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Research Article

Developing a shared language within arts psychotherapies: A personal construct psychology approach to understanding clinical change

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ABSTRACT

This study aims to answer the question, *How do arts psychotherapists describe their practice in session with clients who have severe mental illness?* Personal construct psychology (PCP) methods were used to gather and build consensus about how arts psychotherapists describe in-session therapeutic constructs in adult mental health services, working with patients diagnosed with severe mental illnesses.

PCP techniques were used in interviews with seven arts psychotherapists (art, music, drama and dance movement psychotherapists). The practitioners were encouraged to discuss in-session constructs relating to clinically significant events. PCP assumes that the interviewee holds personal perspectives and makes decisions based on their system of personal constructs.

The results showed that there were overarching categories for the in-session constructs elicited from arts psychotherapists during interviews. These constructs were subjected to an intensive categorising process that produced a final set of 14 bipolar constructs describing 28 alternative therapeutic interventions. The in-session constructs cover a wide range of interventions from empathic attunement to narrative reconstruction.

Introduction

Arts psychotherapies (APs) is a term which covers a number of creative therapies which have a strong non-verbal component. The APs include art therapy, music therapy, dance movement psychotherapy and drama therapy. In the UK, art psychotherapy, dramatherapy and music therapy are legally regulated by the Health and Care Professions Council (HCPC) (Health & Care Professions Council, 2014). Body movement and dance movement psychotherapy is regulated by the National Association of Dance Movement Psychotherapy (ADMP). These therapies have a long history in the UK and art psychotherapy (also referred to as art therapy) is the largest arts psychotherapies profession employed in National Health Service (NHS) contexts, with music therapy being the second largest. Arts psychotherapies are offered in hospital and community settings, individually or in groups, usually in conjunction with medication. According to a recent freedom of information (FOI) request, approximately 200 arts psychotherapists are employed in adult NHS mental health services in London. These professions have been slowing in growth, but less so than other allied health professions.

APs have needed to adapt to the changing function and role of the NHS services over the past ten years. The NHS adult mental health services have been increasingly funded to meet targeted groups of people with highly complex presentations where there is a viable prognosis, moving towards a tariff based model (Docherty & Thornicroft, 2015; Jacobs, 2014). This means that comprehensive treatment is offered to patients within known timeframes of effectiveness which is usually short term. Attempts are made to provide time limited therapy to accommodate more patients (Lubian et al., 2014). Evidence for psychological interventions for complex disorders, suggest that time limited work can be effective (Bateman & Fonagy, 2009a, 2009b; Fonagy et al., 2015; House & Loewenthal, 2008; Roth & Fonagy, 1996).

The traditional work of arts psychotherapists focusing on work with people diagnosed with psychotic conditions, is a field where high level research evidence still remains thin. Due to the limited evidence for treatment of psychoses the NHS focus has moved towards symptom management for schizophrenia by

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non-psychological therapists (Kuipers, Yesufu-Udechuku, Taylor, & Kendall, 2014; Taylor & Perera, 2015). This culture shift requires rethinking what arts psychotherapists are doing, but perhaps more critically at this stage in the transformation of the NHS, examining how arts psychotherapists have adapted practice to meet the demands of a changing health culture. Arts psychotherapists working in adult mental health services are becoming less focused on prevention and sustaining health with ongoing input and are more motivated towards developing sustainable treatment of symptoms and throughput. There is no subtlety in the difference. There have been philosophical (Mountain, 2014) and ethical concerns about the overuse of a medical paradigm (Corrigan, 2007; Dudley, 2004), poor consideration of long-term cost effectiveness (Cagney, 2015), criticism about randomised controlled trials as the *gold standard* of research (Westen, Novotny, & Thompson-Brenner, 2004) and challenges to the belief that there can be standardised responsive practice (Strupp & Anderson, 1997). However, the fact remains that these are key considerations for commissioning of health services where there are increases in demand, costs and complexity of patient presentation. On top of this, the areas that arts psychotherapists have chosen to research in recent years are based on historical methods and paradigms which, arguably, fit poorly with commissioner expectation and the rapid changes in NHS prioritisation.

For example, the UK National Institute of Clinical Excellence (NICE) guidelines (Department of Health, 2014) suggests considering offering APs to all people with schizophrenia. However, two recent randomised-controlled trials in group art therapy (Crawford et al., 2012) and group body psychotherapy (Priebe et al., 2013, 2016) failed to show clinically significant effects in the treatment of patients with schizophrenia (Crawford et al., 2012; Priebe et al., 2013). This led to extensive discussions in the field about ways to move forward (Holttum & Huet, 2014; Huet, Springham, & Evans, 2014; Patterson, Borschmann, & Waller, 2013; Patterson, Crawford, Ainsworth, & Waller, 2011; Wood, 2013).

It has been argued that a central problem of research in APs is lack of consensus about the process of therapy and mechanisms of action or for whom it is most effective (Patterson et al., 2011). Patterson et al. (2011) reflected on interviews from clinicians engaged in the art therapy trial for schizophrenia and commented, "...it is important to note that the how, when and why of a particular mechanism or what benefit might be experienced was infinitely variable dependent upon participant and circumstance" (2011, p.78). This statement might be concerning for clinicians and researchers who wish to conduct scientific enquiry into APs, where the treatment and related outcomes can be considered for a given population. In other words, without clearer indication of the therapist's role in facilitating change for the patient, it is unclear how the intervention works and relates to meaningful and relevant outcomes.

If arts psychotherapists in similar clinical circumstances differ in the approaches and techniques they employ (in this paper termed *constructs*), this would suggest that consensus would be difficult to achieve. The professions of art, music, drama and dance movement psychotherapy could only be grouped according to a *high-level* more abstract categorisation, rather than according to clinical process, as each clinical response would be defined according to the individual or profession. Developing a language to describe how psychosocial in-session constructs affect the patient and related outcomes, that helps to make sense of clinical practice in relation to empirical research, is still in its infancy (Kazdin, 2001b, 2016, 2017). Likewise, developing consensus for how psychosocial in-session interventions affect the patient and related outcomes, is an emergent field of study in psychotherapies (Wampold, 2013).

The success of change process research in APs is dependent upon understanding and defining the variables involved. Traditionally, this has been conceptualised as the relationship between the therapist, arts form, patient and the dynamics and the themes that occur, which together amount to a therapeutic narrative (Cassidy, Turnbull, & Gumley, 2014; Greenwood, 2012; Hines & McFerran, 2014; Huss, 2009; Koch & Fischman, 2011; McFerran & Wigram, 2005). This in itself informs a change hypothesis, but in art psychotherapy case study research the sequential observable actions of the therapist are rarely described and tested against a hypothesis that questions what might be changing for the patient in clinical work, and why the changes have occurred. In order to further build the hypothesis we identified three areas of impact based on patient reported experience measures used locally i.e., the *lived experience consultation group* and therapist feedback. These areas relate to affect regulation, secure attachment and mentalization (mind-mindedness). These areas were also prioritised according to what could be reliably observed and measured and therefore fitted within the research paradigm demanded from the NHS.

These concepts were also considered in the light of recent research by Fonagy and colleagues (Bateman & Fonagy, 2009; Bouchard et al., 2008; Fonagy, Gergely, & Jurist, 2003; Fonagy & Target, 1997; Gabbard, Miller, & Martinez, 2006) as well as feedback from a service user focus group employed to explore *what works for whom* and an expert arts therapies reference group.

Rationale for using personal construct psychology as the basis for investigation

In the first instance, a method was required that would allow for emergent personal reflections on therapeutic actions. We chose personal construct psychology (Note: in this article we use the acronym PCP, solely to refer to personal construct psychology) as this appeared to satisfy the objectives of the task and also had scope for further development in terms of surveys or conceptual analysis. Personal construct theory was developed by Kelly (1955) and it underpins all personal construct methods (Caputi, Viney, Walker, & Crittenden, 2012; Fransella, Bell, & Bannister, 2004; Kelly, 1955). A fundamental aim of PCP is to understand how a person 'construes' their world. How a person construes their world determines their behaviour. As Kelly (1955) says: "The construing process may be said to govern all forms of behaviour, verbal and non-verbal, 'conscious' and 'non-conscious'". (p. 668). A necessary implication of this is that in order to change behaviour (e.g., the interventions that an arts therapist chooses to use) *reconstruing* is necessary. Viney (1996) says: "People construe themselves and their worlds and then act according to their construing (Landfield & Epting, 1987). They do not react directly to their physical worlds but to their interpretations of it... When interpretations are based on these created meanings, it is always possible to change them." (p. 78).

The basic *units of construing* are bipolar personal constructs (Fransella, 2016) such as *kind –v- cruel*, *professional –v- unprofessional* and *organised –v- disorganised*. The term *bipolar* in this context should not be confused with the mental health disorder of that name. A person develops their own system of personal constructs as they successively construe (and differentiate between) different experiences. It is key to the personal construct approach that a person can reconstrue how they perceive a situation, thing or person (including themself) and thereby reflect on their behaviour – and themself (see e.g., Chiari & Nuzzo, 2005; Winter, 2016). It is also central to understanding the PCP way of working with people, to accept that different people can see the same event (people, situations, things) in different ways, as well as in the same ways. Kelly (1955) described this philosophical underpinning of PCP as *constructive alternativism*. Kelly states that people apply their personal constructs to situations, people and things in order to differentiate between them, to understand them and to predict what will happen – a type of scientific investigation. Indeed, Kelly described his