

# **Towards a Shared Understanding - Using Personal Construct Psychology to differentiate in-session interventions in Arts Psychotherapies**

## **Abstract**

This study aims to answer the question, ‘How do arts psychotherapists describe their practice in sessions with clients who have severe mental illness?’ The authors explore the use of personal construct psychology (PCP) methods to gather and build consensus about how arts psychotherapists describe in-session therapeutic interventions (constructs) in adult mental health services, working with patients diagnosed with severe mental illnesses.

We used PCP techniques to interview seven arts psychotherapists (art, music, drama and dance movement psychotherapists) about 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 constructs. The in-session constructs cover a wide range of interventions from empathic attunement to narrative reconstruction.

**Key Words:** Arts Therapies, Personal Construct Psychology, Consensus, Interventions, constructs

## **Introduction**

Arts psychotherapies (APs) is a term which covers a number of creative therapies which have a strong non-verbal component, such as 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 and these professions have been slowing in growth, but less so than other allied health professions.

However, APs have largely adapted 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 psychoses, is a field where using a quantitative paradigm of evidence still remains thin. Due to the limited evidence for treatment of psychoses the NHS focus has moved towards symptom

management for schizophrenia by 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 3where 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, Priebe et al, 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, Crawford, Ainsworth & Waller, 2011). Patterson et al. (2011) reflected on interviews from clinicians engaged in the MATISSE trial 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 use very different therapeutic interventions (NB. in this paper we use the term *constructs* to describe therapeutic interventions) in similar clinical circumstances, this would suggest that consensus would be difficult to achieve, and that 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 for 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 effect 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 of 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, 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 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 George Kelly (1955) and it underpins all personal construct methods (Kelly, 1955; Fransella, Bell, & Bannister, 2004; Caputi, Viney, Walker & Crittenden, 2012). 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 behavior, 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 and 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 themselves) and thereby reflect on their behaviour - and themselves (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

model of the person as the 'person as scientist' (see e.g., Dalton & Dunnett, 2005; Denicolo & Pope, 2001; Fransella, 1983).

This study aimed to explore the use of PCP methods to gather data and build consensus about how arts psychotherapists describe in-session constructs in adult mental health services working with patients diagnosed with severe mental illnesses. Finding a common language in the pursuit of a shared understanding has not been undertaken for APs, although in related fields there has been an attempt to unify language - albeit not through structured interview methodologies (Marks, Sibilis & Borgo, 2010; Miller & Duncan, 1997; Strong, 1987). In Karkou's (2006) analysis of theoretical orientations in APs, the main influences were Winnicottian approaches, object relations, other psychoanalytic theory and *eclectic* approaches. We wanted to explore whether PCP based interviews could reveal whether or not the differences between what clinicians do in practice, is too diverse to be considered for developing any kind of consensus.

## **Methods**

This study consists of four phases as listed in Figure 1.

The research team consisted of seven people: four honorary researchers who conducted the interviews and had an art therapy background, two senior art psychotherapist clinicians, and a personal construct psychologist. An expert reference group made up of eleven arts therapists, including music therapy, dramatherapy, art psychotherapy and dance movement psychotherapy, was established to explore the validity and reliability of the findings. Whilst the expert reference group did not have experience in research, they were all experienced senior clinicians having each worked in an NHS mental health context for in excess of 10 years.

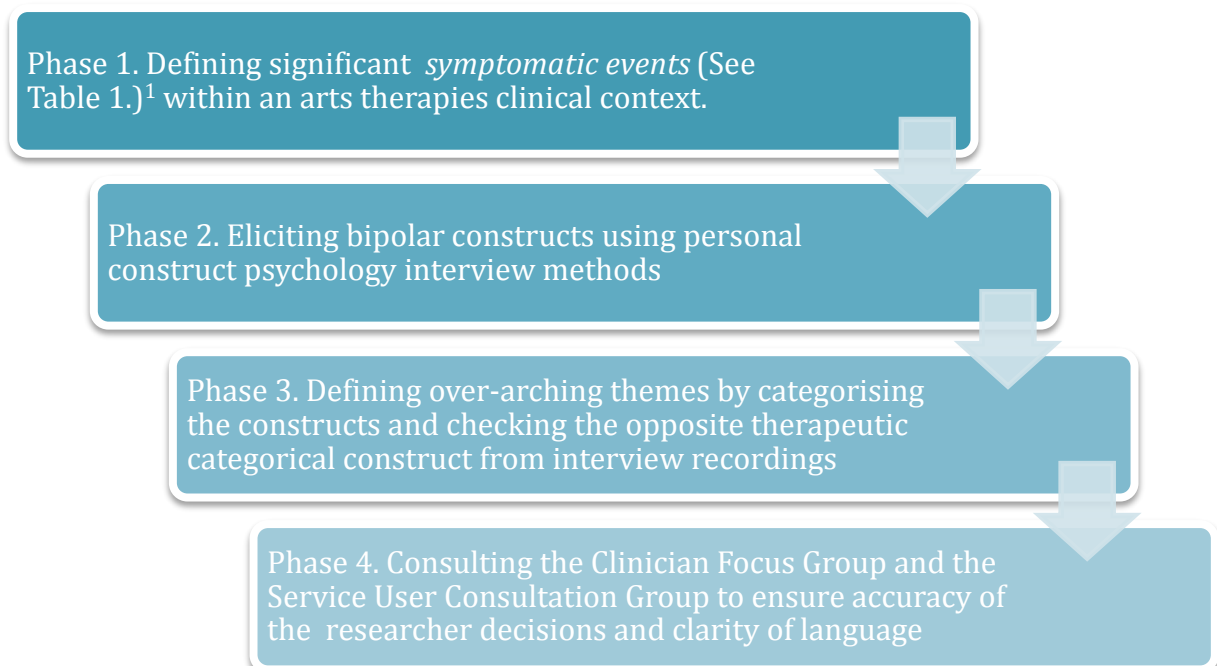
The study participants were seven arts psychotherapists who had been working together for a period of between one and eight years and who had similar clinical populations and regular exchanges about patient treatment in their clinical supervision (weekly or monthly). By '*working together*', we mean that these therapists were selected on the basis that they represented a group of psychotherapists who work within a shared geographical and clinical context and have relatively shared aims of treatment. For example, enabling the patient to name and communicate their affective states in ways that were more socially cognizant, developing a capacity to explore their interpersonal worlds and increasing reflexivity through arts making processes. The rationale for this type of homogenous clinician selection, was on the basis of effecting service design, management of clinicians and being able to account for similar demographics, service infrastructure, management directives and expected constructs.

However, even with a relatively homogenous group of therapists, we were aware of significant differences in theoretical orientation and therefore the results could indicate the impact of the theoretical orientation on the description of clinical constructs disconfirming the hypothesis that within a local context there is a shared language amongst arts therapists about clinical actions.

Whilst the arts psychotherapists selected for this study had received different trainings and used different arts media to treat their patients, the clinicians were also included on the basis that there was a common ground for what were considered as being mediators of change effected by arts psychotherapies in the clinical process. These criteria were requested at the first point of contact with each clinician and reiterated during the interview. The fundamental therapeutic criterion being that the therapist's interactions influenced the way that the patient related to another, particularly with reference to attachment patterns and the associated affect.



The interviewers wanted to elucidate what clinicians do when a client who is diagnosed with affective disorders, schizophrenia or borderline personality disorder, presents with a specific significant symptomatic event. By using the term symptomatic event, we are referring to symptoms as presented in the diagnostic statistical manual (Association & DSM-IV, 1994) with the assumption that the symptoms relate to imagined or real changes to the environment within the context of the therapeutic encounter, or within other contexts that are affecting the patient.



**Fig. 1. Four Phases of Research**

<sup>1</sup>Symptomatic events were considered to be potential issues, problems or deficits that the patient experienced and that linked with psychiatric diagnostic criteria used for admission into mental health services.

### **Phase 1**

The arts therapies expert reference group and service users were consulted about what they considered to be clinically significant events that are influenced by arts therapies constructs. Where there was a high correlation between services user's feedback and the reference group, we formulated a theoretical model based on a causal hypothesis of mental illness that included environmental factors. The arts therapies expert reference group and service users worked together to formulate the theoretical framework used in this study. In summary, the model proposes that the patient would behave in relationally destructive ways when there were rigid and unfounded ideas about themselves and/or others, and that these ideas were exacerbated by high affective arousal states linked with experiences of being mistreated. These moments manifest in a range of different ways and constituted the assumptions underpinning *symptomatic events*. Symptomatic events (Table 1) were defined as times in the clinical session when constructs were perceived to have had an impact on the occurrence, or manageability of symptomatic states. The service user focus group referred to using arts as being a method of 'getting a handle on' feeling states that were felt to be overwhelming. They also described the group experience as enabling changes to 'feeling safe with others' and that discursive reflection ('dialogue') enabled being open to another person's experience. The ways in which the issues became manifest in terms of the diagnoses being treated was also examined. From this, ten salient symptomatic events were described in accordance with the proposed clinically significant events that were initially proposed by the patients and clinicians. The ten symptomatic events were seen as being pivotal to the significant event, in as much as it was hypothesised that the patient's state of mind changed according to the constructs offered by the therapist, due to there being a real or imagined relational context influencing the symptomatology. However, symptomatic events were only considered significant if the therapist responded in a way that suggested that there would be a

marked change to this presentation in the immediate or intermediate future, based on the proposed change hypothesis.

<i>Symptomatic event</i>
<i>1. High affect (e.g., unmanageable emotional arousal due to acute illness and/or due to interpersonal triggers)</i>
<i>2. Acute psychotic state of mind (e.g., experiencing auditory/visual hallucinations)</i>
<i>3. Distorted sense of self (e.g., grandiosity or extreme worthlessness)</i>
<i>4. Low affect (e.g., when the person has low mood, blunted affect, feels hopeless and/or suicidal)</i>
<i>5. Psychosomatic symptoms (e.g., when the person has severe stomach ache without any medical explanation)</i>
<i>6. Ambivalent responses (e.g., ambivalence in attendance and engagement, ambivalence about interpersonal interactions/choices)</i>
<i>7. Psychic equivalence (e.g., feeling bad and therefore assuming that was the other person's intention)</i>
<i>8. Immediate concrete solutions to interpersonal problems (e.g., when the person presents completing a tax form as a solution to interpersonal problems)</i>
<i>9. Pretending to be insightful about interpersonal relationships (e.g., rationalising their experience)</i>
<i>10. Dissociative state (e.g., profound identity confusion and sense of unreality)</i>

**Table 1. The symptomatic events - patient experience in relation to symptoms**

## **Phase 2**

In the second phase of the study the aim was to elicit the in-session constructs. The interviewers asked the clinicians to take part in a symptomatic event comparison task known as the *Triadic Method* (Denicolo, Long & Bradley-Cole, 2016; Fransella, Bell, & Bannister, 2004; Kelly, 1955). The symptomatic events were noted on record cards, one event per card. Participants were presented with three symptomatic events at a time and asked, ‘In the context of a clinical competency that you might use, would you respond in a similar way when presented with two of the symptomatic events, that differs from what you would do with the third. symptomatic event?’ If the interviewee replied that they would do something similar, they were asked to describe more specifically in plain language what it was that they would do After giving their reply (the ‘emergent’ therapeutic construct), the interviewee would then be asked for the *opposite* in meaning to what they had said, thereby creating a bipolar construct. For example an interviewee could be asked to think about a situation with a client that they have worked with who was in a state of *high affect*, another who was *being avoidant* and a third who was in a *psychotic state of mind*. The interviewer would then ask the participant to say whether they can recall responding therapeutically in similar ways to two of the symptomatic events that was not shared in the third instance. When asked what it was that they did that was similar in two of the scenarios, an interviewee responded that they would ‘mirror the patient’s affective state through the use of an arts form’. The interviewee would then be asked for the opposite in meaning to ‘mirroring the patient’s affective state through the use of an arts form’. This process was repeated with other triads of symptomatic events. The interviewee was also asked to elaborate on their descriptions of the clinical constructs, so that they were expressed in clear and specific language. The interviewer recorded the responses of the interviewee in the form of concise statements about the

therapist's actions. Each symptomatic event was compared at least twice in the triads, to ensure that each event was compared approximately the same number of times.

The typical Triadic Method interview process was modified in these interviews, as the polar opposite of the emergent therapeutic intervention was required to be a *therapeutic alternative* i.e., the interviewee could not simply say *not* doing the emergent therapeutic intervention. This was primarily in consideration of the uses of the construct poles to discern orientation, where two possibilities can potentially hold equal therapeutic value, rather than one construct *always* being preferred. An exception was the case of the construct 'Not exploring self-other states of mind vs Explore self-other states of mind' (the emergent pole was the latter pole). In this instance, the categorisers were unable to think of an appropriate opposite pole other, than a simple negative statement. Our use of the Triadic Method was to provide us with a method of understanding art therapists' in-session interventions in the context of another possible intervention that they *chose* not to implement. It is notable that by the time we got to the seventh interviewee, though they produced highly relevant material, no new constructs emerged. Whilst the interviews could have continued, the researchers decided that the interview material had reached saturation.

### **Phase 3**

In the next part of the process, the clinician was asked to review the constructs that the interviewer had elicited from them. During this process the constructs could be edited or even deleted by the participant. When all the interviews had been conducted, the research team categorised the bipolar constructs that had been elicited from the clinician interviewees, into broad bipolar 'therapeutic intervention' themes.

### **Phase 4**

In the fourth and final phase the bipolar constructs were verified in two groups. The first group was made up of the seven clinicians that were interviewed together with four more arts therapists which included a dramatherapist, music therapist and two additional art psychotherapists working in the same locality and similar clinical groups (See Table 2).

PROFESSION	NUMBER OF ARTS PSYCHOTHERAPISTS INTERVIEWED	NUMBER OF MEMBERS OF THE EXPERT REFERENCE GROUP
Art Psychotherapists	2	4
Music Therapists	2	2
Dance Movement Psychotherapists	1	2
Dramatherapists	2	3

**Table 2. Number of Arts Psychotherapists interviewed and informing the expert reference group.**

The service user focus group was made up of five service users. There was one focus group held with service users and the expert reference group met three times. During this phase it became increasingly apparent that whilst the perceived action of the therapeutic intervention was shared, the way in which the arts form was used to facilitate this action could be considerably different. All of the constructs were discussed in some detail, especially the last construct *embodiment* which was changed to *embodying the emotional situation*. Whilst the theoretical and particular nature of each construct was extremely important in establishing a shared understanding and formulating the in-session intervention as a construct, there is not scope to go into further detail about these considerations here. Table 3 in the results section lists the final fourteen bipolar construct themes in terms of alternative therapeutic constructs. These categories are *mid-level* categories according to

shared principles. All of these constructs could be described in greater detail with further differentiation. For example, a music therapist would perform the action of empathically attuning in a different way to a drama therapist, dance movement psychotherapist or an art psychotherapist.

## **Results**

Each of the personal construct interviews produced around thirty bipolar constructs. An example of a bipolar construct that was elicited during the interview is: “I would, use embodied image making to reflect the patients affective state. The opposite to this from my perspective would be to verbally closely question their rationale”. Initially three members of the research team categorised approximately 210 bipolar constructs that had been elicited from the clinician interviewees into fourteen broad themes (Table 2). The remaining four research team members then reassessed the themes and edited them until there was a consensus. This process involved extensive discussion between the team as to what the emerging themes were, and whether constructs belonged to more than one theme. In reaching a consensus about construct themes we also concluded that several constructs overlapped within two or more themes. We then used words that reflected the language used by the clinicians to formulate fourteen bipolar categorical overarching constructs. For example, we identified a theme of *empathically attune* within the clinician’s constructs. In referring back to the language the clinicians used, we found that *empathically attune* was a term used that encapsulated a collection of more subordinate constructs. The opposite of this construct *explore perspectives* was derived from the clinicians’ constructs using a similar approach and where this commonly featured as a polar opposite of the initial therapeutic action.

<b>Construct 1</b>	<b>Construct 2</b>
Empathically Attune	Explore Perspectives
Adapt Personal Boundaries	Establish/ Maintain Personal Boundaries
Adapt time/ space boundaries	Establish/ Maintain time/ space boundaries
Regulate affect	Take a Neutral position/ non-action / witness/ observe
Be Challenging	Mirror affect
Be Non-directive/ collaborative	Be directive
Ask direct questions	Be openly curiosity/ explorative
Focus on working within the therapeutic/ group relationship	Focus on working with external relationships
Use arts media to make contact	Use verbalisation to make contact
Work in the here and now	Explore relational patterns
Use a structured exercise / game	Use arts based improvisation
Not exploring self-other states of mind	Explore self-other states of mind
Work with meaning in the implicit	Make implicit meaning explicit
Communicate the embodied emotional	Reconstruct narrative/ story



situation	
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**Table 2. Table of categorised bipolar constructs**

## **Discussion**

Results of the interviews revealed considerable overlaps between the arts psychotherapists' descriptions of types of in-session constructs. During the interview process interviewees revealed emergent constructs using novel and personal ways of describing their practice. This result of nuanced personalised language appeared to be a consequence of the PCP methodology - the interviewers focused on eliciting in-session constructs that were based on examining clinical material and personal descriptions with which they were presented, rather than the theories underlying how or why such constructs were made.

In change process research, understanding the therapist's constructs and impact on mediators of change is critical for formulating hypotheses about the outcomes of treatment (Gibbons et al., 2009; Johansson & Høglend, 2007; Kazdin, 2005). Whilst we can use language to define discrete human actions, the actions themselves commonly overlap and are dependent upon one another, for example two constructs that were elicited were: *working in the here and now* and *being affectively attuned*. These constructs appeared to describe aspects of the same therapeutic action, but given their different emphasis within the clinical endeavour, the research team decided that these constructs required separate categorisation. This process of in-session construct categorisation is the first step to considering a model for a change process in arts psychotherapies, on the basis that there are therapeutic interactions that influence outcomes (Greenberg, 1986).

In this study, we set out to examine whether arts based practice can be explained through the use of simple language and whether those terms are shared by different arts

psychotherapists within a given setting. We captured the observable nature of what was being described. In this way we took a *snap-shot* of how arts psychotherapists describe their practice to help us to understand whether there are discrete groups of descriptions for clinicians' in-session constructs. The researchers worked together to provide categories that allowed for some variation of practice within the arts modality to reach a mid-level categorisation.

When referring to categorisation in change process research Greenberg (1986) stated that mid-level categorisation allows for sufficient detail of what is being observed, whilst also remaining sufficiently differentiated. In the results, this level of categorisation allowed for a successful level of differentiation whilst each construct was also sufficiently related to one another as being a therapeutic intervention.

The psychotherapy researcher Kazdin (2001a, 2007) suggests that there are a number of factors involved in making a plausible assertion about a change mechanism. Primarily, the intervention can be observed to have an effect on the underlying influential factors that cause, sustain or exacerbate the illness (such as family relationships, lack of emotional connection with another, insecure attachment, affect dysregulation) and that the change process is consistent in other similar situations. For example, what happens in the absence of working in the here and now and affective attunement in a specific situation, and what happens when the intervention is observed in other clinical contexts?

Whilst, in principle, it seems a useful endeavour to describe therapeutic clinical actions, there is also a key issue as to whether this kind of study *oversimplifies* highly complex interpersonal and arts based actions. For example, what a dance movement psychotherapist described during the interview process when talking about encouraging the use of rope, through holding it between people or positioning it such a way as to help the patient nonverbally express their bond to another. How can the therapeutic action be

sufficiently defined through a set of simple verbal constructs? It was apparent in this study that the researchers attempted to take a non-biased position through suspending their knowledge about arts therapies, which was continually tested by feedback from the wider research team. It is arguable that the results suggest that arts therapies have the basis of a shared language. This is a significant development from the early pioneers of psychological interventions. For example, perhaps evidence of psychological advancement in this area can be compared to Carl Jung's belief that plurality of approaches simply reflected our limited knowledge of the human mind. "At present we have merely more or less plausible opinions that cannot be squared with one another" (Jung, 2014, p. 38). Since the times of Jung we have gathered knowledge, research and evidence that accumulatively form the basis of an often intuitive shared understanding. In itself this study in its simplicity is a platform for further inquiry about why and when arts therapists do what they do. Given that this is the first overarching list of categories, these can be further examined through similar research studies to inquire into the timing, level of competency, nuances of action and their influence. The Horizons Project (2014) honorary researchers are continuing to interview therapists about the conceptual understanding of the constructs, what the intention is for performing specific constructs and how this relates to clinical outcomes.

The question that this research set out to answer was simply whether there was a shared language for *what action* an arts psychotherapist employs in his or her clinical work when presented with particular clinical symptoms. We believe that this study, as the first of its kind, goes some way towards developing a framework of constructs that can be useful for the types of research within arts psychotherapies treatment of severe mental illnesses.

The definitions required significant review and refinement which has led to overarching constructs, however a better understanding of how the constructs relate conceptually to one another, and what they mean in practice is required if they are to be

useful for professional guidelines or as part of a practice framework. Therefore, developing a shared language that is relevant to people within a particular context, requires further work, for example, carrying out repertory grid survey studies, to clarify the relevance of this study to effective clinical practice. If we can confirm that arts therapists have a common language, we can begin to look at the role of various constructs in relation to what works best for whom. Ideally, quantitative research would be undertaken that can make sense of the impact of a collection of constructs used and the hypothesised effect of those constructs within the treatment mechanism (see Kazdin, 2001). Such research would be more likely to bear results that are useful to the clinician and patient. The authors and others have used the constructs and symptomatic events reported in this research to design a repertory grid (Kelly, 1955; Fransella, Bell & Bannister, 2004) and we have collected quantitative data using the grid. We hope to publish the results of that further research in due course.

Furthermore, the process of eliciting the constructs during the interviews was frequently commented on by the clinicians as shedding light on the range of in-session constructs that they knew were part of their repertoire, but remained preconscious or intuitive and therefore did not form part of their dominant clinical discourse. In other words, this study was context dependent and within other contexts there is likely to be more that the therapist does to produce change for the patient than the therapist is consciously aware of. The method that we used to elicit constructs relating to therapeutic constructs, by comparing clinical symptoms in triads, produced results that were revealing something to the clinicians. It appeared the arts therapists developed a dominant discourse predominantly through training, supervision and organisational demands. However, this study also helped to capture some of the in-session constructs that evolved through pragmatism, intuition, trial and error and were not brought to awareness through other institutional processes, suggesting that PCP also has something to offer for gaining more breadth of clinical perspective.

## **Further Research**

From coordinated discussions with the service user focus group and the expert reference group, this study also revealed that there are multiple in-session constructs that occur simultaneously, and are dependent upon each other. This leads to an important question, namely, ‘Which in-session constructs have a significant impact on patient health, especially if there is not an empirically grounded change process identified in relation to given in-session ?’ Having a shared language may have the potential to reduce an overly limited notion that one construct is superior to other constructs and can also help to make sense of sequential observational studies. There is not a single intervention for the treatment of mental health conditions and by eliciting the language used by clinicians this became increasingly apparent. This first stage of our research demonstrated that there may be overarching clinical constructs for in-session constructs and that these constructs have the potential to be used to be part of a map of clinical procedures for how arts psychotherapists treat severe mental health disorders. However, it should be noted that the study was limited to a group of arts psychotherapists that worked within a similar context, with similar patients and who had over time shared their understanding of change processes with one another in clinical meetings and professional development forums. The generalisability is as yet unknown as this would require further studies of a similar type to be conducted on a wider scale and to consider different arts psychotherapists’ therapeutic orientations within health services. Further to this process, research could be conducted to examine the specific observed quality of the constructs within different professions. Whilst the primary data was elicited from a small number of clinicians, the authors believe this study is an important step towards establishing consensus about in-session constructs for arts psychotherapists in health care settings and moving towards examining clinical treatment mechanisms in more detail.

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Miriam Usiskin (Art Psychotherapist / Research Lead)

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