Identification of the contexts and mechanisms of Art Psychotherapy treatment that supports healing and recovery for adults who have experienced complex trauma:

The development of a treatment manual – Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP)

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This thesis is submitted in partial fulfilment of the requirements of the award of Doctor of Philosophy of the University of Northumbria.

This research was undertaken in the School of Health and Life Sciences, Northumbria University. August, 2022.

Covid-19 Impact on the study

The initial research design, before covid-19 measures were announced in March 2020, aimed to compare data from an international survey with the respondents being practicing Art Psychotherapists who treat adults who have experienced complex trauma, with data gathered from incorporated case-based analysis. Ethics approval was sought and granted by Northumbria University Ethics Committee (reference 16945, 17204, 29392), and Health Research Authority (HRA) and Health and Care Research Wales (HCRW) (reference 20/WS/0048). In response to the restriction of lockdown measures, the research design was re-evaluated. Art Psychotherapy sessions were no longer able to take place in person which meant we had to reconsider the case-based component of the study. There was an option to deliver Art Psychotherapy sessions online for individual and group sessions. However, we concluded it would be too time consuming to set up, and it potentially may have lost some of the case-based components that could be captured from in-person treatment. After much consideration, we decided to use the data from the narrative literature review, BAAT focus workshop, international survey, and clinical experience and expertise, to inform the design and development of a therapeutic treatment manual. The study may have benefitted from having a case-based data set to inform the development of the treatment manual. However, the restructure of the research design has further enabled a thorough initial validation process including additional data analysis using Reflexive Thematic Analysis. My understanding is, should the manual be applied to undergo further testing through clinical trials, the opportunity to be informed by case-based data will be fulfilled.

ABSTRACT

Objectives:

Design: Focus group session with British Association of Art Therapists regional group; narrative literature review; international survey; development of a treatment manual and validation via expert panel using rubrics, qualitative questionnaires, and Reflexive Thematic Analysis.

Participants: International Art Psychotherapists; expert panel members including people with lived experience.

Main analysis tools: Hierarchical cluster analysis, SPSS, rubrics and Reflexive Thematic Analysis.

Adults who have complex trauma can experience mental ill health that invariably results in significant restrictive impact upon their lives. The purpose of this study was to identify what components and contexts of Art Psychotherapy practice support recovery and healing for people who have compromised mental health resulting from experiences of complex trauma.

Four stages within the study were completed, consisting of a focus group and narrative literature review; an international survey; the development of a therapeutic treatment manual; and the validation of the manual which included the completion of rubrics, narrative interviews and Reflexive Thematic Analysis.

International Art Psychotherapists treating people with complex trauma were invited to answer four categories of questions: participant information, environment, practical/clinical components, and additional information. Whilst there is a good evidence base for the uses and effectiveness of Art Psychotherapy in general, there has been little causal analysis of which mechanisms and contexts of Art Psychotherapy can prove effective. The survey data identified that expert practitioners consider positive therapeutic impact to be associated with specific art medium, the therapeutic environment, and clinically informed approaches. The focus group, narrative literature review, the findings from the international survey, and clinical experience and expertise informed the development of a therapeutic treatment manual, Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP).

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that the work fully acknowledges opinions, ideas, and contributions from the work of others. The work was done in conjunction with Northumbria University.

Ethics approval has been sought and granted by Northumbria University Ethics Committee (reference 16945, 17204, 29392), and HRA and Health and Care Research Wales (HCRW) (reference 20/WS/0048).

I declare that the word count of this Thesis is 54104 words

Signature …

Date…24th of August

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I must give special thanks to the participants who took the time to complete the international survey, and to BAAT regional group 12 administrators Jillian Archibald and Kristen Ricci for enabling the opportunity to deliver my workshop.

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Glossary of Terms

Adverse childhood experiences (ACE's) - are stressful or traumatic experiences that can have a huge impact on children and young people throughout their lives (Liverpool CAMHS, 2021). There are ten widely identified ACE's: physical abuse; sexual abuse; verbal abuse; physical neglect; emotional neglect; a family member who is depressed or diagnosed with other mental illness; a family member who is addicted to alcohol or another substance; a family member who is in prison; witnessing intimate partner violence; and losing a parent to separation, divorce or death (National Centre for Injury Prevention and Control, Division of Violence Prevention, 2021). Many other types of trauma may also have an impact such as natural disasters and community violence.

Anterior cingulate cortex – A structure in the cerebral cortex that mediates affect and mind-body conflicts such as anxiety. The anterior cingulate cortex helps to direct cognitive and emotional processing errors and facilitates visuospatial and memory processing, reward-based learning, and social awareness. It connects the limbic brain with cortical regulation (Hass-Cohen, 2008).

Arousal – The excitation and energising of neural networks or structures and consequently their respective functions (APA, 2020).

Attributed meaning (attribution) – Attributed meaning or attribution is an inference regarding the cause of a person's behaviour or an interpersonal event. Three dimensions are often used to evaluate a person's attributional styles, or characteristic tendencies when inferring such causes: the internal – external dimension (whether they tend to attribute events to the self or to other factors), the stable – unstable dimension (whether they tend to attribute events to enduring or transient causes), and the global – specific dimension (whether they tend to attribute events to causes that affect many events or just a single event) (APA, 2020).

Bilateral stimulation - Bilateral stimulation is a process used to activate and integrate information from the brain's two hemispheres (Landin-Romero, 2018). The term 'unilateral' is used to describe this process within the treatment manual.

Bottom-up processing – Experiential learning that uses awareness of low order sensory or emotional features to progress, step by step, to higher order perceptions (Front, 2013).

Trauma – The American Psychological Association (APA) describes trauma as being:

‘any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behaviour, and other aspects of functioning. Traumatic events include those caused by human behaviour (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual’s view of the world as a just, safe, and predictable place.’ (APA, 2020).

Complex trauma – The UK Trauma Council describe complex trauma as being ‘a set of severe and sometimes pervasive adverse events that are often protracted or interpersonal in nature’ (UK Trauma Council, 2021). The UK Trauma Council report that in childhood, complex trauma frequently refers to experiences of abuse and neglect, including exposure to interpersonal violence (UK Trauma Council, 2021). Several features are described. They may arise within the context of a child’s relationships. Furthermore, they may occur during child development, and they are chronic or repeated. There are other forms of complex trauma in childhood e.g. repeated exposure to community violence, racial trauma or war trauma (UK Trauma Council, 2021). The UK Trauma Council add that exposure to complex trauma can impact a child’s emotional, psychological, social and physical development. However, it does not necessarily follow that all children are affected in the same way.

Construct - Examples of psychological construct are a person's motivation, anger, personality, intelligence, love, attachment, or fear. A construct is a skill, attribute, or ability that is based on one or more established theories. Constructs are not directly observable. For example, a person may be observed to be smart by the way they speak and what they say but you cannot directly observe intelligence. You may be able to tell if someone is anxious if they are trembling, sweating, and restless, but you cannot directly observe anxiety. You also cannot directly observe fear or motivation. They are all complex, abstract concepts that are indirectly observed through a collection of related events (Binning, 2016).

Disconfirming knowledge – a term used in Coherence Therapy meaning the knowledge of a person that contradicts previous emotional learning or does not confirm it. Disconfirming knowledge can be newly learned emotional lessons or imagined alternative experiences (Ecker, 2020).

Dissociation - a defence mechanism in which conflicting impulses are kept apart or threatening ideas and feelings are separated from the rest of the psyche (APA, 2020). When people are dissociating, they disconnect from their surroundings, which can stop a trauma memory and lower fear, anxiety, and shame. Dissociation can happen during the trauma or when thinking about or being reminded of the trauma.

Emotional dysregulation – Emotional dysregulation is any excessive or otherwise poorly managed mechanism or response. This can be an extreme or disproportionate emotional response to a situation that may be associated with psychological trauma, or other causes such as brain injury, autistic spectrum disorder or personality disorders. Emotional dysregulation refers to the inability of a person to control or regulate their emotional responses to provocative stimuli or when triggered (APA, 2020).

Emotional numbing - Emotional numbing can happen as a result of physical or emotional pain. It is a coping mechanism that attempts to protect oneself from being hurt and can be presented as disconnection, detachment, or numbing of feelings related to the situation. A person may feel temporary relief that allows them to move on with their lives. However, this protective shield can prevent connection with others and accessing feelings that are both positive and negative (Litz, 2002).

Explicit emotion (conscious) – Explicit emotions are a cognitive process that can be described accurately and that are available to introspection. Explicit emotional memory is manifested when individuals reexperience the original emotions engendered by an event (e.g. terror when describing an accident, joy when describing a close family member's wedding) (Dulany, 2012).

Hyperarousal – Hyperarousal is one of three proposed ICD-11 (Keeley, 2016) sets of criteria used to diagnose post traumatic stress disorder and acute stress disorder: re-experiencing, avoidance and hyperarousal (Haravuori et al. 2016). Symptoms of hyperarousal include exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, and excessive vigilance.

Implicit emotion (nonconscious) - Implicit emotion regulation may be defined as any process that operates without the need for conscious supervision or explicit intentions and which is aimed at modifying the quality, intensity, or duration of an emotional response. Implicit emotion regulation can thus be instigated even when people do not realise that they are engaging in any form of emotion regulation and when people have no conscious intention of regulating their emotions (Koole, 2011).

Kindling – A progressively increasing neuronal response to a stimulus that effects memory and is associated with trauma. Traumatic kindling may reflect amygdala and hippocampal conditioning that results in flashbacks (Weiss, 2015).

Limbic system – A conceptual, rather than anatomical, designation used to group central brain structures that regulate; evaluate and integrate emotion into motivational states; survival responses and memories (Swenson, 2015).

Mental model - A mental model is an explanation of someone's thought process about how something works in the world. It is a representation of the surrounding world, the relationships between its various parts and a person's intuitive perception about his or her own acts and their consequences (Al-Diben, 2012). Mental models guide a person's perception and behaviour. They are thinking tools that are used to understand life, make decisions, and solve problems (Al-Diben, 2012).

Polyvagal Theory – A social engagement theory that correlates body immobilisation, motivation, and social communication. The vagus nerve enables self-soothing, calming, and sympathetic adrenal inhibition. The theory proposes a biological basis for social behaviour based upon phylogenic stage-based activation of the vagus nerve (Porges, 2017).

Post-Traumatic Stress Disorder (PTSD) – The American Psychiatric Association report PTSD as being a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence or serious injury (psychiatry.org, 2020).

Psyche split – also known as splitting, is described by APA as being,

'in Kleinian analysis and Fairbairnian theory, a primitive defence mechanism used to protect oneself from conflict, in which objects provoking anxiety and ambivalence are dichotomised into extreme representations (part-objects) with either positive or negative qualities, resulting in polarized viewpoints that fluctuate in extremes of seeing the self or others as either all good or all bad. This mechanism is used not only by infants and young children, who are not yet capable of integrating these polarised viewpoints, but also by adults with dysfunctional patterns of dealing with ambivalence; it is often associated with borderline personality disorder. Also called splitting of the object'. (APA, 2020).

Garret (2016) describes the term psyche spit as manifestations of psychosis to ordinary mental life, and how psychotic symptoms arise as meaningful expressions of unbearable psychological pain in the aftermath of adverse life events (Garrett, 2016).

Recall – Spontaneous retrieval of information from memory, with or without cues (Walkins, 1979).

Schema – Psychologist Jean Piaget introduced the term schema in 1923. He described schema as being mentally applied in appropriate situations to help people both comprehend and interpret information. A self-schema is a cognitive framework comprising organised information and beliefs about the self that guides a person's perception of the world, influencing what information draws the individual's attention as well as how that information is evaluated and retained. The American Psychiatry Association (APA) describes schema as being:

'a cognitive structure that represents a person's knowledge about an entity or situation that includes the qualities and the relationships between them' (APA, 2020).

Schemas are usually abstractions that simplify a person's world. A schema is an assumption that an individual has of the self, others, or the world that endures despite objective reality. In this thesis, a schema is also referred to as emotional learning.

Stress response – Mind-body arousal that ensures survival and / or manages stressors, so that homeostasis or normal functioning can be re-established (Lewis, 2012).

Top-down processing – Information processing utilising complex cortical, often cognitive, functions (Sun, 2012). These cortical functions enlist and regulate subcortical sensory or affect-based, limbic processes.

Vagus nerve – The most important nerve in the parasympathetic nervous system. It connects the body organs with the brain stem. Excessive vagal activation during emotional stress causes it to compensate for overly strong sympathetic nervous system reactions by slowing heart rate and creating a freeze response or faint (Breit, 2018).

CHAPTER 1 – INTRODUCTION

1. 1. Introduction

The research presented in this thesis explores specialist areas. The introductory chapter will focus upon defining and clarifying terminology related to the areas of study. The research has been carried out to investigate Art Psychotherapy as a treatment for adults who have experienced complex psychological trauma. The intention of the research has been to study what components of this treatment are most effective from the perspectives of international Art Psychotherapists who work with adults whose lives are impacted by experiences of complex trauma. The combined findings from the BAAT regional focus group, systematic literature review, survey, and clinical experience and expertise, were used to design and develop a treatment manual which was then taken to an expert panel for review and validation.

This chapter introduces terminology defining psychological complex trauma, trauma informed approaches in the UK, established areas of practice for this client group, the arts therapies, and Art Psychotherapy terminology. The chapter concludes with an outline of the research hypothesis and aims of the study.

1. 2. Psychological complex trauma

There is rapidly expanding literature that confirms high prevalence of trauma and abuse in all psychiatric presentations, such as borderline personality disorder, eating disorders, depression, anxiety, phobias, self-harm and psychosis (Read and Bentall, 2012). The main focus here will be on Complex Post Traumatic Stress Disorder (CPTSD).

1. 3. Trauma informed approaches

Trauma informed approaches (TIAs) were developed in North America with the intention to minimise that people presenting to services have their symptoms disconnected from the context of their lives. However, there are relatively few published models from public services across Europe (Sweeny, 2016). TIAs are based on the understanding that most people who are in contact with mental health services have experienced psychological trauma, and this consideration needs to permeate service relationships and delivery, (Harris and Fallot, 2001). The principles of TIAs stem from therapeutic community and social psychiatry treatment (Harris and Fallot, 2001). TIAs can be described as a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service users' neurological, biological, psychological, and social development, (Paterson, 2014).

Art Psychotherapy has key healing strategies when addressing traumatic stress (Bolwerk, 2014). As this PhD research specifically associates Art Psychotherapy in the context of treatment for people who have experienced complex trauma, the term Art Psychotherapy will be used as a trauma informed approach.

1. 4. The Arts Therapies

The Arts Therapies including music; drama and dance movement, are used to foster a positive therapeutic alliance and provide an alternative means of communication when words are hard to find. Within the trusting therapeutic relationship, opportunities arise to learn from new experiences and develop an improved understanding of social relationships and associated behaviours and actions (Mind, 2018).

In the UK anyone who refers to themselves an Art Therapist/Psychotherapist, drama therapist or music therapist must be registered with the Health and Care Professions Council (HCPC). The representative professional bodies in the UK are,

The British Association of Art Therapists (BAAT)

The British Association of Drama Therapists (BADTh)

The British Association for Music Therapy (BAMT)

In the UK Dance Movement Therapists are not regulated by the HCPC. However, it is a requirement to belong to a relevant professional body such as the Association for Dance Movement Psychotherapy UK (ADMP-UK) and/or be registered with the UK Council for Psychotherapy (UKCP).

Arts Therapists support people to engage with an art form as a medium to emotional experiences that may be distressing or hard to understand. For example, a musical interaction can hold multiple meanings which, when explored with the therapist, can help a person with complex difficulties make sense of their experience, feel heard and understood and have a sense of agency in their own recovery. The creative focus also offers an opportunity to try taking a flexible approach to situations and move away from black and white or rigid thinking (Mind, 2018).

1. 5. Art Therapy / Art Psychotherapy / Analytical Art Psychotherapy

This thesis uses Art Psychotherapy as a generic term. Ever since the time when Art Therapy became established as a therapeutic approach, there have been different strands of Art Therapy, with initial focus on supporting spontaneous artistic expression within hospitals in the first half of the 20th century (McNiff, 2004; Wood, 1997), and later, the increasing adoption of different strands of psychoanalytic thinking (Wood, 1997). Waller

(1993) identified two major conceptions of Art Therapy: Art as Therapy; and Art Psychotherapy. The former appears consistent with the historically earlier approach, in which artistic activity is viewed as healing by its very nature and is often instigated by the person suffering mental distress (McNiff, 2004; Wood, 1997). This strand can also focus on developing artistic skills and celebrating creativity. Approaches in the "Art Psychotherapy" mode entail more emphasis on understanding clients and their artwork in psychodynamic terms and making interpretations, which may or may not be communicated to clients at different points in therapy. A range of psychodynamic theories may be drawn upon, for example, Wood (1997) offers a possible explanation of why such a split may have been perpetuated in the 1970s and beyond. She suggests that tensions within institutional psychiatry led to Art Therapists choosing one of two routes: either emphasising their use of psychodynamic theory to demonstrate clinical credentials, or their art expertise and focus to avoid conflict with psychiatry by offering something different.

According to Jungian Analyst, Schaverien (2000), there are three types of Art Therapy practice: Art Therapy; Art Psychotherapy; and Analytical Art Psychotherapy. Art Therapy places a strong emphasis upon the relationship of the client with the image on one hand and the therapist with the image on the other. Art Psychotherapy emphasises more the client–therapist relationship rather than the relationship of the two individuals with the image. Analytical Art Psychotherapy has a dynamic quality where the client, the therapist and the image interplay equally with each other (Schaverien 2000). In this thesis, I will use the term Art Psychotherapy.

1. 6. Research study: hypothesis and aims

The purpose of this research was to evaluate the extent to which one therapeutic intervention – Art Psychotherapy – can influence the symptoms of complex psychological trauma and provide healing. Whilst there is a reasonable evidence base for the uses and effectiveness of Art Psychotherapy in general (Jayne, 2021) there has been little causal analysis of which elements of Art Psychotherapy can prove effective (Jayne, 2021). For example, NICE guidelines recommend the Arts Therapies as a psychological treatment for children who have depression (depression in children and young people: identification and management consultation on draft guideline - Stakeholder comments table, 2019, page 11), and children and adults who have psychosis, emphasising particularly on the depressive symptoms of psychosis (NICE CG178, 2014).

The National Institute of Clinical Excellence (NICE) recommends a variety of psychological therapies for the treatment of adults who have PTSD and CPTSD. NICE

recommend offering an individual trauma-focused CBT intervention to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event (NG116, 2018). Interventions include cognitive processing therapy; cognitive therapy for PTSD; narrative exposure therapy; and prolonged exposure therapy. For adults who have experienced symptoms of PTSD for more than 3 months, NICE (NG116, 2018) recommend offering Eye Movement Desensitization and Reprocessing (EMDR). All treatment is recommended to be based on a validated treatment manual.

The American Psychological Association (APA) strongly recommend four interventions, all of which are variations of cognitive behavioural therapy (CBT). The category of CBT encompasses various types and elements of treatment used by cognitive behavioural therapists, while Cognitive Processing Therapy, Cognitive Therapy and Prolonged Exposure are all more specialised treatments that focus on aspects of CBT interventions (APA, 2020). APA conditionally recommend brief eclectic psychotherapy; EMDR; and narrative exposure therapy. Interventions that received a conditional recommendation all have evidence that indicates that they can lead to good treatment outcomes. However, the evidence may not be as strong, or the balance of treatment benefits and possible harms may be less favourable, or the intervention may be less applicable across treatment settings or subgroups of individuals with PTSD (APA, 2020).

Art Psychotherapy is not currently recommended by NICE or APA for the treatment of PTSD or CPTSD, therefore this study aims to contribute to the current evidence base of Art Psychotherapy treatment when used to treat adults impacted by complex psychological trauma.

1. 7. Pre Covid-19 research design

Initially, an intensive, mixed methods case-based analysis was planned to provide one possible means of identifying specific Art Psychotherapy treatment components and contexts associated with successful outcomes. Additional to the systematic literature review and international survey, a second phase where adults within Tees Esk Wear Valley NHS Foundation Trust (TEWV) would be invited to engage in Art Psychotherapy sessions to determine key treatment components from their own experiences. Due to staff absence in TEWV, the research site was later changed to Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW). Ethics approvals were sought and granted by Northumbria University Ethics Committee (reference 16945, 17204, 29392), and HRA and

Health and Care Research Wales (HCRW) (reference 20/WS/0048). Participants (*n*=10) were to be recruited from the NHS and the research treatment sessions were due to be delivered in Sunderland. Outcome measures were to be completed by participants before each Art Psychotherapy session and two months post-intervention. The identified measure was CORE10 (Barkham, 2013) and the International Trauma Questionnaire (ITQ) (Cloitre, 2018). Then additional narrative interviews were planned to identify further specific components associated with improved outcomes. This case-based analysis aimed to further offer the possibility of identifying how interactions between context could be combined to produce differential outcomes. Such contexts could be environment, personal history and psychological formulation. The mechanisms: could be identified elements that would be most effective; the quality of the therapeutic relationship and psychotherapist attributes. All data would have been analysed and formulated as part of the final stage of the study.

In March 2020 a national lockdown was announced in the UK following the outbreak of a global pandemic. Due to social-distancing restrictions this significantly impacted on the research, not being able to recruit participants for face-to-face therapy meetings, as per the proposed protocol and design of the case-based research. Initially, there was some consideration on how to alter the research design to fit with government guidelines and restrictive measures, such as changing the delivery of Art Psychotherapy sessions to be provided online and/or for a shorter duration (Zubala & Hackett, 2020; 2021). However, NHS staff capacity was compromised due to Covid-19. In discussion with the supervisory team for this PhD, we concluded the best way to continue with the study was to use the data from the systematic literature review, the international survey, and clinical experience and expertise, to design a treatment manual. The treatment manual was approved within supervision and underwent a validation process via an international expert panel.

1. 8. Summary

This introductory first chapter has briefly informed of psychological complex trauma; trauma informed approaches; the Arts Therapies followed with a description of the three titles used to describe the visual art modality of the arts therapies - Art Therapy, Art Psychotherapy and analytical Art Psychotherapy; the hypothesis and aims of this research study and an explanation of the changes that occurred because of Covid-19 restrictions and measures.

CHAPTER 2 – COMPLEX TRAUMA

2.1.1. Introduction

This chapter will describe the diagnosis of Complex Post Traumatic Stress Disorder and refer to the International Classification of Disease (ICD) - 11, and the Diagnostic and Statistical Manual of Mental Disorders 5th edition. Reference to The National Institute for Health and Care Excellence will be made in relation to their description of CPTSD. UK statistics for Complex Trauma will be explored.

2.1.2. Diagnosis – Complex Post Traumatic Stress Disorder

The International Classification of Disease (ICD) -11 diagnosis reports complex post-traumatic stress disorder (CPTSD), as being a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for Post-Traumatic Stress Disorder (PTSD), are met. In addition, CPTSD is characterised by severe and persistent problems such as feeling diminished, defeated, or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event and difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (Maerker, 2021).

The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in England, which publishes guidelines on: the use of health technologies within the National Health Service (England) and within NHS Wales; clinical practice; guidance for public sector workers on health promotion and ill-health avoidance; and guidance for social care services. The National Institute for Clinical Excellence (NICE) in the UK describes CPTSD as characterised by the core symptoms of PTSD, that is, all diagnostic requirements for PTSD are met. In addition, CPTSD is characterised by severe and pervasive problems that affect regulation; persistent beliefs about oneself as diminished; defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt, or failure related to the traumatic event; persistent difficulties in sustaining relationships and in feeling close to others.

Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM) does not include a diagnosis of CPTSD. However, it covers the complexity of presentation through a wider range of core PTSD symptoms.

It is important to note that PTSD is more often associated with other psychiatric disorders than occurring as the sole diagnosis. Several mental health syndromes can be considered as post-traumatic. In an introduction to anxiety disorders (Nutt, 2001), Loos (2001) reports six disorders that are directly associated with psychological trauma. He states that psycho-traumatic syndromes depend in their phenomenology on the developmental stage in which they are induced in any person and by the duration of traumatisation and of the syndrome itself in the individual. The clinical diagnoses that Loos arranges within this spectrum are borderline personality disorder (Gunderson and Sabo, 1993; Lonie, 1993; Van der Kolk et al., 1994); behavioural hyperactivity (Haddad and Garralda, 1992); dissociative disorders (Putnam et al., 1986; Van der Hart and Horst, 1989; Van der Kolk et al., 1989; Van der Kolk and Van der Hart, 1989); somatoform (Cheung, 1993; Barsky et al., 1994; Labbate et al., 1998) and functional disorders (Scarinci et al., 1994); post-traumatic stress disorder and post-traumatic personality change or disorder (Herman, 1992; Southwick et al.,1993; Jongedijk et al., 1996).

Because the diagnosis or categorisation of the symptoms of mental illness of a person who has experienced psychological complex trauma can be complex, only the term, psychological complex trauma, is used in the survey without specific diagnostic terms.

2.1.3. UK statistics

According to PTSD-UK (2021), one in two people in the UK will experience trauma at some point in their life, and around 20% of those people can go on to develop PTSD. Anyone can be diagnosed with PTSD, and it is estimated that one in ten people develop PTSD. One in five firefighters; one in three teenagers who have survived a horrific car crash; 70% of rape victims, two in three prisoners of war, 40% of people who experienced a sudden death of a loved one, and an estimated 10,000 women a year following a traumatic childbirth, develop PTSD (ptsduk.org, 2021). The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, (Natcen, 2014) (see figure 1) reports the

following percentages of people aged over 16 years of age who screened positive for PTSD.

Ethnicity	All	Men	Women
Asian	5.8	6.1	5.3
Black	8.3	5.1	10.9
Mixed/Other	5.8	5.4	6.2
White - British	4.2	3.5	4.9
White - Other	2.2	1.8	2.5

Figure 1 - The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, (Natcen, 2014), reports the following percentages of people aged over 16 years of age who screened positive for PTSD.

However, this survey only covers people who live in private households. It does not include those who live in institutional settings (such as hospitals or prisons) or in temporary housing (such as hostels or bed and breakfasts) or those who are homeless. People living in such settings are likely to have poorer mental health than those living in private households (McManus, 2016).

A study by the Office of National Statistics (2017) reports that survivors of childhood abuse rated their wellbeing as lower than adults who did not experience abuse as a child. They were less likely to be happy, satisfied with life and feel their lives were worthwhile than those who were not abused as children, (ons.gov.uk, 2017). Furthermore, the National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England (Bellis, 2014) reports almost half (47%) of individuals experienced at least one of the nine adverse childhood experiences. Prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively. The results from this survey suggest that nearly half of all individuals in England are exposed to at least one adverse childhood experience (ACE), and 9% experience four or more ACEs. An article published by the European Journal of Psycho-traumatology (Frewan, 2019) reports that lifetime traumatic stressors and adverse childhood experiences uniquely predicted concurrently measured severity of DSM-5 and ICD-11 PTSD Complex PTSD (CPTSD), and dissociative subtype of PTSD (D-PTSD) symptoms among 418 participants.

2.1.4. Psychological responses to trauma

In a paper – The Biology Basis of Post Traumatic Responses, (Nutt et. al, 2001), Loos discusses two basic stress responses: defence and inhibition. The defence reaction consists of both behavioural and physiological components as efforts to survive

confrontations with members of their own species, predators, or physical dangers, also associated with fight or flight responses. Understanding of the ethology and comparative physiology of the defence reaction permits excellent understanding of the psychophysiology of alarm and anxiety in humans (Loos, 2001). More psychophysiology will be explored when I mention the Poly Vagal Theory later in this thesis. The other survival response, inhibition, which can also be described as general adaptation syndrome, is characterised by behavioural inhibition when all possible active ways of surviving a challenge are being blocked off. It can be compared to the psychodynamic concept of unsolvable conflict or to Martin P. Seligman's behavioural model of learned helplessness (Seligman, 1975; Maier and Seligman, 1976; Abramson et al., 1978), while Henry (1976;1992) described it from a comparative physiological and ethological point of view as conservation-withdrawal (Henry, 1976; Henry, 1992).

Reisinger, (2020) reports that the 'fight or flight' response to stress is oversimplified, and that there are other ways that humans have evolved to adapt to stress. The six responses to stress include fighting a threat (fight), fleeing a threat (flight), freezing and not doing anything in response to a threat (freeze), being flooded with emotions in response to a threat (flood), cooperating or submitting to one's threat or captor (fawn), or feeling tired and/or sleeping in response to a threat (fatigue).

Complex traumatic experiences can manifest in lots of ways and continue to affect a person and their behaviour. If a person has learned helplessness (Ford, 1985) in initial traumatic experiences, they may unconsciously attempt to overcome this experience through reactive behaviours to potential threats (Grupe, 2013). Hockenbury (2011) explains that learned helplessness occurs when an animal is repeatedly subjected to an aversive stimulus that it cannot escape. Eventually, the animal will stop trying to avoid the stimulus and behave as if it is utterly helpless to change the situation. The American Psychological Association report that although the concept is strongly tied to animal psychology and behaviour, it can also apply to many situations involving human beings (APA, 2021). When opportunities to escape are presented, this learned helplessness will prevent any action. The defence is informed by the initial inhibition position from initial traumatic experiences. Anxiety is a common and natural response to a dangerous situation. For many people it lasts long after the trauma has ended. Grupe (2013) reports that this happens when views of the world and a sense of safety have changed. Someone may feel anxiety when remembering their trauma. But sometimes anxiety may be triggered without an obvious cause. Triggers or cues that can cause anxiety may include places,

times of day, certain smells or noises, or any situation that reminds someone of their trauma. If a trauma is unprocessed or psychologically unresolved, it can be re-experienced as flashbacks, or very vivid images, which can feel as if the trauma is occurring again. Nightmares are also common. These symptoms occur as the psyche attempts to resolve the experience. Increased vigilance is also a common response to trauma (Grupe, 2013). This includes feeling on guard, jumpy, jittery, shaky, nervous, on edge, being easily startled, and having trouble concentrating or sleeping. Continuous vigilance can lead to impatience and irritability. This reaction is due to the trauma responses in the body and is the way to protect ourselves against danger. When we protect ourselves from real danger by either trauma response, we need a lot more energy than usual, so our bodies release extra adrenaline to help us get the energy we need to survive (Grupe, 2013). People who have experienced complex psychological trauma may experience the world as dangerous, so their bodies are on constant alert, being ready to respond immediately to any attack. Research suggests that overactivation of adrenaline can contribute to high blood pressure, promotes the formation of artery-clogging deposits, and causes brain changes that may contribute to anxiety, depression, and addiction (Bonnet, 2010). More preliminary research suggests that chronic stress may also contribute to obesity, both through direct mechanisms and indirectly (Farr, 2014). PTSD alone has been associated with higher Body Mass Index (BMI), obesity and may be the psychiatric disorder most linked with obesity.

Avoidance is a common way of trying to manage PTSD symptoms (NHS, 2018). For example, avoiding environments or situations similar to that of their traumatic experiences. This can restrict potential life enhancing and positive experiences and exacerbate anxiety. In severe formation, this process can cause phobias and obsessive-compulsive disorder (OCD) (National Institutes of Health, 2020). Complex psychological traumatic experiences may lead to feelings of anger, guilt, and shame. It is common that a person may blame themselves for things they did or did not do to survive such experiences. Mate (2020) reports that this process perpetuates secondary psychological impact from the initial events. Other common psychological responses to complex psychological traumatic events may be an altered perspective of others and the world, not being able to trust people, low self-esteem, suicidal ideations, self-harm, eating disorder, conflicted relationships, inhibited or increased sexual relationships, addiction, maladaptive daydreaming, threat seeking behaviours, disturbed sleep and physical ill health (Mate, 2020). A person may become dissociated or psyche-split (Garrett, 2016) as a coping

mechanism. Perry (2006) reports that the negative effects from psychologically traumatic experiences are caused by alterations in various neural systems in the brain that compromise the functional capacities mediated in such systems, particularly when the events occur in childhood, when the brain is still developing (Perry, 2006).

A person can become dissociated to cope with extreme traumatic experiences. What Freud described as “stimulus too painful to be dealt with”, translates into what Daniel Siegal designates as outside a person’s window of tolerance, beyond a person’s ability to manage and tolerate emotionally (Siegal, 2001).

Ross describes dissociation as being the opposite of association: not interacting, split apart, disconnected to experiences that are too overwhelming for the psyche (Ross, 2004).

The American Psychiatric Association (2013) describes dissociation as:

‘a subjective loss of integration of information or control over mental processes that, under normal circumstances, are available to conscious awareness or control, including memory, identity, emotion, perception, body representation, motor control, and behaviour’.

Cardena and Carlson (2011) have specified the dissociative symptoms as characterised by:

(a) a loss of continuity in subjective experience with accompanying involuntary and unwanted intrusions into awareness and behaviour and/or

b) an inability to access information or control mental functions, manifested as symptoms such as gaps in awareness, memory, or self-identification, that are normally amenable to such access/control and/or

(c) a sense of experiential disconnectedness that may include perceptual distortions about the self or the environment. When dissociative symptoms are present, a person may know or not know what happened, as aspects of the self-connect with the truth then disconnect because that truth cannot be tolerated.

Evidence suggests that therapeutic input may be able to ameliorate some, or all, of the consequences of complex traumatisation (McFetridge, 2017). However, as the next chapter will explore, there is little evidence or literature that reports the impact of Art Psychotherapy treatment for this. A person who dissociates as a consequence of experiences of complex psychological trauma, or who has a diagnosis of dissociative

identity disorder (DID) will appear normal when in the window of tolerance (Lynette, 2017). This is referred to as Apparently Normal Personality (ANP). However, the person's other emotional state may be below or above the line within their window of tolerance (Siegal, 2001) and referred to as Emotional Personalities (EP). In general terms this can also be referred to as hyper arousal (above the line) or hypo arousal (below the line) (Siegal, 2001). Danylchuk (2017) states that with therapeutic treatment, a person who dissociates as a consequence of experiences of complex psychological trauma, can learn to tolerate and integrate greater amounts of emotional material, and their window of tolerance grows larger, incorporating the history and experiences that had been separated in the EP's, resulting in an integrated person.

This study will report the findings from a systematic literature review for the literature and research on Art Psychotherapy treatment when used to treat people who have experienced couple trauma. Findings will contribute towards the design and development of an international survey and a treatment manual.

2.1.5. Summary

This part of Chapter two has described several stances of the diagnostic characteristics of Complex Post Traumatic Stress Disorder, then reported UK statistics of complex trauma. The next section will explore theories and recommended interventions for people who have complex psychological trauma.

THEORIES AND INTERVENTIONS

2.1.6. Introduction

This part of Chapter 2 will explore the psychological response to trauma extending to Attachment Theory. It will then explore how trauma can affect a person from a neurological perspective, then biologically through The Poly Vagal Theory (Porges, 2009). A description of trauma informed interventions will then be explored, covering Eye Movement Desensitisation Reprocessing; Trauma Focused Cognitive Behavioural Therapy; Prolonged Exposure Therapy; Emotional Freedom Therapy and Mindfulness. I will then refer to Art Psychotherapy and neuroscience, and a brief look at the evidence for Art Psychotherapy and trauma, laying the ground for a systematic literature review in Chapter 3 that will report literature for the treatment of Art Psychotherapy and complex psychological trauma over the last five years. This evidence and literature will inform the continuation and development of this study.

2.1.7. Attachment Theory

The overwhelming fear, anxiety and helplessness of interpersonal attachment trauma stimulates post-traumatic stress reactions which have the ability to fragment the self and alter personality (Sanderson, 2008).

It is only recently that people have made the connection between a person's attachment style and her or his behaviour in adulthood, and in therapy (Sanderson, 2008). John Bowlby and Mary Ainsworth studied the nature of relationship between mother and child, creating theories and studies seeking to understand the impact of the attunement and misattunement of the mother and her child's development. The term 'attachment' is applied in describing the affective bond that cultivates between an infant and their caregiver; although attachment is ongoing and applies within adult relationships. The attachment within infancy is key in the development of a person's understanding of relationships and how to grow developmentally within them. Ainsworth's 'Strange Situation' (Ainsworth et al. 1978) was a classic experiment into how babies responded to their mothers in different scenarios. From this research, the babies' reactions were categorised into secure, ambivalent, and avoidant responses. The secure babies expressed distress when their mother left; were friendly with a stranger when mother was still present, but avoidant of the stranger when left alone with her and were happy when the mother returned. The ambivalent babies were intensely distressed when the mother left, fearfully avoided the stranger and approached the mother when she returned, only to push her away again. The babies labelled avoidant were not distressed when the mother left, were

fine playing with the stranger and were not interested in the mother when she returned. Another style of attachment beyond these three is ‘disorganised’, which is categorised by a confused response to the mother, running towards then away from the mother as if not able to decide if she is safe or not. Fonagy (2005) believes that such bonds have a huge impact on psychological health and development, and that deficits in this area are responsible for most psychiatric disorders. Research identifies several damaging disorders associated with interpersonal trauma which include personality disorder, schizophrenia, anxiety disorder, dissociative disorder, PTSD, depression, and self-harm (Sanderson, 2009).

Research reveals that infants require a relationship with a parent or caregiver that is nurturing, secure and supports development. The absence of such a relationship can traumatise an individual, consequently making them incapable of connecting appropriately with others. Gaffney reports that the destructive and disabling effects of traumatic experiences stemming from parental neglect, abuse and/or violence can propel an individual into fractured versions of themselves, forcing them to cope with the arduous task of adaptation (Gaffney, 2006).

While secure attachment with one’s caregiver is ideal, many individuals experience attachment organisation that is avoidant, ambivalent, or disorganised (Gerhardt, 2004). While secure attachment can enhance resilience, augment coping abilities and buffer stress responses, attachment disturbance or distortion may increase vulnerability to cognitive disruptions, autonomic reactivity and emotional distress and dysregulation. Furthermore, chronic misattunement with one’s caregiver may also prime an individual to develop dissociative tendencies, which over time can grow progressively more complex and detached from normal consciousness (Putnam, 1997).

2.1.8. How does trauma affect the brain? A neurological perspective

A growing body of research describes altered neurological structure and function in individuals who experience early emotional trauma (Thomason, 2017). Brain networks evolve, grow and adapt to changing cognitive demands (Bullmore and Sporns, 2012). When thinking of traumatic attachment from a neurological perspective, the brain encodes different types of memory (sensory, emotional, verbal and pre-verbal) in different ways and in various cortical areas (Harvey, 1990). If the trauma is severe, the memory will more likely be stored in the right hemisphere of the brain, split off from the conscious linguistic functions of the left hemisphere. If traumatic stressors or disordered attachment occur in

infancy, brain regions that record conscious autobiographical memory will not have developed. Instead, traumatic memories will be stored in the limbic system (the emotional and sensory memory), midbrain (emotional arousal, sleep, appetite) and brain stem (regulation of instinctive responses, and the autonomic nervous system); thus, being less amenable to influence by thought and less easy to regulate through language (Harvey, 1990).

Complex psychological trauma causes adaptations in the brain and body of the victim. The person needs to adapt to survive, and healing requires sufficient time to create new neural pathways that will allow a person to have the option of experiencing and behaving differently (Kozlowska, 2015). Complex psychological trauma results in hyper and hypo-arousal, waves of emotions and reactions that are outside of the window of tolerance and difficult to manage (Siegal, 2001). Hyperactivation means too much is happening. Our brains shift out of a calm and rational state and fall into survival-oriented mechanisms (Kozlowska, 2015). As mentioned in the first stage of this chapter, this process can take a person through one or several trauma responses; fight, flight, fright, flood, fawn and fatigue, depending on the severity of the threat, complexity and amount of exposure (Reisinger, 2020).

In the middle of the brain is the limbic system that contains the amygdala, which is the focal point of our strong emotions such as pleasure, fear, and anger. Here is also the hippocampus which is involved in the storage of memory. When a person is confronted with a traumatic event, the amygdala is charged and information that is sent to the hippocampus to be stored as memory overwhelms the hippocampus, resulting in trauma memories failing to be stored in an integrated manner (Van Der Kolk, 2000). The hippocampus cannot work fast enough to take all parts of the trauma experience and is unable to store the information in a coherent narrative. Consequently, some of the elements of the memory remain unconnected to others, like fear with no memory of what caused it, or a strong reaction to a smell without the knowledge of the cause of the reaction (Van Der Kolk, 2000). The amygdala is in the centre of the brain in the temporal lobe. This is part of the limbic system that helps alert us to danger. LeDoux suggests (1996) that the amygdala is essential to understanding and experiencing fear. Studies have demonstrated that trauma survivors have increased blood flow to the amygdala in comparison to non-trauma survivors. The theoretical implication is that trauma survivors have adapted and become hard-wired to be more on guard than the non-traumatised person (Morey, 2012).

Regarding the storage of memory in relation to complex psychological trauma, Solomon (1985) reports that such events overwhelm the brain's capacity to process information. We process disturbing memories by thinking, talking, and dreaming about the experience. As the brain slowly processes the memory, it is abstracted and transferred into the left neo-cortex where it is filed away along with other memories and becomes part of the narrative of one's life. Payne (2015) reports that these stored memories can be retrieved when needed to understand future events. If the traumatic memory is too overwhelming, it may be dysfunctionally stored in the right limbic system indefinitely and may generate vivid images of the traumatic experience, terrifying thoughts, feelings, body sensations, sounds, and smells. Such unprocessed traumatic memories can cause cognitive and emotional looping, anxiety, PTSD, maladaptive coping strategies, depression, and many other psychological symptoms of distress (Solomon, 2005). Because the episodic memory is not processed, a relevant semantic memory is not stored, and the individual has difficulty using the knowledge from the experience to guide future actions.

2.1.9. The Polyvagal Theory

The Polyvagal Theory is a collection of evolutionary, neuroscientific and psychological claims pertaining to the role of the vagus nerve in emotion regulation, social connection and fear response (Todorov, 2011).

Porges (2009) summarises the Polyvagal Theory as:

'The polyvagal theory proposes that the evolution of the mammalian autonomic nervous system provides the neurophysiological substrates for adaptive behavioural strategies. It further proposes that physiological state limits the range of behaviour and psychological experience. The theory links the evolution of the autonomic nervous system to affective experience, emotional expression, facial gestures, vocal communication, and contingent social behaviour. In this way, the theory provides a plausible explanation for the reported covariation between atypical autonomic regulation (eg, reduced vagal and increased sympathetic influences to the heart) and psychiatric and behavioural disorders that involve difficulties in regulating appropriate social, emotional, and communication behaviours' (Porges, pg. 7, 2009).

When a person feels threatened, they will typically move through a sequence of three autonomic nervous system pathways; each aimed for survival. When possible, they will first try to engage their social nervous system to re-establish a sense of connection and safety (Schwartz, 2020). For example, a child who is facing separation from his or her mother might initially try to smile or reach out for their mother's hand for reassurance or to

prevent her departure. However, if the child is unable to secure a safe, relational bond, he or she will begin to cry or cling. This might evolve into feelings of fear or anger which may be seen as the child runs away or begins to hit their mother. These behaviours indicate that the child has mobilised into fight and flight through sympathetic nervous system activation (Schwartz, 2020). In situations of ongoing threat such as when a child is being abused or when a person is held in captivity, then fight or flight may not help the individual establish safety. In this case, the individual will rely upon the evolutionarily older expression of the Dorsal Vagal Circuit which is characterised by immobilisation into collapse, loss of muscle tone, slowed heart rate, nausea, dizziness, and numbness (Schwartz, 2020).

Bonilla (2020) states that the polyvagal theory and the expressive arts, combined, are a great tool for enabling survivors to be more present in their bodies and to be able to self-regulate, by understanding where they find themselves in their bodies when they are triggered.

In her book, The Polyvagal Theory in Therapy, Dana (2018) explores co-regulation as an interactive process that engages the social nervous systems of both therapist and client. It is common for clients with trauma, especially those with CPTSD, to alternate between hyper-arousal and hypo-arousal states (Schwartz, 2020). Co-regulation requires the Psychotherapist to feel with a wide range of affect and arousal states. Clients with developmental trauma may have never had another person who was able to be with them in their distress without becoming anxious themselves, shutting down, or leaving them with their pain (Schwartz, 2020). Dana states that applying polyvagal theory in psychotherapy involves engaging the social nervous system as the Psychotherapist, and the client (Dana, 2018). Schwartz (2020) states that the importance of engagement of the social nervous system is not the same as simply offering support. Rather, engagement offers an experience of mutuality and reciprocity in which the Psychotherapist is open to receiving the client as they are. When the Psychotherapist offers their openness and receptivity to clients, they feel accepted and understood (Schwartz, 2020).

2.1.10. Trauma informed therapeutic interventions for treating complex trauma

The National Institute of Health and Care Excellence (NICE) guidelines current recommended psychological treatment for Post-Traumatic Stress Disorder is Trauma-focussed Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and

Reprocessing (EMDR) and Prolonged Exposure Therapy (PET). People who have experienced psychological complex trauma may develop a range of mental health difficulties. It is important to note that the common disorders that follow a traumatic event or a series of complex traumatic events, have a large body of evidence indicating that certain interventions can be highly efficacious. Exposure therapies, including Prolonged Exposure Therapy, have also been proven efficacious in many Randomised Control Trials (Foa, Keane, Friedman, & Cohen, 2009), and have been recommended as a first line treatment for PTSD in several treatment guidelines. Adults who have experienced complex psychological trauma can experience mental illness that invariably results in significant restrictive impact upon their lives. Various psychotherapeutic modalities attempt to effect potential palliative solutions and are claimed to ultimately promote mental health recovery for those who have PTSD. The 11th revision to the WHO International Classification of Diseases (ICD-11) identified CPTSD as a new condition. There is a pressing need to identify effective CPTSD interventions (Karatdiaz, 2019).

2.1.11. Eye Movement Desensitisation and Reprocessing (EMDR)

Shapiro (1995, 2001, 2007a) reports EMDR as being:

> "a therapeutic approach that emphasises the brain's intrinsic information processing system and how memories are stored. Current symptoms are viewed as resulting from disturbing experiences that have not been adequately processed and have been encoded in state-specific, dysfunctional form".

EMDR therapy (Shapiro, 2001) was initially developed in 1987 for the treatment of PTSD and is guided by the Adaptive Information Processing model (Shapiro 2007). EMDR is an individual therapy typically delivered one to two times per week for a total of 6-12 sessions. Unlike some other treatments that focus on directly altering the emotions, thoughts and responses resulting from traumatic experiences, EMDR therapy focuses directly on the memory, and is intended to change the way that the memory is stored in the brain, thus reducing and eliminating the problematic symptoms (APA, 2017).

EMDR is based on Shapiro's (Shapiro, 2001) observation that certain techniques using bilateral eye movements, while focused on a traumatic memory, "caused the simultaneous desensitization and cognitive restructuring of memories" (p. 13). Bilateral eye movements as well as other forms of bilateral stimulation reduce the distress associated with the memories, allowing the development of more adaptive thinking patterns (Shapiro, 2002). EMDR is recommended as a treatment for people who have PTSD, or to treat isolated experiences of trauma. Although there is consensus about the application of

EMDR for patients with PTSD, there is less agreement in the field about its (timing of the) use in individuals suffering from the consequences of early traumatisation (Cloitre et al., 2011, 2012) in particular those suffering from CPTSD. However, Shapiro reports,

"it is better to provide practitioners with a conceptual framework or model to serve as a guide to their clinical practice than merely to give them inflexible, step-by-step procedures for implementing EMDR therapy." (Shapiro, pg. 12, 2018).

2.1.12. Trauma focussed cognitive behavioural therapy (TF-CBT)

Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) is a conjoint parent-child treatment developed by Cohen, Mannarino, and Deblinger that uses cognitive-behavioural principles and exposure techniques to prevent and treat posttraumatic stress, depression, and behavioural problems (de Arellano, 2014).

A systemic review from the U.S. (Ross, 2021) exploring how trauma chronicity and PTSD presentation affect treatment outcomes when using trauma focussed CBT, reports that there were no baseline differences between youth with acute versus chronic trauma. At baseline, participants who had PTSD plus two or three of the ICD-11 CPTSD symptom domains had significantly worse functioning than those with simple PTSD. Furthermore, they found significant improvement on most measures of PTSD and CPTSD domains. Level of improvement was found to vary, based on PTSD presentation at baseline (Ross, 2021). The findings support the effectiveness of TF-CBT for simple and complex PTSD for youths who have experienced acute and chronic trauma.

Research concerning the treatment of PTSD suggests that TF-CBT and EMDR are equally effective to, or exceed the effectiveness of, psychopharmacology in the long term (Church 2018).

2.1.13. Prolonged Exposure Therapy (PET)

Exposure is an intervention strategy commonly used in cognitive behavioural therapy to help individuals confront fears. Prolonged exposure is a specific type of cognitive behavioural therapy that teaches individuals to gradually approach trauma-related memories, feelings and situations (APA, 2020). Prolonged Exposure Therapy consists of imaginal exposures, which involve recounting the traumatic memory and processing the revisiting experience, as well as in vivo exposures in which the client repeatedly confronts trauma-related stimuli that were safe but previously avoided.

2.1.14. Emotional Freedom Therapy (EFT)

EFT international is registered with NICE as a stakeholder for the PTSD Guidelines and participated in a recent review (NICE, NG116, 2018) that recommended further research into EFT for the treatment for adults who have PTSD. Emotional Freedom Therapy is an evidence-based method that combines acupressure with elements drawn from cognitive and exposure therapies (Church, 2018). It is a form of psychological acupressure, based on the same energy therapies used in traditional acupuncture, to clear the emotional block. The client uses simple tapping of the fingers to input kinetic energy onto specific points on the body while thinking about your trauma and voice positive affirmations (PTSDUK, 2021).

2.1.15. Mindfulness

Mindfulness-based treatments for post traumatic stress disorder have emerged as promising adjunctive or alternative intervention approaches (Boyd, 2018). Research regarding mindfulness mediation's impact upon the brain points to changes in brain structure and function that could account for the reduction of symptoms of PTSD. Wolkin (2016) reports that deregulation of the brain areas associated with emotional regulation and memory are key contributors to the symptoms associated with PTSD in addition to the over activity of the fear centre, the amygdala. Wolkin (2016) adds that Mindfulness reverses these patterns by increasing prefrontal and hippocampal activity, and toning down the amygdala.

Chickerneo (1993) states that there is a popularity of spiritual approaches in mental health, as in many kinds of treatment programmes based upon the twelve-step method of overcoming addiction (Chickerneo, 1993; Waller, 1999). Mindfulness can be defined as a state of consciousness, one characterised by attention to present experience with a stance of open curiosity. Furthermore, it is a quality of attention that can be brought to any experience, (Smalley and Winston, 2010).

There is a distinction between mindfulness-based therapy and mindfulness informed therapy that psychotherapists have found helpful in understanding ways of incorporating mindfulness into their practice differently to treat trauma (Smalley and Winston, 2010). In mindfulness-based therapy, mindfulness is taught to the client, by the therapist guiding mindfulness practices and through psychoeducation. In mindfulness-informed therapy, the therapist embodies mindfulness through their presence, communication and through relational mindfulness without specifically presenting instructional elements to the client (Siegal, 2010).

Zacaro et al (2018) report that the psycho-physiological changes in brain-body interaction observed in most of meditative and relaxing practices rely on voluntary slowing down of breath frequency. However, the identification of mechanisms linking breath control to its psychophysiological effects is still under debate. Self-regulating breathing practices and mindfulness practices are widely studied and used in clinical settings (Caldwell, 2013) but there is room for expansion in the realm of understanding the application of activating breath practices that foster self-exploration or somatic releases.

2.1.16. Art Psychotherapy and neuroscience

Art Psychotherapy is poised to take advantage of the abundance of information from clinical neuroscience research. Hass-Cohen reports that Art Psychotherapists can draw from clinical neuroscience to describe and enhance the therapeutic advantages of art and further illuminate the unique contributions of Art Psychotherapy to well-being and health (Hass-Cohen, 2008). The Art Therapy Rational Neuroscience (ATR-N) theoretical and clinical approach (Hass-Cohen, 2016; Hass-Cohen & Clyde Hindlay, 2015; Hass-Cohen, Clyde Hindlay, Carr & Vanderlan, 2014; King-West & Hass-Cohen, 2008a) was developed to link developments in clinical neuroscience and Art Psychotherapy treatment. This framework draws on the affective-sensory experience of art making, which keeps clients grounded in their surroundings and provides relief through the expression of emotion and kinaesthetic actions of art making (Hass-Cohen, 2008a). The ATR-N approach includes six theoretical principles informed by the neuroscience of relationships: creative embodiment, relational resonating, expressive communication, adaptive responding, empathising, and compassion (CREATE).

An aspect common to Art Psychotherapists' approaches to treating clients who have experienced psychological trauma, is the ability of art to aid in the cognitive restructuring and subsequent integration of trauma experiences. This process could be described as the creation, organisation, and integration of a trauma narrative (Hass-Cohen et all, 2014). Such non-verbal expressions and the creation of a narrative through Art Psychotherapy is the hemispheric integration of non-verbal implicit memories. This process, along with an additional component of holding a contradictory emotional learning in juxtaposition, is referred to as memory reconsolidation (Ecker, 2015). This theoretical and scientific base informs the development and validation of the treatment manual. This will be discussed later in the thesis.

Evidence for Art Psychotherapy and trauma

Qualitative research shows consensus among experts on the core elements of Art Psychotherapy in accessing traumatic memories and emotions, increasing emotional control, strengthening self-esteem, and a sense of autonomy. (Collie et al, 2006). There are indications that Art Psychotherapy can be effective in reducing PTSD symptoms such as avoidance, arousal and re-experiencing, and in reducing depression (Schouten et al, 2015). However, more empirical inquiries are needed. Art Psychotherapy in mental health: a systematic review of approaches and practices (Van Lith 2016), aimed to develop a bridge between what Art Psychotherapists know and what they do in supporting those with mental health issues. This and broader research will be reported and explored in Chapter 3. Although trauma may be a significant contributing factor to diagnostic outcomes such as depression, BPD, and schizophrenia, Studies that only focus on the studies directly about PTSD or CPTSD will be highlighted in Chapter 3.

2.1.17. Summary

This part of Chapter 2 has expanded to psychological effects of trauma and Attachment Theory. How trauma affects a person neurologically and biologically, making reference to The Polly Vagal Theory were brought, leading to descriptions of trauma informed psychotherapeutic interventions for this client group. These interventions and theory bases led to a description of Art Psychotherapy and neuroscience, and some evidence for the use of Art Psychotherapy for trauma. This is the grounding for a systematic literature review that is reported in Chapter 3.

CHAPTER 3 – SYSTEMATIC LITERATURE REVIEW

3.1.1. Introduction - Effectiveness of Art Psychotherapy for Adults who have Complex Psychological Trauma: A Systematic Literature Review

This review explores Art Psychotherapy and its contributions to the treatment for adults who have experienced complex psychological trauma. It set out to critically review existing evidence of the impact of Art Psychotherapy for adults who have experienced complex psychological trauma.

The method used is a systematic literature review to answer the above stated review question. The search yielded 63 papers. Following application of inclusion and exclusion criteria, 2 papers were included in the systematic review.

This review explored and identified literature that refers to the impact of Art Psychotherapy when used to treat adults who have complex psychological trauma or CPTSD, within the last five years. As this literature is not expansive, it is necessary to include some background literature that refers to PTSD and Art Psychotherapy as the commonality is the trauma, noting that the trauma experiences are less complex. I will expand on literature here that is older than five years.

3.1.2. Background - Complex Post Traumatic Stress Disorder

The International Classification of Disease (ICD) -11 diagnosis reports complex post-traumatic stress disorder (CPTSD), as being a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for Post-Traumatic Stress Disorder (PTSD), are met. In addition, CPTSD is characterised by severe and persistent problems such as feeling diminished, defeated, or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event and difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (Maerker, 2021).

The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in England, which publishes guidelines on: the use of health technologies within the National Health Service (England) and within NHS Wales; clinical practice; guidance for public sector workers on health promotion and ill-health avoidance; and guidance for social care services. The National Institute for Clinical Excellence (NICE) in the UK describes CPTSD as characterised by the core symptoms of PTSD, that is, all diagnostic requirements for PTSD are met. In addition, CPTSD is characterised by severe and pervasive problems that affect regulation; persistent beliefs about oneself as diminished; defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt, or failure related to the traumatic event; persistent difficulties in sustaining relationships and in feeling close to others.

Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM) does not include a diagnosis of CPTSD. However, it covers the complexity of presentation through a wider range of core PTSD symptoms.

It is important to note that PTSD is more often associated with other psychiatric disorders than occurring as the sole diagnosis. Several mental health syndromes can be considered as post-traumatic. In an introduction to anxiety disorders (Nutt, 2001), Loos (2001) reports six disorders that are directly associated with psychological trauma. He states that psycho-traumatic syndromes depend in their phenomenology on the developmental stage in which they are induced in any person and by the duration of traumatisation and of the syndrome itself in the individual. The clinical diagnoses that Loos arranges within this spectrum are borderline personality disorder (Gunderson and Sabo, 1993; Lonie, 1993; Van der Kolk et al., 1994); behavioural hyperactivity (Haddad and Garralda, 1992); dissociative disorders (Putnam et al., 1986; Van der Hart and Horst, 1989; Van der Kolk et al., 1989; Van der Kolk and Van der Hart, 1989); somatoform (Cheung, 1993; Barsky et al., 1994; Labbate et al., 1998) and functional disorders (Scarinci et al., 1994); post-traumatic stress disorder and post-traumatic personality change or disorder (Herman, 1992; Southwick et al.,1993; Jongedijk et al., 1996).

The National Institute of Health and Care Excellence (NICE) guidelines current recommended psychological treatment for Post-Traumatic Stress Disorder is Trauma-focussed Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and

Reprocessing (EMDR) and Prolonged Exposure Therapy (PET). Exposure therapies, including Prolonged Exposure Therapy, have also been proven efficacious in many Randomised Control Trials (Foa, Keane, Friedman, & Cohen, 2009), and have been recommended as a first line treatment for PTSD in several treatment guidelines. The mentioned psychotherapeutic modalities attempt to effect potential palliative solutions and are claimed to ultimately promote mental health recovery for those who have PTSD. However, the 11th revision to the WHO International Classification of Diseases (ICD-11) identified CPTSD as a new condition, and there is a pressing need to identify effective CPTSD interventions (Karatdiaz, 2019).

Qualitative research shows consensus among experts on the core elements of Art Psychotherapy in accessing traumatic memories and emotions, increasing emotional control, strengthening self-esteem, and a sense of autonomy. (Collie et al, 2006). There are indications that Art Psychotherapy can be effective in reducing PTSD symptoms such as avoidance, arousal and re-experiencing, and in reducing depression (Schouten et al, 2015). However, more empirical inquiries are needed.

Art Psychotherapy in mental health: a systematic review of approaches and practices (Van Lith 2016), aimed to develop a bridge between what Art Psychotherapists know and what they do in supporting those with mental health issues. Research undertaken between 1994 and 2014 was examined to ascertain the Art Psychotherapy approaches applied when working with people who have mental health issues, as well as to identify how the approaches were used within the clinical mental health system. In this review thirty articles were identified, and the search strategy resulted in articles being grouped into four diagnostic terms: depression, borderline personality disorder (BPD), schizophrenia, and PTSD. For Art Psychotherapy approaches practiced with people who have PTSD, seven articles were identified that explored specific approaches by providing clinical implications.

The group Art Psychotherapy model (Backos and Pagon, 1999); the Psychoanalytic Art Psychotherapy approach (Buck, 2009); the Neurobiological Art Psychotherapy model (Gantt and Tinnin, 2009); the Task oriented Art Psychotherapy approach (Rankin and Taucher, 2003); the cognitive behavioural intervention Art Psychotherapy approach (Sarid and Huss, 2010); the Art Psychotherapy trauma protocol (Talwar, 2007); and the Art Psychotherapy with EMDR through bilateral stimulation (Tripp, 2007) reported benefits from each approach. Buk (2009) article reported the exploration of mutative actions of

psychoanalytically informed Art Psychotherapy intervention, the art making process enabled the client to become conscious of and verbally processed dissociated memories involving the threat of sexual abuse. Gantt and Tinnin (2009) reported that Art Psychotherapy techniques utilise right brain processes by activating limbic structures in the brain involved in processing fear (trauma) furthermore proposing that Art Psychotherapy addresses the root cause due to evidence of trauma involving aetiology of intrusive arousal and avoidant symptoms. Rankin and Taucher (2003) provide an outline for how to use a task orientated approach to Art Psychotherapy. The six identified basic tasks are safety planning; self-management; telling the trauma story; grieving losses; self-concept and world view revision; and self and relational development. Their article reports the promotion of exploration of meaning through the identified tasks.

Sarid and Huss (2010) completed an extensive literature review which illustrates the benefits of Cognitive Behavioural Art Psychotherapy. It reports that by using this approach, new connections and pathways can be created between the physical, emotional, and cognitive components of trauma memory, resulting in decreased stress levels which enables the restricting of fragmented traumatic memories into more coherent positive memories. Talway (2007) proposes an Art Psychotherapy trauma protocol with integration of cognitive, emotional and physiological levels of trauma by combining Eye Movement Desensitisation and Reprocessing (EMDR), bilateral art and painting. This approach is seen to help process non-verbal traumatic memories, creates sensory awareness, sensorimotor experiences, and promotes proprioception. The Tripp (2007) article also explores the approach of Art Psychotherapy and EMDR. Associations of traumatic memory are brought to conscious awareness through drawing. As new information is accessed, affective material is metabolised and integrated, leading to transformation of traumatic memory and an adaptive resolution of the trauma.

A review that explored the effectiveness of Art Psychotherapy in the treatment of traumatised adults (Schouten, 2014) found six controlled comparative studies on Art Psychotherapy for trauma in adult patients (n=223). Over half of the studies reported a decrease in psychological trauma symptoms and one of the studies reported significant decrease in depression. Holmes and Bourne (2008) report, the visual and tangible characteristics of Art Psychotherapy in PTSD treatment appear to be consistent with the often wordless, image-based, sensory-perceptual nature of traumatic memories (Holmes and Bourne, 2008). Furthermore, Art Psychotherapy enables patients to express and

externalise memories and emotions in visual art and connect implicit and explicit memory (Collie et al. 2006).

In 2019, the World Health Organisation (WHO) reported (Fancourt, 2019) global evidence on the role of the arts in improving health and well-being, with a specific focus on the WHO European region. Results from over 3000 studies identified a major role for the arts in the prevention of ill health, promotion of health, and management and treatment of illness across the lifespan (Fancourt, 2019). In relation to Art Psychotherapy and mental health, specifically psychological trauma and trauma related ill health, the review reports that Art Psychotherapy has been shown to improve general symptoms, negative symptoms, depression, anxiety and functioning in those in the community and within inpatient settings. It is thought that these changes may result from modulation of neurochemical interactions, improved brain function and enhanced neuroplasticity (Dogan, 2018). For patients with major depressive disorder, creative activities such as clay therapy have been found to reduce depression, enhance well-being and reduce Alexithymia (lack of emotional awareness). The study further reports that Art Psychotherapy may help to reduce anxiety in adults who have experienced trauma, as well as potentially lessening the impact of an event and reducing avoidance, re-experiencing and arousal (Schouten, 2015). This study reports that drawing can reduce depressive symptoms, anxiety and PTSD symptoms, although these improvements are specific to PTSD (Hass-Cohen, 2018).

This evidence-base for the use of Art Psychotherapy when used to treat adults who have PTSD reports significant positive effect and outcomes. It identifies effective approaches and results from using Art Psychotherapy and can be used as a guide or informant on how to design treatment plans and models. However, as this review will report, there is little literature that focusses specifically on how Art Psychotherapy can support healing for people with complex psychological trauma or CPTSD. There were no articles that compared the impact of Art Psychotherapy for people with PTSD vs CPTSD. A case is made for Art Psychotherapy and its contributions to the treatment for adults who have experienced complex psychological trauma.

3.1.3. Methodology

A systematic literature review of the effectiveness of Art Psychotherapy for Adults who have Complex Psychological Trauma was undertaken.

Search Dates: searches were restricted to the dates 2017 – 2022 to allow a contemporaneous perspective and more detailed synthesis than possible with a broader time range.

Search restrictions: searches were restricted to articles published in English and non-grey literature.

Sources: electronic databases: ASSIA (ProQuest Platform, Google Scholar; Pub Med); Web of Science (Social Sciences Citation Index (SSCI); Arts and Humanities Citation Index (AHCI); Emerging Sources Citation Index (ESCI)); APA PsycNet; tandfonline; and Science Direct.

Searches included a combination of words: (Art Therapy OR Art Psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults).

All English peer-reviewed papers exploring the effectiveness of Art Psychotherapy/Art Therapy in the treatment of adults (aged 18 and above) with complex psychological trauma or CPTSD were included. The main searches were completed by the first author in July 2022. 50% of the searches were sifted by the second searcher, referring to the inclusion and exclusion criteria, and contributing to the Risk of Bias - Assessment of Methodological Quality in August 2022.

3.1.4. Aims of the systematic review

The purpose of this systematic review was to evaluate the literature within the last five years that reports the extent to which one therapeutic intervention – Art Psychotherapy – can influence the symptoms of complex psychological trauma and aid recovery. Whilst there is a reasonable evidence base for the uses and effectiveness of Art Psychotherapy in general (Jayne, 2021) there has been little causal analysis of which components of Art Psychotherapy can prove effective (Jayne, 2021), specifically when working with adults who have experienced complex trauma.

3.1.5. Inclusion Criteria

Inclusion criteria: all published, peer-reviewed public studies were included (randomise control trials; before/after cohort studies), quantitative measures. Studies published after 2017.

Exclusion criteria: studies without before/after measures, participants under the age of 18 years, qualitative studies, or descriptive papers. Studies published before 2017.

3.1.6. Strategy for Data Synthesis

Data on effectiveness has been assessed narratively in four phases (Popay et al, 2006). (i) the conceptual approach was defined i.e., Art Psychotherapy/Art Therapy, effectiveness, complex psychological trauma, (ii) information was extracted from the articles (iii) comparisons within and across studies were made (iv) a formal assessment of bias was integrated into the narrative synthesis.

This study is registered with PROPERO (reference 348680) (https://www.crd.york.ac.uk/PROSPERO/). Articles were selected (KJ) based on the inclusion/exclusion criteria. 50% of the selected abstracts were checked and agreed (SH) in August 2022. At the time, the use of RAYYAN was considered (Ouzzani, 2016) but due to the limited numbers of articles identified in initial title only screening/searches I concluded that systematic review software was not required in order to complete the review.

3.1.7. Flow chart based on PRISMA diagram (2009)

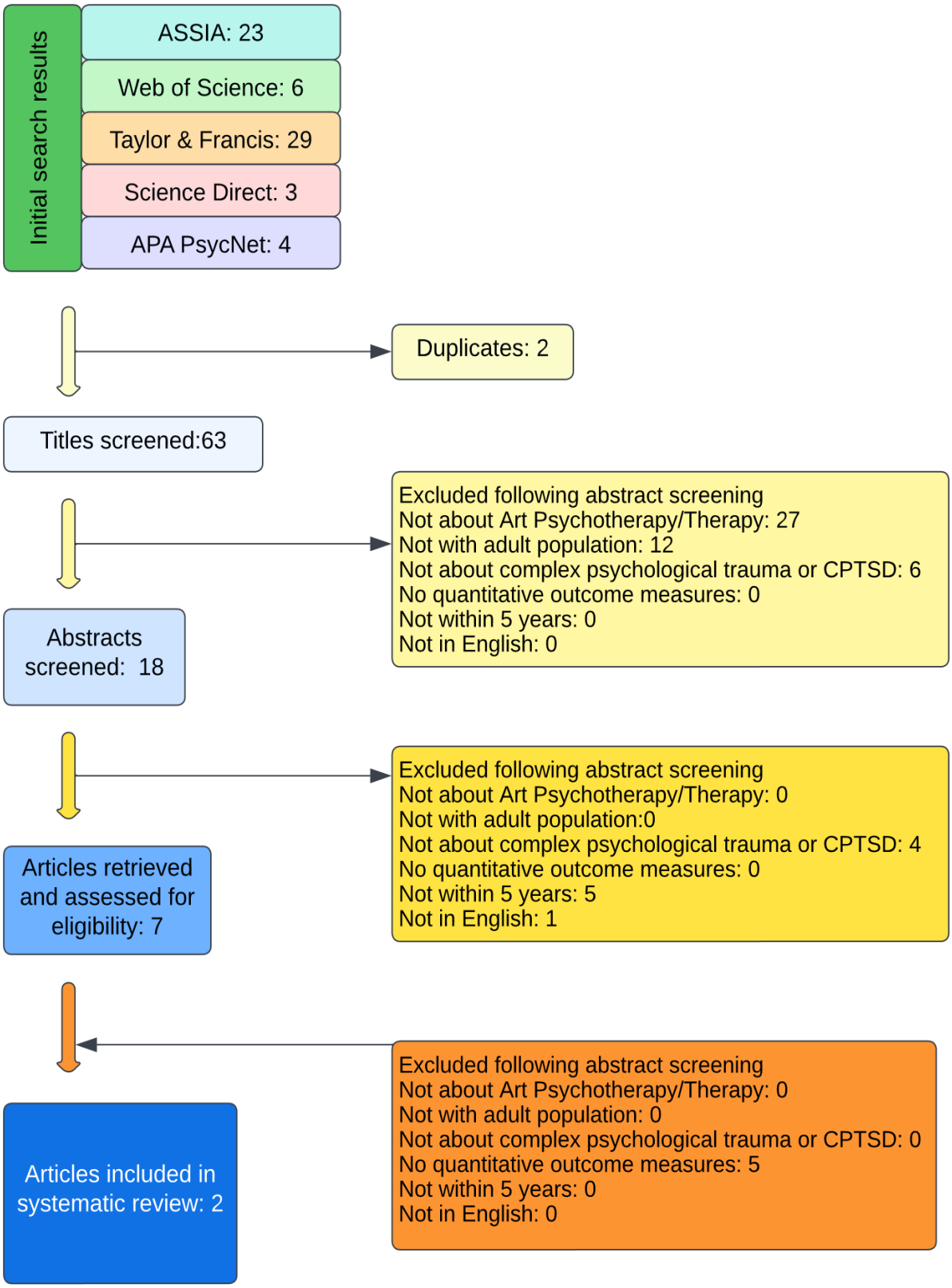


Figure 2 - A flow chart of the systematic literature review search process (based on PRISMA diagram, Moher, et al. 2009)

3.1.8. Process – Initial search (titles screened)

The total number of articles identified from the search that met the inclusion and exclusion criteria was 63, after reducing by 2 for duplicates. After screening the titles of the papers, 27 were not specifically referring to Art Psychotherapy or Art Therapy; 12 were not with the adult population; and 6 were not about CPTSD or complex psychological trauma. There were 18 articles remaining.

The articles selected through each screening process can be seen on appendix 1.

Initial search – titles screened

	ASSIA	Taylor & Francis	Web of Science	Science Direct	APA PsycNet	Total
Total search results	22	29	5	3	4	63
Not about Art Psychotherapy/Therapy	19	3	2	1	2	27
Not with adult population	2	9	0	1	0	12
Not CPTSD or complex psychological trauma	0	5	0	1	0	6
Remaining articles	1	12	3	0	2	18

Figure 2 – Initial search of titles

3.1.9. Abstract Screening

When the article abstracts were screened (n=18), they were all specifically referring to Art Psychotherapy or Art Therapy and were with the adult population. However, 4 papers do not refer to CPTSD or complex psychological trauma or CPTSD, 5 papers were not within 5 years, and 1 paper was not in English. There were 7 papers remaining.

Abstract Screening

	ASSIA	Taylor & Francis	Web of Science	Science Direct	APA PsycNet	Total
Total search results	1	12	3	0	2	18
Not about Art Psychotherapy/Therapy	0	0	0	0	0	0

Not with adult population	0	0	0	0	0	0
Not CPTSD or complex psychological trauma	0	4	0	0	0	4
Not within 5 years	1	3	0	0	2	5
Not in English	0	0	1	0	0	1
Remaining articles	0	5	2	0	0	7

Figure 3 - Searches of abstracts

3.1.10. Full read article screen for eligibility

At this stage, the number of articles remaining became 7. The papers that did not meet the full criteria in this screening had no outcome measures (n=5) which left 2 papers included in the systematic literature review.

	Full read screening					
	ASSIA	Taylor & Francis	Web of Science	Science Direct	APA PsycNet	Total
Total search results	0	5	2	0	0	7
Not about Art Psychotherapy/Therapy	0	0	0	0	0	0
Not with adult population	0	0	0	0	0	0
Not CPTSD or complex psychological trauma	0	0	0	0	0	0
Not in English	0	0	0	0	0	0
No measures	0	3	2	0	0	6
Remaining articles	0	2	0	0	0	2

Figure 4 - Fully read articles

There were 2 remaining articles (refer to figure 5) included in the systematic literature review:

- Coles & Harrison, (2017). Tapping into museums for Art Psychotherapy: an evaluation of a pilot group for young adults

This article describes a pilot museum-based Art Psychotherapy group for seven 18 to 25-year-old adults with severe mental health difficulties. Existing evidence for the psychotherapeutic value of museums is outlined, and an explanation is provided on the use of quantitative data from outcome measures and qualitative data from the therapy sessions and post-therapy reflective interviews delivered in order to assess therapeutic outcomes and the contribution of the museum setting. This article reports that the therapy group was beneficial to participants. The young adults reported that the museum setting helped them to reflect on feelings and experiences, facilitated interaction between group members, encouraged independence, fostered motivation and creativity, and helped them to feel valued and connected with the world outside mental health services.

- Schouten et al., (2019). Trauma-focussed Art Therapy in the treatment of PTSD: A pilot study

This pilot study tested the feasibility and applicability of trauma-focused Art Psychotherapy in clinical practice. Participants were adults with PTSD due to multiple and prolonged traumatisation such as patients with early childhood traumatisation and refugees and asylum seekers from different cultural backgrounds. Patient reports showed satisfaction and improvements after treatment. Some patients (five out of nine participants) reported decreased PTSD symptom severity. Schouten (2019) states that Art Psychotherapy might help to decrease avoidance by providing concretised forms of representation, either visual or tactile, in visual artworks.

3.1.11. Risk of Bias - Assessment of Methodological Quality

Quality appraisal was assessed (Effective Public Health Practice Project (EPHPP)) (Berghs, 2016). Agreement on inclusion/exclusion criteria was ascertained. Both reviewers (KJ/SH) reported unanimous strengths for each section for each article.

The Coles & Harrison (2018) paper had an overall bias of moderate. The Schouten et al. paper had an over bias of weak.

Risk of Bias - Assessment of Methodological Quality

	Selection Bias	Study Design	Confounders	Blinding	Data collection method	Withdrawals/ dropouts	Overall bias
Coles & Harrison, 2017	Strong	Strong	Strong	Strong	Strong	Moderate	Moderate
Schouten et al., 2019	Moderate	Strong	Strong	Strong	Strong	Moderate	Weak

Figure 5 - Findings from the assessment of bias and quality appraisal (Effective Public Health Practice Project (EPHPP))

3.1.12. Findings

Extracted information from the articles

Authors, title, and year	Number and age of participants	Demographic service	Gender	Intervention and setting	Outcome measure used	Results
Coles & Harrison, Tapping into museums for Art Psychotherapy: an evaluation of a pilot group for young adults 2017	13 offered, 10 agreed, 7 completed 18 – 25-year-olds	Demographic of participants not provided. Gloucester [2]Gether NHS Foundation Trust	100% female (not deliberate)	Group Art Psychotherapy (18 weekly sessions for 90 mins). 1st – 10th session held Folk Museum. 11th – 18th session held at City Museum.	PSYCHLOPS Rosenburg self-esteem scale	Decrease in scores reported overall beneficial impact. Increased self-esteem (n=3), small decrease in self-esteem (n=4)
Schouten et al., Trauma-focussed rt Therapy in the treatment of PTSD: A pilot study 2019	13 offered, 12 agreed, 9 completed Mean age - 49	Russia (n=3), Iraq (n=2), Bosnia (n=2), Iran (n=1), Congo (n=1), Afghanistan (n=1), Ireland (n=1), Netherlands (n=1) Dutch National Centre for diagnostics, Netherlands	67% male	Short-term (11 weekly sessions for 60 mins) - individual Art Therapy. 3 phases: stabilisation; trauma-focussed; and integration.	Harvard Trauma Questionnaire (HTQ)	Decrease in PTSD symptoms (n=5). 2 of these showed decrease across all measures. Increased PTSD symptom severity in participants (n=4).

Figure 6- Findings

3.1.13. Discussion

This systematic literature review screened articles adhering to inclusion and exclusion criteria, that reported the effectiveness of Art Psychotherapy when used to treat adults who have experienced complex psychological trauma. Following the staged screening processes (online database searches; title screening, abstract screening; full read screening), only 2 articles remained. To see the articles that underwent this screening, see appendix 1.

A formal assessment of bias was undertaken for both articles, scoring for the following areas: selection bias, study design, confounders, blinding, data collection method, withdrawals and drop-outs, intervention integrity, and analysis. The Schouten global ratings score was ‘weak’, reporting less risk of bias than the Coles and Harrison article that scored as ‘moderate’. The Schouten article scores suggest strengths in the selection bias, and withdrawals and drop-outs. The Coles and Harrison article scores suggest less risk of bias also relating to the withdrawal and drop-outs.

Both articles presented anecdotal changes in complex trauma or CPTSD symptomology. Coles and Harrison article (2018) reported an evaluation of a pilot for young adults who attended Art Psychotherapy group sessions held within museums. The age range of participants was 18 – 25 years old, and all were females (not intended). This article outlines the existing evidence for psychotherapeutic value of museums, and then evaluates the group to assess therapeutic outcomes and the contribution of the museum setting using quantitative data from outcome measures (UCL (University College London) Museum Well-being Measure, PSYCHLOPS and Rosenberg Self-esteem Scale). Overall, the data reported in this article suggests the therapy group was beneficial to participants. The adults reported that the museum setting helped them to reflect on their feelings and experiences; facilitated interactions between group members; encouraged independence; fostered motivation and creativity and helped them to feel valued and connected with the world outside mental health services.

The sessions ran for 18 weekly sessions with each session lasting 90 minutes. The first ten sessions were helped in a Folk Museum, then were based at the City Museum for the remaining sessions. The participants explored museum objects and exhibitions in the presence of Art Psychotherapists, spending the rest of the session for art making and discussion about their art works. The art making and discussions were held in a private room within the Museum to foster privacy and safety.

For evaluation, quantitative data was gained by:

- The UCL (University College London) Museum Well-being Measure (Younger adults) (Camic &Chatterjee, 2013) completed at the end of each session.
- The PSYCHLOPS measure (www.psychlops.org.uk) and Rosenberg Self-esteem Scale were completed once at the initial meeting (pre therapy), at session 1, 10, 18 and again at a post-therapy reflective interview.

The quantitative data yielded evidence that the group had an overall beneficial impact on participants. PSYCHOPS asked participants to describe their main problems and how the group affected them. This measure is designed to measure changes during the course of the therapeutic treatment. A decrease in scores indicated an improvement to problems, function and well-being. The scores from PSYCLOPS reported a mean change score for the group as being 3.42, giving the mean effect size of 1.81. The PSYCHOPS guidelines (www.psychlops.org.uk) states that an effect size of above 0.8 is considered to be large in health service research.

However, the Rosenberg Self-esteem Scale reported only three participants as having improved self-esteem from the pre to post therapy score, and four of them had a decrease in their self-esteem. An explanation is given that some answers on the pre therapy Rosenberg questionnaire reflected a 'lack of feeling' for some participants, according to the Art Psychotherapists who facilitated the group sessions.

Coles & Harrison report that the evaluation of other Art Psychotherapy groups in a clinical setting would allow them to compare outcomes and participants experiences, shedding more light on the impact of the museum setting. They acknowledge there is a need for research in partnership with service users, exploring in depth how museum objects and environments impact on the therapeutic process, and how Art Psychotherapists can best tap into the therapeutic benefits of this resource. Although this article meets the inclusion and exclusion criteria for this review, (the pilot uses Art Psychotherapy to treat adults who have experienced complex psychological trauma), the goal is to not only evaluate what or how Art Psychotherapy can enable recovery, but to evaluate the impact of the environmental space, the museum. Further consideration could have been given to the effectiveness that occurred and to what measure, relating to the intervention of Art Psychotherapy and the environment. For example, would an alternative therapeutic intervention have the same positive outcomes if held in this space? Environmental considerations for therapeutic outcomes are important and have informed

the progression of the following stages of this PhD research. The questions designed for the international survey aimed to obtain a variety of answers that refer to several areas of practice. See chapter 7 for more details.

The Schouten article (2019) reports a pilot study that uses trauma focused Art Psychotherapy in the treatment of Post-Traumatic Stress Disorder. Schouten reports that all participants had experienced multiple and prolonged albeit complex traumapsycho-trauma disturbances (asylum seekers, and early childhood traumatization). This pilot aimed to identify the preliminary effectiveness of Art Psychotherapy with less emphasis or focus on the environment, but from the perspective that there is a lack of evidence that might support the recommendation for Art Psychotherapy for this client group.

This pilot had 12 participants, and lasted for 11 weekly sessions of 60 minutes, consisting of 3 phases focusing on stabilization and symptom reduction, trauma-focused, and the third phase focused on integration and meaning making. The sessions were held for individuals, not as group sessions. PTSD symptom severity was measured using part IV of the Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1996) prior to treatment and immediately after the last session of Art Psychotherapy treatment. Patients were asked to indicate how much difficulty they had experienced over the last week in relation to 16 items on the questionnaire, using a 4-point scale. The preliminary findings of measures of the PTSD symptom severity using HTQ showed some reduction of avoidance and arousal among individual participants. Schouten reports that these decreases in PTSD symptoms could be due to the Art Psychotherapy protocol: Art Psychotherapy might help to decrease avoidance by providing concretised forms of presentation such as visual and tactile, in the visual artworks. Furthermore, that patients can express experiences non-verbally without the need to talk about traumatic memories in detail. And, by using the 3 phased process of stabilization, trauma focused, and integration. Patients of this pilot reported beneficial impact such as more relaxation, externalisation of memories and emotions into artwork, less intrusive thoughts of traumatic experiences, and confidence in the future.

However, preliminary measures showed that there was an increase in PTSD symptoms for some of the participants, and for almost all patients, a follow up treatment plan was needed. I wonder if this identifies a need for further research that explores the length of Art Psychotherapy treatment and the positive impacts associated with longer engagement. This area of potential inquiry was applied to the questions within the

international survey (see Chapter 7). Furthermore, as 1 article reports the findings from a group Art Psychotherapy pilot, and the other for individual sessions, the therapeutic impact of these two approaches to treatment was applied to the areas of questions within the survey. Schouten recommends that research into the effectiveness of Art Psychotherapy with a larger sample size and a control group is required.

3.1.14. Conclusion

Only 2 articles were identified for this systematic literature review. This indicates a lack of evidence that reports the effectiveness of Art Psychotherapy when used to treat adults who have complex psychological trauma. Both articles reported positive therapeutic outcomes resulting from a pilot of Art Psychotherapy treatment (see discussion). Further questions and gaps in research have also been identified (group / individual sessions, the impact of the environment, and the length of treatment). Through the screening process, this review identified some research articles that report findings for the treatment of Art Psychotherapy for people who have PTSD (this review is for CPTSD and therefore did not include these articles). However, there is a lack of research for the use of Art Psychotherapy for people who have experienced complex psychological trauma or CPTSD, and However, more research is needed.

3.1.15. Summary

This chapter, the process, and findings of a systematic literature review, have been reported on the effectiveness of art psychotherapy for adults with a diagnosis of complex post-traumatic stress disorder. This included an overview of Art Psychotherapy treatment when used to treat adults who have PTSD in publications between 2017 and 2022, (five years), including findings from research and studies carried out with the WHO, and identifies gaps in research for complex psychological trauma and how Art Psychotherapy can support recovery.

The identified gaps that inform the research undertaken are:

- The impact of the environment
- The length of Art Psychotherapy treatment
- The comparison (difference in impact) between individual and group Art Psychotherapy
- Follow up care of participants of Art Psychotherapy treatment

Furthermore, the findings from both articles partly informs the areas of exploration within the BAAT focus group, the development of the international survey questions, and the design and development of the treatment manual, UNTRAP:

- Informed areas of exploration within the BAAT focus group that incorporated elements and stances of therapeutic approach (philosophical, biological, psychodynamic/analytical, neurological).
- Questions relating to environment and the impact on therapeutic outcome (survey).
- The length of Art Psychotherapy treatment and the duration of each session, and the impact on therapeutic impact (survey).
- Having a limited number of sessions (with flexibility) within the treatment manual based on the answers from the survey (UNTRAP)
- Ensuring a safe, calm, therapeutic space that has muted colours on the walls with a view overlooking nature, based on answers from the survey (UNTRAP).

CHAPTER 4 – HEALING

4.1.1. Introduction

In order to study how Art Psychotherapy can support recovery and healing for a person who has experience complex psychological trauma, it is relevant to explore what healing is and to acknowledge a variety of theoretical perspectives.

4.1.2. What is Healing?

Healing is a natural process by which bodies, minds and other organic systems repair the wear and tear of life's stresses, accidents, and abuse. When-ever we are hurt or damaged, the healing process begins a cycle of restorative phases which unfold if conditions support recovery. Conners reports that the phases in this process lead us through the cleansing, resting, rebuilding and reusing periods that our body, mind and spirit need in order to overcome what has happened and resume our lives (Conners, 2010). She adds that healing occurs in a series of categories: physical versus psychological healing; numbing; a fighting spirit; awareness of self; awareness of fear; relationship awareness; blocks to therapy; psychotherapy; and empowerment (Conners, 2010). Her idea is that healing depends wholly on self-trust, and trust in relationships, adding that it is the relationship with the self and in safe relationships where healing happens.

To expand on this theory, I refer to Kazdin (2008), who talks of mediators and mechanisms of therapeutic change. Understanding why and how therapy leads to change can explain and identify key factors of why certain therapies are evidenced as effective. Having order can optimise change and inform the development of interventions that do not dilute the successful factors (Kazdin, 2008). Furthermore, this understanding can permit better selection of suitable patients. Knowing the need and potential of understanding why psychotherapy works is clear. However, Kazdin reports that currently, we do not know the reasons why psychotherapy leads to change or enables healing. He explores constructs that might explain treatment effects including therapeutic relationship; catharsis; therapist warmth; learning; change in expectations; mastery; and common factors among different therapies. He puts focus on patient therapist interaction and the personal bond that emerges in treatment, as being central to effectivity. This is understandable given the consistent findings that the stronger the alliance, the greater the therapeutic change (Horvath and Bedi, 2002, Orlinsky et al., 2004). This aspect will be explored in some of the questions within the international survey as part of this study.

Roache reports that there is no universally accepted account for how psychotherapy works (Roache, 2015). She argues that whether a given explanation is useful depends largely on what purpose one intends the explanation to serve, and that this point has not been adequately recognised in her profession (psychiatry). In Roache's article (2015) she explores this point and identifies some diagnosis specific purposes for the identification of needing an explanation. For example, some cases of depression are best explained primarily in terms of psychological factors and that some others are best explained in biological factors, such as abnormal brain activity (Roache, 2015). But what factors in general determine whether and when attention to one or another level, or to multiple levels, is explanatorily more appropriate and useful is an issue that requires further investigation (Roache, 2015). Common factors in psychotherapy have a long history in psychiatry, which have both been embraced and dismissed, creating some tension (Wampold, 2015). Wampold's article, (2015), reports a contextual model that provides an alternative explanation for the benefits of psychotherapy to ones that emphasise specific ingredients that are beneficial for particular disorders. The common factors are described as being the therapeutic relationship; the creation of expectations through explanation of disorder and the treatment involved; and the enactment of health promoting actions. He reports that before any of these pathways can be activated, an initial therapeutic relationship must be established. He further adds that some basic level of trust marks all varieties of therapeutic relationships, but when attention is directed towards the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed, thus the therapeutic relationship is key to recovery (Wampold, 2015).

In a recent interview (March, 2019) held with Art Psychotherapist Dr Neil Springham, the same area of reflection was discussed. When I asked him what components of Art Psychotherapy are the biggest contributors for healing for adults who have experienced complex psychological trauma, he responded by saying:

"Without the relationship, there is no such thing as art. The relationship between the Art Psychotherapist and the patient is a hundred percent of the therapeutic healing process. Art Psychotherapy can only occur within the relational space' (Springham, 2019).

Brett Kahr identified fifteen ingredients for good psychotherapy (Kahr, 2005): permission to confess; supreme reliability; interest in the smaller detail; the provision of tonal factors; the Psychotherapist having emotional and cognitive intelligence; the guarantee of confidentiality; having neutrality of purpose; the psychotherapist having

anonymity; loyalty and relatedness; posture of benignity and concern; identification of joyfulness, zestfulness, playfulness and vitality of the Psychotherapist; staying power; psychotherapist having a rich private life; dedication to principles of accountability; and cooperation of the patient / client. He describes each ingredient as an enhancing component of the therapeutic process, each having a healing affect. These fifteen identified key ingredients are referred to in the international survey as part of this study.

Gwen and Fonagy (2012) state that neuroimaging has provided evidence that psychological therapies change brain function. At least 27 studies were conducted using different imagine modalities with patients presenting with a range of psychiatric diagnosis, (including obsessive compulsive disorder, major depressive disorders, schizophrenia, phobias, PTSD, and personality disorder). The psychological therapies included behavioural, cognitive-behavioural, interpersonal, group, cognitive rehabilitation, EMDR, and dynamic therapies. The evidence shows that major modalities can be effective in producing change in certain groups of patients but that different techniques operate on different parts of the neural system. Gwen and Fonagy (2012) describe three levels of mental organisation: the personality, a function of behavioural traits that are largely genetic and is comparatively stable; the self, which is individual and consists of values, beliefs and attitudes that can be modified; and identity, which is constructed in social narratives with others and therefore changes in relationships over time. Duggan (2004) reviews the issue of change in personality and concludes similarly that there are some basic aspects of personality that do not change, but that characterological adaptations are amendable to change.

In an interview with Public Seminar Series (Public Seminars, 2019) exploring a new way to heal borderline bodies (people who have a borderline personality disorder) and relating to trauma, healing and the reconstruction of truth, Mucci (2019) explains:

> “Implicit work at the margins of affect tolerance between patient and therapist is a new way of understanding the unconscious, now considered as the implicit remnants of memory traces encoded in the amygdala and retained in the form of internal working models, to use John Bowlby’s language or representation of self in connection with another. Healing is the release of these identifications. This is finally a way of letting go, of liberating oneself.” (Mucci, 2019).

However, little is known about service users’ perception of the recovery approach within mental health services. A study (Peterson, 2014) aimed to explore the service user’s perspective on recovery, the experienced facilitators and barriers associated with recovery

and the contribution of recovery-oriented mental health services. The service users described how several interacting factors facilitate the process of recovery. Learning, in the service users' perspective, was reported as being a pivotal factor in attaining recovery as it involves practical and social skills and being able to make changes in one's life and learn how to recover (Patterson, 2014). Another reported factor was social relations. Patterson (2014) reports that the service users in the study were dependent on receiving help and support from family and friends, staff, and peers. Being close to other people was seen as having a positive impact on recovery and as preventing psychotic episodes: one of the service users reported ''I know that I am not alone, and this is enough for me to prevent being psychotic''.

Willpower was also reported as a factor for recovery and healing from the service users within this study (Patterson, 2014). They viewed their own willpower to be of importance in attaining recovery and to be able to live independently, and to make a deliberate choice to work on themselves and decide to make changes in their lives. Patterson reports that the process of recovery was also characterised as involving periods of doubt and uncertainty, struggles, and periods with less faith and hope (2014). Many hoped to get life back to how it was before the mental illness occurred and the process of recovery in the service user's perspectives was dependent on mobilising the necessary willpower and overcoming periods with less hope.

4.1.3. Summary

Chapter 4 has introduced 'Healing' for exploration and to acknowledge this part of the study content. Understanding what healing and recovery means, and the exploration of contributing factors necessary for healing and recovery to occur, has partly informed the design and development of a series of questions for an international survey as part of this study. Furthermore, the design and development of a treatment manual or set of principles.

The next chapter will report further the design of this study.

CHAPTER 5 CHAPTER FIVE – DESIGN

5.1.1. Introduction

This chapter will describe the design and stages of this study with a diagram. Each stage will then be summarised.

5.1.2. Diagram

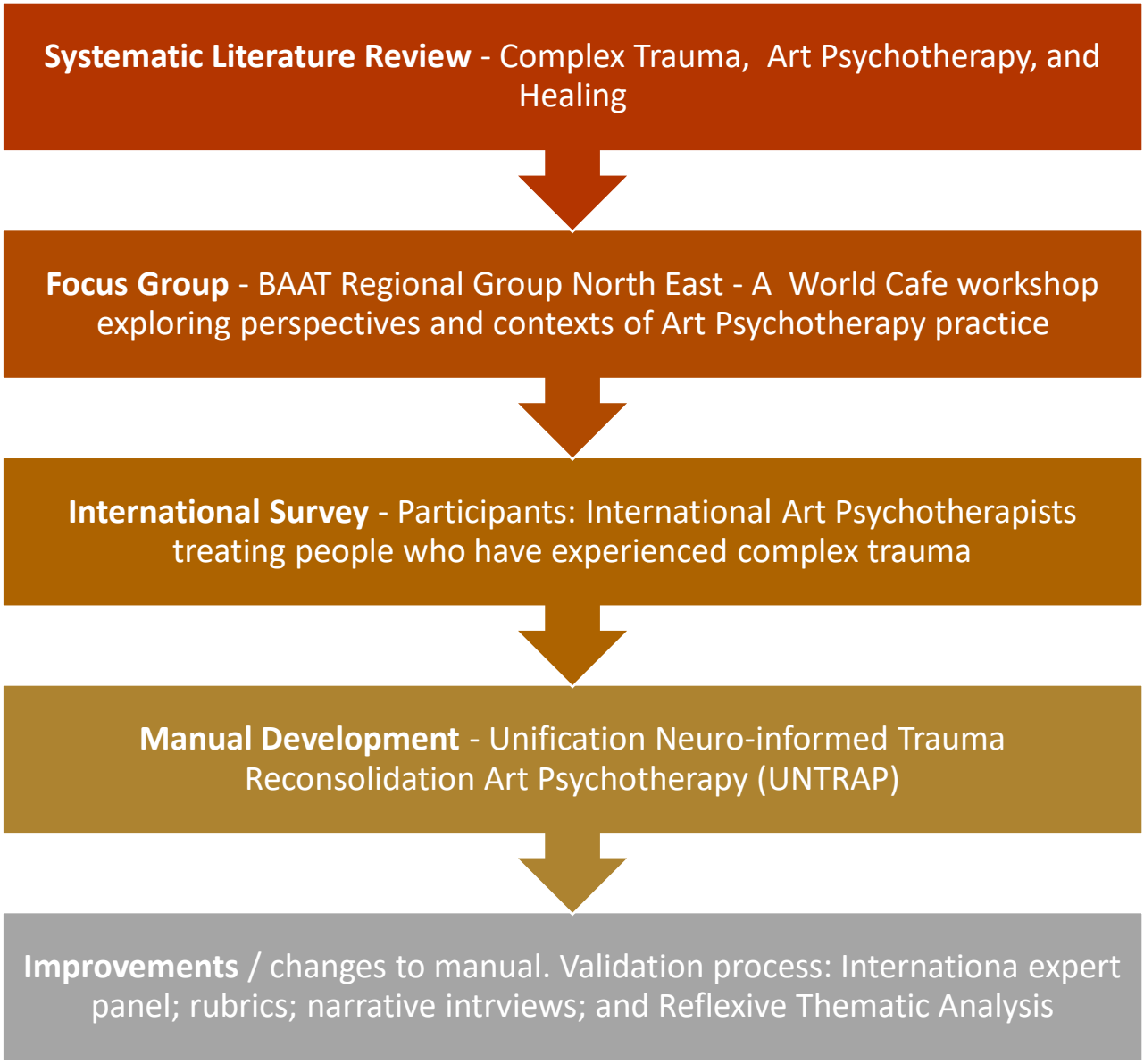


Figure 7 - Design diagram of study

5.1.3. Systematic literature review

A systematic literature review explored current evidence and theory of complex trauma; Art Psychotherapy; and recovery. The sources of theory and evidence were gathered from electronic databases: ASSIA (ProQuest Platform, Google Scholar; Pub Med); Web of Science (Social Sciences Citation Index (SSCI); Arts and Humanities Citation Index (AHCI); Emerging Sources Citation Index (ESCI)); APA PsycNet; tandfonline; and Science

Direct. Searches included a combination of words: (Art Therapy OR Art Psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults).

All English peer-reviewed papers exploring the effectiveness of Art Psychotherapy/Art Therapy in the treatment of adults (aged 18 and above) with complex psychological trauma or CPTSD were included. The main searches were completed by the first author in July 2022. 50% of the searches were sifted by the second searcher, referring to the inclusion and exclusion criteria, and contributing to the Risk of Bias - Assessment of Methodological Quality in August 2022.

The purpose of this systematic review was to evaluate the literature within the last five years that reports the extent to which one therapeutic intervention – Art Psychotherapy – can influence the symptoms of complex psychological trauma and aid recovery. Whilst there is a reasonable evidence base for the uses and effectiveness of Art Psychotherapy in general (Jayne, 2021) there has been little causal analysis of which components of Art Psychotherapy can prove effective (Jayne, 2021), specifically when working with adults who have experienced complex trauma.

5.1.4. Focus group

The process of a focus group, using World Cafe (Löhr, 2020), invited BAAT regional group members to engage and provide opinions and perspectives relating to contexts of Art Psychotherapy practice. A variety of categories were suggested for participants to consider such as psychoanalytical / psychodynamic; neurological; biological; and philosophical. Discussions generated organic conversation and reflection in relation to the categories, and participants were asked to choose which they felt was the most appealing to them as practicing Art Psychotherapists. Each focus group member was asked to record their thoughts and discussion points and then share within the whole group to finish. The findings from the focus group were partly informed by the development of the international survey.

5.1.5. International survey

In order to capture the perspectives of international Art Psychotherapists working with people who have experienced complex trauma, a survey was developed and designed. Qualified practicing international Art Psychotherapists were invited to engage in a survey, using Online Surveys (formally BOS). International Art Psychotherapy associations were approached to generate interest. Direct contact and word of mouth was also used to invite respondents.

Respondents were asked a series of questions within the structure of four categories: participant information; environment; clinical practice and orientation; and additional information. The questionnaire combined open-ended questions and multiple-choice questions with predefined answers offering respondents the possibility to choose and rank among several options or the possibility to grade on a ‘significantly detrimental impact’ to ‘significant positive impact’ scale. The ending category for additional information offered an optional space to elaborate on the answers.

The findings were analysed using cluster analysis (SPSS) and informed the development of a treatment manual/set of principles.

5.1.6. Manual development

The findings from the systematic literature review, focus group, international survey, and clinical experience informed the development of a therapeutic treatment manual or set of principles. The intended users of the manual are Art Psychotherapists, researchers and for the treatment of people who have compromised lives and mental health as a consequence of experiencing complex trauma. The manual name is Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP).

5.1.7. Improvements

After several stages of refinement with supervision approval, the manual underwent a first stage initial validation via an international expert panel process. For the first stage of validation, the experts were asked to read the manual and use rubrics scoring to respond, then add optional additional comments for improvement. Stage two consisted of an online expert panel meeting that was recorded and later transcribed. The meeting enabled opportunity for experts to liaise with each other to share thoughts and opinions about the manual. Experts were then invited to make further edits or changes to the manual if they wished. The amended manual was shared with all experts for the third stage, and each was asked to complete the rubrics questionnaire again and add additional comments if they chose. All data was then compiled and documented for Reflexive Thematic Analysis.

The initial validation process of UNTRAP manual provided several opportunities to gain valuable feedback and suggestions on how to improve the manual. Furthermore, Reflexive Thematic Analysis provided clarity on areas of suggestion and information provided by the experts. Themes were generated through familiarisation of this data. Further generation and definition of the themes were identified, which then provided

extended clarification on how best to amend the manual. The amended version of UNTRAP Manual is added to this thesis as an appendix for reference.

5.1.8. Summary

Chapter five has presented the design of this study in the form of a diagram, then each stage of the design has been summarised.

CHAPTER 6 CHAPTER SIX - FOCUS GROUP

6.1.1. Introduction

This chapter will summarise the use of a focus group and explain the meaning of a World Café approach and the benefits for the study design. The workshop attendee information will be provided, including the number of years each participant had practiced as an Art Psychotherapist at the point of engagement, and the structure of the workshop will be explained. The findings will be reported from each trauma context group and include images of the written reflections from each group, followed by a discussion of the findings.

6.1.2. A focus group

Focus group research involves organised discussion with a selected group of individuals to gain information about their views and experiences of a topic. Focus groups have a long history in market research (Morgan 1988); key data output = interaction between participants.

Focus groups have been variously described as:

Organised discussions (Kitzinger 1994)

Collective activities (Powell et al 1996)

Social events (Goss & Leinbach 1996)

Focus groups are:

‘a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research.’

(Powell et al. 1996: 499).

Focus groups are a form of group interviewing but it is important to distinguish between the two.

Group interviewing involves interviewing a number of people at the same time; emphasises questions and responses between the researcher and participants. Focus groups however rely on interaction within the group based on topics that are supplied by the researcher. (Morgan 1993: 12).

6.1.3. Why use a focus group?

The main purpose is to draw upon respondents’ collective attitudes, feelings, beliefs, experiences, and reactions. This is especially useful in relation to attitudes, feelings and beliefs that would be facilitated via the social gathering and the interaction which being in a focus group entails. Morgan & Kreuger (1993) report several reasons for the use of focus

groups. A multiplicity of views were explored and mediated via group processes. Focus groups encourage participants to take the initiative. Potentially, a large amount of information may be gained in a short period of time. This might be particularly useful when there are power differences between the participants and decision-makers or professionals. They are useful for exploring the degree of consensus or conflict on a given topic. Focus groups can be used at the preliminary or exploratory stages of a study. Focus groups can be used for the preliminary development of a particular programme of activities / actions (Race et al 1994). Furthermore, they can be used for purposes of triangulation, and used to explore or generate questions or concepts for questionnaires and interview guides, (Morgan & Kreuger 1993).

6.1.4. Focus group - BAAT regional members

Using a focus group approach to stimulate and generate information from the Art Psychotherapy population to inform this study felt like the most user friendly and organic process. Focus groups have advantages for researchers in the field of health and medicine (Kitzinger, 1995) as they do not discriminate against people. They can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say. Kitzinger (1995) reports that although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, they can explicitly use group interaction as part of the method. Instead of asking each person within the group to respond to a question in turn, people are encouraged to engage with one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view (1995). This is relevant in that it allows information to emerge that is generated within the group and avoids assumptions. The workshop was held at The Shipley Gallery in Gateshead as part of the regional BAAT meeting. The workshop was delivered with the focus being on contexts of trauma in relation to Art Psychotherapy practice.

6.1.5. World Café

World Café is a participatory assessment tool widely used in community development and organisational change processes, as an additional qualitative research method (Löhr, 2020). Lohr (2020) reports that, as a research method, World Cafe complements other methods in important ways. For example, when there are many participants, it can help to guide the exploration and verification of themes. Furthermore, integrating the method into the research design can help to increase both the reference sample and the level of participation (Lohr, 2020). Lohr further adds that on a participatory method, it not only

produces data for the researchers but also has the potential to benefit the participants, as it facilitates dialogue and mutual learning, thus motivating their participation and responses (Lohr, 2020).

6.1.6. Workshop attendee information

Figure 8 shows the workshop attendee information. A total of 12 people participated in the workshop, ten males and 2 females. Two of the female participants were the region coordinators. The following table shows the number of years the participants have been qualified as Art Psychotherapists.

Years qualified as an Art Psychotherapist	**Participants**
Art Psychotherapist trainee	1
0-5 years	3
6-10 years	2
11 – 15 years	0
15 + years	6

Figure 8 - Workshop attendees, years qualified as an Art Psychotherapist

out of 12 of the participants work with adults, and 3 of the total participants specialised in working with trauma although it was not in their job title, or for a specialist trauma team. All participants said they recognise that their clients have experienced trauma and that they support the healing of the trauma, but that their roles were to treat the more immediate presenting issues and that they had limited time to provide the treatment.

6.1.7. Workshop

The workshop consisted of the following schedule:

- Introduction - workshop structure, content, and participation.
- What is my research about? An exploration of Art Psychotherapy elements and components, and how these contribute to the healing for adults who have experienced relational or complex trauma.
- What is healing? Healing by Joanie V Connors (2010)**:**

  ‘Healing is a natural process by which bodies, minds, and other organic systems repair the wear and tear of life's stresses, accidents, and abuse. Whenever we are hurt or damaged, the healing process begins a cycle of restorative phases which unfold – as long as conditions support recovery. The phases in this process lead us through the cleansing, resting, rebuilding, and reusing periods that our body, mind,

and spirit need to overcome what has happened and resume our lives'. Conners, pg. 2, 2010)

- An overview of different contexts of psychological trauma:

- Psychoanalytical - psychological theory and therapy that investigates the interaction of conscious and unconscious elements in the psyche and brings repressed fears and conflicts into the consciousness. APA describes psychoanalysis as,

  'an approach incorporating aspects of several theoretical perspectives, such as object relations theory and interpersonal theory. It focuses on an individual's sense of self and patterns of relating to others as developed in early relationships and in treatment it emphasizes the importance of the relationship between a patient and analyst or therapist in helping the patient understand those patterns and form new ones' (APA, pg. 1, 2021).

- Neurological - Grawe (2007) states that neurology can inform psychotherapy approaches. He describes it is being an integrative approach to therapy that takes into account the dynamic interplay between the mind, body, social interaction, and the environment on a person's well-being with a focus on neuroscientific research. By understanding the mechanisms of our neurology, the processes of our psychology, and the influences of social interaction, he believes a holistic therapeutic practice can be formulated.
- Biological - life and living organisms, including their physical structure, chemical processes, molecular interactions, physiological mechanisms, development, and evolution. McLeod (2017) states that biological psychotherapy focuses on the nervous system, hormones and genetics, focusing on the relationship between mind and body, neural mechanisms, and the influence of heredity on behaviour.
- Philosophical – a detached approach to problems from a societal, world, universe, or spiritual perspective.

- Task one - Each trauma context was named on a piece of card. The participants were asked to stand by the trauma context that they felt most drawn to when thinking about trauma and healing. When in position, the groups were asked the following questions and to write their responses on the paper provided.

- What does it feel like to be standing in this trauma context?
- Why did you choose this trauma context?
- What is evoked when thinking about this trauma context in relation to the way you practice as an Art Psychotherapist?

- Task two - Each trauma context group were asked to engage in a 'World Café' exercise to collaboratively make notes on their reflections of what they think heals

trauma from their professional and personal perspectives. World Café is a structured conversational process for knowledge sharing in which groups of people discuss a topic at several small tables like those in a café (Elliot, 2005). Some degree of formality was retained to make sure that everyone got a chance to speak. Although pre-defined questions have been agreed upon at the beginning, outcomes or solutions are not decided in advance (Bache, 2008).

- Task three - Discussion and sharing of trauma context reflections.
- End

6.1.8. Findings

Figure 9 shows the amount of people who chose the named trauma contexts.

Trauma context	Number of attendees who chose the context
Psychoanalytical	4
Neurological	2
Biological	1
Philosophical	5

Figure 9 – Number of attendees for each chosen context

The person who chose the biological trauma context joined the psychoanalytical group towards the end of the exercise.

6.1.9. Neurological trauma context

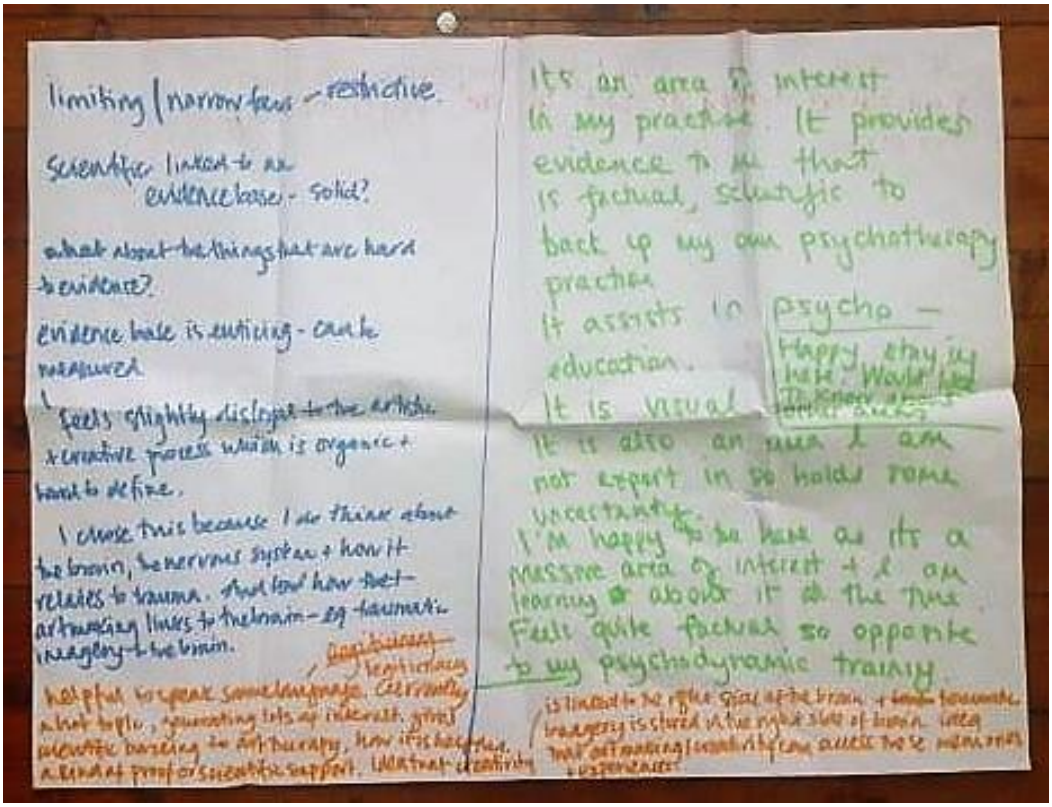


Figure 10 - Front, neurological trauma context.

Comments made:

“Limiting, narrow focus and restrictive to choose one context. It is scientific, linked to an evidence base. What about the things that are hard to evidence? Evidence base is enticing as it can be measured. It feels slightly disloyal to the artistic and creative process which is organic and hard to define. I chose this because I do think about the brain, the nervous system and how it relates to trauma. And how art making links to the brain – e.g. traumatic imagery and the brain”.

This participant suggests the importance of an evidence-based approach within Art Psychotherapy practice. However, they include consideration of the components that may not be measurable. This was an overall perspective within the workshop. Some Art Psychotherapists expressed some fear of losing something ‘organic and hard to define’.

“This is an area of interest in my practice. It provides evidence to me that is factual, scientific to back up my own psychotherapy practice. It assists in psyche – education. It is visual. It is also an area I am not expert in so holds some uncertainty. I’m happy to be here as it’s a massive area of interest and I am learning about it all of the time. Feels quite factual so opposite to my psychodynamic training. I am happy to stay here (in this context). I would like to know more about the others”.

Here the participant acknowledges how their training focused on psychodynamic components and this potentially raises questions regarding the development of training

programs and if they need to be more inclusive of ‘factual’ and ‘scientific’ components and considerations within the practice.

“Neurology – helpful to speak the same language, legitimacy. Currently a hot topic generating lots of interest. It gives scientific backing to Art Therapy. How it is helpful, a kind of proof or scientific support. Idea that creativity is linked to the right side of the brain and traumatic imagery is stored in the right side of the brain. Idea that art making / creativity can access these memories and experiences. We feel it is an essential component to have neurological training as part of art psychotherapy training”.

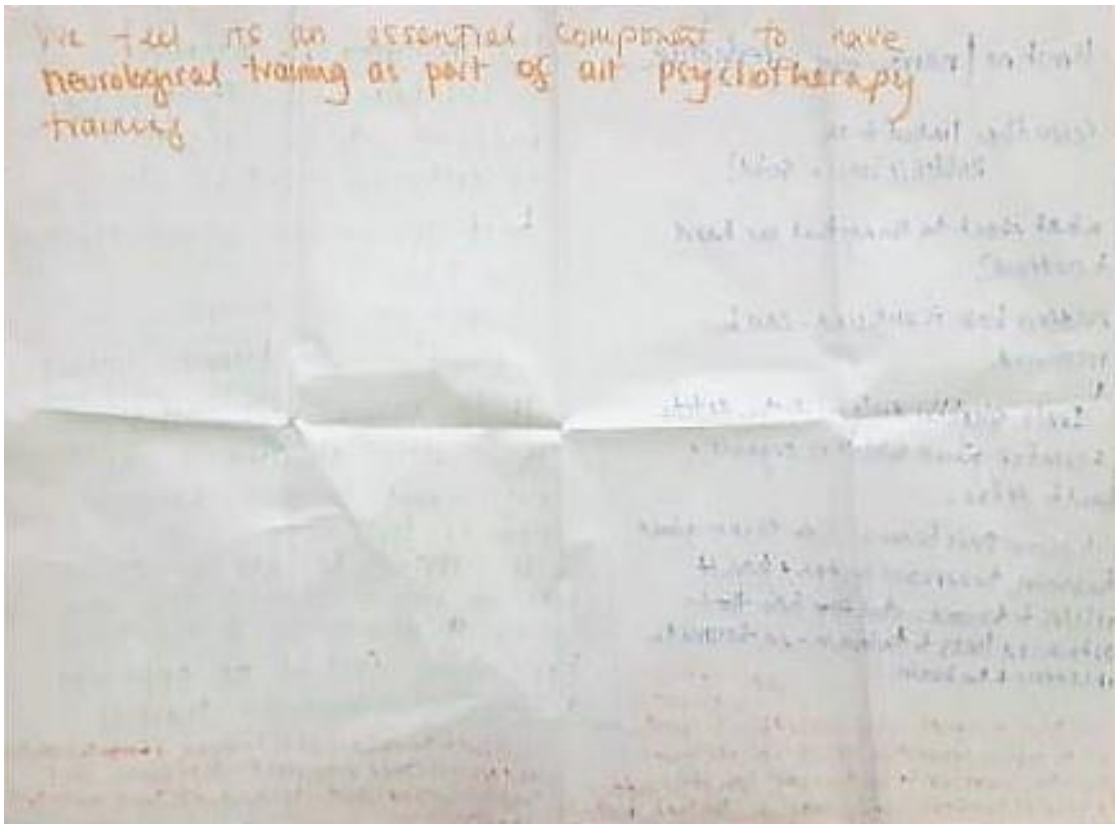


Figure 11 – Back, Neurological trauma context.

The neurological group unanimously reported an identified need for training to incorporate ‘neurological training as part of Art Psychotherapy training’ as it gives ‘scientific backing’ to the practice and enables additional ‘legitimacy’.

6.1.10. Philosophical trauma context

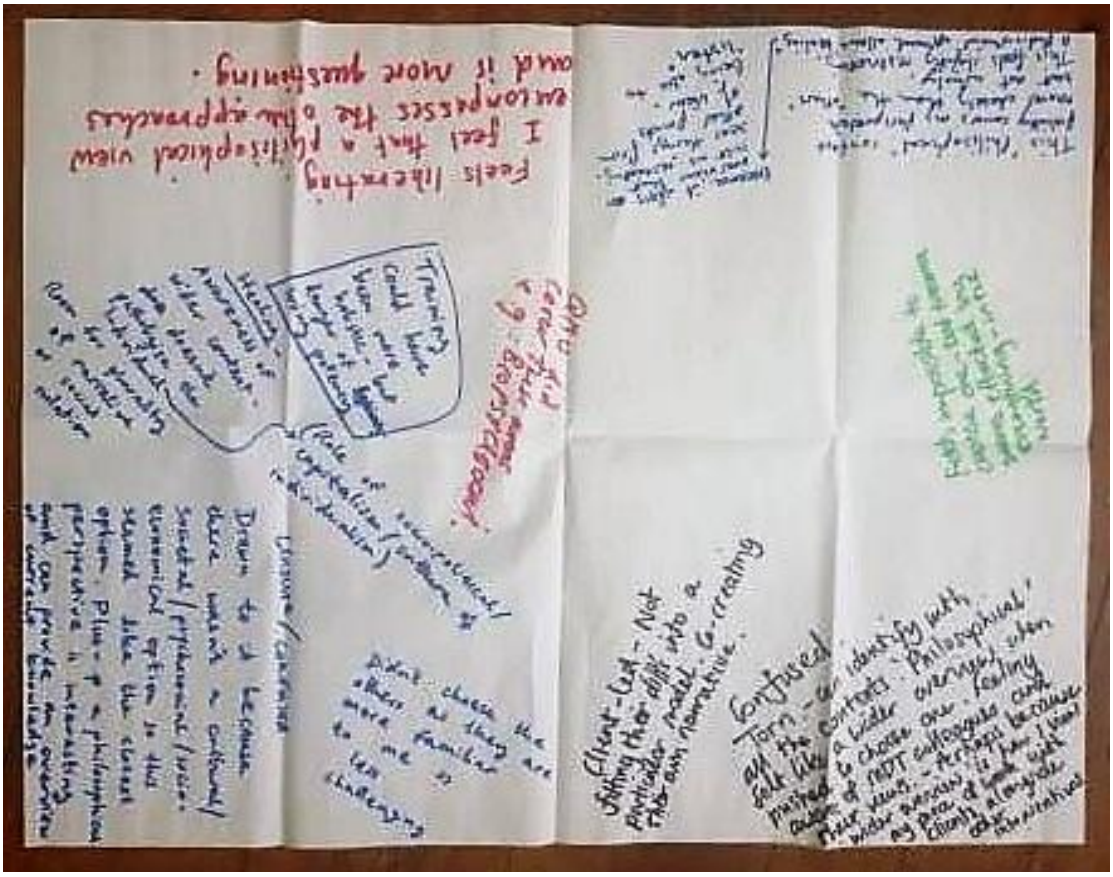


Figure 12 – Philosophical trauma context.

Comments made:

“I felt confused and unsure, drawn to Philosophical because there wasn’t a cultural / societal / psychological / socioeconomical option, so this seemed like the closest option. A Philosophical perspective is interesting and can provide an overview of current knowledge. I didn’t choose the others as they are more familiar to me and less challenging”.

This group member highlighted that a ‘cultural / societal / psychological / socioeconomical option’ would have captured additional insight and reflection. Furthermore, this member adds that ‘healing is awareness of the wider context’. This participant is potentially highlighting the positive role of psychoeducation and how this can reduce experiences of difference and stigma associated with mental ill health.

“Healing is awareness of the wider context, it doesn’t pathologize the individual (role of socio-political / capitalism / culture of individualism). Room for plurality of narrative or social isolation.”

“Feels liberating, I feel a Philosophical view encompasses the other approaches and is more questioning”.

However, another participant expresses that a philosophical approach can encompass the other approaches. My understanding is that a philosophical awareness or approach can feature within all approaches or components of practice. This is further emphasised by another participant:

“This Philosophical context possibly covers my perspective more closely than the others, but not wholly. This feels slightly restricting. A philosophical approach allows healing because it offers an overview that isn’t as restricting and sees things from other points of view. Being able to listen”.

“It feels impossible to choose one context, but trauma seems effected by everything in the world”.

I wonder if this participant is suggesting the necessity of a trauma informed approach and identifying how trauma threads through most presenting issues of the patient.

“I feel confused. Torn. I can identify with all the contexts. Philosophical felt like a wider overview when pushed to choose one. Feeling aware of MDT colleagues and their views, perhaps because wider overview is how I view my piece of work with clients alongside other interventions”.

I wonder if participants within this group are noticing and expressing that all components can overlap and have an equally important role, that a philosophical approach combines a multitude of considerations and is particularly inclusive.

6.1.11. Biological trauma context

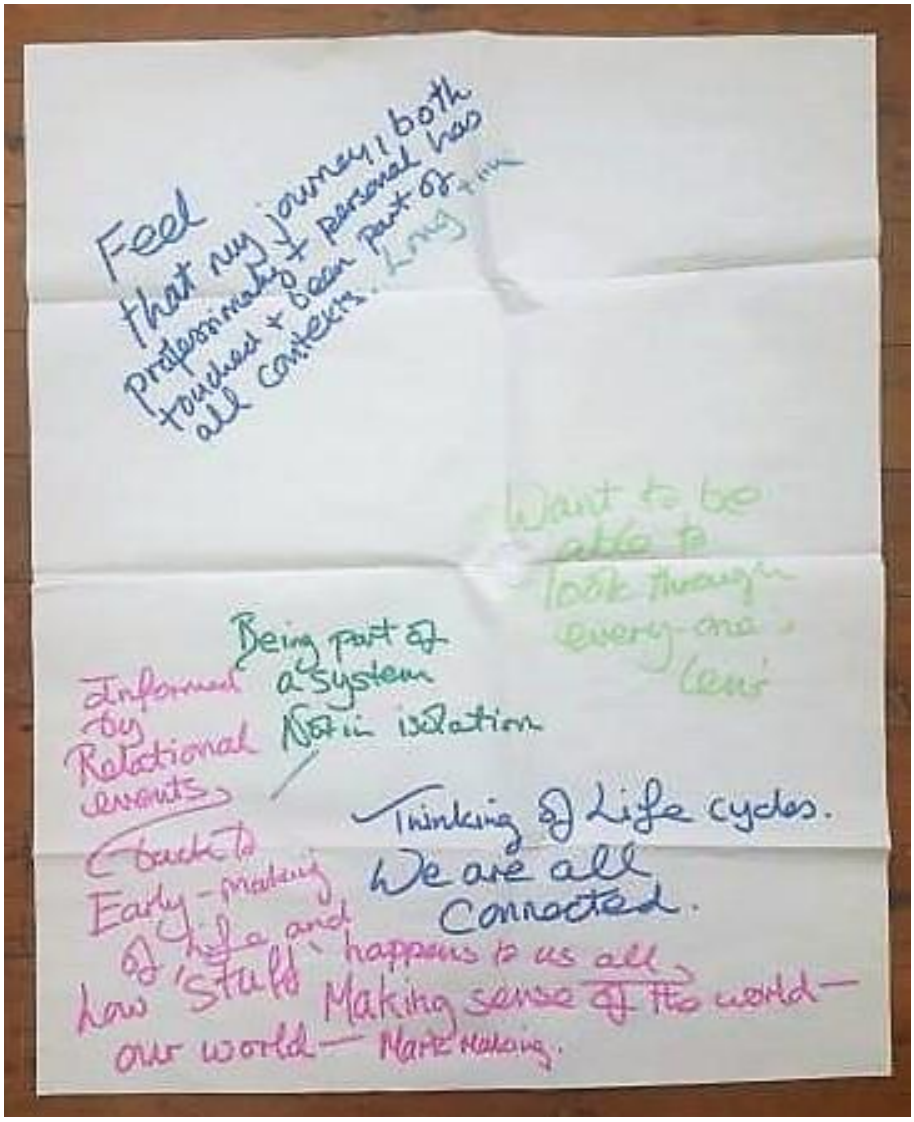


Figure 13 – Biological trauma context.

Comments made:

“I feel that my journey, both professionally and personally has touched and been part of all contexts for a long time. I want to be able to look through everyone’s lens. Informed by relational events back to early making of life and how stuff happens to us all, our world, mark making. Thinking of life cycles. We are all connected. Being part of a system, not in isolation”.

One participant chose the biological component. They reflected through an inclusive lens, referring to personal and client perspectives from a relation point, and how this can be manifested through mark making. This participant shares their view that a biological component of Art Psychotherapy practice can reduce isolation and form a sense of being together, ‘how life and how stuff happens to us all’.

6.1.12. Psychoanalytical trauma context

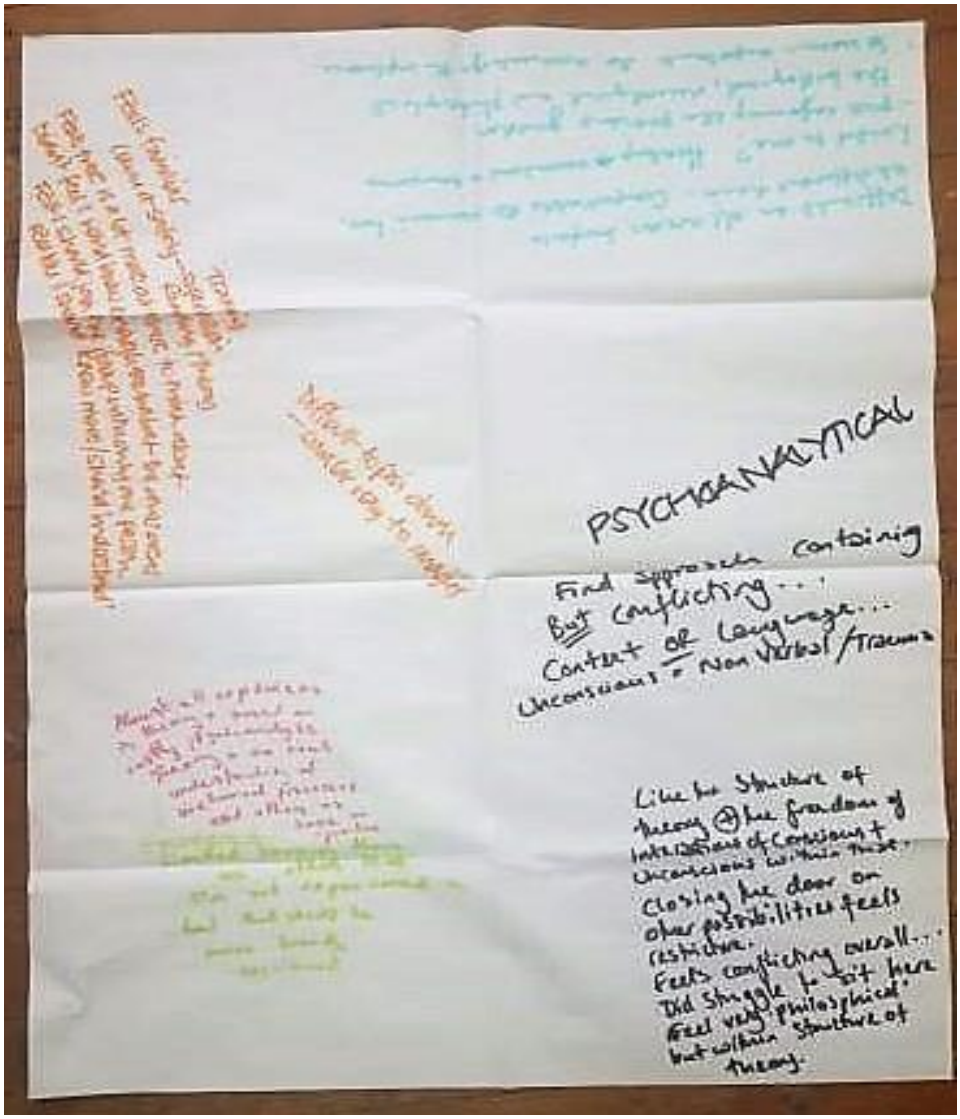


Figure 14 - Psychoanalytical trauma context.

Comments made:

“Almost all experience is theory and based on mostly psychoanalytical theory and no real understanding of biological processes and others as have no practice. Limited knowing there are others that I’m not experienced in, feel that should be more broadly experienced”.

This participant expresses some requirement in being ‘more broadly experienced’. Adding that ‘almost all experience is … based on analytical theory’. I wonder if this perspective refers to Art Psychotherapy training components and how Art Psychotherapy was described as being ‘the richness of artistic symbol and metaphor illuminates the process’ (Standing Committee for Arts Therapies Professions, 1989).

“Difficult to pin down, similar way to images. Feels familiar, a sense of safety, training, supervision, reading and theory. Feels there is a lot more out there to think about”.

This participant acknowledges an established and familiar part of training that incorporates psychoanalytical psychodynamic perspectives, but that ‘there is a lot more out there to think about’. The following comment further highlights a potential gap or requirement for additional perspectives of Art Psychotherapy training.

“I didn’t feel I would know enough about the other areas. I felt I should join the group with only one person (biological). Felt like I should know more, should understand”.

“Difficult on all areas, surface at a different time. I am comfortable to remain here. Limited to one?”

I wonder if this comment suggests there may be a comfort of familiarity and established culture within Art Psychotherapy training and practice, however, with a question of there being a ‘limit to one’.

“Healing – assimilated, framing, past informing the present guides, the biological, neurological, and philosophical so sees important to acknowledging the influence”.

This comment from another participant attempts to include and validate all Art Psychotherapy practice components in the frame of healing.

6.1.13. Discussion

The group joined to share and discuss their comments and reflections on their chosen trauma contexts, and how these inform their current Art Psychotherapy practices. Reflections were also made on the workshop exercise.

A general sense among the participants was a feeling of disloyalty towards the psychoanalytical psychodynamic trauma context, and a desire to branch out to other contexts from the psychoanalytical group. A need for evidence to support and qualify Art Psychotherapy practice was highlighted, expressed, and given as a part of the reason for choosing other contexts. It was agreed that the use of art making enables healing generally as it supports expression and healing of psychological material through externalising and re-internalising the material. A general need to protect the creative process of image making was expressed in the group with a requirement to avoid reducing the freedom and organic process that threads through all contexts. Some participants

reported appreciation of being presented with alternative contextual approaches for reflection and learning.

6.1.14. Summary

This chapter described the method, a focus group using World Café, and how it suited the design and process for this study. The schedule of the workshop was described, as were some details of the participants. The results of each trauma context group were reported with images to highlight the reflections within each group. The findings were then discussed.

CHAPTER 7 - INTERNATIONAL SURVEY

7.1.1. Introduction

Chapter 7 will report the process of this international survey. A scientific realism methodology – online surveys will be explained, then the survey data collection and analysis. Qualitative data analysis and hierarchical cluster analysis will then be discussed. The aim of the survey will be explained, being to expand understanding of what causes positive impact from the perspectives of international Art Psychotherapists when treating people who have experienced complex trauma. This chapter will then report the method used and a description of the questionnaire will be provided.

Following this, the results from the international survey will be reported, covering the respondent information; environment; and Art Psychotherapy practice components. The data from cluster analysis will be stated showing a dendrogram that used Ward linkage. The two cluster memberships will be reported within a chart, followed by independent samples of Mann-Whitney U-test results covering: the length of practice for each cluster group; the time and duration of session; environmental importance including the décor of the therapy space; and the preferences for therapeutic impact for each cluster including the adaptation of other interventions combined with Art Psychotherapy practice, including the impact of art mediums used. Information provided by the survey respondents within the 'additional information' section will be reported.

7.1.2. The international survey

Marsh (1982: 6), defined surveys in terms of the following characteristics:

a. Systematic measurements are made over a series of cases yielding a rectangle of data. A survey can be defined as any instrument capable of yielding a (at least 2 X 2) case by variable matrix.

b. The variables in the matrix are analysed to see if they show any pattern.

c. The subject matter is social.

Various comments can be made on this definition. The 'case' is the unit of analysis which is usually not always a respondent. Other units of analysis tend to be neglected in health research, e.g., episodes, wards, hospitals. Marsh's definition implies that surveys involve the collection of quantitative data which is, at least nomothetic (e.g. implies that respondents derive the same meaning from questions and respond accordingly). However,

the extent to which surveys will often include qualitative elements should not be neglected e.g. space on questionnaires inviting respondents to amplify their answers.

Adults who have complex psychological trauma can experience mental ill health that invariably results in significant restrictive impact upon their lives. The purpose of this international survey was to evaluate how Art Psychotherapy can influence recovery and healing for this client group. International Art Psychotherapists treating adults with complex psychological trauma were invited to answer four categories of questions: participant information; environment; practical/clinical component; and additional information. Whilst there is a reasonable evidence base for the uses and effectiveness of Art Psychotherapy in general, there has been little causal analysis of which mechanisms and contexts of Art Psychotherapy can prove effective (Jayne, 2021). The survey data identifies significant positive therapeutic impact directly associated with Art Psychotherapy mechanisms and contexts such as art medium, environment, and clinically informed approaches. The survey confirms the notion that Art Psychotherapy is associated with successful outcomes within a wider therapeutic intervention. Furthermore, it identifies specific areas of positive impact.

7.1.3. Online surveys, a scientific realism methodology

A survey of 750 University Human Research Ethics Boards (HRECs) in the United States revealed that internet research protocols involving online, or web surveys are the type most often reviewed (94% of respondents), indicating the growing prevalence of this methodology for academic research (Buchanan & Ess, 2008). Online surveys which include such products as Zoomerang ©, Survey Monkey ©, and Questionpro ©, have emerged over the last few years as highly convenient research tools. Survey research is a widely used methodology across the social sciences; it enables researchers to collect data on an array of issues surrounding the behaviour, thoughts, and feelings of people or groups. The purposes of survey research include describing a population, identifying characteristics of a group, describing attributes and characteristics of research interest, explaining a phenomenon, or explaining how variables are related. Survey data can be either quantitative in nature with numeric outcomes, or qualitative with detailed narrative outcomes (Buchanan, 2009). This enables data analysis for questions that have a scoring number scale, additional information or elaboration on answers, and information about the respondents.

This study used an online survey method inviting international Art Psychotherapists to participate in answering a range of questions covering 4 themes: participant information;

environment; clinical practice; and additional information. The online survey was open for a month then the data was analysed using SPSS software to identify clusters from the data set. Online Surveys software (formerly known as Bristol Online Surveys, or BOS) was used to collect data for phase one of this research.

7.1.4. Qualitative data analysis – hierarchical cluster analysis

Hierarchical cluster analysis was used to determine statistically significant differences (Bock, 2004). Cluster analysis is the partitioning of similar objects into meaningful classes, when both the number of classes and their composition are to be determined, (Kaufman and Rouusseeuw 1990). Hierarchical clustering, also known as hierarchical cluster analysis, is an algorithm that groups similar objects into groups called clusters. The endpoint is a set of clusters, where each cluster is distinct from each other cluster, and the objects within each cluster are broadly similar to each other (Bock, 2004).

Statistical Package for the Social Sciences (SPSS Version 26, IBM Inc.; Armonk, NY, USA) was the statistical package used for data analysis. SPSS is popular within both academic and business circles, making it the most widely used package of its type. SPSS is also a versatile package that allows many different types of analyses, data transformations, and forms of output (Arkkelin, 2014).

After initial descriptive analysis of variables, Kruskal-Wallis tests were used to determine statistically significant differences ($p < 0.05$) in response to the survey questions between key grouping variables, e.g. geographical location of practice, length of professional practice, sector of practice, and gender of the respondent (Jayne, 2021). The Kruskal–Wallis test is a statistical method for ascertaining the significance of differences between the median values for K+ sub-groups from within the same sample: sometimes referred to as ‘ANOVA by Ranks’, this is the test of choice when analysing ordinal data such as that generated by a survey instrument (Jayne, 2021) (Macfarland, 2016). Cases (individual participants) are clustered based upon chosen characteristics - in this instance, similarity in the way they scored responses in the main domains of the survey instrument – and not any of the grouping variables outlined above. Cases in each specific cluster share many characteristics and are dissimilar to those not belonging to that cluster.

Yim and Ramdeen (2017) identified that,

‘Cluster analysis refers to a class of data reduction methods used for sorting cases, observations, or variables of a given dataset into homogeneous groups that differ from each other.’ (Yim and Ramdeen, pg 8, 2017)

A cluster solution proved most economical and was ascertained using Ward’s method and Mann – Whitney U Test as a means to determine cluster membership. This process minimises variance within each cluster. In this current study, the analysis procedures identified clusters based upon similarity in response to the survey statements. Arranging response patterns together and classifying these as belonging to different broader groups provides a means of applying some organisation to individual survey responses, which at first sight might appear highly individualised or even chaotic. The technique of cluster analysis originated in biology and ecology (Sokal, 1963).

7.1.5. Aims

There is a lot of research and evidence that reports positive impact following Art Psychotherapy treatment for people who have PTSD. The literature briefly identifies a reduction in trauma symptoms such as depression and anxiety and improved emotional well-being as well as increased confidence in expression of trauma experiences. NICE guidelines also recommend Art Psychotherapy to treat children and adults who have schizophrenia or psychosis. However, there is little evidence of what specific contexts and mechanisms of Art Psychotherapy treatment cause certain impacts. The justification of this survey is based on the aim to increase the evidence base to extend understanding of what causes the positive impact from the perspectives of international Art Psychotherapists currently treating this client group.

7.1.6. Method

International Art Psychotherapists who specialise in working with adults who have experienced complex trauma, were invited to engage in an online survey in attempt to identify a consensus of what components of Art Psychotherapy treatment are most impactful for healing and recovery. The questions covered a range of considerations including context and mechanisms of practice. The Art Psychotherapists anonymously answered the questionnaire and were invited to elaborate on their answers in the additional information section.

Online Surveys (2022) was used to create and implement the survey. The online survey tool was originally designed for Academic Research, Education and Public Sector organisations within the United Kingdom and is compliant with General Data Protection

Regulations (GDPR). The GDPR is a regulation in European Union law on data protection and privacy in the European Union (EU), and the European Economic Area (EEA). It also addresses the transfer of personal data outside the EU and EEA areas. The GDPR aims primarily to give control to individuals over their personal data and to simplify the regulatory environment for international business by unifying the regulation.

This study employed an international survey process, a research method used for collecting data from a pre-defined group of respondents. The focus of the survey was to gain information and insights from International Art Psychotherapists concerning four categories of questions around the intervention Art Psychotherapy when used to treat adults who have experienced complex trauma. The design and structure of the questionnaire was informed by current literature and the identification of gaps within the research, clinical experience and expertise, and to expand further on current findings.

Potential respondents were invited to complete the survey via ebulletins with Art Psychotherapy Associations around the world. The following associations were approached.

- Art- Nederlandse Vereniging Beeldende Therapie (NVBT)
- Australian Creative Arts Therapies Association (ACATA)
- Global Alliance for the Arts and Health
- International Expressive Arts Therapy Association (IEATA)
- International Association for Art, Creativity and Therapy (IAACT)
- International Society for the Psychopathology of Expression & Art Therapy (SIPE)
- American Art Therapy Association (AATA)
- Association of Art Therapists of Québec (AATQ)
- The Canadian Art Therapy Association (CATA)
- Ontario Art Therapy Association (OATA)
- British Columbia Art Therapy Association (BCAT)
- Australian and New Zealand National Art Therapy Association (ANZATA)
- Brazilian Union of Art Therapy Associations (UBAAT)
- Chilean Art Therapy Association
- British Association of Art Therapists (BAAT)
- Art Therapy Italiana Association
- Northern Ireland Group for Art as Therapy (NIGAT)

- Germany Association of Art Therapy
- The Swedish National Association for Art Therapists (SBRT)
- The Israeli Association of Creative and Expressive Therapies (ICET)
- The Hong Kong Association of Art Therapists (HKAAT)
- Korean Academy of Clinical Art Therapy (KACAT)
- The African Consortium of Art Therapy (ACAT)

The British Association of Art Therapists; The American Association of Art Therapists; and The Hong Kong Association of Art Therapists obliged.

Participation criteria was exclusive for qualified and practicing Art Psychotherapists who work with adults who have experienced complex trauma. The survey aimed to gather expert opinion from appropriate individuals with experience of the research topics in question. All questions were carefully constructed to associate with a variety of considerations relating to Art Psychotherapy practice. The four categories of questions within the survey were: participant information; environment; practice and clinical components; and additional information. The survey was live for one month from 25th October 2019 to 25th November 2019. All respondents were offered a data report on completion of analysis.

7.1.7. The questionnaire

The questionnaire had 21 questions and was designed to capture the impact of the main contexts and mechanisms of Art Psychotherapy practice. The questions were organised into four categories. The first asks about the participants gender; age; location; duration of practice as an Art Psychotherapist and work sector. The second focuses on the environment where the sessions take place including: accessibility; aesthetics and decoration of the therapy room and surrounding spaces; and comfort. The third asks about the practical and clinical mechanisms including: art materials; the number, duration, and time of the sessions; theoretical orientations; combined therapeutic approaches and exhibitions of art works. The questionnaire combined open-ended questions and multiple-choice questions with predefined answers offering respondents the possibility to choose and rank among several options or the possibility to grade on a “significantly detrimental impact” to “significant positive impact” scale. The ending category for additional information offered an optional space to elaborate on the answers. This open part contributes to improving the interpretation of its overall results and provides additional valuable material.

7.1.8. International survey - respondent information

There were 23 female and 4 male respondents. All survey respondents were anonymised, and personal identifiable questions were not asked. Figure 15 shows the geographical locations of the respondents.

Geographic location	Participants
North East England	3
North West England	1
South East England	2
South West England	5
UK	3
Scotland	5
Netherlands	2
Belgium	1
USA	4
Hong Kong	1

Figure 15 – The geographical locations of the respondents.

The geographical locations of the respondents were broken down into five locations: England; Scotland; Europe; USA; and the rest of the world, for data analysis.

Most respondents reported to be qualified for more than ten years, with only one respondent being qualified for under five years.

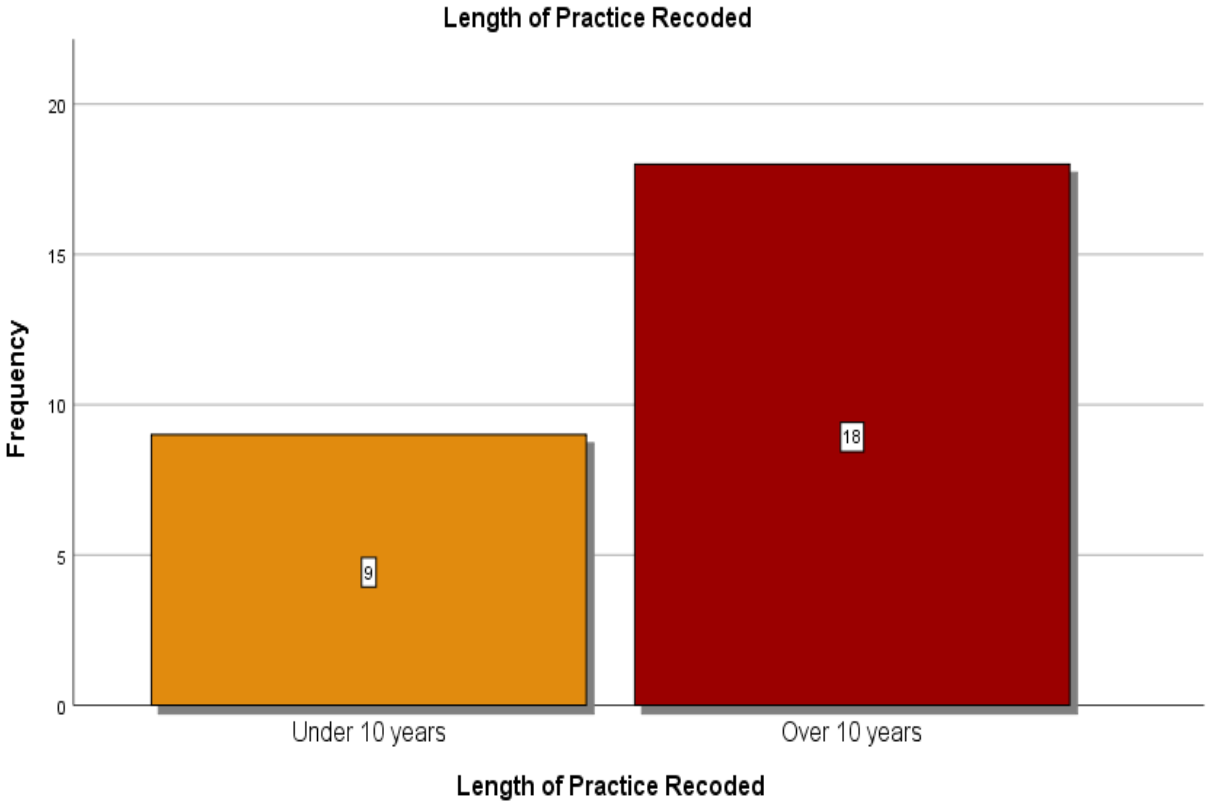


Figure 16 – Length of practice record of participants.

The respondent Art Psychotherapists worked in a variety of sectors, with some selecting more than one. For analysis purposes, the sectors were broken down into two categories: The National Health Service (NHS) or Voluntary/Private sector. For the full list, see figure 17.

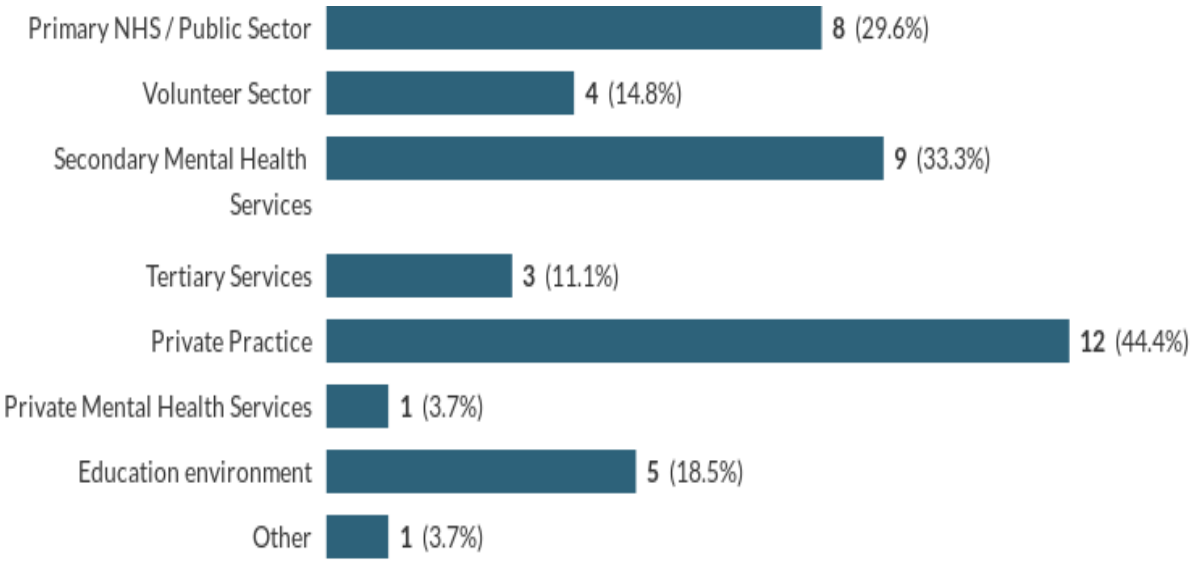


Figure 17 - Working sectors of participants

7.1.9. Environment

Participants were asked a range of questions relating to the environment where their patients or clients attend Art Psychotherapy treatment. This includes the décor of the building where sessions take place, and the architecture and location of their treatment. 81.4% of participants reported some or significant positive impact on treatment outcomes if the location of treatment is on a bus or train route. Furthermore, 77.8% of respondents reported some or significant detrimental impact on treatment outcomes if the location of treatment is in a rural or remote place. This strongly suggests that an easily accessible location and premises of treatment is an integral component for positive treatment outcomes. 88.9% reported some or significant positive impact on treatment outcome when the premises have easy access for people who have a physical disability. When asked how the architecture of a building can impact on therapeutic outcome, 64% reported some or significant positive impact. Data from this survey shows that the importance of the décor of the therapy room or surrounding spaces can have considerable impact on therapeutic outcome. 84% of respondents reported either some or significant positive impact.

79.2% of respondents reported some or significant positive impact when asked to consider sensory environmental factors. More research is needed to explore sensory environmental factors to decipher how a traumatised person might experience their environment, and how these considerations can support positive therapeutic outcomes.

7.1.10. Practice components

When considering the amount of time spent on a waiting list and how this can impact on the effectiveness of Art Psychotherapy treatment, the survey data reported a clear definition that without a waiting list, there would be no detrimental impact. In contrast to these findings, the opposite affect is clear for a waiting list of three months where 81.5% of respondents reported some or significant detrimental impact on therapeutic outcomes. The Health and Social Care Act (2012) put mental health on a par with physical health and the government reiterated this commitment through its current mental health strategy, No Health Without Mental Health. The current mandate to NHS England requires NHS England to achieve parity of esteem between mental and physical health. As a first step towards achieving this commitment, timely and appropriate access to psychological therapies was agreed to be available in the NHS to all who need them. However, a question arises here about the branding of Art Psychotherapy as it is unknown whether it is a talking therapy. The current recommended waiting time is 28 days (Mind, 2010). Mind released findings from their research; ‘We Need to Talk’ (2010) reporting that: one in ten

people have been waiting over a year to receive treatment; over half have been waiting over three months to receive treatment; and around 13 per cent of people are still waiting for their first assessment for psychological therapy. Their report states:

“Timely access to mental health services is a critical issue. Considerable harm can be caused by long waits for psychological therapies, which can exacerbate mental health problems and lead to a person experiencing a mental health crisis.”, (Mind, 2010).

Furthermore, British Medical Association research found 3700 patients waited more than six months for talking therapies in 2017 and 1500 for longer than a year, according to Freedom of Information requests. However, this data grossly underestimates the full scale of the problem as nine in ten clinical commissioning groups, (CCG’s), keep no records of waiting times (Cooper, 2018). The findings from this survey reiterate the detrimental impact of long waiting times for therapeutic treatment.

The survey data reported some slight preference for sessions being held in afternoons, weekends, or evenings for positive therapeutic outcomes, with mornings being the least desirable, although the definition was slight. Regarding the amount of Art Psychotherapy sessions allocated to clients or patients, the survey data reported a distinct shift in impact. For example, 48.1% of participants reported some or significant detrimental impact on therapeutic outcome for an allocation of 12 (limited) sessions, reducing to no detrimental impact when clients / patients were offered 12 – 46 Art Psychotherapy sessions. This being the highest percentage of reported positive impact of 92.6% participants. The number of allocated sessions also has an impact on attendance. The survey data reports an improvement in attendance as the allocated number of sessions increase, with the most affective being 12 – 46 sessions.

Figure 18 shows the reported therapeutic and attendance impacts in relation to the amount of allocated Art Psychotherapy sessions.

Number of sessions	Detrimental (some and significant) impact	Neither impact	Positive (some and significant) impact	Reduced/non-attendance	Improved attendance
Up to 6 sessions	29.8%	23.1%	46.1%	19.2%	19.2%
Up to 12 sessions (restricted)	48.1%	11.1%	40.7%	18.5%	7.4%
12 sessions (can extend)	14.8%	11.1%	74%	11%	40.7%
12 – 46 sessions	0%	7.4%	92.6%	7.4%	40.7
Unlimited sessions	18.5%	14.8%	66.7	18.5%	40.7%

Figure 18 - Therapeutic and attendance impact resulting from quantity of allocated Art Psychotherapy sessions

When participants were asked if they use outcome measures to measure therapeutic impact when working with people who have experiences complex psychological trauma, over half reported that they do not. See figure 19.

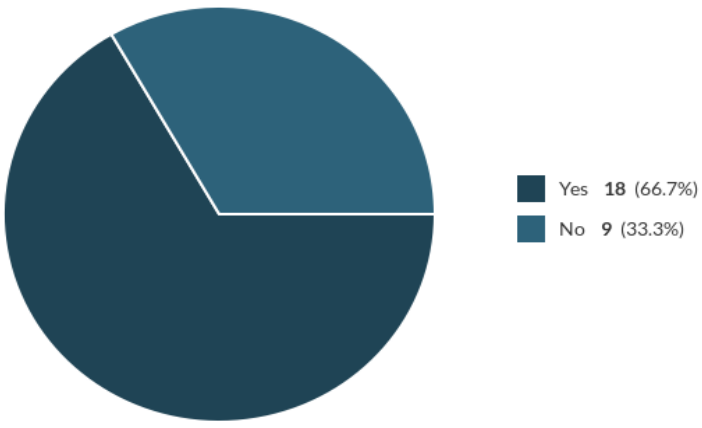


Figure 19 - Participants use of outcome measures when working with people who have experienced psychological trauma

A recent British Association of Art Therapists (BAAT) online survey - Art Therapy Practice with Complex Trauma, PTSD and Dissociation (2019), found that 56.61% of survey participants combined approaches with Art Psychotherapy practice. The survey data reports that the three mostly used combined interventions were: mindfulness; three stage approach; safety, and stabilisation; processing traumatic memories and consolidation; integration and reconnection; and Psychoanalytical Psychodynamic Informed Psychotherapy.

Survey participants were asked what the five most affective art mediums are when used to treat adults who have Psychological Complex Trauma. The three most affective art mediums were reported to be: painting with brushes; using clay or plasticine; and pastels (including oil) or charcoal. For a full list of art medium choices, see figure 20.

Art medium	Count	Percentage	Rank
Pencils	9	7.5%	6
Pens	7	5.8%	7.5
Oil pastels	12	10%	3.5
Pastels or charcoal	12	10%	3.5
Painting with brushes	15	12.5%	1
Painting with hands	6	5%	9
Using small paper	3	2.5%	15
Using large paper	5	4.2%	10.5
Using coloured paper	2	1.7%	16
Using white paper	5	4.2%	10.5
Clay or plasticine	13	10.8%	2
Sculpture making	4	3.3%	13
Creative writing	7	5.8%	7.5
Photography	1	0.8%	17.5
Collage	10	8.3%	5
Portraiture	1	0.8%	17.5
Digital	4	3.3%	13
Other	4	3.3%	13

Figure 20 - Multi answer: Percentage of selections across all answer options (adding up to 100% across all options). 5 most affective art mediums when used to treat adults who have Psychological Complex Trauma

These mediums offer an immediate and malleable component in their use. Making a mess is accessible and unavoidable with each. Painting, clay, pastels and charcoal can all be manipulated to the desired affect without the restriction of an immediate permanence. This offers potential for exposure of internalised psychological material with the available process of changing the image or mark, therefore offering the opportunity for control, expression and negotiation of this material.

The three least affective mediums reported are portraiture, photography and using coloured paper. These mediums are more prescribed, require accuracy and aim towards a fixed image. Coloured paper offers immediate sensory stimuli which may be avoided by adults who have psychological complex trauma, in avoidance of over sensory stimulation. Furthermore, a coloured sheet of paper reduces the potential of a desired colour outcome.

Participants were asked how additional creative tools impact on therapeutic outcomes. See figure 21. Some of these question parts were not answered by all participants. Joint image making and nondirective tasks were reported as having the most positive therapeutic impact when incorporated as part of Art Psychotherapy practice.

Additional creative tools	Positive therapeutic impact	None/detrimental therapeutic impact
Joint image making	24	2
Directive tasks	19	8
Free association/Nondirective tasks	24	3
Focus on dreams	19	8
Guided imagery	16	7

Figure 21 - Effect of additional creative tools.

Participants were asked if they have a theoretical orientation in their approach to working with adults who have experienced complex psychological trauma. Twenty two out of 27 answered yes. Figure 22 shows the reported theoretical orientations.

Orientation	Count	Rank
Psychodynamic	4	10.5
Psychoanalytical	3	9
Expressive trauma integration	2	12.5
Person-centred using a combination of orientations	4	10.5

Mindfulness	2	12.5
Mentalisation	2	12.5
Transactional Analysis	1	3
Psychodynamic / Mentalisation / DBT	1	3
Alderian	1	3
Three phases approach / schema therapy	1	3
Body focused / holotropic breath work	1	3

Figure 22 – Theoretic orientation.

Dr Brett Kahr, a Senior Clinical Research Fellow of Psychotherapy, states there are 15 identified psychotherapeutic components that contribute towards healing (Kahr, 2018). There are no publications that challenge this evidence. Survey participants were asked how these components contribute to therapeutic impact when used to treat adults who have experienced complex psychological trauma. See figure 23. Not all participants answered all question parts. Supreme reliability; the guarantee of confidentiality; the cooperation of the client; and the Psychotherapist having staying power were reported as being the most impactful in enabling recovery.

Psychotherapeutic components	Positive impact	Non/detrimental impact
Permission to confess	26	1
Supreme reliability	26	1
Interest in the smaller detail	18	7
The provision of tonal factors	15	7
7.1.11. The psychotherapist having emotional and cognitive intelligence	25	1
The guarantee of confidentiality	26	1
Having neutrality of purpose	20	7
Psychotherapist having anonymity	17	10
Loyalty and relatedness	24	2
Posture of benignity and concern	22	5

Identification of joyfulness, zestfulness, playfulness, and vitality of the Psychotherapist	20	7
Staying power	23	4
Psychotherapist having a rich private life	17	10
Dedication to principles and accountability	23	2
Cooperation of the patient / client	24	2

Figure 23 – Reported positive and detrimental impact of Dr Bret Kahr's 15 identified psychotherapeutic components.

The components that reported the least positive impact were the Psychotherapist having a rich life; identification of joyfulness, zestfulness, playfulness and vitality of the Psychotherapist; and the Psychotherapist having anonymity.

A systemic review of randomised and nonrandomised controlled trials that explored the effectiveness of Art Psychotherapy for adults who have anxiety (Adding, 2018), describes the following mechanisms of art making:

- induction of relaxation
- emotion regulation by creating the safe condition for conscious expression and exploration of difficult emotions, memories, and trauma
- cognitive regulation by using the art process to open up possibilities to investigate and change cognitions, beliefs and thoughts
- a quiet, comfortable and consistent environment
- individual sessions
- group sessions
- a positive, safe, and containing therapeutic relationship.

When asked of the impact of each mechanism, the mechanism that reported the highest significant positive impact was a positive, safe, containing, therapeutic relationship. See figure 24. Not all participants answered each question part.

Mechanism	Positive impact	Non/detrimental impact
Induction of relaxation	21	4

Emotion regulation by creating the safe condition for conscious expression and exploration of difficult emotions, memories, and trauma	27	0
Cognitive regulation by using the art process to open up possibilities to investigate and change cognitions, beliefs and thoughts	25	1
A quiet, comfortable, and consistent environment	26	0
Individual sessions	21	4
Group sessions	17	9
A positive, safe, and containing therapeutic relationship	26	0

Figure 24 - Reported positive and non/detrimental impact of mechanisms reported from a systemic review (Adding, 2018).

Art Psychotherapist, Martyn (2019) states:

“Intrinsic to the Social Art Psychotherapy frame is the intention to address the division between the self and public, and if the dichotomy between patient and public is not addressed, then the person remains isolated”. (Martyn, pg 5. 2019).

Eleven respondents reported that they enable opportunities for their patients or clients to exhibit their art works. See figure 25.

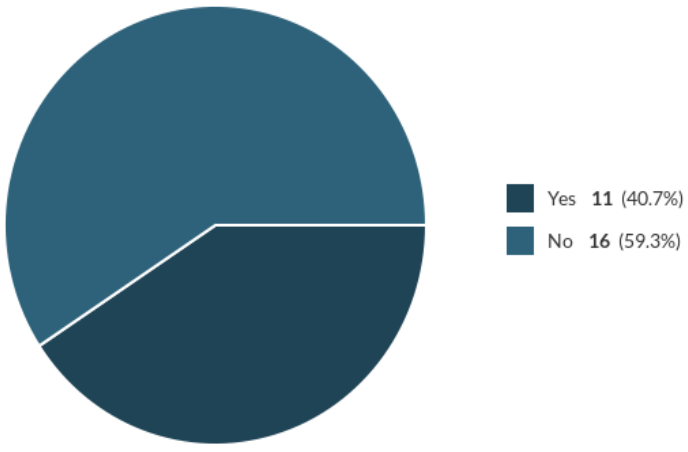


Figure 25 - Respondents who enable opportunities for patients / clients to exhibit art works.

Respondents who answered yes were then asked how this affects the therapeutic impact**.** 90% reported positive therapeutic impact and increased opportunities. 100% of respondents reported that enabling opportunities to exhibit art works also improved confidence and self-esteem and enabled empowerment.

7.1.12. Cluster analysis

Statistical Package for the Social Sciences (SPSS, Version 26, IBM Inc.; Armonk, NY, USA) was used to further analyse the quantitative data. SPSS Statistics is a software package used for interactive, or batched, statistical analysis.

Hierarchical cluster analysis was used to determine statistically significant differences. A cluster analysis was performed in order to identify patterns of similarity of response. Cluster analysis is an exploratory analysis that tries to identify structures within the data. Hierarchical cluster analysis is a statistical procedure that identifies relatively homogeneous groups of respondents (cases) based upon selected characteristics – in this case similarity in the way survey participants answered the survey questions. All quantitative data analysis was undertaken using the Software Package for the Social Sciences (SPSS; Version 26, IBM Inc.; Armonk, NY, USA). The level of statistical significance was predetermined as a p value of <0.05.

Twenty-seven practitioners responded to the international survey: 19 were UK-based therapists and eight were based in the ‘rest of the world’; 23 were female and four male; 18 had practiced for ten years or longer whilst the remaining nine had practiced for less than ten years; ten were NHS-based whilst 14 were practicing in the private and voluntary sectors (N.B. there were four non-responses to this question).

Figure 26 shows a dendrogram using ward linkage, rescaled distance cluster combine.

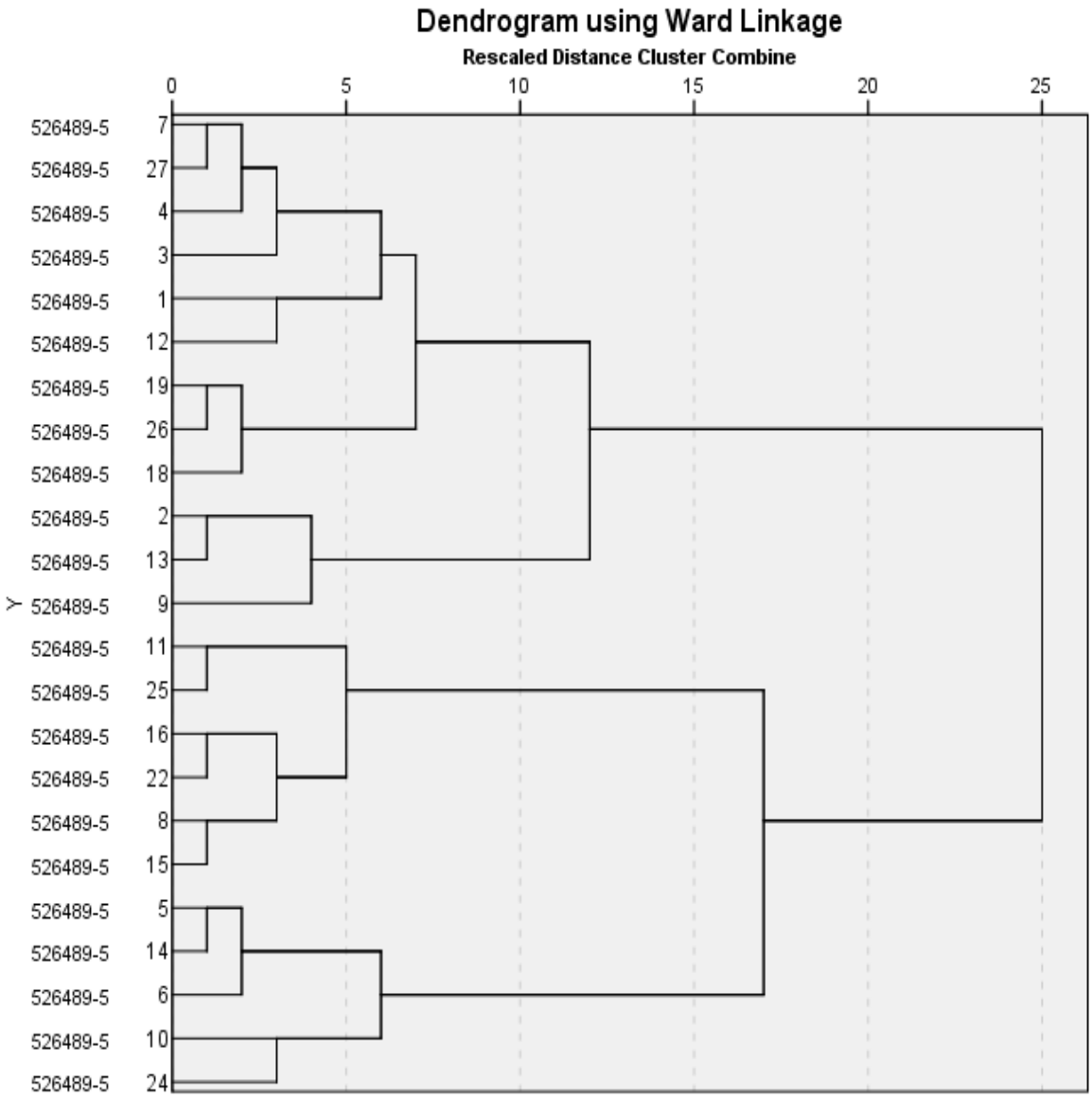


Figure 26 - Dendrogram.

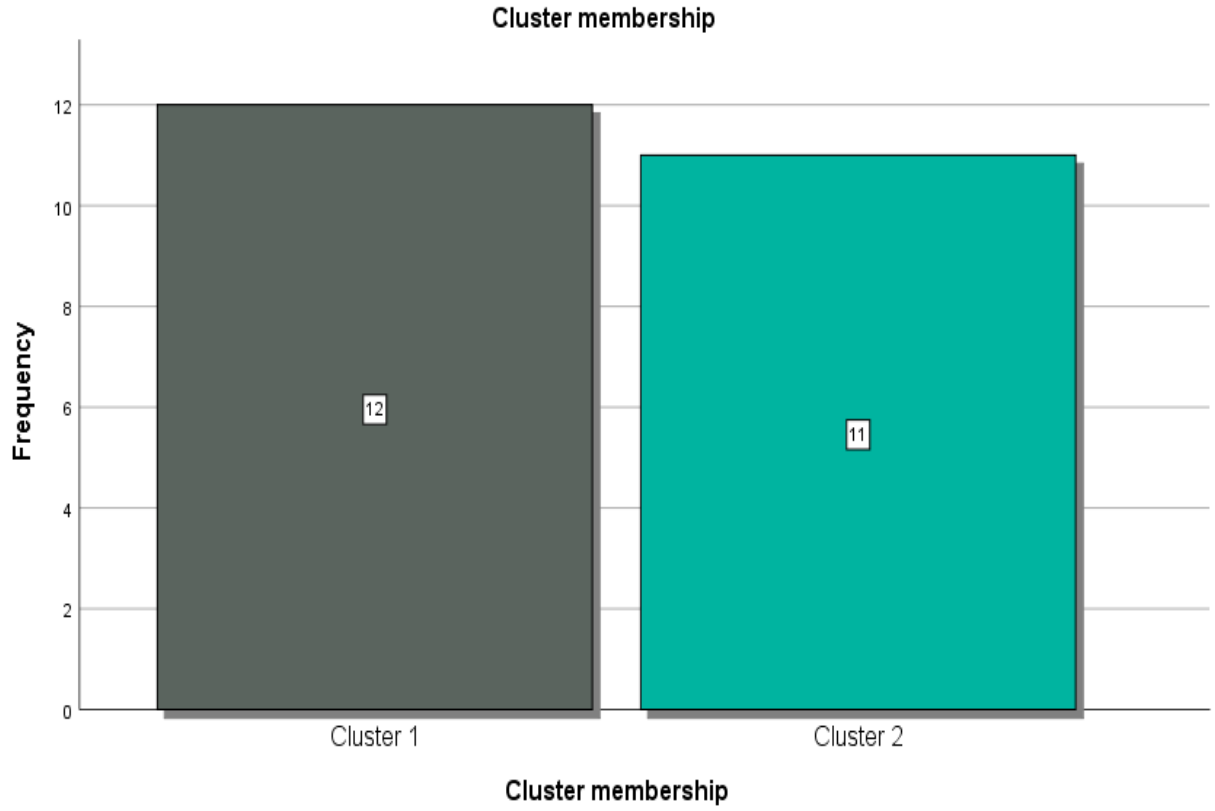


Figure 27 - Cluster membership.

The differences behind the clusters were based upon how respondents answered in relation to:

- Time effect of waiting list - up to a month
- Impact of location of practice on treatment outcomes - in town / city centre
- Architecture of building
- Up to 12 sessions (restricted)
- 12-46 sessions - effect on attendance

They were chosen because they (a) represented the main 'domains' of the survey and (2) showed maximum variation in the way in which they were answered.

After initial descriptive analysis of variables, Kruskal-Wallis tests were used to determine statistically significant differences ($p < 0.05$) in response to the survey questions between key grouping variables, e.g. geographical location of practice, length of professional practice, sector of practice, and gender of respondent. Only one grouping variable – that of length of practice yielded significant differences. Those in practice for over ten years favoured:

Extended assessment – up to six weeks ($u = 109.50$, $p < 0.033$)

Up to 12 sessions with the possibility to extend ($u = 121.00$, $p < 0.041$).

The statement that the latter had a positive effect on attendance ($u = 121.00$, $p < 0.041$).

The Kruskal–Wallis test is a statistical method for ascertaining the significance of differences between the median values for K+ sub-groups from within the same sample: sometimes referred to as 'ANOVA by Ranks'. This is the test of choice when analysing ordinal data such as that generated by survey instrument.

Because no further consistent patterns of difference emerged based upon grouping variables, a hierarchical cluster analysis was undertaken to identify patterns of similarity and difference of response within the data.

Yim and Ramdeen (2017) identified that:

'Cluster analysis refers to a class of data reduction methods used for sorting cases, observations, or variables of a given dataset into homogeneous groups that differ from each other.' (Yim and Ramdeen pg. 8, 2017).

Cases (individual participants) are clustered based upon chosen characteristics – in this instance, similarity in the way they scored responses in the main domains of the survey instrument – and not any of the grouping variables outlined above. Cases in each specific cluster share many characteristics but are also dissimilar to those not belonging to that cluster. A two-cluster solution proved to be the most parsimonious, and 12 respondents were classified as in cluster 1 whilst 11 were in cluster 2 (N.B. 4 respondents were excluded from the analysis on the basis of non-response).

Otherwise, the clusters differed on the following basis:

Those classified in cluster 1 favoured afternoon appointments ($u=33.00$; $p < 0.044$);

When the clusters were cross-tabulated with original grouping variables, only one significant pattern emerged – namely that all male respondents were classified in cluster 1 ($\chi 2 = 4.439$, $p < 0.035$ with 1 df).

Those classified in cluster 1 were more likely to identify aesthetic aspects of the therapeutic environment as significant in determining treatment outcomes, such as architecture of the building ($u=14.00$; $p < 0.001$), and décor ($u=31.00$; $p < 0.032$). Those classified in cluster 1 favoured providing more than 12 sessions in order to achieve therapeutic effect ($u=6.00$; $p < 0.000$).

Cluster 1 favoured a digital /computer-based approach in their chosen art mediums; morning sessions for a more effective therapeutic outcome; architecture having more influence on therapeutic outcomes; overrepresented male respondents; short-term intervention with up to 12 sessions being preferred; more likely to use outcome measures: and UK dominant. Cluster 2 were more likely to use EMDR; female overrepresented respondents; preferred afternoon sessions for effective therapeutic outcomes; overrepresented non National Health Service employees; preferred long-term treatment; and less likely to use outcome measures.

Cluster 1	Cluster 2
Favoured digital approach	More likely to use EMDR
Favoured morning sessions	Overrepresented female respondents
Architecture	Preferred afternoon sessions
Overrepresented male respondents	Overrepresented non-NHS employees
Favoured short-term intervention (up to 12 sessions preferred)	Preferred long-term treatment
More likely to use outcome measures	Less likely to use outcome measures
UK dominant	

Figure 28 - Cluster 1 and 2 comparable features

7.1.13. Additional Information

Survey participants were invited to expand on their answers, and comment on what they thought were the main components of Art Psychotherapeutic practice that supported recovery for adults who have psychological complex trauma. Emphasis was placed on the

art materials being the means to verbalise a person's distress; feeling safe within the therapeutic relationship; the provision of psychoeducation; consistency of the Art Psychotherapist and the sessions; and using body-based approaches including sensory materials.

Findings from the international survey were used to inform the design and development of a treatment manual, Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP).

7.1.14. Summary

Chapter 7 introduced and explained the process of this international survey. A scientific realism methodology – online surveys was explained, then informing of survey data collection and analysis. Qualitative data analysis and hierarchical cluster analysis were then discussed. The aim of the survey was then explained, to expand understanding of what causes positive impact from the perspectives of international Art Psychotherapists when treating people who have experienced complex trauma. This chapter then reported the method used and a description of the questionnaire was provided before then reported the international survey findings.

The findings from the international survey informs the design and development of a treatment manual, Unification Neuro-informed Trauma Art Psychotherapy (UNTRAP). This will be discussed in detail in chapter 8.

CHAPTER 8 - THE DEVELOPMENT OF A TREATMENT MANUAL

8.1.1. Introduction

In this chapter, I will discuss the development of treatment manuals from the perspective of Carrol and Rounsavelle (2008), referring to their six major roles and function; manual based psychotherapies in clinical practice, referring to the assets, liabilities and obstacles of dissemination; the advantages of a manual based treatment within psychotherapy, and the development of UNTRAP manual will be explained.

8.1.2. Developing treatment manuals: Six major roles/ functions

Carroll and Rounsavelle report (2008) that the development of treatment manuals, which specify psychotherapies and provide guidelines for their implementation, has both revolutionised psychotherapy research (Luborsky & DeRubeis, 1984) and provoked controversy around their roles and value in clinical practice.

The purpose of a psychotherapy manual is to specify a treatment and provide guidelines to therapists for its implementation (Carrol and Rounsaville 2008). The optimal level of specification of a treatment manual should be driven by the design and research questions asked within the research. Carrol and Rounsaville (2008) discuss six major roles / functions of treatment manuals in clinical research.

1. Comparative component for clinical efficacy research, and specification of the treatment for clinical trials.
2. Provides definitions and standards, and criteria for evaluation and competence.
3. Facilitates treatment and reduces variables in the delivery of treatment.
4. Provides quality assurance standards and to develop competencies and certification standards for treatment.
5. Facilitates replication of studies. A well-defined detailed and clear treatment manual is necessary to foster valid replication research.
6. Foster dissemination and transfer of effective therapies to clinical practice.

Despite the mentioned roles or functions of a treatment manual, including those specific to psychotherapies, they have been met with mixed enthusiasm and acceptance by the clinical community (Carrol and Rounsaville 2008). Existing manuals have been criticised on several grounds including: limited applicability to the wide range of populations and complex problems encountered in clinical practice (Abrahamson, 1999; Henry, 1998; Schulte & Eifert, 2002; Westen et al., 2004); excessive emphasis on technique with inadequate focus on the working alliance and other important common elements of

treatment (Dobson & Shaw, 1993; Henry, Strupp, Bulter, Schacht & Binder, 1993; Vakoch & Strupp, 2000); restriction of clinical innovation and the clinical expertise of the therapist (Castonguay, Schut, Constantino, & Halperin, 1999; Wampold & Bhati, 2004; Wolfe, 1999); emphasis on technique over theory (Mahrer, 2005; Silverman, 1996; Vakoch and Strupp, 2000); overemphasis on adherence may reduce therapist competence (Henry et al., 1993; Mahrer, 2005); and feasibility when the manual is implemented by clinical of great diversity regarding experience, discipline, and clinical expertise (Addis et al., 1999).

8.1.3. Manual based psychotherapies in clinical practice: assets; liabilities and obstacles of dissemination

Mansfield (2001) reports that the most articulated criticism of manual-based treatments is that they lead to a bland, rule governed, and emotionally detached form of therapy, adding that therapists fear that practising therapy under these conditions may feel more like following a recipe than the intuitive and creative process that drew therapists to the field. However, he goes on to report the arguments in favour of manual-based treatment rest on its ability to capitalise on an actuarial approach to clinical decision-making, and in so doing, avoid many of the pitfalls of clinical judgment (Mansfield, 2001). Manual-based treatments are also supported by empirical research and ensure that clients are receiving interventions that have been shown to be effective, rather than those that are simply popular or seem helpful to practising clinicians (Wilson, 1998).

Similarly, Wilson (1996) states that treatment manuals can make supervision easier and facilitate dissemination of psychotherapies. Knowledge of manualised treatments broadens the repertoire of treatment skills available and encourages greater technical eclecticism (Wilson, 1996). Furthermore, the use of manuals has focused attention on patients who do not respond to treatment (Wilson, 1996). Additionally, Addis (1997) argues that knowing a treatment is empirically supported can help clinicians to feel confident and optimistic when working with particularly difficult clients.

Some barriers to using manual-based therapies are that so few clinicians are trained to provide manual-based treatments, or even know what they are. Addis and Krasnow surveyed a national sample of licensed psychologists in practice (Addis & Krasnow, 2000). They found that 77% of therapists had heard of treatment manuals, leaving a full 23% who had not. They also found that 37% of those surveyed reported having a “somewhat” to “totally” unclear idea of what a treatment manual is. Furthermore, they found that of the practising psychologists they surveyed, 47% reported never having used a treatment manual. These findings suggest that psychologists as a group have had

limited experience with treatment manuals. In addition, Addis and Krasnow (2000) found that therapists' understandings of what manuals were, informed their attitudes about them; those who viewed manuals as rigid guides to treatment that impeded creativity and the therapeutic alliance, viewed manuals negatively, whereas those who had more flexible views of manuals regarded them more positively. This suggests that education about what manuals are, and how they can and should be used, is imperative.

While there are some concerns about manual-based treatments, they encourage therapists to take greater responsibility for their work and to think critically about why they do what they do (Mansfield, 2001).

Manual based treatment: the advantages in psychotherapy

There is an ethical imperative to provide treatments that work for our patients and clients, and empirically supported treatments can help us to do that; in this case, an empirically informed Art Psychotherapy treatment manual. Mansfield (2001) states that practitioners sometimes disagree about what constitutes effective treatment. Mansfield and Addis (2001) frame success as a decrease in symptoms and distress, as well as a possible increase in functioning at work or in school and in relationships. Proponents of empirically supported treatments have drawn attention to the need for research that targets effectiveness, or how they work in real clinical practice, as well as efficacy which can be measured within clinical trials, strict exclusion criteria, and expertly trained therapists (Mansfield and Addis, 2001). Chambless and Ollendick (2001) argue that the existing evidence from effectiveness research suggests that empirically supported treatments, such as treatment manuals, are effective as well as efficacious. Thus, relying on efficacy studies is an acceptable way to identify treatments that work.

Some literature suggests that structured treatments produce comparable or superior results to flexible treatments (Jacobson, 1989; Schulte, 1992). Addis (1997) states that since empirically supported treatments take advantage of the superiority of actuarial prediction over clinical prediction, adherence to empirically supported treatments should lead to a higher percentage of successful outcomes for patients. Addis reports (1997) that clinicians who base their decisions on research are more likely to make better decisions than those who are guided by intuition alone. It is important to mention that following a research-based treatment such as a psychotherapy treatment manual, does not mean that individual clinical decision-making is abandoned. However, relying on clinical judgement alone does not guarantee better outcomes for patients and may make decisions less

accurate (Mansfield and Addis 2001). Wilson (1996) states that individualised clinical judgement is less reliable than standardised treatment because individualised treatments can introduce errors and misguided strategies that are not present in manualised treatments.

8.1.4. The development of UNTRAP

The original design of this study included a systematic literature review; a focus group; an international survey; and case-based analysis working in partnership with an identified National Health Service who would provide the referrals and intervention sites. Initially, this was Tees Esk Wear Valley NHS Foundation Trust (TEWV) but was changed to Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) for practical reasons. As this stage of the study was about to go ahead, following approval from IRAS and Northumbria University for the required ethics applications, and completing all the relevant checks and processes in preparation for induction with CNTW, it was announced by government that there would be a national lockdown as a Covid-19 measure. Subsequently, this meant a halt would take place on my study, and a reassessment of the study design was required. There was some consideration of altering intervention features such as delivering Art Psychotherapy online for both individual and group sessions. However, it was agreed that this would be too time consuming for the required training to take place, and I wondered also if it might lose some of the required material for this study. I wanted to capture experiences from participants when engaging in Art Psychotherapy, environmentally, for individual and group sessions, and felt that online treatment may potentially impact on this. There was also a staff shortage due to covid-19 sickness, which informed the decision.

Figure 29 shows a TIDieR (Template for Intervention Description and Replication, 2013) UNTRAP Checklist.

Name	Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP)
Why	UNTRAP was informed with a unification approach, combining several theoretical perspectives and evidence bases. The systematic literature review explores current evidence regarding what interventions and theories support healing for people who have compromised mental health resulting

	from complex trauma. The UNTRAP model is Art Psychotherapy, and the aim is trauma memory reconsolidation. The international survey data, clinical expertise, and the focus group data also informed the development of the manual.
What	Materials: Facilitators of UNTRAP (qualified Art Psychotherapists) will complete training on how to deliver the treatment, pre delivery. All potential participants will be given a participant introduction pack which details the content, aims, length and structure of the manual. Potential participants are invited to ask questions and take the time they need to decide if they wish to engage. UNTRAP includes several integrated and interlinking areas: An underpinning Memory Reconsolidation Model (Ecker, 2012). An underpinning three stage approach – safety and stabilisation; identification and processing; and integration and rebuilding (Seiler, 2016). An approach that supports communication through using visual methods and gives choice, structure, and support to the client. A range of tools for grounding, regulation and soothing for the client. Psychoeducation for increased awareness and understanding. A range of key features that encourage personal coping responses, exploration of relationships and interactions, processing of past and current events that build towards a shared understanding between the therapist and the client. A range of techniques to identify symptoms and retrieve emotional learnings: discover and explore the client's implicit emotional learnings, core beliefs, attributed meanings, schemas, constructs, and mental models unique to that particular client's emotional learnings from experiences of trauma. A range of approaches that identify or create disconfirming knowledge or contradictory experiences. The client-therapist relationship is used to support and/or create a relational experience that contradicts pre learned expectations. A range of verbal and visual tools for the client to feel both the target emotional learning or schema's expectation, and the non-fulfilment of that expectation in the new contradictory experience.

	An optional opportunity to share art works made to other participants of UNTRAP, at an organised, private sharing event. Tools: A growing set of tools can be added to support the treatment including homework tasks, client self-monitoring, and therapist monitoring.
Who provided	Qualified Art Psychotherapists (HCPC registered) who have completed UNTRAP provision training.
How	At this stage, the manual is appropriate for individuals, and to be delivered in person. There is scope to develop additional delivery options such as for groups, younger people, and online.
Where	The treatment must be delivered in a trauma-informed therapeutic environment that adheres to the findings from the international survey. For example: easily accessible location; calming colours; quiet environment; therapy room with comfortable furnishings and a window.
When and how much	Number of sessions: 12 with more to added according to the needs of the client. This adheres to the survey findings. Each session to be for one hour. The sessions to occur weekly. The client will decide the set time that the session will occur. UNTRAP treatment is free to all participants.
Tailoring	The manual is to be used as a set of principles, and for the participant to use it according to their needs and requirements.
How well	UNTRAP was informed by clinical expertise; a focus group; a systematic literature review; and an international survey. The manual was improved as part of a validation process that was informed by an international expert panel (all data from this process was analysed using Reflexive Thematic Analysis to identify themes). After all amendments and improvements were made, all experts unanimously reported that the manual is ready for a clinical trial. Clinical judgement regarding treatment should be made based upon individualised risk assessment and/or appropriate risk reduction measures as required within the setting.

Figure 29 - The TIDieR (Template for Intervention Description and Replication) checklist for UNTRAP

It was identified that the development of a treatment manual could be confidently informed by the data from the already completed focus group with BAAT regional group members, the systematic literature review, and my own clinical experience and expertise. Several strands of evidence and theory emerged from the systematic literature review that informed the next stages of manual development, as did the findings from the international survey. For example, the duration (number of sessions) of the manual, the length of each session, as well as the time of the sessions, was informed by the data provided by the survey respondents. Within the survey there were high scores that indicated a significant positive impact for patients offered 12 sessions with potential for additional session if required; positive therapeutic outcomes were reported for patients who are not held on waiting lists for more than three months; and sessions to last for an hour, preferably being held in the afternoon. These were suggested as important considerations within the manual.

The suggested use of art materials for some of the sessions within the manual, such as paints, clay, pastels, and charcoal, were also informed by the survey data. These materials were reported to be the most effective when used to treat people who have experienced complex trauma as they are more malleable and changeable. The quality of these materials was reported by a survey respondent as being an opportunity to experience mess and changeability in a safe and expressive way.

UNTRAP manual consists of a structured session plan, although it is encouraged that the patients / clients use this as a guide only and to engage with the stages and steps that appeal to their needs. Rankin and Taucher's article (2003) mentioned in the systematic literature review, reports the promotion of exploration of meaning through identified tasks. Furthermore, Sarid and Huss (2010) completed an extensive literature review which reports, by using a structured approach, new connections and pathways can be created between the physical, emotional, and cognitive components of trauma memory, resulting in decreased stress levels which enables the restricting of fragmented traumatic memories into more coherent positive memories.

UNTRAP is an acronym for Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy. The manual development was informed by several perspectives, therefore includes a unified approach. From a neurological Art Psychotherapy, and memory reconsolidation perspective, Hass-Cohen (et al. 2014) reports that a common aspect of Art Psychotherapy treatment is the ability of art to aid in the cognitive restructuring and

subsequent integration of trauma experiences. This process could be described as the creation, organisation, and integration of a trauma narrative, (Hass-Cohen et al. 2014). In the manual this process is referred to as memory reconsolidation. Collins Dictionary (Collins, 2022) describes the meaning of reconsolidation as, the act or process of consolidating something again or in a different way. Sara (2000) describes memory reconsolidation as the process of previously consolidated memories being recalled and actively consolidated. She adds that it is a distinct process that serves to maintain, strengthen, and modify memories that are already stored in the long-term memory (Sara, 2000). Memory reconsolidation is the intended process within the manual, with Art Psychotherapy being the method.

To elaborate further on some features that were draw from clinical neuroscience and Art Psychotherapy practice, as Hass-Cohen et al. (2014) explains the non-verbal expressions and the creation of a narrative through Art Psychotherapy is the hemispheric integration of non-verbal implicit memories. This process, along with an additional component informed by memory reconsolidation of holding a contradictory emotional learning in juxtaposition (Ecker, 2015), was applied to the manual. However, this process cannot be predicted. The process happens when and if the client or patient intends. This informed the initially termed process within the manual: multi-image making / bilateral processing, which later became ‘multi-image making / emphasis of unilarity’ following the manual validation process (fully reported in chapter 9). During this process an expert panel member (Expert J) highlighted the importance of using the word ‘unilarity’ instead of ‘bilateral’ as the theory of left-side and right-side brain function may no longer stand according to current neurological findings. Expert J emphasised that when using art and processing psychological material, albeit memory recall or present emotional experiences, the brain is stimulated unilaterally, as opposed to the left side for one thing and the right side for another. In the manual, multi-image making / emphasis of unilarity process involves making an image with both hands at the same time. One image expresses the feeling of an identified trauma. The other image expresses the feeling of an identified contradictory experience. This is discussed in more details in chapter nine, and in the manual (appendix 2).

The inclusion of all UNTRAP components, being informed by a wide range of theory and evidence, is the unification of the manual. As Cambridge Dictionary states (Cambridge Dictionary, 2022), unification is the act or process of bringing together or combining things. Unification within a Psychotherapy context is described by Marquis, (2021):

‘The defining feature of unification adopts a metatheoretical perspective that allows for the major psychotherapy paradigms and their interrelations to be seen from a more comprehensive vantage point.’ (Marquis, pg. 1, 2021)

The development of the manual was also informed by my understandings of how and why therapy works from my own clinical experience and expertise (10 years working in ?? services/private practice). Although the manual is a directive approach that has a set of optional and flexible structured sessions, it is imperative to ensure the person delivering the treatment manual is always a step behind the patient/client’s process. There may be a temptation to take the lead or instruct, as opposed to guiding through the manual and ensuring the process is owned by the patient/client. For memory reconsolidation to occur, the patient/client must recall and then experience their traumatic memory cognitively and emotionally and have control over this process within the containment and not the control of the Art Psychotherapist. Furthermore, in a quote by Springham (2019) in an interview I held with him in the early stages of the study, he said:

“Without the relationship, there is no such thing as art. The relationship between the Art Psychotherapist and the patient is a hundred percent of the therapeutic healing process. Art Psychotherapy can only occur within the relational space” (Springham, 2019).

I designed the manual with the therapeutic relationship at the core of my thinking. All features of the manual are woven within a setting that ensures safety, comfort, a person-centred and co-production approach, and being led by the needs, required pace and level of engagement of the patient or client. As referred to in the survey, and scored by the respondents, the Kahr (2018) psychotherapy components most likely to aid recovery and healing were reported as: supreme reliability; the guarantee of confidentiality; the cooperation of the client; and the Psychotherapist having staying power. These psychotherapy components are woven within the manual to ensure the most positive therapeutic outcome for the patients or clients.

UNTRAP manual is intended to be a time-limited and structured intervention, initially for the use of adults who have compromised mental health caused by experiences of complex trauma. The manual was not designed to have a rigid quality, but to be a set of principles for the client to engage as they choose, and to have flexibility in the number of sessions they will need. In these early stages, UNTRAP is designed to be delivered individually and in person. However, the manual could become applicable for children and young people, and to be delivered for groups. Furthermore, sessions could be adapted for online engagement.

8.1.5. The structure, components, and principles of UNTRAP

UNTRAP manual follows a trauma-informed process that ensures safety, goal making, tools for grounding, image making, the identification of emotional learnings and contradictory learning, trauma memory reconsolidation and transformational change within an ongoing cycle or containment of safety and stabilisation, identification and processing, and integration and rebuilding. There is a suggested order for these processes within the manual. However, the principle is that the participant interacts with the manualised approach in a way that suits their needs and requirements.

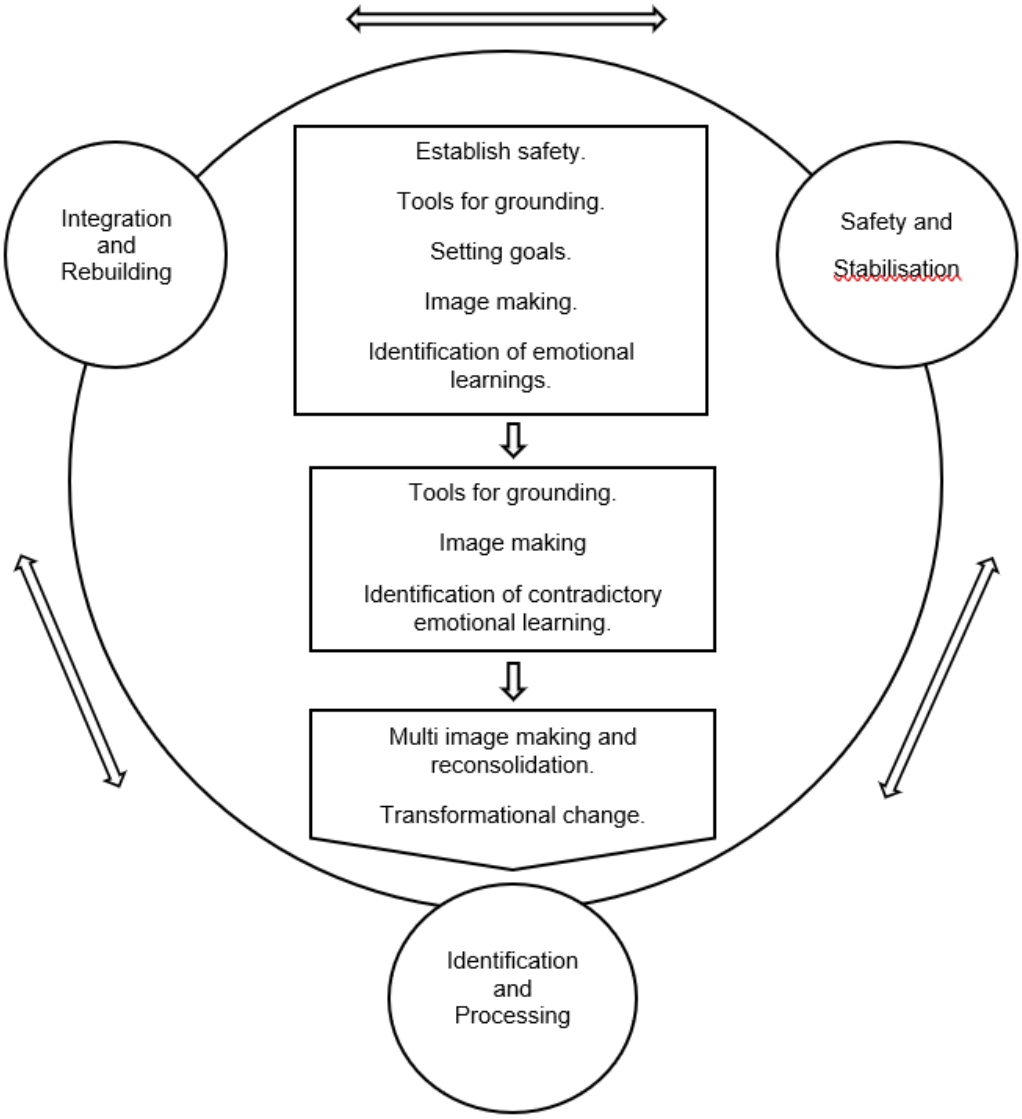


Figure 30 - UNTRAP frame

UNTRAP treatment is likely to be appropriate for:

- Adults who have experienced complex psychological trauma.
- Adults who present with a range of symptoms, associated with functional impairment such as: re-experiencing; hyperarousal (including hypervigilance, anger

and irritability); negative alterations in mood and thought; emotional numbing; dissociation; emotional dysregulation; interpersonal difficulties or problems in relationships; negative self-perception (including feeling diminished, defeated or worthless) (NICE, NG116, 2018).

- Adults who present with additional characteristics (associated with Complex PTSD) such as: severe and pervasive problems in affect regulation; persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to traumatic event/s; and persistent difficulties in sustaining relationships and in feeling close to others (NICE, NG116. 2018).

UNTRAP treatment is not likely to be appropriate for:

- Adults who are under the influence of self-medicated substances such as alcohol or non-legal drugs.
- Adults who have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use and/or if the impairment means the person is unable to make a specific decision when they need to. The Mental Capacity Assessment (MCA, 2018) says a person is unable to make a decision if they cannot understand the information relevant to the decision; retain that information; or use or weigh up that information as part of the process of making the decision. When referrers are considering a client for UNTRAP treatment, they will assess if client has capacity to engage before making a referral.
- Adults who have high risk ideations of suicidal or harm to others.

Figure 31 summarises the structure, components, and principles of UNTRAP.

Structure	Components	Principles
Pre-treatment	Awareness of common trauma symptoms and how to present and respond to the patient. Train Art Psychotherapists on verbal de-escalation techniques and provide them with tools to help patients self sooth and emotionally regulate. Provide patients and facilitators opportunities for feedback so they can participate in improving the program. Create an emotionally safe and supportive environment. Demonstrate respectful interactions.	Trauma Informed Approach

	Generate culture of open communication, tolerance, respect, and community. Maintain consistency, predictability, and transparency. New patients to be introduced to staff members.	
During treatment phase	Art Psychotherapists can interact with people in distress without telling them what to do or immediately giving consequences. Art Psychotherapists listen to and validate a wide range of emotions (e.g., grief, sadness, anger, and fear) from patients.	Trauma Informed Approach
	These components can occur at any time during the manual process (see sessions in the manual for unilateral image making and juxtaposition emotional learnings). 1. Reactivated, symptom generating target learning experienced in awareness. 2. Experience of mismatch / prediction error destabilises the target learning's neural encoding. 3. Experience of counter-learning drives unlearning, nullification, re-encoding and replacement of target schema.	Memory Reconsolidation - Ecker has termed three experiences as empirically confirmed process of erasure (ECPE) (Ecker, 2018).
	Image making – recommended use of paint, pastels, charcoal and clay to support healing and expression (informed by the survey data). Image making in response to themes, schema material, aims and goals, and safety. See session content (appendix 2) in the manual for session content.	Art Psychotherapy – literature reports the importance of sensory motor aspects involved in expression through art to images and emotions resulting from trauma, emphasising that the experience of trauma is encoded as non-verbal sensation (King, 2016). Image making can aid in the cognitive restructuring and subsequent integration of trauma experiences ((Hass-Cohen et all, 2014).
Throughout the treatment	Ideas for enhancing communal and therapeutic environment • Colourful artwork • Live plants, fish tanks	Trauma Informed Approach

	• Calming music • Comfortable, soft seating • Offer quiet rooms or spaces to take an emotional time-out • Rocking chairs **Safety and stabilisation** The client/patient working with the Art Psychotherapist to develop aims and goals. Improving the sense of personal stability, security, and safety. Finding new ways to process and express emotions in a healthy way. Distinguishing between healthy and unhealthy behaviours and tendencies through reflection. Establishing a routine of psychological and emotional self-care. Practicing forms of self-love and self-appreciation. Revealing and exploring sources of inner strength. Developing coping mechanisms and emotional regulation tools. **Identification and processing** Evaluate painful and traumatic memories. Redefining the role that certain events play in one's life by identifying no longer needed symptoms or emotional learnings. Exploring and mourning any losses associated with the trauma in question. Determining the impact that traumatic experiences have had on one's life. Mourning the loss of good experiences or opportunities due to trauma or trauma-related hindrances. **Integration and rebuilding** Transformational change. No longer needed symptoms or emotional learnings will be replaced by positive contradictory experiences. Build upon newly emerging positive healthy beliefs of self. Imagine experiencing life in a new way, including connecting with others and engaging in meaningful activities and life experiences.	Theoretical and evidence informed. Trauma Informed Approach.
Post UNTRAP treatment	Opportunity for sharing art works. Each participant will be invited to exhibit their art works made in sessions as part of a (private or public, depending on what the client/patient chooses) exhibition, or to share in a private group with other UNTRAP participants. These opportunities are COMPLETELY optional.	Empowerment, de-stigmatisation, expression and sharing. All survey respondents reported that sharing of art works made in

		sessions, in a safe way, significantly improves confidence and self-esteem, and enables empowerment.
	To maintain safety and stability, the provision of a gradual step down for service support options for these patients is essential. Following UNTRAP treatment, all patients will be offered continued support from their care team with weekly contact. Patients will be sign-posted to support groups, community projects, art projects, additional therapeutic intervention, and general support in response to their individual needs and requirements.	Continuity of Care - patients who have experienced complex traumas may require a continued connection to the 'secure base' (Brown and Elliot, 2016), as they continue to explore the new freedom and gain independence.
Care of the clinician	It is essential that each facilitator of UNTRAP manual has regular clinical supervision and follows a selfcare program alongside the manual delivery.	Trauma Informed Approach for all.

Figure 31 - the structure, components and principles of UNTRAP

8.1.6. Summary

This chapter has discussed the development of a therapy treatment manua, exploring the perspectives including Carrol and Rounsavelle (2008), and Mansfield and Addis (2001). The design and development of UNTRAP manual was then explained. Chapter 9 will describe the validation process for UNTRAP manual.

CHAPTER 9 – THE VALIDATION PROCESS OF UNTRAP

9.1.1. Introduction

Chapter 9 explains the validation process of a treatment manual referring to Dinnesons (2018) five stage process, pre validation process for UNTRAP manual including the quantitative methodology, the procedure, initial expert review and expert panel meeting online, then the subsequent expert panel review. The procedure and stages will be described. Following this, this chapter reports the results from the validation process of the treatment manual – UNTRAP, covering the input from each expert for each component of the Rubrics questionnaires (stage one and three). The results from the online expert panel meeting (stage two), the rubrics findings, and the data from the reflexive data analysis process will be reported and discussed. Chapter 9 will finish with an explanation of how the findings will be applied to UNTRAP treatment manual.

9.1.2. Validation of a treatment manual

Dinneson (2018) reports that there is an ongoing effort to bridge the researcher–practitioner gap by utilising models of implementation science during intervention development to produce interventions that are both evidence-based and feasibly sustainable in real-world settings. The principle of content validity fits neatly within many implementation frameworks. For example, the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) includes five domains to consider during intervention development: (Dinnesen, 2018).

1. The intervention itself
2. The inner setting
3. The outer setting
4. The individuals involved
5. The process for accomplishing the intervention

Dinnesen report that experts validating an intervention must consider components such as: context; format; and method of instruction. In healthcare and nursing interventions, qualitative methods for measuring content validity include interviews and feedback with content experts (Brod, Tesler, & Christensen, 2009). Although there is general consensus on qualitative methods for establishing content validity, there is a lack of consensus regarding the best way to quantify content validity. An example of some quantitative methods:

- The Index of Content Validity (CVI; Polit & Beck, 2006**;** Waltz & Bausell, 1981) is a commonly used means of quantifying content validity of assessment instruments.
- A Proportion Agreement (e.g**.** Beck & Gable, 2001**;** Lindell & Brandt, 1999**)**
- Kappa Coefficient Analyses (e.g. Wynd, Schmidt, & Schaefer, 2003**).**

In one study utilising quantitative methods for establishing content validity of an intervention, Bakas et al. (2009) employed a panel of ten experts, including researchers, clinicians, and caregivers who had experience working with stroke patients. The experts determined content validity for components of their stroke-patient caregiver intervention across four criteria: accuracy; feasibility; acceptability; and problem relevance. Each member of the panel rated the components of the intervention using a five point rating system questionnaire. The panel members also submitted recommendations for improvements. Overall, the use of an expert panel determined initial content validity and informed the development process for future iterations of the intervention. Conducting a content validity study in the development phase of an intervention conceivably prevents significant revisions to an intervention after its implementation (Rubio, Berg-Weger, Tebb, Lee, & Rauch, 2003**).**

9.1.3. Quantitative methodology

Analytical rubrics was used to quantitively measure the Unification Neuroscience Trauma Reconsolidation Art Psychotherapy (UNTRAP) manual. Rubrics facilitate peer-review by setting evaluation standards and are most often used to grade written assignments (Burt et al., 2009).

The term "rubric" refers to a scoring guide used to evaluate the quality of participants constructed responses to either written compositions, oral presentations, or science projects (James, 1997). Content validity scales or rubrics are often used to capture ratings on materials or assessments being developed (Grant and Davis, 1997). I adapted the rubrics from those originally developed by Grant and Davis (1997) to assess expert opinions in response to UNTRAP treatment manual. Revisions were made to the rating categories to capture information relevant to the manual components and contexts being evaluated.

Analytic rubrics feature a grid of “criteria” (columns) and “levels” of achievement (rows). I assigned points to criteria in the manual and then each individual area was evaluated. Among the advantages of using the rubric technique, is the possibility that the experts can be from different parts of the world and can participate electronically because

there is not a mutual influence between them (Burt et al., 2009). Tojib and Sugianto (2006) pointed out that assembling experts for discussion allows for clarification and expansion of opinions immediately and encourages more in-depth exploration of the construct and concepts being targeted. An assessment of the validity of both the structure and content of the intervention were derived by comparing the ratings across experts.

The rubrics process identified a need for further analysis, a depth of exploration of the information provided by the experts. Therefore, the process of Reflexive Analysis was used to generated potential themes of key phrases and texts. Each theme category was examined to highlight key strands of the content.

9.1.4. Procedure

The validation process for UNTRAP manual incorporated multiple reviews of the manual by the expert panel. This structure included six parts:

1. Recruitment of expert panel
2. Initial expert review of developed manual
3. Expert panel online meeting
4. Subsequent expert review of revised manual to ensure that feedback was captured and incorporated accurately
5. Reflexive Thematic Analysis
6. Improvements made to UNTRAP manual

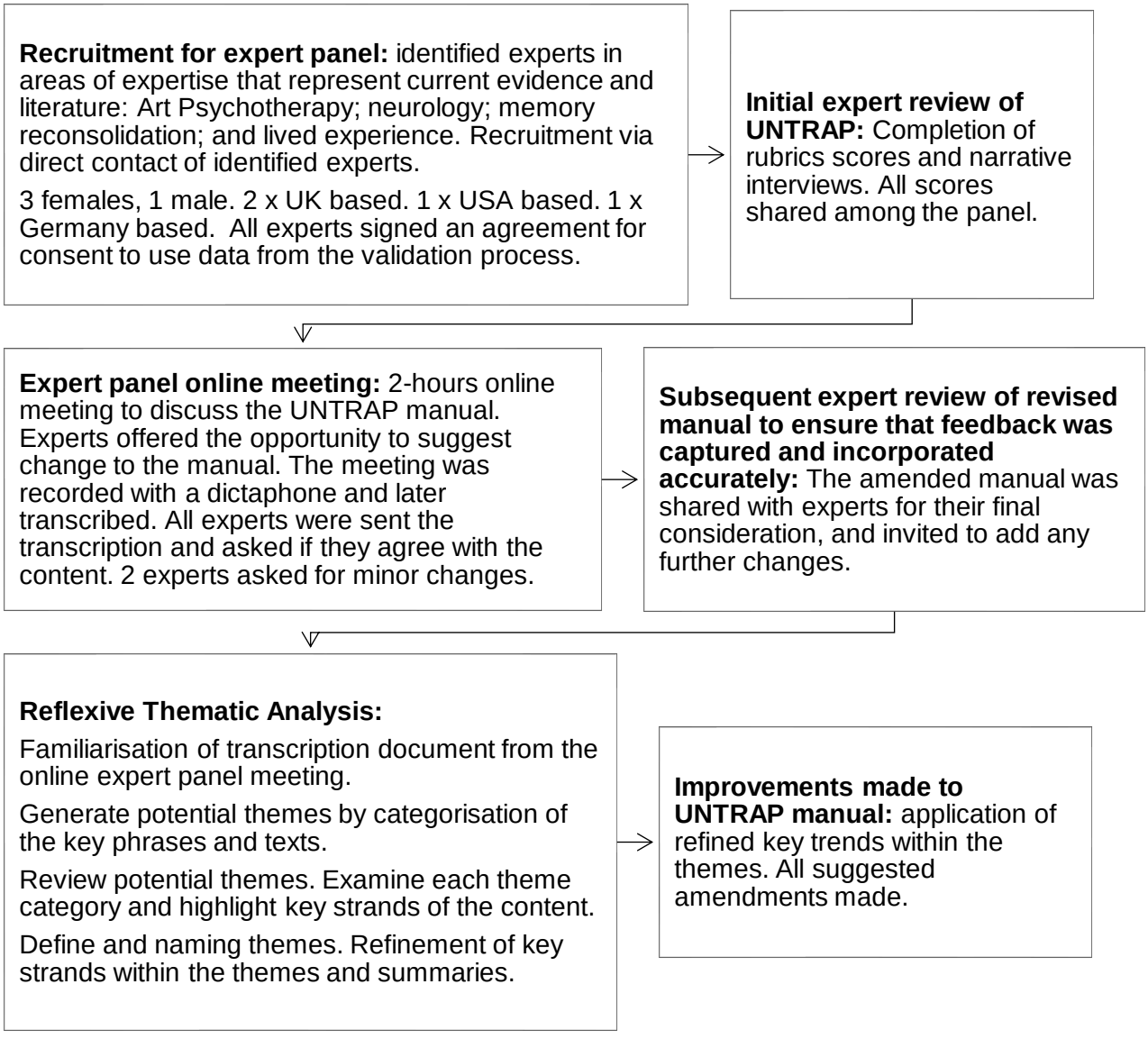


Figure 32 - Flow chart of UNTRAP validation process

9.1.5. Validation process of UNTRAP treatment manual

Four experts were invited to partake in the validation process of UNTRAP treatment manual. The panel members are from the following areas of expertise:

- Expert J – Neuro-informed Art Psychotherapist, USA
- Expert N – Art Psychotherapist (mentalisation and co-production), UK
- Expert R – Coherence Therapist (memory reconsolidation), Germany
- Expert I – Lived experience of trauma (co-production), UK

Initial expert review

UNTRAP manual was emailed to each expert panel member, along with the content validity rubrics, directions for the completion, and a brief rationale. Experts were instructed to take a copy of their completed rubrics to the online expert panel meeting for discussion. Experts received the rubrics scores of other experts the day before the online panel meeting.

9.1.6. Expert panel meeting

Members of the expert panel convened for a two hour online meeting to discuss the UNTRAP manual. The purpose of the meeting was to discuss the UNTRAP manual and rubric scoring. Experts were advised that if they wished to change their original rubrics scores, to send the amendments within 24 hours of the meeting ending. The Chair (KJ) took key notes during the meeting and the audio recording was later transcribed for the Reflexive Thematic Analysis. The audio recording was managed by the Assistant Researcher (HR). Experts were asked to confirm or not confirm the transcription content within a few days after receiving the document. Two experts asked for minor changes to be made to words that had been transcribed inaccurately by the transcription software.

9.1.7. Subsequent expert review

Significant changes were made to the UNTRAP manual. The subsequent review is designed to solicit feedback from the expert panel regarding the substance and form of changes made. This opportunity allowed us to verify that we incorporated the feedback shared from the initial review and expert online meeting. Experts were sent content validity rubrics and were given two weeks to complete and return to the Researcher for analysis. An assessment of the validity of both the structure and content of UNTRAP manual was derived by comparing the ratings across experts.

9.1.8. Pre-validation considerations UNTRAP

There are three identified questions that will inform the content validation methodology approach.

- How can the Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy manual be systematically measured?
- What themes will emerge from data collected from an expert panel of researchers and practitioners related to this area of clinical practice and expertise?
- How will these themes be used to inform further development and refinement of the manual?

With these questions in mind, the following 3 stage procedure has been identified as the most appropriate expert panel validation process.

Expert panel members

Expert panel approach: identify a panel of international experts who can provide feedback on the UNTRAP manual. Panel members to be experts in Art Psychotherapy; Neuroscience; psychological trauma; and lived experience.

Role of the expert panel Chair – to hold the expert panel online meeting, manage time and items and materials. The Chair will not complete any validation evaluation materials and will only contribute to the meeting discussions when invited or explain aspects of the manual for clarification purposes.

Role of the Assistant Researcher - gather permissions for recording the online meeting; audio record the online meeting, transcription of the recording, and provision of material for the Researcher.

9.1.9. UNTRAP treatment manual validation – rubrics stage 1

The following shows the first stage rubrics scores and additional comments made by the expert panel. The comments are written here as they present on the documents for accuracy. The scores are on a 1-4 scale:

1 - This component is not addressed comprehensively.

2 – Major revision is required.

3 – Minor revisions are required.

4 - This component is addressed comprehensively

9.1.10. Manual structure

	Comprehensiveness	Clarity
Expert I	3	3
Additional comments:	Clear structure and definitions – maybe a little too comprehensive/text heavy.	As previous.
Expert J	3	2
Additional comments:	The manual structure is fine, but I am confused as to whether this is a protocol that is to be followed similar to manualized tx, what flexibility there is for interventions, etc. For example, there are 12 sessions outlined with instructions for what to do, but do not account for client presentation/status in the process. Contradictions in terms of freedom to move throughout stages and specific instructions offered. Unsure what UNTRAP means in terms of unification neuro-informed.	-
Expert R	4	4
Additional comments:	-	-
Expert N	3	4
Additional comments:	I felt the manual jumped a bit between theory and practice.	Language used is a strength.

Figure 33 - Validation stage 1. Rubrics, question 1 – manual structure

9.1.11. Demonstrates accuracy

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:	-	-
Expert J	2	2
Additional comments:	While there are some solid references suggested throughout, I am concerned about the scientific validity of the theory and interventions noted.	-

I am concerned about the underlying frameworks and what they exactly are (e.g. there is a note about meta memory reconsolidation but this section is not very detailed in terms of neural processes involved). In the beginning, there is a note on the underpinning theories but there lacks a specific identifier for how these theories specifically relate to the interventions.

Another example is bilateral, which generates a strong emphasis in this protocol but what does it really mean? Aren't all activities bilateral? Visions fields are binocular, whether there is EMDR involved or not, thus the tapping, 'bilaterality' etc. is really an alternating unilaterality…. Terms like 'psychoeducation' are used but are ambiguous.

Operational definitions are listed but are not all cited nor clearly defined.

Statistics are included in certain areas but not in others.

Responses to trauma includes good information but could be re-organised to read more methodically and grounded in evidence.

CYA's; broad generalisations about topics that we do not know all that much about (e.g. The Unification Neuro-informed Trauma Reconsolidation Model in UNTRAP is based upon memory reconsolidation, a neurobiological mechanism of reconsolidation that leads to reconsolidation of a memory which produces permanent change in clients)….can we really make that claim?....."…enables a profound change that is effortless to maintain with no relapses…" (yikes!)

Expert R	2	3
Additional comments:	-	-
Expert N	4	4
Additional comments:	Yes, very comprehensive.	

Figure 34 - Validation stage 1. Rubrics, question 2: demonstrates accuracy

9.1.12. Demonstrates feasibility

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:	ical steps during sessions 1-12.	-
Expert J	3	2
Additional comments:	The protocol itself, focus on environment, material choice, etc. seems feasible but I not sure how it is different than a general trauma-informed approach to treatment as usual. For example, the stages are defined within three domains, but I am not seeing how these domains are anything different than what one would seek to do, depending upon when the person is in treatment and what their presenting problems are at the time. The intake procedures are ambiguous; how are you going to ensure that the vast range of trauma sx are addressed and accessed for applicability?	Feasibility will be improved when these areas are more specifically defined.
Expert R	3	3
Additional comments:	-	-
Expert N	3	4

Additional comments:	Yes, I think it may be helped by outlining the competencies needed to follow the procedures.	-

Figure 35 - Validation Stage 1. Rubrics, question 3: demonstrates feasibility

9.1.13.

9.1.14. Demonstrates acceptability

	Comprehensiveness	Clarity
Expert I	3	3
Additional comments:	What if the therapists have not previously worked in a trauma informed way?	-
Expert J	3	3
Additional comments:	-	-
Expert R	2	3
Additional comments:	See separate documents re memory reconsolidation.	
Expert N	4	4
Additional comments:	A real strength - very good care to open and close sessions	Yes, very clear.

Figure 36 - Validation Stage 1. Rubrics, question 4: demonstrates acceptability

9.1.15. Demonstrates problem relevance

Comprehensiveness	Clarity
4	4
-	-
3	3
Trauma is certainly a relevant problem. The etiology of trauma and range of manifestations of trauma could use clarification. For example, there is some confusion surrounding the definitions of trauma. In the intro there is no reference to ICD9 or DSM5 and there is the focus of this manual to address a range of symptoms of trauma, but these can change quite	Clarity will improve overall when definitions and approaches are more specific and clearly defined.

	significantly depending upon the experience, presentation, etc. There is inclusion of ACES but could be bolstered by more applicable and thorough resources that pertain to this population and also inform the larger areas of trauma. Etiology; type of trauma, type of interventions specific to bx presentation could be clarified. Art therapy interventions that have been used in the past to inform present protocol. Ambiguity of protocol itself; the diagram looks good but the instructions are less clear in terms of explaining the 12 sessions.	
	4	4
	-	-
	4	4
	Again, a real strength.	Yes, I think people will find their problems sensitively but clearly described.

Figure 37 - Validation stage 1. Rubrics, question 5: demonstrates problem relevance

9.1.16. Demonstrates knowledge of Art Psychotherapy principles: theories and practice

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:	-	-

Expert J	3	3
Additional comments:	Art psychotherapy is well represented throughout the manual and it is clear that art therapy informs the protocol. A deeper and more thorough description of the theories, models frameworks used in art therapy and where they emerge from would strengthen the piece. While I encourage art therapy interventions of course, I am again not clear how these interventions specifically inform and address and rely upon the 'unwanted emotional learning' (UEL) and empirically confirmed process of erasure (ECPE) in a systematic way. Perhaps instead of developing and adhering to a protocol you could use these theories and methods to inform practice in general. There is only Hass Cohen references re: integration of trauma experiences and cognitive restructuring. Where does this come from? How does ECPE. Wondering about the art materials and the survey Jayne (2021) is not in the reference list. Opportunity for sharing art works; this is a nice inclusion, is it part of the protocol ongoing? There invites a whole different conversation about community-based art making and artwork, I am wondering how this section and continuity of care can be integrated more explicitly. Similar to the inclusion of vicarious traumatisation how will this be considered and is there accountability in the process? Including these areas are important	-

	but I wonder if it detracts from the focus of the manual and the intervention?	
Expert R	4	4
Additional comments:	To the best of my knowledge. Art Psychotherapy is not my area of speciality.	
Expert N	3	4
Additional comments:	Yes, good description of literature, though I think competencies could be stronger.	Very well-articulated.

Figure 38 - Validation stage 1. Rubrics, question 6: demonstrates knowledge of Art Psychotherapy principles: theories and practice

9.1.17. Demonstrates knowledge of psychological trauma and trauma informed care

	Comprehensiveness	Clarity
	3 Psychological responses to trauma more than trauma informed care, which is more of an outline.	3 As previous.
	3 See above problem relevance. Danger in lumping stress syndromes and behavioural presentations into a manualised treatment. Also concerns with intake/assessment in capturing the nuances of stress syndromes and behavioural variances. The piece could be strengthened with citations and references that are scientifically sound and more thoroughly present the neurobiological underpinnings of art therapy approaches (based on work conducted in similar professions). Explaining how these theories (whether evidence based or not) inform the protocol more specifically would also be useful. For example p. 19 there is mention of how	2 Same as above comment re: problem relevance; I see these domains as quite similar but perhaps I am not understanding. Overall I don't quite understand the title of the protocol…what does this

	theories inform psychotherapy in general, but how do these translate to art psychotherapy? Are trauma informed considerations any different for this protocol than any other? Should they be cited?	actually mean, unification neuro-informed? Do you mean bringing together different neuro-informed theories in one singular approach? ECPE: Empirically confirmed? UEL: Clarity needed with manifestation and applications in treatment.
	3	3
	-	-
	4	4
	A strength.	Very clear.

Figure 39 - Validation stage 1. Rubrics, question 7: demonstrates knowledge of psychological trauma and trauma informed care.

9.1.18. Method: Demonstrates a clear and concise explanation of session content and aims

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:	Very clear.	-
Expert J	2.5	2.5

Additional comments:	See above, accuracy. How do the interventions specifically address the three stages that underlie them? Where did TIA come from? (Trauma Informed Approach) Is there a script? Would this be of value? Is there psychoeducation regardless of the state of the client upon start of session? Is psychoeducation always the same? The images in the manual are nice, but what is their point? Who are they by (clients/artists)? What if the clients are not prepared to respond to the prompts that are being presented?	Is this protocol going to be tested?
Expert R	3	3
Additional comments:	-	-
Expert N	2	3
Additional comments:	Perhaps (in addition to competencies) it may be useful to help the reader think about what they are trying to achieve in each session, and how they might assess if the achieved those aims.	Very clear.

Figure 40 - Validation stage 1. Rubrics, question 8: Method of instruction: demonstrates a clear and concise explanation of session content and aims

9.1.19. Demonstrates theoretically informed and empirical grounding

	Comprehensiveness	Clarity
Expert I	3	3
Additional comments:	There is some disagreement amongst researchers around the necessity of bilateral movement during trauma processing.	-
Expert J	2	2

Additional comments:	See above in accuracy domain.	-
Expert R	2	3
Additional comments:	-	-
Expert N	4	4
Additional comments:	Very comprehensive.	Very clear.

Figure 41 - Validation stage 1. Rubrics, question 9: demonstrates theoretically informed and empirical grounding

9.1.20. Demonstrates prioritisation of safety for clients with a person-centred and flexible approach

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:	Fully agree with this – very flexible approach and opportunity to extend sessions.	-
Expert J	3	3
Additional comments:	Attempt made to prioritise safety and environment. Could be tightened up. See comments especially re: intake. While there is emphasis that clients move throughout the stages during the process of therapy, examples for how this might happen, what this might look like, why, etc. would be useful.	-
Expert R	4	4
Additional comments:	-	-
Expert N	4	4
Additional comments:	This is a strength - will be even stronger if aims of session (above) are perhaps articulated.	Very clear.

Figure 42 - Validation stage 1. Rubrics, question 10: demonstrates prioritisation of safety for clients with a person-centred and flexible approach

Within this stage one time frame, two of the experts voluntarily provided additional feedback on the UNTRAP manual. One expert gave feedback from a memory reconsolidation perspective. Her main points of reference were the suggestion that the term 'unwanted emotional learning' was changed as it potentially implies a negative association with how a person may have experienced and survived traumatic events. She emphasised that the emotional learning at the time of the trauma events is a demonstration that the emotional brain adapts and works to enable survival, that this is not a negative process, and an acknowledgment of this process is essential for memory reconsolidation. The expert states:

"Emotional learnings are created for adaptive purposes. The fact that they persist, unchanged, indefinitely (even when no longer needed) and can create other problems is typically what leads people to therapy. Those other problems of emotion, behaviour, thought, somatics, etc.—generated by the emotional learnings—are clearly unwanted, but to label the emotional learnings themselves as unwanted pathologises them, making them "wrong" in some way".

The expert adds that:

"although the trauma is no longer happening, so in the therapist's view the emotional learning is no longer wanted, the learning isn't over… and then there's the further complexity that it may well be in the client's best interest to retain some portion of that learning".

In response to this focus area, I changed the term 'unwanted emotional learning' to 'emotional learning' or 'schema'. In relation to the term used in the manual 'memory recall', the expert states:

"I think it's very important to explain the different types of memory involved. Autobiographical (episodic) memory of events is not absolutely necessary in order to heal from trauma. It can be helpful but isn't essential. What's essential is the discovery and transformation of the implicit emotional memory (or learnings or knowings) that were formed in the wake of the experiences, i.e. the meanings that were formed, which is a type of semantic memory. It's important to understand that autobiographical memory of events and experiences remains intact after an emotional learning is dissolved. It's the meanings of those experiences that become transformed'.

In response to this feedback, the manual was edited to define the terms and ensure the autobiographical memory of events remain intact, and to focus on the emotional learning in attempt of memory reconsolidation. The expert suggested additional terms to be added to the glossary, such as 'traumatic memories', 'Coherence Therapy', 'implicit'

and ‘explicit’ memories, and for the manual to be augmented to add case examples or use the examples she provided, of how the theory may be presented and applied in sessions.

Another expert (I) gave feedback from the perspective of having lived experience of trauma. Referring to the manual glossary explanation of the term ‘emotional dysregulation’ she stated, “I wonder if disproportionate is less offensive than inappropriate”. The glossary stated:

Emotional dysregulation – Emotional dysregulation is any excessive or otherwise poorly managed mechanism or response. This can be an extreme or inappropriate emotional response to a situation that may be associated with psychological trauma, or other causes such as brain injury, autistic spectrum disorder or personality disorders. Emotional dysregulation refers to the inability of a person to control or regulate their emotional responses to provocative stimuli or when triggered (APA, 2020).

In response to her comment on this, I changed the wording to ‘disproportionate’.

The expert further suggested, when referring to grounding and selfcare techniques within the session structure:

“When working with lived experience colleagues, this is the one activity all have said aggravates them most when told this may be helpful. Having therapists/MH professionals tell you to take a hot bath can feel very dismissive. Maybe leave this open to suggestion by the client, ask them what helps normally”.

In response, amendments were made to the manual accordingly.

9.1.21. UNTRAP treatment manual validation stage 2 – expert panel meeting

Expert panel members were invited to attend an online meeting to discuss and compare scores and comments made in the first stage. All experts attended the meeting, as did the Research Assistant (HR) and the Chair (KJ). The meeting lasted for two hours. For details of the content, see appendix 3, the transcription of the audio recording.

The meeting adhered to the following schedule:

- Introductions
- The Research Assistant, explained about the audio recording and transcription. The panel were asked to provide confirmation that the transcription would be accurate before further amendments were to be made to the manual, within 24 hours of receiving the transcript.

- Information was provided about the structure of the validation process – experts were asked for confirmation if they do or do not wish to be included in any publications of articles of the validation process in the future. An explanation of the meeting structure and aims were provided with information about Stage 3 of the validation process. Experts were invited to ask questions if needed. If the experts wished to amend their scores for the rubrics during or after the meeting, experts were asked to send them within 24 hours of the meeting ending.
- Reflection and discussion on stage 1 rubrics score. Chair/Researcher remained neutral and did not give input as to avoid steering the scoring. Chair/Researcher did respond to questions about the manual to provide clarity for the experts.
- June 18th panel will receive an amended version of UNTRAP. Panel to complete the final rubrics by June 23rd.
- Any other business.
- Close

Each expert gave insight from their area of expertise in relation to the manual. Views and opinions were shared, and questions were asked for elaboration on each point. Expert J gave input in relation to a neurological perspective and asked for clarity on the meaning of empirically confirmed process of erasure (ECPE), the empirical grounding and how this was used within the manual. Expert R responded with clarity from a Coherence Therapy, memory reconsolidation perspective. Expert J asked further about the meaning of 'memory' and what the term referred to specifically in the manual. She advised to add more clarity and defined explanation of this. Expert J expressed clearly that examples were needed to describe the type of memory, for example 'somatic' memory. Expert J asked for clarity on the recruitment process and the alternative options for the client should they wish not to engage in UNTRAP treatment.

The phrase used in the first version of the manual; 'unwanted emotional learning' was discussed in depth. Expert R explained her concerns about this term and how it could pathologise the client with a negative association of their survival processes. The response to this point from the other experts was supportive and in agreement. Further agreement was made in relation to asking the clients what grounding and self-care techniques the client wished to use or had already established, as opposed to suggesting 'have a hot bath' as an option. The consensus among the experts was that the client's process should lead the treatment process and the therapist must respond to that in a flexible way. Expert

R and expert N stated that the manual should not be used as a ‘cookbook recipe’ (expert N), but a guide, and that it is likely that the client may need more time to reach memory reconsolidation.

Expert N referred to the manual as a potential set of principles for the therapist. He stated that he saw the fundamentals of the manual as having three users: the therapist, the researcher, and the client, and that it needs to be framed accordingly. Expert N discussed the importance for the manual to be flexible and to enhance the portrayal of the principles for working with people who have experienced complex trauma.

Expert R stated that the memory reconsolidation part of the treatment cannot be dictated or planned, mostly it happens spontaneously, and the therapist responds to it when it arrives. She emphasised the importance to identify the clients emotional learning from the trauma experiences. Expert R asked for clarity on how the manual captured this process through image making and asked that the manual has more of an explanation of the details for this process. Experts N and R suggested the use of layman language more for the client information document part of the manual.

Expert I contributed to discussions from the perspective of having lived experience of trauma and used examples of how she had experienced previous therapeutic treatment to enhance her points. For example, she referred to her previous experience of being offered Art Psychotherapy treatment and how she felt ‘slightly intimidated’ as she ‘did not really understand what it was or how to use the art making without feeling not good enough at art’. She stated that the recruitment process for the manual treatment needs to be informative and thorough. She added that her experience of Art Psychotherapy treatment was ‘helpful’, and she liked a focused and explanatory version in the form of a structured treatment manual.

The meeting ended with agreement among the experts that the manual needs to be clearer regarding the meaning of phrases and terminology, shorter, and the language should be simplified in parts.

9.1.22. UNTRAP treatment manual validation – rubrics stage 3

The experts were sent the rubrics scoring document and were asked to score the questions with focus on the amended version of the manual, following the stage 2 online meeting. The scorings were based on the same scale of 1-4 as the stage one rubrics version.

1 - This component is not addressed comprehensively.

2 – Major revision is required.

3 – Minor revisions are required.

4 - This component is addressed comprehensively

9.1.23. Manual structure

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	3	4
Additional comments:		
Expert R	4	4
Additional comments:		
Expert N	4	2
Additional comments:	The manual is very comprehensive. Theory, practice descriptions.	The manual may be a little too long, in that it repeats some aspects (environment, materials etc). Although I love the pictures, I wonder about

	their purpose or unintended consequences - what if the imagery in the session is not so skilled?

Figure 43 - Validation stage 3. Rubrics, question 1: manual structure

9.1.24. Demonstrates accuracy

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	3	3
Additional comments:		
Expert N	3	2
Additional comments:	I am satisfied within the realm of my knowledge but can't comment on neuroscience.	Can we link theoretical concepts directly to why an action is being taken please?

Figure 44 - Validation stage 3. Rubrics, question 2: demonstrates accuracy

9.1.25. Demonstrates feasibility

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	3	3

Additional comments:		
Expert N	4	4
Additional comments:	This is a well-rounded intervention.	This would guide practice and is doable in the world of practice.

Figure 45 – Validation stage 3. Rubrics, question 3: demonstrates feasibility.

9.1.26. Demonstrates acceptability

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	-	-
Additional comments:		
Expert R	3	3
Additional comments:		
Expert N	3	4
Additional comments:	I recognise this as a well-grounded way of working. Perhaps inclusion of service user experience may strengthen.	I can see myself doing this.

Figure 46 - Validation stage 3. Rubrics, question 4: demonstrates acceptability

9.1.27. Demonstrates problem relevance

	Comprehensiveness	Clarity
Expert I	4	4

Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	4	4
Additional comments:		
Expert N	4	2
Additional comments:	All the elements are there to address trauma.	I think the manual is best (though inconsistent) when it defines the what, why and how (including assessing impact) of the intervention - all the elements are there, but for clarity as a user of the manual I would find this helpful as a structure.

Figure 47 - Validation stage 3. Rubrics, question 5: demonstrates problem relevance

9.1.28. Demonstrates knowledge of Art Psychotherapy principles: theories and practice

	Comprehensiveness	Clarity
Expert I	4	4

Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	4	4
Additional comments:		
Expert N	4	3
Additional comments:	Very comprehensive.	I think it could be shortened. It's a strength that it now includes the target audience of ATs. Now that is done, I think it may oversell the need to understand trauma as this is already a battle that is won.

Figure 48 - Validation stage 3. Rubrics, question 6 : demonstrates knowledge of Art Psychotherapy principles: theories and practice

9.1.29. Demonstrates knowledge of psychological trauma and trauma informed care

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	3	3

Additional comments:		
Expert N	4	
Additional comments:		Similar comment to above. Perhaps being more concise to an audience that is already informed.

Figure 49 - Validation stage 3. Rubrics, question 7: demonstrates knowledge of psychological trauma and trauma informed care

9.1.30. Method: Demonstrates a clear and concise explanation of session content and aims

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	3
Additional comments:		
Expert R	3	3
Additional comments:		
Expert N	3	3
Additional comments:	I liked the inclusion of what to do and not do. Could we still include something about how to tell if it is going well or badly and I would need to change track.	Its better because it separates out practice description. I still think what, why, how

		structure may serve clarity if applied more consistently.

Figure 50 - Validation stage 3. Rubrics, question 8: Method of instruction: demonstrates a clear and concise explanation of session content and aims

9.1.31. Demonstrates theoretically informed and empirical grounding

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	3	3
Additional comments:		
Expert N	4	4
Additional comments:	Very thorough.	As strength of the manual.

Figure 51 - Validation stage 3. Rubrics, question 9: demonstrates theoretically informed and empirical grounding

9.1.32.

9.1.33. Demonstrates prioritisation of safety for clients with a person-centred and flexible approach

	Comprehensiveness	Clarity
Expert I	4	4
Additional comments:		
Expert J	4	4
Additional comments:		
Expert R	4	4

Additional comments:		
Expert N	3	3
Additional comments:	I still think it need something about identifying when it's not on target and how to return to grounding would help.	It's clear - but direction to re-set to grounding would help.

Figure 52 - Validation stage 3. Rubrics, question 10: demonstrates prioritisation of safety for clients with a person-centred and flexible approach

9.1.34. Rubrics scores

Figure 55 shows the scores for stage 1 and stage 3 rubrics for all experts. Stage 2 is not included here as no experts decided to change their scores during the online meeting. The data reports an improvement in scores from most experts, for most questions in stage 3 scorings. This suggests that the UNTRAP treatment manual has progressed and gained acceptability for the next stage of testing, with some pointed necessary amendments (scoring of 2) from expert N.

The data was applied to SPSS for further analysis, with aim to identify significant changes in the score sets. No changes in the data sets were identified as significant.

Expert I		Expert J		Expert R		Expert N	
Stage 1	Stage 3	Stage 1	Stage 3	Stage 1	Stage 3	Stage 1	Stage 3
3	4	3	3	4	4	3	4
4	4	2	4	2	3	4	3
4	4	3	4	3	3	3	4
3	4	3	4	2	3	4	3
4	4	3	4	4	4	4	4
4	4	3	4	4	4	3	4
3	4	3	4	3	3	4	4
4	4	2	4	3	3	2	3
3	4	2	4	2	3	4	4

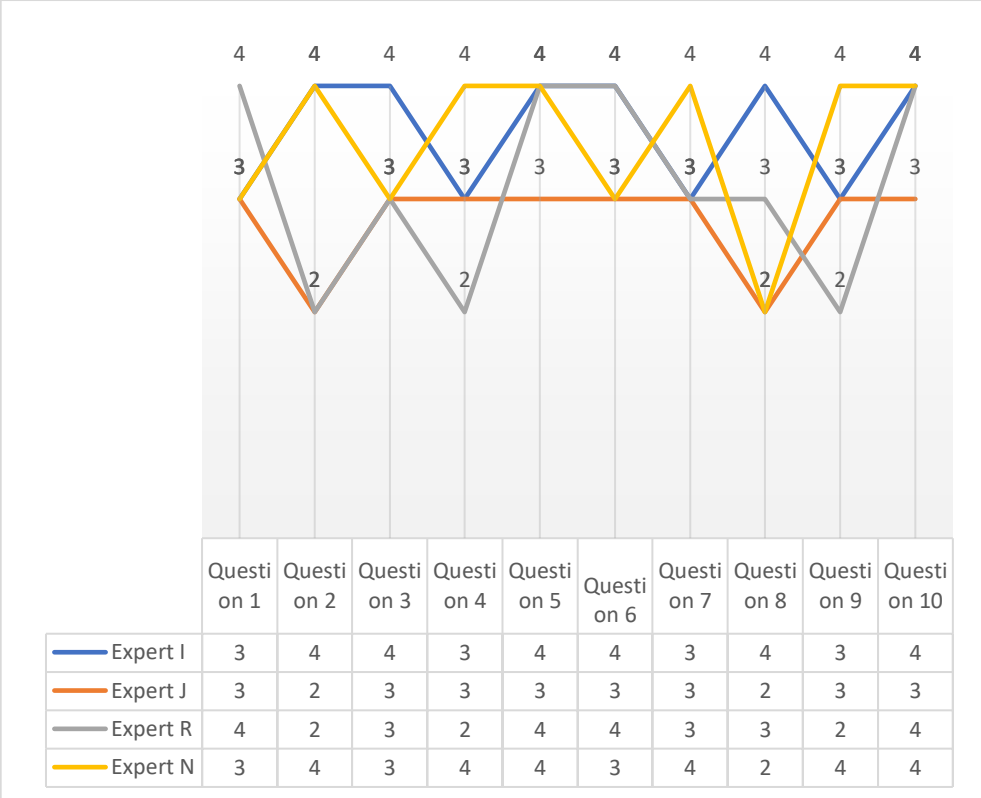
4	4	3	4	4	4	4	3

Figure 53 - Scoring data for comprehensiveness, UNTRAP manual validation process

Expert I		Expert J		Expert R		Expert N	
Stage 1	Stage 3	Stage 1	Stage 3	Stage 1	Stage 3	Stage 1	Stage 3
3	4	2	4	4	4	4	2
4	4	2	4	3	3	4	2
4	4	2	4	3	3	4	4
3	4	3	4	3	3	4	4
4	4	3	4	4	4	4	2
4	4	3	4	4	4	4	3
3	4	2	4	3	3	4	/
4	4	2	3	3	3	3	3
3	4	2	4	3	3	4	4
4	4	3	4	4	4	4	3

Figure 54 - Scoring data for clarity, UNTRAP manual validation process

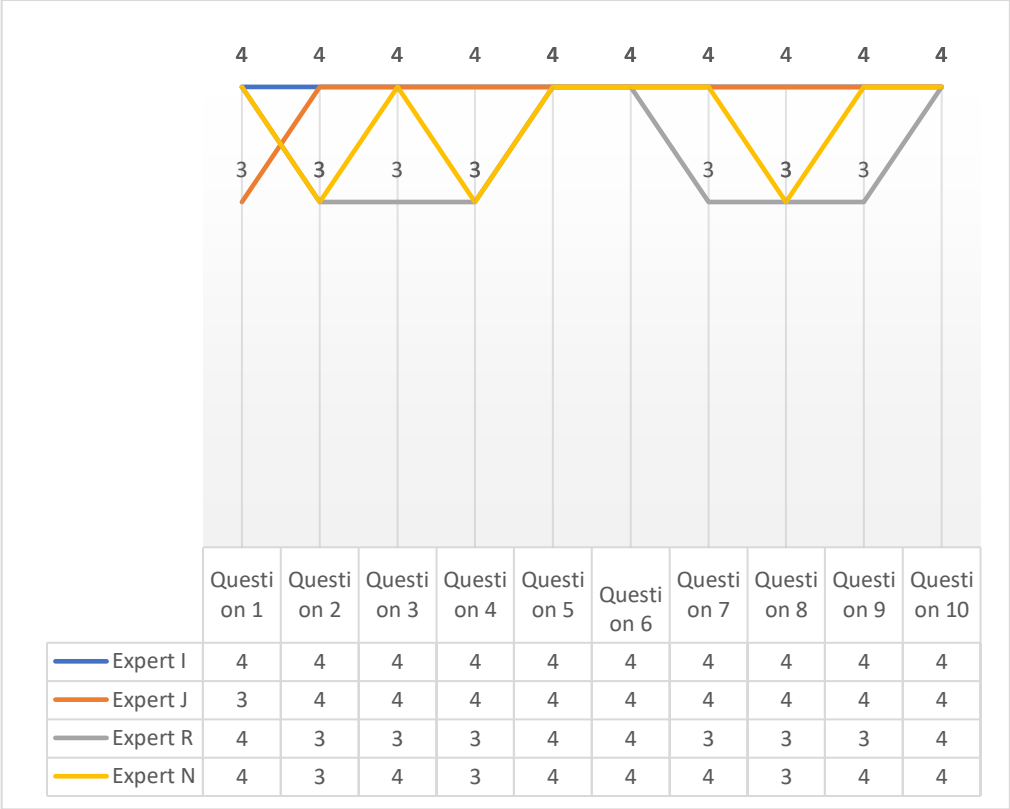
The two following line graphs outline the differences in scores for each expert, for all questions in stage 1 then in stage 3, for either comprehensiveness or clarity. Blue represents Expert I; orange represents Expert J; grey represents Expert R; and yellow represents Expert N. The number scores are placed accordingly.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
Expert I	3	4	4	3	4	4	3	4	3	4
Expert J	3	2	3	3	3	3	3	2	3	3
Expert R	4	2	3	2	4	4	3	3	2	4
Expert N	3	4	3	4	4	3	4	2	4	4

Figure 55 - All scores for stage 1: comprehensiveness

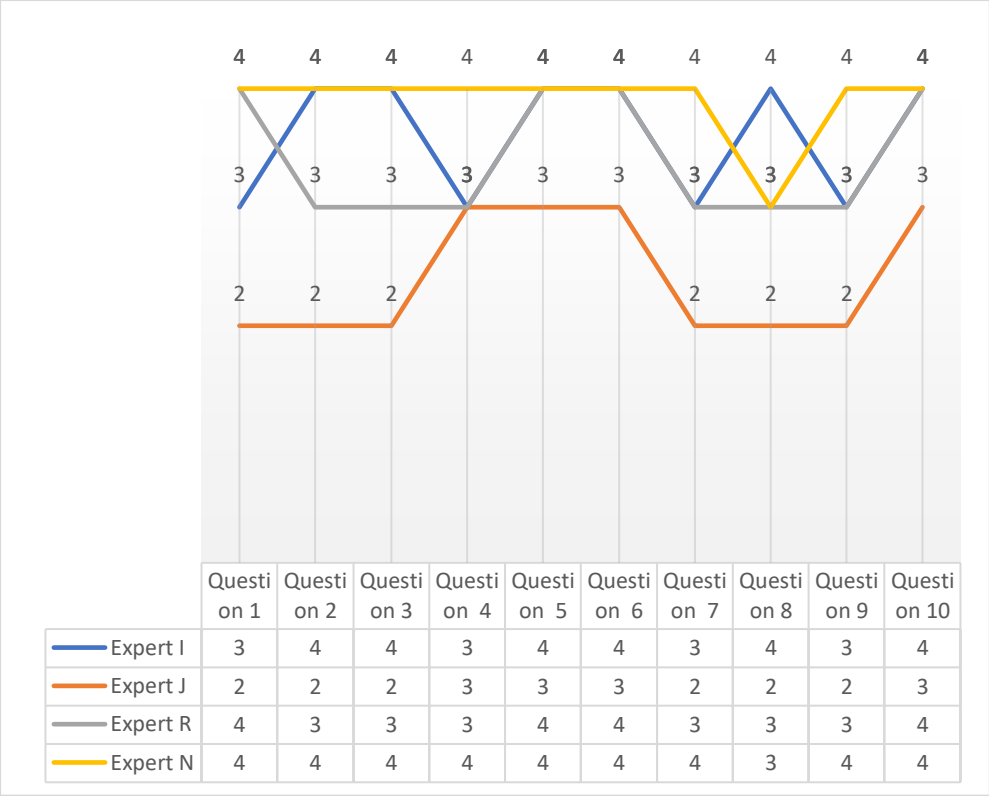
For comprehensiveness in stage 1 scores, three out of four experts reported a requirement for major revision, for four of the ten areas of questioning: demonstrates accuracy; demonstrates acceptability; method of instruction, demonstrates a clear and concise explanation of session content and aims; and demonstrates theoretically informed and empirical grounding. All areas of questioning had at least one expert scoring 4 - this component is addressed comprehensively.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
Expert I	4	4	4	4	4	4	4	4	4	4
Expert J	3	4	4	4	4	4	4	4	4	4
Expert R	4	3	3	3	4	4	3	3	3	4
Expert N	4	3	4	3	4	4	4	3	4	4

Figure 56 - All score stage 3: comprehensiveness

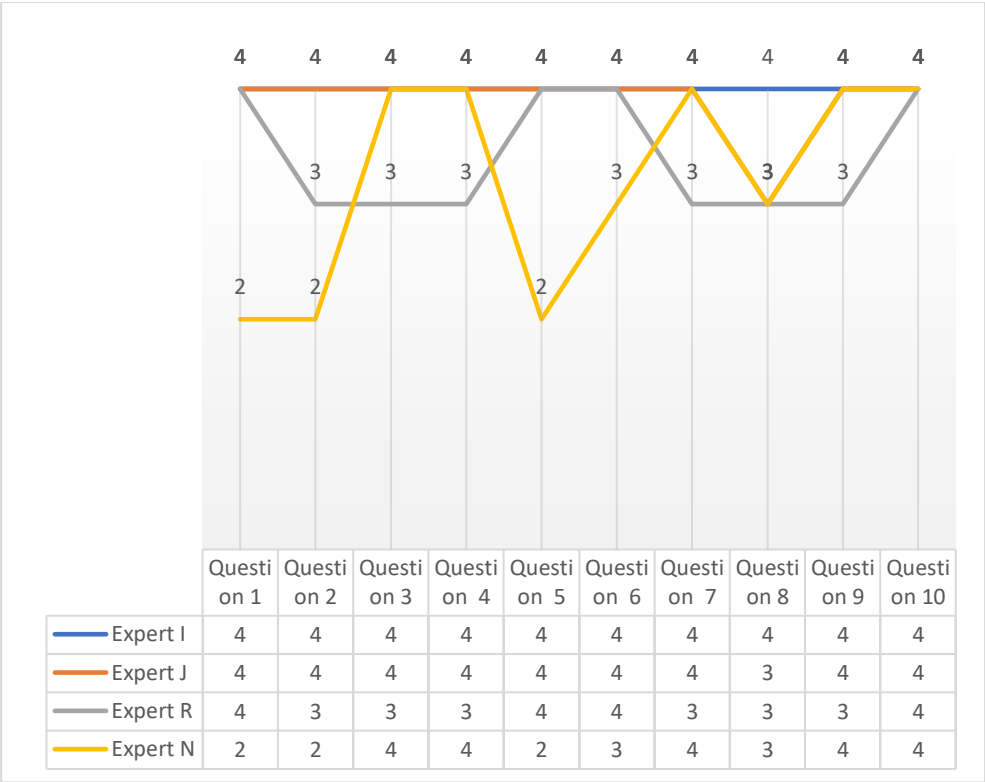
For comprehensiveness in stage 3 scores, the data shows an improvement, with no reported requirements for major revision to the manual (score 2). There are some requirements for minor revisions for seven of the ten areas of questioning. The questions that have been scored by all experts with 4 - this component is addressed comprehensively are: demonstrates problem relevance; demonstrates knowledge of Art Psychotherapy principles: theories and practice; and demonstrates prioritisation of safety for clients with a person-centred and flexible approach. Expert I scored 4 - this component is addressed comprehensively, for all questions, and Expert J scored nine of the ten questions with 4. The scores report clear improvement for comprehensiveness with some required minor revisions.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
Expert I	3	4	4	3	4	4	3	4	3	4
Expert J	2	2	2	3	3	3	2	2	2	3
Expert R	4	3	3	3	4	4	3	3	3	4
Expert N	4	4	4	4	4	4	4	3	4	4

Figure 57 - All scores for stage 1: clarity

For the clarity component of the questions in stage 1 scores, Expert J reported major revision (2) for six of the ten question areas. The six question areas being: manual structure; demonstrates accuracy; demonstrates feasibility; demonstrates knowledge of psychological trauma and trauma informed care; method of instruction, demonstrates a clear and concise explanation of session content and aims; and demonstrates theoretically informed and empirical grounding. The other experts scored 3 and 4 throughout, with Expert N scoring nine out of ten questions with 4 - this component is addressed comprehensively.

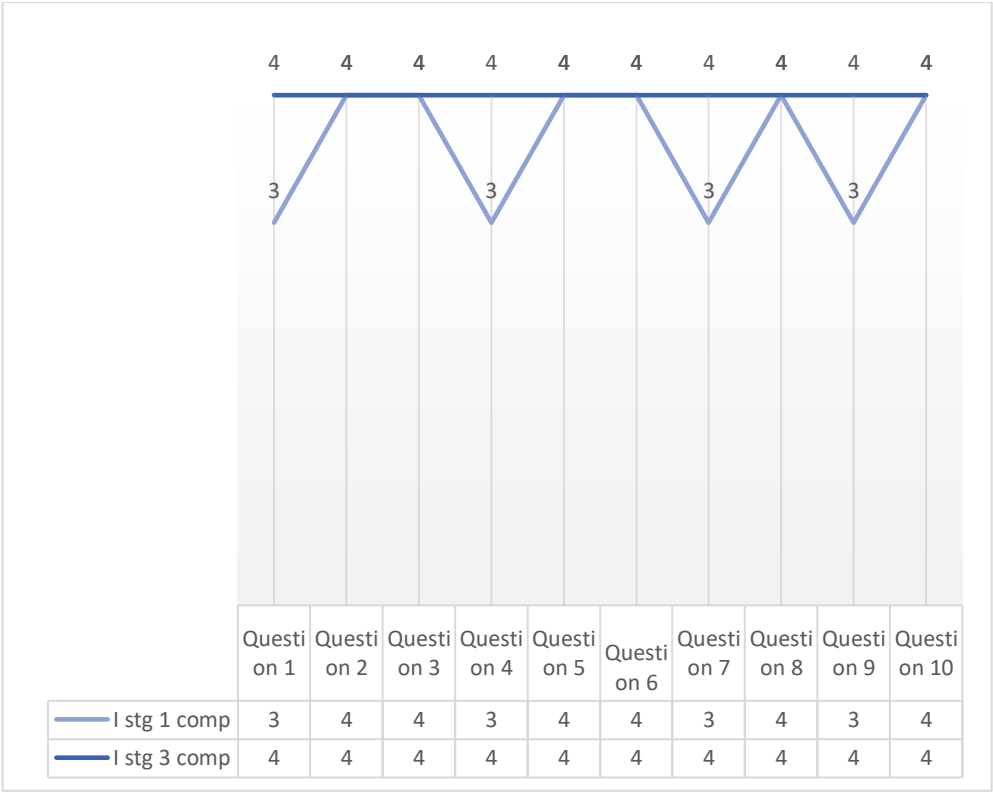


	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
Expert I	4	4	4	4	4	4	4	4	4	4
Expert J	4	4	4	4	4	4	4	3	4	4
Expert R	4	3	3	3	4	4	3	3	3	4
Expert N	2	2	4	4	2	3	4	3	4	4

Figure 58 - All scores stage 3: clarity

For the clarity component of the questions in stage 3 scores, Expert N scored down by 2 scores from 4 to 2 – requires major revision, compared to stage 1 clarity component for three of the questions: manual structure; demonstrates accuracy; and demonstrates problem relevance. Expert R scored the same throughout as stage 1 for clarity, Expert J scored higher for all questions with five questions having an increased score of 2, being: manual structure; demonstrates accuracy; demonstrates feasibility; and demonstrates knowledge of psychological trauma and trauma informed care. Expert I scored 4 for all questions, increasing the score from 3 to 4 for four of the questions.

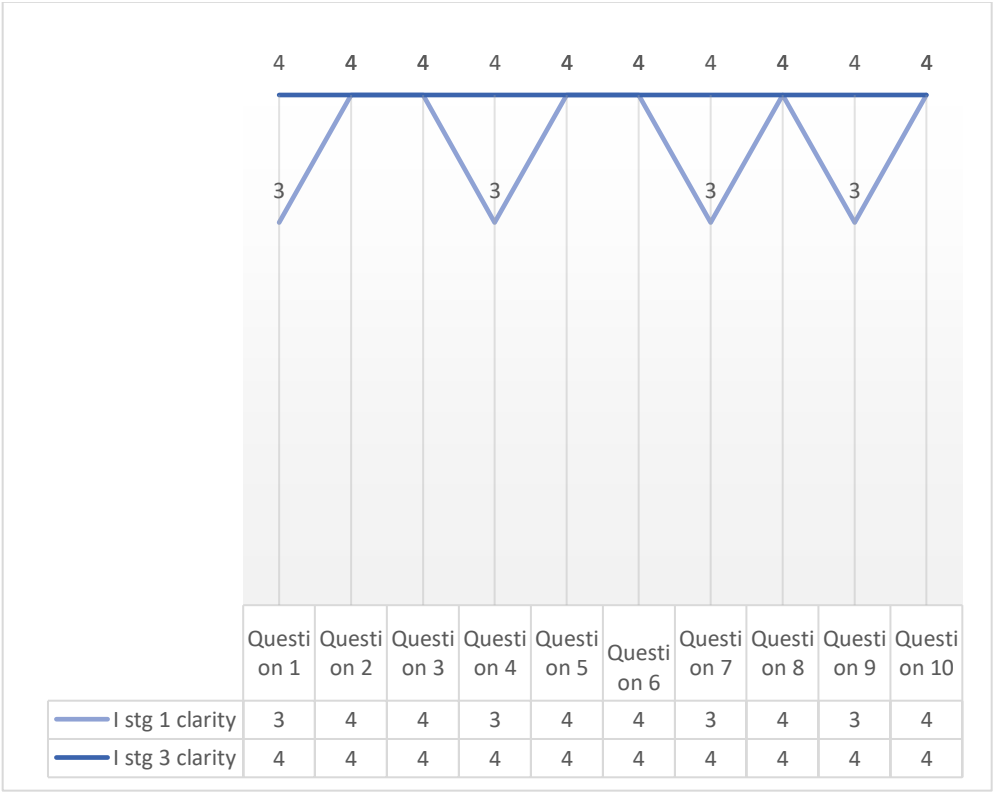
The following line graphs (figures 59 - 66) show individual expert scores with the comparison of stage 1 and stage 3 for each question. The darker tone of each colour representation is for stage 3 scores.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
I stg 1 comp	3	4	4	3	4	4	3	4	3	4
I stg 3 comp	4	4	4	4	4	4	4	4	4	4

Figure 59 - Expert 1 - Scores for stage 1 & 3 comprehensiveness

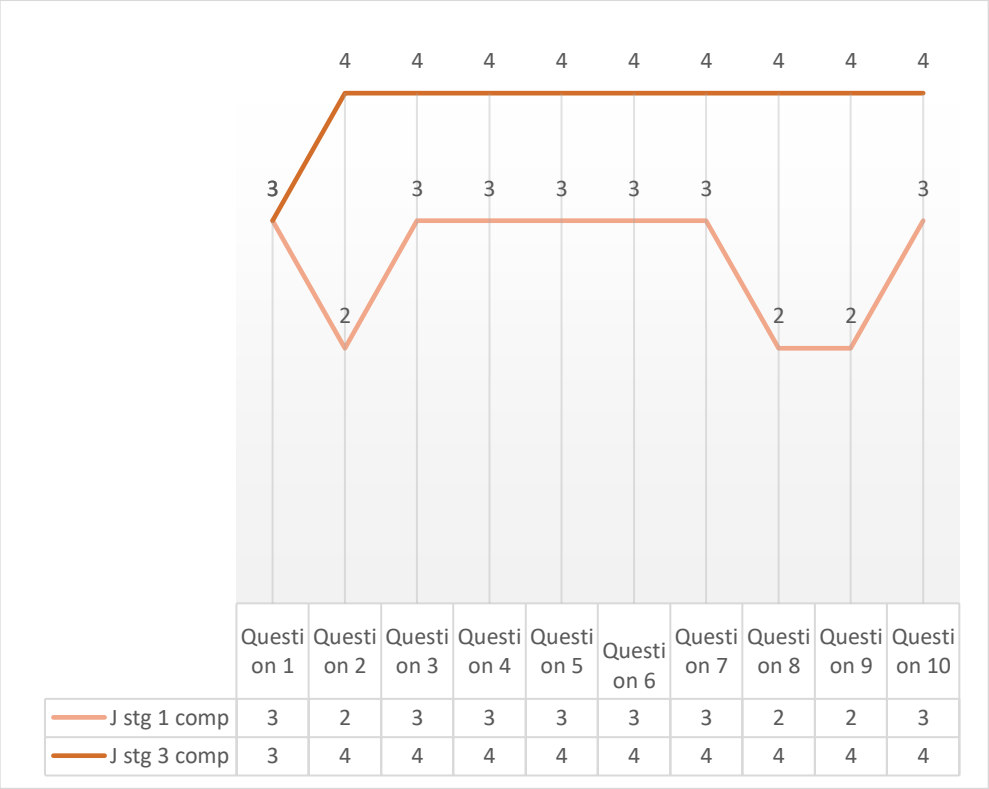
Figure 59 shows the scores for stages 1 & 3 from expert I, for comprehensiveness.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
I stg 1 clarity	3	4	4	3	4	4	3	4	3	4
I stg 3 clarity	4	4	4	4	4	4	4	4	4	4

Figure 60 - Expert I - Scores for stage 1 & 3 clarity

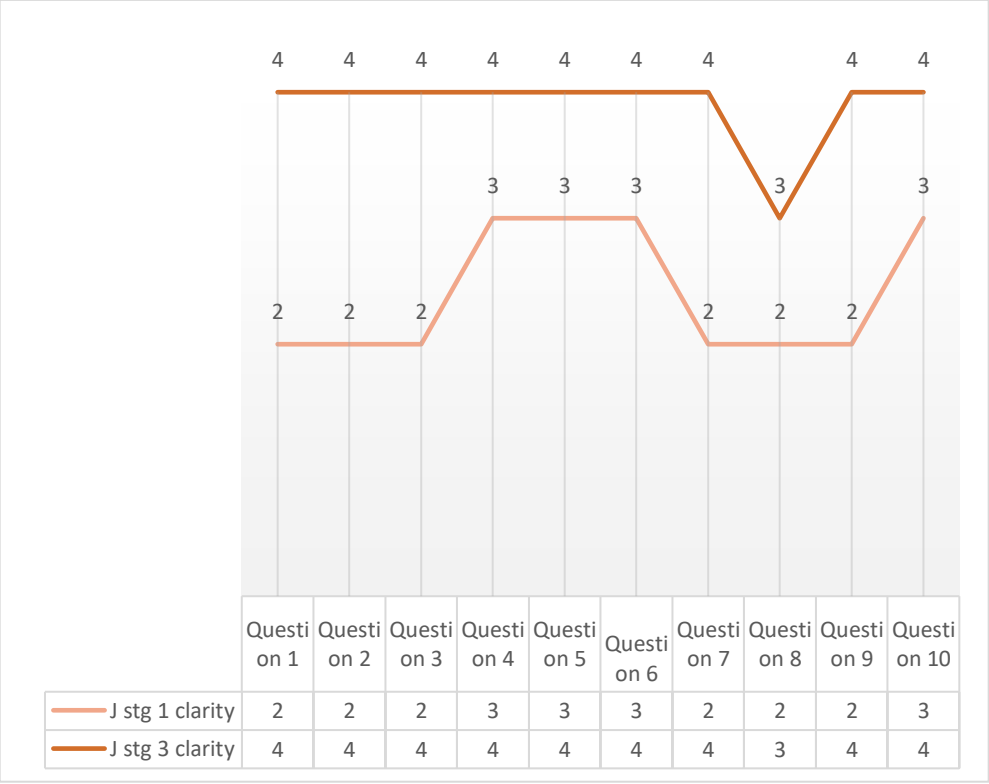
Figure 60 shows the scores for stages 1 & 3 from expert I, for clarity.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
J stg 1 comp	3	2	3	3	3	3	3	2	2	3
J stg 3 comp	3	4	4	4	4	4	4	4	4	4

Figure 61 - Expert J - Scores for stage 1 & 3 comprehensiveness

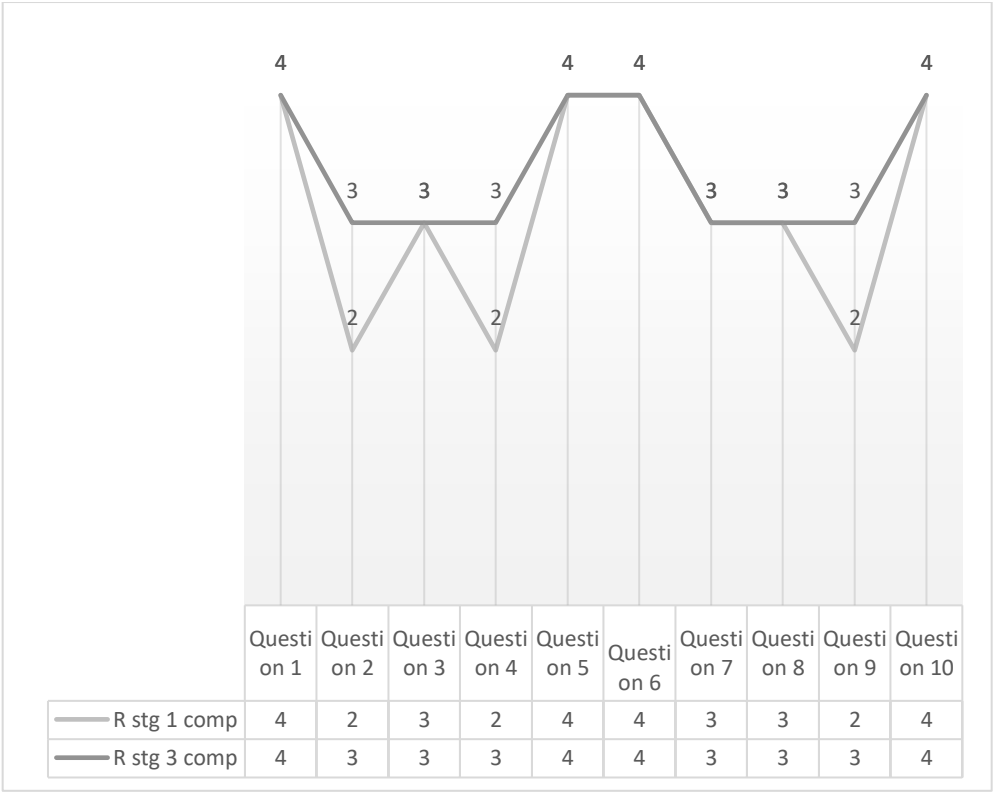
Figure 61 shows the scores for stages 1 & 3 from expert J, for comprehensiveness.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
J stg 1 clarity	2	2	2	3	3	3	2	2	2	3
J stg 3 clarity	4	4	4	4	4	4	4	3	4	4

Figure 62 - Expert J - Scores for stage 1 & 3 clarity

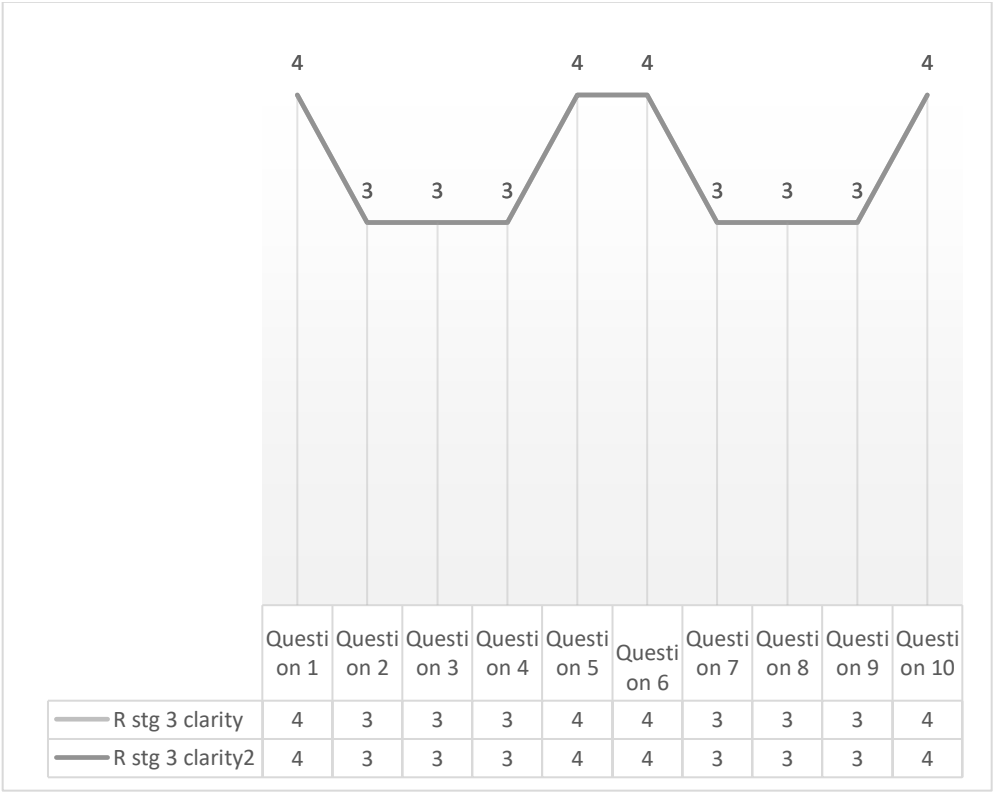
Figure 62 shows the scores for stages 1 & 3 from expert J, for clarity.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
R stg 1 comp	4	2	3	2	4	4	3	3	2	4
R stg 3 comp	4	3	3	3	4	4	3	3	3	4

Figure 63 - Expert R - Scores for stage 1 & 3 comprehensiveness

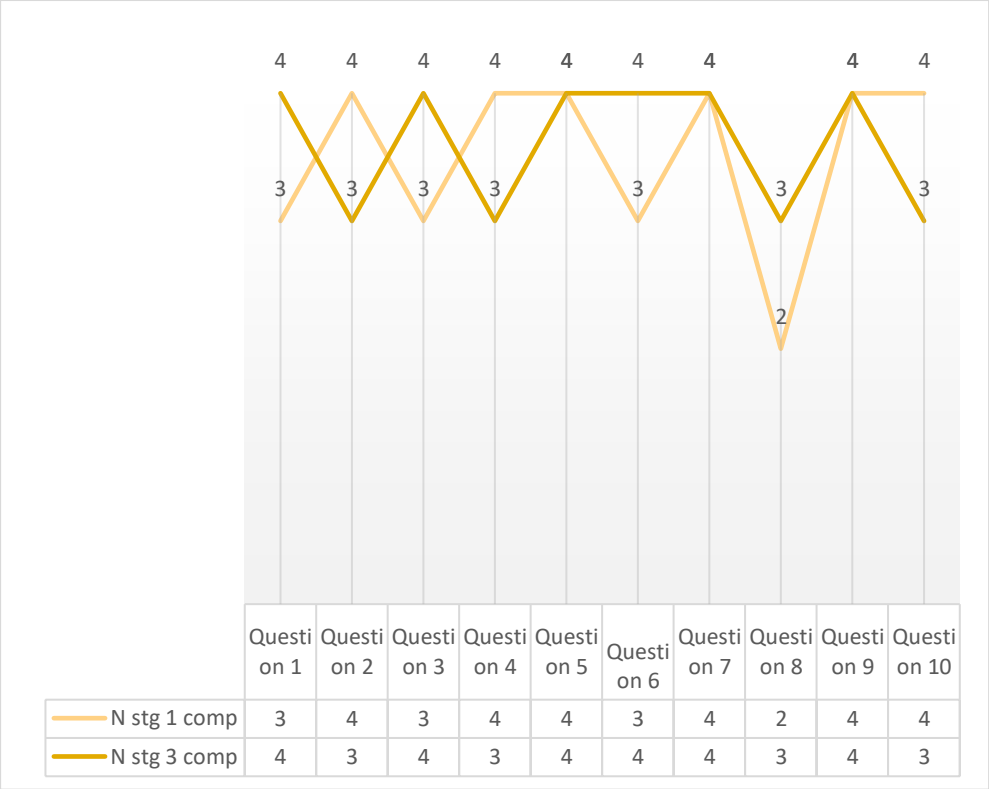
Figure 63 shows the scores for stages 1 & 3 from expert R, for comprehensiveness.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
R stg 3 clarity	4	3	3	3	4	4	3	3	3	4
R stg 3 clarity2	4	3	3	3	4	4	3	3	3	4

Figure 64 - Expert R - Scores for stage 1 & 3 clarity

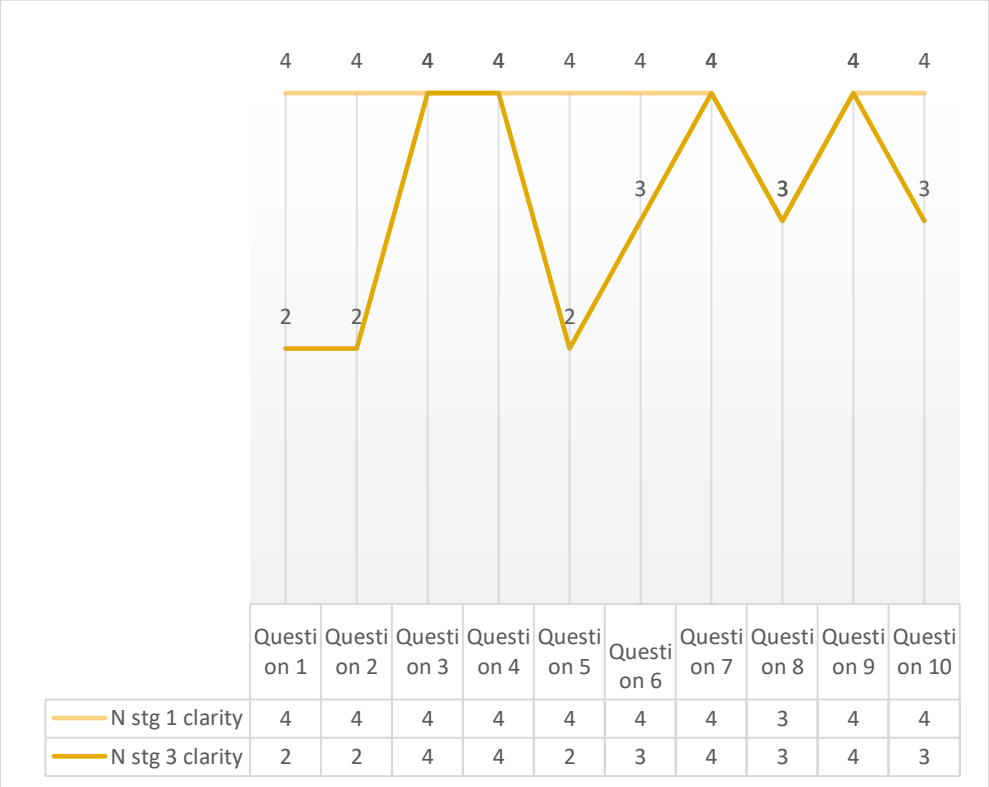
Figure 64 shows the scores for stages 1 & 3 from expert R, for clarity.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
N stg 1 comp	3	4	3	4	4	3	4	2	4	4
N stg 3 comp	4	3	4	3	4	4	4	3	4	3

Figure 65 - Expert N - Scores for stage 1 & 3 comprehensiveness

Figure 65 shows the scores for stages 1 & 3 from expert N, for comprehensiveness.



	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6	Question 7	Question 8	Question 9	Question 10
N stg 1 clarity	4	4	4	4	4	4	4	3	4	4
N stg 3 clarity	2	2	4	4	2	3	4	3	4	3

Figure 66 - Expert N - Scores for stage 1 & 3 clarity

Figure 66 shows the scores for stages 1 & 3 from expert N, for clarity.

A meeting, following receipt of stage 3 rubrics scores, was arranged with Expert N for clarification for the reduction of his scores for clarity from stage 1 to 3. Expert N reported that he recognised progress in the standards of the manual after the amendments were made. However, he reported to recognise improved critical understanding following the online meeting with the other expert panel members and stated that:

"The basis of feedback added more critique for reflection, therefore the scores for stage 3 for clarity reflected this".

Expert N reported that:

"The initial individual scores provide a view which is useful but not a master measure and it needs to speak to many audiences, therefore, the panel meeting discussion is better, allowing a more in depth and thorough response to the questions" (Expert N).

He added that he felt the manual was ready to otherwise be tested following its current state of being a 'working hypothesis version'. Expert N expressed his thoughts on how the manual could be further tested, stating that the moment of delivery of UNTRAP treatment manual can provide proof of effectiveness through data collection of the delivery and receipt of the treatment.

9.1.35. Thematic analysis

Braun and Clarke (2006) describe thematic analysis as being one of several methods that focus on identifying patterned meaning across a dataset. Thematic analysis is an umbrella term used to describe sets of approaches for analysing of qualitative data that share a focus on identifying themes (patterns of meaning). Thematic analysis can be used widely across the social, behavioural and more applied (clinical, health, education, etc.) sciences (Braun & Clarke, 2006).

9.1.36. What is Reflexive Thematic Analysis (RTA)?

Braun and Clarke (2006) call their approach reflexive thematic analysis (RTA) as it differs from most other approaches to thematic analysis in terms of both underlying philosophy and procedures for theme development. Braun and Clarke (2006) report the purpose of RTA to identify patterns of meaning across a dataset that provide an answer to the research question being addressed. Furthermore, that patterns are identified through a process of data familiarisation, data coding, and theme development and revision.

Brawn and Clarke's (2006) Six step Reflexive Thematic Analysis:

- Familiarisation

- Generating initial codes
- Generating themes
- Reviewing potential themes
- Defining and naming themes
- Producing the report

Braun and Clarke report RTA as being theoretically flexible; it suits questions related to people's experiences, or people's views and perceptions, and it suits questions related to understanding and representation (Braun and Clarke, 2006). This is particularly useful for the process of analysing the data from this manual validation, as it identifies the opinions and perspectives brought from each expert panel member. Five of the six Braun and Clarke (2006) RTA steps were identified as necessary for the purpose of this analysis. The steps used are shown in figure 67. Generating initial codes was not included.

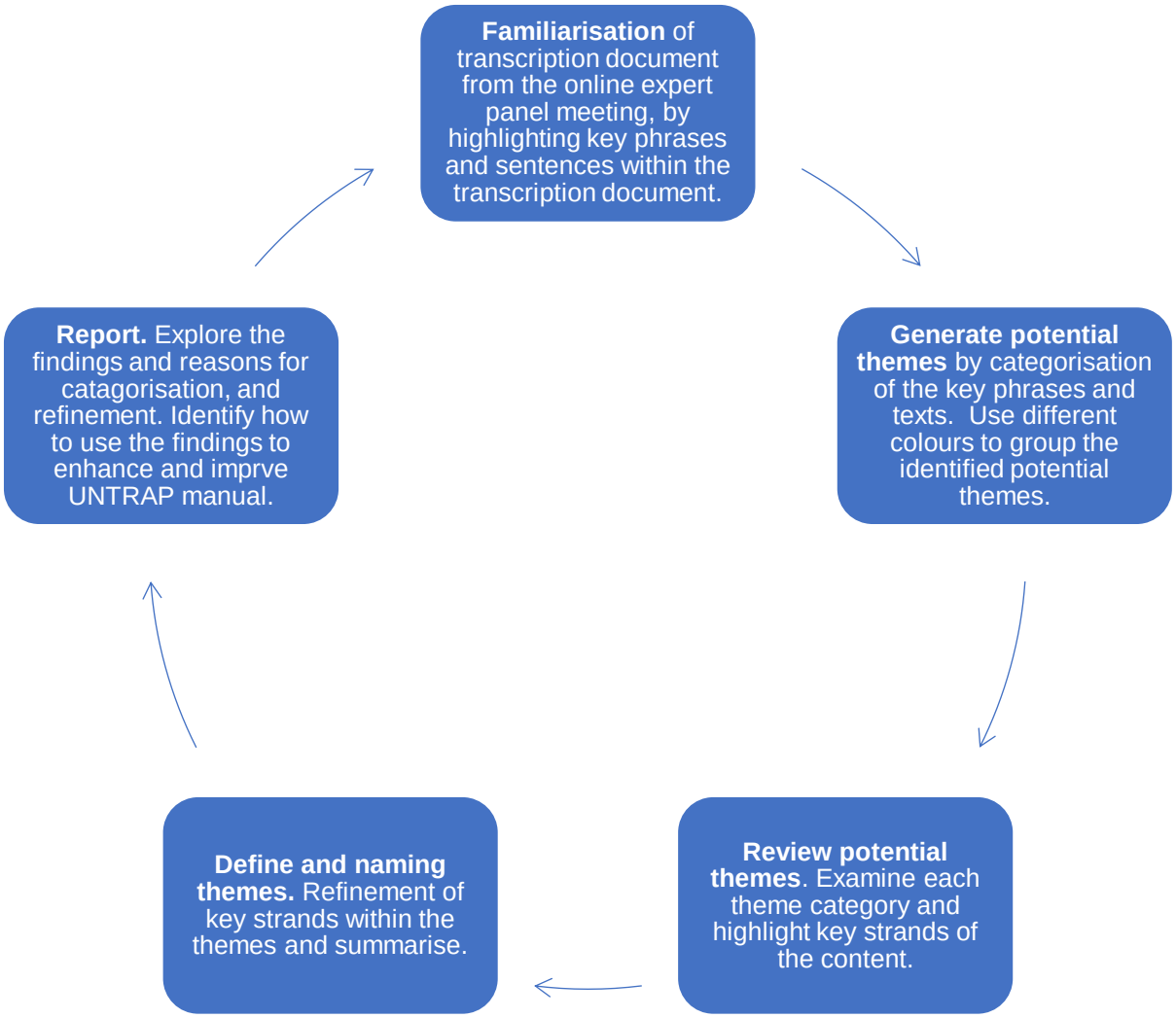


Figure 67 - 5 stages required for Reflexive Thematic Analysis

9.1.37. Familiarisation

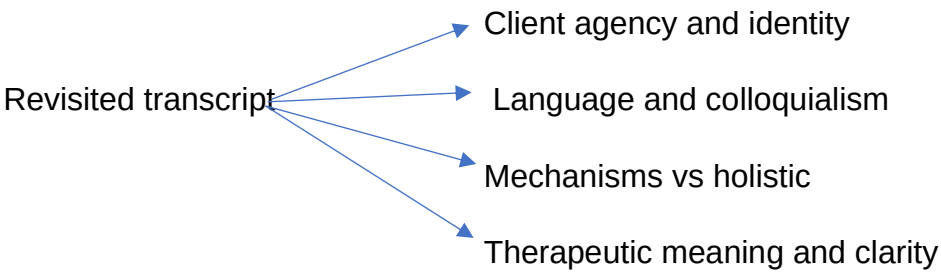
Recording of audio ⟶ written transcript ⟶ panel input ⟶ applied edits

A meeting was held online with all expert panel members to discuss the initial stage of the validation process – rubrics scoring and narrative responses. The meeting was chaired by the Researcher and attended by the Research Assistant. The meeting was recorded with a Dictaphone and the audio data was then transcribed. All expert panel members were sent the transcription and asked to make comment on accuracy. Minor edits were applied, and the final transcription was written.

Generating themes

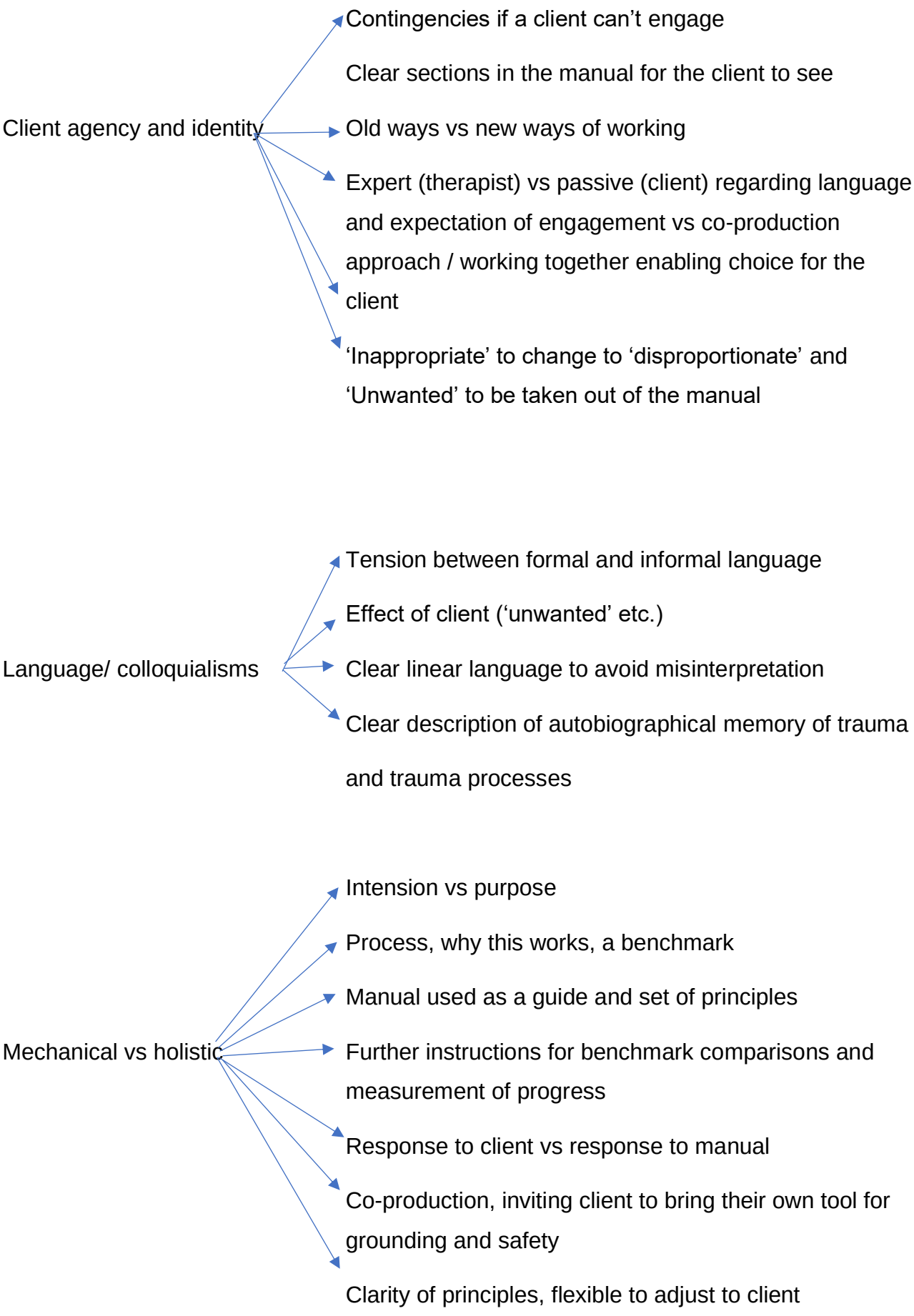
The transcription was revisited and key points within the transcription were highlighted to identify potential threads or patterns of meaning across the transcription dataset. The process occurred individually and in isolation. Potential threads of meaning were intuitively identified without attempt to capture an intended thread.

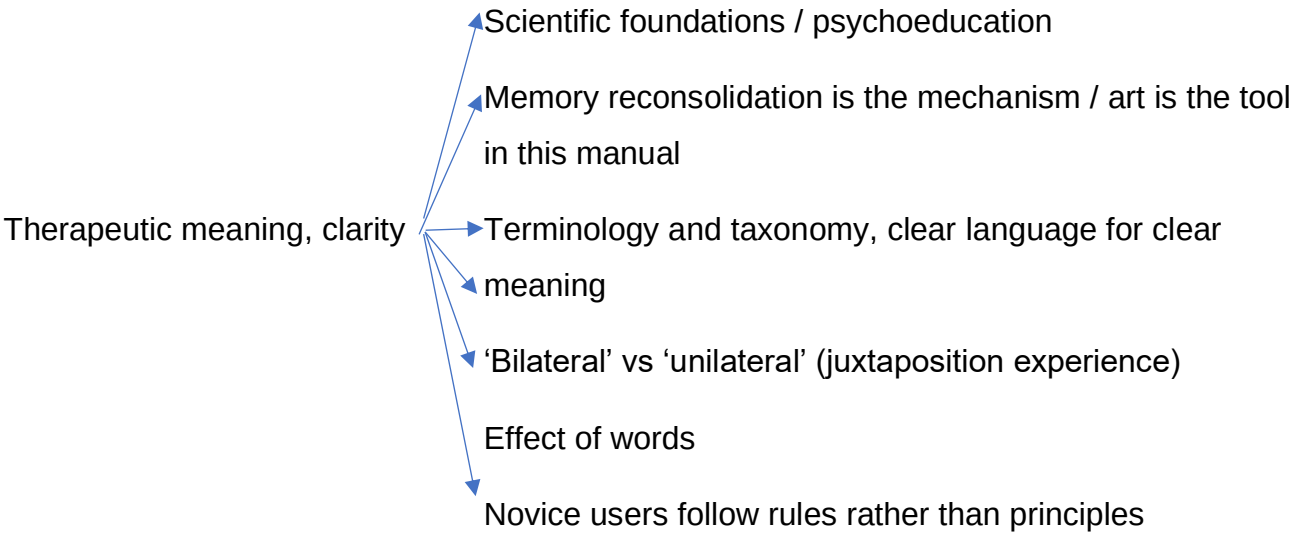
The following categories of themes were then generated:



9.1.38. Review the themes

The process of breaking down the quotations within the transcript enabled further refinement of the content. The transcript was reviewed and a different coloured highlighter was used to mark the quotations relating to the generated themes. Key points resulting from the refinement:


Client agency and identity
Contingencies if a client can't engage
Clear sections in the manual for the client to see
Old ways vs new ways of working
Expert (therapist) vs passive (client) regarding language and expectation of engagement vs co-production approach / working together enabling choice for the client
'Inappropriate' to change to 'disproportionate' and 'Unwanted' to be taken out of the manual
Language/ colloquialisms
Tension between formal and informal language
Effect of client ('unwanted' etc.)
Clear linear language to avoid misinterpretation
Clear description of autobiographical memory of trauma and trauma processes
Mechanical vs holistic
Intension vs purpose
Process, why this works, a benchmark
Manual used as a guide and set of principles
Further instructions for benchmark comparisons and measurement of progress
Response to client vs response to manual
Co-production, inviting client to bring their own tool for grounding and safety
Clarity of principles, flexible to adjust to client



Some of the themes have overlaps of identified points made within the transcript. For example, highlighted within the theme of language and colloquialism, the manual would benefit from having clearer, consistently cited scientifically grounded, linear language to avoid misinterpretation. This is also apparent in the theme of therapeutic meaning and clarity, where terminology and taxonomy are considered to highlight how a therapist may perceive how to use the manual, and that clear language is required for clear meaning. As Expert N puts it,

"that's really important for manuals so we don't each read a word and go and do something different" (Expert N: 302 – 304).

Furthermore, Expert J states, when referring to the definitions within the manual,

"Some might be very specific and nicely cited and then others are more colloquial and kind of conversational" (Expert J: 274 – 277).

Also referring to the definitions within the manual, Expert I reported that, although she:

"found those useful to understand what some of the language meant … the structure overall was quite clear … a bit too text heavy" (Expert I: 197 – 200).

These findings consistently report that the manual requires and would benefit from having simplified, non-colloquial use of language that can be less open to interpretation with simplified and summarised content.

Client agency and identity, featured as an identified theme within the transcript. Further refinement of the theme content showed strong strands identifying how the manual

could be improved. For example, clarity in the text, and having sections for the client to read was a generic suggestion that also related somewhat to the theme strands of language. Expert N and Expert I referred to co-production as an approach to strengthening the impact of the manual for clients. Expert N states that he would:

"be interested in whether the whole co-production thing is the idea of people both being the therapist … as part of the approach" (Experts N &I: 237 – 240).

Expert I, who has lived experience of trauma, agrees when referring to co-production by adding:

"I feel like I've got a choice … like I'm contributing to the therapy process … I feel like I have then some control over how the therapy will work for me and how I might engage in it" (Expert I: 1078 – 1082).

The input from Expert I demonstrates and emphasises the value and importance of co-production. Within this theme and also bridging with the theme of language and colloquialism, Expert I also brings her perception and experience of how the use of words can impact on a client who may access the treatment. She explains that the phrase 'extreme inappropriate emotional response', which was used in the manual to describe how a person may react when triggered, could be challenging for the client. The quoted text (APA, 2020) that described emotional dysregulation within the manual stated:

'Emotional dysregulation is any excessive or otherwise poorly managed mechanism or response. This can be an extreme or inappropriate emotional response to a situation that may be associated with psychological trauma, or other causes such as brain injury, autistic spectrum disorder or personality disorders. Emotional dysregulation refers to the inability of a person to control or regulate their emotional responses to provocative stimuli or when triggered.' (APA, 2020).

Expert I suggested an alternative phrase,

"In place of "inappropriate" use "disproportionate" it could be less offensive" (Expert I: 438 – 440).

Another phrase, 'unwanted emotional learnings' was heavily referred to as not an appropriate term for clients. This was highlighted in all identified themes. The term was initially used, meaning that a person may identify an experience of trauma that created an

emotional learning that may no longer be useful or wanted in a person's current life. For example, a person may learn that men are dangerous, having had a traumatic experience inflicted by a man. At the time of the experience, the learning may have been necessary for safety and survival for the person. It may also enable caution in the future for a person to stay safe. However, the person may eventually come to believe that not all men are dangerous, and the degree of the initial emotional learning may no longer be wanted or relevant. The points made by the experts gave strong suggestion that this use of language may be perceived as the emotional learning being inaccurate, and not be seen as a positive process for survival for the client. Expert I comments:

"I wouldn't want to consider them "unwanted" because that takes away part of my identity of who I built myself to be that I'm now a stronger person" (Expert I: 606 – 609).

Expert R adds:

"I don't think the clients themselves ever experience the emotional learnings as unwanted. It's not a relevant term for clients" (Expert R: 549 – 551).

These insights are extremely valuable in that they demonstrate how language and meaning can be well intended but interpreted in a way that is not conducive or accurate for the client. This process further demonstrates the importance of using clear, sensitive, and non-colloquial language, as well as being widely informed, particularly from people with lived experience. Expert N states, when referring to the term 'unwanted' and how it could be perceived,

"In any sense Kelly, I can see you're not aiming for that at all, it's just a shame if it's inherited language that we haven't really noticed" (Expert N: 626 – 629).

The power and impact of language is a strong strand that runs through all identified themes within the reflexive thematic analysis of this validation process.

Another strand running through the identified theme, client agency and identity, is old way vs new way. Expert N states that:

"There was this long period where therapy was trying to act as if it was prescribing something … experts dispensing something where the patient is passive" (Expert N: 1067 – 1070).

This strand raises an important reflection about a potential power balance within the therapeutic dynamic, and who the expert is within that relationship. Expert N elaborates:

"It's not about having mastery, it's more about having some sort of choice … maybe that is a really important part of what we're trying to do … even our old school Art Therapy language still talks about labelling people" (Expert N: 585 – 598).

This input supports the value in using co-production to include and empower the client by informing treatment manuals and working through a manual as how Expert N states:

"both being the therapist" (Experts N 238).

Further refinement of the identified theme, mechanism vs holistic, revealed important considerations for the manual, particularly relating to applied contingencies, and benchmarks to assess progress and engagement, or non-engagement. Experts asked how they would know if the manual is working, or not working. Expert J asks,

"If the client isn't prepared to be engaged in treatment that way … are those intake procedures specific enough to really be able to capture holistically where the person is" (Expert J: 133 – 138).

She further questions the contingency plan if a person doesn't wish to engage in the treatment manual, adding:

"Would it be treatment us usual?" (Expert J: 149).

UNTRAP manual informs of a necessary recruitment process that involves introducing the manual to the client and explaining the process and requirements. Expert J's considerations suggest that the manual could mention an alternative route for therapeutic support if a client wishes to disengage. Her comment made about 'business as usual' if a person does not wish to engage in the manual, or opts out during the process, prompts curiosity about what 'business as usual' means and how the manual would sit in parallel to usual support and treatment within mental health services.

Relating to the structure and mechanisms of the manual, Expert N contributes,

"In terms of the structure of the manual … I'd want to know what I'm going to do but also why I'm doing it, and, what's the aim. I've seen some horrible manuals which are just cookbooks, and you have no idea what to look for about whether it's going right or wrong… I thought there was something about the structure that maybe

should separate those things a little bit more. "Here's what you are going to do" but also "Here's how you know if you are doing it right" (Expert N: 93 – 107).

Although the manual has clear step-by-step instructions for the therapist and client to follow, I agree in that the inclusion of an assessment tool, albeit it holistic or mechanic, would inform the process further. The importance of using a holistic approach within the manual was generic within the identified strands. Showing and being respectful of a person's emotional process when exploring and sharing traumatic experiences, was highlighted by Expert R:

"Having the utmost respect for what happens when people get triggered … needs to be reflected in the language" (Expert R: 462 – 464).

Relating to the aims of the manual, and the mechanism of change, she states,

"In this manual, reconsolidation is the mechanism of change… what this manual is ideally addressing is how can we use artwork to bring about memory reconsolidation for deep lasting transformational change for trauma clients" (Expert R: 856 – 868).

Relating to the process of how art can support healing for the clients who engage in the manual, Expert J comments,

"I think the juxtaposition, the ability to keep within the same space, this is a beautiful work of Art Therapy" (Expert J:731 – 734).

Expert J further focuses on the use of the term 'bilateral' which is a mentioned process within the manual steps, by stating:

"I think we've got to get rid of bilateral … everything's bilateral, like EMDR, tapping, using different hands, what we're doing is we're emphasising unilarity" (Expert J:718 – 730).

Expert J goes on to explain:

My humble opinion, although I don't sound all that humble but I think we've gotta get rid of bilateral … Why is it bilateral? Everything's bilateral [pause] so like EMDR, the tapping, using different hands like it's all—really what we're doing is we're emphasising unilarity … because when we talk about this bilateral terminology we're going back in the day to when lateralisation was a thing like "left brain does this and right brain does that" and

that is debunked and … from a scientific perspective, it decreases it, diminishes our credibility [pause] I think you're able to say your point that you just said it beautifully - the holding of opposites .. like the juxtaposition - the ability to keep this within the same space. I mean this is a beautiful work of art therapy … but let's be careful what we are calling it, and I know bilateral has been all over art therapy for a long time and the processes that were engaging in are useful and meaningful, but scientifically we're not defining what we're actually doing" (Expert J:717 – 739).

This input is of huge value in that Expert J, bringing her knowledge and expertise in neurology and how this informs her Art Psychotherapy practice, ensures current, accurate and scientifically supported content in the manual.

Expert R offers insight from a Coherence Therapy perspective,

"I think Kelly, what you mean by bilateral largely overlaps with the step of memory reconsolidation where two different but mutually exclusive, emotional learnings, are being held in the same field of awareness at the same time, the juxtaposition experience" (Expert R: 745 – 750).

The term used in the manual for this process 'multi-image making / bilateral image making' will be changed to 'multi-image making / emphasis of unilarity'.

The combined insights from a scientific neuro-informed, and memory reconsolidation perspective regarding the juxtaposition stage of treatment within the manual, have enabled focus and clarity within the language and descriptions for people delivering and receiving the treatment. Further input from the other experts confirmed the suggestions.

Some discussion emerged relating to safety, a client's capacity to engage, and how to use grounding for emotional regulation. UNTRAP manual recommends several grounding tools for the client to consider. They range from breathing techniques to gentle movement. Although these tools are evidence-based techniques, the manual did not invite the client to identify or bring their own tools. This was recommended by Expert I:

"Let's just ask them, what are you going to do over the coming weeks … to ground yourself. How are you going to look after yourself between sessions? What tools have you got in your box to make yourself safe?" (Expert I: 1039 – 1044).

Expert I gave examples of her experiences when engaging in therapeutic treatment in the past, and how it would have been very helpful to have been given the leadership of her own grounding and emotional regulation tools.

Further mention of scientific foundations was highlighted as being necessary by Expert J in relation to providing psychoeducation. She reports:

"My biggest challenge I have at the manual which was the list of definitions, which I think is really important [pause] and I think really needs to be bolstered with scientific evidence and citations and perhaps even a similar format cos to me I read the definitions and they seemed a little wonky, in terms of some might be very specific and nicely cited, and then others are more colloquial and kind of conversational" (Expert J: 269 – 282).

Experts R and N gave an interesting perspective on their views on treatment manuals, especially when used to treat people who have experienced complex trauma. The strand is identified within the mechanism vs holistic, and therapeutic clarity themes. Expert N talks of the function of a manual being used as a set of principles because:

"The principles … are a better guide. You have the principles, I found it quite convincing… Principles are likely to be very flexible and adjust to what's in front of you" (Expert N: 1238 – 1244).

I appreciate this insight, particularly as it supports a person-centred approach, and makes more room for flexibility. Expert N also considers the experiences of learning how to use the manual for a novice. He states:

"Novice users follow rules rather than principles" (Expert N: 1243 – 1244).

Because it is the principle that has informed the development of the manual, my understanding is that the manual would benefit from having clearer, simplified instructions, that always refer to the set of principles, marked as such. Furthermore, that the use of a set of principles as a guide within the context of a treatment manual support personalisation for the client or patient.

When considering the length of the treatment manual and having set stages within the plan, Expert R comments:

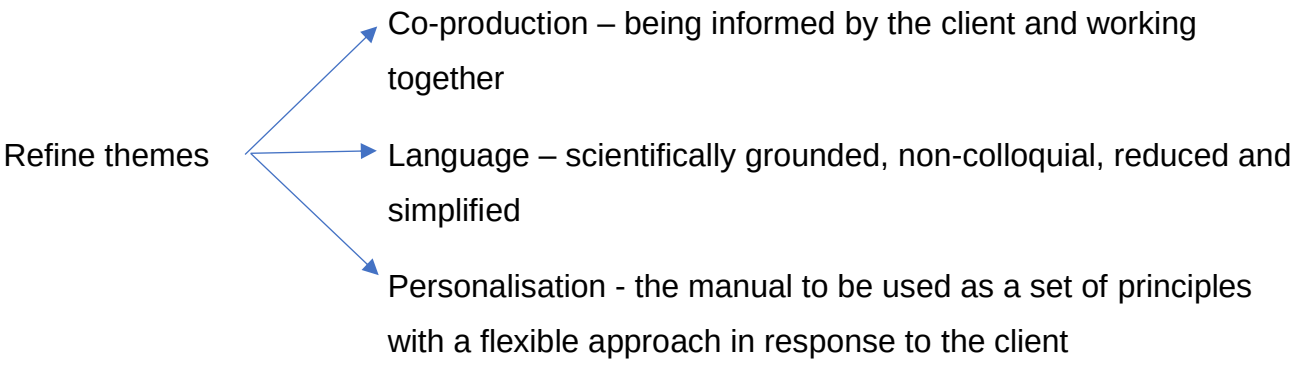
"I think it's important for the therapist and the clients to understand that whatever portion of this process unfolds over the course of the twelve sessions, that's ok" (Expert R: 1218 – 1219).

This leads me to point out the strand, response to client vs response to manual. The logical approach to using or delivering a treatment manual is to follow and respond to the content and stages within it. This analysis has highlighted the importance of balance within the therapeutic relationship, having a person-centred, collaborative approach to the manual, and to use the manual as a set of principles to ensure personalisation for the client, that can guide the therapeutic process. As Expert N describes:

"It's a really good guide … and if you were able to say … that your mechanism of change … that everything else can flow from it, it doesn't mean everything has to be about the mechanism" (Expert N: 810 – 816).

9.1.39. Define the themes

By generating the identified themes within the transcript, then reviewing them further, clear strands of insight have emerged that enable additional enhancement and clarity for the development of UNTRAP manual. Strands of insight were identified within plural themes and were mostly unanimous. The defined themes are:



Springer and Xenophontes (2021) broadly define co-production as:

'people who use and provide Art Therapy services working together to develop theory in such a way that values both the consensus and differences between each perspective' (Springer and Xenophontes, pg. 1, 2021).

They further add that:

‘Co-production can be applied to both practice and research, and the methodology requires flexibility to ensure those contributing lived experience will share control and influence with professionals’ (Springer and Xenophontes, pg. 1, 2021).

The process of validation, through an expert panel’s engagement with rubrics scoring and narrative responses, and the Reflexive Thematic Analysis, has demonstrated the value of co-production by ensuring UNTRAP manual development, and being informed by clinical professionals and a lived experience expert. The structural approach of the validation process, and the content from these processes have provided a rich source of guidance from a variety of perspectives. Furthermore, the necessity and importance of approaching the manual in situ from a co-production perspective was highly expressed.

The findings from this RTA suggest that specialised therapeutic jargon vocabulary used within the manual may create hurdles to the acceptability and understanding of the treatment. However, the use of scientifically grounded and cited language would provide professional consistency and clarity for all components of the treatment. The application of clear, non-jargon, non-colloquial, scientifically grounded and simplified language was reported as necessary for client engagement with the manual.

This analysis recognised the importance of tailoring Art Psychotherapy intervention UNTRAP manual to the needs and characteristics of the individual clients, using a personalisation approach, using the manual as a set of principles and as a guide to suit the clients process and needs. Personalisation refers to the integration of Psychotherapy for individuals (APA, 2020). Flückiger (2019) reports that a patient-centred approach suggests that the treatment course should be guided by patients' specific needs, preferences, and perspectives on their own therapeutic change.

9.1.40. How to apply the changes to the manual

The defined themes will be applied to the manual. A co-production / working together approach will be referred to throughout the manual, including the identification of grounding methods and tools, the pace of engagement, which steps within the manual to approach, and the time taken to complete the manual. The client will inform the Art Psychotherapist how to approach the manual in a way that is suited to their needs. A method for evaluation to assess if the manual is working or not working, will be mutually created. The option of the outcome measure - international trauma questionnaire (ITQ) will be added as a choice

for the patients/clients. Aims and goals for the therapeutic outcome for the client will be identified initially and used as a benchmark for assessment and evaluation.

The language within the manual will be revised for clarity and simplicity to avoid misinterpretation and enable ease of use. All theoretical statements will be cited with scientific grounding. Explanations of theory will be simplified and reduced so not to be word heavy. Definitions of terms will be non-colloquial. Words that have been identified as not relevant will be changed, such as 'unwanted', 'inappropriate', and 'bilateral'. Language used to describe trauma, emotional learnings, and triggers, will be clearer and have a respectful and sensitive tone. Symptoms of a client's trauma will be referred to as having a purpose and identified in a positive way. Memory reconsolidation will be clarified as being the mechanism of change for the client, and Art Psychotherapy will be clarified as the method.

The manual will be framed as a set of principles that have been empirically informed, to be used in a flexible way, and in response to the client. The steps within the manual will remain as a guide and will be referred to as choice options for which the client wishes to engage.

The manual will have a 12-session duration, with flexibility to last longer if the clients need more time. The 12-session duration is a guide and does not guarantee achieved aims (memory reconsolidation) within this time frame. As Expert R states:

"I think it's important for the therapist and the clients to understand that whatever portion of this process unfolds over the course of the twelve sessions, that's ok. Everybody will have an individual path or trajectory, but the idea is to keep on going in that direction" (Expert R: 1217 – 1221).

9.1.41. Summary

Chapter 9 described the validation process of UNTRAP manual, then reported the results from the validation process including Reflexive Thematic Analysis. How the findings were used to improve the manual were then explained. Chapter 10 will discuss the study further.

CHAPTER 10 – DISCUSSION

10.1.1. Introduction

Chapter 10 discusses the research design in response to Covid-19 restrictions and measures and summarises the findings from this study, with some reflection on the processes, findings, and adaptations. Furthermore, it contains some consideration of how things could have been approached differently, and how to move forward with the findings, closing with conclusions.

10.1.2. Covid-19 – the impact on the study

The initial research design pre Covid-19 measures being announced in March 2020, aimed to compare data from an international survey with the respondents being practicing Art Psychotherapists who treat adults who have experienced complex trauma, with data gathered from incorporated case-based analysis. Ethics approval was sought and granted by Northumbria University Ethics Committee (reference 16945, 17204, 29392), and Health Research Authority (HRA) and Health and Care Research Wales (HCRW) (reference 20/WS/0048). In response to the restriction of lockdown measures, the research design was re-evaluated. Art Psychotherapy sessions were no longer able to take place in person which meant we had to reconsider the case-based component of the study. There was an option to deliver Art Psychotherapy sessions online for individual and group sessions. However, we concluded it would be too time consuming to set up, and it may have lost some of the case-based components that could be captured from in-person treatment. After much consideration, we decided to use the data from the systematic literature review, BAAT focus workshop, international survey, and clinical experience and expertise, to inform the design and development of a therapeutic treatment manual. The study may have benefitted from having a case-based data set to inform the development of the treatment manual. However, the restructure of the research design has enabled a thorough initial validation process including additional data analysis using Reflexive Thematic Analysis. My understanding is, should the manual be applied to undergo further testing through clinical trials, the opportunity to be informed by case-based data will be fulfilled.

10.1.3. Original piece of research

Contributing to existing research on Art Psychotherapy and the treatment of complex psychological trauma, this study identified components and contexts associated with recovery and healing for this client group from data gathered from responding international Art Psychotherapists. It adds to the body of research on this topic by providing evidence on which mechanisms and contexts of Art Psychotherapy can prove the most effective for

healing and recovery. There are no other studies that have done this, particularly relating to specific components and contexts of Art Psychotherapy practice.

Furthermore, this study has informed the design and development of a therapeutic treatment manual that delivers Art Psychotherapy for adults who have compromised mental health resulting from experiences of complex trauma. The content of the manual unifies several evidential aspects, using Art Psychotherapy as the model and aiming for trauma memory reconsolidation. The components within the manual are also neurologically informed. UNTRAP is an original treatment manual designed to treat this client group in a unified manner. This is the first therapeutic treatment manual combining this range of current evidence based and empirically informed processes, aiming for trauma memory reconsolidation within an Art Psychotherapy model that uses research-based components.

10.1.4. Implication of practice

Complex trauma can have a severe impact on a person's mental health. The systematic literature review explores the impact trauma can have on a person neurologically and psychologically and refers to identified therapy interventions that are used to support this client group. This study focuses specifically on practice associated with CPTSD. However, there is reference (Bonnet, 2010, Roache, 2015) to how trauma can be the cause of other presenting diagnosis including anxiety disorders, depression, personality disorders, and psychosis. Having a trauma informed care process within practice for all presenting issues, both for physical and mental health perspectives, may have beneficial results.

This study design is specifically focused on the treatment for adults who have experienced complex trauma. The manual is designed to treat this population and has undergone its first steps of development. Moving forwards, the aim is to be inclusive for children and young people, and for sessions to be in person or online, for groups and individual sessions as the manual is developed further.

It may also be of benefit to integrate other Arts Therapies within the treatment manual. The systematic literature review refers to studies (WHO, 2020) that have reported positive impact from the use of other Arts Therapies (Music, Drama and Movement), including somatic approaches (Fancourt, 2019), in addition to Art Psychotherapy. This study aimed to explore Art Psychotherapy specifically and has produced an original piece of research. There is scope and intention for an inclusive approach in using all strands of creativity within the continuation of development.

The next stage of validation for UNTRAP manual would be a clinical trial. Had the case-based analysis occurred within this study, the outcome measure - international trauma questionnaire (ITQ) (Cloitre, 2018) would have been used to measure the trauma symptoms pre, during and post Art Psychotherapy treatment. The ITQ is a self-report diagnostic measure of PTSD and CPTSD, as defined in the 11th version of the International Classification of Diseases (ICD-11). Further investigation would be needed to ascertain the appropriate use of the ITQ for patients/clients who present with or report to have impacted mental health resulting from complex trauma yet do not have a diagnosis of PTSD or CPTSD. They may have other diagnosis such as anxiety disorder, depression, personality disorder or psychosis, or may not have received a diagnosis. The intention would be to have an inclusive approach with the engagement criteria being that of compromised mental health resulting from experiences of complex trauma, as opposed to having a limit on use for people who have a PTSD or CPTSD diagnosis.

A clinical trial of UNTRAP would enable the assessment of therapeutic impact through case-based analysis, having already undergone initial validation and having unanimous agreement from the expert panel that the manual is ready. Developing the manual in this order has ensured the appropriate considerations and improvements have occurred before the patient or client interact with the manual within the next stages of development and validation.

10.1.5. The value of Art Psychotherapy with adults who have experienced complex trauma

NICE (CG178, 2014) recommend Art Psychotherapy for the treatment of schizophrenia. This study reports the benefits of Art Psychotherapy when used to treat people who have experienced complex trauma. As trauma is identified often as the cause or root of many mental health diagnosis (Read and Bentall, 2012), there is potential for Art Psychotherapy to be a recommended treatment for other mental health diagnosis. Further research is needed to inform this process.

Art Psychotherapy, and other Arts Therapies (drama, music and movement) offer an alternative option to talking therapies. Traumatic experiences can be remembered visually and the process of making art can not only recall unprocessed traumatic memories (Hass Cohen, 2008) but enable a creative process for expression and control. A patient / client can choose to keep their traumatic memory within the image and change the image to add and alter aspects of the memory which can support empowerment and positive change.

The process of choosing to keep the memory held within the image also enables the client/patient to prevent unwanted exposure. If the patient / client lost control within their initial traumatic experience, this process provides the opportunity to experience control in a gentle way. The act of making a reflective image, then choosing to talk about the meaning verbally remains the choice of the client and supports their control within the therapeutic process.

The information generated within the focus group workshop suggested a strong lean towards Psychoanalytical/dynamic and philosophical approaches within Art Psychotherapy practice. Although there was interest in other approaches such as neurological and biological, it was widely reported that the most established is psychoanalytical/dynamic. As reported within the systematic literature review, Art Therapy has mostly been associated and informed by psychoanalytic/dynamic theory bases, and until recently (Standing Committee for Arts Therapies Professions, 1989), Art Therapy was described within this frame of practice. The description of Art Therapy (BAAT, 2014) now focuses more on the relationship between the therapist and the client and having an overall aim to enable a client to effect change and growth on a personal level using art materials in a safe and facilitating environment. The language is generic and less leading of a specific theoretic ground. This lends to the potential of new and innovative approaches that can be used within this frame.

This study has invited the opinions of international Art Psychotherapists, experts in trauma and memory reconsolidation, neurologically informed Art Psychotherapy, co-production, and lived experience of complex trauma, to produce a treatment manual, using a unification approach.

The data from the international survey reported the most effective art mediums for recovery and healing for people who have experienced complex trauma. Painting, pastels, charcoal, and clay offer a malleable quality that enables expression and the potential for making mess and change, with clay having a haptic quality that invites a gentle yet powerful opportunity for attachment through touch (haptic process). The identification of which art mediums work most effectively for people who have experienced complex trauma, can also inform provisions such as education for early years and older children, Local Authority services such as children in care and the elderly, and mental health services that use creative components within treatment such as Occupational Therapy, Psychotherapy and Psychiatry.

Contexts within Art Psychotherapy practice that would support significant positive change for clients were also reported. The length of time a person spends on a waiting list; the time and duration of the session; the number of sessions; the therapy room; and the environment are all identified as important considerations that can support the impact of treatment. For example, the international survey data reports if a person is on a waiting list for more than three months, or if a person does not have the option for additional sessions (after 12 sessions) if needed, this can have significant detrimental impact of therapeutic outcomes. This study provides evidence that can be used to support and inform services for the best therapeutic outcomes, and to support a trauma informed approach. Furthermore, Art Psychotherapy treatment can be used for extended aims such as sharing and gained empowerment via exhibiting art works made in sessions. 100% of survey respondents reported that when their patients had the opportunity to exhibit their art works made in sessions, there were significant positive therapeutic outcomes, with additional new opportunities (90%).

The value of UNTRAP

The therapeutic treatment manual named – Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP), underwent a validation process. Experts in neuroscience, complex trauma, memory reconsolidation, Art Psychotherapy, and lived experience of complex trauma, were identified, and invited to form an expert panel. All experts agreed to participate in a three-stage process for evaluation, that provided quantitative and qualitative data for analysis. The experts were asked to provide rubrics scores for each version of the manual. Stage 2 of this process included an online expert panel meeting for the opportunity to compare scores, concerns and for assuredness. Expanding on these findings, a Reflexive Thematic Analysis (RTA) was conducted. The findings enabled clarity through the identification of themes within the data that was then applied to improve and enhance the manual. The experts were unanimous in their opinion that the manual was ready to be tested further.

This study has produced an Art Psychotherapy treatment manual that is empirically informed. It offers a focused approach other than ‘treatment as usual’ (Expert J, validation transcript: 717 - 739), which may often rely on clinical interpretation and insight alone. UNTRAP manual includes this way of working, with added principles that serve as a guide and framework for the client and the Art Psychotherapist. There is an additional confidence for all users that the manual is empirically informed and has a unification approach for better outcomes.

10.1.6. Conclusion

This study set out to investigate the efficacy of Art Psychotherapy as a treatment for adults with complex trauma. This is an original study that reports significant empirically informed research and presents the design and development of an unanimously validated therapeutic treatment manual (UNTRAP). Initially, the design of the study included case-based analysis that would have measured the impact of individual and group session Art Psychotherapy treatment for adults who have experienced complex trauma. The ITQ and CORE-18 would have been used as the measurement tools, and Comparative Qualitative Analysis (CQA) would have been used for analysis of the data. In response to Covid-19 lockdown measures, this component of the study could no longer take place. After much consideration, it was decided that the data from the BAAT regional focus group, systematic literature review, international survey, and clinical experience and expertise would suffice to inform the design and development of a therapeutic treatment manual. UNTRAP manual underwent a validation process that included three stages of assessment involving rubrics completions, an online panel meeting, verbal and written suggestions, and Reflexive Thematic Analysis of the panel meeting transcript content. During each stage of the validation process, amendments were applied to the manual. All expert panel members reported that the manual was ready to be tested clinically.

This study has produced new evidence reporting which components and contexts of Art Psychotherapy practice are mostly effective when used to treat adults who have experienced complex trauma. The findings of this study can not only inform Art Psychotherapy practice, and therapeutic treatment interventions for adults who have experienced complex trauma, but also services supporting this client group in general.

UNTRAP manual is in its early developmental stages, having completed an initial validation process. The aim is for the manual to be tested within a clinical trial. As the manual is tested and developed further, there is potential for the manual to be developed for the use of children and young people, for sessions to be held online, and for both individual and group sessions. However, this is an area that requires more studies to be conducted.

10.1.7. Summary

Chapter 10 has discussed and summarised the findings of this study. Acknowledgement of the original research design was made, including the details of the ethics approval with Northumbria University and IRAS. A positive stance on the new design and the benefits associated with the outcomes were reported, leading to potential future progression of the

development of the manual and how the circumstances of changing the design have benefitted the research. Chapter 10 concludes with a note of requirement for further studies to be conducted.

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Appendix 1.

Preliminary Searches

Initial search results – titles screened:

Web of Science:

Search: (art therapy OR art psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults)

Results: 5 articles

Excluded following titles screening:

- Not about Art Psychotherapy/Therapy: 2
- Not with adult population: na
- Not about complex psychological trauma or CPTSD: na

Articles remaining: 3

- The silent intermediary': a co-authored exploration of a client's experience of art psychotherapy for C-PTSD
  Winter, N and Coles, A (2021). INTERNATIONAL JOURNAL OF ART THERAPY 26 (1-2), pp.29-36

- Truncated Creativity. Child Abuse Influence on Creative Capacity. Art Therapy with Neurotic Patients.
  Coll, MD (2021). ARTETERAPIA-PAPELES DE ARTETERAPIA Y EDUCACION ARTISTICA PARA LA INCLUSION SOCIAL 16, pp.191-201

- Trauma Treatment through Art Therapy (TT-AT): a 'women and trauma' group in Tanzania
  Luzzatto, P; Ndagabwene, ; Likindikoki, S. 2022. INTERNATIONAL JOURNAL OF ART THERAPY 27 (1) , pp.36-43

Taylor & Francis online:

Search: (art therapy OR art psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults)

Results: 29 articles

Excluded following titles screening:

- Not about Art Psychotherapy/Therapy: 3

- Not with adult population: 9
- Not about complex psychological trauma or CPTSD: 5

Articles remaining: 12

- Seven lived experience stories of making meaning using art therapy
  Elise Ford, Nicholas George, Edith Holland, Shane Maher, Leesa Maree, Kate Naylor, Karen Rossel & Justine Wake
  International Journal of Art Therapy, Volume 26, 2021 - Issue 1-2

- A systematic literature review of the impact of art therapy upon post-traumatic stress disorder
  Gabriel Schnitzer, Sue Holttum & Val Huet

- 'Tomorrow, we make it better': an art therapist's reflection on a community mural in a refugee camp in Greece
  Emily Hollingsbee
  International Journal of Art Therapy, Volume 24, 2019 - Issue 4

- Facing our shadows: understanding harm in the arts therapies
  Neil Springham & Val Huet
  International Journal of Art Therapy, Volume 25, 2020 - Issue 1

- Military museum collections and art therapy as mental health resources for veterans with PTSD
  Janice Lobban & Dominic Murphy
  International Journal of Art Therapy, Volume 25, 2020 - Issue 4

- Community adult mental health: mitigating the impact of Covid-19 through online art therapy
  Edit Biro-Hannah
  International Journal of Art Therapy, Volume 26, 2021 - Issue 3

- Trauma-Focused Art Therapy in the Treatment of Posttraumatic Stress Disorder: A Pilot Study

Karin Alice Schouten MATh, Susan van Hooren PhD, Jeroen W. Knipscheer PhD, Rolf J. Kleber PhD & Giel J.M. Hutschemaekers PhD
Journal of Trauma & Dissociation, Volume 20, 2019 - Issue 1

- Holly Bowen-Salter, Ashley Whitehorn, Rhianna Pritchard, Jocelyn Kernot, Amy Baker, Miriam Posselt, Ella Price, Jade Jordan-Hall & Kobie Boshoff (2022) Towards a description of the elements of art therapy practice for trauma: a systematic review, International Journal of Art Therapy, 27:1, 3-16, DOI: 10.1080/17454832.2021.1957959

- Dual perspectives on art therapy and EMDR for the treatment of complex childhood trauma
  Nili Sigal & Rob
  International Journal of Art Therapy, Volume 26, 2021 - Issue 1-2

- Using art therapy to overcome avoidance in veterans with chronic post-traumatic stress disorder
  Janice Lobban & Dominic Murphy
  International Journal of Art Therapy, Volume 23, 2018 - Issue 3

- Art therapy and underlying fMRI brain patterns in military TBI: A case series
  Walker, Stamper, Nathan & Riedy
  International Journal of Art Therapy, Volume 23, 2018 - Issue 4

- Tapping into museums for art psychotherapy: an evaluation of a pilot group for young adults
  Coles & Harrison
  International Journal of Art Therapy, Volume 23, 2018 - Issue 3

<u>Science Direct:</u>

Search: (art therapy OR art psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults) Arts in Psychotherapy

Results: 3 articles

Excluded following titles screening:

- Not about Art Psychotherapy/Therapy: 1
- Not with adult population: 1
- Not about complex psychological trauma or CPTSD: 1

Articles remaining: 0

ASSIA:

Search: (art therapy OR art psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults)

Results: 22 articles

Excluded following titles screening:

- Not about Art Psychotherapy/Therapy: 19
- Not with adult population: 2
- Not about complex psychological trauma or CPTSD: na

Articles remaining: 1

- The effectiveness of art therapy for anxiety in adults: A systematic review of randomised and non-randomised controlled trials
  Abbing Ponstein; Vn Hooren; de Sonneville, Leo; Swaab, Hanna; et al.
  PLoS One; San Francisco Vol. 13, Iss. 12, (Dec 2018): e0208716.

APA PsycNet:

Search: (art therapy OR art psychotherapy) AND (complex psychological trauma OR C-PTSD) AND (Adults)

Results: 4 articles

Excluded following titles screening:

- Not about Art Psychotherapy/Therapy: 2
- Not with adult population: 0
- Not about complex psychological trauma or CPTSD: 0

Articles remaining: 2

- A systematic review of the efficacy of creative arts therapies in the treatment of adults with PTSD.
  Baker, Metcalf, Varke, & O'Donnell

Psychological Trauma: Theory, Research, Practice, and Policy, Vol 10(6), Nov 2018, 643-651. https://doi.org/10.1037/tra0000353

- Kalmanowitz. (2017). Art therapy and mindfulness with survivors of political violence: A qualitative study. APA Psyche Articles.

Appendix 2

Art Psychotherapy for adults who have experienced complex trauma: An International Survey

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Abstract

Adults who have complex trauma can experience mental ill health that invariably results in significant restrictive impacts upon their lives. The purpose of this international survey was to identify what Art Psychotherapy practitioners consider to be the important aspects of treatment supporting recovery and healing for this client group. International Art Psychotherapists treating adults with complex trauma were invited to answer four categories of questions: participant information, environment, practical/clinical components, and additional information. Whilst there is a good evidence base for the uses and effectiveness of Art Psychotherapy in general, there has been little causal analysis of which mechanisms and contexts of Art Psychotherapy can prove effective. The survey data identified that expert practitioners consider positive therapeutic impact to be associated with specific art medium, the therapeutic environment, and clinically informed approaches.

This article first describes Art Psychotherapy and complex trauma to contextualise the international survey. It then reports the recommended treatments for adults who have experienced complex trauma and the evidence for the use of Art Psychotherapy when used to treat this client group.

The aims of the study will be outlined, including a description of the method used, the questionnaire, respondent information, environment, practice components, and additional information. The data analysis will then be explained and reported, followed by a discussion of the findings.

Art Psychotherapy

In 2019, the World Health Organisation (WHO) reported that,

> *(...) global evidence on the role of the arts in improving health and well-being, with a specific focus on the WHO European Region. Results from over 3000 studies identified a significant role for the arts in the prevention of ill health, promotion of health, and management and treatment of illness across the lifespan.* (Fancourt, 2019, p.4)

Art Psychotherapy uses art media as its primary mode of communication. People referred to an Art Psychotherapist need not have experience or art skills (BAAT, 2014). The Art Psychotherapist is not primarily concerned with making an aesthetic assessment of the person's image. The overall aim is to enable a person to develop and grow on a personal level using art materials in a safe and facilitating environment. Art Psychotherapists have a considerable understanding of art techniques and are proficient in using materials to facilitate non-verbal communication. Metaphors, symbols, and the expressive use of art materials combine to create a rich language for self-reflection and the opportunity to translate strong emotions into a pictorial expression that can be visceral in its intensity. Differences in scale or perspective, tone, and colour, along with the use of metaphors, allow for a potentially sophisticated articulation of thoughts and feelings (Hogan, 2016).

Art Psychotherapy integrates Psychotherapeutic techniques with the creative process. In addition to the process of making and reflecting upon one's image or how one makes an image, other components of Art Psychotherapy such as attachment, the therapeutic relationship, the environment, theoretical orientations, duration of treatment, location of sessions, and a persons' intentions, contribute to how Art Psychotherapy works and how a person interacts with the process.

When a person engages in the process of seeing or making an image and is witnessed within a therapeutic and safe environment whilst engaging in such processes, changes occur psychologically, neurologically, biologically and physiologically. Research shows that visual art interventions stabilise an individual by reducing distress, increasing self-reflection and self-awareness, altering behaviour and thinking patterns, and normalising heart rate, blood

pressure, and cortisol levels. Cortisol is the hormone directly associated with stress (Bolwerk, 2014). Whilst there is a reasonable evidence base for the uses and effectiveness of Art Psychotherapy in general (Regev, 2018), there has been little causal analysis of which mechanisms and contexts of Art Psychotherapy can prove effective for people who have experienced complex trauma.

Complex Psychological Trauma

The International Classification of Disease (ICD)-11 diagnosis reports Complex Post Traumatic Stress Disorder (C-PTSD), as being 'a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible' (ICD-11, 6B41, 2020). All diagnostic requirements for Post-Traumatic Stress Disorder (PTSD) are met. In addition, C-PTSD is characterised by severe and persistent problems as feeling diminished, defeated, or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event and difficulties in sustaining relationships and feeling close to others. Regier (2019) reports that these symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (https://www.michaelregier.com/what-is-complex-ptsd-how-does-ptsd-affect-relationships/).

It is important to note that PTSD is more often associated with other psychiatric disorders than the sole diagnosis. Several mental health diagnoses can be considered as post-traumatic (Nutt, 2001). Because the diagnosis or categorisation of the symptoms of mental illness of a person who has experienced psychological complex trauma can be complex, only the term, psychological complex trauma, is used in the survey without specific diagnostic terms.

Treatment for Complex Psychological Trauma

The National Institute for Health and Care Excellence (NICE) guidelines currently recommend Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) as the psychological treatments for Post-Traumatic Stress Disorder. People who have experienced psychological complex trauma may develop a range of mental health difficulties. It is important to note that the common disorders that follow a traumatic event or a series of complex traumatic events have a large body of evidence indicating that certain interventions can be highly beneficial. Exposure therapies, including Prolonged Exposure Therapy, have also been proven efficacious in many Randomised Control Trials,

and thus have been recommended as a first-line treatment for PTSD in several treatment guidelines (Foa, Keane, Friedman & Cohen, 2009). The design of this survey considered questions that would focus on the treatment of the trauma, therefore the impact and presenting symptoms and issues.

Evidence for Art Psychotherapy and Psychological Trauma

Art Psychotherapy is often applied in clinical settings offering PTSD treatment. Qualitative research shows consensus among experts on the core elements of Art Psychotherapy in accessing traumatic memories and emotions, increasing emotional control, strengthening self-esteem, and a sense of autonomy (Collie et al., 2006). There are indications that Art Psychotherapy can effectively reduce PTSD symptoms such as avoidance, arousal, re-experiencing, and reduce depression (Schouten et al., 2015). A systematic review (Van Lith 2016) aimed to identify and connect what Art Psychotherapists know and what they do when they support people who have mental health difficulties. The review reports that research undertaken between 1994 and 2014 was examined to ascertain the Art Psychotherapy approaches applied when working with people who have mental health difficulties. Furthermore, to identify how the approaches were used within clinical mental health systems. Thirty articles were identified which demonstrated an Art Psychotherapy approach to a mental health issue. From the search, the review reports four identified groups of diagnostic terms: depression, borderline personality disorder (BPD), schizophrenia, and PTSD.

For Art Psychotherapy approaches practised with people who have PTSD, seven articles were identified that explored specific approaches by providing clinical implications. Although trauma may be a significant contributing factor to diagnostic outcomes, our focus here is on the studies directly about PTSD. Namely, the group Art Psychotherapy model (Backos and Pagon, 1999), the Psychoanalytic Art Psychotherapy approach (Buck, 2009), the Neurobiological Art Psychotherapy model (Gantt and Tinnin, 2009), the Task-oriented Art Psychotherapy approach (Rankin and Taucher, 2003), the Cognitive Behavioural Intervention Art Psychotherapy approach (Sarid and Huss, 2010), the Art Psychotherapy Trauma Protocol (Talwar, 2007) and the Art Psychotherapy with Eye Movement Desensitization and Reprocessing through bilateral stimulation (Tripp, 2007). All articles reported benefits from each approach.

The Buk (2009) article reported that, through the exploration of mutative actions of psychoanalytically informed Art Psychotherapy intervention, the art-making process enabled

the client to become conscious of and verbally process dissociated memories involving the threat of sexual abuse. The Gantt and Tinnin (2009) literature review article reported that Art Psychotherapy techniques utilise right brain processes by activating limbic structures in the brain involved in processing fear (trauma). The Rankin and Taucher (2003) article provides an outline for how to use a task-orientated approach to Art Psychotherapy. The six identified basic tasks are safety planning, self-management, telling the trauma story, grieving losses, self-concept and world view revision, and self/relational development. Their article (Rankin and Taucher, 2003) reports exploring meaning through the identified tasks. The Sarid and Huss (2010) extensive literature review article illustrates the benefits of Cognitive Behavioural Art Psychotherapy. It reports, by using this approach, new connections and pathways can be created between the physical, emotional, and cognitive components of trauma memory, resulting in decreased stress levels which enables the restricting of fragmented traumatic memories into more coherent positive memories. The Talwar (2007) article proposes an Art Psychotherapy trauma protocol. It reports the integration of cognitive, emotional, and physiological levels of trauma by combining EMDR, bilateral art-making, and painting. It reports that this approach helps to process non-verbal traumatic memories, creates sensory awareness, sensorimotor experiences, and promotes proprioception. The Tripp (2007) article also explores the approach of Art Psychotherapy and EMDR. Associations of traumatic memory are brought to conscious awareness through drawing. As new information is accessed, affective material is metabolised and integrated, leading to the transformation of traumatic memory and an adaptive resolution of the trauma.

In addition, a pilot study, ‘Trauma-Focused Art Psychotherapy in the Treatment of Post-traumatic Stress Disorder’ (Schouten, 2018) tested the feasibility and applicability of trauma-focused Art Psychotherapy in clinical practice. Participants were adults with PTSD due to multiple and prolonged traumatisation, such as patients with early childhood traumatisation and refugees and asylum seekers from different cultural backgrounds. Patient reports showed satisfaction and improvements after treatment. In addition, some patients reported decreased PTSD symptom severity. Schouten (2018) states that Art Psychotherapy might help to decrease avoidance by providing concretised forms of representation, either visual or tactile, in visual artworks. These changes appear to be consistent with Collie and colleagues' findings (Collie et al., 2006), who reports that relaxation in Art Psychotherapy reduces arousal and offers safe and gradual access to traumatic memories, thus enabling the patient to overcome avoidance and to endure exposure.

Aims of the Study

The Art Psychotherapy literature identifies a positive influence upon trauma symptoms such as depression and anxiety, improved emotional well-being, and increased confidence in expressing trauma experiences. However, there is little evidence of what specific contexts and mechanisms of Art Psychotherapy treatment cause certain impacts. This survey aimed to capture what international expert practitioners consider to be important factors in Art Psychotherapy to enhance positive outcomes for clients who have experienced complex trauma.

Method

The software used was Online Surveys, formally named Bristol Online Surveys, to create and implement the survey. The online survey tool was originally designed for academic research, education and public sector organisations within the United Kingdom and is compliant with General Data Protection Regulations (GDPR).

This study employed an international survey process, a research method used for collecting data from a predefined group of respondents. The survey's focus was to gain information and insights from International Art Psychotherapists concerning four categories of questions around the Art Psychotherapy intervention when used to treat adults who have complex trauma. The design and structure of the questionnaire were informed by current literature, as previously outlined, and expanded further on current findings.

Potential respondents were invited to complete the survey via e-bulletins with Art Psychotherapy associations around the world. Some associations include the British Association of Art Therapy, The American Art Therapy Association and Hong Kong Art Therapy Association. Participation criteria was exclusive for qualified and practising Art Psychotherapists working with adults who have experienced complex trauma. All questions were carefully constructed to associate with a variety of considerations relating to Art Psychotherapy practice. The four categories of questions within the survey were: participant information, environment, practice and clinical components, and additional information offering respondents more space to respond further to the questions. The survey was live from 25th October 2019 for one month. Respondents were offered a data report on completion of the analysis.

The Questionnaire

The questionnaire had 21 questions and was designed to capture practitioners' views about the impact of the primary contexts and mechanisms of Art Psychotherapy practice. The questions were organised into four categories. The first asked about their participants, their gender, age, location, duration of practice as an Art Psychotherapist and work sector. The second focused on the environment where the sessions occur, including accessibility, aesthetics and decoration of the therapy room and surrounding spaces, and comfort. The third asked about the practical and clinical mechanisms, including art materials, the length, duration and time of the sessions, theoretical orientations, combined therapeutic approaches, and exhibitions of artworks. The questionnaire combined open-ended questions and multiple-choice questions with predefined answers offering respondents the possibility to choose and rank among several options or grade on a five point scale with 'significantly detrimental impact' to 'significant positive impact'. The ending category for additional information offered an optional space to elaborate on the answers.

Respondent Information

There were 23 female and 4 male respondents, all meeting the survey inclusion criteria. All survey respondents were anonymised, and identifiable personal questions were not asked. The geographical locations of the respondents were broken down into five locations. England; Scotland; Europe; the USA and the rest of the world.

Most respondents were qualified for more than 10 years, with only one respondent qualified for under 5 years. The respondent Art Psychotherapists worked in a variety of sectors, with some selecting more than one. For analysis purposes, the sectors were broken down into two categories: The National Health Service (NHS) or Voluntary/Private sector.

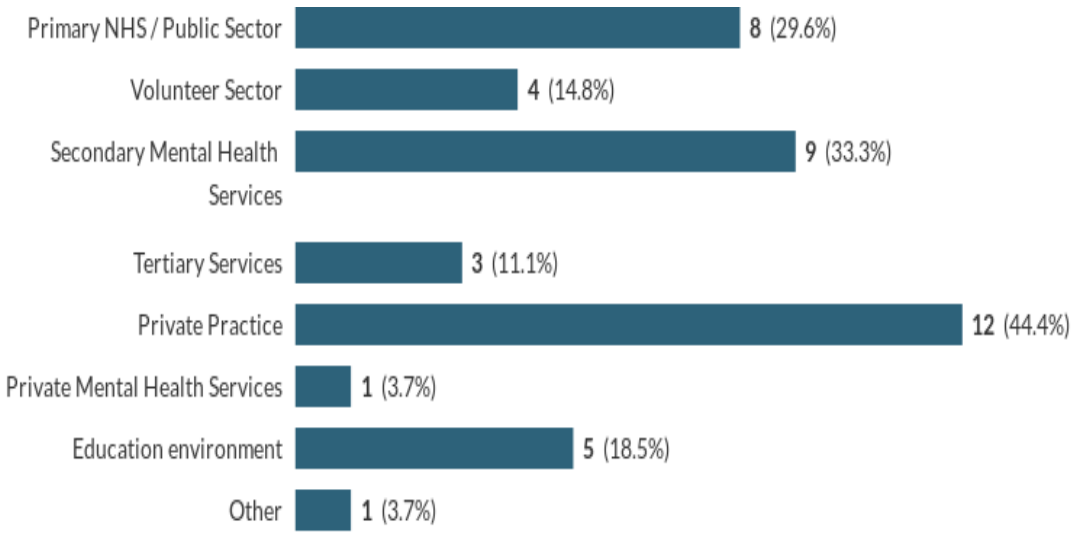

Figure 1.

Percentage of respondents who selected each place of practice option

Environment

81.4% of participants reported some or significantly positive impact on treatment outcomes if the location of treatment is on a bus or train route. Data from this survey also shows that the importance of the décor of the therapy room or surrounding spaces can have a considerable impact on therapeutic outcomes. Again, 84% of respondents reported either some or a significantly positive impact.

79.2% of respondents reported some or significantly positive impact when asked to consider sensory environmental factors.

Practice Components

When considering the amount of time spent on a waiting list and how this can impact the effectiveness of Art Psychotherapy treatment, the survey data reported a clear definition that there would be no detrimental impact without a waiting list. In contrast to these findings, the opposite effect is apparent for a waiting list of 3 months where 81.5% of respondents reported some or significant detrimental impact on therapeutic outcomes.

The mental health charity Mind (2013) states that,

"*The Health and Social Care Act (2012) put mental health on a par with physical health, and the government reiterated this commitment through its current mental health strategy" (Mind, 2013, pg. 4).*

Furthermore, the current Mandate to NHS England requires NHS England to,

> *"(…) achieve parity of esteem between mental and physical health. As a first step towards achieving this commitment, timely and appropriate access to psychological therapies was agreed to be available in the NHS to all who need them" (Mind, 2013 pg.4).*

However, a question arises here about the branding of Art Psychotherapy as it is unknown whether it is a talking therapy.

The current recommended waiting time is 28 days. Mind released findings from their research (2010) reporting that one in ten people have been waiting over a year to receive treatment; over half have been waiting over three months to receive treatment; around 13 percent of people are still waiting for their first assessment for psychological therapy. Their report states, 'Timely access to mental health services is a critical issue. Considerable harm can be caused by long waits for psychological therapies, which can exacerbate mental health problems and lead to a person experiencing a mental health crisis.' (Mind, 2010). Furthermore, British Medical Association research found 3700 patients waited more than six months for talking therapies in 2017 and 1500 for longer than a year, according to Freedom of Information requests. However, this data grossly underestimates the full scale of the problem as nine in ten clinical commissioning groups (CCG's), keep no records of waiting times (Cooper, 2018). The findings from this survey reiterate the detrimental impact of long waiting times for treatment.

The survey data reported slight preference for sessions being held in afternoons, weekends, or evenings for positive therapeutic outcomes, with mornings being the least desirable, although the definition was slight. Regarding the amount of Art Psychotherapy sessions allocated to clients/patients, the survey data reported a distinct shift in impact. For example, almost half of participants reported some or significant detrimental impact on the therapeutic outcome for an allocation of 12 (limited) sessions, reducing to no detrimental impact when clients/patients were offered 12 – 46 Art Psychotherapy sessions. The number of allocated sessions also has an impact on attendance. The survey data reports an improvement in attendance as the allocated number of sessions increase, with the most effective being 12 – 46 sessions. 'Figure 5' shows the reported therapeutic and attendance impacts to the amount of allocated Art Psychotherapy sessions.

Amount of sessions	Detrimental (some and significant) impact	Neither impact	Positive (some and significant) impact	Reduced/non-attendance	Improved attendance
Up to 6 sessions	29.8%	23.1%	46.1%	19.2%	19.2%
Up to 12 sessions (restricted)	48.1%	11.1%	40.7%	18.5%	7.4%
12 sessions (can extend)	14.8%	11.1%	74%	11%	40.7%
12 – 46 sessions	0%	7.4%	92.6%	7.4%	40.7
Unlimited sessions	18.5%	14.8%	66.7	18.5%	40.7%

Figure 5 – Therapeutic and Attendance Impact resulting from Quantity of Allocated Art Psychotherapy Sessions

This survey reported the three most effective art mediums used to treat adults who have psychological complex trauma to be painting with brushes, using clay or plasticine and pastels (including oil) or charcoal. The three least effective mediums reported are portraiture, photography, and using coloured paper. The survey data also reported that joint image-making, mirroring, free association and non-directive creative tools were reported as having the most positive impact when incorporated as part of Art Psychotherapy practice.

The questionnaire asked respondents which mechanisms from those identified within a systemic review exploring Art Psychotherapy when used to treat adults who have anxiety (Adding et al, 2018), had the most significant impact within their own practice. Respondents reported the mechanism ‘a positive and containing therapeutic relationship’ as being the most effective for positive therapeutic outcomes.

Additionally, 40.7% of participants reported that they enable opportunities for their patients/clients to exhibit their artworks and that it has a positive impact on the therapeutic process (90%); improves confidence and self-esteem (100%); enables empowerment (100%) and it increases opportunities (90%).

Additional Information

Survey participants were invited to expand on their answers and comment on what they thought were the main components of Art Psychotherapeutic practice that supported recovery and healing for adults with psychological complex trauma. Emphasis was placed on the art materials being the means to verbalise a person's distress, feeling safe within the therapeutic relationship, the provision of psychoeducation, consistency of the Art Psychotherapist and the sessions, and using body-based approaches including sensory materials.

Data Analysis

All quantitative data analysis was undertaken using the Software Package for the Social Sciences (SPSS; Version 26, IBM Inc.; Armonk, NY, USA). The level of statistical significance was predetermined as a p-value of <0.05.

27 practitioners responded to the International Survey: 19 were UK-based therapists and eight were based in the 'rest of the world'; 23 were female and four male; 18 had practised for 10 years or longer whilst the remaining nine had practised for less than 10 years; 10 were NHS-based whilst 14 were practising in the private and voluntary sectors (n.b. there were four non-responses to this question).

After initial descriptive analysis of variables, Kruskal-Wallis tests were used to determine statistically significant differences ($p < 0.05$) in response to the survey questions between key grouping variables, e.g. geographical location of practice, length of professional practice, sector of practice, and gender of the respondent. Only one grouping variable – that of the length of practice yielded significant differences. Those in practice for over ten years favoured:

- Extended assessment – up to 6 weeks ($u = 109.50$, $p < 0.033$);
- Up to 12 sessions with the possibility to extend ($u = 121.00$, $p < 0.041$); and,
- The statement that the latter had a positive effect on attendance ($u = 121.00$, $p < 0.041$).

The Kruskal–Wallis test is a statistical method for ascertaining the significance of differences between the median values for K+ sub-groups from within the same sample: sometimes referred to as 'ANOVA by Ranks', this is the test of choice when analysing ordinal data such as that generated by a survey instrument.

Because no other consistent patterns of difference emerged based upon grouping variables, a hierarchical cluster analysis was undertaken to identify patterns of similarity and difference of response within the data. Yim and Ramdeen (2015) identified that,

> *'Cluster analysis refers to a class of data reduction methods used for sorting cases, observations, or variables of a given dataset into homogeneous groups that differ from each other.'* (*Yim and Ramdeen, 2015 pg. 8).*

Cases (individual participants) are clustered based upon chosen characteristics – in this instance, similarity in the way they scored responses in the main domains of the survey instrument – and not any of the grouping variables outlined above. Cases in each specific cluster share many characteristics and are dissimilar to those not belonging to that cluster. A two-cluster solution proved to be the most parsimonious, and 12 respondents were classified as in cluster 1 whilst 11 were in cluster 2 (n.b. 4 respondents were excluded from the analysis based on non-response). When the clusters were cross-tabulated with original grouping variables, only one significant pattern emerged – namely that all male respondents were classified in cluster 1 ($\chi 2 = 4.439$, $p < 0.035$ with 1 df). Otherwise, the clusters differed on the following basis:

- Those classified in cluster 1 favoured afternoon appointments ($u=33.00$; $p < 0.044$);
- Those classified in cluster 1 were more likely to identify aesthetic aspects of the therapeutic environment as significant in determining treatment outcomes such as the architecture of the building ($u=14.00$; $p < 0.001$), and décor ($u=31.00$; $p < 0.032$); and,
- Those classified in cluster 1 favoured providing more than twelve sessions to achieve a positive therapeutic effect ($u=6.00$; $p < 0.000$).

Discussion

Contributing to existing research on Art Psychotherapy and the treatment of complex trauma, this study identified components and contexts primarily associated with recovery and healing for this client group. International Art Psychotherapists treating adults with complex psychological trauma were invited to answer four categories of questions:

participant information, environment, practical/clinical components, and additional information. The data reported significant positive impact for healing and recovery, within a variety of areas of Art Psychotherapy practice. Additionally, the study reports how Art Psychotherapy can offer further processes for expression and enable a route of recovery that does not solely rely on verbal communication.

The study highlights significant positive impact of certain art mediums when used to access and express traumatic memories, such as the use of malleable mediums (paint, clay, pastels) all of which include the use and process of haptic engagement and experiencing embodiment as part of the process of expression.

Art Psychotherapy offers a gentle and powerful opportunity for accessing, expressing and processing traumatic memories. An individual who engages in Art Psychotherapy can choose to share their retrieved memories verbally should they wish but it is not an essential part of the therapeutic process. This makes space for the individual to have control of their own healing process and lead the pace and direction of their treatment. This process differs by offering an alternative approach to talking therapies. Furthermore, Art Psychotherapy treatment can be used for extended aims such as sharing and gained empowerment via exhibiting art works made in sessions.

This study provides clarity from cluster identification of survey participants, that highlights patterns of preference for therapeutic practice and contexts aimed at healing and recovery. There is a consensus that the environment, time of sessions, length of waiting lists, and the duration of treatment, are an important consideration for client engagement. If not approached responsive to the client's needs, such contexts can persuade non engagement or detrimental therapeutic impact. Furthermore, the study reports a majority emphasis on the importance of the therapeutic relationship.

This study adds to the body of research for Art Psychotherapy when used to treat adults who have experienced complex psychological trauma, by providing evidence on which mechanisms and contexts of Art Psychotherapy can prove effective. In future studies, exploring the limitations and/or challenges that clients who engage in an Art Psychotherapy intervention in the context of complex trauma, has also been considered.

Although this study reports significant empirically informed research, this area requires more studies to be conducted. Further comparisons of interventions when used to treat adults who have experienced complex psychological trauma, with the aim to ascertain

empirically evidenced key benefits for clients to consider when accessing treatment, would be useful. In addition, further research of somatic expression and healing within Art Psychotherapy practice, particularly when using identified mediums from this study, would be of benefit for people impacted by trauma, and trauma informed services.

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Appendix 3

Treatment Manual – Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP)

UNIFICATION NEURO-INFORMED TRAUMA RECONSOLIDATION ART PSYCHOTHERAPY (UNTRAP)

TREATMENT MANUAL

UNTRAP Manual was developed by Kelly Jayne as part of a PhD program at Northumbria University.

Content

Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy Treatment (UNTRAP) for the treatment of adults who have experienced complex psychological trauma.

UNTRAP is a treatment manual that is the early stages of development. It is to be used as a guide or set of principles, to engage with as and how the patient or clients requires.

Introduction

Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP) has been developed and informed by an International Survey (Jayne, 2021); a literature review; clinical expertise with people who have experienced complex psychological trauma; and a validation process of using an expert panel. This approach has been developed specifically for people who have experienced complex psychological trauma with the intended audience being the facilitator of the treatment (Art Psychotherapist); Researchers; and the clients. UNTRAP aims to reconsolidate emotional learnings in a modified form which can lead to strengthening, change in content, and erasure of unwanted symptoms of the emotional learnings. Such symptoms of emotional learning can present as unwanted behaviours, beliefs, bodily tensions, and states of mind that exist based on earlier emotional learning and conditioning from traumatic experiences. However, the emotional learnings demonstrate the unique process of the emotional brain and enabled survival at the time of the events or experiences.

UNTRAP is delivered in one-to-one, in person or online sessions with an Art Psychotherapist and a client. UNTRAP can be delivered in twelve sessions, but if needed additional sessions can be added. This manual serves as a set of principles and is a guide or reference for the application of Art Psychotherapy treatment for adults who have experienced complex trauma in their lives. It is directive, meaning that the client is supported by the therapist to complete specific tasks in the session. However, the therapist is led by the how the client wishes to engage, and the structure of sessions will follow the pace and order of the client's engagement.

UNTRAP includes several integrated and interlinking areas:

- An underpinning Memory Reconsolidation Model (Ecker, 2012).
- An underpinning three stage approach – safety and stabilisation; identification and processing; and integration and rebuilding ((Seiler, 2016).

- An approach that supports communication through using visual methods and gives choice, structure, and support to the client.
- A range of tools for grounding, regulation and soothing for the client.
- Psychoeducation for increased awareness and understanding.
- A range of key features that encourage personal coping responses, exploration of relationships and interactions, processing of past and current events that build towards a shared understanding between the therapist and the client.
- A range of techniques to identify target no longer required symptoms and retrieve emotional learnings: discover and explore the client's implicit emotional learnings, core beliefs, attributed meanings, schemas, constructs, and mental models unique to that particular client's emotional learnings from experiences of trauma.
- A range of approaches that identify or create disconfirming knowledge or contradictory experiences. The client-therapist relationship is used to support and/or create a relational experience that contradicts pre learned expectations.
- A range of verbal and visual tools for the client to feel both the target emotional learning or schema's expectation, and the non-fulfilment of that expectation in the new contradictory experience.
- An optional opportunity to share art works made to other participants of UNTRAP, at an optional private sharing event.
- Tools: A growing set of tools can be added to support the treatment including homework tasks, client self-monitoring, and therapist monitoring.

1.1 Mission Statement

This trauma informed manual is supported by empirical research and thereby ensures that clients are receiving a treatment that is effective. The structure and time limited nature of this manual based treatment aims to enable focus and facilitate the client's active engagement of the treatment process. To prevent the potential for re-traumatisation, I aim to apply sensitivity to the needs of trauma survivors. As a trauma focused Art Psychotherapist, I believe it is our duty to create a system in which trauma treatment can be done safely, creatively, and effectively so that our clients can heal and become empowered.

Clinical Judgement and professional responsibilities

Whilst this therapy manual is designed to support Art Psychotherapists to deliver UNTRAP treatment it should not overshadow or contradict local policies and procedures and professional standards of proficiency.

Clinical judgement regarding treatment should be made based upon individualised risk assessment and/or appropriate risk reduction measures as required within the setting.

Targeting of the treatment

UNTRAP treatment is likely to be appropriate for:

- Adults who have experienced complex psychological trauma.
- Adults who present with a range of symptoms, associated with functional impairment such as: re-experiencing; hyperarousal (including hypervigilance, anger and irritability); negative alterations in mood and thought; emotional numbing; dissociation; emotional dysregulation; interpersonal difficulties or problems in relationships; negative self-perception (including feeling diminished, defeated or worthless). (NICE, NG116, 2018).
- Adults who present with additional characteristics (associated with Complex PTSD) such as: severe and pervasive problems in affect regulation; persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to traumatic event/s; persistent difficulties in sustaining relationships and in feeling close to others. (NICE, NG116. 2018).

UNTRAP Treatment is not likely to be appropriate for:

- Adults who are under the influence of self-medicated substances such as alcohol or non-legal drugs.
- Adults who have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use and/or if the impairment means the person is unable to make a specific decision when they need to. The Mental Capacity Assessment (MCA, 2018) says a person is unable to make a decision if they can't: understand the information relevant to the decision; retain that information; or use or weigh up that information as part of the process of making the decision. When referrers are considering a client for UNTRAP treatment, they will assess if they have capacity to engage before making a referral.

- Adults who have high risk ideations of suicidal or harm to others.

Glossary of Terms

Arousal – The excitation and energising of neural networks or structures and consequently their respective functions (Niven, 2013).

Attributed meaning (Attribution) – Attributed meaning or attribution is an inference regarding the cause of a person's behaviour or an interpersonal event. Three dimensions are often used to evaluate a person's attributional styles, or characteristic tendencies when inferring such causes: the internal – external dimension (whether they tend to attribute events to the self or to other factors), the stable – unstable dimension (whether they tend to attribute events to enduring or transient causes), and the global – specific dimension (whether they tend to attribute events to causes that affect many events or just a single event). (APA, 2020).

Bilateral stimulation - Bilateral stimulation is a process used to activate and integrate information from the brain's two hemispheres (Amano, 2016).

Bottom-up processing – Experiential learning that uses awareness of low order sensory or emotional features to progress, step by step, to higher order perceptions (Front. 2013).

Construct - Are all complex, abstract concepts that are indirectly observed through a collection of related events. Examples of psychological construct would be a person's motivation, anger, personality, intelligence, love, attachment, or fear. a construct is a skill, attribute, or ability that is based on one or more established theories. Constructs are not directly observable. For example, a person may be observed to be smart by the way they speak and what they say but you cannot directly observe intelligence. You can tell someone is anxious if they are trembling, sweating, and restless, but you cannot directly observe anxiety. You also cannot directly observe fear or motivation (Binning, 2016).

Disconfirming knowledge – a term used in Coherence Therapy meaning a person's knowledge that contradicts previous emotional learning or does not confirm it. Disconfirming knowledge can be already existing knowledge, newly learned emotional lessons or imagined alternative experiences (Ecker, 2020).

Dissociation - a defence mechanism in which conflicting impulses are kept apart or threatening ideas and feelings are separated from the rest of the psyche (APA, 2020). When people are dissociating, they disconnect from their surroundings, which can stop a

trauma memory and lower fear, anxiety, and shame. Dissociation can happen during the trauma or when thinking about or being reminded of the trauma (APA, 2020).

Emotional dysregulation – Emotional dysregulation is any excessive or otherwise poorly managed mechanism or response. This can be an extreme or disproportionate emotional response to a situation that may be associated with psychological trauma, or other causes such as brain injury, autistic spectrum disorder or personality disorders. Emotional dysregulation refers to the inability of a person to control or regulate their emotional responses to provocative stimuli or when triggered (Beauchine, 2018).

Emotional numbing - Emotional numbing can happen as a result of physical or emotional pain. It is a coping mechanism that attempts to protect oneself from being hurt and can be presented as disconnection, detachment, or numbing of feelings related to the situation. A person may feel temporary relief that allows them to move on with their lives. However, this protective shield can prevent connection with others and accessing feelings that are both positive and negative (Kashden, 2007).

Explicit process (conscious) – Explicit processes are a cognitive process that can be described accurately and that are available to introspection. Explicit emotional memory is manifested when individuals reexperience the original emotions engendered by an event (e.g., terror when describing an accident, joy when describing a close family member's wedding) (Dulany, 2012).

Hyperarousal – Hyperarousal is one of three proposed ICD-11 sets of criteria used to diagnose posttraumatic stress disorder and acute stress disorder: re-experiencing, avoidance and hyperarousal (Haravuori et al. 2016). Symptoms of hyperarousal include exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, and excessive vigilance.

Implicit emotional regulation (nonconscious) - Implicit emotional regulation may be defined as any process that operates without the need for conscious supervision or explicit intentions and which is aimed at modifying the quality, intensity, or duration of an emotional response. Implicit emotional regulation can thus be instigated even when people do not realise that they are in any form of emotion regulation and when people have no conscious intention of regulating their emotions. (Koole, 2011).

Kindling – A progressively increasing neuronal response to a stimulus that effects memory and is associated with trauma. Traumatic kindling may reflect amygdala and hippocampal conditioning that results in flashbacks (Weiss, 2015).

Limbic system – A conceptual, rather than anatomical, designation used to group central brain structures that regulate; evaluate and integrate emotion into motivational states; survival responses and memories (Swenson, 2015).

Mental model - A mental model is an explanation of someone's implicit, unconscious knowing about how something works in the world. It is a representation of the surrounding world, the relationships between its various parts and a person's intuitive perception about his or her own acts and their consequences (Al-Diben, 2012). Mental models guide a person's perception and behaviour. They are tools that are used to understand life, make decisions, and solve problems.

Polyvagal Theory – A social engagement theory that correlates body immobilisation, motivation, and social communication. The vagus nerve enables self-soothing, calming, and sympathetic adrenal inhibition. The theory proposes a biological basis for social behaviour based upon phylogenic stage-based activation of the vagus nerve (Porges, 2017).

Recall – Spontaneous retrieval of information from memory, with or without cues (Walkins, 1979).

Schema – Psychologist Jean Piaget introduced the term schema in 1923. He described schema as being mentally applied in appropriate situations to help people both comprehend and interpret information. A self-schema is a cognitive framework comprising organised information and beliefs about the self that guides a person's perception of the world, influencing what information draws the individual's attention as well as how that information is evaluated and retained. The American Psychiatry Association describes schema as being a cognitive structure that represents a person's knowledge about an entity or situation that includes the qualities and the relationships between them (APA, 2020). Schemas are usually abstractions that simplify a person's world.

A schema is a set of assumption that an individual has of the self, others, or the world that endures despite difference to objective reality. In this manual, a schema is also referred to as an emotional learning.

Stress response – Mind-body arousal that ensures survival and / or manages stressors, so that homeostasis or normal functioning can be re-established (Lewis, 2012).

Top-down processing – Information processing utilising complex cortical, often cognitive, functions (Sun, 2012). These cortical functions enlist and regulate subcortical sensory or affect-based, limbic processes.

Vagus nerve – The most important nerve in the parasympathetic nervous system. It connects the body organs with the brain stem. Excessive vagal activation during emotional stress causes it to compensate for overly strong sympathetic nervous system reactions by slowing heart rate and creating a freeze response or faint (Breit, 2018).

What is Trauma?

Emotional and psychological trauma is the result of extraordinarily stressful events that compromise and challenge a person's sense of security, causing feelings of helplessness in a perceived dangerous world. Psychological traumas can lead a person to experience ongoing difficult and upsetting emotions, memories, and anxiety that will persists through adulthood. A person may feel numb, disconnected, and unable to trust other people as a consequence of traumatic experiences. (Thorp, 2017). Gabor Mate (2019) states that, 'trauma is not what happens to you, it's what happens inside you as a result of what happened to you'. He adds that, **'**trauma is a psychic wound that hardens you psychologically that then interferes with your ability to grow and develop' (2019). He further explains that trauma pains a person who can then go on to act out their pain.

To review research on associations of trauma type with PTSD in the World Health Organisation (WHO) World Mental Health (WMH) surveys a series of epidemiological surveys that obtained representative data on trauma-specific Post Traumatic Stress Disorder (PTSD). WMH surveys in 24 countries (n = 68,894) assessed 29 lifetime traumas and evaluated PTSD twice for each respondent: once for the 'worst' lifetime trauma and separately for a randomly selected trauma with weighting to adjust for individual differences in trauma exposures. PTSD onset persistence was evaluated with the WHO Composite International Diagnostic Interview. Results found that in total, 70.4% of respondents experienced lifetime traumas, with exposure averaging 3.2 traumas per capita (Kessler, 2017)**.** There is rapidly expanding literature that confirms high prevalence of trauma and abuse in all psychiatric presentations, such as borderline personality disorder,

personality disorder, eating disorders, depression, anxiety, phobias, self-harm, and psychosis. (Read and Bentall, 2012).

UK statistics

According to PTSD-UK, 1 in 2 people in the UK will experience trauma at some point in their life, and around 20% of those people can go on to develop PTSD. Anyone can be diagnosed with PTSD, and it is estimated that 1 in 10 people develop PTSD. 1 in 5 firefighters, 1 in 3 teenagers who have survived a horrific car crash, 70% of rape victims, 2 in 3 prisoners of war, 40% of people who experienced a sudden death of a loved one, and an estimated 10,000 women a year following a traumatic childbirth, develop PTSD (ptsduk.org). The Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, (Natcen, 2014), reports the following percentages of people aged 16 years and over who screened positive for PTSD.

Ethnicity	All	Men	Women
Asian	5.8	6.1	5.3
Black	8.3	5.1	10.9
Mixed/Other	5.8	5.4	6.2
White – British	4.2	3.5	4.9
White – Other	2.2	1.8	2.5

Figure 1 - Percentage of people aged 16 years and over who screened positive for PTSD in the month prior to the survey (Netcen, 2014) by ethnicity and sex.

However, this survey only covers people who live in private households. It does not include those who live in institutional settings (such as hospitals or prisons) or in temporary housing (such as hostels or bed and breakfasts) or those who are homeless. People living in such settings are likely to have poorer mental health than those living in private households (McManus, 2016). Furthermore, the COVID-19 Mental Health and Wellbeing Surveillance Report (2020), reports that average mental distress was 8.1% higher in April 2020 than it was between 2017 and 2019 in the UK. While it is unknown exactly how many people will be affected by trauma as a result of the pandemic crisis, it is known that large numbers of the population will be exposed to traumatic experiences that put them at higher risk of developing or worsening mental health problems. Evidence points to increased rates of post-traumatic stress disorder following pandemics (Sprang, 2013).

A study by the Office for National Statistics reports that survivors of childhood abuse rated their wellbeing as lower than adults who did not experience abuse as a child. They were less likely to be happy, satisfied with life and feel their lives were less worthwhile than those who were not abused as children, (ons.gov.uk, 2017). Additionally, the National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England, (Bellis, 2014), reports almost half (47%) of individuals experienced at least one of the nine adverse childhood experiences. Prevalence of childhood sexual, physical, and verbal abuse was 6.3%, 14.8%, and 18.2% respectively. The results from this survey suggest that nearly half of all individuals in England are exposed to at least one adverse experience during childhood, and 9% experience 4 or more ACEs. An article published by the European Journal of Psycho-traumatology, (Frewan, 2019), reports that lifetime traumatic stressors and adverse childhood experiences uniquely predicted concurrently measured severity of DSM-5 and ICD-11 PTSD, Complex PTSD (CPTSD), and dissociative subtype of PTSD (D-PTSD) symptoms among 418 participants.

Psychological responses to trauma

In a paper, The Biology Basis of Post Traumatic Responses, (Nutt, 2001), Loos discusses two basic stress responses: defence and inhibition. He states the defence reaction consists of both behavioural and physiological components as efforts to survive confrontations with members of their own species, predators, or physical dangers, also associated with fight or flight responses. Understanding of the ethology and comparative physiology of the defence reaction permits excellent understanding of the psychophysiology of alarm and anxiety in humans. The other survival response, inhibition, which Loos describes as, general adaptation syndrome, is characterised by behavioural inhibition when all possible active ways of surviving a challenge are being blocked off. It can be compared to the psychodynamic concept of unsolvable conflict or to Seligman's behavioural model of learned helplessness (Abramson et al., 1978). Clinical Psychologist, Dr Curtis Reisinger, (Reisinger, 2020) reports that the 'fight or flight' response to stress is oversimplified, and that there are other ways that humans have evolved to adapt to stress. He reports six responses to trauma that include: fighting a threat (fight), fleeing a threat (flight), freezing and not doing anything in response to a threat (freeze), being flooded with emotions in response to a threat (flood), cooperating or submitting to one's threat or captor (fawn), or feeling tired and/or sleeping in response to a threat (fatigue).

Complex traumatic experiences can manifest in lots of ways and continue to affect a person and their behaviour. If a person has learned helplessness in initial traumatic experiences, they may unconsciously attempt to overcome this experience through reactive behaviours to potential threats. The defence is informed by the initial inhibition position from initial traumatic experiences, in UNTRAP this will be referred to as no longer needed symptoms. Anxiety is a common and natural response to a dangerous situation. For many people it lasts long after the traumatic experiences end. This happens when views of the world and a sense of safety have changed. Someone may feel anxiety when remembering their trauma. But sometimes anxiety may be triggered without an obvious cause. Triggers or cues that can cause anxiety may include places, times of day, certain smells or noises, or any situation that reminds someone of their trauma. Traumatic experiences can be re-experienced as flashbacks, or very vivid images, which can feel as if the trauma is occurring again. Nightmares are also common. These symptoms occur as the psyche attempts to resolve the experience. Increased vigilance is also a common response to trauma. This includes feeling on guard, jumpy, jittery, shaky, nervous, on edge, being easily startled, and having trouble concentrating or sleeping. Continuous vigilance can lead to impatience and irritability. This reaction is due to the freeze, fight, or flight response in the body, and serves the process of protection against danger. When we protect ourselves from real danger by freezing, fighting, or fleeing, we need a lot more energy than usual, so our bodies release extra adrenaline to help us get the extra energy we need to survive (Farr, 2014). People who have experienced complex psychological trauma may experience the world as dangerous, so their bodies are on constant alert, being ready to respond immediately to any attack. Research suggests that overactivation of adrenaline can contribute to high blood pressure, promote the formation of artery-clogging deposits, and causes brain changes that may contribute to anxiety, depression, and addiction (Bonnet, 2010). More preliminary research suggests that chronic stress may also contribute to obesity, both through direct mechanisms and indirectly (Farr, 2014). PTSD alone has been associated with higher BMI/obesity and may be the psychiatric disorder most linked with obesity.

Avoidance is a common way of trying to manage PTSD symptoms. For example, avoiding environments or situations like that of their traumatic experiences. This can restrict potential life enhancing and positive experiences and exacerbate anxiety. In severe formation, this process can cause phobias and Obsessive-Compulsive Disorder (Perry, 2008). Complex psychological traumatic experiences may lead to feelings of anger, guilt,

and shame. It is common that a person may blame themselves for things they did or did not do to survive such experiences. This process perpetuates secondary psychological impact from the initial events. Other common psychological responses to complex psychological traumatic events may be an altered perspective of others and the world, not being able to trust people, low self-esteem, suicidal ideations, self-harm, eating disorder, conflicted relationships, inhibited or increased sexual relationships, addiction, maladaptive daydreaming (Somer, 2002), threat seeking behaviours, disturbed sleep and physical ill health. A person may become dissociated or psyche-split as a coping mechanism. Bruce Perry reports that the negative effects from psychologically traumatic experiences are caused by alterations in various neural systems in the brain that compromise the functional capacities mediated in such systems, particularly when the events occur in childhood, when the brain is still developing, (Perry, 2006).

A person can become dissociated to cope with extreme traumatic experiences. What Freud described as" stimulus too painful to be dealt with", (Freud, 1926), translates into what Daniel Siegal designates as outside a person's window of tolerance, beyond a person's ability to manage and tolerate emotionally (Siegal, 2001). Ross describes dissociation as being the opposite of association. Not interacting, split apart, disconnected to experiences that are too overwhelming for the psyche (Ross, 2004). The American Psychiatric Association describe dissociation as: 'a subjective loss of integration of information or control over mental processes that, under normal circumstances, are available to conscious awareness or control, including memory, identity, emotion, perception, body representation, motor control, and behaviour'. Cardena and Carlson (2011) have further specified the dissociative symptoms as characterised by: a loss of continuity in subjective experience with accompanying involuntary and unwanted intrusions into awareness and behaviour and/or; an inability to access information or control mental functions, manifested as symptoms such as gaps in awareness, memory, or self-identification, that are normally amenable to such access/control and/or; a sense of experiential disconnectedness that may include perceptual distortions about the self or the environment. When dissociative symptoms are present, a person may know or not know what happened, as aspects of the self connects with the truth then disconnect because that truth cannot be tolerated. Evidence suggests that therapeutic input may be able to ameliorate some, or all, of the consequences of complex traumatisation (McFetridge, 2017).

Trauma Informed Approach considerations for UNTRAP

Educate Art Psychotherapist facilitators and involved clinicians about trauma and traumatised patient's special needs.

- Awareness of common trauma symptoms and how to present and respond to the client.
- Train Art Psychotherapists on verbal de-escalation techniques and provide them with tools to help clients self sooth and emotionally regulate.
- Provide clients and facilitators opportunities for feedback so they can participate in improving the program.

Create a safe and supportive physical environment

- Building is well maintained and clean.
- Adequate lighting is provided inside and outside of buildings.
- Things are fixed when broken.
- The building can be locked and secured.
- Building is accessible for people with physical limitations.

Ideas for enhancing communal physical environment

- Colourful artwork.
- Live plants, fish tanks.
- Calming music.
- Comfortable, soft seating.
- Offer quiet rooms or spaces to take an emotional time-out.
- Rocking chairs.

Create an emotionally safe and supportive environment

- Demonstrate respectful interactions.
- Generate culture of open communication, tolerance, respect, and community.
- Maintain consistency, predictability, and transparency.
- New clients to be introduced to staff members.

Maintaining a respectful and responsive community

- Art Psychotherapists can interact with people in distress without telling them what to do or immediately giving consequences.

- Art Psychotherapists listen to and validate a wide range of emotions (e.g., grief, anger, and fear) from clients.

Components of UNTRAP

An overview

The aim of UNTRAP treatment is to change the valence and the intensity of the traumatic memory, and to increase control of memory retrieval. A goal of the treatment is to change a reliving intruding memory into a more distant episodic memory. This is enabled by using memory recall through the creative process, and bilateral expression and experiencing in a juxtaposition of holding the unwanted and contradictory emotional learning together.

Figure 1 shows a basic framework of UNTRAP. Clients will be supported in following steps of the UNTRAP manual that follows an order, while being contained within a 3-stage approach (safety and stabilisations; identification and processing; and integration and rebuilding). Clients will likely move through and around, according to their individual needs, while following the UNTRAP frame in an ordered manor. The manual serves as a set of principles and is used as a guide when following and supporting the process of the client. It may be that the client needs to stay longer with a theme in a particular session, or revisit sessions.

UNTRAP frame

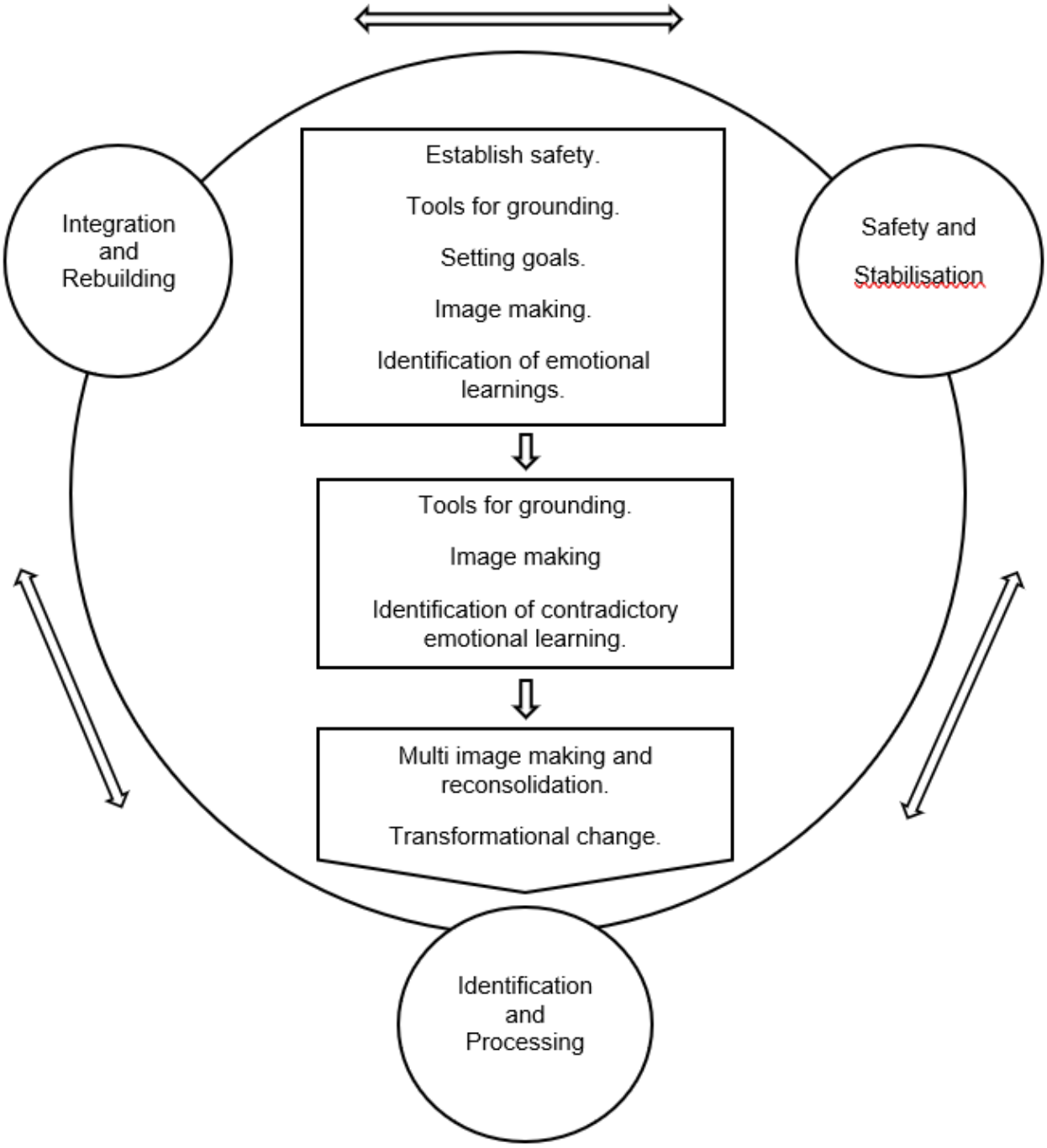

Figure 2 - UNTRAP process

Unification Neuro-informed Trauma Reconsolidation Model

UNTRAP is based on memory reconsolidation, a neurobiological mechanism of reconsolidation that leads to reconsolidation of a memory which produces permanent change in clients; three stages of treatment that occur according to the client's process needs which are: safety and stabilisation; identification and processing; and integration and

rebuilding; memory reconsolidation and Coherence Therapy approaches; and Art Psychotherapy.

Three stages: Safety and stabilisation; Identification and processing; and Integration and rebuilding

The three stages of Safety and stabilisation; Identification and processing; and Integration and rebuilding, allow considerable flexibility for the Art Psychotherapist to modify treatment to the individual client. Components are as follows:

- Safety and stabilisation
- working with the Art Psychotherapist to develop aims and goals
- improving the sense of personal stability, security, and safety
- finding new ways to process and express emotions in a healthy way
- distinguishing between healthy and unhealthy behaviours and tendencies through reflection
- establishing a routine of psychological and emotional self-care. Ask the client what works for them already and build on those tools.
- practicing forms of self-love and self-appreciation
- revealing and exploring sources of inner strength
- developing coping mechanisms and emotional regulation tools
- Identification and processing
- evaluate painful and traumatic memories
- redefining the role that certain events play in your client's life by identifying no longer needed symptoms or emotional learnings
- exploring and mourning any losses associated with the trauma in question
- determining the impact that traumatic experiences have had on your client's life.
- mourning the loss of good experiences or opportunities due to trauma or trauma-related hindrances
- Integration and rebuilding
- Transformational change. No longer needed symptoms or emotional learnings will be replaced by positive contradictory experiences
- Build upon newly emerging positive healthy beliefs of self
- Imagine experiencing life in a new way, including connecting with others and engaging in meaningful activities and life experiences.

The points within safety and stabilisation (except the first one) will/can happen transformationally after memory reconsolidation has taken place, meaning that once a construct has been erased it no longer generates, for example, unsafe behaviours. Furthermore, the three stages will not necessarily follow a strict order but move around according to the features and requirements of the client's therapeutic process.

The ability to identify mental schemata or emotional learnings that underpin unwanted behaviours in therapy and bring them into conscious awareness is a vital step toward transformative change. Causing implicit emotional learning logic to become explicit and to juxtapose it with a contrasting experience can cause the original learning to become unstable and able to be changed. (Ecker, 2015).

The Unification Neuro-informed Trauma Reconsolidation Model in UNTRAP is further based on current literature and evidential findings on psychotherapeutic treatment (including Art Psychotherapy) for people who have experienced psychological trauma; the biology and neuroscience of trauma, such as the writings of Noah Hass-Cohen, Richard Carr and Juliet King, national and international guidelines, the World Health Organisation (WHO), an International Survey (Jayne, 2021); clinical experience and expertise, and guidance from an expert panel via a validation process.

Memory Reconsolidation

Memory reconsolidation research by neuroscientists has demonstrated the erasure of emotional learnings (Ecker, 2020). Memory reconsolidation enables transformational change as opposed to incremental change. Transformational change leads to the elimination of symptoms caused by emotional learnings formed during experiences of trauma for example, it enables a profound permanent change that is effortless to maintain with no relapses. Ecker reports that there are three experiences required for the erasure of emotional learning, and it is not a particular external procedure, but rather the internal occurrence of the following experiences. Ecker has termed these three experiences as empirically confirmed process of erasure (ECPE) (Ecker, 2018).

1. Reactivated, symptom generating target learning experienced in awareness.

The first experience is the deliberate use of cues to reactivate the target emotional learning that underlies the client's symptoms and problems. To assure the schema is being directly accessed at its roots in the emotional learning and memory system and is not merely a cognitive insight, it is important that the emotions accompanying the re-activated schema

are fully felt affectively and somatically while being cognised verbally and conceptually. Emotion accompanies the ECPE in therapy not because emotion is required by the memory reconsolidation mechanism, but because the target learnings encountered in therapy almost always were formed in intensely emotional experience, so they generate emotion when reactivated, and memory reconsolidation requires target learning reactivation.

2. Experience of mismatch / prediction error destabilises the target learning's neural encoding.

While the target schema has been reactivated in awareness, as in above, this is an additional concurrent experience that contradicts what the client knows and expects according to their schema. In response to this experience of the world differing from the target learning's expectation, the client's brain starts to unlock rapidly transform the neural encoding of the target learning from its stable and consolidated state in long term memory, into a destabilised, de-consolidated state which is susceptible to being updated and re-encoded by any relevant new learning that may occur next.

3. Experience of counter-learning drives unlearning, nullification, re-encoding and replacement of target schema.

The experience consists of repetitions of the same mismatched experience created in the previous step. Each mismatch is a juxtaposition experience where the client experiences both realities according to the target schema and a contradictory perception or knowing. In UNTRAP, multi-image making is used to support this necessary experience.

The ECPE experiences defined above have been detected in previously published accounts of cases of transformational change from numerous different forms of psychotherapy. For example, Ecker et al (2012) provide demonstrations of ECPE detection in published cases of Accelerated Experiential Dynamic Psychotherapy (AEDP), Coherence Therapy; Emotion-Focused Therapy (EFT), Eye Movement Desensitisation and Reprocessing (EMDR), and Interpersonal Neurobiology (IPNB). ECPE that is required for memory reconsolidation to occur, is a core process shared by diverse forms of psychotherapy and could lead to integration and unification of the psychotherapy field (Ecker, 2011, 2018; Ecker et al 2012).

The memory reconsolidation component of UNTRAP is the main formula that integrates methods and approaches to achieve its goal of psychological transformation and

healing. All of which occurs within the containment of the three staged approach designed specifically when treating adults who have experienced psychological trauma.

Art Psychotherapy

Using Art Psychotherapy for memory recall and memory reconsolidation is particularly valuable in that the schemas that exist tend to be implicit and nonverbal. Art making can support awareness and understanding of how such learnings have manifested in their lives. Högberg reports that the use of art in psychotherapy can be summarised as 'activating the ability to get into a memory and/or a fantasy with emotional content', (Göran Högberg, 2011).

In addressing the use of Art Psychotherapy in the treatment of trauma, several authors recently have referred to information about neuroscience foundations of brain function and behaviour, differentiating different components involved in non-verbal expressions (Chapman, 2014; Crenshaw, 2006; Gantt and Tinnin, 2009; Hass-Cohen & Carr, 2008; Hass-Cohen et al., 2014; Klorer, 2005; Lusebrink, 2004, 2010; McNamee, 2005, 2006; Pifalo, 2009; Sarid and Huss, 2010; Talwar, 2007). These authors discuss the importance of sensory motor aspects involved in expression through art media to images and emotions resulting from trauma, emphasising that the experience of trauma is encoded as non-verbal sensation, which may remain unaltered as implicit memory, (King, 2016).

The second aspect common to Art Psychotherapists' approaches to treating clients who have experienced psychological trauma, is the ability of art to aid in the cognitive restructuring and subsequent integration of trauma experiences. This process could be described as the creation, organisation, and integration of a trauma narrative, (Hass-Cohen et all, 2014). Such non-verbal expressions and the creation of a narrative through Art Psychotherapy is the hemispheric integration of non-verbal implicit memories. This process, along with an additional component of holding a contradictory emotional learning in juxtaposition, is referred to in this manual as memory reconsolidation.

Within the three necessary experiences (ECPE) required for memory reconsolidation, Art Psychotherapy aids the recall and identification of a clients' schema. Furthermore, image making is used to develop essential components of the three staged approach such as safety, by evoking and solidifying symbolic reference of a clients' idea of what safety means to them and enabling clarity of emotions and experiences through

image making and externalisation. Making images of both schemas and mismatch or contradictory experiences, and observing both as an external and explicit symbol, aids clarity, control and differentiation.

Art materials

A survey reported that the 3 most effective art mediums when used to treat adults who have psychological complex trauma are reported to be painting with brushes; using clay or plasticine; and pastels (including oil) or charcoal. (Jayne, 2021). These mediums offer an immediate and malleable component in their use. Making a mess is accessible and unavoidable with each. It is possible that a person may not be immediately able to recall a trauma memory or realise an unwanted emotional learning. Art Psychotherapist Frances O'Brian reports that mess may be a consequence of damaged neural pathways resulting from early relational abuse with dissociation used to repress the memory of abuse or neglect and to stop thinking taking place. (O'Brian, 2004). Using messy or malleable art materials is a valuable tool for an Art Psychotherapist in tracing the experience of abuse back to infant life and enabling preverbal memory to be accessed for the adult patient. Painting, clay, pastels and charcoal can all be manipulated to the desired affect without the restriction of an immediate permanence. This offers potential for exposure of internalised psychological material with the available process of changing the image or mark therefore, offering the opportunity for control, expression and negotiation of this material. Art Psychotherapy approaches that allow rhythmic movements are the preferred mediums to stimulate the kinaesthetic motor function in individuals (Hindz, 2009).

Environment

Trauma can push the activation of the nervous system beyond its ability to self-regulate. When a stressful experience pushes a person's psychological system beyond its limits, it can become stuck (Danylchuk, 2014). When a system is overstimulated in this way, a person can experience anxiety, panic, anger, hyperactivity, and restlessness. If possible, ensure the therapy space is a neutral, comfortable room with a window, as this can be conducive for therapeutic engagement, positive therapeutic outcomes and can reduce anxiety triggered by environmental stimulation that may be experienced by the patient as a reactivation of traumatic learnings and re-traumatisation (Jayne, 2021).

Quantity and time of sessions

When considering the amount of time spent on a waiting list and how this can impact on the effectiveness of Art Psychotherapy treatment, data from an international survey (Jayne, 2021) reported a clear definition that without a waiting list, there would be no detrimental impact to therapeutic outcomes or engagement. In contrast to these findings, 81.5% of respondents reported significant detrimental impact on therapeutic outcomes with a waiting list of 3 months. The survey also reported significant positive impact when sessions are held in afternoons, and when there is an option for sessions to be extended beyond 12 sessions if needed. This number of allocated sessions and having a flexible approach, also has a positive impact on attendance (Jayne, 2021).

Multi- making / bilateral processing

Bilateral simply means “involving two sides.” Sensory integration is often associated with bilateral techniques that assist individuals in organizing specific sensations. In the process of reparation from psychological trauma, various forms of bilateral stimulation or movement seem to be effective in engaging cross-hemisphere activity in the brain (Shapiro, 2001). In Art Psychotherapy it is possible because it reconnects thinking and feeling (Malchiodi, 2003/2011) via the sensory-based processes involved in art making. These applications have an impact on recovery from traumatic events because for many individuals, the limbic system and right hemisphere of the brain are hyperactivated by actual experiences or memories of trauma. In brief, specific processes found in multi-image making using both hands/bilateral image making may help regulate body and mind thus allowing explicit memory to be reconnected with implicit memory. (Malchiodi, 2003/2011).

In the case of bilateral drawing or image making in UNTRAP, both hands are engaged therefore the brain is stimulated bilaterally. This concept reflects Shapiro’s model of Eye Movement Desensitization and Reprocessing (EMDR) treatment that involves dual attention stimulation and consists of a practitioner facilitating bilateral eye movements, taps or sounds as sensory cues with an individual. When combined with trauma narratives, it is believed that visual, auditory, or tactile cues help the individual by directing focus on the present, and what has happened in the past (Shapiro, 2001). This is a one of myriad possible ways of discovering implicit emotional learnings and bringing them into conscious awareness.

Van der Kolk states the goal of trauma therapy is to move the survivor away from being held captive by the unspeakable past and to engage more fully in present, (Van der Kolk, 2014). However, this is not an easy task as emotional memory is strong, vivid, and long lasting. LeDoux (1996) suggests that trauma may bias the brain in such a way that the lower, limbic regions predominate over the higher cortical ones, with emotional learning taking precedence over cognitive insight. For healing to occur, traumatic memories need to be transformed, contextualised and given meaning. However, words alone may be inadequate for addressing the negative imprint of trauma that is lodged in the emotional right brain (Van der Kolk, 2014). Because art making engages both mind and body, a client can rapidly access implicitly stored traumatic memory and remain mindfully focussed on the present.

A bilateral Art Psychotherapy protocol developed by McNamee (2003, 2004, 2006) and based on the work of Cartwright (1999), purposefully engages both hemispheres of the brain in multiple sensory systems to 'perturb maladaptive neural organisations' (McNamee, 2006). McNamee aske the client to create drawings using their dominant and, subsequently, non-dominant hand in response to client identified conflicting beliefs, cognitions, and feelings. The multi-image making bilateral component of UNTRAP asks the client to use both hands to create 2 images of their schema, and of their mismatched or contradictory learning experience, specifically for the integration of non-verbal implicit memories in juxtaposition with the verbal functions that have formed explicit, reconstructed, and coherent verbal memories.

Art Psychotherapy in UNTRAP aims to utilise all hemispheres of the brain, pairing the unconscious, emotional sensations with rational, verbal thought processes. The multi-image bilateral image making in UNTRAP is specifically developed with the above process in mind. Additionally, drawing from the theories of sensorimotor psychotherapy, EMDR, Coherence Therapy, and interpersonal neuroscience, this unique trauma informed component of UNTRAP aims to induce two discovering implicit emotional learnings and bring them into conscious awareness, where mutually contradictory experiences occur concurrently to enable transformational change. It involves making separate images with both hands at the same time. The one chosen hand is used to make an image of the client's schema while they make an image of their identified contradictory emotional learning with their other hand, which facilitates resolution using sensorimotor processes and holding both learnings in a juxtaposition. It may be that the client has developed symbolic identification in previous image making and processing sessions for their schema

and mismatched or contradictory learning. Therefore, enabling easier accessible states for each position.

Unification

UNTRAP unification is the application of the three stages approach; Art Psychotherapy; a trauma informed approach; memory reconsolidation; having tools for grounding and safety; being informed by current literature; expertise gained from experience of working with adults who have experienced psychological trauma; and input from an expert panel as part of a validation process for UNTRAP manual.

Bruce Ecker states (2020) that there is immense value for the psychotherapy field, in now having transtheoretical, empirical knowledge of the brain's mechanism of change that comes from outside of the psychotherapy field. He suggests that only in this way can the field find robust, universally acceptable unification that escapes the field's entrapment in inconclusive theorising that is perpetually contested. Many existing theories and methodologies of psychotherapy successfully guide clinicians to produce transformational change. However, under the meta-framework of memory reconsolidation, challenge is not required for any theories or methodologies as it now becomes possible to see how and why each system works (Ecker, 2020).

Bottom-up approach and grounding tools

Modern neuroscience suggests that traumatic events can leave long-lasting imprints on the body and mind (van der Kolk, 2014). Trauma can negatively influence physiological responses in the body such as the nervous system and immune function (van der Kolk, 2014). With the new understanding that trauma has a wide influence on the body and mind, UNTRAP uses a range of approaches that incorporates a bottom-up approach to encourage emotional regulation and centredness. Bessel van der Kolk (2014) suggests that top-down approaches such as talk therapy may not be enough, and that incorporating bottom-up approaches are essential in understanding how to work with trauma in all its complexities fully. Breathwork, body scans through Mindfulness and gentle movement can be incorporated as grounding tools and bottom-up techniques. UNTRAP adopts techniques that encourage identifying and noticing how the client is thinking, feeling emotionally and in their bodies to ensure the bottom-up approach. In sessions, this may consist of asking the client how they feel in their body, if there is any tension or tightening

of their shoulders and jaw and noticing if they are breathing differently. It is important to notice any changes for the client as it may indicate discomfort for them, and they may be leaving their window of tolerance as described earlier.

Trauma and Breathing

Breathwork and various breathing practices are known to produce feelings of relaxation and promote well-being. Brown and Gerbarg (2012) suggest that breathwork may help to treat trauma symptoms because many of these practices can help an individual to feel more connected with their body. Physiologically, breathwork practices can activate the parasympathetic nervous system (Brown & Gerbarg, 2012). Activating the parasympathetic nervous system (PNS) also helps to reduce emotional reactivity, which is a useful way to support grounding and promote feelings of safety. The PNS also plays a role in producing oxytocin, also known as the “love hormone”, and helps to facilitate bonding and feelings of love (Brown & Gerbarg, 2012). Individuals who suffer from trauma may not feel safe or trust others easily. The activation of the PNS and the production of oxytocin in the body helps to facilitate human connection and bonding, which leads to feelings of safety (Brown & Gerbarg, 2012) which would enhance the therapeutic relationship and support the healing process within UNTRAP. Along with safety, breathwork is also known to activate the vagus nerve which reduces activity in the fear circuits and stress-response systems (Brown & Gerbarg, 2012). According to Levine (2010), understanding the vagus nerve is crucial for knowing how to treat clients with trauma. The smart vagus is considered the volume control for emotions. It also plays a role in healthy attachments, bonding, trust, and emotional intelligence (Levine, 2010). Levine (2010) states that therapy usually fails for most clients with trauma because clients who suffer from trauma may feel frightened to develop authentic connections with others, which can lead to isolation. Helping a client strengthen his or her smart vagus and regain control over the parasympathetic and sympathetic nervous systems is important in the treatment of trauma, as strengthening these systems can promote healthier attachment schemas, facilitate bonding, and foster a sense of safety (van der Kolk, 2014).

Opportunity for sharing art works

Art Psychotherapist - John Martyn states: “Intrinsic to the Social Art Psychotherapy frame is the intention to address the division between the self and public, and if the dichotomy between patient and public is not addressed, then the person remains isolated.”. A survey reports (Jayne, 2021) that this process significantly improves confidence and self-esteem

(100%); enables empowerment (100%); and it increases opportunities (90%) for the participants. All participants of UNTRAP will be offered an opportunity to share their art works with other UNTRAP participants, in an event following their treatment. Attendance of this event is optional.

Continuity of Care

Patients who have experienced complex traumas may require a continued connection to the 'secure base' (Brown and Elliot, 2016), as they continue to explore the new freedom and gain independence. To maintain safety and stability, the provision of a gradual step down for service support options for these patients is essential. It is not uncommon for complex trauma survivors to have little or no family support, (Seiler, 2016). It is possible that a client may not wish to continue their UNTRAP treatment. If this happens, it is important that the client is aware that they can continue to access support from their care providing team. This may involve being offered an alternative therapeutic intervention of a client's choice.

Care of the Clinician

Prevalence of vicarious traumatisation (VT) or secondary traumatic stress (STS) has been studied more extensively among professionals who work with survivors of trauma in therapeutic professions. In a meta-analysis of 38 studies by Hensel, Ruiz, Finney, and Dewa (2015), 17 risk factors for STS among professionals who do therapeutic work with trauma victims were identified across studies. These risk factors included caseload volume, caseload frequency, caseload ratio, and having a personal trauma history. Among the studies they reviewed, prevalence of STS was reported as 34% among child protective service workers (Bride, Jones, & Macmaster, 2007) and 15.2% among licensed social workers using the Secondary Traumatic Stress Scale (STSS), (Bride, 2007). More than half (55%) of Bride's sample likewise met at least one of the core criteria for PTSD. Relatedly, in a comparable study by Choi (2011), also assessed by the STSS, findings indicated a 21% STS prevalence in a national sample of social workers treating survivors of family or sexual violence (N-154; Choi, 2011). About 65% of Choi's sample also met at least one of the core PTSD criteria. Participants in a study of mental health therapists (i.e., 320 licensed mental health professionals assessed via the STSS) reported comparable STS symptoms to Bride (2007) and Choi (2011), with a mean score of 32.1 (SD = 10.0; Bride, Jones, et al., 2007; Choi, 2011; Robinson-Keilig, 2014).

To avoid the development of vicarious traumatisation or secondary trauma stress, it is essential that each facilitator of this manual has regular clinical supervision and follows a selfcare program alongside the manual delivery.

Instructions

This manual was written for three types of users: the Art Psychotherapist who will deliver the treatment; Researchers; and the client. Art Psychotherapists who will deliver UNTRAP will undergo training in preparation of delivering the treatment. Part of the manual includes an information document for the client's reference (see appendix 3).

UNTRAP treatment is framed within a 3 steps approach: safety and stabilisation; identification and processing; and integration and rebuilding. It is likely the client will move within the 3 stages. For example, safety and stabilisation may need to be re-visited as the client explores their traumatic experiences and identifies how this has impacted on their lives.

Principles - Things to do

- Share the therapy plan, negotiate, and agree on in an open manner with the client.
- Help clients feel at ease and to know what to expect and what is coming next in the treatment. It is important the client feels safe and in control of their process, speed, and level of how they engage. Offer them reassurance if needed, check if they have questions and respond to them in a clear and open manner.
- Be friendly, be interested, be open and inquiring with a view to working collaboratively and support the patient to see the therapy as being useful and relevant to them. Let the client know that you have listened to them by repeating back what they have said, to assure a mutual understanding. Always have a non-judgemental presentation.
- Acknowledge potential and express hope and optimism about the possibilities for change.

Principles - Things to avoid

- Avoid making assumptions. When necessary, check things out and inquire about what the client has meant by the words they use.
- Avoid making interpretations. A client's experiences and responses to their trauma or emotional learnings are personal to them and may not be related to how you

interpret it. Offer psychoeducation as stated in the session outline, and in response if the client requires further understanding of their own processes.

- Avoid speculating about what the client has or has not said but rather summarise, give feedback, or annotate client's words in a way that builds their confidence that they are being understood. Always invite the client to correct you if you have misunderstood them.

Planning and agenda setting

Planning and agenda setting can be used at the start of therapy and at the start and end of each session.

- At the start of therapy, discuss the session plan and provide a hard copy for the client to look at between sessions. Invite the client to ask questions about the plan and offer additional information if needed. The session plan is person centred, therefore will respond to the needs and requirements of the client. Revisiting plans throughout the therapy can be helpful and plans can always be adjusted and revised.
- At the start of each therapy session, ask for feedback on the last sessions; how they found the pace, how they felt afterwards; if they needed more grounding time; if there is anything they wish to process further etc. and ask if the client is ready to move forward on to the next session.
- At the end of the session, allow time for the client to discuss the session and invite any feedback or questions the client might have.
- Close the session in a way that helps the client to move on to the next thing in their day without them feeling upset or distressed. At the point of closing the session the therapist should also monitor risks related to the client's presentation/reporting and if concerns are raised act accordingly. Facilitating 'grounding', helping the client to connect with the present moment, is something that can be useful at the end of therapy sessions and this should be initiated by the therapist.

Goals and Objectives

We intend to expand awareness and knowledge of the importance of addressing the need of adult trauma survivors by delivering UNTRAP, a model of treatment that is empirically informed and aims to appeal to a large population with a variety of needs. The model adopts a Trauma Informed Approach (TIA) where the safety and therapeutic needs of the

participant are paramount, and all considerations are made with the experience of the trauma survivors' perspective at the core of the program.

The delivery of UNTRAP adopts a co-production approach to ensure the most authentic understanding of the needs of the client, and that the client remains in control of their own healing process. This manual was validated using an expert panel that consisted of therapists who specialise in working with people who have experienced complex trauma, and people with lived experience of trauma. Springer (2021) broadly defines co-production as 'people who use and provide art therapy services working together to develop theory in such a way that values both the consensus and differences between each perspective'. Springer (2021) states that 'co-production can be applied to both practice and research. In all cases, the methodology requires flexibility to ensure those contributing lived experience will share control and influence with professionals' (Springer, Xenophontes, 2021).

All Art Psychotherapist facilitators are to have completed training on the UNTRAP model. As part of the training, all therapists will be invited to engage in UNTRAP as a participant of the treatment. It is important that the therapist who delivers UNTRAP has experienced the treatment first-hand as this best informs the facilitation for the client.

Pre-treatment considerations

The structure of a person's sessions and how they are delivered are important components to a person's experience and recovery process. It is important to consider all aspects of the treatment outside of the internal treatment plan to ensure the person has the most supportive experience and to avoid additional challenges that may cause stress or anxiety.

- Plan treatment to avoid a waiting list if possible.
- Deliver sessions on afternoons unless a person specifically asks for a morning session.
- Inform each participant that they will be offered 12 sessions, with more sessions to be added if needed.
- Ensure to inform all potential participants that although the treatment is directive and follows a treatment plan, it is flexible to suit the psychological needs of the person.

Environment

People who have experienced psychological complex trauma are likely to be more sensitive to sensory stimulation.

Figure 3 – Bowl (unnamed and untitled).

- Deliver sessions in a comfortable, neutrally decorated, warm therapy space, ideally with a window.
- Ensure the location for the treatment is in an easily accessible location, and on public transport route.
- Ensure the building has easy access for people with physical disabilities.

Art materials

- Provide a variation of art materials including paints, brushes, pastels, oil pastels, charcoal, and clay.
- Ensure to provide measures for messy creative expression such as table covers, aprons, cleaning products, storage boxes and dry racks.

Figure 4 – Paint palette (unnamed and untitled)

Twelve session structure and content summaries

The session structure acts as a guide only. Ensure to follow the speed and direction of the client's process which may involve spending more than one session on a theme or revisiting the content of a previous session.

Session 1

In the first session, introduce the client to the UNTRAP program and invite them to ask any questions they may have. Reassure the client that the pace of the sessions will adhere to their needs and that regular breaks and grounding exercises will occur to ensure their safety.

Provide the client with an explanation of the clinical framework such as confidentiality; out of session care; contact numbers for external services; and safeguarding. Discuss the session requirements such as attendance, time keeping, how to report a non-attendance; and clothing for art making.

Inform the client of the general rules such as keeping phones off or on silent; and not being under the influence of alcohol or non-prescribed medication when attending a session. Suggest that the client holds up their hand if they wish to pause the session and use grounding techniques at any moment, so that the sessions move at their pace, and they do not have to use their spoken voice to ask for what they need.

Discuss the structure of UNTRAP, and identify any goals, aims and intentions the client might have. Then ask the client to make a list which can be changed and referred to in following sessions. Advise the client that this, and other images and writings will be stored on premises in a locked container so that they are accessible for future reference. If the sessions are online, this is not applicable.

Ask the client what helps them to feel safe and grounded. Clients may already have their own tools for this that can be referred to and used in sessions. A collection of grounding techniques may also be of interest to the client.

If the client feels comfortable, teach breathing techniques, and encourage them to practice daily at home. (See appendix 1 for examples of breathing exercises).

Session 2

Each session to be started with a check in.

In session 2, provide the client with information on the reactions commonly experienced by traumatised people, which provides the client with a framework for understanding their symptoms (see appendix 2 for a psychoeducation template). Explain that avoidance behaviours are effective in reducing anxiety in the short term but maintain symptoms because avoiding anxiety situations hampers the process of treating and integrating

trauma memories. Provide the client with reassurance that in treatment they can pause sessions and have breaks as they need them, and that their safety, that may have aspects that are unique to that particular client, is a priority throughout the process.

Invite the client to make an image in response to the phrase ‘I am safe’. To avoid the client steering towards feelings of unsafety ask them to stay with the safety feeling or memory for this exercise. The clients’ image of safety can be accessible to reignite feelings of safety and stability at any point in the treatment process. This may be something a trauma client finds difficult as it may feel too risky. The speed and process of the client must be respected and, where possible, be unpacked for deeper understanding of emotional learnings formed through trauma.

Invite the client to share any thoughts or feelings they may have in relation to the image and art making exercise.

End session 2 with a grounding exercise of the client’s choice.

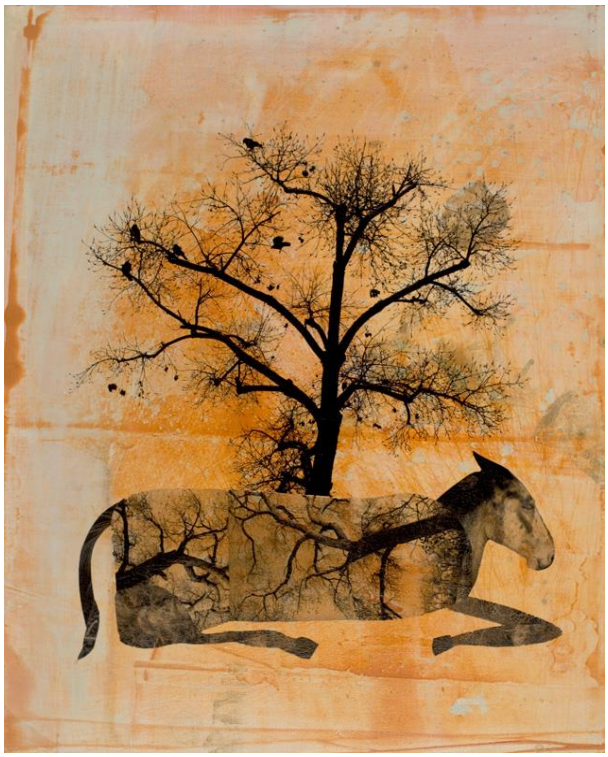

Figure 5 - Image by Holly Roberts (Horse and golden tree)

Session 3

Check in.

In sessions 3, 4, 5, 6 and 7, the first experience of empirically confirmed process of erasure (ECPE) - reactivated, symptom-generating target learning experienced in awareness may occur:

In session 3. explain to the client that you wish to ground them in positive emotions before you progress to them sharing their trauma event that they wish to be soothed. Ask the client to share any positive experiences or moments they may have had since their previous session. And ask the client what and who in their lives are supportive and positive.

Ask the client to think of and choose the traumatic event for which he or she wishes to be soothed. If the client suffers from multiple traumas, ask them to determine the one they want to treat first, and which causes them the most intense distress or the most significant dysfunction. Before talking about the trauma event, invite the client to make an image in response to the phrase ‘What happened to me’. A key component to this exercise is for the individual to allow and describe within their image their feelings and body sensations associated with the trauma memory. Inform the client that they have 20 minutes of image making time, adding that you will let the know when they have 2 minutes remaining. Remind the client to hold up their hand if they need to stop and spend time using grounding techniques as and when needed.

When the client has finished their image, invite them to discuss the image and if they can identify what the emotional learning might have been from their trauma experience. Ask the client to describe how they feel emotionally (their feelings), and somatically (in their bodies).

End the session with a grounding exercise then ask the client what they have planned next after the session. Advise the client to take their time in doing things for the rest of the day, and to be kind and gentle to themselves.

Figure 6 - Image by Kelly Jayne (potential volcano)

Session 4

Check in. Ask the client how they found the previous session, how the pace worked for them, how they felt afterwards. Inform the client that you will respond to their needs and ensure they are comfortable and that they feel safe.

Ask the client to share something positive that they remember or that has happened to them since their previous session.

Remind the client that they can hold up their hand if they wish to pause and use grounding techniques if they feel overwhelmed.

Invite the client to engage in a writing exercise that will focus on their trauma experience. Ask your client to complete sentences in writing after you start. Say each starting sentence after the client has finished their writing in response to the previous. The sentences are:

- It happened when …
- I remember feeling …
- I could see …
- I survived by …

Allow 15 minutes for this exercise. When the client has finished writing, ask them to make an image in response to the phrase ‘What I learned to survive’. Allow 5-10 minutes for the exercise.

When the client has completed their image, ask the client if they would like to stand and walk around the room, or use gentle movement as a grounding technique. The client may not wish to move but use a grounding tool of their own choice. (See appendix 1 for grounding tools).

Invite the client to read their writing out loud and inform them that you will listen with your full attention. Ask the client how they feel emotionally (what they feel), and somatically (what they feel in their body), and cognitively (what they think). Gently start to identify with the client what they learned to survive the experience, and what their emotional learning might be. What did they learn at the time? How did they stay safe? What trauma response did they adopt? Refer to psychoeducational information if necessary (see appendix 2). How is this applied in the individual’s current life and relationships?

End the session with grounding technique and ask the client what their plans are for the remainder of the day. Ask the client what they might choose to do before the next session that might help them to feel grounded.

Session 5, 6 and 7

In sessions 5, 6 and 7, use the therapeutic space to identify with the client what their emotional learning might be. Use these sessions to explore with the client how their trauma experience has influenced how they think and behave as an adult, and in relationships, what their expectations might be and how they see themselves.

Start each session with a check in.

Ask the client to share a positive experience that has occurred since their previous session.

Invite the client to share any realisations or memories they wanted to bring that relate to their trauma experience and their trauma symptoms.

Ask the client to make an image in response to the phrase:

Session 5 – ‘Who am I without the trauma experience’.

Session 6 – ‘What is my emotional learning’.

Session 7 – ‘What can I add to my trauma experience image to make it feel less powerful’.

Allow 15 minutes for each image making exercise. When the client has finished their image, ask them to discuss their image, and how they found the exercise. Ask the client how they feel emotionally, somatically, and cognitively.

Allow more time or additional sessions if the client wishes to focus more on any of the themes. Follow the client’s pace and direction as they explore and express their meanings of each theme.

End each session with a ground exercise of the client’s choice.

Session 8

In sessions 8, 9 and 10, the second experience of empirically confirmed process of erasure (ECPE) - experience of mismatch / prediction error destabilises the target learning’s neural encoding, may occur. It is not possible to determine beforehand that at a given point in time a mismatch experience will occur. It can occur at any point along the way, or not at all. The aim is to support this occurrence as or when it happens.

Check in.

Ask the client to share a positive experience they have had since their previous session.

Explain to the client that the next two sessions will be spent exploring contradictory learning experience compared to those resulting from the traumatic event. It is possible your client will be drawn to their established emotional learnings or schemas. Daily life between sessions often has an experience that contradicts the clients emotional learning, and it may become noticeable once the symptom requiring emotional learning has become integrated and routinely conscious. An example of how to support the client in identifying a mismatch or contradictory experience: if the client’s schema tells them, “I’m always in danger so I must do everything in my power to be vigilant at all times”, you could ask, “Have you ever been in a situation where you have felt at ease or not in danger?”, or, “When I’m in need, nobody is there to help me. I’m utterly alone in this life.” You could ask, “Can you think of a time when someone has helped you or been there for you”.

As the client starts to identify contradictory experiences, ask them to describe how they felt at the time emotionally and somatically. Aim to use affirmative language that confirms their contradictory experience, for example: “It felt good to feel at ease or not in danger”, or “It felt good to receive support and not feel alone in the world”.

Invite you client to make an image to expresses their contradictory experiences. Allow 10 minutes for image making.

Once the client has finished image making, invite them to discuss their image, and to describe how they feel emotionally, somatically, and cognitively.

End the session with a grounding exercise of their choice. Ask the client to notice any new contradictory experiences they may have between now and their next session. Invite the client to report how they have found the sessions and if they wish to visit other session structures in the coming weeks.

Session 9

Check in.

Ask the client to share a positive experience they have had since their previous session. Then, ask the client if they noticed any new contradictory experiences as mentioned in session 8. It may be possible the client did not notice any additional experiences. Ask the client to describe their new experience or the contradictory experience from the previous session including their feelings at the same time.

Invite the client to make an image that creates an imaginal, empowered re-enactment of their trauma experience. Guide the client to make an effective self-protective response that contradicts the helplessness that was felt originally and was built into the emotional memory formed from experience. Dissolution of the helplessness component of the traumatic memory can dispel the intense emotion valence and reactivity of the memory. Suggest the client uses large paper. Allow 20 minutes for image making.

When the client has finished their image, invite them to discuss their image and how they felt making it.

End the session with a grounding exercise of the client choice.

Session 10

In sessions 10 and 11 the third experience of empirically confirmed process of erasure (ECPE), - experience of counter-learning drives unlearning, nullification, re-encoding, and replacement of target emotional learning, may occur. However, memory reconsolidation is an organic process that cannot be predetermined. The aim is to notice and support the clients process of memory reconsolidation when it occurs.

Check in.

Ensure the client accesses positive emotions by using grounding techniques and/or ask them to share a positive experience they had since their previous session.

Explain to the client the structure and content of the session and remind the client that they can hold up their hand at any moment if they wish to pause and engage in grounding techniques. Bring the image of safety that the client made in session 2. Ask your client if they wish for the image to be displayed or placed somewhere near for easy viewing.

Memory reconsolidation supported by multi-image making / unilateral image making - invite the client to recall and describe their associated emotional learnings and meanings, and their contradictory experiences and knowings. Explain to the client that to aid recovery, the intention is to hold both experiences, including the emotional and somatic parts, in a juxtaposition, or both at the same time.

Ask the client to make an image of their emotional learning with one hand, and simultaneously, with their other hand, make an image of their actual or created contradictory experience. The primary focus of this multi-image making / unilateral image making is to reconsolidate the emotional learning by enabling and holding a juxtaposition of both emotional learnings. Reactivation alone does not reconsolidate the schema (Ecker, 2012). You can suggest your client focuses on sensory details such as images, sounds, smells, physical feelings, and emotions, whilst focusing on the meanings. Allow 20 minutes for this exercise.

Invite the client to reflect on their images and to hold both contradictory emotional learnings in a juxtaposition. It is important that the client emotionally feels each learning rather than only thinking about them.

Ask the client how they found the exercise and how they feel.

End the session by accessing positive emotions by using grounding techniques.

Ask the client to make notes and/or images at home of how they feel and to notice of there are any changes in their trauma symptoms and ask the client to feed back in the next session.

Figure 7 - Image by Holly Roberts (Two headed bird).

Session 11

Check in.

Ask the client if they wish to share any notes or images they made at home, and if they noticed any changes in their trauma symptoms since the last session.

If the client chooses, repeat the process described in session 10 for multi-image making / unilateral image making and holding both the emotional learning meaning and the contradictory or mismatch experience in a juxtaposition. The client may choose to create similar images as the previous session. It is important that the client experiences the exercise with emotional and somatic experiences as well as cognitive. Allow 20 minutes for the exercise.

Ask the client how they found this process the second time. Invite the client to discuss their images and to describe how they feel in that moment, emotionally, somatically, and cognitively.

If the client wishes, end the session with gentle movements and stretching. Inform the client that their next session will be used to reflect on their process, their future and to

identify if they require further sessions should they have multiple trauma experiences they wish to be soothed.

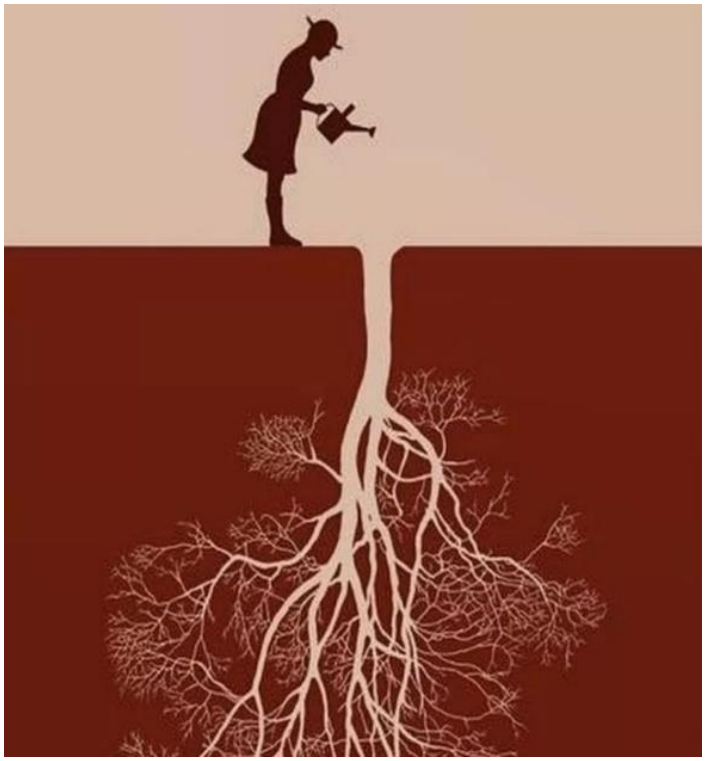

Figure 8 - Image by Samuel Yossef (untitled)

Session 12 – End session

Check in.

Ask the client if they can share a positive experience they have had since their previous session. Then ask the client if they have noticed a change or reduction in their trauma symptoms since their previous session.

Invite the client to reflect on their changes. There are often processes of grieving that become necessary as the changes occur.

Ask the client to respond to the following sentence prompt, ‘From today and onwards…’ and keep writing for as long as the need.

Ask the client to then make an image that represents themselves and their future. Allow 15 minutes for image making.

When the client has finished their image, invite them to read their writing and to share the meaning of their image.

End the session with grounding techniques chosen by the client.

Advise your client that you will be in touch in 2 months' time to ask how they are.

Figure 9 - Image by Kelly Jayne (Eclipse).

Clients will be given opportunities to engage in support groups, opportunities for social integration and connection, and continued individual clinical support following their engagement in UNTRAP.

Art and writing made in UNTRAP session will be given to the clients once their treatment has ended.

Clients will be invited to consider an opportunity to share images and writings with other participants of UNTRAP at an event following.

Appendix 1 - Four Breath Technique

Explain to your client that you will be asking them to close their eyes and take 4 deep breaths. Suggest they rest their eyelids if they wish not to fully close their eyes.

Ask your client to ensure they are sitting comfortably and that they feel supported in their seat, or if they choose, in their standing position. Ask that they are positioned in a symmetrical position with their feet flat on the ground and pointing forwards, and their arms resting on their legs or hanging comfortably. Aim to avoid crossed limbs and for shoulders to be relaxed.

When the client is ready, ask them to close their eyes if they feel comfortable to do so, and take a deep breath in while silently counting to four, then exhaling to the count of four. Ask your client to do this four times. As your client does this, ask them to focus on how their body feels as the breath enters and leaves. On their fourth breath, ask them to allow their breath to form it natural rhythm, and ask them to return to the room and open their eyes when they are ready.

Gentle Movement

Exercise 1

Inform your client that gentle movement can help to regulate and sooth emotions. Ask your client to stand and gently allow their arms to swing and sway and twist their body. Ask them to describe what their feet feel like as they do this.

Exercise 2

Inform your client that gentle movement can help to regulate and sooth emotions. Ask your client to either sit or stand, and to stretch their arms and body. Suggest they move on to have a walk around the room slowly if it feels right. You can suggest they gently move their arms in circles and roll their heads slowly. When they return to their seat, ask them if they noticed any feelings in their body such as relief, aches, nerves, heaviness, lightness etc.

Exercise 3

Inform your client that gentle movement can help to regulate and sooth emotions. Ask your client to feel their body in the chair, the weight against the seat, the contact with the seat and frame. Ask them to shift around and to see how it feels. If your client feels

comfortable, then ask your client to hold the opposite shoulder with their hands, forming a crossed arm self-hug. Ask them how they feel.

Mindfulness exercise

Ask your client to ensure they are sitting comfortably and that they feel supported in their seat. Suggest your client closes their eyes, or to rest the eyelids if they prefer. Ask your client to take a deep breath in slowly, then exhale fully while relaxing their body and dropping their shoulders. Ask them to do this until they start to feel relaxed and centred. Ask your client to resume a gentle and natural breathing rhythm, then to connect with their toes, tummy, elbows, shoulders, then the top of their head. Take approx. 1-2 minutes to do this. Inform your client that you will then count back from 5, and when you reach 1, ask them to open their eyes and come back to the room. Ask your client if they noticed anything such as pains, aches, nerves, soothing etc.

Happy Place Guided Imagery

Ask your client to ensure they are sitting comfortably and that they feel supported in their seat. Invite your client to imagine or remember a place that makes them feel happy and safe. For example, a place in nature, on a beach, in a comfy chair etc. Ask them to describe the place in detail as if they were there. They may wish to close their eyes. What can they smell, see, hear, etc. Suggest that this is their happy and safe place that they can revisit when needed. It may be beneficial for your client to make an image of their happy and safe place, if this is doable for the client.

Short grounding exercises

- Ask your client to notice the colours in the room, and to slowly identify five things that are yellow, or red, etc., describing each one.
- Ask your client to listen – what do you hear?
- Ask your client to share what they had for breakfast or lunch.
- Ask your client to toss a ball back and forth, or an orange, or an eraser, or something easily and safely tossed back and forth.

Appendix 2 - UNTRAP Patient Information Pack

Unification Neuro-informed Trauma Reconsolidation Art Psychotherapy (UNTRAP) Information Pack

This is an information pack that might be useful when you begin UNTRAP treatment. We have provided some basic information for your consideration. We have also defined some terms that we use frequently. We welcome any additional questions, please feel free to ask us.

Treatment description

The typical length of treatment for UNTRAP is 12 one-hour sessions. Additional sessions may be offered to meet individual needs. Your UNTRAP sessions will occur on a weekly basis at a time that suits you. There will be times when you will be asked to do work at home that will contribute to your therapy process such as, writing a journal and practicing grounding techniques. We believe that continuing this home working that you begin in our UNTRAP program is a valuable process for your continued recovery and wellbeing.

UNTRAP treatment follows a three-stage framework approach that consists of safety and stabilisation; identification and processing; and integration and rebuilding.

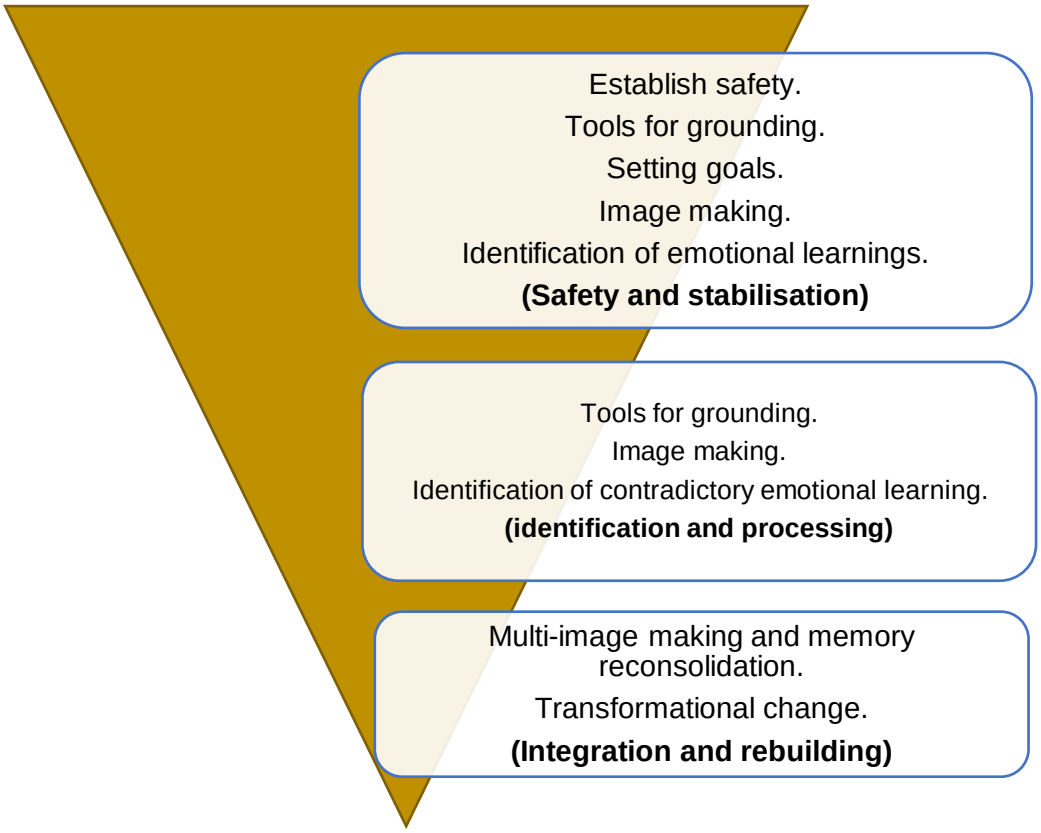

Figure 10 - Three-stage framework approach: consists of safety and stabilisation; identification and processing; and integration and rebuilding.

Safety and stabilisation - you will begin therapy by assessing your strengths and developing good coping skills. This will include identifying what tools and techniques you use to help you feel grounded and exploring others such as: breathing exercises, gentle movement or positive guided imagery. It will be your choice in which grounding methods you choose to use. This phase will also include establishing safety so that you always feel in control and able to steer the speed and direction of the session to suit your needs.

Identification and processing - After practicing these coping skills and achieving sufficient emotional stability, you and your Art Psychotherapist will determine some individual goals and define what you would like to gain from the treatment. The goals may become clearer and apparent as the treatment continues. This will involve an identification of trauma symptoms established from earlier traumatic experiences, and how they have impacted on your life thus far. This part of the therapeutic treatment will

take several sessions. You will be invited to make images in each session. It is not important to have skills or training in art making as it serves only for expression. Evidence shows that art making can be a powerful process for accessing memories in a safe and non-intimidating way. Further to this process will be support in identifying new experiences that give a positive emotional learning experience which contradict your identified emotional learnings born from trauma experiences.

Integration and rebuilding – once you have explored and reflected on experiences that have caused symptoms and emotional learning, then identified contradictory experiences, transformational change can occur. You will be invited to engage in a multi-image making / bilateral image making. This involves making images with both hands at the same time to express both emotional learning experiences.
This process supports memory reconsolidation where your emotional learnings from trauma experiences will have less emotional impact, and positive contradictory experiences will inform your perspectives and understandings. The sessions are structured as a guide and are flexible according to your needs. Your Art Psychotherapist will also offer additional sessions should they be needed. Following this process, you may feel more able to build upon newly emerging positive healthy self-beliefs, and imagine experiencing life in a new way, including connecting with others and engaging in more meaningful activities and life experiences.

It is possible you may wish to attend to several emotional learnings from trauma experiences. If so, you will be offered additional sessions to process each separately.

Artwork

Any artwork you make will generally be stored on NHS premises in a safe place allowing for your work to remain confidential. You may wish to revisit a piece of art you make in sessions. The artwork belongs to you, and you can take them home at any time.

You will be provided with art materials and asked you wear comfortable clothing. We will provide aprons for messy art making.

Sharing of your artwork and UNTRAP experiences

After your treatment, you will have an opportunity to attend a sharing event with other UNTRAP participants. You may feel you wish to share your images and writings and

make connections with others who have had participated in the treatment program. This event is an optional part of UNTRAP that is not essential for your recovery.

If you would like more information on UNTRAP treatment, please contact kelly.jayne@northumbria.ac.uk**.**

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Appendix 4

Analytical content rubrics

Directions: Please complete the following rubrics during your review of UNTRAP Manual. Please include positive comments and/or suggestions for improvement in each area.

UNTRAP Manual	Comprehensiveness	Clarity
Component	1 - This component is not addressed comprehensively. 2 – Major revision is required. 3 – Minor revisions are required. 4 - This component is addressed comprehensively	1 - This component is not covered clearly. 2 – Major revision is required. 3 – Minor revisions are required. 4 - This component is covered clearly.
Manual structure	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates accuracy	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates feasibility	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates acceptability	1 2 3 4 Comments:	1 2 3 4 Comments:

Demonstrates problem relevance	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates knowledge of Art Psychotherapy principles; theories and practice	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates knowledge of psychological trauma and trauma informed care	1 2 3 4 Comments:	1 2 3 4 Comments:
Method of instruction - demonstrates a clear and concise explanation of session content and aims	1 2 3 4 Comments:	1 2 3 4 Comments:
Demonstrates theoretically informed and empirical grounding	1 2 3 4 Comments:	1 2 3 4 Comments:

Demonstrates prioritisation of safety for clients with a person-centred and flexible approach	1 2 3 4 Comments:	1 2 3 4 Comments:

Appendix 5

Transcription of expert panel meeting for UNTRAP validation (final version)

UNTRAP Manual Expert Panel Transcription

Panel Discussion Length:	01:26:55	
Participant Labels:	Kelly	
	Expert I	
	Expert J	
	Expert N	
	Expert R	
Transcription notation key:	,	small pauses in speech (less than one second)
	[pause]	long pauses in speech (over one second)
	—	latched speech (either interrupted or when a person doesn't finish a word and moves quickly to the next)

Kelly: If we just start with the first question then and then it's just, I guess, it's just up to you all about how you want to discuss any comments that you had particularly around, you can kind of jump from the comprehensiveness over to the clarity section on each question if you want and just discuss further about what each other thought about that, some of the questions I've noticed that you all answered pretty much the same and then there's other questions where they were very different answers and so

it will be interesting just too kind of see how that evolves and if anyone wants to talk that though anymore so, regarding the manual structure of the manual, with the first question [pause] does anyone want to say anything about that or discuss it further?

[pause]

Expert N: So sometimes, I remember this now, sometimes I was a little bit thinking I was confused between comprehensiveness and clarity sometimes [pause] could you, would you mind just redefining those terms just so that, cos I wasn't sure it was always answering that correctly

Kelly: Yeah so I guess, so the structure of the rubric it is quite a simple structure and it is quite I guess general so it's easy to, yeah to be to misinterpret but the comprehensiveness I would say is it thorough enough or does it cover all of the areas it needs to cover within that area, that the clarity—is it easy to understand and I would just come from those very simple perspectives on that on that

Expert N: Ok so that's helpful because I was thinking particularly about the clarity, trying to think about who that the end—user is for a manual, so clear to whom

Kelly: Oh ok so that is a really good question, so the user is, so the person using the manual is the art psychotherapist who is going to be delivering the treatment and also it's really-thank you for that question, it's really important as well to say that whoever the person is who is going to deliver the treatment they will, when we get to that point there's going to be a training program so it's not applicable for any art psychotherapist who doesn't have a background knowledge of trauma or who doesn't understand

the manual to deliver the treatment so they would have to go through training, a week's training or some kind of training to get to the point where they would then use the manual so it's for the attention of the therapist

Expert N: So, ok so that's really interesting because it would be nice to hear from (Expert J) and (Expert N) about whether there's even a difference in the UK and other art therapists in terms of language you know because, I certainly recognise the language but I, are you thinking it would be art therapy internationally [pause] is that right?

Kelly: The approach was, again it's in the very very early stages of the development

Expert N: Oh yeah sure sure

Kelly: But definitely thinking internationally eventually but starting in the UK, so obviously that would have to be developed for the appropriate audience and with the right language, absolutely

Expert R: Yeah it's err as a native speaker of American English I have to say there was really only one phrase that I was unfamiliar with so I think the way it was written was –

Kelly: Sleeping…

Expert R: Sleeping rough yeah I didn't know what that meant but other than that I found the language totally appropriate for the other side of the pond as well so I don't know (Expert J)?

Expert J: Yeah I had a couple of questions just looking here because I made track changes on the manual itself that helps me kind of keep track of things, I did have a question about some of the colloquialisms cos that's how I was reading the phrasing, it sounded very colloquial

and I thought to kind of bolster the professional read of it then we might wanna replace the colloquialism I mean that's how we talk let's get real but in a manual I think it should probably be a bit more linear

[pause]

Kelly: So the structure of the manual [pause] are there any additional comments or that anyone wants to sort of mention in a sharing way

Expert N: So if I were imagining being, sort of, the ordinary punter, PUNTER, maybe you don't know what that means

[laugh]

Expert N: (Expert I) can you translate [pause] so being, just a job in art therapy who's had a sort of basic training that we'd recognise, so if I was thinking about myself being that person, in terms of the structure of the manual, I supposed I'd want to sort of know what I'm going to do but also why I'm going to do it and to know whether I am doing it right or not which is what the why is so it's a bit like what am I doing but also what's the aim, I've seen some horrible manuals which are just cookbooks, and you do it you have no idea what to look for about whether it's going right or wrong, and I'm really bad at following cookbooks really I'm really bad at all those things so to me, I thought there was something about the structure that maybe should separate those things a little bit more, just so that I know for instance when I'm reading about what is trauma was the current thinking what are the domains you look at in trauma, breathing and what not, and then we go to, "here's what you're going to do" but also "here's how you

know if you're doing it right or not", I thought that could be quite helpful so for instance if you're doing something with [pause] grounding someone through breathing, and you start to notice that their breathing gets worse you know because they're focusing on the breathing and become self—conscious and then get anxious, you're kind of not doing it right it's not grounding them so I wondered about just having a bit more—talking to the reader a little bit more just so that you know if I was coming into a new job to trauma and it's like I get this off the shelf then I'd sort of go "oh ok so here's where why I'm doing this"

Kelly: That's really helpful

Expert J: I think that's a really important point(Expert N) and I had some similar kinds of questions surrounding the state of the client in the treatment itself so—and that's, I think this isn't specific to your manual Kelly I think it's kind of manualized treatment in general where we have a plan and a protocol set out but what if the client isn't "there" in terms of mentally, physically, emotionally ready and able and some of the prompts in the beginning of the sessions themselves are quite confrontational, not that that's a bad thing but they're pointed prompts and so my question is I didn't see any contingencies for if the client isn't prepared to be able to answer any of those questions or if the client isn't prepared to be engaged in treatment that way and that kind of backing up a little brings to the intake procedures and are those intake procedures specific enough, thorough enough, to really be able to capture holistically where the person is

Kelly: So the recruitment process, the process that happens before a patient or client gets to that early stage of the manual treatment process, there needs to be a process

there as well doesn't there and is this person as you say present enough already for this kind of treatment, is that what you mean (Expert J)?

Expert J: Sure and you do, I don't remember where it is but you do have an intake procedure, I'm just wondering if it's thorough enough and to (Expert N)'s point if the person isn't prepared to engage in the protocol then what is the therapist to do right, do we just do treatment as usual, do we, how is, it's almost like here is the structure for the intervention but then where is the cushioning for if the intervention isn't ready

Expert N: I think that's really good because it's a bit like, here's another colloquialism, if things start to go a bit pear shaped, does that translate? [laughs] it doesn't does it oh God I can't speak English, or if things go a bit squiffy [laughs] no if you're working with someone and you try to stretch the procedure a bit so you're trying to challenge someone a little bit as (Expert J) was saying which I think is really helpful, a little bit out of somebody's comfort zone or something like that, if they start to get much much worse there's like a reset to grounding isn't there, so it maybe worth sort of like if once you find some things which keep people in their zone of tolerance, maybe they need to be reverted back to that a bit more [pause] I had a different thought as well which because I'm a bit ADHD I need to get it off my chest but I've just been thinking it's a bit—this is one for you (Expert) I so don't think you're gonna to sit there [laughs] when one of the things that (Expert I) and I practice together and [pause] I was just thinking about our comments about this should be accessible to the art therapist, well we're finding, that actually everything works much better if it's also accessible to the person using it if it makes sense to the service user or the

person who is receiving the treatment just because you maximize the co—production, you maximize the alliance all of that stuff, so I was wonder whether we should challenge ourselves to say the reader is not only the art therapist—I get the are therapist needs to have some, competencies to be able to do some of the things and that's not going to be able to ever be written into manual cos that's training and what not, but I just wondered if it should, if it would really strengthen it to be accessible to somebody coming into treatment so that they know what they're getting, what do you think (Expert I)? I mean that something that we've been working on a lot on our, coproduction stuff

Expert I: Yeah that makes complete sense I mean [pause] the overall structure I've put down, I've put you know as a lay person that's only received art therapy and certainly doesn't proclaim to be some sort of practitioner or anything related to do with art therapy but, the definitions for me were helpful throughout the manual when I was reading it, as a lay person I found those useful to understand what some of the language meant [pause] I did think the structure overall was quite clear when I put comprehensive a bit too text heavy I think that's more in terms of actually what something—you know I said earlier about breaking it up a little bit more in terms of [pause] clear [pause] I lost my train of thought what it you said

Expert N: About separating out the kind of why you're doing something and how you do it and all that sort of stuff

Expert I: So why you're doing it as someone who's received art therapy and reading that, it made a lot of sense to me for the most part, but actually how you know that it's working well for the individual, and how to sort of

benchmark that against something within the manual, I thought yeah

Kelly: Do you think, cos outcome measures haven't been introduced to the manual at this point, but because there are so many different ways of measuring whether or not something's working and, sometimes as well it can, either enhance the process or hinder the process and you know all of those kind of self—conscious processes that might hinder or, it's harder to take and to do it etc., so I was kind of gonna gently mention whether that might be something that you would add into the mix about how to monitor "is this working for the person" [pause] to have, whether it's a narrative feedback on is this working and using that as part of the organic processes of the sessions and within the structure or can you fill in this form and do a ticky-box thing and then we'll analyse it at the end, or both and so I was wondering about what you would recommend, (Expert I) what would you say about that, what would your thoughts be about that?

Expert I: I mean it'd probably be more work but I think to go for both because tick boxes are just too easy to tick to get it done with and actually you can say many things in an art therapy session because you want to please the therapist in front of you, so what they're saying is in terms of narrative does that match really what they're sort of putting down about their initial feelings as the therapy is progressing [pause] and then sort of putting those two together

Expert N: I would agree I'd be interested in, (Expert R) and (Expert J), whether the whole coproduction thing is—the idea of people both being the therapist as well you know is that sort of part of your sort of reading and approach or? Because in a way the outcome measure is also part of the alliance

Expert R: Yeah yeah I had this thought that maybe certain portions of the manual could be marked clearly as being areas that should be shared with the client or the patient, it doesn't have to be something separate and I don't think that the entire manual is something that would be relevant to all clients there may be some, exceptions of people that would really want to read that but I don't think the typical client would, but certainly, information about trauma, information about why this kind of process is helpful or can be helpful, and so on and so forth could be very useful for the client or patient and, could contribute to the therapist—client alliance as you have pointed out

Expert J: Yeah I'll just piggy back on that a little bit, I think I made comments in the rubric about the psychoeducation component which—this is how I'm understanding this conversation and I think to (Expert R)'s point that psychoeducation, is extremely powerful and important for clients, especially when we're talking about trauma and the brain and like really it helps to destigmatise and really helps to normalise, kind of "we're all in this together" sort of thing our bodies our minds our brains respond very similarly to trauma so I think especially with this population, it's very important to engage a psychoeducational component but I did have some questions because the to me the psycho-ed seemed vague, I would want it to be more specific I would want to know exactly what it is that we are looking to teach or to share knowledge or to translate knowledge about and that brings me to my biggest challenge I have at the manual which was the list of definitions, which I think I really important [pause] and I think really need to be bolstered with scientific evidence and citations and perhaps even a similar format cos to me to I read the definitions and they seemed a little wonky, in terms of

some might be very specific and nicely cited and then others are more colloquial and kind of conversational and so I'm reading through this and the beginning on of the manual and I'm saying "oh woah woah woah wait a minute though hold on, there could be a lot of argument", if we take this to a cognitive neuroscientist then we're gonna have a big problem with validity and I know this isn't necessarily about establishing some kind of validity however we need to be resting on I think very firm scientific foundations because, not to do so is only going to make our jobs harder, so yeah it's all kind of connected there, the psychoeducation, to be more specific, what are we trying to teach but then let's make sure the framework and our foundations are very well-founded within the science of them, within the theory that the science emerges from so polyvagal is a very beautiful example most people are familiar with polyvagal theory but let's throw some specific Porges references in their and to make sure that we are really attributing and kind of coming from a place that is universally accepted in our understanding of what trauma and the brain and therapeutics are this time

Kelly: That's really helpful, thank you (Expert J)

Expert N: I think that's a great point [pause] it makes me wonder [pause] because the point of terminology or taxonomy is so that, different people reading that work will see the same thing in that word isn't it, and that's really important for manuals so we don't each read a word and go and do something different, and it makes me wonder if, because it is so hard to get consensus on words, to just try and reduce as much as possible to simple language and then when you have specific points to really make sure it is I think as (Expert J says) on this sort of solid footing [pause] yeah and I wondered if it's a

case of just being if you're giving any kind of, not jargon, but any technical term, why? Why does that add value, because also in art therapy we have so much verbiage so many terms I mean they're not really proper taxonomy a lot of the time they're just things people said, and I wonder if again that test of could a client understand it is a really, really good test because then it has to be really clear

Expert J: And to that point I think that what would really be a beautiful addition or shift would be to have a very clear cut scientific definition in this glossary of terms but then an example of (inaudible) what you would say to a client, and it kind of goes back to that quote that, I forget you said it, but it's like "if you really know what you're talking about then you can reduce it to simple terms" and so that's why [laughs] a lot of times, like I'm projecting a lot of times because I'm getting a lot of feedback from my science community saying "no no no no come on now" like you can't be using these wishy-washy, whoever said that at the beginning of our conversation right, it was you (Expert I) [laughs] like what is this wishy-washy stuff right so it's been drilled into me over the last decade of being very cautious and thoughtful about the way that I frame things and talk because to not do so, this makes an already difficult job of advocacy and translation even harder so

[pause]

Kelly: So to add examples as an additional add-on when describing an idea or a theory or a scientific point put "this might be presented as this" [pause] for example [pause] is that what you mean so there's something as an

extra kind of, way to understand it, it adds a bit of clarity

Expert J: Sure so like top-down processing right, and we're gonna define top-down and bottom-up processing differently than a neuro-engineer, differently than a cognitive neuroscientist, that's just a fact, but for our purposes top-down processing really means looking at how it is that we are using materials and intervention strategies right and how it is that we go about the unfolding process of therapy are we gonna use materials that are sensory based and kinaesthetic based, or are we gonna use materials that require more cognitive engagement and so we can say we can grab Lusebrink and Haines and we can have a nice description of top-down bottom-up I don't think we have to get into what the neuro-engineers think about predictive processing and all that jazz, but then the caveat for the clients is "are we thinking more or are we feeling more?" [pause] like "do these materials help to make you feel grounded or are they unsettling and regressive?" so there's a way I think of being able to translate what it is that Lusebrink and Haines are saying within this kind of ETC top-down bottom-up processing in a way that would make the most sense for the clients themselves

Kelly: That's really useful thank you [pause] ss there anything that you wanted to add about that (Expert R) or did you, I'm just thinking about what peoples' thoughts were—so (Expert R) and I have had an additional discussion around some of the terminology and my feeling is that there's kind of a general feeling that it could be tightened up or more simpler, or easy to understand and definitely more universal and has more of a general understanding but the term "unwanted emotional learnings" is something that we discussed and, I just wondered certainly from our

discussion (Expert R) that I'm definitely going to be approaching that and making it less, what could be offensive language to be more [pause] honouring of the processes that were required to survive the trauma in the initial instance, and to be more respectful of the body's processes of how to handle the trauma but rather than calling it "unwanted emotional learning" but maybe "emotional learnings that were necessary at the time and what's necessary now", so I just wanted to ask what everyone else felt about that [pause] about the terminology used around the emotional learnings from the trauma

Expert R: And specifically we talked about the wisdom of using the term "unwanted", and the accuracy or lack of accuracy in using the term

Expert N: Well I'll be honest that slipped me by completely but now that you say it I really here it, isn't that amazing [laughs] I think I'll leave the expert panel I miss that one completely but actually, that's really lovely I really like that because, "unwanted" as well you can imagine that really playing into trauma as well you know I think then the whole person ends up feeling unwanted but no that's really [pause] yeah yeah no ok I'll stop agreeing cos I agree

Kelly: It got me really thinking about the use of language, the power of language and how—and the perception of the language and again I don't want to say too much but how one phrase can be interpreted in such different ways but how does that feel for the person who is, engaged in the treatment as well the most important part, so, and thinking of the other—the way I've used the language in the rest of the manual if anyone had any thought "ooo that actually might be offensive or intimidating or confrontational" and I'd really appreciate it if anyone

had any—if I've missed anything or if I haven't been fully considerate of the language if anyone—I think (Expert I) you said something, some of your feedback was particularly useful around how, I think it was the one comment that you made when you added it to the actual manual itself and I think it was around how, you might find it confrontational or suggestive in a bit of a negative way and I was really grateful of the input but I can't remember what it was at this particular moment in time I'm sorry

Expert I: It was about the "extreme or inappropriate emotional response" so I said in place of "inappropriate" use "disproportionate" it could be less offensive

Kelly: Yeah

Expert I: Because you know talking from a traumaed place, someone telling me that my behaviour or my responses are inappropriate I'm so very already aware of that but in my mind it's out of my control, and it's in some ways I don't feel that they were always inappropriate they were very appropriate for some of the situations that I'd experienced, but actually having this language I've had used with me so having someone say "disproportionate response" I'm like OK and that got me thinking more about, as a service user I have been more thinking about what would be a more, appropriate response that wasn't disproportionate to situation that I was in at the time rather than going from zero to a hundred at every point, so for me it's just something about the word "inappropriate" which stuck with me

Expert R: Yeah I think that's a very important point because based on the, implicit emotional learnings that a person creates in—during the traumatic situation or in the wake of the traumatic experience that these emotional

learnings are absolutely appropriate and they persist, in a timeless, ongoing way and based on those learnings [pause] any kind of reaction that a person has in the here and now, that may look to the outside and even to the person's rationale mind to be exaggerated or inappropriate or too strong for the situation and those reactions are absolutely consistent with the emotional learnings from the traumatic experience so, objectively looked at, we can say that when a person's triggered [pause] the reactions don't match the actual current situation, but when we take into consideration what's being triggered then any kind of derogatory or critical terms are completely out of place in my opinion [pause] the emotional brain is doing, what it learned to do, and that may no longer be and often is no longer a useful way of dealing with a situation and that is exactly what brings people into therapy, so, but I think having the utmost respect for what happens when people get triggered is very important and needs to be reflected as we talked about, Kelly, and needs to be reflected in the language

[pause]

Kelly: It's so important isn't it—

Expert J: —Where is whe—

Kelly: Sorry, go on yeah thanks

Expert J: I was just wondering where "unwanted emotional learning", where that term came from?

Kelly: So the "emotional learning" part of that is part of the cour—is part of memory reconsolidation within the coherence therapy model, which is absolutely amazing and really exciting, and the "unwanted emotional learning" part was my input because I was thinking, and I don't

think I though enough about this, that if someone needed to have an emotional learning at the time of the trauma to survive [pause] in the current situation which is different in a, more present moment they might recognise that they know that that emotional learning is no longer wanted for today's life, but I think the association with the word “unwanted” and actually at the time it might have kept someone alive and for them to survive and therefore there needs to be more respect around the emotional learning of which can stay until it's reprocessed through the memory reconsolidation process, so the word “unwanted”, it really does have and can have a really negative association for the person who's working through their whole emotional realities and I think I think if they are currently in therapy and they still—a person still has an emotional learning that’s triggered from a trauma experience that reality might still be for them in the current time, so to then, label that with the term “unwanted”, like you were saying earlier (Expert N) I think it really—it might trigger someone into feeling that they’re unwanted, that if it is their sense of reality now and it hasn't been reprocessed or reconsolidated, so the “unwanted” part came from me and, the “emotional learning” part comes from the coherence therapy model

Expert J: And so the memory reconsolidation, that was another question I had the memory reconsolidation is the theoretical underpinning, so does that mean that the coherence theory is the theoretical underpinning for the model—for your manual?

Kelly: Yeah so the memory reconsolidation part is a scientific component and I'm going to ask you to see a bit more about that (Expert R) but the coherence therapy part might be the theoretical component of the manual but

although more informed but the memory reconsolidation do you want to say something about that (Expert R)?

Expert R: Well I could talk for hours about that [laughs] yeah memory reconsolidation is scientifically grounded [pause] and, it's been shown over and over and over again to be, used in psychotherapy and, we have looked at case examples of many different types of psychotherapy that on the surface of things look really different, from one another and, kind of used x-ray vision kind of analysis of what's really happening under the hood [pause] and we reconstructed the same process the same steps of memory reconsolidation in all kinds of psychotherapies where deep transformational lasting change takes place, and it is the only, process of the brain that is known today to create that kind of transformational change so, coherence therapy is simply the transformation from the neuroscience into the therapy room, although coherence therapy existed for a decade or more before memory reconsolidation was discovered so it's kind of a nice, convergence of the two fields of psychotherapy and neuroscience, which is what makes it so interesting [pause] so—and I want to get back to the question of "unwanted" I think it's important to differentiate between what is really unwanted on the part of the client, and, on other hand the emotional learnings, because the symptoms that are generated by an emotional learning are, surely unwanted you know that's why a person comes into therapy and says "I have nightmares, I can't function, I can't—I have no concentration, I'm afraid every time I hear a loud noise" whatever the whole, gamut of symptoms is that trauma clients present with and, everybody agrees those are all unwanted that's what we wanna relieve the client of but I think it is important to understand that those are all by-products of

the emotional learning and [pause] we might label the emotional learnings at some point as no longer necessary or unnecessary, no longer current or useful but I don't think that—in my experience I don't think that clients themselves ever experience the emotional learnings as unwanted it's not a relevant term for clients, now we as therapists look at certain emotional learnings like, you know "my parents abused me so I must be a worthless person" and we think to ourselves, yeah we want that gone we wanna get rid of that from the client" but that's not—wanted or not wanted that's not something the client would come up with [pause] so I think it's not only somewhat pejorative but not even relevant that's just in my experience and I've done an enormous amount of work with trauma clients

[overlapping inaudible]

Expert J: Go ahead Expert N

Expert N: No you go Expert J it's fine

Expert J: I was just gonna say I'd stay away from making up your own terms [pause] in general [pause] for a manual [pasue] I don't mean to be a jerk, I hope I don't sound like a jerk [laughs] I'm just saying, yeah I wouldn't do that

Kelly: I think you're right I agree [laughs] I tried that and it didn't work [laughs]

Expert N: I really like this thread and I wondered if it's worth doing a sense check of the language so, in a way it's that unwanted—wanted, unwanted by whom and all that sort of stuff, I think old school psychotherapy still has a bit of, "you're a weirdo and we're gonna make you normal" type of, and we might like to—and I think trauma,

particularly at this stage in the culture so interesting and I think the things you're saying (Expert R) is so interesting about, these are things that makes—it's kind of all good, it's just that it doesn't all fit where you are now and I wondered about, I can't think of a way of talking about is it a bit like a, a bit of a positive attitude towards all of it but just with more accuracy about, and it's not about having mastery it's more about having some sort of choice or something like that, maybe that is a really important part of what we're trying to do cos I still think even our own old school art therapy language still talks about labelling people and still, there still a little bit of like this with "this well therapist is going to make this sick person blah blah blah" and, it would be a good chance to have a bit of a clear out, of any of that sort of underlying discourse really [pause] so I've found that very helpful (Expert R) with what you've been saying but it sounds like quite a tricky thing to explain more about, time, than about appropriateness, or weirdness more about "that was then this is now" and, I'm not quite sure how to articulate that in the language

Expert I: For me coming from a PD brain [pause] so if I think of unwanted emotional learnings, there are so many emotional learnings that I carry with me to this day from my, childhood growing up etc but I don't have the same, as you were saying (Expert R), I don't have the same I bi product, the same effect, the same responses to these emotional learnings but I wouldn't want to consider them "unwanted" because then that takes away part of my identity of who I built myself to be that I'm now see as a stronger person, it's—

Expert N: —a lovely point—

Expert J: —it's something that I reconciled with that'll always be part of me and what I don't want are the responses that I had to these emotional learnings, but would I want to take them away? No because I think they've made me more empathetic, more open minded, more curious person, as part of my personality, so if I'm being told they're completely unwanted it's like I'm being stripped back bare, and I have to start again [pause] I've not even got these to fall back on in terms of building myself into any sort of recovery space, if that makes sense

Expert N: I think that makes enormous sense I suppose, it makes me think well does that mean all that period of my childhood was that just wasted time, I might as well have not been alive then and it's like trashing your [pause] trashing that formative experience isn't it and that would be so much not what, in any sense Kelly I can see you're not aiming for that at all, it's just such a shame if it's inherited language that we haven't really noticed that's just got these kind of like, "you were rubbish until you met me" type of therapy

Expert R: Well I put lots and lots and lots of track changes in the version of the manual that I sent back to you Kelly as you know, and I was, just by second nature continuously scanning for any such, language usage, coming from a background of, coherence therapy which means we assume, emotional coherence [pause] always

Expert N: Yeah

Expert R: Yeah [pasue] so probably I picked up on a lot of, ter—or I would say probably the majority of anything that smacks of, being pathologising

Expert N: Yes it sounds very strength based, sort of like actually everything was [pause] is that what it means coherence

thera—that everything was coherent to the situation you were in? Is that sort of the—

Expert R: —Yeah the, that the emotional brain is fully coherent and has a logic, you know a lot of people think "well I have a feeling that's totally, at the opposite end of the spectrum from logic" but the more emotional learnings that we discover and make explicit in the work, the clearer it becomes to the client and us too that's all very logical and so often clients will say "Ugh, now I understand why I've been doing this or that this whole time maybe I don't need to do it anymore but ah, and I thought this whole time I was, sick or stupid or was lazy or something was wrong with me, it all makes sense now" and that is already a major piece of work when a client de-pathologises him or herself at that stage

Kelly: I think that's exactly what I was meaning by the "unwanted" part so if the person gets to the stage where they realise and decide that the part isn't working or the symptom isn't working for them anymore but it was appreciated at the time and it was necessary, but "actually now I don't need to do that anymore" and I think that's what I was meaning by the unwanted part

Expert R: But you're talking about the symptom

Kelly: Yeah exactly, it's the symptom, yeah, and but then trying to phrase that and we're trying to think of ways that might be worded and, the terminology it's becoming really clear to me actually how important words are in general and just, getting that right especially in a manual it's just absolutely key isn't it, sorry I'm saying too much [laughs]

Expert J: I have a question [pause] am I understanding then that the manual really is grounded in coherence therapy, which is then grounded in memory reconsolidation?

Kelly: So when I was writing the manual I was thinking in, from that perspective more about the memory reconsolidation part, and that's why there's certain exercises that have been brought into the stage program within the manual which, it's got a staged order but I think it needs to be responsive to where the client is and what they need and where they're at in terms of "you've got to follow one to ten and that's the order we're gonna do this" there needs to be a process, the coherence therapy model does have a bit of a structure the three stage structure which I have incorporated into the manual but my thinking was mainly around the memory consolidation so how does that work so, and then using the bilateral stimulation which again (Expert R) and I discussed about a little bit, not from and EMDR perspective although that is very bilateral but more of about holding, in a juxtaposition the two experiences of "this is my emotional learning that might not be necessary now but this is what happened and this is how I feel about this experience or this trauma and that's what I learnt from that" and then to a contradictory or juxtaposition experience that might contradict that that's more present and holding both of those things together at the same time and that's where the reconsolidation happens, so I'm, yeah

Expert J: So are we really—so now is some of the questions I had about the manual I got confused with the three domains that are from the coherence therapy, it seems like ok I got kind of lost, and hearing you talk about it a little bit more I'm understanding a little bit more but [pause] why wouldn't then this manual be framed as an art therapist's perspective take, creation of a protocol that helps to translate memory reconsoli—the science of memory reconsolidation using this theory, this theory, and this theory so "here's what Kelly came up with", like why

aren't we working in that realm cos like [pause] I get a little confused like what is "unification neuron-formed trauma reconsolidation" like what does that mean, what does it mean, right?

Expert R: Yeah I also don't know what that's supposed to mean

Kelly: Ok

Expert N: Well we might be doing it now, you don't know

Expert J: Yeah, and we've gotta get rid of—well, my humble opinion, although I don't sound all that humble but I think we've gotta get rid of bilateral [pause] now we are getting blown out of the water with this bilaterality, when you think well why is it bilateral? Everything's bilateral [pause] so like EMDR, the tapping, using different hands like it's all—really what we're doing is we're emphasising unilarity right because when we talk about this bilateral terminology we're going back in the day to when lateralisation was a thing like "left brain does this and right brain does that" and that is debunked and it makes us sound foolish, from a scientific perspective, it decreases it diminishes our credibility [pause] I think you're able to say your point that—you just said it beautifully the holding of opposites and then I think very union right and I think like the juxtaposition the ability to keep this within the same space I mean this is our—this is a beautiful work of art therapy right but like let's be careful when we are calling—and I know bilateral has been all over art therapy for a long time and the processes that were engaging in or useful and meaningful, but scientifically we're not defining what we're actually doing, the right

[pause]

[laughs]

Expert R: And I think Kelly what you mean by bilateral largely overlaps with the step in memory reconsolidation where, two different but mutually exclusive, emotional learnings, are being held in the same field of awareness at the same time, which we in coherence therapy call the "juxtaposition experience"

Kelly: And expressed from a physical perspective by the activity of both sides of the body [pause] (Expert J) what would you call it if it wasn't bilateral? What would you—cos I've been trying to think of something else to call it, just that process in itself within that one session, what would you call it?

Expert J: Yeah so I'm thinking about—

Kelly: —You said emphasising uni-urilar-[laughs] I'm sorry what did you say

Expert J: What we're really doing is like [pause] we're really talking about unilarity

Kelly: That's it—

Expert J: —and emphasising—so different parts of the brain are weighted to different activity right [pause] but what we are learning more and more is that there' isn't a part of the brain that's responsible for acts, it's about the connection it's about the networks right [pause] what (Expert R) was just saying was about the juxtaposition, ain't no better place other than an art therapist, right and a client to be able to see to actually see that juxtaposition which is where the beauty and importance of the art part comes in, like to be able to express and work through that juxtaposition in the visual field, so and then the person we look at what it is that we made we look at what's around us and our vision is binocular so

what the, the left brain is gonna hold what our right eye sees and vice vera so I think we should just kind of like talk about the, the crux of what you're discussing which is the ability to integrate information, the ability to hold positive and negative in the same space, the ability—positive and negative emotions or cognitions in the same space and if that accurately represents it, the ability that the art process has, to, help a person work through as you said physically the creative process allows the working through but then also the response and objectification that the art product itself holds, and how we are able through our relational exchange within that context be able to learn more about what it is that happening, with the support and guidance of the therapist

Kelly: So what would you call it? [laughs] sorry [laughs]

Expert J: Well what's the "it"? What's the "it"?

Kelly: Exactly yeah exactly

Expert J: Yeah

Expert N: I think these are great points (Expert J), and I wonder—I was going down a bit of a similar road so maybe the third audience, so you have the art therapist as sort of the fist audience, the user of the service is the second and I wonder if—if this is a manual, that can be tested, if a research is the third audience and I wondered if you could try and say what your hypothesis is about the mechanism for your testing, so, I think the talk about, and it's really hard to do you know so for instance in the game that I've been involved with mentalizing, the mechanism would be, to engage the attachment system so that people can start to share perspectives and develop epistemic trusts, that's the sort of testable hypothesis, that's what mentalizing is trying to do you can sort of say well what does get

engaged within the attachme—you can do all of those things, it's not mine, that's work that hundreds of other people have done, but it's a really good guide because it's a bit like well what, if you look at your manual and if you were to be able to say what you think is the mechanism that your—the mechanism of change that you're actually doing, then everything else can flow from it and it doesn't mean everything has to be about that mechanism, you can do other things but some manuals have this thing of essential [pause] I can't remember, essential, "you can do it permitted" and "don't do it under any circumstances" type of behaviours, I can't remember I did a publication in 2016 on language and everything there was some references in there about manuals, I always thought that was really good because the essential is the bit that's "here is the mechanism of change happening" so "here's mentalizing focus, here's the therapy focusing on the mentalizing", that doesn't mean you can't do something else that's actually quite nice like people can have a cup of tea when they come so that could just be generally being welcomed or, but what you don't do is something that is un-mentalizing like using really complex language or metaphors or anything like that, to me I wondered if you were to really try and do that that it might also sort out some of the other issues about, well what terms do you use and what ones can you forget that you don't need to get into it because you're really trying to say "here's the testable bit someone can actually video this session and see those mechanisms, see if you're actually adhering to the manual", whether you're actually, or whether you're off model or something like that, very hard to do particularly if you're, in a—working in an approach which has perhaps not, really reached the point of being able to develop its own hypothesis but if you have, it

works really really well so when I was doing all that stuff on mentalizing it was great because these other people have done this work about "here's the mechanism, it's not the only mechanism in the world but here's what we're focussing on, here's the target", and I wondered cos I felt when you were answering (Expert J)'s question that you were actually beginning to describe some of that like "here's the actual mechanism of what we're doing" and then in a way you have a way of explaining to the art therapist you have a way of explaining that to the client, do you see what I mean?

Kelly: Yeah

Expert R: This touches on a huge question in the psychotherapy field, what is the mechanism of change? [pause] and so in this manual Kelly you're postulating, without actually saying it yet that'll be in the new version maybe, you're postulating that memory reconsolidation is the mechanism of change [pause] and, memory reconsolidation, doesn't dictate the type of therapy, the steps, the external trappings, it's simply a series of internal experiences that the client goes through and so, it can be via art psychotherapy or music therapy or anything, EMDR, coherence therapy, there's no limit [pause] so I guess what this manual ideally is addressing is how can we use art work to bring about memory reconsolidation for deep lasting transformational change for trauma clients?

Expert N: I would put that very essentially, I think (Expert R) you've said that very well so if I'm the punter, you need to look that word up by the way, you probably don't have a German word for it but if I'm the user of this manual, which is what punter means, I would want to know am I, so if I'm working with someone in front of me, am I actually helping them to, what was the word to, to consolidate their memories?

Expert R: Well the term that the neuroscientists use is "memory reconsolidation"

Expert N: So am I helping their memory reconsolidation or am I making it worse, so—or am I just not impacting it at all? That would be so helpful, and how do I target that memory reconsolidation so my choice of our materials like you're saying (Expert J) or the type—do I go to breathing this minute or to some other grounding some other minute, why am I doing that? And if it's towards this target, that I would find really helpful so again to contrast it with mentalising, if the ultimate aim is epistemic trust getting people to trust their own a—and interacting with other people's perspectives, I know that I'm doing everythin—that's why I know we're all looking together at one picture, so that we can share perspectives and try them out, so it doe—I've found that very help (Expert R) and I'm wondering if you should centralise that more and push for one of those really brutal level hypotheses, it doesn't have to be right it just has to be a bit testable

Expert R: And it probably will be right [pause] it's what I'd predict, and so then that connection I think is necessary to [pause] explain what is meant by memory because this is, something that is, people are prone to not understanding properly, when we're talking about autobiographical memory of the trauma, traumatic events, or are we talking about implicit emotional learnings, semantic memory, that—those aspects have to be very clearly laid out otherwise I think the therapist will be lost

Kelly: What about the meaning of the, what actually are those words meaning specifically in a simple way

Expert N: (Expert I) it's like that stuff we do about breaking down the question, every single word you have to spend

half your time defining it but it's really important to do, that's a great point, memory what's memory? And you could define it

Expert R: And what are we, what is the category of memories that we are trying to modify via reconsolidation? It's not the autobiographical memory of what happened, it's the knowings that a person formed like a typical one in the trauma experience is "I am completely helpless, to protect myself", and when that is brought into awareness and reconsolidated it looks like or sounds like [pause] "I know how I can help myself" or "I know how to protect myself, something like X-Y-Z will never happen to me again because I am a changed person through this experience", this is just an example it doesn't apply to every trauma of course, but it's the knowings, the memory the semantic memory that we're trying to modify is these, large scale ontological knowings about oneself, about other people, about the word, these really overly generalised learnings that come about when somebody has suffered trauma

Expert N: See what's nice about that is if I was listening to you as s talking manual, it gives me the term, it gives me the definition and then it gives me a few things to listen out for about the way someone is—so that thing I found very helpful of like "well I'm just helpless" a very black and white sort of statement, where as something more modified, and we would have the same in mentalising, "all men are bastards" or all these people these generalisations you know that's not a mentali—of course men are lovely so mentally, you need a more mentalising, it's a joke [laughs] you need a more statement than that

[laughs]

Expert N: But I found when I was learning that approach I found those things really helpful and it would be the type of things people would say when they're not mentalising are this and so when (Expert I) I was thinking we use that a lot in psycho-ed don't we you know when we're working with people when you hear yourself saying this, or when you hear someone else say this about you, they're probably not mentalising either so

Kelly: Yeah

Expert N: It is really really helpful isn't it, and you also come out with some real corkers about when you are and when you're not, corker yeah, another word

Kelly Ok yeah [laughs] how'd you describe corker?

Expert N: I don't even know what it means see I'm just, corker what does it mean when someone says somethings a right corker? Oh god this is awful isn't it [laughs] look at your blank faces, language eh

Expert R: Yeah there's actually some British terms that I'm actually familiar with because my husband is Australian and so there's an overlap there but not a complete overlap but corker is not one that he's taught me

(48:31) [laughs] so I will ask him afterwards

(49:03)

Expert N: I've taken us so far off track I really apologise but I think having helpful phrases about what to listen for, what to watch because presumably with trauma, I mean I— who was it, Babette Rothschild came over the other year so I went to see her talk on trauma and everything and really lovely things about [pause] watching for peoples— whether their face is going whiter or redder and all

these kinda, and I wonder about in trauma because it's not particularly my field but just things to look out for so if someone is reconciliating their memories" probably not you're probably making it terrifying for them you're taking them in the wrong direction I wonder there was sort of a, a kind of set of phrases that—a lexical for all of that

Expert R: Yeah what to watch out for to know that a client is no longer in the what we would a "window of tolerance" [pause] and then that's where these grounding tools come in and (Expert N) what you addressed at the outset have you—how does the therapist know that he or she is doing the right thing, doing these steps successfully, and is it helping the client

Kelly: Is it ok to ask (Expert I), is it ok to ask about what you said about the feedback about, the grounding tools and self-care exercises and—

Expert I: —Ah, the taking a hot bath?

Kelly: Yeah I thought that was really interesting

Expert I: The most hated phrase within the entirety of my lived experienced colleagues, it's just it's one thing, we just felt like obviously I can't talk to everyone, for everyone but I've spoken to a number of my lived experienced colleagues at Oxford and [pause] I was told once to take a hot bath in the middle of a crisis and throw on some Kenny G and I could have climbed over the counter and throttled the woman, it was, the most dismissive phrase that point that, even coming out—if for every time I went through therapy and I did that for 18 months twice a week, never once did I wanna run home and take a hot bath but actually the idea of grounding myself on my route home really appealed to me so I wasn't taking my experience of therapy into my home with me, I was

going for a long walk or, just trying to find something that worked for me personally but, one of the things—I work with acute nursing but they have zero mental health training and they always throw out this taking a hot bath thing, and I just always try and ask them just don't just ask the person what works for them what do they normally find comforting what, if they don't like nature can they—are they into art materials are they into lego are they into anything that is not necessari—cos also taking a bath is, it can be a form of self harm so you could take it to quite a dark place if you chose to, I feel the same way about DBT and ice cubes and elastic bands, how best to cut off my blood supply [pause] so it's just something that angers a lot of people with lived experience is being told to take a hot bath

Kelly: It's assuming isn't it it's doing the thinking for—does it feel like it's doing the thinking for the person cos it's assuming that that's gonna work kind of thing

Expert I: Yeah somewhat and also I feel like my—everything that I'm feeling and experiencing has been reduced to a hard day at work when I come home and I think I just wanna shower off my day after a day in the office [pause] I can't shower off my emotional state in that same way otherwise I wouldn't have been in therapy [pause] I'm sure there's many people out there that might find it a very useful tool and very relaxing but let's give that back to them rather than give people ideas to, throw in the service user's face that could just offend them

Expert R: And how about the location of the, traumatic experience [pause] a lot of trauma happens in the bathroom

Expert I: Yeah absolutely so it's, I've locked myself in many a bathroom over the years I don't find that it's been the most holistic environment if I'm honest but, it's a case

of let's rather than give people the ideas let's just ask them, let's find out as part of the introductory as part of the assessment like "what are you gonna do over the coming weeks if you leave therapy, how are you gonna ground yourself how are you gonna look after yourself in between sessions, what tools have you got in your box to make yourself safe in-between sessions, what works for you?", I found it really hard to sort of describe any interests but it turns out I had loads I just didn't consider them as worthy like, playing with lego, like being outdoors in nature, walking, all of these things that I was really dismissing but I found and still find to this day and still occasionally employ as very grounding techniques for me [pause] but having a conversation with someone, or many people over the years that how I found out that they were grounding, I used to use walking as something to get away from whatever situation [pause] little did I realise that actually that way very much me grounding myself I just didn't know the word grounding

Expert N: I think it's lovely I think, it takes us more towards coproduction doesn't it because it's like this person has already worked out quite a lot of what they need to do to survive and what they need to do to get through, it's strength based and actually the opposite is to is still that thing of "let me prescribe you something" cos none of this treatment is, cos I think there was this long period where therapy was trying to act as if it was prescribing something like a medicine or something like that and it just doesn't work in that "expert dispensing something where the patient is passive" that's not the model at all so what you're saying (Expert I) sounds—I think is really essential to me that it's a lot about drawing on what the person

already—the skills and strengths already have and it's also co-production because they're learning that they're already doing, quite a lot of it is already reframing quite a lot of important-

Expert I: —And I feel like I've got a choice, I feel like I'm contributing to be therapy process I'm not just giving you all of my worst experience but actually I feel like I have then some control over how the therapy will work for me and how I might engage with it, I just think it's a dangerous place where we start suggesting to people what they do, I mean we do it a lot in psycho-ed but we don't say "you should be doing this" we say "let's map it out, what do you enjoy let's talk about what it is that keeps you happy keeps you sane keeps you grounded keeps you in whatever form, ok that's your grounding technique that's what works for you" in the same as the five senses don't make it that they have to find something for every sense because you'll drive yourself mad doing that, for me it's sight and hearing, food means nothing inhale chocolate like there's no tomorrow it means absolutely nothing, but I know that sight and hearing really work for me but that was again though a discovery process and many conversations [pause] but if someone had told me to find something for all five of my senses I would have just thrown the whole thing back going "this does not work"

Expert N: I bet you feel like a failure if you can't find something for all—

Expert I: —I am coming to therapy I'm already feeling like a failure you don't need a therapist to lump it on top as well [laughs]

Expert R: And (Expert I) what you were saying about a client feeling that he or she has a choice and has, agency over what is being done and what is being displayed just that

in itself can be kind of a contradictory knowing that can dissolve emotional learning forged in therapy-in trauma, [pause] but in a traumatic situation often a person learns "I have no agency I have no choice in this matter something is being done to me something is happening to me and that's how my existence is" and then it's generalised and carried forward in time and just the experience in therapy of being given that choice and, being given that—allowed to have that agency and be, a juxtaposition experience which is what we refer to in coherence therapy as, and that could be represented by two different pieces of art work if we wanna look at art psychotherapy, so the—it may sound like a minor point in the grand scheme of things, teaching coping strategies and grounding strategies and so on and so forth but the point that you're making is, very key I think

Expert I: I don't know obviously what it's like in the US but in the UK unless you pay privately you don't get a choice in what therapy you're getting they tell you pretty much "we think this will work" or "this is what your options are and you can take it or leave it" to some extent

Expert R: Yeah

Expert I: And so to have any sort of—within my MBT therapy, the choices I made were to what materials to use, there was a whole array of things that I was never presented with "you must know mix-up, you must draw something you, must use words" it was just "here's a room, go crazy, whatever you want"

Expert R: You had the choice

Expert I: Yeah and that made me then engaged with it because I was terrified at any sort of are therapy, one I never considered myself artistic I still don't, so the idea of being put into an art therapy situation was my living

nightmare, especially when I started looking at other members of the group who really could draw and really drew beautifully, but after the initial couple of weeks I never really sort of pitted my work against theirs it became something very different at that because I had the choice over what I could put on paper whether that was cutting words out and sticking it down or choosing to paint or use pencils or whatever, and that was a choice that was important to me

[pause]

Kelly: Thank you that's really, sitting well and I'm really grateful that you've said all of that

[pause]

Kelly: I'm aware of the time and I'm wondering how people are feeling, and, if anyone else has anything else they want to—if anyone wants to bring anything else and [pause] yeah I'm just checking in I guess [pause] is there anything about the rubrics, or the manual that anyone wants to say at this stage I mean it feels really valuable with everything—it's so important to have the conversations because it brings the answers alive doesn't it, it just helps to expand on it so I'm just taking that in but is there anything else they want to add to that today and, you can always—if you think of anything else later please email me if something else kinda comes

[pause]

Kelly: I'm getting a sense very much about kinda defining, enabling clarity, backing everything up with, scientific grounding as well and just being a concise and clear manual that, very much comes from the perspective of person-centred and honouring a person's process and inviting—I really love that kind of cooperative what is it, coproduction I really love that so I'm just really, I'm quite excited that I'm informed about those things now and I'm thinking about it from that perspective, so I'm getting the sense that those things are really kind of key from this meeting [pause] does that sit well? Am I getting it right? Am I picking it up right do you think?

Expert N: I think so I mean I suppose, I think in a way the rubric we've sort of surpassed that because it went quite deeply into, and just hearing other people's thoughts on this just really, getting down to the fundamentals of what the manual is for and what it should be doing also who it's for, those three audiences the practitioner, the user and the researcher, and it just, I'm glad it feels clarifying because I wondered if it felt like a bit like quite a lot of work to do just because it is about all the component parts are there they just need realigning, and rationalising around the "what are we trying to aim for, how do we know if we're kind of getting there, how do we know if things are going wrong" and how to kind of try and help that a bit, like for trauma it's so important you go in there and like make it worse or something

Expert R: I think there are a couple of things that stand out for me as being important to either finetune or incorporate still into the manual and Kelly these are the things I wrote to you [pause] but I'll just say them in this setting and I think one really necessary piece that needs to be added is how, how does a therapist look for,

identify, and get clarity on the person's [pause] emotional learnings I mean these are the things we're trying to shift and or dissolve even, or, change in some way, what does the therapist do to isolate those there's nothing that I could tell, nothing about that in the manual, and that's a step before how do we know that we've done it but how do we do it, to begin, with so that's one thing and the other is [pause] so you're basing this on memory reconsolidation memory reconsolidation consists as I said of certain internal experiences and it can't really be manualised as "ok these are the twelve sessions we're going to do and this is what happens in each session", there's no way to control that or predict that and so, but that's ok you can still have the twelve sessions but I think it's important for the therapists and then for the clients too to understand that, whatever portion of this process unfolds over the course of the twelve sessions, that's ok and that everybody will have an individual path or trajectory, but the idea is to keep on going in that direction, and we can't say that in session ten, just to pick a number, that's when the juxtaposition experience and the transformation will take place, there's no way to know that

[pause]

Kelly: Does anyone else want to add anything?

Expert N: Yeah I think that's right (Expert R) anything that stops it being a cookbook is, do you know what I mean by session eight this will happened and—

Expert R: It doesn't work that way yeah

Expert N: Exactly and that's where I think being clear about the principles that are operating because principles I

think are a better guide and procedures and, but it sounds like you have the principles, I found it quite convincing when you were speaking about that, but that needs to be got across because think—novice users I mean we're so desperate when we start to know what we doing and you sort of follow rules and things like that rather than principles, and of course principles are likely to be very flexible, and adjust to what's in front of you

[pause]

Expert R: Yeah and I think an important point to understand is that the therapists, are in charge of the process, of guiding the process and moving it forward but everything that is content related comes from the client [pause] we have no idea at the outset what is going on in the client's mind all we know is these are the symptoms that he or she wants to get rid of, and so we need to know as therapists we need to know how do we do this, what do we do, how do we find that which we want to modify, how do we get that out of the client and so the art psychotherapy is one, wonderful way of kind of getting at that content that initially is below the conscious level and we want to bring it up to, the level of awareness, so how do we do that is the, big question

[pause]Kelly: Thank you for the comments End of interview

Appendix 6

HRA and Health and Care Research Wales (HCRW) Ethics Approval

Dr Mick Hill
Northumbria University, Coach Lane Campus
15 Coach Ln,
Newcastle Upon Tyne
NE7 7T

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

27 April 2020

Dear Dr Hill

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**RESEARCH STUDY: Identification of Components and Elements of Art Psychotherapy treatment that contribute towards healing for Adults who have Experienced Complex Psychological Trauma.**
IRAS project ID:	**266849**
Protocol number:	**V1**
REC reference:	**20/WS/0048**
Sponsor	**Northumbria University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance

report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see **IRAS Help** for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to **obtain local agreement** in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "**After Ethical Review – guidance for sponsors and investigators**", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The **HRA website** also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **266849**. Please quote this on all correspondence.

Yours sincerely,

Thomas Fairman

HRA Approvals Manager

10.1.7.

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*	
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Employers Liability]		01 August 2019	
Contract/Study Agreement template [Internal Approval Form]	1	11 February 2020	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		01 August 2019	
HRA Schedule of Events			
IRAS Application Form [IRAS_Form_10032020]		10 March 2020	
Letter from statistician [Letter to Art Psychotherapists]	1	11 February 2020	
Organisation Information Document			
Other [Patient Leaflet (revised)]	2	09 April 2020	
Other [Email clarification of CI and study sites as requested in validation under consideration email]		11 February 2020	
Participant consent form [Consent Form]	V2	09 April 2020	
Participant information sheet (PIS) [Participation Information Sheet]	V3	16 April 2020	
Research protocol or project proposal [Qualitative Protocol Document]	v0.1	04 March 2020	
Summary CV for student [CV]	1	11 February 2020	
Summary CV for supervisor (student research) [Supervisor CV]			
Validated questionnaire [CORE 18 questions a]			
Validated questionnaire [CORE 18 questions b]			
Validated questionnaire [Pre Intervention questions for Assistant Researcher]			
Validated questionnaire [Post Intervention questions for Research Assistant]			
Validated questionnaire [Two Intervention questions for Research Assistant]			

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisational Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No application for external funding has been made.	A Principal Investigator should be appointed at study sites of this type	As a non-commercial study undertaken by local staff, it is unlikely that letters of access or honorary research contracts will be applicable. If members of the external research team will be attending NHS sites to conduct the study activities detailed at IRAS A18 and A19 they should obtain an Honorary Research

					Contract for this purpose from one NHS organisation, followed by Letters of Access for subsequent organisations. This would be on the basis of a Research Passport or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). Pre-engagement checks should confirm enhanced DBS checks, appropriate barred list checks, and occupational health clearance. For research team members only administering questionnaires or surveys, a Letter of

					Access based on standard DBS checks and occupational health clearance would be appropriate.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.