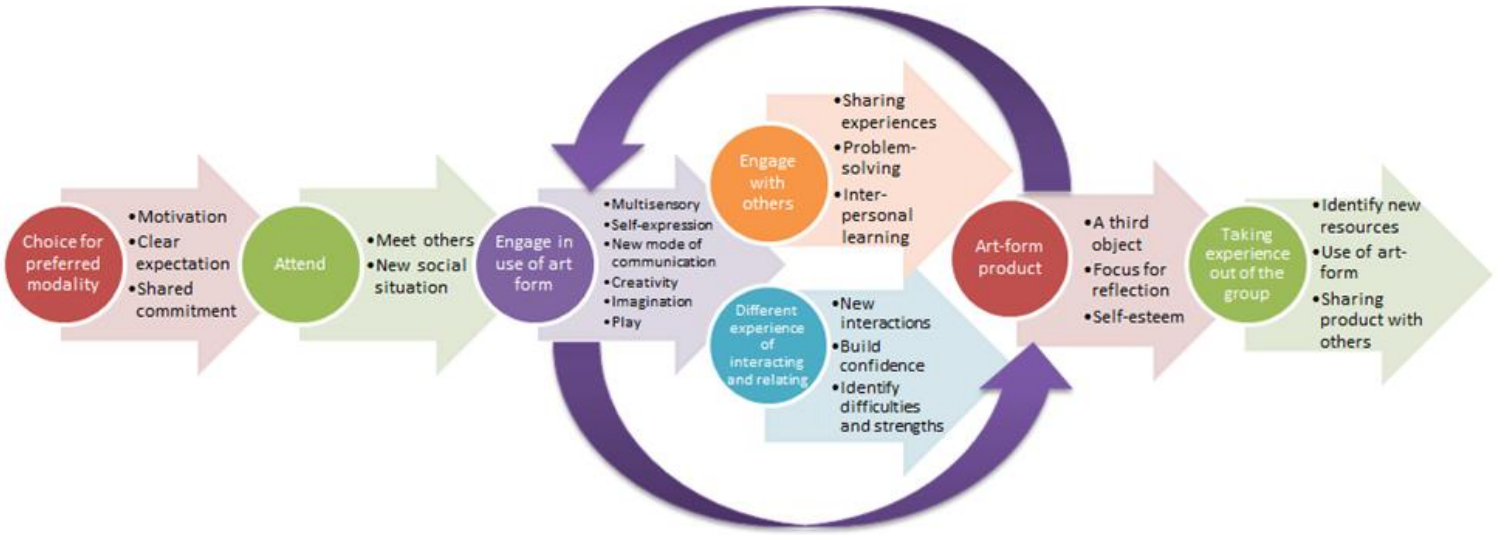

Figure 1: Proposed model of processes in arts therapies groups

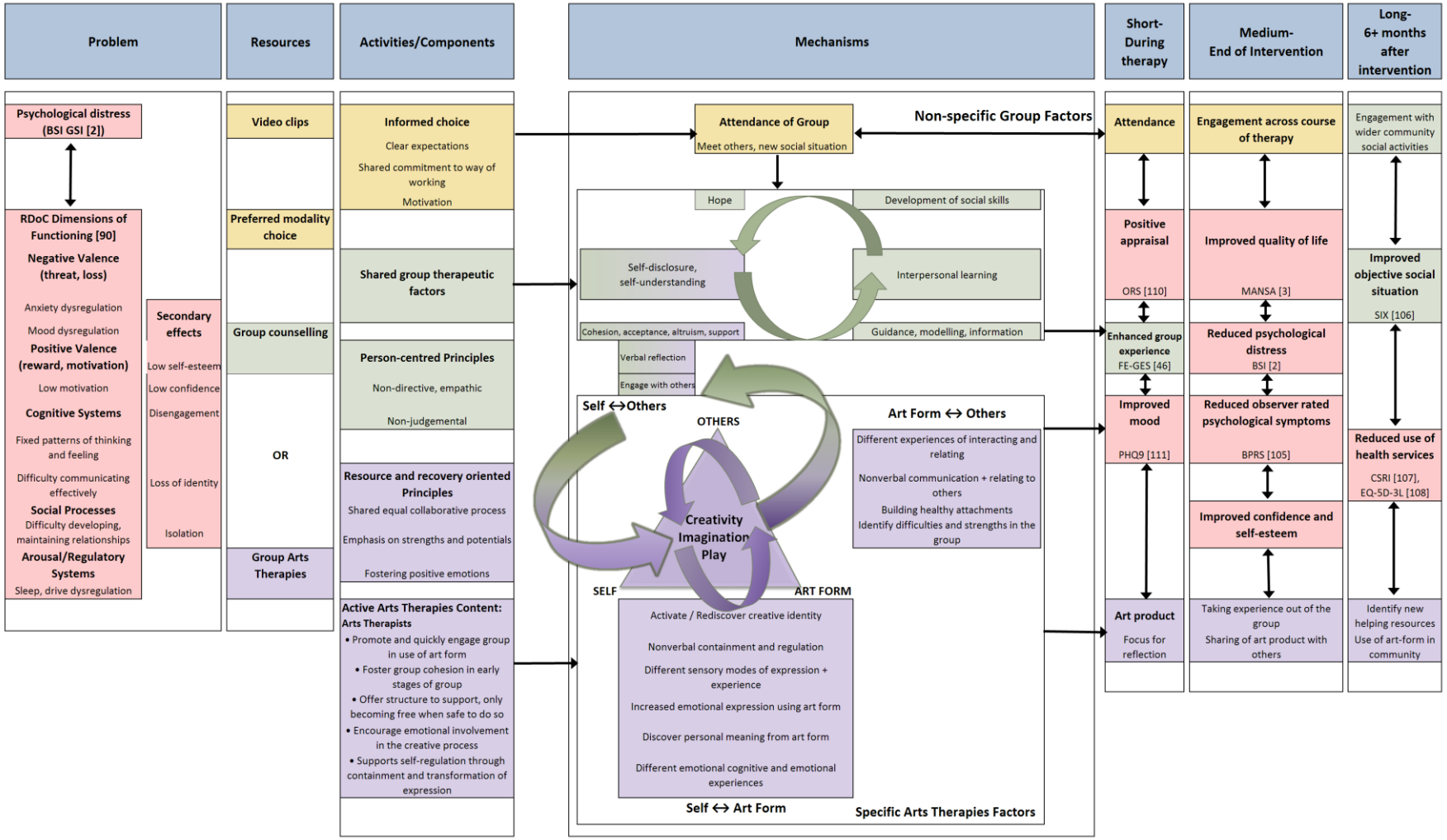

Figure 2: Logic model and outcome measurement

Figure 2 outlines how transdiagnostic theories of mental illness (pink), informed choice (yellow), common factors to group therapies (green) and specific arts therapies processes (purple) relate to the outcomes that we are measuring in this trial. We contextualise the arts-based processes within arts therapies groups as being an additional process to those that already occur within talking-based group therapy.

Ten core principles

On the basis of this, we suggest ten core principles for the arts therapies groups:

1) The arts therapies groups are fully explained with information and video material so that patients can make an informed choice as to their preference
2) Attendance is encouraged and supported through maintaining active contact with patients throughout the treatment phase
3) The therapists ensure communication is maintained and held with the multi-disciplinary care team throughout.
4) Group structure always contains: a) an opening warm-up b) use of the art-form, with space for verbal reflection, c) a closing circle to reflect upon the group experience.
5) Active participation, exploration and use of the art-form is encouraged.
6) Therapists always offer structure within the art-form to promote group cohesion and only let this become free when there is space and safety to do so.
7) Within the early phase of therapy (weeks 1-5), the therapist focuses upon building trust and active engagement with the art-form, allowing plenty of time for this to happen.
8) Middle to late sessions (weeks 6-17): Developing content and arts-based activities in collaboration with service users to build variety (as opposed to doing the same arts-activity each session).
9) End phase (weeks 18-20): The group reflects on the process as a whole and review to prepare for ending. Therapists signpost patients to wider arts-based opportunities in the community.
10) Sessions are recovery-oriented: Therapists work collaboratively with patients so that their strengths and preferences in using the art-form are acknowledged to support their future recovery and signposting.

Group aims

Our discussions identified five core group aims of arts therapies groups. Importantly, these aims incorporate both implicit (embodied, felt or lived) and explicit (verbal and reflective) relational experiences:

1. To provide a safe space to be with others

2. To promote engagement with the art form:

- to explore ways of using the art form and its relevance to one's own life
- to explore inner creativity
- to explore opportunities to extend and use the arts in daily life

3. To provide regulation of arousal and affect

- to explore ways of using the arts to aid self-regulation
- to become aware of and find new ways of expressing and transforming emotions

4. To offer opportunities to build upon existing relational capacity:

- To build awareness of self and others
- To facilitate nonverbal engagement and expression with others
- To explore new and different ways of relating to others
- To break isolation and offer opportunities for support and socialisation

5. Through the above, use the arts to build confidence, self-esteem, self-agency and autonomy in interactions with others and to further develop connectedness, hope, identity, meaning and empowerment (recovery).

Setting up the group

Group make-up and size

Group members in this study, will be offered a place in the group based on:

- Experiencing a high level of self-reported psychological distress (measured on the Brief symptom inventory)
- Making an informed choice as to which arts modality they prefer (art, dance movement or music)
- Being randomised to their chosen arts therapy modality (and not to group counselling).

The groups will have up to 10 members in total.

Managing group numbers

We have designed the trial to accommodate the importance of ensuring a critical mass of group membership at all times in group therapy. The therapist leading the group should keep track of the numbers attending the group each session. Should the number of group members drop below 4 attending members for 2 consecutive sessions, the therapist should inform the Trial Manager and

work with local services to refer additional non-trial participants into the group. Additional new referrals will be accepted until week 10 of the group, after which point, the group will be closed to new referrals.

As the groups use audio-visual recording, new referrals must meet the inclusion criteria as defined for this study, be provided with a specific information sheet and provide written informed consent. The local research team will support the therapists in following the necessary procedures for this. Additional referrals will NOT be required to complete research assessments.

Withdrawal from the group

If a group member chooses to withdraw from the group, the therapist must let the group member know that a member of the research team will be in touch and inform the Trial Manager. The group member has the choice whether or not they continue to stay in the study. A member of the research team will then contact the group member to check whether they wish to remain in the study and to explore their reasons for withdrawal.

Should the therapists feel it is in the best interests of the patient and group for them to be withdrawn, they should contact the PI and CI in the first instance to discuss their concerns and ascertain whether further safeguarding, incident or adverse event reporting is required.

Reasons for withdrawal can include:

- Becoming too unwell to continue group participation
- Loss of capacity to consent to group attendance
- Level of risk assessed by the clinical team to require hospitalisation
- Current mental state, behaviour or risk to self or others requires discontinuation of group attendance.

All withdrawals should be documented in the patient's medical record and followed up with the clinical team in charge of that person's care, PI and Trial Manager.

Role of the arts therapist and co-facilitator

The groups will run by an HCPC/UKCP accredited arts therapist (art therapist, dance movement therapist, music therapist) and a co-facilitator. Whilst the therapist takes overall clinical responsibility and leads the group, the co-facilitator assists with group equipment setup and set-down, group member communications, and individual support during sessions. The co-facilitator will take the lead from the arts therapist and will be trained to participate actively and supportively in using the art-form during sessions. The co-facilitator is expected to debrief with the therapist after sessions and may assist in making entries onto clinical records.

It is the responsibility of the group arts therapist to complete the group attendance and manual adherence forms. Co-facilitators are invited to assist the group arts therapist with this through joint reflection.

Session duration, frequency and duration of therapy

Sessions will run for 60-90 minutes, twice per week for 20 weeks. There will be 40 sessions offered in total.

Therapy space

The therapy space must have the following properties:

- In a location with good transport links, easily accessible by group members
- In a quiet location, free from interruptions
- Good light and temperature control
- Space for up to 12 people, chairs plus arts equipment
- Art therapy: Access to art materials, desk-space, sink
- Dance movement therapy: Space for up to 12 people to move freely, access to DMT equipment
- Music therapy: Sufficient sound-proofing or away from others who may be disturbed by the sounds, space for music therapy equipment.

Therapists should have access to NHS computers with facility to view medical records either via a desktop situated on site, or through an NHS laptop with wireless connectivity. If relying on NHS laptops to access medical records, therapists should ensure these are piloted prior to the groups starting in case of issues with connectivity.

There should be a landline nearby for therapists to use, or NHS Trust issued mobiles, for communication with group members on the day.

The group space must have a lockable filing cabinet or cupboard, accessible only to the therapists and research team for the storage of any person identifiable and clinical data for the duration of the study.

Before the groups start: Introductory meeting

As this is a clinical trial, the referral process into the therapy groups differs from usual clinical practice. One of the main differences is that patients will not have met the therapist who will be running the group. To ensure that patients have a clear idea of what to expect, they will be invited to meet individually with the group therapist and co-facilitator, in the space that the group is happening before the first group session.

Procedure

Therapists will be informed of the patients allocated to their group as soon as randomisation has been completed. A list of names, medical identification numbers (eg. NHS/Rio), patient contact details and responsible clinician contact details will be sent by the Trial Manager directly to the therapists, with the site PI and unblinded CI copied in.

Therapists should review each patient's clinical records for:

a) Any notable risks identified in the clinical record (noting whether past or current)
b) Any background information necessary for the running of the current group in their own process notes
c) Any risks or concerns should be followed up directly with the clinical team, copying in the PI. Outcomes of this follow-up should be recorded in the patient's medical record.

Therapists then arrange a 30 minute appointment with each group member, to take place in the group space.

The individual meeting should be led as much as is possible by the patient's presenting concerns. Whilst there is some core information to provide, the meeting should be conducted so that it supports the patient to ask questions, share anything they feel is relevant or important and to establish a first sense of trust and rapport with the therapist and co-facilitator.

During the meeting the therapist should:

- Introduce themselves, the cofacilitator, the group space and the art materials
- Explore the person's reason for coming to therapy, including hopes and expectations
- Enquire as to what personal, social and health resources are available to and helpful for that person right now
- Enquire if there is anything the patient feels is important for the therapists to know
- Explain the general aim, structure and process of group therapy
- Provide an opportunity to view, try out and explore the arts materials available
- Outline ground rules and expectations, explaining that more may be decided by the group in the first few sessions:
  - To try to attend regularly and on time
  - To try to stay for the duration of the session
  - To communicate with the group (if advance notice) and/or therapist immediately if unable to attend a session
- Agree the level of communication and support the person might need in coming to sessions (do they want a text reminder? Do they need help getting to the session?)
- Checking out with the person any preferred risk management strategies or support
- Check main clinician and preferred family/friend/carer contact (if any)

- Reminding of confidentiality and limits of this
- Inviting any questions from the patient, offering reassurance and/or follow-up regarding any concerns
- Therapists should confirm the date and time of the first group session and provide a handout which includes a calendar of the group sessions and contact details for the therapists. There is space to record agreed actions and strategies on this form if the patient wants this.

Group structure and activities

These principles provide the main outline of the session.

The group structure always contains: a) an opening warm-up b) use of the art-form, with space for verbal reflection, and c) a closing circle to reflect upon the group experience.

What this means:

Sessions have an element of predictability, giving space for individuals to share at the beginning and end of the group. The middle section is flexible and amount of alternation between using the art-form and talking may vary across modalities.

Opening and closing sections should be led by the therapist to start, but may be developed or expanded on by the group as sessions progress. The amount of time given to each section will vary depending on the stage of the group (early/later on in the process) and how group members are on any given day.

What this is not:

Rigid reliance on exactly the same opening and closing activity each week.

Not following the lead of the group in when to transition from and to activities.

Active participation, exploration and use of the art-form is encouraged at all times.

What this means:

Therapists aim to begin using the art-form with group members as quickly as possible in sessions, particularly where members are reluctant, reticent or avoidant. Use of the art-form should be introduced in a sensitive way, with a level of activity and degree of structure that fits the presentation of the group (see point 3 below).

The therapist should ensure that the group does not go for long periods of talking or silence, without any use of the art-form.

What this is not:

Forcing members to use an art-form when they are not ready to do so –a single group member might not directly use the art-form themselves, but may watch attentively to the rest of the group's creations.

Ignoring the current situation of a group member which may make use of the art-form difficult on that day

Therapists always offer structure within the art-form to promote group cohesion and only let this become free when there is space and safety to do so.

What this means:

Structure is always offered to begin to establish an atmosphere of safety and cohesion between members within the group. Time should be allowed for group members to explore the art-form within the safety of such structures so that self-agency and competency in using the art-form are established.

What this is not:

Limiting the level of freedom and activity in sessions to rigid or predefined structures.

Not varying the level of structure according to presenting needs on the day.

We suggest three core phases of group process in arts therapies. Whilst we give suggestions as to which weeks these phases correspond to, we acknowledge that each group will have its own unique process in practice, so these are guides only.

1) Within the early phase of therapy (weeks 1-5), the therapist focuses upon building trust and active engagement with the art-form, allowing plenty of time for this to happen.
2) Middle to late sessions (weeks 6-17): Developing content and arts-based activities in collaboration with service users to build variety (as opposed to doing the same arts-activity each session).
3) End phase (weeks 18-20): The group reflects on the process as a whole and review to prepare for ending. Therapists signpost patients to wider arts-based opportunities in the community.

Sessions are recovery-oriented

What this is:

Therapists work collaboratively with patients with a here and now focus, so that their strengths and preferences in using the art-form are acknowledged. Group members are supported to explore issues raised, with challenges acknowledged. The therapist models curiosity in understanding members' experiences but does not interpret or suggest meanings for the group. Throughout the sessions, the therapists acknowledge these strengths and preferences in terms of supporting future recovery. Therapists signpost group members where appropriate to wider community services which may meet the strengths and preferences expressed in the group.

What this is not:

Ignoring risks, problems or clinical issues.

Minimising or ignoring the impact of events from the past upon group members.

Referring group members onto services without exploring preferences and wishes to do so together first.

Therapist qualities and practice principles

Therapists will adhere to HCPC/ UKCP standards of practice at all times. We also refer arts therapists to the Arts Therapist Benchmark statement on standards of practice (Quality Assurance Agency for Higher Education, 2004).

Specifically, within the model outlined in this manual, we wish to emphasise the following practice principles:

- A person-centred approach, including conveying an empathic, congruent, non-judgemental and validating attitude towards group members at all times with unconditional positive regard.
- Maintaining a calm, reflective and holding presence for the group.
- Listening actively, paying attention not only to the content of words, but noting the nonverbal cues and communication throughout the group
- Encouraging active participation, exploration and use of the art-form in self-expression; creativity; sharing and helping between group members.
- Therapist bringing their own emotional involvement in the creative process
- Supporting self-regulation through containment and transformation of expression
- Maintaining a stance of curiosity and openness and interest in clients' experience of the modality and modelling this for other group members
- Help members to discover personal meaning and understanding from the arts process
- Offering encouragement and facilitating/fostering positive experiences
- Focusing upon group members' strengths and potentials, recognising members' competence in the creative process and unique creative identity.
- Modelling and encouraging ways of using the modality outside of sessions
- Developing relationships that are shared, equal, collaborative, respectful and mutually trusting, ensuring equal opportunity for each group member to participate and contribute
- Collaborating with group members regarding goals and methods of working
- Use of transference and group dynamics to aid understanding of the evolving relationships within the group
- Highlighting group interactions and encouraging clients to make their own meaning from this and try out new ways of relating
- Modelling reliability and trustworthiness through actions by maintaining regular communication, reminding group members of upcoming breaks and endings, following up quickly on any issues raised after the group.
- Establishing, reminding and upholding group boundaries for members (reviewing them with the group if necessary)
- Actively leading the group and being present at all times, consistently challenging the group and individual members when safety is established

Proscribed practices

These are elements of practice that the group identified as going against the principles and model of group arts therapies for severe mental illness.

- Direct interpretation without checking the client's understanding of events or ignoring the client's communicated understanding of events
- Not intervening and/or being completely non-directive in the group
- Not assisting or intervening when the client is unable to use the art-form
- Allowing the group to avoid or not use the art form
- Focusing only on deficits and problems
- Over-focusing on a single area of interpersonal experience (eg. cognition, affect, self, other)
- Avoiding problems
- Therapist directs without giving the group the opportunity to lead or direct
- Focus upon past events without connection to the here and now of the group
- Therapist over-involvement in emotional processes
- Rigid adherence to boundaries without collaborating or seeking mutual understanding with the group
- Contributions of group members are ignored or dismissed by the therapist
- Not intervening when expression is uncontained
- Persisting in an activity which is not appealing or helpful to the group
- Problem solving for the group
- Once cohesion and trust are established, not challenging the group to try out new things or take risks

Common scenarios and management

The following 14 scenarios are common occurrences in arts therapies groups where the therapist would intervene.

	Item	**Definition/examples**
1	Unmanageable affect	High / low affect that impacts upon ability to relate to/ be with art form/others and is difficult to self-regulate
2	Power dynamics	Interpersonal dynamics, criticism, scapegoating, blame, dominance, boundaries, them and us
3	Collaboration	Empathy, attunement, relating, working with others, co-production of the art form
4	Ambivalence about using arts media	Difficulty using art form due eg. to lack of experience, current feeling state, self-consciousness in front of others
5	Using the arts for retreat/distraction/avoidance	Avoiding contact with others by focusing solely on the arts medium, avoiding connection to feelings
6	Identity	Artistic biography, narratives, cultural associations, rites of passage, rituals
7	Linking arts process with personal relationships and community	Making connections between use of the art form and relationships within/outside the group.
8	Improvisation	Authentic, new artistic element, expression, play, creativity in use of art form in the moment
9	Incongruence between art form and feelings	Expression within the art-form does not match the presentation or stated affect of the group/group member
10	Concrete, rigid, stuck	Set ways of using art-form,lack of flexibility, lack of connection to feelings and interpersonal process.
11	Sub-groups	Pairing, trios, quartets
12	Diverse uses of the arts forms	New ways of using the arts media eg. playing a chair with drumsticks, finding a different movement, different styles and genres of the art form introduced.
13	Over-compliance / need to 'fit in'	Taking a background role in the group, using the arts to hide from/avoid challenge by others. Working to please the therapist.
14	Pre-occupation with an 'aesthetic' or competence	Valuing the artistic product over and above the arts/group process. Focusing on ability/competence to use the arts without relating back to self and situation.

After the group: Final meeting with therapists

During the final group session, the therapists should arrange individual 30 minute meetings with group members to review the group process, explore any remaining issues or concerns and any wishes for further support. The meeting is an opportunity to provide information and assist with referrals to existing services, both within the NHS and outside (such as local community arts groups). The therapists should explore the group member's experience of using the arts, how this may have helped their ongoing recovery and plans for continued arts involvement.

Outcomes of the meeting including plans for future referrals should be documented in clinical notes.

Supervision

Therapists will receive monthly supervision with an arts therapist. Additional joint meetings with therapists from all 3 modalities will be arranged to happen in week 2 (beginning), week 10 (midpoint) and week 19 (ending)of the therapy groups.

Additional meetings with clinical supervisors will be arranged to review adherence to the manual in the first 3 weeks of the study. If any issues are identified, further ad hoc meetings can be arranged to provide additional therapist support.

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