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ART PSYCHOTHERAPY WITH ADULT OFFENDERS WHO HAVE INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SIMON S. HACKETT

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

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ABSTRACT

Objectives: To evaluate the effectiveness of art psychotherapy with adult offenders who have intellectual and developmental disabilities within an inpatient setting. The research looked at significant events taking place within the treatment that supported therapeutic outcomes. The aims of the research were to investigate a range of explanations for measurable therapeutic change that could be plausibly related to the processes observed in therapy.

Design: Four single-case studies were conducted with pre-treatment, treatment, and post-treatment assessment using multiple measures of change and observations of process.

Participants: Four male participants with mild intellectual and developmental disabilities from an NHS medium-low secure forensic hospital in the UK.

Intervention: Each participant completed up to 20 individual art psychotherapy sessions within six months. The treatment sought to engage each participant in making personally-generated art work which was then discussed with the therapist.

Main outcome measures: Core Conflictual Relationship Theme (CCRT); Daily Self-Rating Scale for specific symptoms; Personal Problem Scale; Modified Overt Aggression Scale (MOAS); Brief Symptom Inventory 18 (BSI-18); Glasgow Anxiety Scale for adults with Intellectual Disabilities (GAS-ID); Glasgow Depression Scale for people with a Learning Disability (GDS-LD); Rosenberg Self-Esteem Scale (RSES).

Results: The main outcomes show a post-treatment reduction in aggressive styles of interacting with others for two participants in a medium secure unit. Daily Self-Rating Scale measures show an improved post-therapy trend for three participants, with all participants reporting improvement on the Personal Problem Scale and positive changes in CCRT interpersonal schemas. Behavioural and relational outcomes were observed to promote pro-social responses towards others three months following the end of treatment. Art psychotherapy was found to have positive therapeutic benefits for each of the four participants.

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ACKNOWLEDGEMENTS

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 this work fully acknowledges opinions, ideas and contributions from the work of others. The work was done in conjunction with Northumberland, Tyne and Wear NHS Foundation Trust.

Ethical approval has been sought and granted by Northumbria University Ethics Committee, Northumberland, Tyne and Wear NHS Foundation Trust Research and Clinical Effectiveness Department, the National Institute for Health Research, County Durham and Tyne Tees Valley 2 Research Ethics Committee (reference 08/H0908/63).

Signature... Simon S. Hackett

Date..2012

CHAPTER 1: INTRODUCTION

1.1 Introduction

The research presented in this thesis touches upon a small number of specialist areas. The introductory chapter will focus upon defining and clarifying terminology related to the specific area of study. This research has been carried out to investigate art psychotherapy as a treatment for offenders with intellectual and developmental disabilities within medium and low secure NHS facilities in the UK. The intention of the research has been to study the effectiveness of this treatment within a clinical setting. A single-case study methodology has been used to carry out the research and four separate cases are presented within successive chapters. In this chapter a brief introduction to the terminology defining intellectual and developmental disabilities, NHS forensic services in the UK, and art psychotherapy is provided. The chapter concludes with an outline of the research hypothesis and the aims of the study.

1.1.2 Intellectual and developmental disabilities.

A learning disability is defined as "a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning) which started before adulthood, with lasting effect on development" (Department of Health, 2001, p. 14).

In the general population in England 1.2 million people are estimated to have a mild or moderate learning disability indicated by an IQ below 70 (Department of Health, 2001). The American Association of Intellectual and Developmental Disabilities (AAIDD) classification criteria for intellectual disabilities include an IQ range below 75 to allow for measurement error. The term "learning disability" is interchangeable with the term "intellectual disability". Both terms cover the same population in level, type, and duration of disability. There appears to be a greater trend towards "intellectual disability" being

used as the accepted international terminology. This has been particularly evident within the American literature where intellectual disability is increasingly used in place of the term "mental retardation" (Schalock, et al., 2007). Literature in the UK has previously shown greater use of the term "mental handicap". The term "developmental disability" also has current usage and includes a range of "pervasive developmental disorders". This incorporates conditions such as autism, Asperger's syndrome, Rett syndrome, and other neurodevelopmental disabilities with an onset before the age of 22 years. The combined terminology of "intellectual and developmental disabilities" is considered to reflect the recipient populations in forensic services in the UK (Gillmer, Taylor, & Lindsay, 2010). The term "intellectual and developmental disabilities" also provides the most appropriate description of the participants who have taken part in this research and these terms will be used throughout, with the small exception of direct quotes from other sources where text will remain unchanged.

1.1.3 Offenders with intellectual and developmental disabilities.

Within the prison service it is estimated that between 20-30% of offenders have learning difficulties or intellectual disabilities that interfere with their ability to cope within the criminal justice system (Bradley, 2009). Estimates of the prevalence of the offending population who have intellectual disabilities within the UK range from 1% to 10% (Bradley, 2009) and 5-10% (Talbot & Jacobson, 2010). Offenders with intellectual and developmental disabilities are not a homogeneous group and may have committed a wide range of criminal offences. The England and Wales Mental Health Act 1983, amended in 2007, allows "mentally disordered" offenders to be diverted from the criminal justice system into compulsory treatment in the healthcare system (Talbot & Jacobson, 2010). A "mental disorder" is defined as "any disorder of disability of mind". Intellectual disability is only considered as a mental disorder if it is "associated with seriously irresponsible or

abnormally aggressive conduct". The Mental Health Act also classes autism and Asperger's Syndrome as mental disorders.

1.1.4 NHS forensic services in the UK.

Referral to NHS forensic services in the UK can occur either before or after conviction; prisoners cannot be sectioned under the Mental Health Act and remain in prison. Forensic services in the UK are provided within distinct categories of security, including high, medium, and low secure hospitals. The research presented within this thesis has been conducted within a medium and a low secure NHS forensic facility.

Medium secure services provide treatment for people who present a serious but not grave and immediate danger to others. They are expected to operate within best practice principles governing physical and procedural security arrangements aimed at minimising the opportunity for and means to escape or abscond. Admission criteria include but are not limited to

- risk predominantly to others including serious risk to the public
- significant risk of and/or attempts to escape/abscond
- present or history of violent behaviour that cannot be managed in less secure conditions.

Patients in low secure units typically require treatment in conditions with a higher level of physical and relational security than open wards because of the level of risk they pose to themselves or others. The physical security is less than provided in a medium secure unit. Admission criteria may include

- history of non-violent offending behaviour
- low risk of abscond or escape

- offending behaviour connected to mental disorder

- risk of self neglect, challenging behaviour and/or self-harm

- risk of lower level violent offending e.g. common assault, actual bodily harm. (Man, 2011, p. 19)

1.1.5 The Arts Therapies.

In the UK the term "arts therapies" is inclusive of the range of professions such as art therapy, music therapy, drama therapy, and dance movement psychotherapy. All of these therapies employ arts media as principal means of communication. Arts therapies are concerned with engaging people in creative processes and then, within the bounds of a trusting and safe therapeutic relationship, exploring the meaning of the experience with a view to bringing about helpful changes for individuals or group members. In the UK a qualified arts therapist has a specialist training to a master's degree level. With the current exception of dance movement psychotherapists, practising arts therapists in the UK have been required to register with the Health Professions Council (HPC) since 1999.

1.1.6 Art psychotherapy / art therapy.

The terms art psychotherapy and art therapy are interchangeable; art therapy has increasingly been referred to as art psychotherapy due to the overt psychotherapeutic nature of interventions. Both terms will be used interchangeably within this document. Art therapy first developed its identity as an organised profession in the UK in the mid-20th century (Wood, 1997). The professional body for art therapists working in the UK is the British Association of Art Therapists (BAAT) (approximately 1,600 members) which was established in 1964. Founding members of BAAT were predominantly artists with a teaching qualification (Karkou & Sanderson, 2006). Art therapy has a number of different early influences such as child-centred education and outsider art or psychiatric art

produced by patients in psychiatric institutions. With the establishment of training institutions and examples of art therapy becoming available within the NHS in the 1980's a greater emphasis was placed upon psychoanalytic theory and the relationships between the visual arts and psychodynamic therapy (Karkou & Sanderson, 2006).

Although practice and approaches vary considerably within the profession a common description is widely accepted.

Art Therapy is a form of psychotherapy that uses art media as its primary mode of communication.

Clients who are referred to an art therapist need not have experience or skill in art. The art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's image. The overall aim of its practitioners is to enable a client to change and grow on a personal level through the use of art materials in a safe and facilitating environment.

The relationship between the therapist and the client is of central importance, but art therapy differs from other psychological therapies in that it is a three-way process between the client, the therapist and the image or artefact. It offers the opportunity for expression and communication and can be particularly helpful to people who find it hard to express their thoughts and feelings verbally. (British Association of Art Therapists, 2012, paras. 1-3)

This description incorporates strongly-valued ideas held within the profession. Specific ideas related to practice include the art medium being seen to offer an intrinsic vehicle for communication. The art therapist places no judgement or aesthetic hierarchy upon the finished art work. The art work, in and of itself, is not used to make a diagnosis of any kind. The art work created within therapy is given equal value, alongside the pairing

between the therapist and client, which provides the means through which positive therapeutic change can be effected.

In practice, art therapy involves both the process and products of image making (from crude scribbling through to sophisticated forms of symbolic expression) and the provision of a therapeutic relationship. It is within the supportive environment fostered by the therapist-client relationship that it becomes possible for individuals to create images and objects with the explicit aim of exploring and sharing the meaning these may have for them. It is by these means that the client may gain a better understanding of themselves and the nature of their difficulties or distress. This, in turn, may lead to positive and enduring change in the client's sense of self, their current relationships and in the overall quality of their lives. (Edwards, 2004, p. 4)

Edwards' (2004) description of processes that are expected to take place within art therapy and to support positive changes for clients are set out in a logical sequence. The therapy consists of

- image-making by the client;

- taking place in the context of a working relationship with the therapist;

- the therapist and client's exploration and sharing of any meaning that the image or object might have; with the explicit aim of bringing about

- increased understanding for the client about themselves and their difficulties; leading to,

- positive change and improvement.

1.2 Research Study: Hypothesis and Aims

The hypothesis has been chosen to investigate the ideas and theory of change that are strongly valued within the profession (Edwards, 2004). To date, theory and practice have been developed through clinical experience and in many instances the efficacy and effectiveness of art psychotherapy has not been adequately tested within specific client groups. Taylor (2005) suggests that the terms "effectiveness" and "efficacy" can sometimes be conflated in academic texts. Roth and Fonagy (2005) state that "…a clear distinction needs to be drawn between efficacy of a therapy (the results it achieves in the setting of a research trial) and its clinical effectiveness (the outcome of the therapy in routine clinical practice)" (p. 16).

There is a requirement to demonstrate the effectiveness of art psychotherapy as a treatment for people with intellectual and developmental disabilities in routine clinical practice. The research hypothesis being investigated within this study is: that art psychotherapy supports change in symptoms presented by adult offenders with intellectual and developmental disabilities within an inpatient secure forensic setting as measured by a battery of psychological and behavioural tests.

The aims of the research are:

- To investigate if therapeutic change takes place during or as a result of art psychotherapy.

- To establish a plausible link between therapy and outcome and to identify the processes that support change to take place as a result of therapy.

- To establish if there is congruence between the measurable outcomes, the processes by which change has occurred, and broad psychotherapeutic theory.

CHAPTER 2: PSYCHOTHERAPEUITIC WORK AND ART PSYCHOTHERAPY WITH PEOPLE WHO HAVE INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

2.1 Introduction

This selective literature review focuses, where possible, on identifying outcome studies which seek to demonstrate both the efficacy and effectiveness of psychotherapeutic work with the target group of people who have intellectual and developmental disabilities. Important studies of psychotherapeutic work with this group will be emphasised, but other areas will be covered in order to provide a context in which to place the intellectual and developmental disabilities literature. Two additional areas which have also been included are art therapy with adults (without intellectual and developmental disabilities) who have schizophrenia and art therapy in prisons and secure settings.

The initial search strategy for the literature review, using computerised database searches, has been expanded to include less formal literature gathering. Hand searches have been conducted for journals not currently listed on major databases such as PsycINFO and a number of studies are reported from book chapters. One unpublished study is also included. A more general approach has been used to identify literature showing the range of psychotherapeutic work with the target group. The selection of the literature has attempted to highlight research which can be considered good quality such as meta-analysis, randomised controlled trials (RCTs), group or outcome studies, and well conducted case-series and single-case study designs. Where appropriate, some indication is given regarding basic design features and published results of studies. Where no systematic, controlled, or outcome studies have been found in a particular area, descriptive papers with anecdotal findings are reported in order to illustrate the range rather than quality of studies. This review of the literature presents the current position of art

psychotherapy research with adult offenders who have intellectual and developmental disabilities and provides justification for the design chosen to conduct this research.

2.2 Psychotherapeutic work with People who have Intellectual and Developmental Disabilities

The effectiveness of psychotherapeutic work with people who have intellectual and developmental disabilities has been debated within the literature. Prout and Nowak-Drabick's (2003) meta-analysis is probably the most comprehensive search of the literature from 1968 to 1998. Dissertations and published studies formed the basis of the literature review which identified 92 studies including group designs, pre-post designs, single subject studies, and case studies. A total of nine studies provided data for a small meta-analysis which concluded that psychotherapy for people with intellectual disabilities is "moderately effective" based upon an overall effect size of 1.01. In response to Prout and Nowak-Drabick (2003) and claims made by Lynch (2004), Sturmey (2005) stated that there is inconclusive evidence of the effectiveness of psychotherapy for this population in contrast to the use of applied behavioural analysis (ABA)-based interventions. Notable responses to Sturmey's (2005) position (Beail, 2005; Hurley, 2005 ; King, 2005; Taylor, 2005) provide an important critical commentary, presenting a consensus of opinion that psychotherapeutic approaches have been demonstrated to be effective for mental health and emotional disorders, particularly with people who have mild intellectual disability.

The evidence base for psychotherapeutic interventions for people who have intellectual disability has been reviewed on several occasions in recent years, for example (Beail, 2004; Brown, Duff, Karatzias, & Horsburgh, 2011; Gustafsson, et al., 2009; Hatton, 2002; Prout & Browning, 2011; Sturmey, 2004; Willner, 2005). Willner's (2005) review gives preference to the RCT design within psychotherapy research due to the ability to "isolate the elements of an intervention responsible for therapeutic change" (Willner, 2005

p.74) (the possibility of this also being demonstrated in single-case designs will be given further consideration in Chapter 3). Research studies which use A-B-A (A= baseline, B = treatment) designs are also considered to have value in being able to demonstrate that an intervention is more effective than no intervention (Willner, 2005). This approach is clearly presented within behavioural studies which have made substantial use of single-case designs, see (Courtney & Rose, 2004; Malterud, 2001; Scotti, Evans, Mayer, & Walker, 1991) for reviews. Willner (2005) reports no RCTs of the efficacy of psychotherapeutic approaches in people with intellectual disabilities prior to early 2002. A small number of RCTs and controlled outcome studies since this time do provide good quality evidence for the use of psychotherapeutic approaches with people who have intellectual disability.

There is reasonable evidence for the efficacy of cognitive behavioural anger interventions within the literature including controlled studies, see (Taylor, Novaco, Gillmer, Robertson, & Thorne, 2005; Willner & Tomlinson, 2007) for reviews. Anxiety treatment using cognitive behavioural interventions and relaxation techniques have also shown measurable benefits (Douglas, Palmer, & O'Connor, 2007; Lindsay, Baty, Michie, & Richardson, 1989). Interventions of five to 12 weeks of small group treatment for people with mild intellectual disabilities and mild to moderate levels of depression have demonstrated positive results in a controlled study (McCabe, McGillivray, & Newton, 2006). Treatment for symptoms of psychosis have been investigated in one well-conducted clinical case series of individual cognitive behavioural therapy (CBT) for people with mild intellectual disability (Haddock, Lobban, Hatton, & Carson, 2004).

2.2.1 Psychotherapeutic work with offenders who have intellectual and developmental disabilities.

Psychotherapeutic treatment of offenders who have an intellectual disability has more recently focused upon criminogenic interventions. Gillmer, Taylor & Lindsay (2010) provide an informative commentary on practice and legislation for offenders with intellectual and developmental disabilities in the UK. Appraising the literature, Gillmer, et al. (2010) identify limited data related to rates of recidivism for offenders with intellectual and developmental disabilities. They conclude that a period of at least two years of active treatment, either community- or institution-based, appears to be indicated for more successful long term outcomes.

Courtney and Rose (2004) reviewed 31 studies in order to consider the efficacy of sex offender treatment with male offenders with intellectual disabilities. The review identified some credible studies but the conclusions mainly highlighted the need of further research. CBT-based approaches have been developed in sex offender treatment which focus upon reducing cognitive distortions related to beliefs and attitudes offenders may hold towards their offence and victims (Cleveland, 1979; Lindsay, Neilson, Morrison, & Smith, 1998; Lindsay & Taylor, 2009). Interventions which seek to address victim empathy, enhance self-awareness and reduce risk have also been reported (Rose, Jenkins, O'Connor, Jones, & Felce, 2002). Cognitive treatments of sex offenders with intellectual and developmental disabilities include components which identify underlying schemas and challenge cognitive distortions (Beail, 2003). There is a move towards "fine-tuning" components of sex offender treatment, a recent example being Ralfs and Beail (2012), investigating empathy in sex offenders with intellectual disabilities. The study identified that sex offenders and non-offenders with intellectual disabilities showed no difference in a test of emotional perception. Sex offenders with intellectual disabilities who had completed

treatment were seen to perform better in tasks of "emotion recognition, perspective taking and response decision skills" (Ralfs & Beail, 2012, p. 57).

Reviews of RCT studies for anger treatment have previously been mentioned. Anger is an important predictor and activator of violent behaviour in patients living in institutions (Taylor, et al., 2005). Specific anger assessment and treatment programmes with an inpatient forensic intellectual and developmental disability population have shown positive results (Novaco & Taylor, 2004; Taylor, et al., 2005; Taylor, Novaco, Gillmer, & Thorne, 2002). In a controlled trial, Taylor et al. (2005) reported upon CBT-based anger treatment for 40 male participants with mild intellectual disabilities who had a range of offence histories including violent offences, sexual offences, and fire-setting. Treatment was provided in 18 individual therapy sessions encompassing two stages, including psycho-education and treatment. This study showed significant improvement between pre- and post-treatment outcome measures for the anger treatment group against a waiting list control group. Taylor, Novaco and Johnson (2009) demonstrated that these improvements were maintained for up to 12 months following completion of treatment.

Offence-focused treatment for fire-setting has generated a small number of studies. Studies have mainly used single-case or case series designs (Clare, Murphy, Cox, & Chaplin, 1992; Taylor, Thorne, & Slavkin, 2004). Following successful engagement in a group intervention for females who had been involved in fire-setting, Taylor, Robertson, Thorne, Belshaw, and Watson (2006), reported no repeat offences by the participants two years after treatment.

Psychodynamic psychotherapy with men who have an intellectual disability has also been shown to have a positive effect upon a wide range of presenting problems. Beail (1998) looked at outcomes for 20 participants living in the community, 12 with behaviour problems, including aggression towards people, aggression towards property, aggression towards property and theft, soiling and smearing, and persistent questioning. The

remaining eight participants had committed criminal offences including arson, indecent assault, indecent exposure, and indecent assault and exposure. Individual weekly psychoanalytic psychotherapy was provided with treatment length varying from three to 38 months. Results show that in 11 cases problem behaviour was eliminated. Results for the offender group showed that no incidents of re-offending had occurred at six-month follow-up. In one further exploratory study, Beail (2001) reports upon weekly individual psychodynamic psychotherapy with 13 offenders with intellectual disabilities with follow-up. Recipients of treatment had been diverted from the criminal justice system to the clinical psychology service. Average treatment length was 16 months. At the four-year follow-up, 11 out of 13 participants had not re-offended.

2.3 Art Therapy

2.3.1 The arts in health.

General benefits of the role of the "arts" within health care and in support of health and wellbeing have been identified (Staricoff, 2004). This work has supported broad policy initiatives within the United Kingdom (Arts Council Wales, 2009). There has also been recent acknowledgement that participation in the arts can have a beneficial influence on a person's mental health and wellbeing (Department of Health, 2011).

2.3.2 Art therapy: researching the esoteric!

Early forms of art therapy, such as the psychiatric experiments conducted at Netherne Psychiatric Hospital in Surrey from 1946 onwards tried to find diagnostic material in pictures made by patients which were considered to hold a pure representation of an individual's state of mind (Dalley, 1984). The artist working with patients, Edward Adamson, was instructed to provide only basic facilitation and not to make interpretations of images or take an interest in the patients' psychological problems. The psychiatrists

overseeing the work, Dr Reitman and Dr Cunningham-Dax, were both critical of Freudian and Jungian symbol analysis of images believing that interpretations influenced the patients' subsequent creations (Dalley, 1984). Karkou and Sanderson (2006) report that the two psychiatrists thought involvement by the therapist in this kind of work would "train" the patient in psychoanalytic thinking, leading to the images eventually fitting the theoretical preconceptions of the therapist and not serving the patients real needs.

The potentially playful nature of an artistic medium can provide multiple opportunities for communication for those taking part in art therapy. The attention given to non-verbal and "unconscious" expression and the "transference" relationship between therapist and client in art therapy has developed from psychoanalytic and psychodynamic theory (Edwards, 2004). The influence of the therapist's theoretical preconceptions, such as Jungian analysis, upon clients' images, are demonstrated in the work of Schaverien (1987) who had also raised a dilemma about researching the more "esoteric" nature of art therapy practice (Schaverien, 1994).

Professional concerns have also been raised regarding researching art therapy using RCT designs (Wood, 1999). A systematic analysis of art therapy research published between 1987 and 2004 in "Art Therapy: Journal of the American Art Therapy Association (AATA)" identified that art therapists typically used mixed approaches and methodologies (Metzl, 2008). Studies were found to be qualitative with some quantitative aspects and were not considered to follow a standardized research design. The studies also tended to focus more on the personal voice of the researcher, more so than other research published in the liberal arts and social sciences (Metzl, 2008). Gilroy (2011), whilst acknowledging the benefits of qualitative approaches, has suggested that a focus upon building a respectable body of rich, descriptive, and inductive art therapy literature has been to the detriment of outcome research.

2.3.3 Art therapy research with adults who have schizophrenia.

Although work with people who have schizophrenia is not a focus of the current research, it is a noteworthy area to consider as it has attracted reasonable research attention within the arts therapies field. It is also one of the few clinical conditions in which arts therapies have been recommended by the National Institute for Clinical Excellence (NICE).

Mental health service user information provides a perspective upon treatment experience. A survey of 959 mental health service users with a subset of 357 having a diagnosis covered by the scope of the NICE schizophrenia guidelines reported that 83% of respondents found arts therapies to be beneficial treatment, with 69% reporting CBT as helpful (Borneo, 2008). Whilst service user surveys in this group have been broadly positive, empirical research has yielded mixed results.

NICE guidelines recommend arts therapies for patients who have schizophrenia presenting with negative symptoms e.g. (Andreasen, 1989). Arts therapies are considered to be an intervention which can increase motivation and reduce a sense of social isolation. "Despite this small but emerging evidence base, the Guidelines Development Group (GDG) recognise that arts therapies are currently the only interventions (both psychological and pharmacological) to demonstrate consistent efficacy in the reduction of negative symptoms" (National Collaborating Centre for Mental Health, 2009, p. 256).

Jones (2011) does report statistically significant improvement in negative symptoms in a pilot study involving 40 participants with schizophrenia, randomised to art therapy rather than standard care. A more recent study is not consistent with NICE guidelines (Crawford, et al., 2012). This pragmatic RCT with 417 participants recruited in multiple centres showed no difference in primary outcomes between art therapy, an activity group or standard care.

2.4 Art Psychotherapy with Adults who have Intellectual and Developmental Disabilities

Ashby (2011) conducted a survey of sixty art therapists working with people with severe intellectual disabilities and challenging behaviour in the UK, 65% of respondents worked within the NHS. Findings indicated that the therapists worked flexibly and used a wide range of theory to underpin their practice, including psychodynamic, client-centred, and behavioural approaches. Despite identifying constraints in many service areas therapists reported that they thought they had offered a wide range of benefits to people with severe intellectual disabilities and challenging behaviour. Therapists' perceptions of their effectiveness included providing safety and containment, empowerment, a thinking space to reflect and process and an opportunity to develop a meaningful and trusting relationship. Therapists also felt that they had a role in enhancing communication through the development of non-verbal skills by modifying and re-directing challenging behaviour into more positive outlets of expression.

The role of the arts therapies in being able to provide an accessible intervention with people who have communication difficulties has been recognised.

> The difficulty of establishing a therapeutic dialogue in the presence of communication difficulties has often been seen as a barrier to people with learning disabilities having access to, or making effective use of, psychotherapy. Arts Therapists and related disciplines have a long history of working through other means of expressions.... (Royal College of Psychiatrists, 2004 p.15)

Despite some acknowledgement of a long history of art therapy with people who have intellectual disability, outcome studies within the UK are very limited in number. The

majority of literature on work with people who have intellectual disability has been general in nature (Gilroy, 2006).

Stott and Males (1984) considered the merits of both directive and non-directive approaches in work with people who had intellectual disabilities within a psychiatric setting. During the 1990s a number of therapists in the UK started to write about their work with adults who had intellectual disabilities. Clinical observations made by therapists led to theory development in relation to practice (Rees, 1998).

Art therapists have applied broad psychodynamic theory to their work, for example (Damarell, 1998, 1999). Clinical vignettes and case description have primarily been used to explore subjects such as transference, communication (Tipple, 1993, 1994), group therapy (Lomas & Hallas, 1998), work with people who have severe intellectual disabilities (Rees, 1995; Tipple, 1992), or subjects such as bereavement (Kuczaj, 1998), work with rape victims (Hughes, 1998), and personality disorder (Willoughby-Booth & Pearce, 1998). In the Canadian literature Barker (1995) has written about self-injurious behaviour.

Only one art therapy study has been identified in the UK which has used a process measure with adults who have an intellectual disability (Pounsett, Parker, Hawtin, & Collins, 2006). Individual therapy sessions were recorded on video and the content was evaluated using an adapted version of the Play Observation Scheme and Emotion Rating (POSER) (Wolke, 1986). Three case studies are reported including one man with a severe intellectual disability and a man and a woman with a moderate intellectual disability. The study concluded that there was evidence of increased "pro-social behaviour" taking place within therapy sessions during the first 12 months of the intervention.

One international RCT investigating art facilitation with adults (*n*=19) who had developmental disabilities found evidence that the treatment group made improvements in communication and social relationships (Got & Cheng, 2008). The 12 week group

intervention used art activities to promote self-understanding. The treatment group were encouraged to express personal views about their lives and set goals for the future. No subjective gains were measured using the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) (Endicott, 1990). Parent and carer ratings using the Scales of Independent Behavior-Revised (SIB-R) (Bruininks, Woodcock, Weatherman, & Hill, 1996), designed to evaluate individuals' functional independence and adaptive functioning, did show treatment effects. An analysis of covariance of post-test with pre-test scores as covariates ($p<.10$) showed a difference between language comprehension and social interaction for the treatment group against the control group (Got & Cheng, 2008).

White, Bull and Beavis (2009) combined case description with a post-therapy interview of a service user, who is also included as an author of the paper under a pseudonym. Although no standardised outcome measures were used, an argument for cost effectiveness of treatment is considered as a benefit of the intervention. A count of the service user's contacts with all professionals within a community team pre- and post-therapy are given as an example of reduced dependence upon services. Prior to therapy the service user was recorded to have had 366 separate contacts with the community team. This reduced to 52 contacts in the year following the end of therapy. Post-therapy interview responses given by the service user suggested that the therapy involved processing emotionally "painful" material, particularly in relation to bereavement.

Damarell (2011) conducted a series of drawing tests in an attempt to explore his "suspicion" that cognitive enhancement occurred when people with intellectual disabilities engaged in image production. The study recruited 10 participants approximately matched according to IQ, age, and verbal skills. Five out of the 10 participants completed a drawing test whilst being videoed. The images that the participants made in the observed sessions were then categorised against two separate criteria of image analysis (Schaverien, 1992;

Simon, 1992). Damarell (2011) concluded that the sample for the study was too small and the fundamental assumptions of the research were not demonstrated.

Hackett (2011b) gave a brief description of the response of a man with an intellectual disability and limited verbal communication within an art therapy bereavement group and highlighted the value of using artwork as an aid to communication. Bull and O'Farrell (2012) identified common themes in case material arising from art therapy practice with people who have intellectual disabilities, such as loss and bereavement, issues of abuse, infantalisation, fear, powerlessness, and self-identity.

2.5 Art Therapy within Prisons and Secure Settings

The positive role that the arts can play within offender rehabilitation in the prison service has also been acknowledged in recent policy review in the UK. Within a joint report produced by the Ministry of Justice and Department for Business Innovation and Skills, "Making prisons work, skills for rehabilitation", there is an endorsement of the role that the arts can have in offender rehabilitation. "We recognise the important role that the arts, collectively, can play in the rehabilitation process through encouraging self-esteem and improving communication skills as a means to the end of reducing reoffending" (Ministry of Justice & Department for Business Innovation and Skills, 2011 p.19).

Arts therapies are used widely within forensic psychiatry services in the Netherlands (Smeijsters & Cleven, 2006). A qualitative inquiry conducted with 31 members of a network of arts therapists in forensic psychiatry, including art, drama, music, and dance movement therapists, sought to identify treatment approaches used for destructive aggression. The survey showed that all therapies used approaches with the aim of helping the patients reach insight into and change aggressive behaviour. Interventions reported by arts therapists included exploring cognitions, feelings and behaviours of patients with the aim of lessening cognitive distortions through making art.

Smeijsters, Kil, Kurstjens, Welten and Willemars (2011) present the first phase of an arts therapies research project with young offenders in secure care. Approaches used by a number of arts therapies are described in the paper. Core problems with this client group were seen to be negative self-image, expressing and discharging emotions, inability to resolve interpersonal problems and negative cognitions regarding other people. Art therapy was seen by therapists working in secure settings as most useful for the core problem of self-image and addressing emotional difficulties and problems of interaction. The art therapy process was seen as intrinsically positive and creative allowing the young person to work on the basis of their own needs (Smeijsters, et al., 2011).

Art therapy literature with offenders in the UK is limited to uncontrolled case studies with anecdotal and descriptive findings. Aulich (1994) describes her practice in work with adolescent sex offenders and gives some consideration to the selection of individuals for art therapy. Karban and West (1994) write about art therapy in a regional secure unit and case vignettes are used to illustrate specific aspects of this work. Teasdale (1997) presents a case synopsis of work with personality-disordered offenders attending 44 weekly, two-hour sessions. Teasdale highlights the benefits of participants creating a story board of images, an approach also demonstrated by Marian Liebmann (1994, 1998) in her work with offenders on probation. Sarra (1998) gives an account of image content from inpatient group work with forensic patients in acute states. Delshadian (2003) outlines case material related to arson. This work took place in Holloway Prison and puts forward the view that art therapy has a unique way of engaging patients in finding alternative ways of processing difficult feelings. Descriptive case studies are also used to illustrate processes believed to take place in art therapy sessions with young offenders in prison (Pittman, 2008). Godfrey (2008) used anecdotal case vignettes to describe aspects of anger explored in therapy sessions with prolific offenders on probation.

In the Canadian literature Burpee (1997) reported upon work with adolescents who have committed sexual offences and described providing art therapy sessions with the aim of facilitating self-exploration in order to promote potential for change. Some outcome studies have been attempted in the USA. Clinical approaches to treatment being reported in the USA have a marked difference to those described within the UK literature. Gussak (2004) used a quasi-experimental, single group pre- and post-test design with 48 inmates accessing an art therapy service in a mental health day treatment unit of a state correctional facility. Art therapy case studies were included for descriptive purposes. Art therapy was thought to encourage inmates to express themselves in an environment where there was an inherent distrust of verbal disclosure.

In a smaller study with 27 participants conducted within the same institution Gussak (2006) sought to improve upon the previous study design with random assignment of participants to either an eight week group or no treatment. The results concluded that the experimental group had greater (but not statistically significant) reduction in depressive symptoms.

Persons (2009) evaluated the psychological needs being addressed in an arts programme with serious juvenile offenders in the USA. Forty-six participants took part in the programme of individual and group art activities from two to 10 hours per week, a mean of five hours a week. The duration of participants' involvement ranged from two months to two years with a mean treatment length of eight months. This phenomenological study concluded that the primary psychological need the programme addressed was the exploration of identity issues with the adolescents taking part. The highest rated helpful aspect of the programme reported by participants was reduced anger.

Meekums and Daniel (2011) conducted a meta-synthesis to investigate the role of the arts in therapeutic goals for offenders. Published articles which focused upon addressing questions of efficacy or effectiveness were included in the review. Conclusions

from the meta-synthesis identify that arts therapies were invariably found to be associated with improvements in emotional literacy, quality of life and lower levels of arousal which were also associated with feelings of anger. Other themes identified in the literature included improved mental health. Theory regarding "process" related to the role of arts with offenders is discussed. The art medium used in treatment is seen to generate a "metaphor" for participants that can give a useful distance from raw emotion and provide a vehicle for transformation (Meekums & Daniel, 2011). This study also recommended the use of mixed method approaches in future research with offenders in order to facilitate understanding of the effects of arts therapies through "different lenses".

Recent description of art therapy work in a low secure unit (Banks, 2012), provides a detailed account of processes in therapy. The case study of a 26 year-old man with a diagnosis of paranoid schizophrenia and a conviction for violent assault with a weapon describes the service user's image-making and discussion that took place with the therapist. The content of therapy sessions included discussing the index offence and a number of adverse early childhood events experienced by the service user. Some of the service user's own responses and descriptions of the images he made in therapy are quoted from a recorded interview conducted by the therapist. The art work produced by the service user and the processes considered to have taken place in art therapy were linked to various theories including the role of mentalisation (Fonagy & Target, 1999).

2.5.1 Art psychotherapy with offenders who have intellectual and developmental disabilities.

No art therapy outcome studies with adult offenders who have intellectual and developmental disabilities have been identified within the UK literature. Art therapy techniques are reported anecdotally to have helped adult sex offenders with intellectual disabilities make concepts more meaningful and comprehensible in CBT (Makenzie,

Chisholm, & Murray, 2000). Manners (2005) completed a "qualitative heuristic exploration" of emerging themes in an art therapy group with six male patients in a forensic intellectual disability service. Conclusions of this unpublished study stated that issues of power and control, and feelings of loss of normality were prominent within group treatment. The complexity of art therapy undertaken with "offender patients with a history of mental illness, personality disorder, and intellectual disability" is described by Rothwell (2008). Specific themes of anger within the patients' art work are linked to the theory that "non-verbal processes in art-making may provide an opportunity for material to surface through the work, held within the therapeutic relationship and space" (Rothwell, 2008, p. 118).

2.6 Conclusion

There is evidence indicating the benefit of psychotherapeutic work with people who have intellectual and developmental disabilities for a range of presenting problems, such as challenging behaviour, anxiety, depression, anger, and psychosis. Criminogenic-focused psychotherapeutic work has made important gains in establishing treatment efficacy focused upon index offences and reducing recidivism. Much of this work is programmatic and principally based upon CBT approaches. There is also an indication that psychodynamic approaches have positive outcomes for offenders with intellectual disability (Beail, 1998, 2001). Art psychotherapy literature for the target group is clinically focused and theoretical in nature with primacy of anecdotal case description forming the literature.

Beail (2004) cites Salkovskis (1995), the "hourglass model", illustrating phases of development in research programmes. The metaphor of the hourglass is used to define three phases in the development and refinement of research design and methods. Early stages of research are often based in clinical problems and development of a theoretical

framework which lead to studies of processes within the therapy. Exploratory studies in this first phase have relatively relaxed standards in design and implementation. Resources may be limited, sample sizes small, and experimental designs such as single-case study and quasi-experimental designs might be used. The second phase, the pinch or narrowing of the hourglass, is much more reliant upon resources, with higher demands being placed upon the research design. Key effects might be investigated with greater and more refined use of control groups, stringent measures and close attention being paid to sample size and statistical techniques. The last phase broadens the scope of the research yet again, with findings from previous phases being applied differently, perhaps using a less selective sample or changing the elements of the approaches previously studied. At this point the cycle is repeated. Salkovskis (1995) suggests that research in the first phase tends to ensure strong effects. In the second phase, where there is more refinement of treatment and measurement integrity there is reduced risk of "false negative" type I errors (not measuring change when it has occurred) and "false positive" type II error (measuring change when no change has occurred). In a third phase, the widening of the hourglass, studies might again become more exploratory and focus on the specific nature of psychopathology in order to inform treatment.

This review of the literature places art psychotherapy research conducted with people who have intellectual and developmental disabilities in the UK at the first stage of the hourglass model. Publications have mainly presented anecdotal accounts of clinical practice that seek to apply theory in order to understand or explain therapists' observations.

To develop the evidence base for art psychotherapy in the subject area investigating the effectiveness of the treatment and using an experimental design would appear logical and in keeping with the hourglass model.

CHAPTER 3: DESIGN AND ANALYSIS IN SINGLE-CASE RESEARCH

3.1 Introduction

The aim of single-case experimental research is to give the strongest scientific demonstration of a causal relationship. Uncontrolled or anecdotal case studies can provide a useful backdrop for single-case experiments, particularly in generating hypotheses to be subjected to more rigorous testing (Kazdin, 2011). Whilst acknowledging the value of anecdotal case studies Kazdin (2011) points out that uncontrolled case studies have little in common with experimental designs seeking to establish scientifically valid inferences.

This chapter seeks to present single-case experimental and quasi-experimental design as a valid research methodology appropriately chosen for use in this research. Key themes explored in the chapter include

- the role of single-case design in being able to draw valid inferences about causal relationships between processes and outcomes in single-subject treatment studies;

- the use of mixed methods or hybrid approaches to combine and corroborate findings from quantitative and qualitative data within a single case;

- testing findings by presenting a plausible alternative hypothesis for change.

Two major bodies of thought have been considered during the development of this chapter: Alan E Kazdin's (1992, 2011) extensive body of work on single-case research design, and Robert Elliott's (2002) demonstration of a "hybrid" mixed methods single-case design. Elliott's (2002) work applies criteria for evaluating the presence of non-therapy explanations for change. It is an approach that can be placed within the context of "change process research" (Greenberg, 1986) in seeking to identify and describe the processes within therapy that bring about therapeutic change.

Researching treatment using single-case studies raises a number of challenges. Kazdin (2001) lists eight key questions for treatment research. Whilst it may not be

possible to address each question within a single-case design the list does provide a helpful guide for setting aims in treatment research.

1. What is the impact of treatment relative to no-treatment?

2. What components contribute to change?

3. What treatments can be added (combined treatments) to optimize change?

4. What parameters can be varied to influence (improve) outcome?

5. How effective is this treatment relative to other treatments for this problem?

6. What patient, therapist, treatment, and contextual factors influence (moderate) outcome?

7. What processes within or during treatment influence (mediate) outcome?

8. To what extent are treatment effects generalizable across problem areas, settings, and other? (Kazdin, 2001, p. 147).

A number of approaches used to investigate treatment efficacy in single-case studies will be discussed. Some single-case research designs do incorporate methods for comparing treatment with a no-treatment or baseline condition. Single-case designs that explore the components of therapy contributing to change, and factors that moderate or mediate outcome will be explored. Elliott's (2002) approach to single-case study is looked at in detail and placed within the wider context of "significant events studies" (Elliott, 2010). These research designs seek to address many of the questions which Kazdin (2001) has identified as being relevant for treatment research.

The chapter concludes with an overview of the research design. Four separate single-case treatment studies have been carried out within the research in order to identify (a) if change has occurred, (b) if a plausible link between the treatment and outcome can be made, and (c) what processes influenced outcome.

3.2 The Single-Case Experiment

Brockardt, et al. (2008) suggest that single subject designs can be viewed alongside common group designs as a viable approach to expanding knowledge in central questions such as whether, how, and for whom psychotherapy works. A number of authors, writing on subjects relevant to this study, (art therapy, psychodynamic psychotherapy with people who have intellectual disability, and research conducted in complex forensic settings), have endorsed the use of single-case experimental designs, for example (Beail, 2004; Davies, Howells, & Jones, 2007; Gilroy, 2006).

Standard single-case designs (Kratochwill & Levin, 1992) seek to reduce the possibility of type I errors (observing change when no change is present) and type II errors (not observing change when change is present). A good design will remove all threats to internal validity by eliminating explanations other than those of the different treatments being investigated (Todman & Dugard, 2001). This is considered to be a "true experiment". Quasi-experimental designs are problem-solving and seek to manage threats to internal validity, making them implausible, rather than categorically being able to rule them out (Kazdin, 2011).

There are three important features within single-case study designs that lead to improved internal validity (a) using a systematic approach and collecting quantitative data (as opposed to anecdotal accounts), (b) using multiple assessments of change over time and (c) measuring the intervention across multiple cases. Change is indicated by observing improvements in previously chronic or stable problems (Kazdin, 2011).

Even with a sound attempt to reduce threats to internal validity in single-case studies it should be recognised that "a causal relation is a judgement" (Haynes & O'Brien, 2000 p.162). One important principle in establishing causality is that of "parsimony", seeking the simplest and clearest explanation for change among a number of competing alternative explanations (Kazdin, 2011). When making a judgement about causality there is

a danger that, when faced with a range of indicators, a disparity in the emphasis placed upon one of them will result in a different set of conclusions. Once causality has been cautiously attributed the next stage is to render alternative explanations for the change implausible by testing a "plausible rival hypothesis" (Kazdin, 2011). Given the difficulties in establishing causality Haynes and O'Brien (2000) propose four conditions for inferring that two variables have a causal relationship in behavioural and psychological inquiry.

1. The two variables must co-vary, having a functional relation or shared variance (co-variation).

2. The hypothesized causal variable must reliably precede the identified response (temporal precedence).

3. There must be a logical mechanism for the hypothesized causal relation; a plausible or logical account must be shown.

4. Alternative explanations for the observed co-variance must be reasonably excluded via a rival hypothesis for change (nonspuriousness).

Within single-case designs, repeated measures and continuous measurement of the subject across phases are a defining feature (Kazdin, 2011). Continuous measures provide a clear assessment of the influence of an independent variable (intervention) upon a dependent variable (performance or behaviour). A-B-A-B designs, also referred to as withdrawal or reversal designs, are a standard approach applied in single-case experiments. These designs rely upon continuously assessing performance or behaviour across phases, with the expectation that the intervention phase will differ (improve) from the established baseline. Baseline measurement is an important feature in this design although there are many variations. A basic assumption is that change in baseline trend is observed during the intervention phase and after the withdrawal of the intervention a return to baseline conditions would lead to the re-emergence of the target behaviour. The repetition of these

phases assesses the impact of the intervention on the target behaviour. Confidence in the intervention increases the more times the effect is demonstrated across repeated phases.

Two-phase (A-B) studies have been applied with positive results, for example Thompson and Beail (2002) used this approach to demonstrate a behavioural and psycho-educational programme with a man who had severe intellectual disabilities. A-B-A single-case study approaches have also been used to assess cognitive and psychodynamic psychotherapy with people who have intellectual disabilities, for example Kellett, Beail, Bush, Dyson, and Wilbram (2009). Unlike classic targeted behavioural experiments, where the withdrawal of the intervention might see a return to baseline levels, there is an expectation that successful psychotherapy will result in carry-over effects from the intervention being maintained in follow-up.

3.2.1 Approches to statistical analysis in single-case designs.

As data is often collected across phases it is perhaps inevitable that methods of trend and time-series analysis are commonly associated with single-case experiments. See (Kazdin, 2011) for a recent review of methods used for visual inspection and statistical analysis of data in single-case studies.

Other statistical approaches have been used in single-cases, the use of Mann-Whitney U and Kruskal-Wallis tests can be applied in alternating treatment designs (phases) (Busk & Marascuilo, 1992), but the validity of such tests is brought into question in some conditions (as the number of tied ranks increases) (Todman & Dugard, 2001).

When assessing trend in single-case studies visual inspection is commonly applied although studies have shown this approach to be problematic, indicating that visual analysis needs careful consideration (Kazdin, 2011; Parsonson & Baer, 1992). Despite its limitations, visual inspection of the trend and variability in data can be beneficial, and this approach is advocated (Kazdin, 2011). The use of trend lines, such as linear trend and least

squares regression, can have an advantage in making outliers less influential within the overall inspection and trend analysis (Franklin, Gorman, Beasley, & Allison, 1997). Statistical process control has been demonstrated as a valuable tool in healthcare and rehabilitative research in being able to identify causes linked to data variability and outliers. Statistical process control also provides a clear set of rules for statistical trend analysis of continuous data (Callahan & Barisa, 2005).

Social comparison methods have been applied in single-case studies and provide a useful indication of clinically meaningful change particularly when comparison is made with an equivalent clinical population or normative sample (Crawford & Howell, 1998). The comparison is based upon the assumption that clinically important changes can be detected if the participant's behaviour or symptoms are brought within "normative" levels (Kazdin, 2011). This form of benchmarking in single-case studies is a useful alternative to approaches which provide a comparison of matched group samples when evaluating an intervention.

Traditional statistical frequentist approaches and more recent Bayesian applications of statistical analysis have been demonstrated as sound methods for comparing an individual test score to a control or normative sample (Crawford & Garthwaite, 2007). The Bayesian approach to inference often presents data in a probabilistic statement, rather than either being on one side or the other of estimated parameters or hypothesis-testing, through assessing the probability of chance findings. "Prior" distribution is used to show the information or data that is available prior to the sample data being collected. This "prior" information is then combined with the collected data (using Bayes theorem) to provide the "posterior" distribution, couched in terms of "likelihood" or probability.

Todman & Dugard (2001) have questioned the use of Bayesian statistical approaches in single-case research but Crawford & Garthwaite (2007) present compelling evidence for its application in small samples. Participant test scores are compared to those

of a comparative control sample resulting in an estimate of the percentage of the control population that would obtain a score lower than the participant (Crawford & Garthwaite, 2007).

3.3 Mixed Methods Research

3.3.1 The paradigm debate in mixed methods research.

Creswell (1994) used the term "mixed-methodology", a term no longer applied and replaced by "mixed methods", when attempting to define models of combined designs. The history of multitrait or multimethod research and decades of debate regarding the philosophical and theoretical thrust of mixed methods are well documented in the literature (Johnson & Onwuegbuzie, 2004; Morse & Niehaus, 2009; Teddlie & Tashakkori, 2009; Todd, Nerlich, McKeown, & Clarke, 2004; Yin, 2006). This methodological debate, sometimes referred to as "the paradigm wars" (Johnson & Onwuegbuzie, 2004), although luckily little blood was spilt, sought to resolve ontological and epistemological concerns.

The philosophical and theoretical perspective underpinning mixed methods approaches have been closely linked with "pragmatism", originating in the writings of Charles Peirce (Hookway, 2004). Within a pragmatist approach there is a strongly valued notion that finding a causal relationship is possible, whilst acknowledging that the relationship may be transitory and hard to identify (Teddlie & Tashakkori, 2009). Pragmatist research is driven by the research question and both narrative and numeric data are equally valued alongside a wide range of methodological tools available to answer the question.

Although mixed methods research has been presented by some as an alternative methodological movement supported by pragmatist theory, such claims have been challenged. "Ideologically, mixed methods covers for the continuing hegemony of positivism, albeit in its more moderate, postpositivist form" (Giddings, 2006, p. 195). There is a view that mixed methods studies can apply forms of analysis and "truth finding"

which are closer to positivism. This has been likened to a "Trojan Horse" for positivism which can carry other "paradigmatic" passengers (Giddings & Grant, 2007). For example, when qualitative methods "exploring meaning" use quantitative methods to confirm, validate or corroborate findings (or vice versa) a "positivistic" orientation is invoked (Crotty, 1998). Crotty (1998) gives a comprehensive overview of the origins of post-positivism describing a "humbler" scientific approach. Outcomes are not considered totally objective and the validity of claims are tentative and qualified relying upon the reporting of methods and processes of research to provide credibility.

> …we may be presenting our findings as objective truths, claiming validity, perhaps generalisability, on their behalf. In that case, we are calling upon people to accept our findings as established fact, or at least as close to established fact as our research has enabled us to reach. On the other hand, we have put on the data. In that case we are inviting people to weigh our interpretations, judge whether it has been soundly arrived at and is plausible (convincing, even?), and decide whether it has application to their interests and concerns. (Crotty, 1998, p. 41)

Within mixed methods research pre-planned procedures and methods of data collection and analysis are considered by some to add rigour to study designs. "The investigators know the reasons that both types of data are needed, and they state these reasons. Also, rigour is added when the authors report detailed quantitative and qualitative procedures and used mixed methods terms to describe their study" (Cresswell & Plano-Clark, 2007, pp. 163-146). Others have questioned this approach, pointing out that use of specific mixed methods terminology, in itself, does not add rigour (Symonds & Gorard, 2008). This school of thought goes further, suggesting that

Mixed methods is in danger of acting against its own aims by prescriptively inhibiting new growth in research. A case is, therefore, made for dropping the paradigms altogether and for a rebirth of real-life research from the ashes of mixed methods acting against its own aims by prescriptively inhibiting new growth in research. (Symonds & Gorard, 2008, p. 2)

In part, this critique is based upon some valid concerns that mixed methods approaches have the potential to encompass an exhaustive category of research. Despite these differing schools of thought, mixed methods research approaches have developed strongly with specific terminology being used to describe a large number of differing research designs.

3.3.2 Mixed methods data collection and analysis.

Both quantitative-deductive and qualitative-inductive logic can be applied within mixed methods analysis. This allows for the intentional integration of statistical and thematic data in a single study (Teddlie & Tashakkori, 2009). Approaches used to corroborate qualitative and quantitative results within a single study have been attended to by Morse and Niehaus (2009). They advocate an orderly and planned approach to data collection and analysis providing a typology and shorthand notation for specific mixed methods terminology. This does differ from some other approaches which seek to synthesise data from the outset and remove what is considered to be the unnecessary use of terminology in reporting qualitative results (Sandelowski, 2007). In contrast to this Morse and Niehaus (2009) advocate a sequential presentation of qualitative and quantitative findings. This approach predominantly focuses upon keeping qualitative and quantitative methods distinct within a single mixed methods study. Providing continuity within methods, it is argued, maintains the integrity of methods with the "form of findings" being derived from the underpinning methodology (Morse & Niehaus, 2009). Once qualitative

and quantitative results have been analysed the separate findings are corroborated at a point of interface. At this point the integration and synthesis of results takes place (Morse & Niehaus, 2009).

A review of twenty-two mixed method studies published between 1989 and 2002 in the counselling psychology literature identified six main types of mixed methods research being used (Hanson, Creswell, Clark, Petska, & Creswell, 2005). One particular example, "concurrent triangulation design" is illustrative of studies which place equal status upon qualitative and quantitative data.

> In concurrent triangulation designs, quantitative and qualitative data are collected and analyzed at the same time. Priority is usually equal and given to both forms of data. Data analysis is usually separate, and integration usually occurs at the data interpretation stage. Interpretation typically involves discussing the extent to which the data triangulate or converge. These designs are useful for attempting to confirm, cross-validate, and corroborate study findings. (Hanson, et al., 2005 p. 229)

Within case study research, "triangulation" of data, comparing separate data sources and measures in order to confirm findings, is a widely used and understood approach. Jick (1979) credits Campbell and Fiske (1959) with the development of the origins of triangulation in social sciences through "multiple operationism". Triangulation has been given specific attention within qualitative research, for example (Creswell, 1994; Mathison, 1988; Seale, 1999; Stake, 1995; Webb, Campbell, Schwartz, & Sechrest, 2000; Yin, 1989, 1993). Bloor (1997) is one noted exception to a broader view that triangulating data is generally considered to add strength and validity to research findings. The corroboration of multiple measurements of change is considered to offer the potential for greater confidence to be placed in making inferences about causal relationships.

Once a proposition has been confirmed by two of more independent measurement processes, the uncertainty of its interpretation is greatly reduced. The most persuasive evidence comes through a triangulation of measurement process. If a proposition can survive the onslaught of a series of imperfect measures, with all their irrelevant error, confidence should be placed in it. Of course, this confidence is increased by minimizing error in each instrument and by a reasonable belief in the different effects of the sources of error. (Webb, et al., 2000, pp. 3-4)

3.4 Elliott's "Hybrid" Single-Case Research Design

Elliott's (2002) Hermeneutic Single Case Efficacy Design (HSCED) uses a "hybrid" mixed methods design which makes use of quantitative outcome data (without baseline measurement), descriptive process observations and a qualitative post-therapy interview.

Elliott's work on single-case study (Elliott, 2002, 2009) is, to some extent, based upon concerns that traditional and highly valued "gold standard" research methods such as the RCT do not always adequately demonstrate a causal link through comparison of a control group and a treatment group; "RCTs are 'causally empty' offering conditions under which inferences can be reasonably made but providing no method for truly understanding the specific nature of the causal relationship" (Elliott, 2002, p. 2). Specific criticism is directed to some controlled studies where, it is argued, a "plausible account" for change is the missing condition. Bohart and Humphreys (2000) also make the point that some manualised therapies delivered within RCTs, when closely scrutinised, contain processes and interactions on many levels that are highly complex, non-linear and interactive.

Bohart and Boyd (1997) consider the complexity of therapy and introduce the idea of "hard" and "soft" causality, describing hard causality as the accounts of therapy that

only report changes as a "linear mechanistic chain reaction leading to the outcome" (Bohart & Boyd, 1997, p. 4). "Soft" causality identifies therapy as providing supportive conditions which can increase or reduce the probability of change in certain areas.

> ...therapy is really the context, the set of defining conditions or parameters, or the set of limits or constraints if you will, which define the boundary conditions within which a complex interactive process can develop and range in a variety of ways with a variety of outcomes. As such, it is meaningless to talk about A causing B. At best we will get "soft" causality. That is, that given this set of boundary conditions, a certain set or range of outcomes becomes more likely, and another set or range of outcomes becomes less likely. But all we can expect is an increase in probability of a certain range of outcomes. (Bohart & Boyd, 1997, p. 4)

This probabilistic approach to understanding change also alters the assumptions that are placed upon events within therapy sessions when seeking to construct a plausible account of change. Bohart, Tallman, Byock, and Mackrill (2000) pursue this logic using novel approaches such as the "research jury" where a panel of experts considers the evidence for and against changes reported within psychotherapy research. A similar approach has also been developed by Elliott (2009) using a team of researchers to assess a single case. Researchers are split into two groups, the first group presenting an "affirmative case" which shows the participant's positive change within therapy, followed by a "sceptic case" which provides an equally plausible alternative explanation for the apparent changes (Elliott, 2009; Stephen & Elliott, 2011).

Within HSCED (Elliott, 2002) qualitative interviews are used to confirm, disprove or corroborate quantitative results indicating that the study design does have post-positivist intentions whilst applying mixed methods. Elliott's (2002) use of the term "hermeneutic" within his approach to single-case research design warrants further consideration.

There is a direct link between critical hermeneutics (Habermas, 1984) and critical inquiry in qualitative research (Crotty, 1998). The traditional 20th century understanding is that hermeneutics explores philosophical and epistemological questions about how the world can be understood (Gadamer, 1984; Giddens, 1976; Ricoeur, 1978). The basis for hermeneutic study is closely related to the theory of interpretation of texts, the hermeneutic circle, which can be briefly summarised as looking at the meaning of the whole of the text informing the meaning of parts of the text, and vice versa. This principle has been widely transferred to, and developed within, social science research, particularly in analysis of text generated from qualitative interviews (Smith, Flower, & Larkin, 2009). In an applied way, Rennie (2007, 2009) also locates hermeneutics within aspects of the development of humanistic psychology and considers the potential for integration of notions of realism and relativism in qualitative psychology research. Rennie (2007) identifies the resolution of ontological and epistemological issues in this area as an on-going project, in that "it needs to examine critically the ways in and extent to which hermeneutics is indeed operative in existing approaches to qualitative research, and to the point where they can justifiably be put under one roof" (Rennie, 2007, p. 17).

Elliott's (2002) HSCED anticipates phenomena such as the "double hermeneutic" within post-therapy qualitative interviews. The double hermeneutic is seen as a process where "...the participants are trying to make sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51). Rennie describes this effect more explicitly, "As agents, people may choose the way in which they represent their experience, and, indeed, may opt either to misrepresent it or not to disclose it" (Rennie, 2000, p. 483).

Researcher reflexivity and the demonstration of trustworthiness of observations are maintained as an important standard in qualitative research (Elliott, Fischer, & Rennie,

1999; Morrow, 2005). In Elliott's (2002) HSCED some consideration is given to "researcher subjectivity" and "reflexivity". Reflexivity is described as

> A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions (Malterud, 2001, pp. 483-484).

Management of researcher subjectivity is incorporated into HSCED through a process that includes critical reflection. "...Critical reflection on the claim that therapy-caused change is also required through maintaining awareness of one's personal expectations and theoretical presuppositions while systematically searching for evidence that casts doubt on one's preferred account" (Elliott, 2002, p. 3). A "good faith effort" is made to present alternative explanations for participant change (Elliott, 2002).

3.4.1 Elliott's tests of causality and alternative explanations for change.

Elliott's (2002) work sets out five distinct tests of causality in order to make valid inferences linking therapy to outcomes: (1) retrospective attribution; (2) process-outcome mapping; (3) within-therapy process-outcome correlation; (4) early change in stable problems; (5) event-shift sequence. Direct evidence should be seen in at least two of the five tests when linking therapy process to outcome (Elliott, 2002). These tests are described in more detail below.

3.4.1.1 Retrospective attribution.

Elliott's HSCED (2002) makes use of retrospective attribution, which allows the participant to give a post-therapy account of their experiences within therapy, which may

be positive or negative. Therapy efficacy can be considered if the participant attributes changes to events within therapy. Confidence in the plausibility of the participant's post-therapy account is increased if a specific example of a helpful event is given. This approach has been demonstrated in studies which incorporate post-therapy qualitative interviews where participants are asked to describe elements of therapy that they found helpful (Elliott, Slatick, & Urman, 2001).

3.4.1.2 Process-outcome mapping.

Process-outcome mapping is intended to show that post-therapy changes correspond with specific events or processes taking place within therapy (Elliott, 2002). It is also helpful if processes of this kind are reported by the participant at post-therapy interview. Investigating process-outcome mapping occurs through identifying post-therapy changes that correspond with processes in therapy. The inquiry into process-outcome mapping within the case can be led by the participant's retrospective attribution.

3.4.1.3 In-therapy process-outcome correlation.

Elliott (2002) suggested that process variables, such as post-session ratings completed by the therapist, for example "adherence to treatment principles", might co-vary with the participant's own rating of week-to-week shifts in problems. The assumption has been that the participant's and the therapist's scores should correlate. Stiles (1988) had put forward the view that it is not possible to infer causation from a correlation as too many additional or unmeasured factors are present in psychotherapy. No evidence for this particular therapy change link have been indicated in single-case studies using this approach (Elliott, 2002, 2009). Elliott's (2010) view has been modified regarding in-therapy process-outcome correlation as this test is problematic.

3.4.1.4 Early change in stable problems.

Therapeutic influence can be inferred when therapy coincides with changes in long-standing problems (Elliott, 2002) (as measured against baseline conditions). This is an established theory in single-case designs. Interpretation of variation in trend is related to treatment effect by observing change in previously chronic or stable problems (Kazdin, 1992). These are also referred to as "projections of performance" by Kratochwill and Levin (1992), in which "the history of the case suggests problems of long duration that have proved intractable to treatment previously" (Kratochwill & Levin, 1992 p.5). Preference for observation of effect impact on stable problems can differ. Kratochwill and Levin (1992) suggest that effect impact is immediate within the treatment phase, whilst Kazdin (1992) extends this requirement to include both immediate or marked effects after the intervention.

3.4.1.5 Event-shift sequences.

Event-shift sequences occur when "an important therapy event may immediately precede a stable shift in client problems" (Elliott, 2002, p. 7). This can be seen when a specific event or sequence of therapy sessions is logically related to reduced symptoms, such as bereavement work leading to reduced levels of distress. Event-shifts may be identified through measurable change in trend, positive or negative observable shifts, which can be linked to events taking place during the treatment phase. It is also possible to identify events preceding change that may be unrelated to therapy.

Event-shift sequences and process-outcome mapping are very similar; process-outcome mapping looks back at how post-therapy changes correspond with events and processes in therapy, event-shift sequences are identified through important events in therapy that immediately precede change. This combined approach, looking back and

ahead within one case, has inevitable cross-over but allows for a thorough investigation of the links between events, processes and outcomes.

3.4.2 Elliott's alternative explanations for change.

If a clear causal inference has been made between therapy process and outcome in two of the five tests Elliott (2002) applies eight further tests in order to assess if the change was due to the therapy or another influence.

There is a need to demonstrate that changes were not (1) trivial or negative; (2) due to statistical or measurement error; (3) induced by relational effects; (4) due to expectancy effects in the participant. A range of plausible alternative influences upon changes observed in the participant are also considered, such as: (5) self-correction or self-help; (6) extra-therapy events; (7) psychobiological effects; (8) reactive effects of research (Elliott, 2002).

3.4.2.1 Trivial or negative change.

Trivial or negative change can be suspected if the participant describes change in ambivalent terms to such a degree that it casts doubt upon its importance. Also, there may be evidence of no change or a deterioration in trend or measures.

3.4.2.2 Statistical or measurement error.

Use of statistical analysis does have an important part to play, but it is recommended that tests should be adequately justified, particularly within single-case designs. Multiple pre-tests are recommended. Measures used should be reliable and attention should be given to the possibility of regression to the mean and experiment-wise error when assessing results (Elliott, 2002). A number of statistical approaches are reliable and can be used in small-n research and single-case studies. One example is the "reliable

change index" (RCI) (Jacobson & Truax, 1991) which gives a value for comparison of repeated test scores against the bounds of measurement error.

3.4.2.3 Relational effects.

Another alternative hypothesis is that change might be due to superficial attempts by the participant to please the therapist or researcher. It is plausible that relational and interviewer effects can influence the processes of gathering data in-therapy and during qualitative post-therapy interview (Webb, et al., 2000). Within analysis of qualitative post-therapy interview there are a number of indicators that can increase confidence in the plausibility of the account. Bohart and Boyd (1997) present criteria for assessing the plausibility of a client's post-therapy attributions, suggesting that the participant should give specific, idiosyncratic and differentiated accounts, containing a mixture of positive, negative, and neutral descriptions.

3.4.2.4 Expectancy effects.

Expectancy effects may take place if the participant has held high expectations that therapy should have helped. Such effects are not considered to be immune from longitudinal measurement with potential for a participant to respond to having invested a great deal of time and effort in the therapy. Detailed content in post-therapy interview responses can indicate a more credible report, particularly if participants express their surprise about change or report their initial scepticism about therapy followed by positive attribution (Elliott, 2002, 2009).

3.4.2.5 Self-correction or self-help.

Is the change an easing of a short-term or temporary problem? It is possible that the participant is in a temporary state of distress that reverts to normal functioning (Elliott,

2002). Self-correction, problem-solving, or self-help processes may be influential in these circumstances. Therapy process notes can provide a useful source of information regarding self-help strategies employed by the participant. Direct questions about influences outside of therapy that may have helped someone change can also be used at a post-therapy interview. When self-help strategies are identified they can be corroborated against continuous measures. It is possible to argue that established problems of long duration have a reduced likelihood of responding to self-correction.

3.4.2.6 Extra-therapy events.

Influential events occurring outside of therapy can include life events such as changes in relationships, changes in occupation, changes in recreational activities and changes in physical health. Such "...extra-therapy events can contribute both positively and negatively to therapy outcome and have the potential to obscure the benefits of a successful therapy and to make an unsuccessful therapy appear effective" (Elliott, 2002, p. 14). To address this problem participants are asked at a post-therapy interview what they think has brought about the changes they have identified and at this point extra-therapy events and influences can be identified (Elliott, 2008; Elliott, et al., 2001). Therapist process notes and audio session recordings can also be reviewed in order to gain important information about extra-therapy events. If specific timing of extra-therapy events is established this can be corroborated with other data.

3.4.2.7 Psychobiological effects.

Psychobiological causes, such as the introduction or change of medication near the start or during therapy, are a particular problem for psychotherapy research. Medication changes can be monitored throughout therapy and again at post-therapy interview. Elliott (Elliott, 2002) also proposes that potential influence of herbal remedies, or hormonal

effects of recovery or stabilization after a major physical illness should be considered.

Elliott's (2002, 2009) approach to managing extra-therapy events of this kind is helpful in

that the presence of such events does not nullify the research; instead their influence can be

placed within the bounds of reasonable judgement.

3.4.2.8 Reactive effects of research.

The hypothesis that participant outcome is affected mostly as a function of being in

research is also considered. Phenomena such as "the guinea pig effect", resulting from the

awareness of the participant being tested, have long been recognised (Selltiz, Jahda,

Deutsch, & Cook, 1959). Research effects can include the interactive and reactive effects

of testing and assessment interviews which may have a potentially therapeutic influence.

Research interviews and self-report measures may have the potential to promote positive

self-monitoring and lead to improved performance. Measurement acting as a change agent,

or the influence of "practice effects", demonstrated between pre- and post-test are

important areas for consideration (Webb, et al., 2000). The participant may have been

influenced by having had either a positive or negative relationship with research staff.

Additional negative influences can arise from specific research activities which may

appear overly challenging or time consuming for the participant. The impact of research

activity upon the outcome of a participant is difficult to establish and corroboration of a

number of sources of information within the case record may be required in order to

provide evidence of this effect (Elliott, 2002).

3.5 Change Process Research

Single-case studies have used increasingly sophisticated approaches to examine

phenomena taking place in therapy with greater specificity. Single-case research driven by

and investigating theory in clinical practice has been seen as an important area of study.

"Theory-based, question-driven, single-case research, in which disconfirmation remains a real possibility, is necessary within psychotherapy" (Hillard, 1993, p. 10). Single-case methodology is well suited to investigating change-process through identifying mediators and specific events influencing treatment outcome. Even if a treatment is demonstrated to be effective important questions about what processes caused the change can still remain unanswered (Greenberg & Malcolm, 2002).

In studying the process of change, both beginning points and endpoints are taken into account, as well as the form of the function between these points. With processes of change as the focus of investigation, the emphasis is not on studying what is going on in therapy (process research) nor only on the comparison of two measurement points before and after therapy (efficacy research) but rather on identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy (Greenberg, 1986, p. 4).

Change process research places equal value upon exploring process and outcome in the investigation. Notable examples of change process research include those exploring therapeutic alliance as a relational variable within in-therapy process, for example (Martin, Garske, & Davis, 2000). Research investigating the assimilation of problems in psychotherapy has also made an important contribution to understanding in-therapy processes (Stiles, 2002; Stiles, et al., 1990). Using this model, Newman and Beail (2002) provide a detailed clinical case discussion of in-therapy process, assessing the content of psychological therapy sessions with a 25 year-old man with mild-to-moderate intellectual disability. A further study supported the findings, that people with intellectual disability

achieved increasing understanding of their problematic experience during psychotherapy (Newman & Beail, 2005).

Stiles (2007) identifies the potential for case-based, change process research to make a contribution to theory-building within psychotherapy. This can be achieved through collecting a rich case record which includes basic facts about the client, recordings of treatment sessions, practitioner's process notes, session-by-session assessments, repeated measurement, outcome assessments, post-treatment interviews, and other personal documents such as journals or diaries, poetry, artwork, letters or e-mail messages (Stiles, 2007).

One art psychotherapy study that investigated links between process and outcome has been identified. Greenwood, Leach, Lucock and Nobel (2007) present a case study linking therapy processes and artwork produced by the client during therapy with clinical outcomes. A 32 year-old female client had longstanding severe anxiety, fluctuating depression and travel phobia identified as chronic problems of long duration. The client was reported to have lacked co-operation with professionals and had had limited responses to psychological therapy, an anxiety management package and antidepressant medication.

The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) and CORE Short Form (CORE-SF) (Barkham, et al., 2001; Evans, et al., 2002) were completed by the client for the duration of the study. The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was completed at referral, before the therapy assessment, before therapy starting, at discharge and six months after discharge. Additional follow-up was completed one, two, and three years after discharge.

Therapy process information was linked to art work produced in long term therapy (233 sessions) which was categorised into seven distinct types based upon the client's descriptions, which in turn was linked to events in the treatment. The client's description of their art work included attributing meaning to a series of work such as "illustrative" images

made to explain to the therapist how she had felt. Categorised art work was then plotted against CORE scores collected during the treatment stages alongside sessions where no artwork was made. Higher CORE scores were associated with sessions where no art work was made and lower score were seen to match specific stages in the therapy. Trend in CORE scores indicated improvement during treatment including post-therapy CORE measures showing a reduction below the clinical cut-off, sustained at three-year follow-up. BDI scores reduced from a moderate to a normal range. Examples of extra-therapy events associated with high and low outlying scores for specific therapy sessions were also identified from process notes. Due to the long duration of treatment a cost/benefit analysis was carried out: the cost of therapy was calculated to be equivalent to a 26 day hospital admission.

3.5.1 Significant Events Studies.

Elliott's (2010) review of the strength and limitations of a number of approaches applied in change process research includes "quantitative process-outcome design", "the qualitative helpful factors design", "microanalytic sequential process design", and "the significant events approach".

Methodological features within significant events studies provide the opportunity to present more clinically relevant and representative models in psychotherapeutic work (Elliott, 2010).

> Significant events studies generally operate at a level of concreteness and explicitness (including frequent use of clinical examples and transcripts) close to practice, which gives greater natural appeal for therapists. They are particularly useful for explicating therapist implicit knowledge and translating findings into clinical microtheories (Elliott, 2010, para. 805).

Significant events studies include a strategy for identifying important moments in therapy, followed by qualitative sequential description of the events, which may also track multiple features of the participant's and therapist's processes. Significant events studies also use post-session and post-therapy outcomes in order to look for connections between within-session processes and outcome. This approach can also lead to theory-testing (Greenberg, 2007) or theory-building (Stiles, 2007). Such approaches have appeal, being highly flexible and amenable to a wide range of types of events and therapies (Elliott, 2010).

3.6 The Research Design

The methodological and design features that have been explored and highlighted within this chapter have been drawn upon and applied to the design, methods and analysis in this research.

Four of Elliott's (2002) five tests of causality are applied in the research design. Due to Elliott's (2010) revision of the HSCED design the test for "in-therapy process-outcome correlation" is not included in this research. Elliott's use of pre- and post-tests without baseline measurement have not been followed in this research in favour of Kazdin's (2011) recommendations for baseline assessment of a no-treatment condition prior to the intervention being introduced. The use of statistical process control and comparison of a participant's test scores to a normative control sample have been applied within each single-case. A diagram showing the five stages of the research design which corresponds with the description below can be seen in Figure 3.1.

1. *Hypothesis:* The research hypothesis, "art psychotherapy supports change" provides scope for detailed exploration of processes, outcomes and factors contributing to change within treatment research (Kazdin, 2001). Tests for conditions that enable inferences about causal relationships to be made are applied (Haynes & O'Brien, 2000).

2. *Distinct single-cases:* Four separate studies are included in the research. The original case was shifted one time period ahead (two weeks) into a new time series, with subsequent cases started at least one week following the previous case (Franklin, Gorman, et al., 1997). For convenience and to aid reporting, phases within each study are shown as A = pre-treatment, B = treatment and C = post-treatment. In this instance "C" should not be confused with notation that indicates that a new intervention has been introduced. Repeated measures, continuous measures, in-treatment measures/observations and post-therapy interviews have been conducted in each single-case study.

3. *Separate data analysis:* Quantitative and qualitative data is analysed and results are reported separately in each of the studies (Morse & Niehaus, 2009).

4. *Corroboration of results:* Integrating the different sources of information within the case takes place at this point. This has been described by Morse and Niehaus (2009) as a point of interface. Some additional features have been included in the design in order to support the corroboration and integration of different sources of information. In addition to Bohart and Boyd's (1997) eight signs of the plausibility of a participant's post-therapy interview account of change, an interview with the participant's named nurse has been included. The opinion from a member of the nursing team is corroborated with the participant's own retrospective attribution towards therapy. The participant's "specific change processes", their experiences of therapy, described in their own words at post-therapy interview, will be included.

The additional area of "change process theory" is included in order to provide further evidence of a "logical mechanism" or plausible account for change, that is, there is congruence between theory already developed in psychotherapeutic practice and the therapeutic processes identified within each case. Whilst this is not considered to follow

methods used for "theory-building" in single-case designs previously mentioned in this chapter there is potential for exploration of clinical micro-theories.

Four of Elliott's (2002) tests linking therapy process to outcome will be applied followed by the eight tests of alternative explanations for change. The integration of data from multiple sources of information, included in the rich case record, has provided the basis for each case to be conducted as a significant events study. Significant events studies identify important moments of therapy and multiple processes within therapy that are linked to outcomes (Elliott, 2010).

5. *Findings:* The findings of the research should demonstrate that the three aims linked to the hypothesis have been met within each single-case study: (a) to investigate if therapeutic change took place during or as a result of art psychotherapy; (b) to identify a plausible link between therapy and outcome (tested against alternative hypotheses); (c) to establish if there is congruence between the measurable outcomes, the processes by which change has occurred and broad psychotherapeutic theory.

Fig. 3.1 Research Design
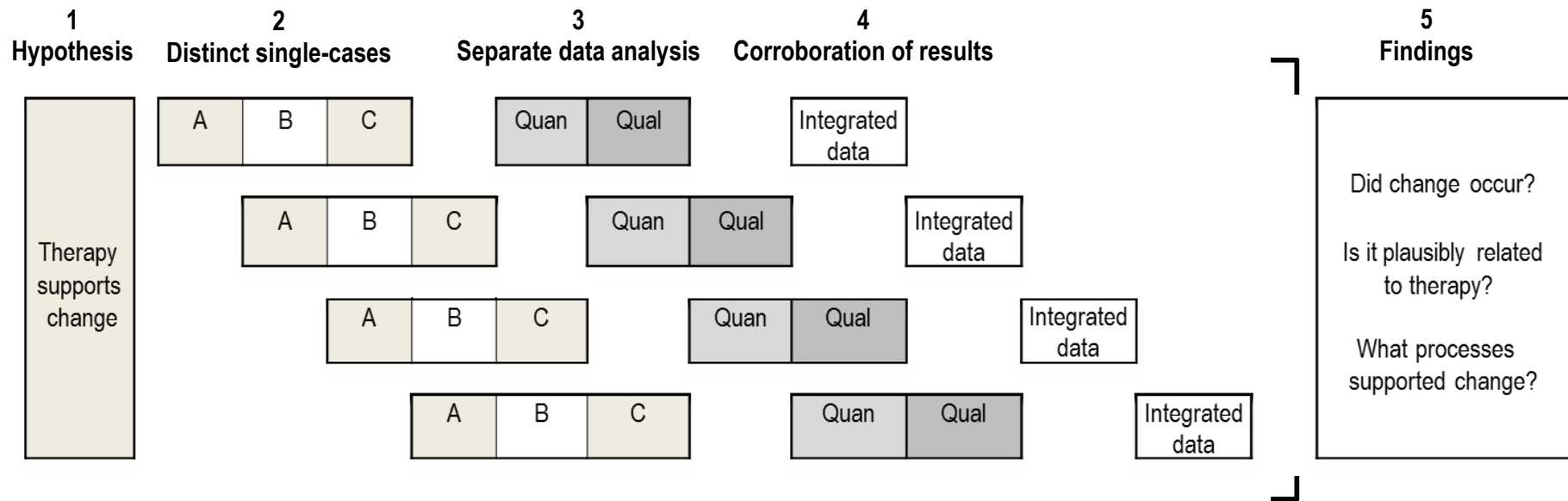
Note: A = Pre-Treatment; B = Treatment; C = Post-Treatment; Quan = Quantitative data; Qual = Qualitative data.

CHAPTER 4: METHODS

4.1 Setting

Northgate Hospital near Morpeth in the Northeast of England offers specialist forensic provision for people with intellectual and developmental disabilities. The hospital provides inpatient forensic services on a local, regional, and national basis. Patients treated at the hospital have been referred to the forensic service from other healthcare settings, the courts and prisons. Hospital provision at Northgate ranges from medium secure, low secure, and rehabilitation provision with accommodation for approximately 160 patients.

Participants in this study were selected from three units on the hospital site, one medium and two low secure wards. There is medium secure unit accommodation for 30 patients, which is split into four small houses, each operating separately and accessed via a central courtyard. Patients in this unit have a highly structured day which consists of ward-based activities, sports, gardening, day services, and education. One low secure unit provides accommodation for 26 patients within three flats, each operating separately. Patients can be moved between the flats depending upon the patient mix and any identified risks or changes to the level of observation they require. The other low secure unit consists of one building with two separate flats for 18 patients. A full mix of day services and activities is provided for patients, with some sessions such as sport and gardening being accessed off the unit in the grounds of the hospital. Other units on the site offer accommodation for smaller numbers of patients also requiring low security. These units are externally locked, but patients may be eligible for unescorted leave in the hospital allowing them to attend work and activity sessions without direct escorts or close supervision. The multi-disciplinary teams working on the units consist of nursing staff, psychiatrists, psychologists, art psychotherapists, speech and language therapists, and occupational therapists.

4.2 Participants

For the purposes of this research each participant is treated as a separate study (see Table 4.1). Two participants were selected from medium secure accommodation and two were selected from low secure accommodation. Although recruitment of participants did not specify their need to have the same index offence, all participants who were recruited had committed a sexual offence. In addition to intellectual and developmental disabilities, two participants, cases 2 and 4, had a diagnosis of personality disorder and one participant, case 3, had a diagnosis of Autistic Spectrum Disorder and Klinefelter's syndrome. Detailed information regarding each individual participant will be given in subsequent chapters.

Table 4.1

Study Participants

Case	Accom.	Age	IQ	Additional Diagnosis	Index Offence	Length of Detention (Months)
1	MSU	21	Mild	None	Sexual Offence & Violence	17
2	MSU	38	Mild	Antisocial Personality Disorder	Sexual Offence & Violence	26
3	LSU	23	Mild	Autistic Spectrum Disorder & Endocrine Disorder	Sexual Offence	27
4	LSU	28	Mild	Psychopathic Disorder	Sexual Offence	98

Note. MSU = Medium Secure Unit; LSU=Low Secure Unit.

4.2.1 Selection.

A convenience sample was taken and the selection process was based upon the premise that recruitment to the study should mirror existing practice for allocating patients to therapy within the service. The multi-disciplinary team (MDT) within each secure unit and the responsible clinician (RC), who had overall responsibility for each patient's case, were given information about the study and asked to identify patients who were clinically

suitable for the treatment. Eight potential participants were initially identified. Five patients were assessed as having met the inclusion criteria by the principal investigator. A decision was made not to include one patient who had met the study criteria but had recently completed an extensive period of art psychotherapy in an adolescent service prior to their transfer to adult services at Northgate Hospital.

4.2.1.1 Inclusion criteria.

1. An inpatient at Northgate Hospital

2. Have had a completed WAIS (Wechsler Adult Intelligence Scale) indicating an IQ of between 55 and 75.

3. Age 18 to 60 years.

4. Able to give informed consent.

5. Able to complete standardised mental health questionnaires validated for an intellectual disability population.

6. Some presentation of difficulties with anxiety symptoms, depressive symptoms, and / or interpersonal difficulties, such as difficulties in forming and maintaining relationships.

7. The participant's involvement in the study is supported by clinicians within the MDT including the RC.

4.2.1.2 Exclusion criteria.

1. Those with measured IQ scores below 55 and above 75.

2. Unable to give informed consent.

3. Those with no clinical indicators for psychological treatment.

4. Planned or expected discharge within 12 months of the start of the study.

5. Current requirement for frequent or ongoing management in seclusion facilities.

6. Those receiving active assessment or treatment for acute psychotic symptoms.

4.2.1.3 Consent procedure.

Individuals identified as potential participants were initially approached via their RC or their named nurse (the named nurse is allocated to a patient on the ward and works closely with them during their admission) and asked if they would like to consider taking part in the study. An associate psychologist then met with potential participants alongside a member of the nursing team and followed the consent procedure. Each component of the consent process was broken down into its constituent parts. Information was verbally presented in accessible language and accompanied by accessible "easy read" material (including symbols). Information sheets outlined treatment, confidentiality issues, and the participant's right to decline involvement without prejudice to their current or future treatment. The participant's understanding of each component was then checked carefully using the "Empirical Assessment of Capacity to Consent" (Arscott, Dagnan, & Kroese, 1998) for people with intellectual disabilities. Design of consent forms and information for the study were based upon recommendations from "understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability" funded by the Department of Health (Cook & Inglis, 2008).

For the "Letter to the Responsible Clinician" see Appendix 1; the "Study Information for Clinicians" can be seen in Appendix 2. The "Research Consent Procedure" can be seen in Appendix 3, followed by "Participant Information Sheet 1" in Appendix 4 and "Participant Information Sheet 2" in Appendix 5. The "Empirical Assessment of Capacity to Consent" can be seen in Appendix 6a followed by the "Participant Consent form 1" in Appendix 6b and the "Participant change interview consent form" in Appendix 6c.

Nursing staff, who worked closely with participants during the study, were recruited for interview three months following the end of the treatment phase. See Appendix 6d for the "Staff change interview consent form".

4.3 Measures

Study measures are divided into four types: repeated measures, continuous measures, in-treatment measures and retrospective attribution (see Table 4.2). The study "Assessment Schedule and Information" for the assessors conducting repeated measures can be seen in Appendix 7.

Table 4.2 *Data Collection Across Phases*

Data Collection	Administered by	Phase A Pre-Treatment (Baseline / Screen)	Phase B Treatment (Intervention)	Phase C Post-Treatment (Follow-Up)
1. Repeated Measures				
The Brief Symptom Inventory -18	Psychology Assistant	8 weeks pre & immediately pre	-	Immediately post & 12 weeks post
Glasgow Depression Scale for people with a Learning Disability	Psychology Assistant	8 weeks pre & immediately pre	-	Immediately post & 12 weeks post
Glasgow Anxiety Scale for people with and Intellectual Disability	Psychology Assistant	8 weeks pre & immediately pre	-	Immediately post & 12 weeks post
Rosenberg Self−Esteem Scale (adapted)	Psychology Assistant	8 weeks pre & immediately pre	-	Immediately post & 12 weeks post
2. Continuous Measures				
Daily Self-Rating Scale (Study Specific)	Participant self-report	Daily	Daily	Daily
Modified Overt Aggression Scale (MOAS)	Nursing Staff	*Weekly	Weekly	Weekly
Serious Untoward Incidents (SUIs) Recorded	Nursing Staff	**Monthly : 12 months pre	Monthly : 6 months	Monthly : 9 months post
3. In-treatment Measures & Observations				
Personal Problem Scale (Study Specific)	Participant self-report	-	Start & End	-
Relationship Anecdote Paradigm (adapted)	Therapist	-	Start & End	-
Therapist Observation Rating Scale (Study Specific)	Therapist	-	Each Session	-
Therapy Process Record (audio recording, notes etc.)	Therapist	-	Each Session	-
Participant selection of most important image	Participant self-report	-	End	-
4. Retrospective Attribution				
Change Interview (adapted) (Participant)	Psychology Assistant	-	-	12 weeks post
Change Interview (adapted) (Named Nurse)	Psychology Assistant	-	-	12 weeks post

Note: For continuous measures daily monitoring is completed for the MOAS and SUIs which are then summed and reported as either *weekly or **monthly totals.

4.3.1 Repeated measures.

For administration of repeated measures, participants were required to attend four meetings each lasting up to one hour with a psychology assistant over a period of eleven months. Testing took place eight weeks before therapy started, at the time therapy started, at the time therapy ended and at a twelve week follow-up. The psychology assistants administering the measures were all experienced in working with patients in the forensic service. Participants were tested individually in private rooms, either with the psychology assistant on their own or with a nurse escort being present. Each participant received an explanation of the procedure for completing measures (in an assisted completion format) and was offered breaks during the meeting if required.

4.3.1.1 Brief Symptom Inventory 18 (BSI-18).

The BSI-18 (Derogatis, 2000) is a self−report symptom inventory designed to be used as a screen for psychiatric disorders, and has been used as an outcome measure in medical and community populations. The BSI-18 scale is divided into three dimensions, somatisation, depression, and anxiety. The measure also generates a Global Severity Index (GSI) which indicates the respondent's overall emotional adjustment and psychopathologic status (Derogatis, 2000). The BSI-18 is a shorter version of the Brief Symptom Inventory (BSI) (Derogatis, 1993), a 53 item measure, which in turn is a shorter version of the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1994). The first five items are provided as an example of the type and style of questions, the instrument asks: "how much were you distressed by…" (1) "faintness of dizziness"; (2) "feeling no interest in things"; (3) "nervousness of shakiness inside"; (4) "pains in heart or chest"; (5) "feeling lonely". The 18 items are scored on a five point Likert scale with the responses, "not at all", "a little bit", "moderately", "quite a bit", or "extremely".

The BSI-18 was selected due to the reduced number of items that participants are required to rate and its focus upon common psychological disorders such as anxiety, depression, and somatisation. Items included in the BSI-18 are derived from the BSI and SCL-90-R which have both shown to discriminate effectively between clinical and community populations with intellectual disabilities (Kellett, Beail, Newman, & Frankish, 2003; Kellett, Beail, Newman, & Mosley, 1999). People with mild intellectual disabilities were shown to respond in a largely similar way to their non-disabled counterparts in a large proportion of the items in the BSI (Kellett, Beail, Newman, & Hawes, 2004). Using an "assisted completion format" with respondents with intellectual disabilities has also been shown not to unduly influence rating (Kellett, et al., 2004; Kellett, et al., 1999). GSI scores for the BSI have been shown to provide valid information on current emotional distress in groups with mild intellectual disabilities in residential care, for example (Endermann, 2005).

A value of 0.70 or above is considered acceptable when assessing internal consistency in psychometric measures using cronbach's alpha (Nunnally, 1978). The BSI-18 compares reasonably with the internal consistency for the equivalent dimensions in the BSI which are: somatisation, 0.80; depression, 0.85; anxiety, 0.81; and GSI, 0.90. Test-retest reliability for the BSI-18 measure is an estimate based upon the longer version of the BSI (Derogatis, 1993). The internal consistency and test-retest reliability for dimensions published for the BSI-18 (Derogatis, 2000) compared with two other studies can be seen in Table 4.3.

Scores of 63 or higher (based on community norms) are considered to be a "case" (Derogatis, 2000). "Caseness" or case rates have been reported to be a score of 64 and above for a male intellectual disability maximum-security hospital sample (n=45) with a mean length of stay of 63.3 months and an average age of 36.11 (SD=8.39) (Kellett, et al., 2003).

Like the SCL-90 and BSI the BSI-18 test T scores reflect percentile equivalents. A T score of 35 places the person in the 7th percentile, a score of 40 is on the 16th percentile, a score of 60 places the individual on the 84th percentile, and a score of 70 places the individual on the 98th percentile (Derogatis, 2000).

Table 4.3

BSI-18 Internal consistency (IC) and test-retest reliability

Study	IC					Test-retest				
	N=	SOM	DEP	ANX	GSI	*N*=	SOM	DEP	ANX	GSI
(Derogatis, 2000)	1,134	.74	.84	.79	.89	60*	.68*	.84*	.79*	.90*
(Andreu, et al., 2008)	200	.78	.88	.71	.89	103	.76	.82	.68	.76
(Meachen, Hanks, Millis, & Rapport, 2008)	176	.75	.84	.83	.91	34	.67	.63	.57	.66

Note: * = test-retest estimate based upon the BSI (Derogatis, 1993). SOM=Somatisation; DEP=Depression; ANX=Anxiety; GSI=Global Severity Index.

4.3.1.2 Glasgow Anxiety Scale for people with Intellectual Disability (GAS-ID).

The GAS-ID (Mindham & Espie, 2003) is a 27 item self-rating scale of anxiety symptoms for people who have mild intellectual disability. The maximum possible score on this scale is 54, with subtotals for component scales, "worries", "specific fears", and "physiological symptoms" (Mindham & Espie, 2003). The first five questions are shown as examples with the additional prompting questions in italics, (1) Do you worry a lot?*…feel worked up/wound up/uptight…*; (2) Do you have lots of thoughts that go round in your head?*…thoughts that you can't stop/come from nowhere…* ; (3) Do you worry about your parents/family? (4) Do you worry about what will happen in the future?*(tailored to the individual:) e.g. What will happen if you can't live with your mum anymore?* (5) Do you

worry that something awful might happen? Item responses are scored on a three-point Likert scale with the statements "never", "sometimes" and "always".

The GAS-ID has been shown to discriminate between anxious and non-anxious subjects. Comparison included anxious intellectual disability subjects, anxious non-intellectual disability subjects, and non-anxious intellectual disability subjects. There was no significant difference between the two anxious groups (Mindham & Espie, 2003). Tests for specificity (excluding people without anxiety) and sensitivity (including those with a diagnosis of anxiety) indicate that a score of 15 is optimal as the clinical cut-off (Mindham & Espie, 2003).

Criterion reliability was assessed using the Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988) and analysed using Spearman's rank order correlation coefficient; this test indicated a criterion validity of 0.72; $P<0.001$. Internal consistency for the GAS-ID total scores when administered to intellectual disability participants is reported to be 0.96, "worries" 0.92, "fears" 0.80, and "physiological symptoms" 0.90. Test-retest reliability is reported to be 0.95, "highly satisfactory" (Mindham & Espie, 2003).

Mean GAS-ID scores for anxious and non-anxious intellectual disability groups are presented in graph format (Mindham & Espie, 2003). In order to establish accuracy of mean scores and standard deviation for different groups' correspondence with the GAS-ID, author J. Burns (née Mindham) has helped clarify results based upon graph measurement. The anxious intellectual disability group (n=19) mean score that has been provided is 31 (SD=10) with a mean score of 32 (SD=10) for the anxious non-intellectual disability group (n=19). The intellectual disability non-anxious group (n=16) had a mean score of 9 (SD=10).

The GAS-ID is routinely used with the Northgate forensic population and a local control sample has been taken from 51 men with a mean age of 31.2 (range 20.9-58.8) (SD=9.4). This provides comparative data for individual test scores. The mean GAS-ID

score for this local forensic intellectual disability sample is 19 (SD=9.6). A table of the intellectual and developmental disability local forensic hospital control sample GAS-ID scores can be seen in Appendix 8.

4.3.1.3 Glasgow Depression Scale for people with a Learning Disability (GDS-LD).

The GDS-LD (Cuthill, Aspie, & Cooper, 2003) is a valid and reliable depressive-symptom rating scale for people with mild to moderate intellectual disability. The rating scale was designed to be used in an assisted self-completion format with instructions and prompts for the test administrator. Answering the questions can take from 10-15 minutes depending upon the respondent's ability and level of co-operation. The "present state" of the respondent's symptoms are assessed for the previous week. The GDS-LD measure includes 20 questions. The first five questions are shown as examples with the additional prompting questions in italics, 1) Have you felt sad? *Have you felt upset / miserable / depressed?* ; 2) Have you felt as if you are in a bad mood? *Have you felt bad-tempered, Have you felt as if you want to shout at people?* 3) Have you enjoyed the things you have done? 4) Have you enjoyed talking to and being with other people? *Have you liked having people around you? Have you enjoyed other people's company? 5)* Have you made sure you have washed yourself, worn clean clothes, brushed your teeth, and combed your hair? *Have you taken care of the way you look? Have you looked after your appearance?* Items can be rated with a choice of three responses: "never/no", "sometimes/a little" and "always/a lot".

The GDS-LD has been shown to have effective discriminant validity across three groups, depressed people with intellectual disability, non-depressed people with intellectual disability, and depressed people without an intellectual disability. The GDS-LD has an internal consistency (alpha) of 0.90, ranging from 0.89 to 0.91. Test-retest reliability

is high at 0.97. Criterion validity is reported to be excellent for the GDS-LD when investigated using the Beck Depression Inventory-II (BDI-II) (Beck, Steer, & Brown, 1996) with a product moment correlation yielding r=0.94, P<0.001. When used for screening depression a lower threshold can be used with a cut-off score of 13, which has 96% sensitivity to detect individuals who are depressed (Cuthill, et al., 2003). A score of 15 is the optimal clinical cut-off in excluding individuals who are not depressed with 100% specificity.

Mean scores for the depressed intellectual disability group (n=19) were 23.37 (SD=6.3) demonstrating a significant difference from the non-depressed intellectual disability group with a mean score of 9.26 (SD=2.94) (Cuthill, et al., 2003).

The GDS-LD is routinely used with the Northgate forensic population and local control sample scores were taken from the routine assessment results of 51 male patients with a mean age of 31.2 (range 20.9 – 58.8) (SD=9.4). The mean score for the GDS-LD for this local forensic intellectual and developmental disability control sample is 14 (SD=7). A table of these control sample scores can be seen in Appendix 8.

4.3.1.4 Rosenberg Self-Esteem Scale (RSES) (adapted).

The Rosenberg Self−Esteem Scale (RSES) (Rosenberg, 1965, 1982; Rosenberg, Schooler, & Schoenbach, 1989) was originally developed with a sample consisting of 5,024 American high school juniors and seniors from ten randomly selected schools in New York State. The first version (Rosenberg, 1965) of RSES has been used with positive results in outcome studies with people who have intellectual disability, for example (Beail, Kellett, Newman, & Warden, 2007; Beail, Warden, Morsley, & Newman, 2005).

Dagnan and Sandhu (1999) adapted the RSES (Rosenberg, 1982) by simplifying wording but retaining the original meaning of each statement (Dagnan & Sandhu, 1999). Each item is presented in a large print format with visual cues alongside the response

categories with a five-point visual analogue of blocks increasing in size to assist rating. See Appendix 9 for a sample of three out of the six questions presented in the RSES adapted format (Dagnan & Sandhu, 1999).

Respondents are required to rate their agreement with a statement by selecting the responses "never true", "hardly ever true", "sometimes true", "often true", or "always true". Dagnan and Sandhu (1999) report internal reliability for the adapted self-esteem scale with an alpha value of 0.62 and a test-retest correlation of 0.68.

Davis, Kellett, and Beail (2009) tested the psychometric utility of the RSES (Rosenberg, 1965) in an intellectual disability sample ($n = 219$). They report moderate internal reliability with some specific problem areas in factor-loading for two items in the RSES. Concerns were raised that items which were considered questionable in the original ten-item version of the RSES were also included, with slightly altered wording, in the Dagnan and Sandhu (1999) adapted version (Davis, et al., 2009).

Dagnan and Sandhu's (1999) RSES adapted version has been used to test the prevalence of low self-esteem in a medium and low secure forensic intellectually disabled population (Johnson, 2012). This population ($n= 44$) had a mean age of 35.6 years (SD = 11.6 years, range 18-61 years) with an IQ range from 60-77 and a mean length of stay of 55.5 months (Johnson, 2012). The adapted shorter version of the RSES was observed to require less verbal explanation and was seen to be useful in assessing self-esteem in an intellectually disabled person with a short attention span (Johnson, 2012). Within this study participants' scores were separated into categories for different levels of self-esteem by dividing total scores into thirds, 0-8 for low self-esteem, 9-16 for moderate self-esteem and 17-24 for high self-esteem (Johnson, 2012). If the RSES (adapted) version is completed without any missing items the minimum possible score is 6 and the maximum (highest self-esteem) score is 30.

RSES (adapted) total scores for a local intellectual and developmental disability forensic control sample are provided in Appendix 8. The sample consists of 43 patients from Northgate Hospital with a mean age of 32.1 (range 21.1-59.6) (SD=9.17). This sample has a mean RSES (adapted) score of 22 (SD=4.5).

4.3.2 Analysis of repeated measures.

Analysis of change in repeated measures includes three components:

1.   Positive change is indicated if the participant's post-treatment scores reduce below the clinical cut-off for the measure.

2.   Change outside the parameters for measurement error between pre- and post-test scores above the Reliable Change Index (RCI) (Jacobson & Truax, 1991). The RCI provides a standard error calculation which indicates if the change is greater than the standard error of the instrument. This test is valuable in establishing a guide for reliable margins of change in specific outcome instruments (Lambert & Ogles, 2009). The RCI for the GAS-ID, GDS-LD, and RSES have been calculated using the "Reliable Change Generator 2.0" (Devilly, 2005) which is easily downloadable from the internet as free software. To generate the RCI the test-retest reliability for the instrument and the standard deviation of the sample is entered and results are given for the standard error of measurement. The RCI has been set for 95% confidence (1.96sd). The RCI has not been calculated for the BSI-18 as test-retest reliability (Derogatis, 2000) is based upon estimates.

3.   Clinically significant change is assessed when a person's score moves from that of a clinical population to a non-clinical population. To identify the difference between a single-case and a control sample a Bayesian approach to inference has been used (Crawford & Garthwaite, 2007). The computer programme used, "SingleBayes.exe" (Crawford, 2007), can be easily downloaded from the internet web page. The data input

requires the control sample mean and standard deviation, the *n* for the control sample and the participant's score. A point estimate is provided for the percentage of the population, a single value estimate for the population mean μ, that would obtain a score lower than the patient's (Crawford & Garthwaite, 2007). Point estimates are given with Bayesian credible limits providing a probabilistic statement about the accuracy of the estimation equivalent to "classical" / "frequentist" confidence intervals. The output gives one- and two-tailed Bayesian *p* value, the specific estimate of parameter or point estimate of the individual participant's score and a 95% credible interval on this percentage (Crawford & Garthwaite, 2007). This test gives meaningful clinical indication of the percentage of the control population that would obtain a lower score than the individual participant's score with the related interval estimate. Each participant's GAS-ID, GDS-LD and RSES (adapted) scores have been compared with an intellectual and developmental disability local forensic control sample and a non-clinical control population. Due to the absence of reliable intellectual disability control sample norms for the BSI-18, this test has not been completed; percentile scores have been calculated using the standard tables (Derogatis, 2000).

4.4 Continuous Measures

4.4.1 Daily Self-Rating Scale.

The daily self-rating scale was devised specifically for this research study and is based upon recommendations from a self-monitoring instruction manual for therapists (Freeston & Thwaites, 2004). The scale is designed in the style of a thermometer, see Appendix 10. The scale was initially tested with a small number of patients in the forensic service prior to the research study being conducted and the opinion of experienced clinicians in the forensic service was sought during its development.

Streiner and Norman (2008) provide evidence-based recommendations on the use of scales in health research. Whist they give no specific recommendations for the use of scales with people who have intellectual disabilities there is some indication that modification of scales is appropriate for different populations. There is one example of a study showing that some illiterate participants found visual analogue scales more difficult than numerical scales. There is also an example in which a thermometer-style scale rather than a horizontal visual analogue scale made completion easier for a geriatric population. When designing scales a general point is made that it is better to use anchor points and labels on scales with descriptors (Streiner & Norman, 2008).

There has been some, albeit limited, recommendation for the use of visual scales in a thermometer style in work with offenders who have mild intellectual disabilities, for example (Clare, 1993). Thermometer-style scales have been used with offenders who have intellectual and developmental disabilities in anger treatment, for example the "stress thermometer" (Taylor & Novaco, 1999). This simplified visual scale has a vertical line with accompanying statements indicating different levels of stress and uses the analogy of temperature levels found in an ordinary thermometer. Therapists are instructed to describe the levels of the stress thermometer as 0 or below indicating a person not feeling stressed, switched-off, sleepy, or very slow, between 0-50 as people experiencing normal everyday levels of stress, 50-100 as feeling very tense, anxious or wound-up and above 100 as "boiling point" where the person feels out of control (Taylor & Novaco, 1999).

The daily self-rating scales used in this research consist of a 50 point thermometer-style rating scale for scoring the severity of either "anger", "anxiety", "low mood", or "somatisation". As an example, the wording for the anger scale is "today, how much have you been feeling cross or angry? Choose a number: 1 is the best it can be, 50 is the worst it can be". The scale is accompanied by descriptive labels for participants to select scores

from 1-10 = "not much"; 11-20 = "a little bit"; 21-30 = "a bit"; 31 - 40 = "quite a bit"; 41-50 = "a lot".

Participants were informed during the consent process about their requirement to complete a daily self-rating scale, taking approximately five minutes each day. Eight weeks prior to therapy participants were shown how to complete all daily self-rating scales by an assistant psychologist. The highest rated scale completed at this point was then selected and supplied to the participant to complete on a daily basis. Additional support was available for the participant from ward staff if required. Each participant was asked to rate the daily self-rating scale during the pre-, treatment, and post-treatment phases of the research studies, encompassing a period of approximately 11 months in total.

4.4.2 Modified Overt Aggression Scale (MOAS).

The Modified Overt Aggression Scale (MOAS) (Oliver, Crawford, Rao, Reece, & Tyrer, 2007) provides a reliable measure of four types of aggression, (a) verbal aggression, (b) physical aggression against objects, (c) physical aggression against self, and (d) physical aggression against other people. The MOAS has been demonstrated as an effective primary outcome measure in a notable randomised controlled drug trial with adults who have intellectual disability and challenging behaviour (Tyrer, et al., 2008). For MOAS total scores the level of agreement between raters has been shown to be high with an intraclass correlation coefficient (ICC) of 0.93; rater agreement between some subscales is equally high, including verbal aggression (ICC = 0.90) and physical aggression against others (ICC = 0.90) (Oliver, et al., 2007).

The MOAS measures both the frequency (<10 or >10 observations) in the previous seven days and the severity of aggression. Due to the detailed recording systems and levels of observation in place within the forensic service, nursing staff were responsible for reporting information on the number and type of aggressive incidents observed. See

Appendix 11, instructions for "Completing the Modified Overt Aggression Scale", followed by a copy of the first two of four MOAS items from the measure which have been provided as an example.

4.4.3 Serious Untoward Incidents (SUIs).

The frequency and type of SUIs were collected from six monthly nursing report summaries held within the patient record. Records of SUIs were checked for all participants for the twelve month period preceding therapy, throughout the therapy period and for an eleven month period following therapy. SUIs are included in continuous measures as they reflect daily monitoring of patients which is reported as a monthly total of recorded incidents. Within Northumberland, Tyne and Wear NHS Trust policy an SUI is defined as

> An incident occurring on health service premises or on other non NHS premises in relation to the provision of healthcare on such premises, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be significant public concern. This shall include "near misses" or low impact incidents which have the potential to contribute to serious harm (Gray, 2009, para.13.1).

SUIs are reported into the Trust monitoring and risk management system and can trigger a range of responses within and outside the organisation depending upon the nature, severity or frequency of incidents. SUIs that were monitored for each participant included,

- Incidents in which a participant had been aggressive or violent to a degree that

required staff to use an approved physical intervention such as "management of violence and aggression" (MVA) techniques. This may include physically taking hold of a patient in order to reduce the risk of the patient harming themselves or others.

- SUIs including a participant being placed in seclusion for a limited period of time. "Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others". (Department of Health, 1999, para. 19.16)

- Use of PRN "when necessary" rapid calming or tranquilising medication to reduce agitated, aggressive, or violent behaviour.

4.4.4 Analysis of continuous measures.

A range of approaches have been used to assess continuous measures. Franklin, et al. (1997) consider visual inspection and statistical analysis to be complementary tools. Statistical process control (SPC) charts were used as the primary method of data analysis for all continuous measures. Visual inspection of trend has been aided by regression lines such as a localised trend line (LOESS) and a linear trend line for reference purposes.

4.4.4.1 Statistical Process Control (SPC).

SPC lends itself to the identification of normal variability in trend, changes over time and pinpointing special events (Wheeler & Chambers, 1990). SPC provides a useful tool to measure change over time using a robust statistical framework that can aid identification and attribution of events precipitating assignable change in variability. SPC

is widely used in quality control for industrial processes (Oakland, 2008) and has been demonstrated as an effective and robust tool for outcome measurement in health rehabilitation (Callahan & Barisa, 2005). SPC has been designed to provide statistically valid data which can identify variation inherent in a process which is considered to be either "controlled variation" or "out of control". Controlled variation is variation which can be seen to follow a stable and consistent pattern over time and can be attributed to "chance" or "common" causes. Patterns of variation in process that change over time or are out of control are identified as "assignable" to either a known or unknown cause and can be attributed to a special factor taking place within the process.

SPC "average moving range (XmR) control charts" are used for data collected over time when data points represent one discrete score. Control charts do not require normal distribution of data in order to work because the dispersion or spread of the data is always three standard deviations (sigma) from the mean in either direction, while the entire range encompasses six sigma within confidence intervals. Confidence intervals define the boundary limits of the spread of the data. SPC charts indicate this via upper and lower control limits (UCL and LCL) allowing simultaneous analysis of average scores and the variability within scores. Statistically, with 99.73% of the normal distribution falling within three standard deviations of the arithmetic mean, the likelihood of an observation falling outside three sigma control limits is 0.27% (3 of 1,000 observations) (Callahan & Barisa, 2005). Figure 4.1 illustrates how the spread of data is shown in SPC. The distribution is turned sideways with the UCL and LCL set at three standard deviations from the arithmetic mean.

Figure 4.1. Illustration of how SPC charts present data
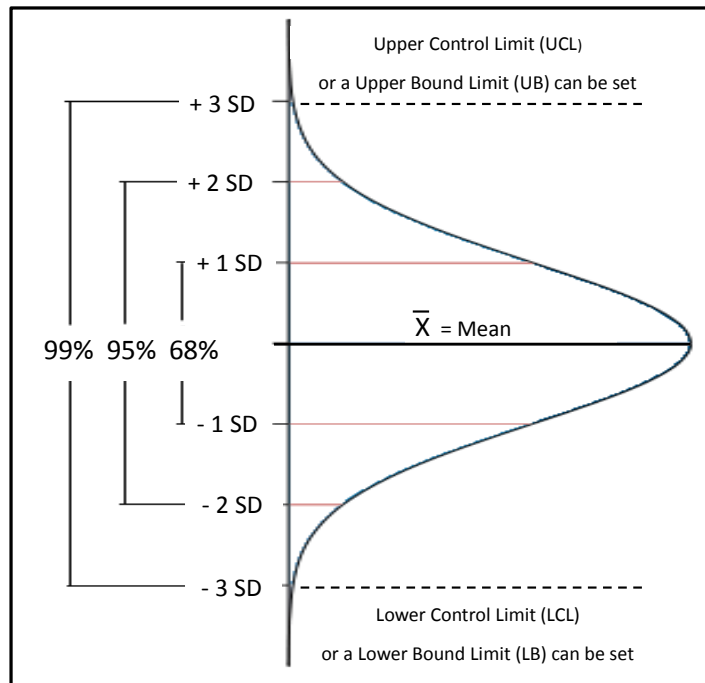
The identification of a "special cause" is an interesting concept when considering "self-rated" measures. In SPC a "special cause" signifies an "exceptional" event which has influenced process and requires action to be taken to adjust or remove the special cause from the "system". In this research special causes will be identified by measurement of higher or in some cases lower self-rated scores. Changes in trend and variability of scores can either indicate deterioration or improvement over time with the expectation that a positive influence can be measured during the treatment phase. If an influence in the variability is not a "common cause", due to chance variation, the second stage is to look at process information and to try to attribute a cause. This may be related to an in- or extra-therapy event. Obvious clinical expectations are that continuous measurement of levels of distress or behaviour will change to a point where less variability and greater stability or control is measured over time.

As quoted by Callahan and Barisa (2005), Wheeler's (1993) view of trend analysis it that "before you can detect a signal within any given data set, you must first filter out the noise" (p. 30). SPC benefits from having clearly determined rules for trend analysis. Walter Shewhart (1931) is credited with the "Western Electric rules", devised during the famous Hawthorne Plant studies from the 1920s in the Bell Telephone Laboratories. The Western Electric rules are able to empirically determine the presence of a special cause (Callahan & Barisa, 2005). Three rules in particular are identified by Callahan and Barisa (2005) as being suitably powerful and robust in identifying special causes and trend in single-case health research. Trend analysis is greatly aided by applying the following rules when inspecting data points: (a) if "one" point falls outside a control limit (see Figure 4.2); (b) a "run" of seven or more consecutive points on the same side of the mean (either above or below) (see Figure 4.3); (c) a "trend" of seven or more consecutive points increasing or decreasing across the centre line (see Figure 4.4). SPC is suited to single-case designs, particularly when there may be limited collection of data over time, with only 12-15 data points needed to provide a good test for stability within process. SPC with 25 or more data points gathered through rational sampling, where the characteristics of process are evident in the data collected from the participant, give a very strong test for stability and a meaningful portrayal of process (Callahan & Barisa, 2005).

In the separate phases of the self-rated measures, MOAS, and SUIs the mean score for phase A pre-treatment has been set for phase B treatment and C post-treatment. This provides a comparative baseline for the assessment of improvement or deterioration (above or below the pre-treatment mean) in the subsequent phases.

Three "Western Electric rules" selected by Callahan and Barisa (2005) for trend

analysis using Statistical Process Control (SPC) in single-case studies.

Figure 4.2 "one" point falls outside a control limit
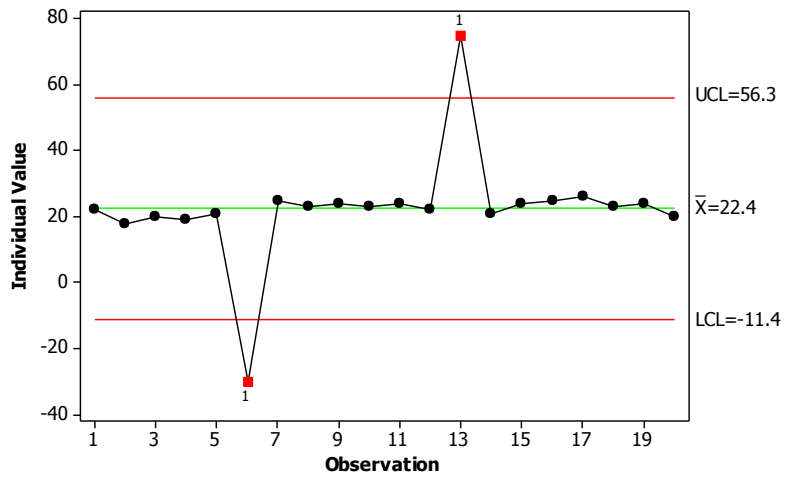
Figure 4.3 a "run" of seven or more consecutive points
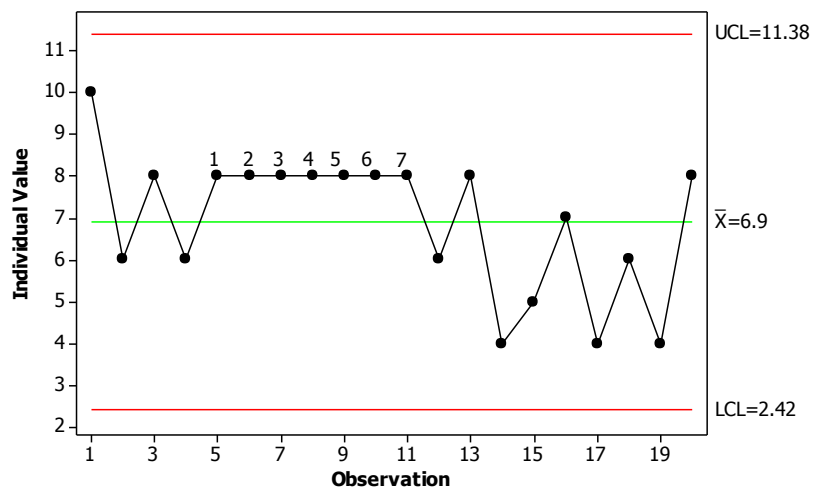
Figure 4.4 a "trend" of seven or more points bisecting the centre line
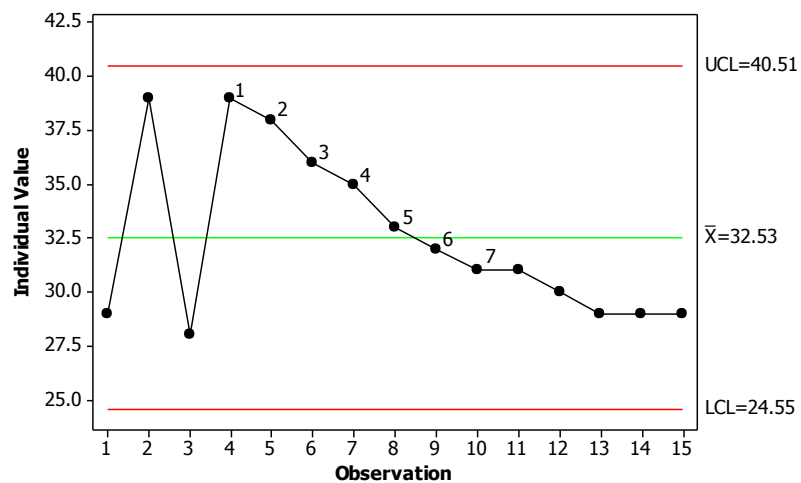
4.4.4.2 Using visual inspection in trend analysis across phases.

When assessing trend in single-case studies methods of visual inspection are commonly applied. Although some studies have shown visual inspection to have limitations (Franklin, Gorman, et al., 1997) careful consideration of data can yield reliable judgement (Kazdin, 2011; Parsonson & Baer, 1992). Parsonson and Baer (1978) give a heuristic (quick reference) aid to visual inspection in single-case research, as cited by Franklin, Gorman, et al. (1997, p. 136).

1. Stability of baseline - baseline should not drift towards improvement.

2. Variability within phases – as variability increases, the need for more data increases.

3. Variability between phases – reduced variability in the treatment phase is an indication of control.

4. Overlap between scores of adjacent phases – greater treatment effect is associated with less data overlap.

5. Number of data points in each phase – more is usually better.

6. Change in trend within phases – collect more data when trends are unclear.

7. Change in trend between adjacent phases – dramatic changes suggest strong treatment effects.

8. Change in level between phases – dramatic changes suggest strong treatment effects.

9. Analysis of data across similar phases – consistency in replication indicates treatment effect.

10. Evaluation of the overall pattern of the data – the overall pattern may overcome faults in the data.

4.4.4.3 LOESS and Linear trend models.

To aid visual inspection localised regression lines show the best-fitting smooth line or curve through the data as a helpful aid to visual inspection of trend. Locally weighted scatter plot smoothing (LOESS) (Cleveland, 1979; Cleveland, Devlin, & Grosse, 1988) filters out variation and therefore provides a clear and simple indication of trend in data by smoothing the parameter of values (weighted polynomial regression).

Linear trend models show the data points and the best fitting straight trend line superimposed. The plot is generated with Y being the dependent variable and time X as the independent variable. The best fitting slope (vector) is plotted giving an indication of the general direction of trend in the data (Franklin, Allison, & Gorman, 1997). This does not accurately represent trend in non-linear data and should be carefully considered and interpreted alongside other information.

4.5 In-Treatment Measures and Observations

In-treatment measures and observations require a range of different methods of recording data. These include: outcome scales administered by the therapist at the start and end of treatment; a brief interview carried out by the therapist in early and late therapy sessions; non-obtrusive observational measures rated by the therapist following each session; electronic recording of the sessions; and the therapist's own process notes. The various types of in-treatment measures and observations are described below.

4.5.1 Personal Problem Scale (PPS).

The PPS is a simple form generated for use in this research which has been based upon a goal attainment scale format. Goal attainment scales have a long history of use in mental health services to assess a patient's individual goals and whether they have been

achieved (Hart, 1978; Kiresuk & Sherman, 1968). The participant is asked to identify individual goals and weight or prioritise them at the start of treatment. This is then re-assessed by the individual at the end of treatment. The PPS identifies three of the participant's primary areas of difficulty and tracks changes in their perception of the severity of each of the problems between the start and end of therapy.

The therapist is instructed to ask the participant to "think of three things you would like to feel less distressed or bothered by at the moment, this can be things like thoughts, feelings or relationships". After the three areas are recorded on the form the participant is asked, "How bothered are you by each of these things, if one is the worst it can be and five is the best it can be?" In the final question the participant is asked "Which one of these things would you most like to feel better about?" The PPS is completed in the first session and then the participant is asked to score the severity of the personal problem in the final therapy session. A copy of the PPS form can be seen in Appendix 12.

4.5.1.1 Analysis of PPS.

Changes in PPS scores have not been subjected to statistical analysis; a table comparing PPS scores at the start and end of therapy has been presented for each participant. Movements between the anchor points (the best or worst it can be) on the scale have been assessed to have improved, not changed, or deteriorated.

4.5.2 Relationship Anecdote Paradigm (RAP) (adapted).

The RAP interview has been developed specifically for use in psychotherapy research to elicit narratives from participants which can be subjected to further analysis (Luborsky, 2003b). The RAP elicits personally generated anecdotes from participants within psychotherapy in order to generate a core conflictual relationship theme (CCRT).

The CCRT method has a long history of application within psychotherapy research (Luborsky, 2003a).

The RAP interview can be conducted as a "one-off" outside therapy sessions or by the therapist within the sessions. Although the RAP has not been used in an intellectual and developmental disability sample, the design of the interview offers the potential for its use in a wide range of clinical populations. In the original format for the interview (Luborsky, 2003b) the participant or narrator is asked to speak about events that have taken place in relationships with other people. Individual narrative accounts, relating to a specific interaction with another person, are described by the participants, including a sample of conversation. The participant is asked to say who the other person was, some of what they said or did, what happened at the end of the interaction, and when it happened (Luborsky, 2003b). The participant is required to give at least 10 relationship anecdotes during the course of the interview, which is expected to take between 30 and 50 minutes (Luborsky, 2003b).

This basic interview outline was adapted for use with participants who have intellectual and developmental disabilities, with a nine-step schedule of instructions for the therapist conducting the interview. See Appendix 13a for the "Relationship Anecdote Paradigm (adapted) Interview Schedule". Additional features in this version include asking the participant to name at least five people they are able to speak about and recording this on a piece of paper by writing names or drawing the people. Each participant was then asked about each person in turn and given instructions to provide at least two anecdotes for each person. Additional prompts were used, as per Schedule, to elicit more detail. The RAP interview was conducted by the therapist at the start and end of therapy. Prior to starting therapy the therapist informed participants that they will be asked about relationships in early therapy sessions. The RAP was included within the first two sessions and repeated in the penultimate session.

4.5.3 The Core Conflictual Relationship Theme (CCRT) method.

Transcripts from RAP interviews were rated according to the CCRT method (Luborsky, 2003a). The CCRT provides reliable extra information which is not usually captured by symptom inventories or clinician ratings (Luborsky & Crits-Cristoph, 2003a). The "core themes" in the anecdotes given by the participant are considered to reflect their core beliefs or schemas within interpersonal relationships, "the CCRT method is the central relationship pattern, script, or schema that each person follows in conducting relationships. It is derived from the consistencies across the narratives people tell about their relationships" (Luborsky, 2003a, p. 3). A narrative account, also called a relationship episode, consists of the person's *response of self*, their own responses, an imagined or actual response from the other person, *response of other,* and the *wish*, the needs or intention of the person which has been formed during or after the interaction.

In a review of eight CCRT reliability studies reported in terms of weighted kappas, average results for each component are *response of self* 0.60; *response of other*; 0.68; and *wish* 0.71 (Luborsky & Diguer, 2003).

The CCRT interpersonal schema is initially identified through participants narratives recorded in early and late therapy sessions using the RAP interview. CCRT relationship episodes extracted from interview transcripts are categorised into five component areas in order to assess changes in positive and negative themes: 1) positive and (2) negative *responses of self*, (3) positive and (4) negative *responses of other* and (5) *wish*. See Appendix 13b for the "CCRT procedure".

When the CCRT is used to assess outcomes of therapy a positive change is observed when there is a decrease in pervasive maladaptive, repetitive, and inappropriately applied relationship themes measured in fewer relationship episode accounts at the end of therapy. This change is calculated by using a CCRT pervasiveness score (Luborsky & Crits-Cristoph, 2003a). CCRT pervasiveness is seen as a valuable alternative method for

the evaluation of psychodynamic interventions although it has been shown to have a limited application when used in some brief interventions (Lunnen, Ogles, Anderson, & Barnes, 2006).

4.5.3.1 CCRT transcript judges.

The method of extracting the CCRT from RAP interviews is labour-intensive and requires a number of trained independent judges who can identify relationship episodes in the anecdotes provided by participants, and attribute themes to the component parts of the narrative. CCRT transcript judges used in this study were taken from a pool of trained staff from the forensic service at Northgate Hospital. Inclusion of the RAP and CCRT method within this study was possible due to a number of preparatory projects which had been successful in training local CCRT transcript judges.

The preparatory work included the development of a CCRT training package and manual for staff (Porter & Hackett, 2007). The training package and manual was then evaluated with multi-disciplinary staff (Porter & Hackett, 2009). Sixteen CCRT transcript judges were trained including two art therapists, eight qualified nurses and six clinical psychologists. They were trained to follow the manual and identify CCRT components and select standard category themes. They were then tested in the task of completing a CCRT independently and measured against a benchmark consisting of two published cases "Mr Howard" and "Ms Cunningham" (Luborsky & Crits-Cristoph, 2003b). The study evaluated the performance of the staff in judging transcripts and compared their CCRT result with the results in the published cases. Results of the study show that trained staff rated first and second "best fitting" standard category items against the benchmark with varying agreement. The agreement for trained staff to identify each component of the CCRT against the two benchmark cases was *response of self* = 81.25-87.5 %, *response of others* = 50-56.25 %, and *wish* = 25-37.5 % (Porter & Hackett, 2009).

4.5.3.2 Converting RAP interview transcripts to a CCRT.

RAP and CCRT transcript analysis involves a number of stages. Each RAP transcript is analysed separately by a total of four independent transcript judges. Relationship episodes (an account of an interaction with another) and their component parts are identified separately by two judges and only included in further analysis if there is a clear match in the selection. The level of "completeness" for each relationship episode is rated separately on a 1-5 scale. For example, levels include 1 = "no CCRT components"; 2.5 = "enough information to score *response of self, response of others,* and *wish*"; 5 = "all three components with added description and detail" (Luborsky, 2003a). Inclusion of relationship episodes with completeness scores of 2.5 and above are recommended for devising the CCRT. Due to the paucity of description in some relationship accounts given by one participant in the research relationship episodes with a completeness score below 2.5 were included in CCRT analysis. This is not problematic as "…there is no indication that exclusion of incomplete relationship episodes distorts the eventual CCRT" (Luborsky, 2003a, p. 20). After the selection of the relationship episodes by the first set of judges a minimum of 10 relationship episodes are randomly selected prior to scoring by a second set of judges (Luborsky, 2003a).

The second set of judges then independently review the 10 relationship episodes by selecting the most frequently recurring themes within each category and entering this onto a form (see Appendix 13c for "CCRT Relationship Episode Record Form"). Selecting dominant themes within narrative accounts is aided by the use of "standard categories" as this provides a uniformed language for judges to use and a means of assessing agreement between judges (Barber, Luborsky, & Crits-Christoph, 2003). See Appendix 13d for "CCRT Standard Categories for others, self, and wish".

The level of inference used in selecting standard category statements for the CCRT component *wish* is also rated by judges. A degree of inference is accepted when selecting

standard category statements for the *wish* component. The degree of inference is limited as "highly inferred" statements elicit less agreement between judge's scores (Luborsky, 2003a). Given lower levels of agreement between judges measured in rating the CCRT *wish* component (Porter & Hackett, 2009) the percentage of statements that are "moderately" or "explicitly" inferred is reported alongside the CCRT. As an additional safeguard, where there is limited or no agreement between judges for *wish* items, all standard category themes selected by both judges for this component are presented in tables showing the CCRT interpersonal schema.

The final CCRT interpersonal schema is constructed from the two judges' highest frequency matched scores for each relationship episode. The CCRT is able to be applied over time based upon the theory that the main conflict relationship patterns should become less pervasive across the relationship episodes as a result of successful therapy (Luborsky & Crits-Cristoph, 2003a). Frequency scores from each component of the CCRT are divided by the number of relationship episodes to derive a percentage score. This is a score indicating the pervasiveness of conflicts across the relationship episodes assessed at the start and end of therapy.

$$CCRT\ Pervasiveness = \frac{Number\ of\ RE's\ that\ include\ the\ CCRT\ component}{Total\ RE's\ in\ the\ session\ (RAP)}$$

Where possible, CCRT results have been related to therapy process and personal characteristics of the participant, particularly where relational issues are a central feature within the case.

4.5.4 Therapist Observation Rating Scale.

The therapist observation scale is study-specific and was devised in order to provide unobtrusive observational information about a participant's level of engagement, participation/motivation and attitude towards creating art within therapy sessions. This provides a descriptive account of the therapist's view of the working relationship, and attitude of the participant towards therapy over the course of treatment. The rating form has been devised in a simple format with five statements for each area. For example participation is rated as: 1 = "did not participate in the session, even when prompted / encouraged"; 2 = "participated in the session with prompting / encouragement"; 3 = "participated satisfactorily"; 4 = "motivated attempt to participate"; 5 = "active participation". The full "Therapist Observation Rating Scale" can be seen in Appendix 14. The therapist is required to complete the form immediately following each session by selecting the closest fitting statement to their observation of the participant.

4.5.4.1 Analysis of Therapist Observation Rating Scale.

Scores from each therapy session are plotted on a statistical process control chart. Methods of trend analysis for statistical process control have been discussed earlier in this chapter. The frequency of recurring scores are also assessed and reported in percentages, for example, engagement was "genuine but guarded" in 50% of the sessions. Patterns and profiles of engagement, participation/motivation, and the participant's attitude towards making artwork in sessions have been reported and corroborated with other sources of data to assess processes taking place throughout the course of therapy. The therapist's observation rating scale scores can be considered to be reflective of the quality of the working alliance perceived by the therapist.

4.5.5 Therapy Process Record (audio recording, session notes, artwork etc.).

All therapy sessions were recorded electronically. Audio recordings offer an accurate source of reference for process material and events taking place within therapy which may have supported either positive or negative events. Participants were required to consent to the recording of sessions prior to the start of each study. Recordings were used for the purpose of devising transcripts from therapy sessions where the RAP (adapted) interviews were carried out. Audio files were held on a secure password-protected hospital computer and used for reference purposes during data analysis.

4.5.5.1 Analysis of therapy process record.

Other information generated within therapy, such as artwork produced by the participant and session notes written by the therapist, are referred to during the later stages of the case analysis where data is integrated and corroborated. The collective therapy process record forms the basis of a rich and valuable resource in the analysis of specific events taking place within therapy and alternative explanations for change. Audio recordings of sessions were also used to establish if any process-outcome or event-shift sequences were present.

4.5.6 Participant's most important image or object.

Reviewing artwork completed in therapy is often a feature in art psychotherapy practice and has been increasingly used as a means of capturing a client's responses to therapy (Brooker & Springham, 2010).

The therapist was responsible for asking the participant to select their most important artwork at the end of therapy. The participant had been given notice of this reflective activity by the therapist a few weeks before it took place. Eliciting a participant's

personal view about the most important image or object has provided further information about significant and important events taking place within therapy.

4.5.6.1 Recording the participant's most important image or object.

The participant's selection of their most important image or object is reported descriptively with contextual information given about the relevant session; images are reproduced in the body of the text.

4.6 Retrospective Attribution.

4.6.1 Change Interview (adapted).

The Change Interview (Elliott, 2008; Elliott, et al., 2001) is semi-structured and captures the participant's post-therapy account of change. The participant was asked about their attributions towards therapy including helpful and unhelpful events. The change interview is used to assess the sources of change the participant may have experienced including events taking place outside of therapy, referred to as extra-therapy events. The interview protocol has a range of questions and additional sub-scales which are divided into nine areas, for example:

1. General experience of therapy. What has therapy been like for you (so far)? How has is felt to be in therapy?

2. Changes. How are you doing now? What changes, if any, have you noticed in yourself since therapy started?

3. Attributions. In general, what do you attribute these various changes to? In other words, what do you think might have brought them about? (both outside and inside therapy).

4. Helpful aspects. What have been the most helpful things about your therapy so far? (general aspects, specific events). What made these things helpful to you?

5. Hindering aspects. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you?

6. Difficult but ok aspects of therapy. Were there things in the therapy which were difficult or painful but still ok or helpful?

7. Missing aspects. Was there anything missing from your treatment?

8. Research aspects. What has it been like for you to be involved in this research?

9. Suggestions. Do you have any suggestions for us, regarding the research of the therapy? (Elliott, et al., 2001)

For the purpose of this study the change interview protocol was adapted for use with participants who have mild intellectual and developmental disabilities. Adaptation has included simplification in wording for some questions and removal of some complex questions and subscales. In the adapted version warm-up and art therapy specific questions have been added. A complete version of the "Client Change Interview Schedule"(Elliott, 2008) can be seen in appendix 15a followed by the "Change Interview (adapted)" version used in this study in Appendix 15b.

The change interview was arranged to take place three months following the end of therapy. Interviews were administered by a psychology assistant who worked in the forensic service but had not had any prior involvement with the research. The psychology assistant was given training in conducting the interview by a consultant clinical psychologist in the forensic service. Each interview was conducted in a private room and nursing staff were available if additional support was needed for the study participants.

The change interview was repeated separately with the named nurses of participants. Named nurses work closely with patients allocated to them and are in a position to give an opinion about positive or negative changes or influences they have observed. Change interview questions were modified for staff by the psychology assistant, for example "Do you think there was anything about the therapy that [participant's name] found unhelpful?" The information from the participant and the nursing change interviews have been corroborated.

4.6.1.1 Assessing retrospective attribution.

To assess the post-therapy interview transcripts three processes take place: (1) assessing the plausibility of the participant's account; (2) selecting participant's statements and descriptions about changes from the interview transcripts; (3) corroborating the participant's account with their named nurse's account of change.

4.6.1.2 Assessing the plausibility of the participant's account.

A number of indicators can increase confidence in the plausibility of the participant's account. Accounts of change are judged to be plausible if they contain "a mixture of positive, negative, and neutral descriptions (differentiation)" (Elliott, 2002, p.11). If detailed and differentiated accounts are present within the participant's interview this is seen to indicate a reduced likelihood of relational effects upon interview responses. Elliott (2002) recommends the use of Bohart and Boyd's (1997) eight indicators supporting the assessment of the plausibility of participant post-therapy self-report and retrospective attribution.

- Clients note themselves that therapy helped.
- Outcomes are relatively specific and idiosyncratic to each client and vary from client to client.

- In their reports, clients are discriminating about how much therapy helped, i.e. they do not in general give unabashedly positive testimonials.

- Clients are relatively specific about how therapy helped.

- They provide supporting detail.

- They describe plausible links to the therapy experience.

- They mention things that make it clear that client's either did something or experienced something different than what they normally do or experience in the course of their everyday lives.

- They mention things that didn't help. (Bohart & Boyd, 1997, p. 7).

4.6.1.3 Selecting the participant's statements from change interview transcripts.

After the plausibility of the account is assessed the change interview transcript is reviewed and statements made by the participant regarding aspects of change are selected. The method used to select and present statements from change interview transcripts cannot be easily linked to a particular type of qualitative analysis as data in the transcripts is minimally organised before findings have been presented. Post-therapy interview data, used here to assess retrospective attribution, does employ some selection and coding against predetermined categories of the participant's statements about change. This basic stage of identifying the statements in the transcript related to a participant's accounts of change is not subjected to further analysis, as is the case in some approaches to qualitative research (Braun & Clarke, 2006).

The process of managing information in the interview transcript is basic and includes only three steps. Statements describing "what changed" during and following the treatment period are identified and coded in the transcript. The participant's dialogue related to the statement about what has changed is also selected. These statements are generally the participant's description of what they believed has influenced the change or

"what helped". Having identified the participant's statements related to "what changed" and "what helped" a level of attribution is given to the influence of therapy, that is: a) the change is fully attributed to therapy with no other influencing factors or extra-therapy events being identified by the participant; b) the change is partially attributed towards the influence of therapy alongside another important influence or extra-therapy event mentioned by the participant; c) the participant believes that a change has not been influenced by the therapy at all and is attributed to an extra-therapy event or alternative influence. When reporting a participant's retrospective attribution frequent use is made of direct quotes from interview transcripts.

4.6.1.4 Corroboration of the participant's retrospective attribution with a nursing account of change.

Statements from the named nurse change interview that agree or disagree with the participant's retrospective attributions were selected. Statements made by the named nurse are used as a comparative account of change. Direct quotes are also frequently used in order to confirm and validate the participant's retrospective attribution or offer an alternative explanation or difference of opinion.

4.7 Assessors

For the repeated measures the assessors were three psychology assistants who worked under the supervision of consultant clinical psychologists within the services in which the studies took place. All assessors were experienced in administering assessments and outcome measures with forensic patients in the service. Assessors were provided with the assessment schedule and study information (see Appendix 7).

A fourth separate psychology assistant who had not had any previous involvement with data collection for the studies conducted the post-therapy change interviews with

participants and staff. The assistant was given specific training prior to conducting the interviews by the principle investigator and consultant clinical psychologist to whom they reported.

4.8 Therapists

Two qualified and HPC registered art psychotherapists provided therapy sessions to the four participants. One male therapist (the principal investigator) provided therapy to participants in the medium secure unit and one female therapist provided therapy to participants in each of the low secure units. The allocation of therapists to the different service areas was pragmatic and based upon the levels of security they already worked in within the different facilities. Both therapists had substantial post-qualification experience, 10 years working with people who have intellectual and developmental disabilities and five years working in forensic settings.

4.9 Treatment

The treatment consisted of up to twenty weekly individual art psychotherapy sessions. All of the sessions were provided during a six-month period. Some adjustment to the frequency of sessions and occasional breaks over the full course of the treatment did take place. Venues for the sessions included a private room on a ward in a medium secure unit, a private room in the grounds of a medium secure unit, a designated art room in a low secure unit and a designated art therapy room in the grounds of the hospital. The therapy venues remained constant for each participant. Art materials available in each of the settings varied but remained consistent for each of the participants throughout the course of treatment. Art materials included a range of pencils, pens and pastels which were brought into the medium secure unit by the therapist. Participants in the low secure unit had access

to a wider range of art materials that also included paints, plasticine and clay. In all cases the therapist kept the participant's art work until all the sessions were completed.

Therapy sessions were provided in a structured, consistent and time limited manner. The sessions mainly took place at a set time each week although occasional changes did occur. The length of time for each session was maintained in a consistent manner for each of the participants. "Adam" in case three (Chapter seven) had sessions each lasting up to 45 minutes. All other participants had sessions lasting up to one hour.

Each therapist was tasked with supporting individuals to take part in creative processes that, in turn, generated opportunities for personal reflection and the development of a constructive understanding of their problems and difficulties. Therapists encouraged participants to consider links between the creative work that they were involved in and their own thoughts, feelings and circumstances. The underpinning model for the therapy was psychodynamic.

Early tasks for the therapists were to familiarise the participant with the therapy setting, to give general information and an explanation about the process and structure of therapy. This scene-setting for the therapy was carried out in an attempt to alleviate any initial anxiety or concerns that the participant may have had about starting the treatment. In early sessions discussion with the participant was led by the therapist in order to identify issues and areas of concern for the participant, to set goals and to elicit conversation with the participant about their experiences in relationships. An attempt was made by the therapists to develop of a sense of consistency in the provision of therapy. This was done with the aim of establishing the therapy space as a safe environment which, combined with the sensitivity of the therapist, became a therapeutic space where the participant could start to develop the confidence that difficult emotions or problematic areas could be managed safely and made bearable. The therapist might also establish their own personal boundaries with the participant at an early stage, for example not disclosing their personal information.

One task in early therapy sessions for the therapist was to support the development of a working relationship with the participant. This was fostered through the therapist showing interest in the participant, being empathic and non-judgemental, and having a neutral but warm presentation. Near to the start of the therapy the participant was asked by the therapist to use art materials to make a personally generated image or object. The participant was encouraged to think about what artwork they could make by themselves, but if needed the therapist would be supportive and suggest art materials or things to try. This supportive approach was employed by the therapist in order to alleviate any anxiety or reservation that the participant might have had about making artwork, in an attempt to put them at ease with the process. Artwork made in therapy sessions was used by the therapist to help the participant engage in some personal exploration as a means of supporting positive change.

The therapist made an assessment of the participant's capacity for self-awareness and self-reflection. The therapist might then try to link themes or subject matter seen in the art image or object to things that the participant had said or aspects of the participant's life. This attempt at "linking" was carried out in a sensitive way with the therapist inquiring about the participant's thoughts or responses in a warm and interested manner. The therapist would also use reflective statements and phrases such as "it seems like…" and in this way the conversation might bridge into a more in-depth discussion about a personal or problematic area.

The emphasis placed upon the personally-generated art work made by the participant can become stronger as therapy progresses. This can lead to further opportunities for connections to be made between the potential meaning of the art object, events in the participant's life or their current difficulties. The therapist might go back to an image that the participant has made and remind them about it. The art object is "concrete" and can be kept and looked at again offering the potential for both the therapist

and participant to see something in the image that might not have been intended. The potential meaning placed upon the artwork is not fixed and can change over the course of therapy in relation to other images or events.

The therapist will consider how helpful it might be to bring their observations to the participant's attention and may start to test the participant's responses to reflective statements or comments about their affect, their presentation in the therapy room, or statements the participant has made about their artwork. As a working relationship between the participant and the therapist appears to strengthen the therapist might then start to highlight pertinent issues within the therapy. This may lead to a point where the therapist sensitively presents challenges to the participant. A series of interventions could include the therapist reflecting back to the participant contradictions in what they have said or repeated patterns of behaviour, strongly held beliefs or interpersonal issues. The therapist continues to recognise emotion and give empathic responses to the participant whilst making observations, with the intention of engendering and supporting the potential for positive change.

During the course of therapy the therapist is engaged in a personal reflective process in order to develop their own understanding of the participant. The therapist attempts to maintain an awareness of interpersonal issues such as how the participant is responding to them and their own responses to the participant. In this way, the therapist tries to be mindful of a "working hypothesis" in relation to the participant which may support and inform their decisions about what to say and how to respond to the participant at different stages in the therapy.

Tasks for the therapist related to ending therapy included trying to consolidate any understanding that had been developed during the course of therapy, reviewing goals and expectations, eliciting responses from the participants about their experiences in relationships and reviewing the artwork that had been made.

It is common for therapists to comment upon the various stages in the course of treatment such as a mid-point, or when getting close to the end of therapy. This was done by each of the therapists in all cases.

CHAPTER 5: CASE 1

5.1 Background Information

5.1.1 Hospital admission.

"John" was a twenty-one year old man who had a mild intellectual disability. He had been detained in hospital in a medium secure unit for seventeen months prior to participating in the study, having been transferred from a Young Offenders Institution (YOI). John was described by his named nurse as a brash but relatively likable young man, acting tough in order to impress his peers with frequent displays of bravado.

A speech and language therapy assessment indicated that the extent of John's language difficulties was not always apparent during everyday conversation as he could communicate clearly with reasonable verbal and conversational skills. Specific assessment for receptive and expressive language skills placed John at a level equivalent to that of a six-year old. John also had limited literacy skills, able to recognise only familiar words such as his own name and address.

A comprehensive post-admission risk assessment concluded that John presented a number of serious risks, including being a violent threat towards staff and patients. One key area of concern was John's unwillingness to reflect upon or take responsibility for his high risk and damaging behaviour.

> If he does not acquire some degree of self-reflection and responsibility for his actions he is at risk of maintaining his dysfunctional pattern of behaviour throughout his life. Given his lack of insight and unwillingness to alter, at this present time he remains a noted risk of violence and sexual violence towards others, especially those that he sees as more vulnerable.

> He will assault, steal and damage according to his wishes with little thought of the consequences to others or himself. He dismisses responsibility for his actions

by blaming his victims for his behaviour and he is supported in this distorted view of the world by his family (Consultant Clinical Psychologist Post-Admission Risk Assessment Report).

In the ten months following John's admission to hospital his level of physical aggression towards staff and patients had reduced. Prior to starting therapy he had achieved approximately seven months without a serious untoward incident (SUIs) being recorded. Despite a reduction in physical violence towards others John continually came into conflict with nursing staff. His hostility and verbally aggressive behaviour could also escalate to a level where he damaged property or made threats of violence. During the period of the study John's aggression did not reach a level that required the use of interventions that would have been recorded as SUIs. Many incidents of low level aggression still occurred and were seemingly provoked by minor disagreements about routine events and basic rules on the ward. John frequently resisted staff direction and became frustrated, was non-compliant and did not like to be restricted or told "no" in response to requests that he had made. He often disengaged from the staff team when they attempted to offer support and said that he had no problems and therefore required no therapeutic work.

5.1.2 Family relationships.

Family telephone calls were seen to destabilise John and contact with his family was sometimes a trigger for threats of aggression toward others. Any perceived slight towards his family led him to plan a physical assault on others following his release from hospital. The post-admission risk assessment report completed by a consultant clinical psychologist also stated that this "protector of the family" role was ingrained in his self-image and that he used it to support an internal view of himself as strong and invincible.

5.1.3 Peer relationships.

John could appear forceful, boastful, loud and sometimes overbearing. He was seen to try very hard to impress his peers although he was observed to find it difficult to form and maintain stable relationships. Accounts he gave of many of his relationships with others involved repeated incidents of revenge, or as John called it, "payback". In recounting events that had taken place in his life he indicated a culture of violent reprisal, getting even, and a demand for "respect" through intimidation of others.

5.1.4 Childhood and adolescence.

John's early childhood history is notable. Documentation states that John and his siblings were placed under child protection orders after concerns were raised that they were being subjected to physical violence and at risk of emotional and sexual abuse. During therapy John gave accounts of his early childhood, describing a background defined by frequent incidents of domestic violence, physical abuse and lack of appropriate supervision. He described becoming involved in petty crime and antisocial behaviour from the age of twelve with few boundaries or restraints being placed upon him. In his early teens one of John's older cousins, to whom he said he had been very close, was murdered.

John attended special school until age sixteen. He frequently exhibited disruptive behaviour and often got into fights with other pupils. This led to his exclusion from school on three occasions for physical assaults on fellow pupils but he was never permanently excluded. John was also seen to experiment with sexual behaviour from an early age at school, with reports of him masturbating and one allegation of him sexually assaulting a male pupil.

Within therapy John spoke about experimentation with drugs and alcohol starting in his early teens. Drug and alcohol use was also a contributory factor in a number of the violent assaults he had committed. His antisocial behaviour within his community also

resulted in his being a victim of reprisal attacks and physical assaults. John described volatile and violent exchanges continuing within his family throughout his adolescent years, evident particularly in his relationship with his brother with whom he said he had frequent fights.

5.1.5 Forensic history.

John's formal criminal history began at age twelve when his first contact with the police is recorded. His history of noncompliance with services is also evident through breached supervision orders which included failing to attend court and not complying with probation orders. During his adolescent years reports from professionals paint a picture of a dangerous young man emerging from a chaotic family. A multi-agency assessment concluded that John presented a general risk of violence to members of the public.

Prior to his transfer to hospital from YOI at age twenty John had accumulated over thirty separate criminal offences. The nature of John's offences contain a history of aggression, violence, and sexual assaults. Charges included racially targeted violence, rape, possession of a weapon, and assaulting a police officer. He was known to target vulnerable females and held a conviction and supervision order for a sexual assault against a minor. Further convictions include theft, taking without consent, driving without a licence, and possession of drugs. His employment history is limited to a few periods of stable work. One short period of employment was terminated after he assaulted a member of staff.

5.1.6 Participation in the study.

John completed 20 art psychotherapy sessions during the treatment phase of the study with a male therapist. Therapy was conducted within the medium secure unit in a small treatment room with a table and chairs, in a separate building from John's ward. John was prescribed a low dose of atypical antipsychotic medication which was introduced by

his psychiatrist as a mood stabiliser during the eighth week of the treatment phase in the study.

5.2 Repeated Measures

5.2.1 Brief Symptom Inventory (BSI-18).

John did not score above the clinical range for symptoms of psychological distress for this measure. There is no difference between pre- and post-test measurement of total scores for Global Severity Index (GSI) (see Table 5.1). For specific items, such as somatisation and depression, scores remain unchanged from pre- to post-test. Improvement in somatisation is seen at three-month follow-up. Anxiety item scores do improve at post-test, returning to equal scores at the screening assessment point. Improvement in GSI scores does occur at three-month follow-up.

Table 5.1

BSI-18

Item	Screen	Pre	Post	Follow-up	Pre-Post Diff.	Pre-Follow-up Diff.
Somatisation	48	48	48	42	0	-6
Depression	62	48	48	48	0	0
Anxiety	50	61	50	50	-11	-11
GSI	60	51	51	48	0	-3
Percentile	84th	54th	54th	42nd	-	-

Note. GSI=Global Severity Index. The BSI-18 clinical cut-off is 63 (Derogatis, 2000) for a forensic inpatient ID maximum-security hospital sample (*n*=45) clinical cut-off is 64 (Kellett, et al., 2003).

5.2.2 Glasgow Anxiety Scale (GAS-ID).

Pre- and post-test difference shows deterioration in reported anxiety symptoms with a return to anxiety levels within the clinical range at post-test and follow-up. Scores are below the clinical range at pre-test. Specific item scores for fears are low and do not change (see Table 5.2).

Table 5.2

GAS-ID

Items	RCI	Screen	Pre	Post	Follow-up	Pre– Post Diff.	Pre-Follow-up Diff.
Worries	-	8	2	9	9	+7	+7
Fears	-	1	1	1	1	0	0
Physiological	-	7	6	7	5	+1	-1
Total	6.20	16	9	17	15	+8	+6

Note. GAS-ID clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Mindham & Espie, 2003).

5.2.3 Glasgow Depression Scale (GDS-LD).

Scores are below the clinical range and remain unchanged between pre- and post-test with no change measured at follow-up (see Table 5.3).

Table 5.3

GDS-LD

Item	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Depression	4.27	10	8	8	8	0	0

Note. GDS-LD clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Cuthill, et al., 2003).

5.2.3.1 Bayesian analysis of Glasgow scales: Comparison of difference between case and controls.

GAS-ID scores for this case compared against the local forensic control sample at pre- and post-test increase by 26.13%. There is negligible overall change compared against the local forensic control sample scores, with only 3.75% difference between the screening assessment point and follow-up (see Table 5.4).

(GDS-LD scores at the screening assessment point for this case compared against the local forensic control sample indicate that 28.69% or 34.06% of the non-depressed community sample would fall below the case score. No change is shown between pre-, post-, or follow-up (see Table 5.5).

Table 5.4

Bayesian point estimate of percentage of the control population falling below the participant's GAS-ID score

	Screen			Pre			Post			Follow-up		
Sample	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	38.16	27.94	49.11	15.92	8.82	25.03	42.05	31.54	52.98	34.43	24.49	45.25
**Community ID	74.63	55.50	89.27	50.01	31.28	68.82	77.94	58.73	91.25	71.56	52.29	86.98

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GAS-ID total scores as compared to a male forensic IDD sample (n=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 19 (SD=9.4). **Participants GAS-ID total scores as compared to a male and female non-anxious community ID sample (n=16) with a mean age of 34.9 (SD=10.4) and a mean score of 9 (SD=10) (Mindham & Espie, 2003).

Table 5.5

Bayesian point estimate of percentage of the control population falling below the participant's GDS-LD score

	Screen			Pre			Post			Follow-up		
Sample	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
* Forensic IDD	28.69	19.41	39.30	20.00	12.02	29.02	20.00	12.02	29.02	20.00	12.02	29.02
** Community ID	59.56	41.83	76.01	34.06	18.60	51.89	34.06	18.60	51.89	34.06	18.60	51.89

Note. Point=Bayesian point estimate of percentage of the control population falling below the participants score. LL=Lower credible limit, UL=Upper credible limit. *Participants GDS-LD scores as compared to a male forensic IDD sample (*n*=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 14 (SD=7). **Participants GDS-LD scores as compared to a male and female non-depressed community ID sample (*n*=19) with a mean age of 39.11 (SD=9.31) and a mean score of 9.29 (SD=2.94) (Cuthill, et al., 2003).

5.2.4 Rosenberg Self-Esteem Scale (adapted).

There was a higher self-esteem rating at the screening assessment point with reducing self-esteem being rated immediately preceding therapy at pre-test. Improvement is seen between pre- and follow-up scores.

Changes in John's selection of statements in relation to his self-esteem across the four test points give a more specific indication of his self-appraisal at the time (see Appendix 16a). Some statements are scored inconsistently, for example, "I like myself" is rated as "always true" eight weeks before starting therapy (screen) and "never true" immediately before therapy (pre). John shows unstable self-esteem in some items in this measure.

Table 5.6

Rosenberg Self−Esteem Scale (adapted)

	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Total score	6.25	22	16	17	20	+1	+4

Note. Maximum score = 30 (highest self-esteem), minimum score = 6 (lowest self-esteem). Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Dagnan & Sandhu, 1999).

5.2.4.1 Bayesian analysis of RSES (adapted): Comparison of difference between case and controls.

The largest percentage of local forensic control sample falling below John's self-esteem score occurs at the screening assessment point eight weeks prior to therapy with 49.97% falling below his score. Immediately preceding therapy this reduces to 9.72% of the forensic sample and 3.61% of the community sample falling below John's score. Improvement is seen between pre- and follow-up scores (see Table 5.7).

Table 5.7

Bayesian point estimate of percentage of the control population falling below the participant's RSES (adapted) score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	49.97	38.25	61.72	9.72	4.07	18.00	13.91	6.85	23.42	33.12	22.48	44.90
**Community ID	36.13	25.21	48.00	3.61	0.91	8.64	5.90	1.95	12.43	19.95	11.37	30.54

Note. Point=Bayesian point estimate of percentage of the control population falling below the participants score. LL=Lower credible limit, UL=Upper credible limit. *Participants RSES (adapted) total scores as compared to a male forensic IDD sample (*n*=43) with a mean age of 32.2 (SD=9.1) and a mean score of 22 (SD=4.5) (see Appendix 8).**Participants RSES (adapted) total scores as compared to a male and female community ID sample (*n*=43) with a mean age of 31.1 (SD=10.2) and a mean score of 23.44 (SD=3.99) (Dagnan & Sandhu, 1999).

5.3 Continuous Measures

At the screening assessment point John gave the following self-rating scores: "feeling tense, panicky or stressed" = 10 (not much), "feeling poorly or unwell" = 20 (a little bit), "feeling low, down or sad" = 30 (a bit), and "feeling cross or angry" = 31 (quite a bit) (see Appendix 10 for examples of all self-rating scales). John completed daily self-rated anger scores for the duration of the study.

5.3.1 Self-rated anger.

Self-rated anger scores were recorded over a period of 281 days in total. The time period encompassed phase A pre-treatment (54 days), phase B treatment (156 days), and post-treatment phase C (72 days). Daily self-rated anger scores were collected for 95.4% of the study period with a minimal amount not completed by the participant. Figure 5.1 shows a statistical process control chart of daily self-rated anger scores across the three phases of the study.

John's daily self-rated anger scores were compared with scores rated by the ward staff based upon their observation of him on the day. A coefficient weighted kappa showed an agreement of 0.85, $p = .003$, 95% CI [0.775, 0.928].

The self-rated anger scale captures the severity of personal angry feelings that John had on a daily basis using a 1 to 50 point scale (1= "the best is can be", 50 = "the worst it can be"). The mean score for phase A pre-treatment is 8.15. The pre-treatment mean has been set across phases B and C. Scores above the upper control limit (UCL) of 21.12 are considered to be out of control and assignable to a special cause which may be known or unknown.

5.3.1.1 Self-rated anger in phase A.

John rates himself with a maximum score for "the worst it can be" on one occasion during phase A (day 52, pre-therapy, week 9).

5.3.1.2 Self-rated anger in phase B.

For phase B a maximum score for anger indicating "the worst it could be" is rated twice (day 106, week 7 of treatment and day 154, week 14 of treatment). In the first two weeks of therapy process rates show that there is an increase in the frequency of days rated above UCL (21.12). A stable run of lower scores on or below x̄ starts three weeks into treatment (from day 75 to 103 and 109 to 143). Following John's last maximum score for self-rated anger in phase B (day 154, week 14 of treatment) stable runs of reduced scores can be identified with markedly lower process rates occurring. Following therapy session 16 only one day (178) is rated above the UCL with runs of the lowest possible score interrupted by only two days (days 196, 197) above mean (8.15).

5.3.1.3 Self-rated anger in phase C.

In phase C, stable runs of scores indicating "the best it can be" are rated for a total of 69 out of 72 days with scores rising above the mean only on days 211, 215 and 242. No days are rated above the UCL out of control limits for a total of 76 in phase C. A trend of 101 consecutive days scored below the UCL starts on day 179 in phase B following therapy session 16 and this continues in phase C post-treatment.

5.3.1.4 Trend for self-rated anger.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 5.2, 5.3, and 5.4. There is a relatively stable trend line in the pre-

treatment phase A (see Figure 5.2). Improving trend can be seen in phase B during treatment (see Figure 5.3). Post-treatment phase C (see Figure 5.4) has minimal variability in scores which shows a low and stable trend.

Fig. 5.1 Self-Rated Anger Scores for Case 1 (John)

A=Pre-Treatment; B=Treatment; C=Post-Treatment

Fig. 5.2 Pre-Treatement (Phase A) Self-Rated Anger for Case 1 (John)
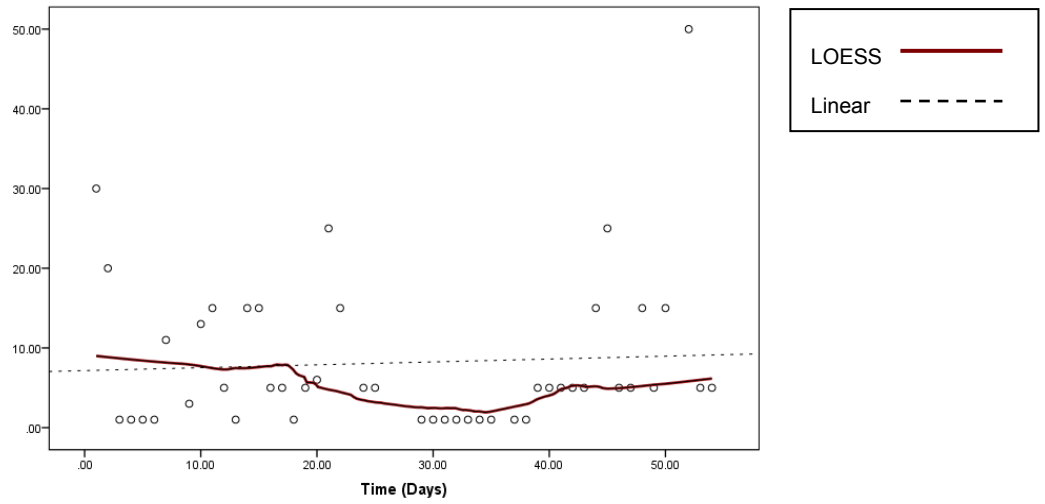
Fig. 5.3 Treatment (Phase B) Self-Rated Anger for Case 1 (John)
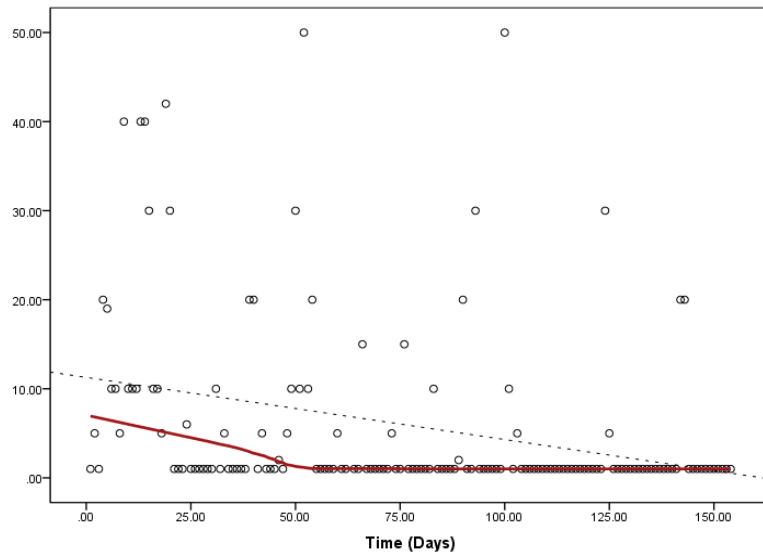
Fig. 5.4 Post-Treatment (Phase C) Self Rated Anger for Case 1 (John)
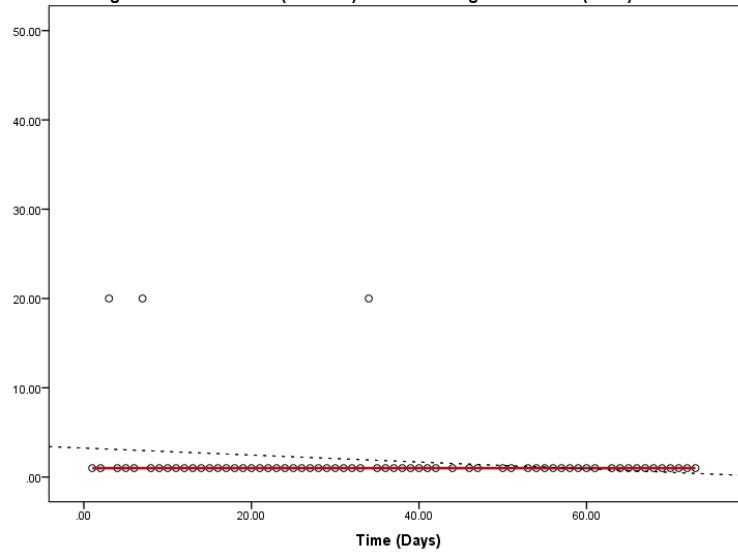
5.3.2 Modified Overt Aggression Scale (MOAS).

The Modified Overt Aggression Scale (MOAS) total scores combine the frequency and intensity of verbal aggression, aggression against objects, aggression against self, and aggression against others. The observation period included a total of 51 weeks. Phase A pre-treatment encompassed eight weeks, phase B treatment was 21 weeks and phase C post-treatment was 22 weeks. The levels of aggression John exhibited during the study, as measured by the MOAS, did not exceed levels that required interventions that would routinely be reported as SUIs. A statistical process control chart showing MOAS scores in the separate phases of the study can be seen in Figure 5.5. The phase A mean ($\bar{x}$) has been set for phases B and C.

5.3.2.1 Total MOAS scores across phases.

Highest total severity scores for overt aggression, above the UCL=10.65, occur in phase A week eight. Change is shown in John's overt aggression in phase B from week 26 following 17 sessions. From this point, starting in week 26 in phase B, reduced scores can be seen in a stable run below the phase A mean continuing for a period of 23 weeks into phase C until week 50 of the observation period.

5.3.2.2 Verbal aggression.

Scores for verbal aggression had been observed in seven out of the eight weeks during phase A, in 13 out of the 21 weeks during phase B, and during one week in the 22 weeks observed in phase C.

5.3.2.3 Aggression against objects.

Aggression against objects is scored in phase A in weeks 5, 7, 8, and 9, within phase B in weeks 16, 17, 21, and week 23, with no scores in phase C. Following the 16th therapy session no scores are given for aggression against objects.

5.3.2.4 Aggression against self.

Aggression against self includes items for minor and serious self-injury. Items for minor self-injury are scored in phase A on weeks 1, 2, and 3, within phase B on weeks 11, 12, 14, and 24. No scores for this item are present following week 24 of observation and no scores are present in phase C. No scores for aggression against self are present following week 17 of therapy.

5.3.2.5 Aggression towards others.

Aggression towards others is characterised by behaviour such as "making threatening gestures, swings at people, and grabs at clothing". There are no scores for aggression towards others in phase A. Scores in phase B occur at weeks 11, 12, and 14 with no scores present for this item in phase C. Rating of aggression towards others does not occur following therapy session seven.

5.3.2.6 Trend for MOAS scores.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 5.6, 5.7, and 5.8.

Pre-treatment phase A (see Figure 5.6) shows increasing trend in total MOAS scores indicating a higher frequency and severity of observed aggression. Trend improves during treatment phase B (see Figure 5.7) with lower variability in scores and flat and stable trend in post-treatment phase C (see Figure 5.8).

Fig. 5.5 MOAS Scores for Case 1 (John)

A=Pre-Treatment; B=Treatment; C=Post-Treatment
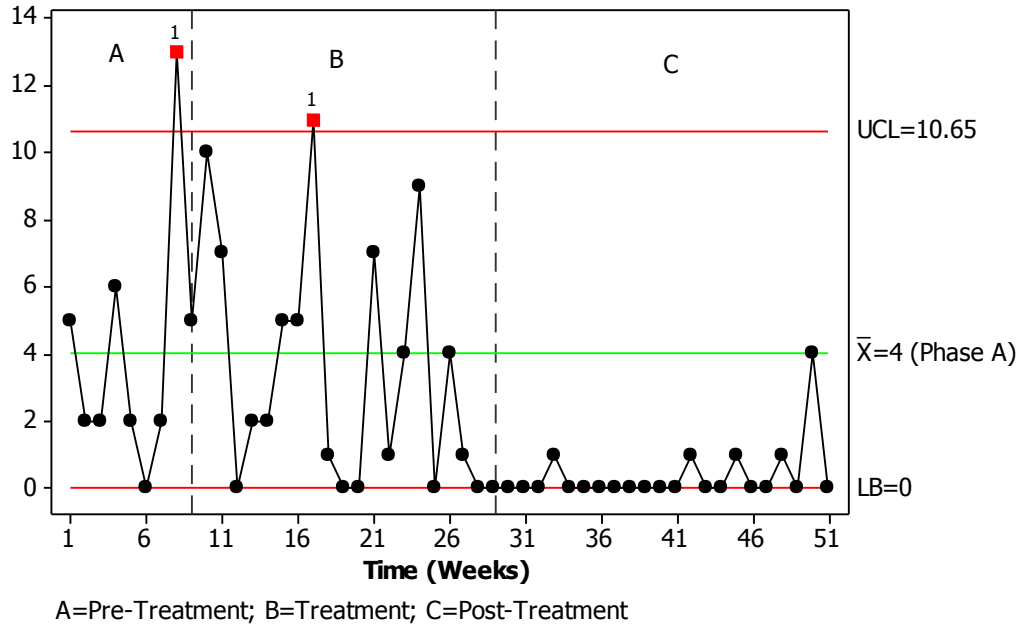
Fig. 5.6 Pre-Treatment (Phase A) MOAS for Case 1 (John)
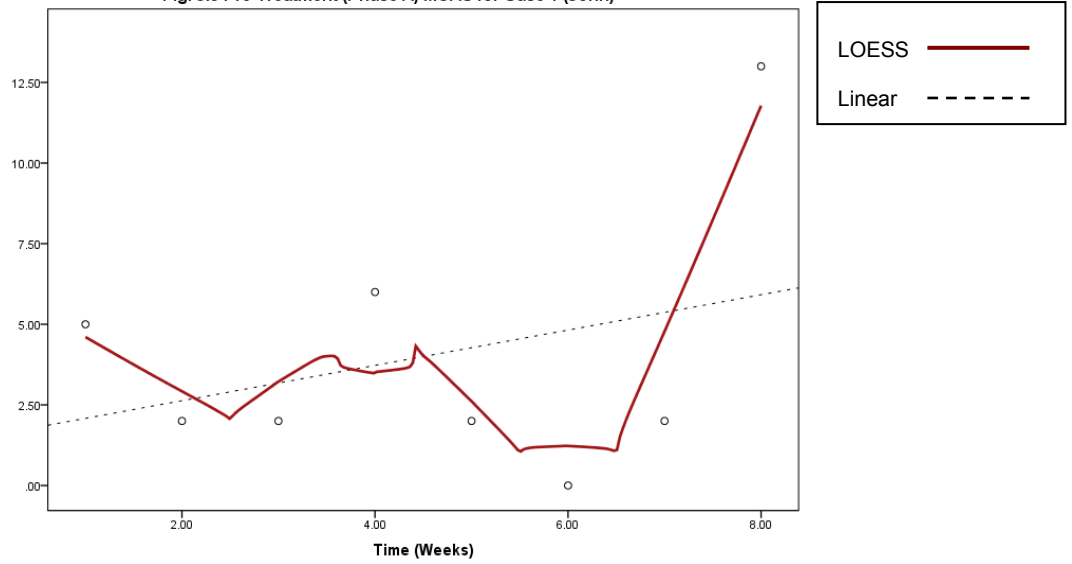
Fig. 5.7 Treatment (Phase B) MOAS for Case 1 (John)
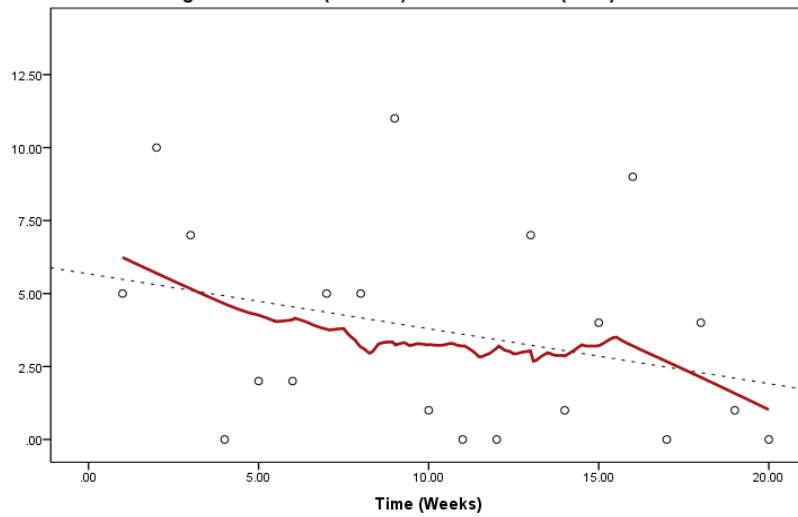
Fig. 5.8 Post-Treatment (Phase C) MOAS for Case 1 (John)
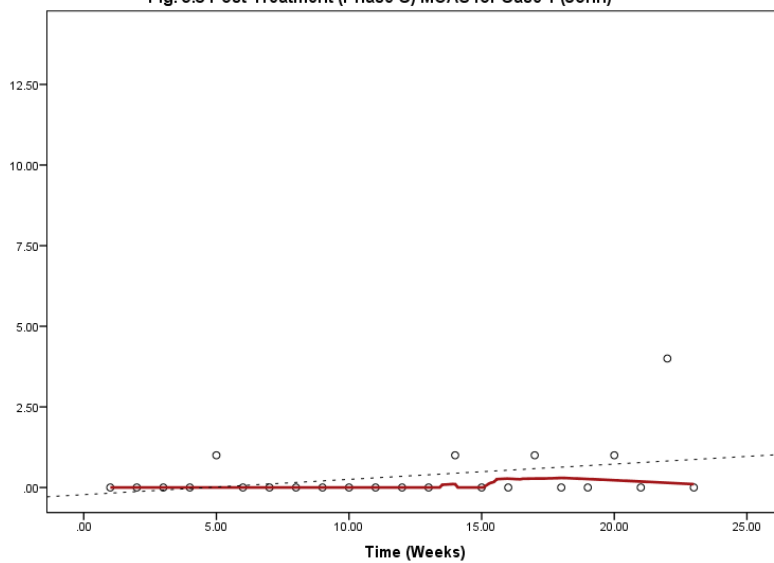
5.3.3 Serious Untoward Incidents (SUIs).

SUIs were reviewed for the 12 months preceding therapy. Ten months before starting therapy one incident was recorded of the use of PRN medication and one incident which required control and restraint techniques is also recorded. Eight months prior to therapy starting there were two incidents of PRN medication being used, two incidents where control and restraint techniques were used and one incident of seclusion. Following this no further SUIs were recorded in the seven months prior to therapy, during therapy, or for eleven months following therapy.

5.4 In-Treatment Measures

5.4.1 Personal Problem Scale (PPS).

Within the first session John was asked by the therapist to identify three areas of his life which he felt were difficult (see Table 5.8). Things that were bothering him at this time included, (1) Feeling as if he was not making progress towards his personal goal of moving from medium secure accommodation to low secure accommodation. (2) Being worried about his mother, which was partly due to her poor health and partly due to his inability to respond to a family crisis if this occurred. (3) John identified his frequent arguments and verbal aggression towards staff, which he euphemistically called "being cheeky".

At the start of therapy John rated all three personal problems as being "the worst that they could be". In the last session John was asked to rate the severity of his personal problems again and did so choosing the statement "the best it can be" (or close to this).

Table 5.8

Personal Problem Scale

Problem Statement	First Therapy Session	Last Therapy Session
I have arguments with staff*	1	5
I am not getting on or making progress.	1	5
I am worried about my mother / family	1	4

Note. 1= worst it can be, 5 = best it can be; *=most difficult problem.

5.4.2 Core Conflictual Relationship Theme (CCRT).

The completeness of John's relationship episodes range from between 4.0 to 5.0, indicating that all CCRT components were present with a high level of added detail. Seventy two percent of *wish* component statements were rated by judges as having an "explicit level of inference" with only 28% being "moderately inferred statements".

John's CCRT at the start of therapy shows a conflict between his positive *response of self*, a negative *response of others* and his *wish* (see Table 5.9). There is a repeated pattern shown in relationship episodes of John "liking others" and having a *wish* "to be close to others" but experiencing others "as not trustworthy".

John's CCRT at the end of therapy does change to the point where dominant themes in his relationship episodes show that his *wish* is to "achieve", that he perceives others as "helpful" and his response is to "understand". There is a shift in John's CCRT interpersonal schema from a negative *response of others* to a positive *response of others* at the end of therapy.

At the start of therapy a pervasiveness score of 45% was given for the presence of this CCRT within John's relationship episodes. Pervasiveness of this CCRT within relationship episodes reported at the end of therapy is reduced to 16%.

Table 5.9

Core Conflictual Relationship Theme (CCRT) Interpersonal Schemas

CCRT at start.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
Are happy; are fun; are glad; enjoy.	***Are not trustworthy;** betray me; are deceitful; are dishonest.	***Like others;** am friendly.	**Hurt others;** am violent; act hostile.	***To be close to others;** to be included; not to be left alone; to be friends.
Are cooperative; are agreeable.	**Are controlling;** are dominating; are intimidating; are aggressive; take charge.			**To not be hurt;** to avoid pain and aggravation; to avoid rejection; to protect/defend myself.
Are open; are expressive; are disclosing; are available.				
Are understanding; are empathic; are sympathetic; see me accurately.				

CCRT at end.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
***Are helpful;** are supportive; give to me; explain.		***Understand;** comprehend; realise; see accurately.		***To achieve;** to be competent; to win.
Respect me; treat me fairly; value me; admire me.		**Feel accepted**; feel approved of.		**To be respected;** to be valued; to be treated fairly; to be important to others.
Are strong; are superior; are responsible; are important.		**Am open;** express myself.		**To be independent;** to be self-sufficient; to be self-reliant; to be autonomous.
		Am helpful; am supportive; try to please others; am giving.		

Note: *= most frequently recurring theme in relationship episodes.

5.4.3 Therapist Observation Rating Scales.

John's level of engagement as rated by the therapist is generally high: John is rated as "open" or "open and trusting" in 18 out of 20 therapy sessions (see Figure 5.9). He is rated by the therapist as "not engaged" in his eighth session.

John's level of participation and motivation within therapy was rated by the therapist as being either "a self-motivated attempt to participate" or "full and active participation throughout" for 19 out of 20 therapy sessions (see Figure 5.10). John was scored by the therapist as not participating in session eight even when "prompted and encouraged".

John was not required to make an image in therapy sessions 1, 19 or 20 (see Figure 5.11), and chose not to do so in his eighth session. John had a generally positive attitude towards image-making within therapy sessions. He was rated by the therapist as either having a "positive" or "active and focused" attitude to image-making in 13 out of a possible 17 sessions.

Therapist Observation Rating Scales

Fig. 5.9 Therapeutic engagement for Case 1 (John)
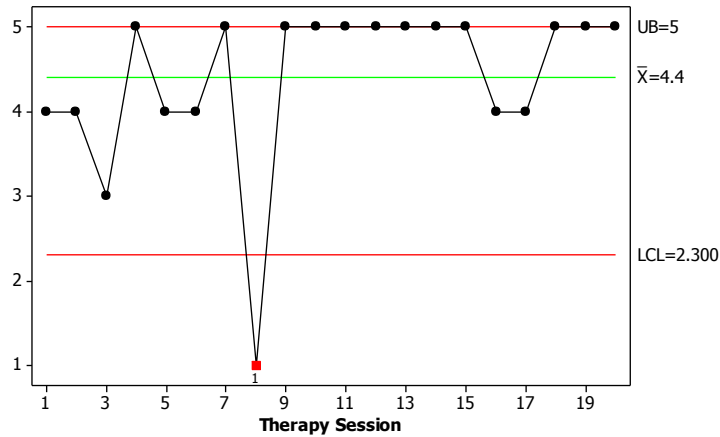
Note. 1=did not engage, 2=reluctantly engaged, 3=genuine but guarded, 4=open, 5=open and trusting,

Fig. 5.10 Participation and motivation for Case 1 (John)
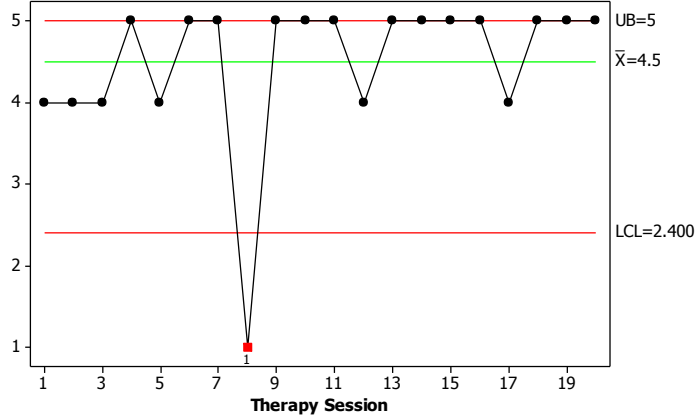
Note. 1=did not participate in session even when prompted and encouraged, 2=participated in session with prompting and encouragement, 3=participated satisfactorily without prompting or encouragement, 4=a self-motivated attempt to participate and 5= full and active participation throughout.

Fig. 5.11 Attitude towards image-making for Case 1 (John)
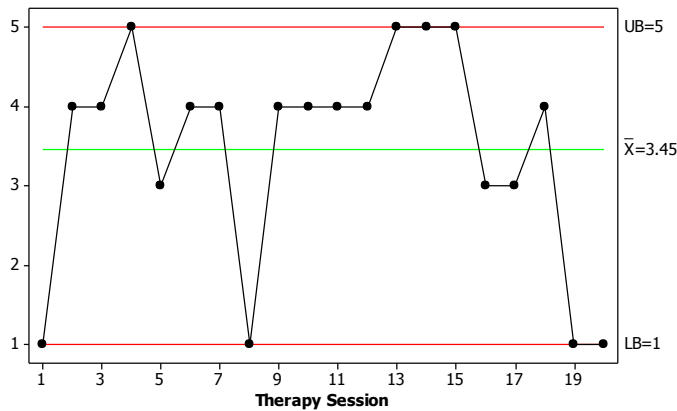
Note. 1= No image or art object made in the session (image-making was not required in session 19 or 20), 2=required encouragement and prompting to attempt image-making, 3=mixed response to image-making, 4=positive response to image-making, 5=active and focused response to image-making.

5.4.4 Participant's most important image or object.

In the final therapy session images made in the preceding sessions were reviewed by John and the therapist. He was asked by the therapist to select the most important picture he had made. John told the therapist at the time that he found it difficult to select one image, but he did select four pictures and said that they were all important to him.

"Playing football with brother and cousin" (see Figure 5.12) made in session three related to John's childhood memories of playing with his cousin who had been murdered. In session nine John had made a picture about going out to a nightclub with his cousin (see Figure 5.14). John spoke about not going to his cousin's funeral during this session. Other pictures related to John's memories about his cousin included "Playing on trampoline with brother and cousin" (see Figure 5.15) made in session 11. John told the therapist that he had stopped using the trampoline when his cousin had died.

The final picture John chose was "Owning my own bar" (see Figure 5.16) made in session 15. John spoke about his feelings of anger in this session and times when he tried to maintain a "tough guy" image in front of others. After drawing this picture John spoke about wishing to own a bar and be in charge of it.

5. 5 Retrospective Attribution

5.5.1 Change Interview (adapted).

At follow-up interview three months after ending therapy a number of areas in John's life had changed. The changes he reported included an improvement in his attitude and improvements in his relationships with his parents and staff. John also said he was feeling happier and less angry. He had been transferred from the medium secure unit to a low secure unit within the hospital.

5.5.1.1 Being argumentative with staff.

What changed? "I've changed my attitude, the way I talk to people. Because I used to be a cheeky little git with loads of people and I've just finally thought to myself, 'what's the point of being cheeky?' And I just stopped being cheeky after I started doing art therapy."

What helped? "It helped me to keep myself to myself and get on with what the staff told me to do and try and move on."

Attribution: Within the interview John attributed being less argumentative with staff to events taking place within therapy. He did not identify any extra-therapy events as contributing towards this change.

5.5.1.2 Relationship with parents.

What changed? "Because I used to be a lot cheekier to my mam and my mam says she's seen a big difference since I did my art therapy. She says I've changed a lot."

What helped? "It was a gradual change. It was like the way I used to talk to them on the phone and that made me realise what I was doing to my mam and dad. Because I know my ma's not very well – that's made me realise why I had to change. For my ma and my ma says, I've changed a lot since I've been in hospital, with my attitude towards both of them."

Attribution: John partially linked these changes to events in therapy. Other attributions towards this change include his response to concerns about his mother's health and not living with them (being in hospital) supporting an overall gradual improvement.

5.5.1.3 Feeling happier.

What changed? "I'm a lot happier."

What helped? "Well, just getting the stuff out in the open, what I've been keeping inside for a long time. Like with my cousin – what happened to my cousin and stuff – just wanted me to realise to get it out in the open instead of keeping it bottled up inside all the time."

Attribution: John attributed feeling happier towards events that took place within therapy, particularly the bereavement work. He did not identify any extra-therapy events contributing towards him feeling happier.

5.5.1.4 Feeling more relaxed.

What changed? "I feel more relaxed and not tense."

What helped? "…my tablet made me more relaxed, and a bit of the art therapy." "When I was talking about my feelings and how it was going to be and what makes me upset and stuff like that."

Attribution: John partially attributed feeling more relaxed to his participation in therapy and he also identified an extra-therapy psychobiological factor that contributed towards this change.

5.5.1.5 Feeling less anger.

What changed? "…if I'm angry. I try and talk to people."

What helped? "We used to talk about what pictures we were going to… what I was going to draw and stuff and we used to talk about, after we drawn the picture, we used to talk about what the picture was about and how it was." "Just one of my pictures that I drew made me even think harder… because… because my cousin, like, being on… having fun and that made me realise that's what I want in life, to

have my fun with my brother and that and stuff, so… and that's made me realise what I want." "I've learnt how to, if I'm like angry, to go to like my room to calm myself down." "I try and talk to them [ward staff], if I'm angry. I try and talk to people."

Attribution: John also linked feeling less angry with bereavement work which took place within therapy sessions. John did not identify any extra-therapy events as contributing towards this change.

5.5.1.6 Making progress.

What changed? Ten weeks after completing therapy John was transferred from the medium secure unit to a low secure unit. "…I wanted to move on from the [medium secure unit] to less secure."

What helped? They [therapist] talk about stuff. If you're angry, instead of going off on one, it helped you to realise what you should do right and what you shouldn't be doing.

Attribution: John attributed the changes that enabled him to be considered for lower security as an improvement in events taking place in therapy. John also spoke about knowing the conditions that he needed to meet in order to be considered for transfer to a low secure unit by his RC.

5.5.2 Attributed changes.

These were, in summary, changes in John's attitude, the way he spoke to people, feeling happier, and feeling less angry. John attributed the therapy as being supportive in helping him to meet the conditions for a transfer to a low secure unit explained to him by this RC. Improvements in relationships with his parents, and

feeling more relaxed were partially attributed to therapy and partially attributed to extra-therapy events such as being in hospital and medication.

5.5.2.1 Corroboration of the participant's retrospective attribution with a nursing account of change.

John's named nurse was interviewed separately using a change interview schedule. Accounts John gave about post-therapy change have been compared with the nursing account of change.

John's named nurse reported a noticeable change in his motivation. This included observations that John had changed a pattern of rejecting professional involvement or ending treatment early. "I think because his history of rejection of services, and that was so great, and his motivation is low to change and his belief system, I mean, very difficult to infiltrate that and I think it was actually a big hurdle."

John's disengagement and re-engagement in therapy was described by the nurse. "And then there was one week he was going to pack it in, I believe. I think I was on holiday or… I wasn't here that week, but he didn't… he did actually miss a week as a result of that. Which [therapist's name] thought would be the best thing and then he decided to carry on. So that was a good thing, I thought."

John's ability to sustain his involvement in treatment was perceived by his named nurse as an important individual goal. "And I mean we did talk about that – the fact that he'd achieved a one-to-one collaboration for the first time in his life and kept with it right until the end of… and I used to compliment him a lot about that, because I thought that was a major thing for John. Because we talked about how he might be able to work with a mentor later on, when he leaves."

The nurse said that John had appeared to be more open at times when he felt angry. "Yeah, and the other thing was that I think he was a bit more genuine about how he really felt, rather than having this, you know, other agenda going on all the time. I think sometimes he could own up to feeling angry and what have you. Which is also… which is really good for him, obviously, behaviourally."; "I think that was the genuineness that was creeping in from his one-to-one work and being able to speak and feel… and… like rehearsing speaking genuinely. Because of the way the art therapy is that would have encouraged him to be more honest."

A specific example was given about John trying to change the way he approached nursing staff. "I think he… I think he came out of the therapy with something to rehearse, because I saw him do it, one or two days running and thought, 'Oh he's… That's completely different for John.' The way he approached me and spoke to me, and I thought, 'he's rehearsing'. So, I might be wrong of course, but I'm sure that is what was happening. It was just completely different for him to approach me so directly and openly and to… I mean, he always used good manners but it was just more of a directness, I think and I thought he's really making an effort there to speak to me and be honest about what he wants."

John's attitude towards being in hospital was identified by the nurse as having changed. "He was exceptionally intolerant of his detention, exceptionally, and I think that he became a lot more tolerant of it because of the… So, therefore, his engagement, generally, should be better in terms of him going into other group work and his other treatment programmes. I think it's got to have made a big difference as regards to that, how much he'll really participate when he gets in there, I would say is better. He's got a better chance now of really engaging, rather than just looking as if he's, you know, making out he's engaging." "I think he started to appreciate… the fact that he was more tolerant of his detention. So he started to

think there was some reason to do the things that we asked him to do, rather than resist them, he started to see that actually it could help him, I think."

John is also reported as having given more attention to nursing staff and he appeared to demonstrate that he had more understanding about things that were explained to him. "So he could link, you know, what we… so he would pay more attention… maybe take a little bit more on board of the things we said to him and talked to him about than he was previously able to do because he wasn't resisting as much."

John's retrospective attribution towards therapy appears to be closely related to observations and comments made by his named nurse.

Figure 5.12 Therapy Session 3 "Playing football with brother and cousin".
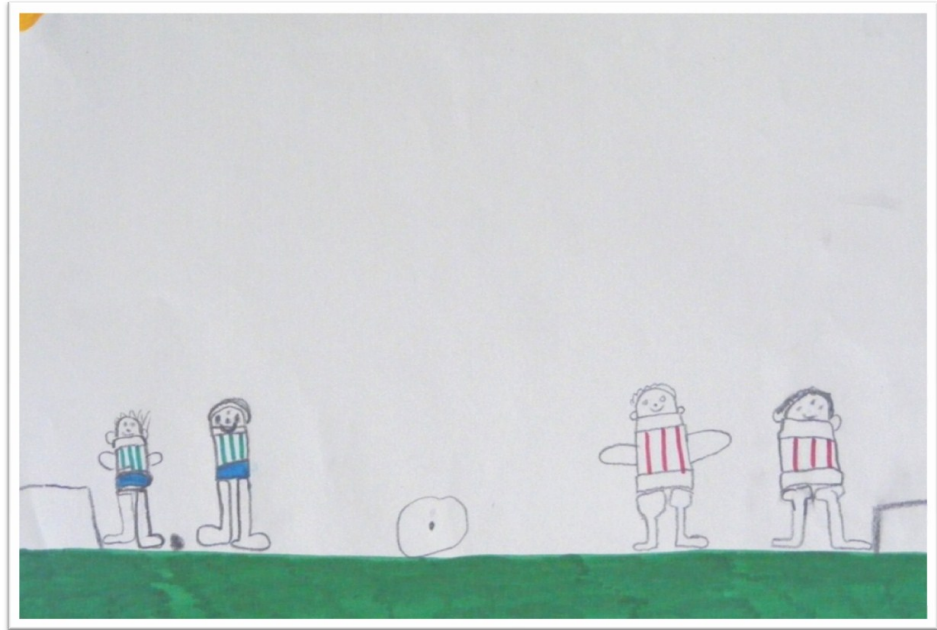
Figure 5.13 Therapy Session 6 "Joy riding, police car chase".

Figure 5.14 Therapy Session 9 "Nightclub with brother and cousin".
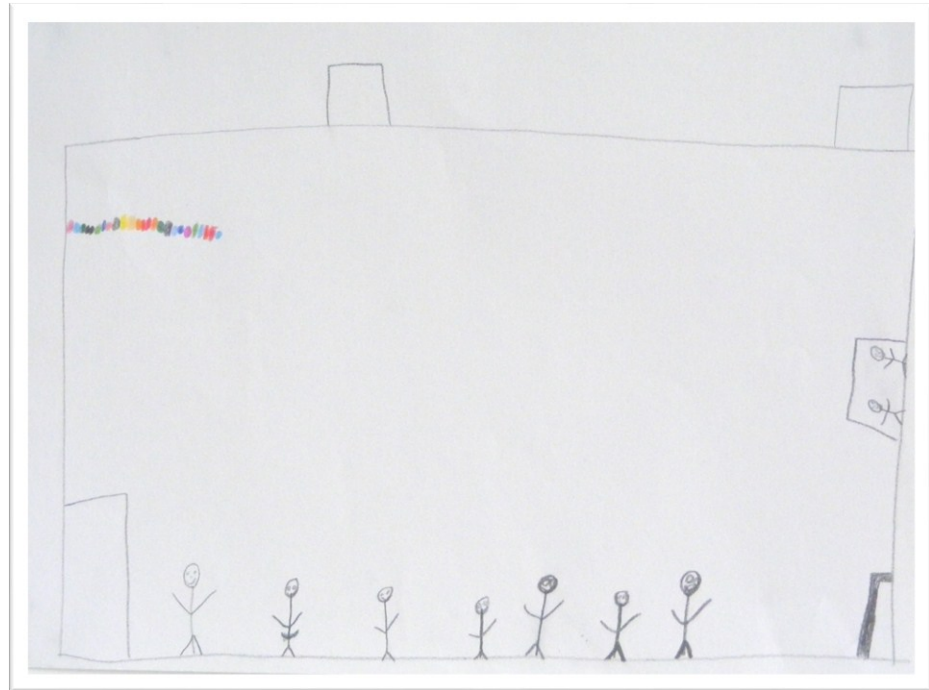
Figure 5.15 Therapy Session 11 "Playing on trampoline with brother and cousin".
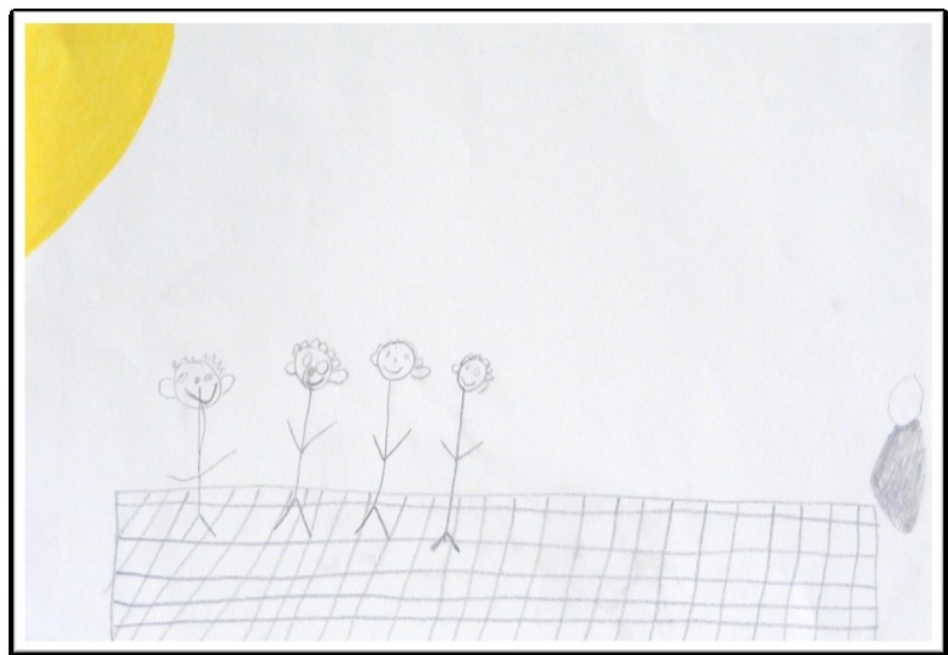
Figure 5.16 Therapy Session 15 "Owning my own bar".

Figure 5.17 Therapy Session 18 "Out with friends in a limousine".
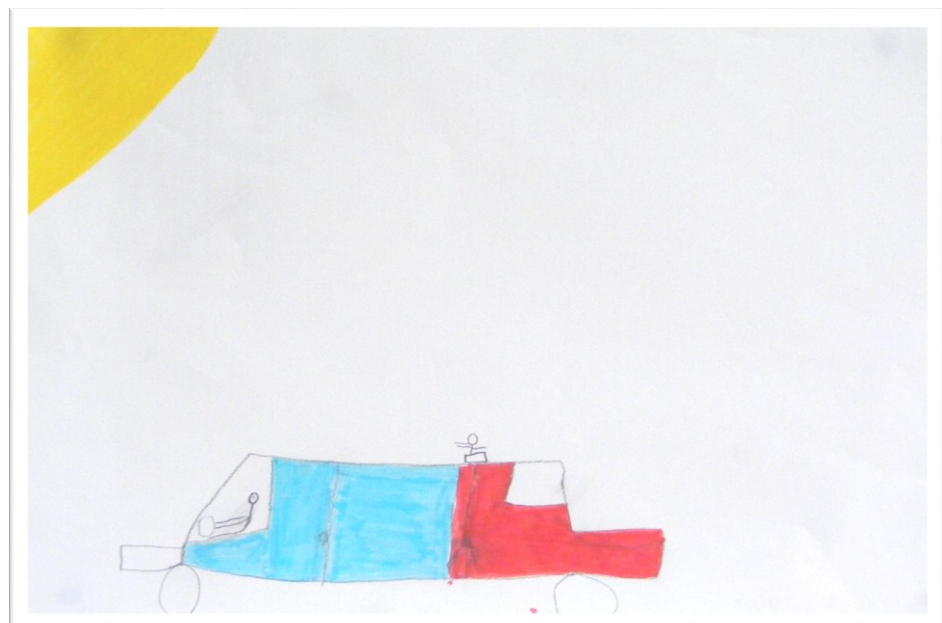
5.6 Evaluation of Explanations for Change Related to Therapy

5.6.1 Process outcome mapping.

In process outcome mapping the content of the patient's post-therapy changes should correspond to specific events, aspects, or processes within therapy.

John specifically highlighted the process of "talking about stuff again, and drawing" and "getting stuff out in the open, what I have been keeping inside for a long time" as being helpful. Non-judgemental reflection upon his anger by the therapist appeared to help him to consider alternatives to his behaviour. "They [therapist] talk about stuff. If you're angry, instead of going off on one, it helped you to realise what you should do right and what you shouldn't be doing."

John said that bereavement work related to the death of his cousin was linked to changes in feeling happier and feeling less angry. John attributed these changes to speaking about the death of his cousin within therapy sessions.

Three out of the four pictures John selected as being most important during therapy were made during therapy sessions three, nine and 11, when he was speaking about memories of being with his cousin who had been murdered.

There is adequate evidence to suggest a link between processes and events taking place within therapy, and post-therapy outcome.

5.6.2 Change in stable problems.

An extract from a formal post-admission risk assessment document reported earlier in this chapter (in background information) demonstrated that John's anger, aggression and attitude towards staff were long-standing difficulties unlikely to respond to spontaneous improvement. John's behaviour included persistent negative relational and behavioural components. MOAS scores show an increasing baseline trend (see Figure 5.6). There is, however, a reduction in the severity and frequency

of observed aggression starting in the treatment phase B (see Figure 5.5 & 5.7). In comparison to the deterioration in aggression in pre-treatment phase A, post-treatment trend in phase C is improved (see Figure 5.8). There is evidence to suggest that change has occurred in a stable problem.

5.6.3 Event-shift sequence.

There are two events identified within therapy sessions that appear to precede change: (1) bereavement work in sessions which included content relating to the murder of John's cousin, and (2) self-image work in sessions which explored issues related to John's self-appraisal.

5.6.3.1 Bereavement work.

In the first session John was asked by the therapists what his thoughts were when he became angry. John replied, "Just to lash out at someone and to hit them and that". When he was asked by the therapist, "...why do you think you want to do that, why do you get angry so quickly and want to hit somebody?" John said, "I lost my cousin, he got murdered and that's made me lose my temper all my life now, I can't stop thinking about him and my family as well".

Within this session John described his fear about being in danger after finding out what had happened to his cousin. John thought that this had contributed to his being wary in his local community and one of the reasons he acted as a "tough guy" and family protector. "That's made us like the way I am now, cos even if I walk in a dark area I cannot see in a dark area, I've got to be where it's like light now, I'm not scared of the dark but like if you're walking down a dark alley and it's someone behind you, you don't know what's going to happen to you. Well I'm

worrying in case it like happens to me or one of my family as well again, that's why I've always been the way I am, so toughens us up more better."

John spoke about the death of his cousin in sessions 1, 2, 3, 8, 9, 11, and 15. At the start of session eight John told the therapist that he had found speaking about memories of his murdered cousin in the previous sessions distressing. John did not wish to participate in this session and a short break in therapy was negotiated with the therapist.

John revisited memories of his cousin in session nine and he drew an image of them both going out to a nightclub together and having fun times (see Figure 5.14). Within this session John told the therapists that it had been seven months following the disappearance of his cousin before his body had been found and that he had not attended the funeral. In session 11 John told the therapist that he was feeling less angry when he spoke about his cousin.

At post-therapy interview John identified that he was "feeling happier" as a result of having spoken about the death of his cousin within therapy.

5.6.3.2 Self-image work.

In session three John gave a boastful account of knocking people out with one punch. He was also observed by the therapist to become excited when speaking about drug and alcohol binges and criminal acts that he had committed.

Taking revenge or "payback" was a recurring theme throughout John's therapy. He existed in a culture of reprisal which was also relevant to the role he had taken on as "family protector". In session six John drew a picture of being caught by the police after stealing a car, joy riding, and setting the car alight (see Figure 5.13). Prior to stealing the car he said that he had heard that his girlfriend at the time had been cheating on him and that he had felt "disgusted" and gone on to break into the

car with some friends. John said that he had beaten up the person who had been involved with his girlfriend and had tried to arrange for a family member to attack his ex-girlfriend for "payback".

The therapy process record also provided information about sessions where John discussed a personal struggle with maintaining his "tough guy" image; for example, he spoke about being bullied in prison in session 10. In session 13 the therapist reflected his observation that John appeared to become more confrontational at times when he reported feeling happy or had a heightened mood. This discussion was also developed in session 14 when John was told by the therapist that he appeared to become excited when speaking about acts of physical violence. John told the therapist that he was deciding whether to be "nasty" or "nice" and was trying to make progress in the hospital.

In session 15 John spoke about his fantasies of being a bar owner in a beach resort and being the "big boy". In this role he said that he would be able to order people around and sack staff (see Figure 5.16). In session 16 John spoke about some of his regrets about criminal behaviour and his wish to change. This event coincided with the start of a stable improved trend in MOAS scores occurring after session 17 (see Figure. 5.5 week 26) and continuing in the post-treatment phase C for 23 weeks.

In session 17 John spoke to the therapist again about being bullied in prison and trying to look "hard" in front of his mates. In session 18 John drew an image of being out with his friends and girlfriend in a limousine (see Figure 5.17), telling the therapist that he was focusing on making progress in the hospital and thinking ahead for his future.

There is evidence within the case record to indicate that sessions including self-image work preceded positive shifts in John's motivation to change his behaviour towards others.

5.6.4 Specific change processes.

Further consideration of the role of therapy change process can be understood through John's post-therapy interview.

1. John acknowledged that raising issues related to the murder of his cousin at the start of therapy was very difficult for him. "I found it a bit hard at first. Because we were like talking about my family and that, and what happened and who was I close to and stuff."

2. Drawing within the sessions appeared to have had a supportive role. "I found the drawing part easy, a lot easier to get it out in the open and show what I was doing with my cousin and stuff like that. It was just getting easier through some of it."

3. John was helped by the therapist to start his drawing and then to explore the content and meaning of the image that he had made. "Before I could think what I was going to draw, we used to have a little chat then and then… I'd at least go, 'right, I've got one that I want to draw now' and he goes, 'right' and then I used to get on with my drawing and do it and we used to talk about, after we drawn the picture, we used to talk about what the picture was about and how it was."

4. The subject of John's drawings and guided reflection supported by the therapist helped him to re-evaluate relationships. "Because drawing pictures of good times that we had with my cousin. It was what we'd done. Because we'd built a trampoline and I drew the one where we built a trampoline, because… because my cousin, like, being on… having fun and that made me realise that's what I want in life. To have my fun with my brother and that and stuff, so… and that's made me realise what I want."

5. As a result of this process within therapy John reports an easing in the distress in relation to the murder of his cousin that he had felt at the start of therapy,

"Well, just getting the stuff out in the open, what I've been keeping inside for a long time. Like with my cousin – what happened to my cousin and stuff – just wanted me to realise to get it out in the open instead of keeping it bottled up inside all the time. Talking and drawing pictures".

5.7 Change Process Theory

5.7.1 Self-esteem, "egotism", aggression and violence.

A number of theories related to violence and aggression can be seen to link with John's presentation and background history. As previously discussed as an event shift sequence John articulated that he wanted to change his behaviour towards others in order to make progress. This event coincided with improvement in some of his aggressive style of interacting with others, described by John as "being nasty". Theory developed in psychotherapeutic work linking the protection of self-image with self-esteem and acts of aggression may provide an explanation for this particular change process within John's case.

Glasser (1998) presents an extensive model of violence which suggests a link between a threat to the "physical or psychological self" as provoking some individuals to act aggressively. This understanding is based upon the view that violent acts may be triggered by "the infliction of a blow to self-esteem, frustration, humiliation, and insult to one's self or an ideal to which one is attached…" (Glasser, 1998, p. 889).

Fonagy (2003), in a brief editorial, considers developmental factors related to violence and highlights studies which show the influence of early attachment upon a child's capacity to regulate anger. Fonagy (2003) also notes that threats to self-esteem can trigger violence in individuals who have a self-appraisal which is on "shaky ground" due to exaggerated self-worth. He links this to a failure of

mentalisation, difficulties recognising the mental states of others, where violence is triggered by "narcissism" in individuals who "are unable to see behind the threats to what is in the mind of the person threatening them" (Fonagy, 2003, p. 191).

In therapeutic work with offenders who have intellectual and developmental disabilities understanding related to self-esteem is developing. Johnson (2012) has completed important work looking at self-esteem scores within a forensic intellectual and developmental disabilities population. Study results indicated that there was no statistical difference in self-esteem between those in medium and low secure services. The majority of offenders with intellectual disability were found to have moderate to high self-esteem. Offenders who had committed violent offences had the lowest self-esteem, followed by those who had committed sexual offences or fire-setting.

Johnson (2012) concluded that the overall results of the prevalence study did not concur with clinicians' anecdotal reports that low self-esteem is dominant among offenders with intellectual disability. A number of factors are discussed, including the concept of self-esteem being a "personal entity". One-off interviews measuring self-esteem could have influenced how participants wish to portray themselves. Johnson (2012) also suggests that negative core beliefs and feelings of low self-worth in intellectual disability forensic patients become more evident within a trusting therapeutic relationship. One clinical implication of this might be that self-esteem scores appear higher at the start of therapy than becomes apparent after exploration of core beliefs (Johnson, 2012).

High or unstable self-esteem has been linked to the increased likelihood that individuals will give a hostile response to negative feedback (Kernis, Grannemann, & Barclay, 1989).

In an interdisciplinary review of evidence about aggression, crime and violence Baumeister, Smart, and Boden (1996) present the view supporting the theory that high or unstable self-esteem can contribute towards increased violence and aggression. Self-esteem, defined as a "favourable self-evaluation", is considered more broadly to include inflated self-appraisal, pride, arrogance, honour, a sense of superiority, and narcissism (Baumeister, et al., 1996). This type of favourable self-evaluation, which can include both valid and inflated self-appraisal, is defined using the term "egotism". When there is a discrepancy between the person's internal and external self-appraisal, egotism is threatened. This threat is acutely seen when a person's internal view of self which is unstable, inflated or uncertain is faced with a negative evaluation by others. At the point when "threatened egotism" occurs the person has a choice about accepting or rejecting the appraisal. Accepting the negative appraisal, and therefore the discrepancy between their internal view of self and the external appraisal would require the person to lower their self-appraisal and accept negative emotions towards him or herself and withdraw. Rejecting the negative external appraisal would allow the person to maintain their self-appraisal and direct negative emotions towards the source of the threat leading to aggression or violence (Baumeister, et al., 1996).

5.7.1.1 Therapy processes.

John's progress was impeded because he would frequently challenge rules and engage in verbally aggressive and threatening behaviour towards staff. Given his history of violence, these incidents had potential to escalate, maintaining his requirement to be managed in a medium secure setting.

The therapy process record shows that a number of sessions involved John drawing pictures which bridged into discussion about his behaviour. This included

recognition of his negative treatment of others, his high sensitivity to criticism or his response to being given "no" for an answer. John was also seen to take part in a culture of reprisal to protect family honour and had an inflated self-appraisal which became apparent when he spoke about criminality and his predilection for risk taking. RSES (adapted) item scores also indicate features of a high but inconsistent or unstable self-esteem, for example inconsistent scoring of the item "I like myself", prior to therapy (see Appendix 16a).

Within the first session John said he had difficulties responding to constraints placed upon him within the medium secure unit. The following transcript from the first session clearly illustrates this.

Therapist: Sometimes they say no, and then what happens?

John: And I just lose my temper over it.

Therapist: And what would you say to them?

John: I swear at them, tell them to do what, do everything like swear, call them names and say other stuff and they don't like it and they put us down on the floor for it, so, and even though I am in the wrong for saying all of it, but I just want to try and stop it as well.

Therapist: So what are you trying to stop, what do you want to stop?

John: Like, the swearing, arguing, take no for an answer and stuff like that and just listen to what the staff say to us.

Therapist: But you find yourself swearing at them and then what happened for you to be taken to the floor? Why would they do that?

John: Cos I don't be quiet, I just keep going on and on and on about it and then I'll start punching walls and that and threaten to hit myself and that and then they'll grab a hold of us and then I'll start moving about, and then

they've got to put us down on the floor to try and stop us from hurting myself and other people. (Transcript: Therapy Session 1)

John did not like having his wishes or intentions thwarted. John spoke about his criminal behaviour associated with his self-image, for example, wanting to look hard in front of his mates and being excited by situations involving danger and criminal acts of violence towards others.

The culmination of self-image work, which was associated with John's negative behaviour towards others, took place in sessions 16 and 17 when John spoke to the therapists about a personal choice (struggle) he was having making a decision about either continuing to be "nasty" (a self-image he appeared to have some investment in maintaining) or trying to comply with treatment and move on. John told the therapist that he had decided to make progress and achieve. As previously discussed, this session coincided with reducing trend in MOAS scores.

Within some elements of psychotherapeutic work and theory, for example the concept of egotism, protecting an unstable or inflated self-appraisal (Baumeister, et al., 1996), it appears plausible that events and processes taking place in therapy could have supported a reduction in John's aggressive style of interacting with others. The model suggests that violence and aggression can occur as a result of a threat to self-esteem rather than the presence of low self-esteem.

5.8 Evaluation of Alternative or Competing Explanations for Change

5.8.1 Trivial or negative change.

In the repeated symptomatic measures BSI-18 and GDS-LD no post-treatment change is measured. The GAS-ID shows negative change in anxiety symptoms with an increase in worries between pre- and post-test.

5.8.2 Relational and expectancy influences.

John's positive end-of-therapy scoring for Personal Problem Scale (see Table 5.8) could be attributable to his having worked with the therapist for six months, influencing his report of positive change. However, John's accounts of end-of-therapy change were maintained at post-therapy interview, where his specific, varied, and detailed descriptions regarding events taking place within therapy provide a plausible explanation of personal change. An account from a member of the nursing team is supportive of John's post-therapy interview responses.

Although it is not possible to fully exclude the potential for a relational element to have influenced John's responses to in-treatment measures and the post-therapy interviewer, it does appear unlikely given the range of corroborated evidence from multiple sources and measures.

5.8.3 Self correction processes.

No evidence has been found within the case record collected during the study that John had used self-help or self-correction strategies. John's background history and presenting problems at the start of therapy were of longstanding duration. Change was not due to a short-term improvement or easing of a temporary problem.

5.8.4 Extra-therapy events and psychobiological influences.

A number of important extra-therapy events can be considered to have supported change: the introduction of medication, protective factors related to the hospital environment, and staff interventions.

The introduction of a low dose of atypical antipsychotic medication as a mood stabiliser during the first half of the treatment phase, in week eight, coincides with improving trend in self-rated anger scores. During the post-therapy change

interview John attributed that his medication had helped him feel more relaxed. It is reasonable to conclude that medication was supportive and influential upon mood stabilisation and that outcomes for improving self-rated anger cannot reliably be attributed to the influence of therapy.

There is a plausible case that improving trend in MOAS scores, starting in week 26 of phase B (see Figure 5.5), can be related to events taking place during therapy which do not coincide with the introduction of psychobiological treatment.

Gradual improvement in John's relationship with his parents, reported by him at post-therapy interview, does appear plausibly related to his living apart from them in a supportive hospital environment. The role of nursing staff in being able to recognise that John was making an effort by "rehearsing", approaching them more positively, can also be attributed as a helpful extra-therapy influence.

5.8.5 Apparent changes attributed to reactive effects of research.

Repeated measures were administered by a psychology assistant at set points. Research administration records from pre-test show that concerns were raised by the test administrator that John had given mixed answers about his emotions for different measures during the meeting. This may account for reduced symptomatic scores at pre-test in some repeated measures. Similar concerns were not raised in John's post-therapy tests. There is no other evidence to suggest that repeated test administration had a positive effect, with a possibility that there was under reporting of symptoms immediately prior to therapy.

For continuous measures the introduction of daily self-rated anger score sheets could have potential to encourage self-monitoring of anger and therefore better self-management leading to reduced anger levels being reported. The pre-treatment phase A provided conditions where only self-rated anger score sheets were

being used (see Figure 5.1 & 5.2). It is reasonable to conclude that the introduction of the daily self-rating anger scale in isolation had no positive therapeutic effect upon trend.

At three month follow-up the change interview was conducted by a psychology assistant who had had no previous involvement with the study. The differentiated responses John gave in the post-therapy interview indicate that he gave a plausible account of change. Corroborating John's post-therapy interview accounts with responses given by his named nurse also provide evidence that change was observed. An alternative explanation that the reactive effects of research procedures during the study account for changes also appears to be unlikely in John's case.

5.9 Conclusion

5.9.1 Did therapeutic change take place during or as a result of art psychotherapy?

Results are mixed. There is no evidence of positive change for any of the repeated symptomatic measures. In continuous measures there is evidence of improving trend in MOAS scores starting during treatment. In-treatment measures show improvement for the Personal Problem Scale and CCRT Interpersonal Schema pervasiveness scores.

5.9.2 Is there a plausible link between therapy and outcome?

There is some evidence of a link between therapy process and outcome. John's retrospective attribution towards therapy, that did not include the influence of extra-therapy events, was that therapy helped him to be less argumentative with staff and feel happier and less angry about the death of his cousin. Therapy events related to and preceding shifts in stable problems included sessions involving bereavement

work and work exploring issues related to John's self-image. It is plausible that improving trend in MOAS scores and changes in CCRT Interpersonal Schemas are linked to the influence of therapy.

Plausible alternative explanations for change have been considered. Repeated symptomatic measures did not improve and were not positively influenced by therapy. Following the corroboration of multiple sources of information relational and expectancy influences do not provide a strong plausible alternative explanation for change. There is no evidence that self-correction processes were used by John during the study.

Extra-therapy events have been shown to be influential. It is likely that the introduction of medication had a direct influence upon self-rated anger scores. At the post-therapy interview John also attributed "feeling more relaxed" to his medication. The potential therapeutic effects of study measures being used for self-monitoring, or the test administration itself, acting therapeutically have been considered. Reactive effects of research do not appear to provide a competing explanation for change.

5.9.3 Is there congruence between the outcomes, processes, and broad psychotherapeutic theory?

Specific change processes reported by John in post-therapy interview show that he experienced a number of events in therapy which fit with strongly valued ideas linked to art psychotherapy practice, for example (Edwards, 2004). John was able to develop a therapeutic working relationship and maintain this despite having a history of disengaging from previous therapeutic work.

Theories related to self-esteem, self-image and aggression (Baumeister, et al., 1996) have been explored as a possible explanation for the changes in John's MOAS scores. It does appear plausible that some of the therapist's interventions, for

example, reflecting upon John's excitement when speaking about violent or dangerous acts, led John to consider changing maladaptive behaviour. There appears to be a plausible explanation that therapy processes and outcomes correspond with elements of psychotherapeutic theory.

Within John's case art psychotherapy can be seen to have had a supportive influence upon some outcomes that can be broadly described as relational and behavioural improvements.

CHAPTER 6: CASE 2

6.1 Background Information

6.1.1 Hospital admission.

"Stuart" was a thirty-eight year old man who had mild intellectual disability. He had been detained in hospital under the Mental Health Act definition of "psychopathic disorder". Stuart had a diagnosis of antisocial personality disorder with paranoid traits. He had been in the medium secure unit for two years and two months after having been transferred from a high security hospital. Stuart had attempted suicide in the past but this was not considered to be a high risk during his admission to the medium secure unit. A comprehensive risk assessment report completed one year and three months prior to his participation in this study indicated that he had presented a risk of violence, sexual violence, and self-harm.

> A gentleman who does not like to have his own needs thwarted. He likes to be in control of people and situations and finds situations where others are in control frustrating and aggravating. He has a long history of learning that violence is a means of gaining control from his own experiences as a child to his own offending against others who were physically vulnerable to him. (Consultant Clinical Psychologist Post-Admission Risk Assessment Report)

Within the medium secure unit Stuart was considered to be a challenge to the system. He would often make negative or derogatory remarks and had an aggressive and confrontational style of interaction with staff and patients. Stuart often presented himself as the victim of injustice and spoke of being stuck in "the system" which led to his becoming confrontational over restrictions put in place by staff. Stuart routinely protested against the enforcement of rules which he felt were beneath him.

His refusals to comply could escalate to the point where he became agitated and verbally or physically aggressive. On frequent occasions he would require PRN rapid tranquilising medication to reduce his agitation. Much of his frustration appeared to stem from his belief that he should have been released following the end of his prison sentence, and from feeling aggrieved that he had been transferred to a high secure hospital before his sentence had ended.

Stuart's behaviour towards female staff members was considered inappropriate and over-familiar. He would sometimes profess his love for female professionals who worked with him and overstep appropriate social boundaries by invading personal space.

His communication difficulties were not fully apparent at first. A speech and language assessment showed that he had difficulties linked to misinterpretation of meaning when processing language. Stuart also found it difficult to accept that he had a mild intellectual disability.

6.1.2 Family relationships.

Prior to his imprisonment Stuart had been in a long-term relationship and had had children. This relationship had broken down following incidents of extreme sexual and non-sexual violence against his partner which resulted in one of his convictions for rape. Stuart did not have any reciprocated contact with his family although he was allowed to send letters to his children via a police liaison officer. This caused him some frustration. Stuart had also formed plans to escape from hospital with another patient in order to visit his children but these plans were not carried out. He had broken off contact with his father and had no contact with his mother.

6.1.3 Peer relationships.

Stuart was reported to have a superior attitude and appeared intolerant of other patients within the medium secure unit. He is reported to have had highly intense and unstable homosexual relationships in prison. He was able to maintain some relationships for a number of years before they eventually broke down. The pattern of his relationships was considered to be highly intense and emotionally dependent with violent expressions of jealously.

6.1.4 Childhood and adolescence.

Stuart's early history is defined by dysfunctional family life, which included his witnessing domestic violence and his father's attempted suicide. During the study Stuart told the therapist that on one occasion he had attempted to stab his father with a knife but that he was stopped by his mother. There are also reported allegations of rape and incest taking place between Stuart and his siblings. Following the separation and divorce of his parents there are continued reports of violent incidents and events that demonstrated his own vulnerability. As a result of his mother's heavy drinking and her soliciting behaviour Stuart became the victim of sexual abuse by one of his mother's male partners.

There is little information about his schooling other than that it was defined by bullying and high levels of aggression. He developed as a violent and dangerous teenager discovering that he was able to attack older boys who were bigger than he was and physically overpower them. In his late teens he became involved in criminal gangs and recreational drug use. Repeated incidents of extreme violence and criminality took place during this period. Stuart reported that he was attacked with a knife, beaten, and shot at as a result of gang violence.

6.1.5 Forensic history.

Stuart had served a custodial sentence for two convictions of rape. He was reported to demonstrate little victim-empathy in response to his offences. Stuart had a long history of violent and aggressive behaviour including domestic violence and threats to kill. His transfer to a high secure hospital from prison had occurred due to public protection concerns raised prior to his prison release date.

6.1.6 Participation in the study.

Prior to his participation in the study Stuart had completed other psychotherapy within the medium secure unit. He had been prescribed anti-depressant medication which he took for the duration of the study and he could request PRN rapid tranquilising medication at any time throughout the study period.

Stuart completed 19 art psychotherapy sessions with a male therapist. The sessions took place in a quiet room based on his ward. Stuart gave his consent to participate in the study but maintained that he was highly sceptical about the treatment for a number of the early sessions.

6.2 Repeated Measures

6.2.1 Brief Symptom Inventory (BSI-18).

At the screening assessment point Stuart scores above the clinical cut-off for BSI-18 Global Severity Index (GSI) indicating high levels of psychological distress prior to treatment and placing him on the 96th percentile. There is improvement immediately before treatment at pre-test with GSI dropping below the clinical cut-off. GSI scores improve between pre- and post-test with gains made in treatment being maintained at follow-up, reducing to the 8th percentile. Item scores for somatisation show no change between pre-, post-, and follow-up. Depression and

anxiety item scores do show improvement between pre-, post-test, and follow-up

(see Table 6.1).

Table 6.1

BSI-18

Item	Screen	Pre	Post	Follow-up	Pre-Post Diff.	Pre-Follow-up Diff.
Somatisation	63	42	42	42	0	0
Depression	71	65	59	45	-6	-20
Anxiety	60	61	48	39	-13	-22
GSI	67	59	51	36	-8	-23
Percentile	96th	82nd	54th	8th	-	-

Note. GSI=Global Severity Index. The BSI-18 clinical cut-off is 63 (Derogatis, 2000) for a forensic inpatient ID maximum-security hospital sample (*n*=45) clinical cut-off is 64 (Kellett, et al., 2003).

6.2.2 Glasgow Anxiety Scale (GAS-ID).

Total scores increase between the screening assessment point and pre-test but

still remain below the clinical range for this measure. Improvement is seen in

reduced total anxiety scores between pre- and post-test but the degree of change is

not above the RCI minimum (see Table 6.2).

Table 6.2

GAS-ID

Items	RCI	Screen	Pre	Post	Follow-up	Pre– Post Diff.	Pre-Follow-up Diff.
Worries	-	8	9	6	2	-3	-7
Fears	-	0	0	0	0	0	0
Physiological	-	0	2	0	3	-2	+1
Total	6.20	8	11	6	5	-5	-6

Note. GAS-ID clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Mindham & Espie, 2003).

6.2.3 Glasgow Depression Scale (GDS-LD).

GDS-LD scores are within the clinical range and stable between screening assessment point and pre-test. Scores improve during treatment between pre- and post-test, reducing below the clinical cut-off and above the RCI minimum. Gains made in treatment are maintained at follow-up (see Table 6.3.).

Table 6.3

GDS-LD

Item	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Depression	4.27	16	16	6	6	-10	-10

Note. GDS-LD clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Cuthill, et al., 2003).

6.2.3.1 Bayesian analysis of Glasgow scales: Comparison of difference between case and controls.

GAS-ID anxiety scores show a 12.92% improvement against the local forensic control sample between pre-test and follow-up with just 7.75% falling below Stuart's score 12 weeks following therapy. At follow-up 35.18% of the non-anxious community intellectual disability group fall below Stuart's score, placing him within a non-clinical sample (see Table 6.4).

GDS-LD depression scores at screen and pre-test place 61.07% of the local forensic control population below his score. This reduces to 13.18% falling below his score at post- and follow-up. In comparison with the non-depressed community intellectual disability group 14.66% fall below Stuart's score at post-test placing him within the non-clinical sample (see Figure 6.5).

Table 6.4

Bayesian point estimate of percentage of the control population falling below the participant's GAS-ID score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	13.11	6.67	21.63	20.67	12.45	30.61	9.28	4.13	16.73	7.75	3.18	14.57
**Community ID	46.18	27.76	65.22	57.57	38.32	75.60	38.71	21.19	58.15	35.18	18.32	54.59

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GAS-ID total scores as compared to a male forensic IDD sample (*n*=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 19 (SD=9.4). **Participants GAS-ID total scores as compared to a male and female non-anxious community ID sample (*n*=16) with a mean age of 34.9 (SD=10.4) and a mean score of 9 (SD=10) (Mindham & Espie, 2003).

Table 6.5

Bayesian point estimate of percentage of the control population falling below the participant's GDS-LD score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
* Forensic IDD	61.07	50.02	71.47	61.07	50.02	71.47	13.18	6.74	21.71	13.18	6.74	21.71
** Community ID	98.10	92.25	99.91	98.10	92.25	99.91	14.66	4.68	30.02	14.66	4.68	30.02

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GDS-LD scores as compared to a male forensic IDD sample (*n*=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 14 (SD=7). **Participants GDS-LD scores as compared to a male and female non-depressed community ID sample (*n*=19) with a mean age of 39.11 (SD=9.31) and a mean score of 9.29 (SD=2.94) (Cuthill, et al., 2003).

6.2.4 Rosenberg Self-Esteem Scale (adapted).

Self-esteem scores do improve between pre- and post-test (see Table 6.6). Notable

changes between pre and post-test items include positive agreement being attributed to the

statements "I feel I am a good person, as good as other people", "I feel I have not done

anything worthwhile", and "sometimes I think I am no good at all" (see Appendix 16b).

Table 6.6

Rosenberg Self−Esteem Scale (adapted)

	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Total score	6.25	17	16	22	21	+6	+5

Note. Maximum score = 30 (highest self-esteem), minimum score = 6 (lowest self-esteem). Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Dagnan & Sandhu, 1999).

6.2.4.1 Bayesian analysis of RSES (adapted): Comparison of difference between case and controls.

Stuart shows low self-esteem in comparison with both control samples with just

9.72% of the forensic group and 3.16% of the community control samples falling below his

score at pre-test. There is considerable improvement in self-esteem at post-assessment with

49.97% of the local forensic control sample and 36.13% of the community sample falling

below Stuart's score (see Table 6.7).

Table 6.7

Bayesian point estimate of percentage of the control population falling below the participant's RSES (adapted) score

	Screen			Pre			Post			Follow-up		
Sample	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	13.91	6.85	23.42	9.72	4.07	18.00	49.97	38.25	61.72	41.36	30.00	53.20
**Community ID	5.90	1.95	12.43	3.61	0.91	8.64	36.13	25.21	48.00	27.42	17.51	38.87

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants RSES (adapted) total scores as compared to a male forensic IDD sample (*n*=43) with a mean age of 32.2 (SD=9.1) and a mean score of 22 (SD=4.5) (see Appendix 8).**Participants RSES (adapted) total scores as compared to a male and female community ID sample (*n*=43) with a mean age of 31.1 (SD=10.2) and a mean score of 23.44 (SD=3.99) (Dagnan & Sandhu, 1999).

6.3 Continuous Measures

At the screening assessment point Stuart gave the following self-rating scores: "feeling tense, panicky or stressed" = 7 (not much), "feeling poorly or unwell" = 5 (not much), "feeling low, down or sad" = 10 (not much), and "feeling cross or angry" = 11 (a little bit) (see Appendix 10 for examples of all self-rating scales). Stuart completed daily self-rated anger scores for the duration of the study.

6.3.1 Self-Rated Anger.

Stuart's self-rated anger was recorded over a total of 273 days (see Figure 6.1). Phase A pre-treatment 59 days, phase B treatment 205 days, and phase C post-treatment 68 days. 40 days in total have missing data with 85% of days during the period of observation being rated.

The self-rated anger scale captures the severity of angry feelings that the participant attributes to themselves on a daily basis, using a 1 to 50 point scale (1= "the best it can be", 50 = "the worst it can be"). Scores of 1 rising to 10 equate to "not much" anger, the lower control limit (LCL) is 2.82. The statement "a little bit" encompassed scores from 11 to 20. The spread of the data is set around (12.13) the mean score for Stuart's self-rated anger in phase A. Scores rated at 21 and above equate to statements of being "a bit" angry. Scores above the upper control limit (UCL) of 21.44 are considered to be out of the control, assignable to a known or unknown event, indicating higher levels of self-rated anger.

6.3.1.1 Self-rated anger in phase A.

Stuart rates the highest maximum score of 50 on four consecutive days in phase A (day 37 to 40) with day 41 scored at 49. In total nine days are rated above the UCL in phase A. Scores ranging from 30 to 40 are rated on days 18, 19, 37, and 42. From day 42

onwards no further days are rated above the UCL in phase A. Four days are rated above the mean (12.13) in phase A but scores remain within control below UCL.

6.3.1.2 Self-rated anger in phase B.

Within phase B two days are rated above the UCL (days 188 and 189). From the start of therapy up until day 86 scores are clustered and range from 4 to 12. This period encompasses therapy sessions one to four. Improving trend in low process rates falling below the LCL occur following therapy session five, starting on day 87 and continuing for a period of 51 days until day 136. This period of 51 days with lower process rates from days 87 to 137 encompasses sessions five to 10. Greater variability in scores above the LCL is seen for a 60 day period from day 136 onwards until day 196. This period includes sessions 11 to 17. Days rated above the UCL in phase B (days 188 and 189) occur on a week when no sessions took place. Following session 17 no further days are rated above the mean, with a run that extends into phase C until day 233 for a period of 36 days.

6.3.1.3 Self-rated anger in phase C.

Within phase C 44 out of 68 days are rated with the lowest possible score of 1. One day is rated above the mean and no days are rated above the UCL.

6.3.1.4 Trend for self-rated anger.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 6.2, 6.3, and 6.4. Self-rated anger scores in pre-treatment phase A show variability with deterioration and then improvement prior to treatment (see Figure 6.3). Improving trend is seen in treatment phase B. Stable trend with reduced variability is seen in phase C (see Figure 6.4).

Fig. 6.1 Self Rated Anger Scores for Case 2 (Stuart)
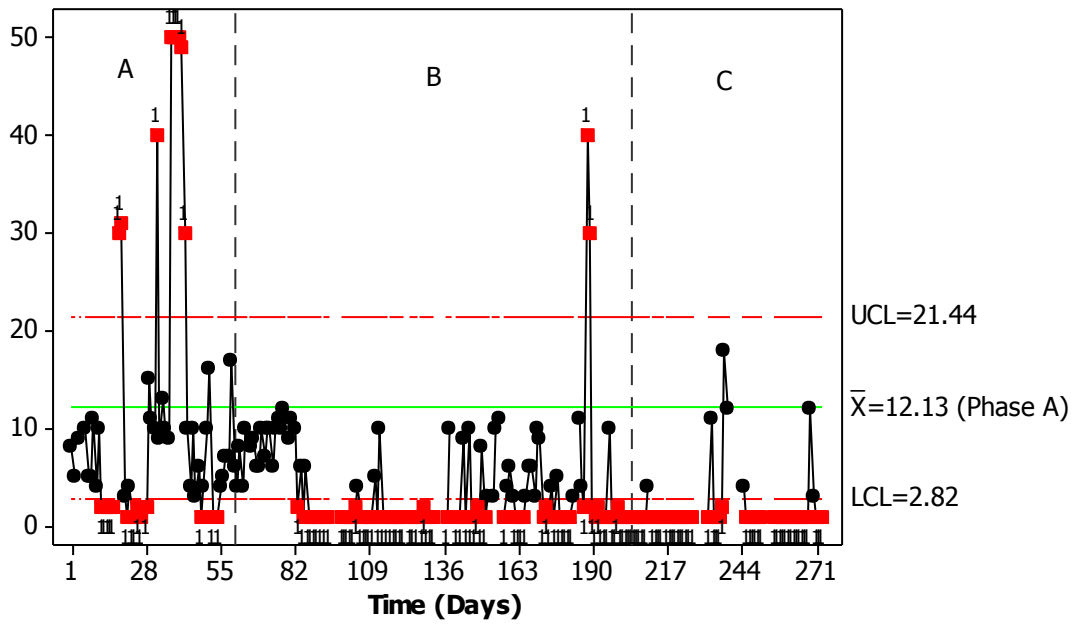
A=Pre-Treatment; B=Treatment; C=Post-Treatment

Fig. 6.2 Pre-Treatment (Phase A) Self Rated Anger for Case 2 (Stuart)
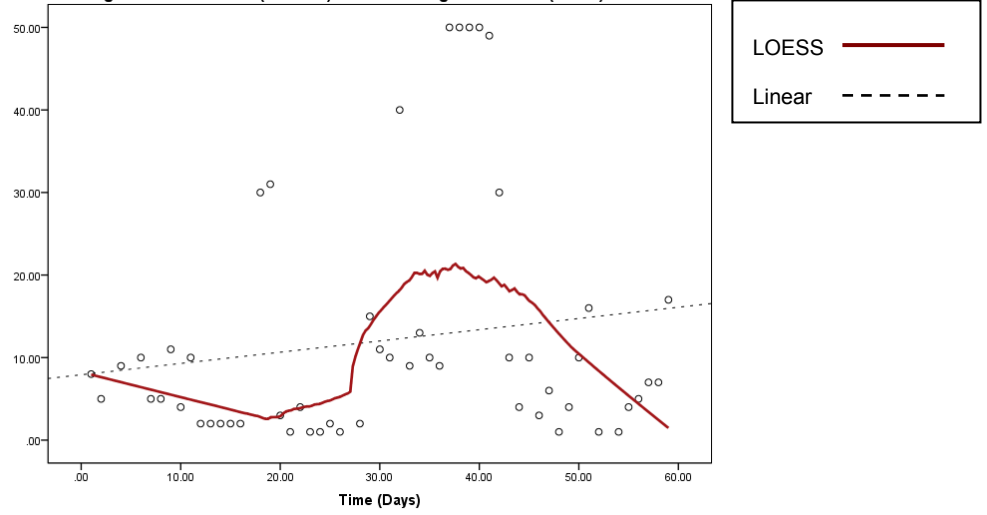
Fig. 6.3 Treatment (Phase B) Self Rated Anger for Case 2 (Stuart)
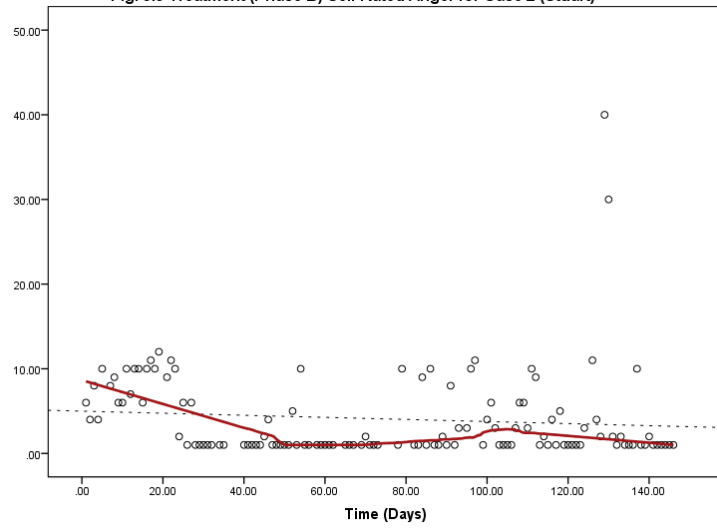
Fig. 6.4 Post-Treatment (Phase C) Self Rated Anger for Case 2 (Stuart)
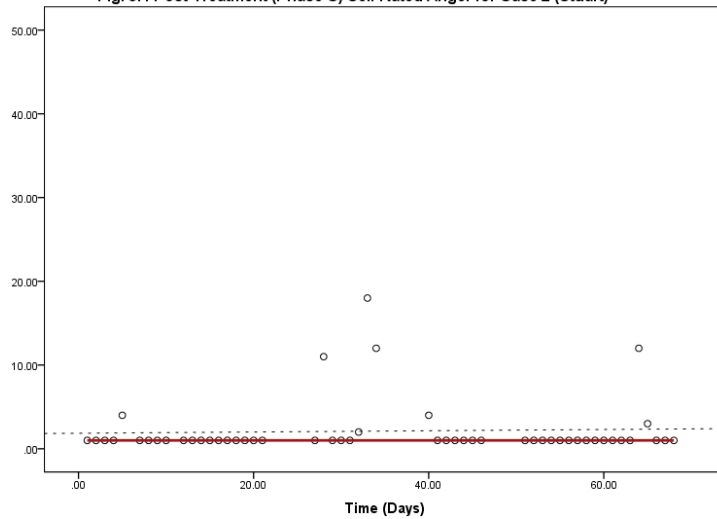
6.3.2 Modified Overt Aggression Scale.

The observation period for aggression included a total of 45 weeks, phase A pre-treatment 9 weeks, phase B treatment 21 weeks and phase C post-treatment 15 weeks (see Figure 6.5). The Modified Overt Aggression Scale (MOAS) total scores combine four types of aggression, verbal aggression, aggression against objects, aggression against self, and aggression against others.

6.3.2.1 Total MOAS scores across phases.

The highest severity scores for overt aggression occur in pre-treatment phase A in weeks seven and eight. Improving change in trend is indicated in week 21 of phase B following therapy session 10 with a run of successive scores falling below the mean and continuing into phase C for a period of 24 weeks.

6.3.2.2 Verbal aggression.

Verbal aggression is scored in phase A for six out of nine weeks. In phase B verbal aggression is scored in nine out of the 20 weeks (weeks 10, 12, 15, 16, 17, 18, 21, 26, and 27). In phase C verbal aggression is scored in six out of 15 weeks but the frequency and severity of scores are lower. In phase C lower levels of verbal aggression are scored in weeks 31, 35, 39, 40, 41, and 43.

6.3.2.3 Aggression against objects.

Aggression against objects is scored in weeks two and seven in phase A. In phase B no scores are given for aggression against objects for the duration of treatment. Aggression against objects is scored in phase C in weeks 31and 41.

6.3.2.4 Aggression against self.

 Aggression against self is not present in phases A, B, or C.

6.3.2.5 Aggression against others.

Aggression against others is scored in phase A weeks 6 and 7. No scores for aggression against others are present in phase B during treatment. In phase C aggression against others is scored in week 41.

6.3.2.6 Trend for MOAS scores.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 6.6, 6.7, and 6.8.

Pre-treatment phase A (see Figure 6.6) shows high variability. Trend improves during treatment phase B (see Figure 6.7). Lower variability is seen in the post-treatment phase C showing low and stable trend (see Figure 6.8).

Fig. 6.5 MOAS Sores for Case 2 (Stuart)

A=Pre-Treatment; B=Treatment; C=Post-Treatment
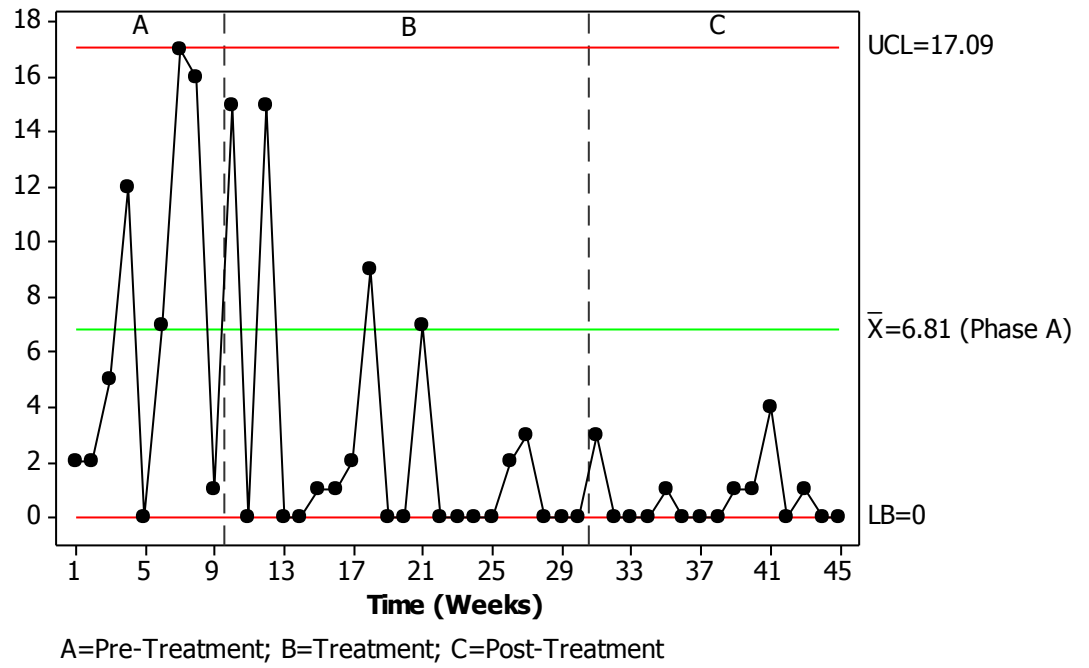
Fig. 6.6 Pre-Treatment (Phase A) MOAS for Case 2 (Stuart)
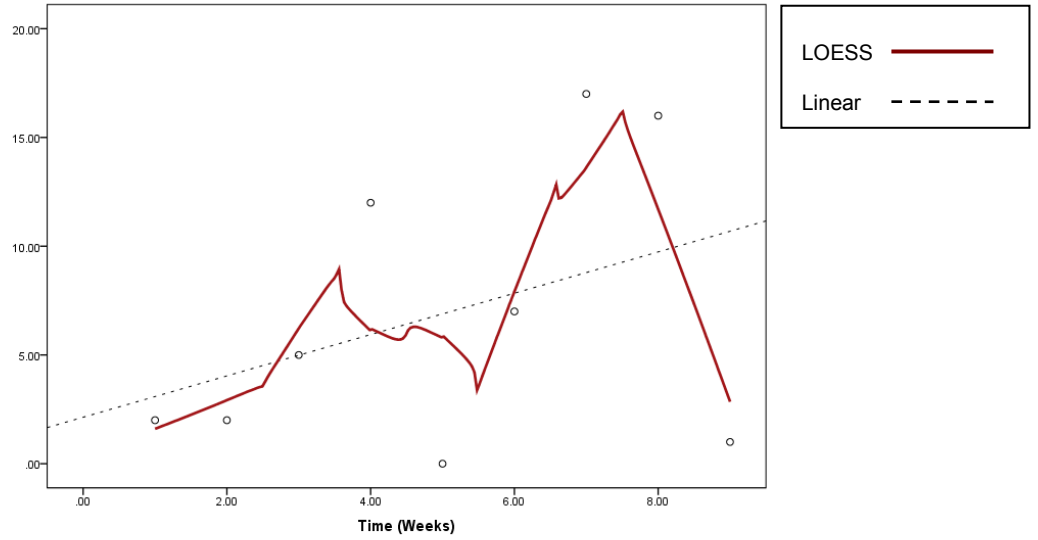
Fig. 6.7 Treatment (Phase B) MOAS for Case 2 (Stuart)
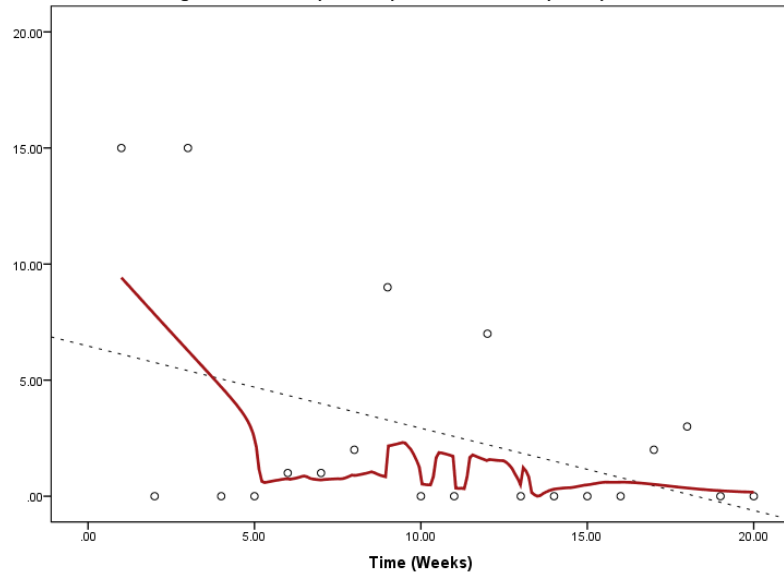
Fig. 6.8 Post-Treatment (Phase C) MOAS for Case 2 (Stuart)
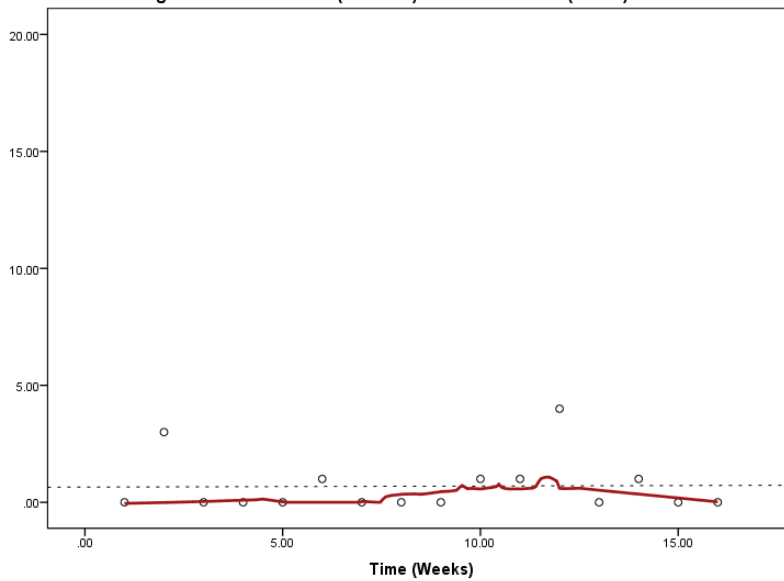
6.3.3 Serious Untoward Incidents (SUIs).

SUIs were recorded for a total of 27 months. 12 months preceding therapy, six months during therapy and nine months following therapy. In the 12 months preceding therapy in phase A Stuart was recorded to have had 26 incidents in which he was given PRN rapid tranquilising medication. Techniques for managing violence and aggression were used by staff on five occasions and Stuart was placed in seclusion on two occasions.

During the six months of treatment in phase B PRN medication was requested by Stuart in month 18, six months into treatment.

No SUIs are recorded for nine months in phase C. A clear improving trend in process rates can be seen in a stable run of scores below the mean from month 13 at the start of the treatment phase and continuing until the end of phase C (see Figure 6.9).

Fig. 6.9 Monthly SUIs for Case 2 (Stuart)

A=Pre-Treatment; B=Treatment; C=Post-Treatment
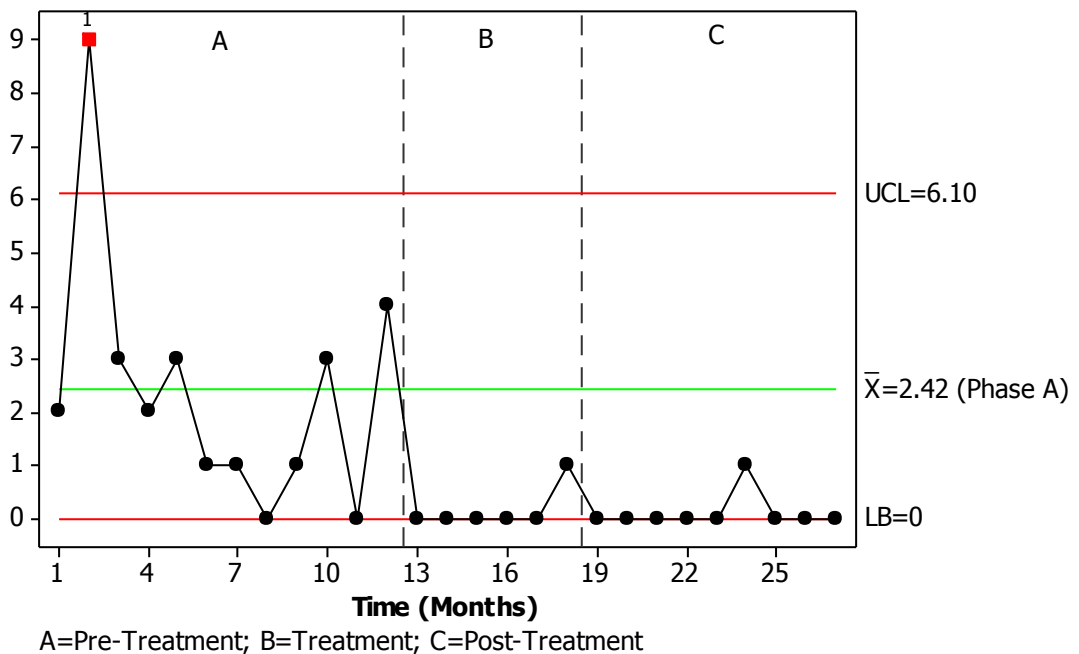
6.4 In-Treatment Measures

6.4.1 Personal Problem Scale.

Stuart identified three main areas in his life that were causing him problems (see Table 6.8). (1) Stuart said that he was "feeling hopeless". This related to Stuart feeling stuck in forensic services which he considered to be a personal injustice, being detained in hospital after he had served time in prison. (2) Stuart did not feel that he was any closer to his personal goal of achieving freedom. (3) Stuart said that he had difficulties trusting others and that it took him a long time to build up trust with people.

At the start of therapy Stuart rated each personal problem as being "the worst it can be" or close to this. At the end of therapy these problems had improved to a point where Stuart rated them as being "the best it can be", or again, close to this.

Table 6.8

Personal Problem Scale

Problem Statement	First Therapy Session	Last Therapy Session
Feeling hopeless*	2	5
Being closer to a personal goal of freedom	1	4
Trusting others	2	4

Note. 1= worst it can be, 5 = Best it can be; *=most difficult problem.

6.4.2 Core Conflictual Relationship Theme (CCRT).

Completeness of relationship episodes collected from Stuart's RAP interviews range from 2 to 3.5. Half of the *wish* component statements were rated as having an "explicit level of inference" with the other half being derived from "moderately inferred statements".

Stuart's CCRT from early therapy sessions indicated a conflict in his dominant interpersonal schema. Stuart saw other people as not trustworthy and he was oppositional

although his underlying *wish* in relationships was to be close to others. There are no negative themes recorded in his responses towards others at the end of therapy (see Table 6.9).

A pervasiveness score for the presence of this CCRT within his relationships episodes at the start of therapy is 50%. At the end of therapy, Stuart's pervasiveness score is reduced to 20%.

Table 6.9

Core Conflictual Relationship Theme (CCRT) Interpersonal Schemas

CCRT at start.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
Are open; are expressive; are disclosing; are available	***Are not trustworthy;** betray me; are deceitful; are dishonest.		***Oppose others;** am competitive; refuse/deny others; conflict with others.	***To be close to others;** to be included; not to be left alone; to be friends.
	Hurt me; are violent; treat me badly; are punishing.		**Dislike others;** hate others.	***To be independent**; to be self-sufficient; to be self-reliant; to be autonomous.
	Are distant; are unresponsive; are unavailable.			
	Are rejecting; are disapproving; are critical.			

CCRT at end.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
***Are helpful;** are supportive; give to me; explain.		***Feel self-confident;** am or feel successful; feel proud; feel self-assured.	**Am uncertain;** feel torn; am ambivalent; feel conflicted,	***To be accepted;** to be approved of; to not be judged; to be affirmed.
Are happy; are fun; are glad; enjoy.		**Feel happy;** feel excited; feel good; feel joy; feel elated.		**To be understood;** to be comprehended; to be empathised with; to be seen accurately.
Are accepting; are not rejecting; approve of me; Include me.		**Like others;** am friendly.		**To better myself;** to improve; to get well.
		Feel accepted; feel approved of.		
		Feel comfortable; feel safe; am or feel satisfied; feel secure.		

Note: *= most frequent recurring theme in relationship episodes.

6.4.3 Therapist Observation Rating Scales.

Stuart was rated as "reluctantly engaged" in his fourth therapy session and "not engaged" in his seventh session (see Figure 6.10). Stuart's level of engagement is rated by the therapist as improving following 10 sessions with the highest rated score of "open and trusting" being attributed for seven consecutive sessions.

Participation and motivation follow a similar pattern with higher scores rated by the therapist following session 10. Prior to this there is greater variability in scores with Stuart needing prompting and encouragement in session two and no participation in session seven (see Figure 6.11).

Stuart was not required to make an image in his final therapy session. His attitude towards making artwork in the sessions was mixed during six of his first 10 sessions. Increasingly positive responses towards making artwork in therapy sessions can be seen following session 10 (see Figure 6.12).

Therapist Observation Rating Scales

Fig. 6.10 Therapeutic engagement for Case 2 (Stuart)
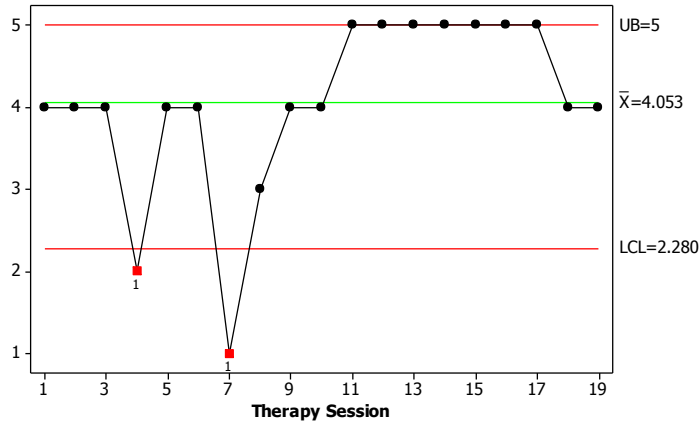
Note. 1=did not engage, 2=reluctantly engaged, 3=genuine but guarded, 4=open, 5=open and trusting,

Fig. 6.11 Participation and motivation for Case 2 (Stuart)
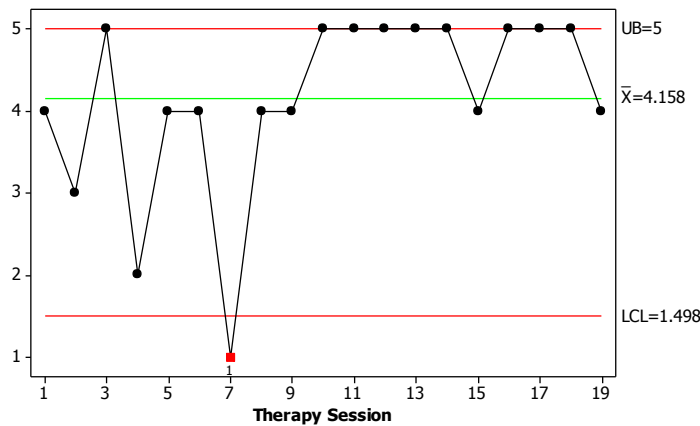
Note. 1=did not participate in session even when prompted and encouraged, 2=participated in session with prompting and encouragement, 3=participated satisfactorily without prompting or encouragement, 4=a self-motivated attempt to participate and 5= full and active participation throughout.

Fig. 6.12 Attitude towards image making for Case 2 (Stuart)
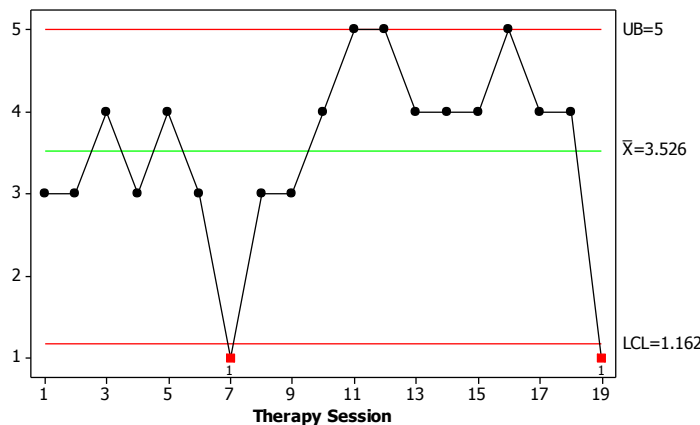
Note. 1= No image or art object made in the session (image making was not required in session 19), 2=required encouragement and prompting to attempt image-making, 3=mixed response to image-making, 4=positive response to image-making, 5=active and focused response to image-making.

6.4.4 Participant's most important image or object.

Stuart selected three pictures made during therapy which he said were important to him. "Farm and caravan" (see Figure 6.19) made in session 11 depicts a farm where he moved to as a child. Stuart said that the farm was the place where his parents broke up and where his father had attempted to hang himself in a barn. In this session Stuart had spoken about witnessing domestic violence and feeling anger towards his parents. He told the therapists about a time when he had attempted to stab his father with a knife but was stopped by his mother. Stuart's picture of a swimming pool made in session 12 (see Figure 6.20) was also related to a childhood memory. He said that he had been swimming in an outdoor pool, was struggling in the water and thought that he might drown. Stuart said that his father had waited on the side of the swimming pool and had tried to stop his sister from getting into the pool to help him. The third picture Stuart selected as being important to him was "Block of flats" (see Figure 6.21) made in session 17. The block of flats Stuart drew represented a place where he had been looked after by some friends after he had been badly beaten up and attacked with a knife in gang- and drug-related violence. He said that this was a serious time because he could have died.

6. 5 Retrospective Attribution

6.5.1 Change Interview (adapted).

Changes Stuart reported at follow-up interview three months after ending therapy included an improvement in his co-operation with staff, starting to rebuild family relationships, and feeling calmer and more optimistic about his future.

6.5.1.1 Co-operating with staff.

What changed? "…I didn't really give a damn of what was going to happen and that, you know and as… like the penny sort of dropped and I sort of like got my head

together. You know. I know where I want to be and I know what I want to do. The only way to do it is just to co-operate with people that are here to help you." *"I think the staff and… relationships I have with the staff here have improved. Because like when I… when I was here with staff before I didn't really care about what they said or what they'd done like, you know, I wasn't really interested in it. You know. But since that, I've like made progress in myself and that, I've found that the staff are a lot more sort of laid-back and more alright, you know." "I think the staff have like shown that I've… they've seen that I've made progress and I'm doing well and that, you know. You know, and that I've achieved things that I couldn't have like done years ago, being… I didn't really sort of pay any interest in it, you know." "And I think that if I do that then I can have a better chance of getting out quicker and I'd like… that makes sense."

What helped? "…I did a big picture with like tables and chairs with like everything inside like the room at the top." "And I did that picture there, and that was basically because I didn't know where I was within my future of where I was going and that, you know. So that's why I drew that one." "We talked about it because like we… I wanted to know where I was going and what I was doing and that and hopefully in my meeting that would be decided on where I would go and that, so… That's what we talked about. So, yeah…"

Attribution: Stuart partially attributed the change in being more co-operative with staff to events taking place in therapy. He also identified that he had built up a positive relationship with his named nurse which he said had also helped him. Stuart identified a specific picture which he made in therapy session eight as helping him to think about changes he needed to make, in order to make progress (see Figure 6.17).

6.5.1.2 Rebuilding a relationship with his father.

What changed? "Well, I… I'm back in touch with my father so, you know, that's a start and that. It was sort of out of the blue when he phoned me so, you know, it's a start… of building a relationship with him again." "Well, I wasn't going to run to him. He made the first call. So, you know, I mean… He phoned by out of the blue and then we talked a bit and then he told me all that was going on and that and… you know… I feel… your family's your family, you know. You all have arguments in families and you just get on with it, you know. So, I think… my Dad's my Dad, you know. So I'm just going to try and… like I said earlier, not rush into it but just take it as it goes, you know." "And I… you know, I never really thought about him as often as I should have but when he made the phone call I thought 'Right. Okay what do I do here? Speak to him or just say no?' But I decided to speak to him so… When I spoke to him I sort of like had a real conversation and that, you know."

What helped? "I did talk about my Dad in art therapy, a few things, and that... it was more like what he used to be like when we were together, you know." "Aye, I did… a modern… I did a… what was it I did? No, I won't say that one. I did… a lorry, did a picture of a lorry and that was talking about my father who was an HGV driver at the time and how he drove long distances and that and I always used to go on trips with him and that, and stuff like that, yeah. I did that one." "Because like there's one picture what I drew and I was with my sister and my Dad and we were in a… I drew a swimming pool, picture of a swimming pool and it was like… we were on a swimming exercise and that and I ended up with cramp in the back of my leg and I started to drown and my Dad wouldn't let my sister dive in and get me. So that was quite hard because I was nearly gone then. But my sister decided to ignore him and jump in and get me and I was… I was under water. So, yeah… that was quite hard to talk about."

Attribution: Stuart said that his father had contacted him after being diagnosed with a serious health problem. Stuart said that if his father had not called him he would not have tried to initiate contact with him. Stuart did describe having to make a decision about choosing to accept or reject his father's wish for renewed contact with him and he decided to accept. As his father had initiated the contact Stuart's attribution toward this change being influenced by therapy is not clear from the interview transcript. Stuart did identify two events in therapy when he discussed his father, including session 10 when he spoke about travelling in his father's HGV (see Figure 6.18) and in session 12 (see Figure 6.20).

6.5.1.3 Keeping in touch with children.

What changed? "And my children really… just keeping in touch with them and, you know, to see how they are and that." "Well, I'm writing a bit more than I was and I'm trying to keep as much contact with them as I can until I get out and hopefully I can leave… go back to court and see my children."

What helped? "I think if I hadn't had the art therapy I wouldn't have bothered. Because like… there's times when I couldn't be bothered to write to them and that, you know, and you know, it just felt like an endless task, you know, having to write to them all the time. And go through the… the policewoman and that, you know. I just didn't really see the point. But when I talked to him [the therapist] in art therapy, you know, it made me think 'well, they're more important to me than anything else, really' you know." "It just makes you realise what you've missed in your life really, yeah." "We talked about my relationship with my children....we talked about where I was in the hospital environment but I wanted to go from here to there but… you know, where I wanted to be in my… ten years' time or five years' time or something."

Attribution: Stuart attributed events taking place within therapy sessions as helping him be more motivated to write letters to his children. Stuart did not attribute any extra events outside of therapy as influencing this change.

6.5.1.4 Feeling calmer, more tolerant of others and less angry with the system.

What changed? "Well, I'm easier to get on with and, you know, I can… tolerate as much as I can sort of thing, you know, till it gets to me. So… yeah. I'm alright." "I'm not so bad-tempered… than I used to be. I sort of like take things in my stride now and just go with the flow but if… if something niggles me then I will say something, but within that sort of polite manner. So, yeah. I've like calmed down quite a bit." "Aye, I'm sort of not taking things… not taking things to heart so much now, you know. I'm just going with the flow, you know. Do what's asked of me and get on with it." "I think the reason that I'm not so angry now is because… I was angry with the system and the way that things were like turned out and that, you know, for me and… I thought 'right, if I continue the way I'm going then I'm not really going to get anywhere' so the only decision I could come to was like calm myself down and just go with the flow. Because I was really angry. You know, I wasn't a nice person to be around… really." "Because there's an evil streak in me when I want to be and I just think that's not nice, you know. It's not nice to be that way towards people."

What helped? "I think the art therapy has helped quite a lot to be quite honest. And like the other courses that I've done has helped as well but… you know… if you draw pictures and you see it from a bit of paper that you've drawn it on, then it makes a lot more sense than what it is in your head."

Attribution: Stuart attributed feeling calmer, more tolerant of others and less angry with the system to events taking place within art psychotherapy. He attributed skills he had learned in other psychotherapeutic treatment as having also helped him.

6.5.1.5 Thinking positively about the future.

What changed? "Yeah, you know like… because I've been locked up for ten years so like it's a case of like the only way is to go out and start a new life and get into something like a new job and that… just start your life again, really."

What helped? "And, you know, we talked about things like I drew a fence with a gate and then I drew like grass on one side and then like nothing on the other side, just mud, you know. We always used to talk about that, you know. Because like… we'd talk about like the grass was greener on the other side, you know, and it… you know, that was like to make a change from my being on that side of the fence to like on the other side of the fence. So, you know, you can like go on the other side of the fence and start a new life or you can stay on the other side of the fence and continue as you want to be, you know. And I opted for the other side, you know, because it was greener, you know, so… and I decided to like make a change in my life and get on with it." "I drew pictures of like wanting my own business and my own house and a new family and stuff like that. So I drew pictures of like… the future, sort of thing, you know."

Attribution: Stuart attributed thinking positively about his future to events taking place within therapy. No extra-therapy events were identified as supporting this change. He specifically mentioned a picture he made in session three (see Figure 6.14).

6.5.2. Attributed changes.

Stuart attributed feeling more positively about the future and writing more letters to his children to specific events taking place within therapy. He partially attributed feeling calmer and less angry with the system to events in therapy. One extra-therapy event included having a helpful relationship with his named nurse as contributing towards his being more co-operative. The complexities of Stuart's relationship with his father were

explored within therapy sessions. Stuart did not make an explicit statement that therapy had helped him make a choice to accept his father's request for renewed contact.

6.5.2.1 Corroboration of the participant's retrospective attribution with a nursing account of change.

Stuart's named nurse observed a point during the therapy when there was a change in Stuart's engagement in therapy sessions. "I think, the first couple of sessions, I think he was showing, presenting, that he might have been a bit stressed by it. But I think that was mainly a bit of him having a few barriers because he wasn't sure what to expect, what it was all about, and I think, once he dropped those barriers and got into it, there wasn't really any signs of any stress. He… I suppose he looked forward to the sessions in some respect in that he would comment 'Oh, I've got [therapist's name] coming to see me on Thursday'."

Stuart's change in his response to others was also observed by the nurse. "Just his clinical presentation has been a lot more settled. He's been more willing to… to look into - insight into his problems and what have you. He's been more willing engage with people."

Stuart's post-therapy attribution that he was less angry with the system is supported by the nurse's observations. "I think his self-esteem has improved but I think he still feels… I suppose, he used to feel very hard-done-by… generally by all the services that he's been through… that he shouldn't be here, he should have received these treatments in prison or special hospital or wherever. He shouldn't have gone to this level. So I think there is still a feeling of injustice there, on his part. But it's not as obvious as what it was and that's evidenced by the fact that he's more willing to partake in things. Because, beforehand, he wasn't really interested because he thought he shouldn't be here, because it was unjustified for him to be here."

Stuart was considered to have been able to build a trusting relationship within therapy. "Yeah, I mean, I wasn't in on the sessions, so I couldn't comment on how they were facilitated. But, obviously, he's got something from it, because he's allowed… he's actually managed to form this sort of trusting, therapeutic relationship if you like and I think it's worked… I think, at first, he maybe thought 'Oh, this is a bit childish, drawing things' or whatever. But obviously, again, it goes back on the first half being a little bit 'Do I, don't I?' and the second half him more accepting it and I think definitely that sort of informal, relaxed approach has definitely helped him. Helped him relax and feel as if he's not being assessed or judged."

Comments from Stuart's named nurse support Stuart's post-therapy account of change in some areas.

Figure 6.13 Therapy Session 1 "Black hole".
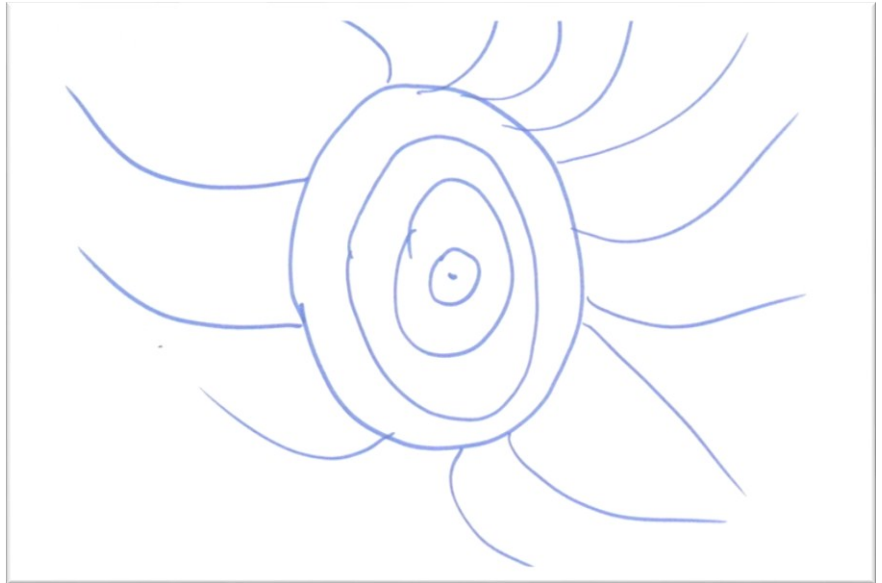
Figure 6.14 Therapy Session 3 "The other side of the fence".

Figure 6.15 Therapy Session 4 "Up against the wall".
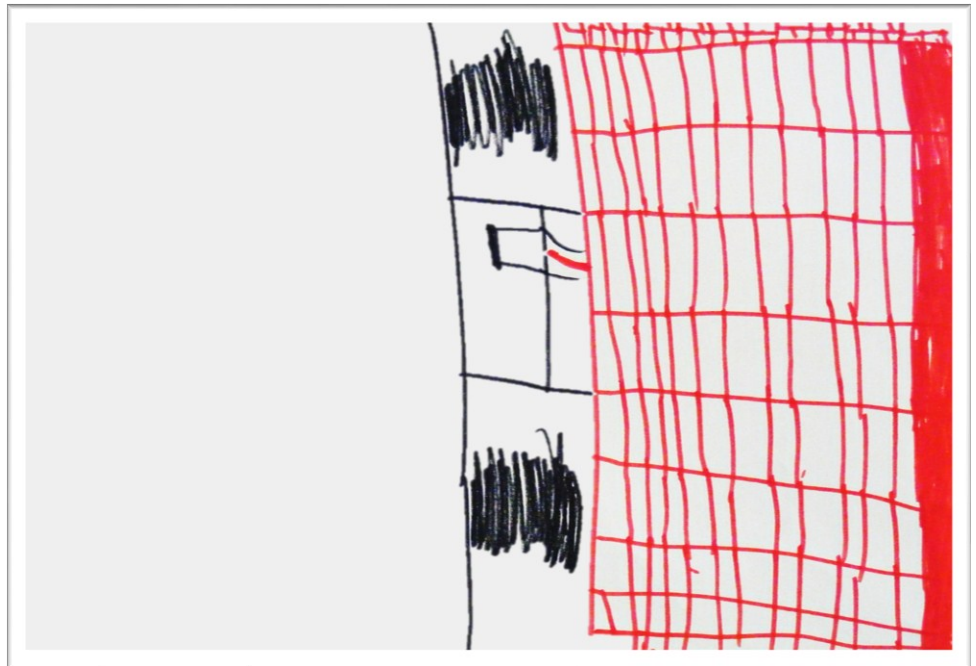
Figure 6.16 Therapy Session 5 "The other side of the wall".
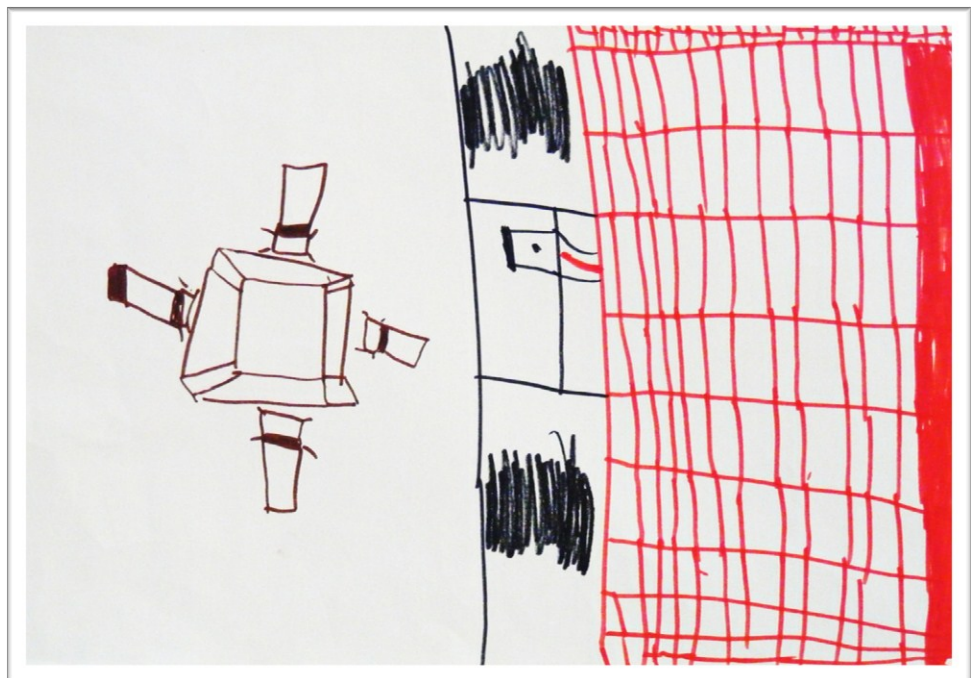
Figure 6.17 Therapy Session 8 "Table and chairs".
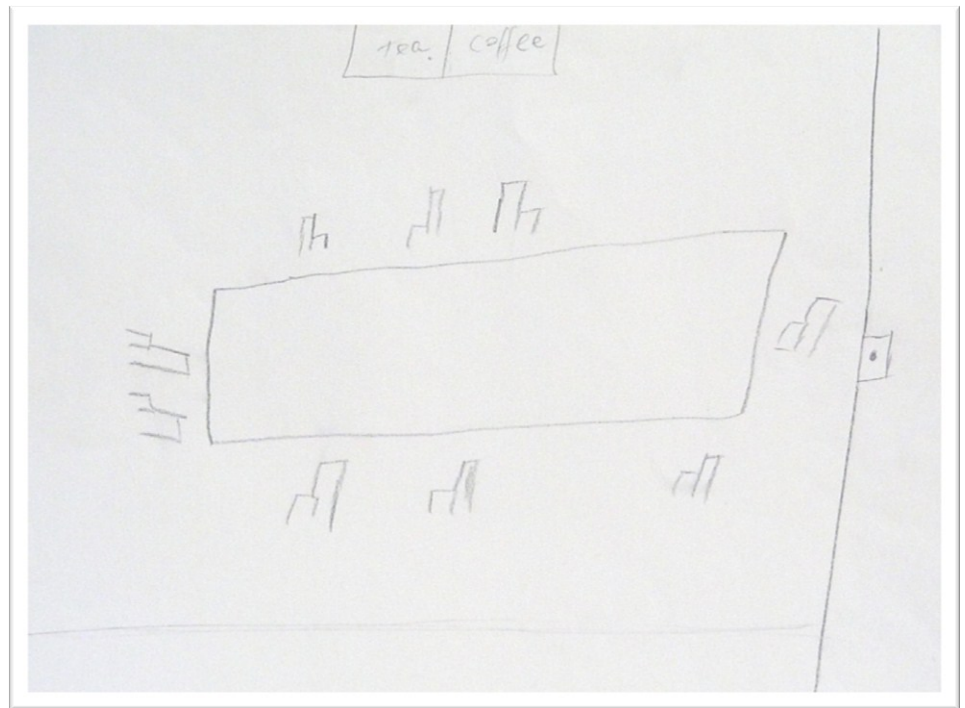
Figure 6.18 Therapy Session 10 "HGV".
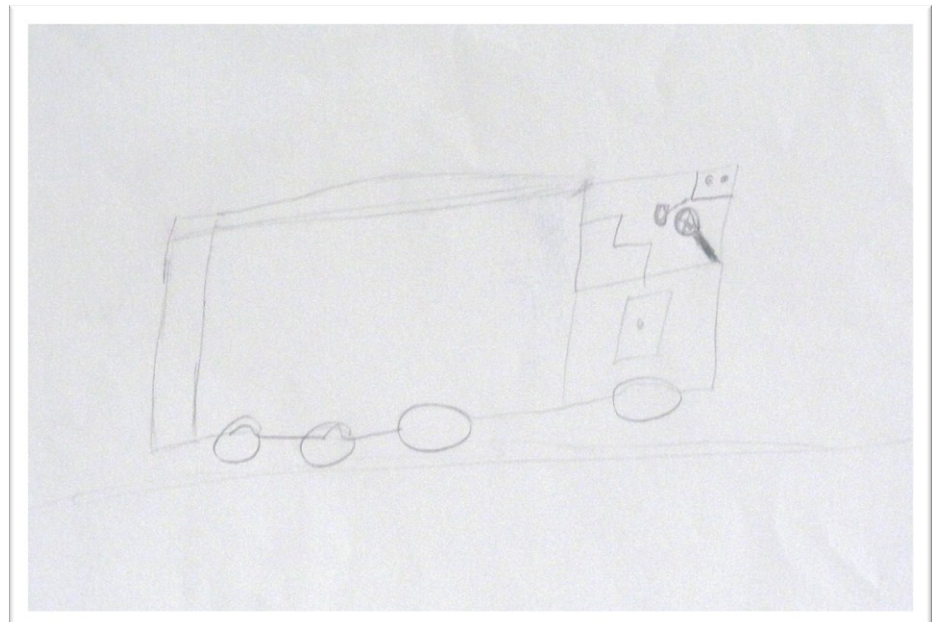
Figure 6.19 Therapy Session 11 "Farm and caravan".

Figure 6.20 Therapy Session 12 "Swimming pool".
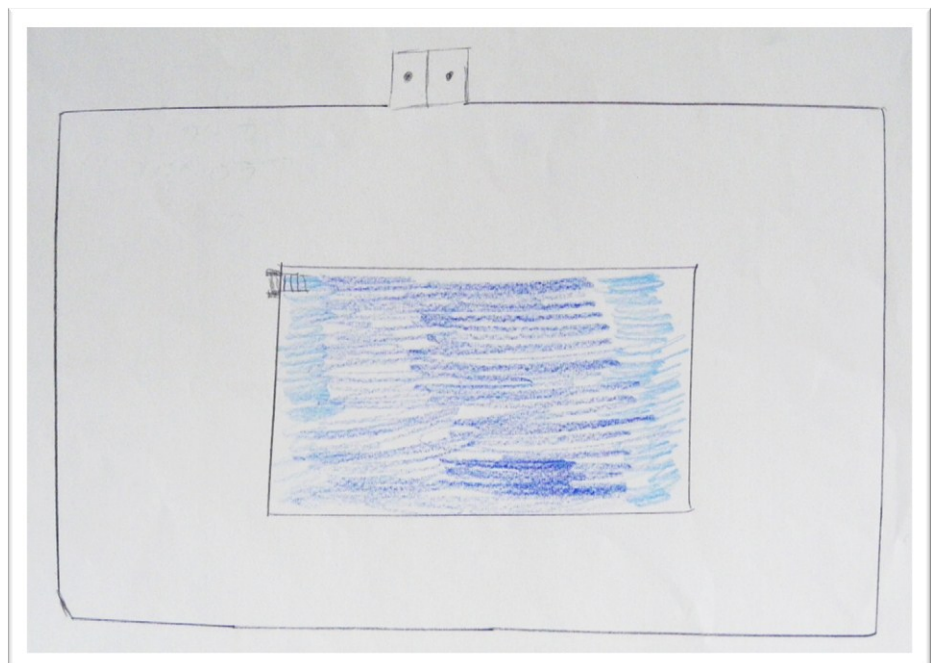
Figure 6.21 Therapy Session 19 "Block of flats".
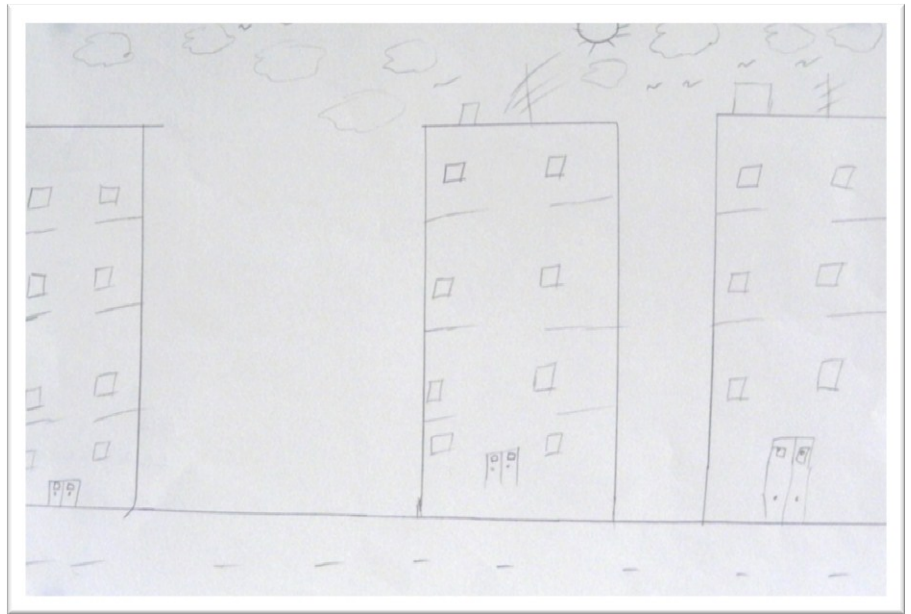
6.6 Evaluation of Explanations for Change Related to Therapy

6.6.1 Process outcome mapping.

A number of post-therapy changes corresponding to specific events and processes were identified within the therapy. Stuart gave detailed accounts of pictures he had made during therapy and of his discussion with the therapist. Two examples of accounts Stuart gave of events he identified within therapy are given below.

6.6.1.1 Thinking positively about the future.

"The first session I had with [therapist] was to draw a picture which was, I think, a picture of a black hole… because I wasn't sure where I was in my life, you know, where I was going and what was happening and I was…" (see Figure 6.13).

Stuart spoke about his feelings of hopelessness and described himself as being a victim who was stuck in an unfair system. Retrospective attribution towards therapy indicates that a process took place which led Stuart to become more positive about his future. One example given at post-therapy interview was the picture "The other side of the fence" (see Figure 6.14) made in session three. Stuart wrote on the picture "this side" for the side with green grass and "other side" for the side that he said he was on at the time.

6.6.1.2 Rebuilding a relationship with his father.

Although Stuart's retrospective attribution about rebuilding a relationship with his father was only partially associated with therapy it has been included in process outcome mapping. As Stuart spoke about his father on a number of occasions within therapy this change will be considered in terms of "soft causality", using a hypothesis that events in therapy may have supported an increase in the likelihood that Stuart would decide to reciprocate his father's request for contact.

Stuart spoke about his father and his parents' separation in sessions 1, 2, 3, 10, 11, 12, 13, 15, and 16. Stuart described his childhood relationship with his father in his first session.

"Me and my father and I – we were supposed to be close but, you know, be like father and son. You know, you're supposed to be close with each other, but during my time with my father, it was more like how many arguments can you have in a day, sort of thing. You know, and I remember when I was about 10 he tried hanging himself in front of me. …he put a bit of string around – a rope – over the sort of bar thing…and he made a loop hole and then put it over his neck and a loose knot and as he's pulled it, it's pulled his neck a bit tighter, like you know. And he's like tried pulling it up as far as he can and he's actually lifted himself off but he hasn't stayed there long enough. So..."; "When I saw him preparing himself to hang himself, like, I just... I just stood there in shock at the moment and just watched, you know, I didn't know what to do and when he actually lifted himself off, I just ran out"; "He came after me. He ran after me and he blamed [name of father's partner] for it and that and he said he was sorry and it wouldn't happen again. But I just kicked him in the shin and ran off. Because I hated him for what he was doing". (Stuart's words in first therapy session)

Stuart also drew a picture of this event in the second session. Other specific images referred to at post-therapy interview include an image of himself being in a HGV lorry (see Figure 6.18). Stuart spoke about this time with his father saying that he enjoyed stopping at truckers' cafes. An image of himself as a child in a swimming pool made in session 12 was also mentioned by Stuart at post-therapy interview (see Figure 6.20).

There is evidence that changes retrospectively attributed by Stuart can be linked to events in therapy which are qualified by detailed and specific accounts corresponding with the therapy process record.

6.6.2 Change in stable problems.

A number of measures indicate that there was a change in stable problems of long duration following treatment. An important change for Stuart appeared to be in his longstanding belief that he was a victim of the system. This change is also demonstrated in his increasing level of co-operation with staff and a reduction in verbal aggression and oppositional behaviour. A graph combining monthly SUIs, average monthly self-rated anger scores, and average monthly MOAS scores can be seen in Figure 6.22.

Fig. 6.22 Monthly SUIs Anger & Aggression for Case 2 (Stuart)

Time (Months)
A=Pre-Treatment, B=Treatment, C=Post-Treatment
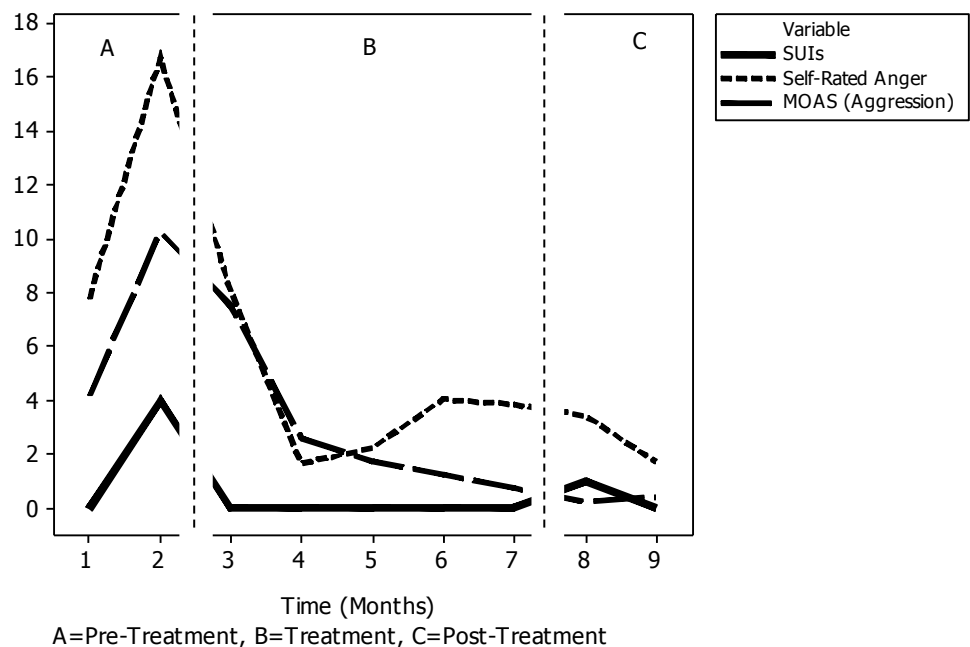
6.6.3 Event-shift sequence.

6.6.3.1 Reduction in use of PRN medication.

A number of changes can be seen to precede events occurring in therapy. Reduced use of PRN medication is seen immediately after starting treatment. In the 12 months prior to therapy starting Stuart used PRN medication on 26 occasions. In the four months immediately preceding therapy PRN medication was given at his request on eight occasions.

In the first session audio recording and process notes show that Stuart spoke about the physical and verbal abuse to which his mother had subjected him in his early teens. He added to this account by saying that following the separation of his parents one of his mother's male partners had raped him.

Shortly after ending this session Stuart had requested PRN medication from nursing staff. Stuart also asked to speak to the therapist immediately following the session. Stuart told the therapist that when he had spoken about his mother he had felt a "deep hatred" towards her. Stuart was supported by the therapist and a member of nursing staff following the session. After some discussion he was asked by the therapist to sit quietly and indicate when he was feeling more settled. He did not use PRN medication on this occasion. Subsequent therapy process notes indicate that the therapist initiated short periods of "sitting quietly" at the end of therapy sessions and checked that Stuart felt "settled" before he returned to communal areas on the ward. Records show that this additional technique was used to support emotional self-regulation at the end of therapy sessions when Stuart had discussed personally distressing material.

These events taking place within therapy precede five months during treatment when Stuart did not request PRN medication. No further SUIs including the use of PRN medication are recorded for nine months following treatment (see Figure 6.9). At post-therapy interview Stuart was asked about things he had found difficult within therapy and

how this was managed; he replied, "We talked about it and then afterwards we would sit for about five or ten minutes and just gather our thoughts…"

6.6.3.2 The function of reflecting upon images.

Stuart's use of drawings in therapy preceded a change in his perception about his future. In session four Stuart drew an image of a high brick wall with nothing on the other side. When discussing this image with the therapist during the session Stuart said that he was "stuck up against the wall" and was unable to articulate what was on the other side of the wall (see Figure 6.15). In the following session Stuart was asked again by the therapist to look at the picture and think about what might be on the other side of the wall; he then added pictures of a table and chairs representing a meeting room (see Figure 6.16). Stuart also repeated a version of this image in session eight when he drew a table and chairs (see Figure 6.17). These images depicted meetings in the hospital which were set up to discuss his future. This image was also mentioned by Stuart in his post-therapy interview as helping him think about his future.

6.6.3.3 Developing a therapeutic working relationship.

Events within therapy appear to have supported Stuart in developing trust. This is evident in differences between his Personal Problem scale (see Table 6.8) and CCRT interpersonal schema (see Table 6.9) at the start and end of therapy. Following Stuart's disengagement and re-engagement in therapy after session seven the therapist's observation ratings for engagement increase following sessions nine and 10 (see Figure 6.10).

6.6.4 Specific change processes.

Stuart's post-therapy interview accounts include specific processes related to his overcoming scepticism about the treatment and building trust with the therapist.

1. His description of the first meeting demonstrates his initial scepticism "…they came and saw me and we talked a bit about what it was about, what we'd do and that and stuff and then it was like he wanted me to draw pictures, which I wasn't too sure about at first. So I was a bit sort like 'who is this guy?' sort of thing." "Well, I didn't trust him. Trust's a big thing with me. You know, if I don't trust a person I won't be with them or speak to them or anything. So that was the big thing to start with drawing, the trust and get to know him as well as he'd get to know me."

2. Stuart eventually found that the process of drawing made therapy feel easier for him. "Once you got into it, drawing the pictures and trying to get the images of what you wanted to draw, it started to like sort of get a bit easier like."

3. Using the images as a starting point for discussion with the therapist was helpful. "The thing that I found helpful was… talking about it. Talking about things and like… You know, when you drew a picture, you know, you can sort of look at it and see like what's it… you know, what's it represent and that."

4. Using the images he made within therapy supported Stuart to think about specific issues and to make sense of them through developing his understanding. "…if you draw pictures and you see it from a bit of paper that you've drawn it on, then it makes a lot more sense than what it is in your head."

5. A process that supported change within therapy appears to relate to Stuart's re-evaluation of his future. "We talked about it because like we… I wanted to know where I was going and what I was doing and that."

6.7 Change Process Theory

    6.7.1 Antisocial Personality Disorder (APD).

    The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) identifies the "pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood and early adolescence and continues into adulthood" (p. 645) as an essential feature in the diagnosis of antisocial personality disorder (APA, 2000). Individuals with APD are often identified as lacking empathy, having inflated self-appraisal, and presenting with a superficial charm. Whilst the DSM-IV diagnostic criteria emphasise criminal behaviour, broader definitions are also applied such as Benjamin's (1996) definition cited in the NICE guidance on treatment, management and prevention of APD:

> ...a pattern of inappropriate and unmodulated desire *to control others*, implemented in a *detached manner*. There is a strong need to be independent, to resist being controlled by others, who are usually held in contempt. There is a willingness to use untamed aggression to back up the need for control or independence. The [antisocial personality (disorder)] usually presents in a friendly, sociable manner, but that friendliness is always accompanied by a baseline position of detachment. He or she doesn't care what happens to self or others. (Benjamin, 1996, p. 197)

    NICE recommendations for APD focus treatment upon group-based cognitive and behavioural interventions. General recommendations propose "that a positive rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment". This includes building a trusting relationship and working in an open, engaging and non-judgemental manner whilst being consistent and reliable (National Collaborating Centre for Mental Health, 2010). Beck (1990) identified problems in

developing and maintaining rapport with patients with APD and emphasises that it is a difficult but crucial component in being able to carry out therapy.

Sainsbury (1993) suggests that the initial response to the therapist by the patient provides a first-hand experience of the patient's attachment behaviour. The process of entering into a therapeutic relationship, by its very nature, requires a counter-intuitive response from some patients whose energy has often been spent avoiding trusting others with their own vulnerabilities. For patients with severe personality disorder it is suggested that "seeking to know them", from the patients point of view, is associated with withdrawal, abandonment, humiliation and abuse (Wheeler, 1993). This provides a challenge within therapy, or therapeutic task, for the therapist to avoid reinforcing the patient's insecure methods of relating to others. In practical terms greater confidence in the relationship can be achieved, as in developmental attachment relationships, through the demonstration of tolerance and the repairing of misunderstandings (Wheeler, 1993).

Continuity of poor attachment patterns linking childhood disruptive behaviour and adolescent delinquency to adult antisocial behaviour has been identified in men with APD (Craissati, 2009). Morrissey (2010) provides an overview of issues related to the identification and assessment of psychopathy in sexual offenders with intellectual disability. Whilst the focus of this work is in relation to specific sex offender treatment programmes, Morrissey (2010) usefully highlights that patients with a hostile-dominant interpersonal style may have a poorer therapeutic alliance and change may not be genuine. "Clients with antisocial and psychopathic disorders may see no need to change; they may nevertheless master the 'language' of treatment in order to convince therapists that they have changed" (Morrissey, 2010, p. 168).

6.7.1.1 Patterns of developing working alliance in therapy.

For a recent summary of theory and research as related to the therapeutic working alliance in psychotherapy, see (Ardito & Rabellino, 2011). A number of patterns of therapeutic alliance have been observed over the course of psychotherapeutic interventions. Bordin (1979) identifies the strength rather than the nature of working alliance between client and therapist as one of the keys to change process in psychotherapies and a concept that is universally applicable. Patterns of working alliance have been given greater scrutiny in process and outcome research. There is evidence that some people can form a strong working alliance in short-term treatment or following the first therapy session (Gelso & Carter, 1994; Kokotovic & Tracey, 1990). Kivlighan and Shaughnessy (2000) identified three patterns of working alliance: stable growth, linear growth, and a quadratic "U-shaped pattern" which is a high-low-high pattern of working alliance. This high-low-high pattern has also been found in earlier studies (Golden & Robbins, 1990; Horvath & Marx, 1990). Breakdown, ruptures, and withdrawal during the course of therapy have also been studied in working alliance relationships:

> Two types of patient communications or behaviors that mark a rupture withdrawal and confrontation markers. In withdrawal markers, the patient withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process. In confrontation ruptures, the patient directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy in an attempt to control the therapist. (Safran, Sastag, Muran, & Stevens, 2001, p. 409)

The experience within therapy for some patients of the high-low-high pattern of alliance, a "tear and repair" pattern, has been linked to better psychotherapy outcomes

(Kivlighan & Shaughnessy, 2000; Safran, et al., 2001). Stiles et al. (2004) attempted to replicate Kivlighan and Shaughnessy's (2000) findings and identified that a subset of patients who experienced "rupture-repair sequences" or "V"-shaped profiles within the process of therapy made greater gains in treatment than those who did not. The improved gains for participants with "V"-shaped profiles in alliance measures were "consistent with the hypothesis that alliance ruptures represent opportunities for clients to learn about their problems relating to others, and repairs represent such opportunities having been taken in the here-and-now of the therapeutic relationship" (Stiles, et al., 2004, p. 89).

6.7.1.2 Difficulties forming a trusting relationship and rupture-repair sequences in engagement and participation.

Therapist observation rating scales and the process record show distinct patterns in Stuart's engagement and participation during the course of therapy most clearly seen in sessions four and seven (see Figure 6.10 and 6.11). These events in the first half of therapy precede highly rated levels of engagement in sessions 11-17.

In the first session Stuart told the therapist, "I judge someone for who they are and whether I can trust that person. But I always say to myself and I always say this to myself afterwards, if that person ever… I don't know how to… I'm not trying to be funny, when I say this, if the person does a funny thing behind my back then that's it – I will never see that person again. If that makes sense to you."

Stuart's first session can be described as highly intense and included a considerable amount of personal disclosure. Ratings for Stuart's engagement in therapy have a spiky profile with Stuart being rated by the therapist as "open" for the first three sessions, and falling to "reluctantly engaged" in the fourth session (see Figure 6.10). Similar patterns are seen for participation in the first half of treatment with low rated sessions preceded by high rated sessions (see Figure 6.11). In session three Stuart is rated by the therapist as having

"full and active participation", followed by a drop in session four when he required "prompting and encouragement" to participate.

In this session Stuart told the therapist that the therapy was not helping him and he also expressed his scepticism about drawing pictures. Stuart recalled these events in his post-therapy interview "There was part of it where I wasn't really sort of like into it because like I didn't think it was really helping me. I didn't think it was really going anywhere to be quite honest and like I didn't think that what I was doing was helping me."

According to Safran et al. (2001) classification, this event is a "confrontation marker" with the client expressing dissatisfaction with the therapist or some aspect of the therapy. In session seven Stuart said that he no longer wished to attend, and spoke about ending therapy at this time. Stuart was given time to decide if he wished to continue. After his re-engagement in treatment being "open and trusting" is consistently scored by the therapist for seven consecutive sessions.

Events within Stuart's case are consistent with the literature related to building and maintaining a rapport and working alliance with APD patients. Therapeutic alliance has not been assessed using standardised measures in this study but there is evidence of "rupture-repair sequence" occurring. Stuart's dissatisfaction with aspects of therapy, shown in his engagement, withdrawal, and re-engagement are shown in the "V"-shaped profile of the therapist's observation scores for engagement and participation (seen Figures 6.10 and 6.11). It is possible that repair to the rupture in the working relationship provided additional opportunities for Stuart to learn about his interpersonal difficulties and develop a level of trust within the relationship. Change can be seen in Stuart's improved rating for the goal of "trusting others" on the Personal Problem Scale and in his positive *response of others* CCRT interpersonal schema at the end of therapy. It is possible that the pattern of a rupture-repair sequence in Stuart's engagement and participation in therapy supported these positive outcomes.

6.8 Evaluation of Alternative or Competing Explanations for Change

6.8.1 Trivial or negative change.

The BSI-18 measure shows improvement in scores reducing below the clinical cut-off prior to treatment. GAS-ID scores are below the clinical cut-off prior to treatment. Improvement that is measured between pre- and post-test scores for the GAS-ID are not within minimum reliable change limits.

6.8.2 Relational and expectancy influences.

It is plausible that an improved therapeutic relationship could influence in-treatment measures such as the Personal Problem Scale administered by the therapist. To check this potential influence on the in-treatment Personal Problem Scale the result can be corroborated with post-therapy measures reported to the psychology assistant. Stuart reported to the therapist that his feelings of hopelessness had improved. The BSI-18 item for "feeling hopeless about the future" shows that Stuart reported the same improvement at post-test interview to the psychology assistant. Corroborating the data shows that his self-report was consistent across relationships.

Stuart did have prior contact with the person conducting the post-therapy interview through routine work within the medium secure unit. It is therefore possible to consider relational influences upon his interview responses. Signs of plausibility and credibility in his personal accounts of change are still present despite this potential influence. Stuart gave differentiated and specific examples of change linked to events in therapy. Strong relational and expectancy influences do not appear to provide a plausible alternative explanation for the changes that have been reported.

6.8.3 Self-correction processes.

Stuart's belief that he was a victim of the system and his opposition towards others can be considered stable problems of long duration. There is no evidence that change was a result of short-term easing of problems. Stuart did report that he had been generally helped by things he had learned from psychotherapeutic interventions he had received prior to his participation in the study and he was able to draw from previous learning when his motivation changed. Self-rated anger scores show reducing variability and improving trend starting in the pre-treatment phase A. There is a reduction in higher levels of self-rated anger prior to treatment from day 43 of the observation period in phase A (see Figure 6.1). The influence of the introduction of daily self-rated anger scoring is a potential explanation for pre-treatment improvement in trend although this possible influence is drawn from the data alone. No evidence in the therapy process record points towards a specific cause linked to this change prior to treatment starting.

6.8.4 Extra-therapy events and psychobiological influences.

Stuart reported that he had built a good relationship with his named nurse which had supported him to improve his co-operation with staff. He was taking antidepressant medication and atypical antipsychotic medication, and he was treated for thyroid hormone deficiency throughout the study.

6.8.5 Apparent changes can be attributed to reactive effects of research.

Potential relational influences within post-therapy interview data collection have been discussed, as have the possibility for self-monitoring. Stuart did have some negative responses towards the research. He expressed that he was uncomfortable with the use of an audio recording device in his first session as this reminded him of police interviews. His initial concerns did not persist and Stuart did not report this as a problem to the therapist in

subsequent sessions. He did express concerns about his participation in the study to the therapist in session seven and this appears to be closely related to his questioning the effectiveness of the therapy at that time. Records indicate that Stuart was advised at the time according to the study information sheet and consent forms that he could withdraw from the study without prejudice. No other potential positive or negative influences accounting for reactive effects of research providing an alternative explanation for change have been identified.

6.9 Conclusion

6.9.1 Did therapeutic change take place during or as a result of art psychotherapy?

Reliable change can be seen in the Glasgow Depression Scale (GDS-LD) with a reduction below the clinical cut-off rate for depression between pre- and post-tests. Self-esteem, as measured by the RSES (adapted) improves when compared with local forensic group norms.

Variability in self-rated anger scores are seen to reduce across phases, with stability of trend being maintained in post-treatment phase C. Improving trend in reduced MOAS scores occurs during treatment, maintained in post-treatment phase C. Change is seen in the reduced frequency and type of SUIs measured in the 12-month period prior to treatment, reducing during treatment, and continuing for nine months post-treatment.

In-treatment measures also show improvement in personal problems and a shift from negative to positive CCRT interpersonal schemas.

6.9.2 Is there a plausible link between therapy and outcome?

Due to the detailed and descriptive account that Stuart gave about events taking place in therapy it has been possible to identify a number of links between therapy and outcome.

Stuart's retrospective attribution towards therapy included specific examples of events taking place in therapy that supported him in thinking more positively about his future. He also said that speaking about his children in the sessions had motivated him to write to them.

Stuart had spoken about his father within therapy and had subsequently agreed to renew contact with him. Whilst this change was identified by Stuart at post-therapy interview it is unclear about the influence therapy played in supporting the change as he stated that he was responding to, rather than initiating, the contact. It is possible that the exploration of difficult issues in Stuart's relationship with his father improved the likelihood that he would respond positively to his father's request for contact. However, this hypothesis cannot be confirmed within the case.

There is evidence to suggest that specific events in therapy link with post-therapy outcomes. This has included accounts by Stuart that certain pictures he made during therapy helped him to think about making changes, for example Figures 6.15 and 6.16.

There is evidence to suggest that Stuart has had longstanding and chronic interpersonal and behavioural problems prior to taking part in the study and that change was not related to a short-term easing of difficulties.

Some events within therapy have been shown to precede specific changes. The inclusion of emotional regulation techniques into therapy in response to Stuart's distress following the first session appear to have been influential. Events taking place in therapy which involved building a trusting working relationship or alliance also appear to have supported a shift in CCRT interpersonal schema's negative responses towards others.

Some plausible alternative explanations for change have been considered although causes linked with pre-therapy improvement in some measures have not been identified.

Stuart did express scepticism and dissatisfaction with therapy in its early stages. Relational and expectancy influences such as superficial attempts to please the therapist do not provide a plausible alternative explanation for change in this case. Stuart did identify that he was able to draw skills and knowledge from previous psychotherapeutic work he had engaged in during his treatment at the medium secure unit.

Extra-therapy events may have been influential. A plausible alternative explanation for change is Stuart's positive relationship with his named nurse. Stuart provides an account of his working relationship with the nurse and it is likely that this also contributed towards his increased co-operation with the nursing team.

Possible reactive effects of research have been considered. Due to Stuart's negative rather than positive responses towards certain elements of the research study strong research effects appear less likely.

6.9.3 Is there congruence between the outcomes, processes, and broad psychotherapeutic theory?

Positive outcomes in Stuart's case can be linked to events and processes taking place within art psychotherapy which fit with theory related to therapeutic working alliance.

Stuart reported specific change processes at the post-therapy interview. Statements he made about his experience of therapy suggest that he overcame his initial distrust of the therapist and scepticism about the treatment. Retrospectively Stuart described drawing images within the therapy as being helpful. His statements related to a process of talking about his pictures and making sense of them with the therapist.

Stuart's pattern of engagement within therapy has been related to therapeutic

alliance theory and specifically rupture repair sequences (Safran, et al., 2001).

CHAPTER 7 : CASE 3

7.1 Background Information

7.1.1 Hospital admission.

"Adam" was a twenty-three year old man who had a diagnosis of mild intellectual disability, autistic spectrum disorder, and Klinefelter's syndrome. Adam had been in hospital for two years and three months before participation in the study. He had been transferred from the hospital medium secure unit to the low secure unit just prior to giving his consent to taking part in the study.

During his treatment in the medium secure unit Adam's verbally and physically aggressive behaviour towards staff had reduced. On a day-to-day basis he presented no difficulties to the nursing staff and would appear to be amicable and compliant. Adam had developed positive relationships with nursing staff after moving to the low secure unit and said that he could trust them. His interactions with staff would mainly revolve around seeking assurance and "getting advice". Some minor incidents of self-harm were reported but this was very infrequent.

A comprehensive risk assessment completed when he was in the medium secure unit stated "Adam presents as a young man who is rigid and inflexible in his approach to life. Any diversion from set routines has the potential to induce anxiety and irritability and lead to confrontation". Within the hospital Adam showed an interest in pre-pubescent girls and was found with pictures of young girls horse-riding. He would report and write down vivid dreams and fantasies about stalking, raping and murdering young girls.

Adam was able to speak clearly although his manner of speech could appear monotonous and repetitive with little use of facial expression. His response time in conversation was delayed with some word-finding difficulties. He also needed longer processing time when thinking about new information. Misunderstandings could be the cause of his increased anxiety and, in turn, states of anxiety could impair his

understanding. He was also reported as having become concerned about his physical health which raised his anxiety.

7.1.2 Family relationships.

Adam did not have any contact with relatives and his requests to have contact with both his birth mother and a foster carer were not reciprocated.

7.1.3 Peer relationships.

He did have some interaction with other patients and his conversations were generally friendly. At the start of therapy Adam described himself as a very quiet person, which made it difficult for him to get to know people. He was "a little" bothered about having problems in relationships and said that he had an issue around girlfriends.

7.1.4 Childhood and adolescence.

Adam was taken into care weeks after he was born. His foster home was not a stable placement and the placement was terminated due to one of the foster carer's misuse of alcohol. Further disruption continued in foster care. During Adam's school years he showed evidence of early developmental delay alongside increasing behavioural disturbance. He was suspended for threatening behaviour and then arrested and excluded from school after being suspected of rape. During his early adulthood Adam was convicted of possession of child pornography. There are also reports that Adam was threatened in the community for his offence and taunted as a "paedophile".

7.1.5 Forensic history.

His admission to the Young Offenders Institute (YOI) followed being charged with and later convicted of fourteen counts of downloading child pornography. His sexual

deviance had also been noted in reports with his predatory interest in pre-pubescent girls demonstrated in his history of trying to associate with young children at a horse-riding stable. He was also suspected of committing rape at age eighteen years but he did not hold a conviction for this. Adam had a serious history of violence which included hiding and using weapons, hostage-taking and making threats to kill whilst in possession of a knife. Adam had initially been transferred to the medium secure unit from the YOI after writing down deviant fantasies about taking a female member of staff hostage.

7.1.6 Participation in the study.

Adam completed 20 sessions of art psychotherapy. Typically his sessions lasted 45 minutes and took place in the art and craft room in the low secure unit where he lived. Therapy was provided by a female therapist and sessions took place with a staff escort seated outside the room.

7.2 Repeated Measures

7.2.1 Brief Symptom Inventory (BSI-18).

All test scores are below the clinical cut-off for this measure. Adam shows improvement between the screening assessment point and pre-treatment with a reduction in all item scores and the Global Severity Index (GSI). Deterioration in GSI is seen at post-test returning to the same level as the screening assessment point. (see Table 7.1).

Table 7.1

BSI-18

Item	Screen	Pre	Post	Follow-up	Pre-Post Diff.	Pre-Follow-up Diff.
Somatisation	65	50	63	50	+13	0
Depression	50	45	59	57	+14	+12
Anxiety	50	39	57	50	+18	+11
GSI	61	47	61	52	+14	+5
Percentile	86th	38th	86th	58th	-	-

Note. GSI=Global Severity Index. The BSI-18 clinical cut-off is 63 (Derogatis, 2000) for a forensic inpatient ID maximum-security hospital sample (*n*=45) clinical cut-off is 64 (Kellett, et al., 2003).

7.2.2 Glasgow Anxiety Scale (GAS-ID).

Anxiety scores are above the clinical cut-off at the screening assessment point and at pre-test. Anxiety scores reduce below the clinical cut-off at post-test but gains are not sustained at follow-up (see Table 7.2).

Table 7.2

GAS-ID

Items	RCI	Screen	Pre	Post	Follow-up	Pre– Post Diff.	Pre-Follow-up Diff.
Worries	-	10	7	6	9	-1	+2
Fears	-	11	8	5	7	-3	-1
Physiological	-	7	3	3	4	0	+1
Total	6.20	28	18	14	20	-4	+2

Note. GAS-ID clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Mindham & Espie, 2003).

7.2.3 Glasgow Depression Scale (GDS-LD).

Scores at the screening assessment point reduce below the clinical cut-off prior to treatment. Scores then remain below the clinical cut-off. (see Table 7.3).

Table 7.3

GDS-LD

Item	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Depression	4.27	18	11	13	13	+2	+2

Note. GDS-LD clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Cuthill, et al., 2003).

7.2.3.1 Bayesian analysis of Glasgow scales: Comparison of difference between case and controls.

Comparison of the GAS-ID scores at the screening assessment point show that 82.12% of patients in the local forensic control sample and 95.75% of the non-anxious community sample would fall below Adam's score. Post-therapy improvement in anxiety places 30.42% of the local forensic control sample and 68.25% of the non-anxious community sample below his score (see Table 7.4).

GDS-LD scores at the screening assessment point place 71.29% of the local forensic control sample and 99.51% of the non-depressed community sample below Adam's score. Pre- to post-test scores deteriorate (see Table 7.5).

Table 7.4

Bayesian point estimate of percentage of the control population falling below the participant's GAS-ID score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	82.12	72.63	89.75	45.89	35.03	56.91	30.42	20.79	41.20	54.10	45.04	64.82
**Community ID	95.75	85.48	99.67	80.14	61.80	92.95	68.25	48.85	84.43	84.86	67.88	95.64

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GAS-ID total scores as compared to a male forensic IDD sample (*n*=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 19 (SD=9.4). **Participants GAS-ID total scores as compared to a male and female non-anxious community ID sample (*n*=16) with a mean age of 34.9 (SD=10.4) and a mean score of 9 (SD=10) (Mindham & Espie, 2003).

Table 7.5

Bayesian point estimate of percentage of the control population falling below the participant's GDS-LD score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
* Forensic IDD	71.29	60.70	80.76	33.66	23.75	44.52	44.39	33.67	55.40	44.39	33.67	55.40
** Community ID	99.51	97.04	99.99	71.42	53.76	85.85	88.45	74.23	96.92	88.45	74.23	96.92

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GDS-LD scores as compared to a male forensic IDD sample (n=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 14 (SD=7). **Participants GDS-LD scores as compared to a male and female non-depressed community ID sample (n=19) with a mean age of 39.11 (SD=9.31) and a mean score of 9.29 (SD=2.94) (Cuthill, et al., 2003).

7.2.4 Rosenberg Self-Esteem Scale (adapted).

RSES (adapted) scores between pre- and post-test reduce. At the screening assessment point Adam rates the statements "I feel I am a good person, as good as any other" and "I like myself", as "always true". His most negative responses before treatment are in rating the statement "I feel I have not done anything worthwhile" as being "often true" (see Appendix 16c).

Table 7.6

Rosenberg Self−Esteem Scale (adapted)

	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Total score	6.25	25	23	20	22	-3	-1

Note. Maximum score = 30, minimum score = 6. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Dagnan & Sandhu, 1999).

7.2.4.1 Bayesian analysis of RSES (adapted): Comparison of difference between case and controls.

At the screening assessment point Adam shows a relatively high level of self-esteem compared with his peers in the local forensic control sample, with 74.37% falling below his score. Adam's self-esteem scores reduce immediately post-treatment with 33.12% of the local forensic control sample falling below his score (see Table 7.7).

Table 7.7

Bayesian point estimate of percentage of the control population falling below the participant's RSES (adapted) score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	74.32	63.12	84.02	58.62	46.83	69.95	33.12	22.48	44.90	49.97	38.25	61.72
**Community ID	64.94	53.19	75.75	45.69	34.16	57.55	19.95	11.37	30.54	36.13	25.21	48.00

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants RSES (adapted) total scores as compared to a male forensic IDD sample (n=43) with a mean age of 32.2 (SD=9.1) and a mean score of 22 (SD=4.5) (see Appendix 8).**Participants RSES (adapted) total scores as compared to a male and female community ID sample (n=43) with a mean age of 31.1 (SD=10.2) and a mean score of 23.44 (SD=3.99) (Dagnan & Sandhu, 1999).

7.3 Continuous Measures

At the screening assessment point Adam gave the following self-rating scores: "feeling tense, panicky or stressed" = 5 (not much), "feeling poorly or unwell" = 4 (not much), "feeling low, down or sad" = 4 (not much), and "feeling cross or angry" = 1 (not much) (see Appendix 10 for examples of all self-rating scales). Adam completed daily self-rated anxiety scores for the duration of the study.

7.3.1 Self-Rated Anxiety.

Self-rated scores for anxiety cover a total of 294 days (see Figure 7.1). Pre-therapy phase A includes 63 days, the period of therapy in phase B includes 154 days and the final phase C of the observation includes 77 days. There are a total of 15 days with missing scores, thus 94.9% of the observation period has complete data.

7.3.1.1 Self-rated anxiety in phase A.

The mean score from phase A (1.98) is set across all phases. In phase A self-rated anxiety is low and stable with only day five scoring above the mean and day 42 scoring above the upper control limit (UCL).

7.3.1.2 Self-rated anxiety in phase B.

Variability in scores increases at the start of the treatment period. The score of 20 on day 74 corresponds with the statement "feeling a little bit tense, panicky or stressed" and follows the second session. Scores then fall below the UCL (15.47) until day 103 with the highest possible score of 50 being rated "the worst it can be".

Scores return below the UCL until day 126 when a score of 31 is given which falls on the same day as session10 and corresponds with the statement "feeling quite a bit tense, panicky or stressed".

After session10 a stable run of scores fall below the mean ($\bar{x}$=1.98) for a period of 24 days. This period covers therapy sessions 11 to 13.

Six consecutive days are then rated above the UCL, from day 160 to day 165. These events are assignable to a special cause. The period from day 160 to day 174 corresponds with three weeks when Adam's sessions were cancelled.

In phase B the last day rated above control limits is rated with the highest possible score of 50; this occurs on day 188 which immediately follows session 18.

Within phase B a total of 99 days are rated with the lowest possible score of 1 or "the best it can be", a further 24 days are rated with scores ranging from 2-10 "feeling tense, panicky or stressed, not much". Eight days are rated with scores ranging from 11-20 "feeling a little bit tense, panicky or stressed" and five days are rated with scores ranging from 21-30 "feeling a bit tense, panicky or stressed". Four days are scored between 31-40 "feeling quite a bit tense, panicky or stressed". Two days are rated with scores of 50 "feeling tense, panicky or stressed a lot" also corresponding with the statement "the worst it can be".

7.3.1.3 Self-rated anxiety in phase C.

In phase C a total of 58 days are rated with scores below the mean (1.98). The longest stable run of scores below the mean is for 13 days shortly after the end of phase B, from day 220 to day 233.

7.3.1.4 Average weekly self-rated anxiety across phases.

Daily scores have been converted into a weekly average for self-rated anxiety scores (see Figure 7.2). According to methods of trend analysis for statistical process control (Callahan & Barisa, 2005) there are no trends or runs in the data occurring in any

phase. There is one data point in week 24 rising above the UCL which can be considered a special case.

7.3.1.5 Trend for self-rated anxiety.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 7.3, 7.4, and 7.5. LOESS trend lines remain flat across all phases.

Fig. 7.1 Self-Rated Anxiety Scores for Case 3 (Adam)

A=Pre-Treatment; B=Treatment; C=Post-Treatment

Fig. 7.2 Average Weekly Self-Rated Anxiety Scores for Case 3 (Adam)
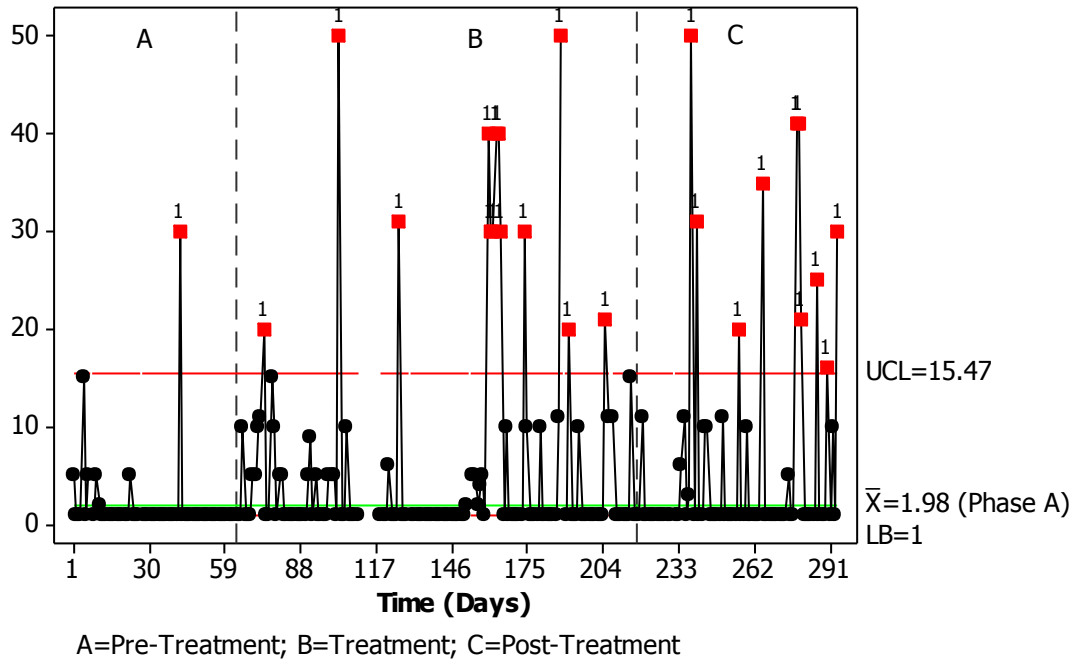
A=Pre-Treatment; B=Treatment; C=Post-Treatment
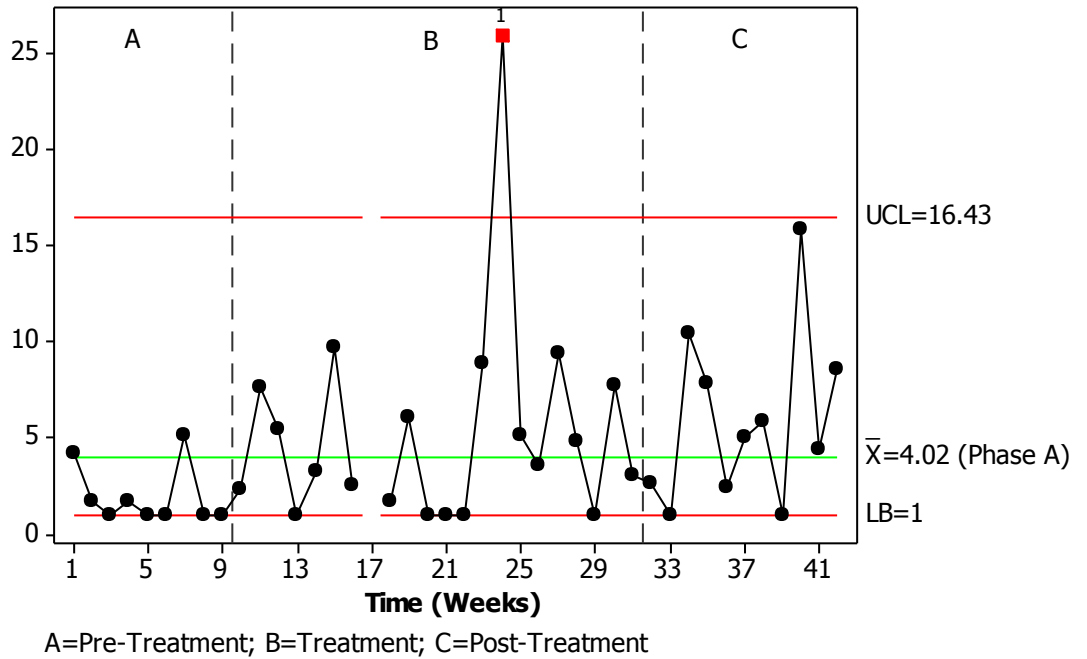
Fig. 7.3 Pre-Treatment (Phase A) Self Rated Anxiety for Case 3 (Adam)

LOESS
Linear
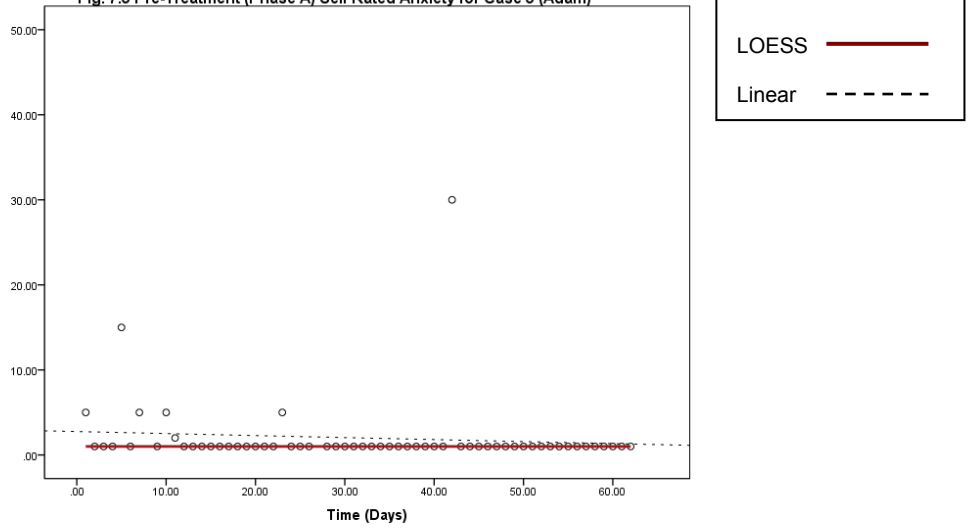
Fig. 7.4 Treatment (Phase B) Self Rated Anxiety for Case 3 (Adam)
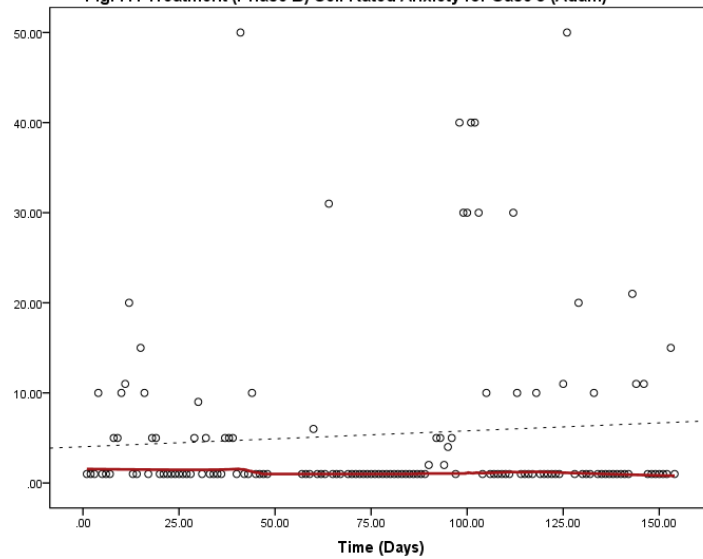
Fig. 7.5 Post-Treatment (Phase C) Self Rated Anxiety for Case 3 (Adam)
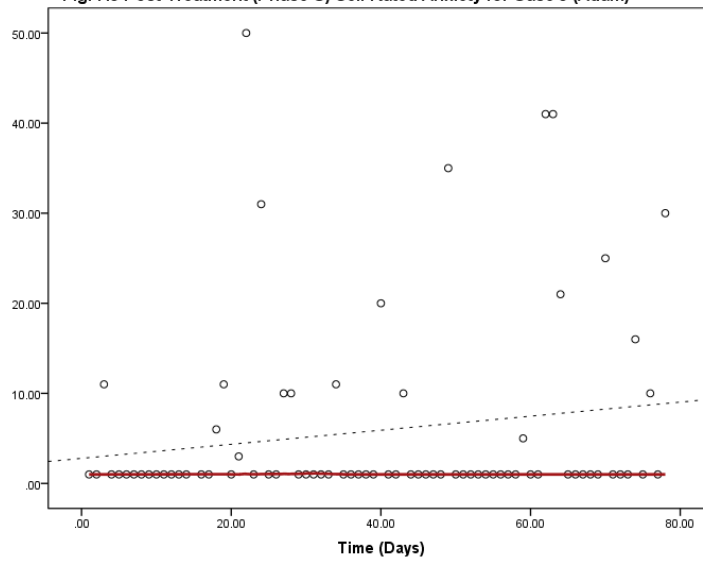
7.3.2 Modified Overt Aggression Scale (MOAS).

No MOAS scores were present during any of the phases of observation.

7.3.3 Serious Untoward Incidents (SUIs).

No SUIs were recorded during the twelve months prior to therapy, during therapy, or following therapy.

7.4 In-Treatment Measures

7.4.1 Personal Problem Scale (PPS).

Adam told the therapist that he was a quiet person and that he found it difficult to get to know people. He said that this had bothered him a little bit and that he also had an issue around girls. His three main stated problems were: (1) He found it difficult to think and talk about relationships. This was indicated as the most difficult issue for him. (2) Adam also said that he did feel low sometimes but that this did not bother him a great deal, rating it to be close to "the best it can be" at the start of therapy. (3) Another area of difficulty for Adam was having nightmares.

Adam rated improved scores at the end of therapy for "thinking and talking about relationships" and "having nightmares", which he rated as being "the best it can be", or close to this (see Table 7.8).

Table 7.8

Personal Problem Scale

Problem Statement	First Therapy Session	Last Therapy Session
Thinking and talking about relationships*	3	4
Feeling low sometimes	2	2
Having nightmares	3	5

Note. 1= worst it can be, 5 = Best it can be; * = most difficult problem.

7.4.2 Core Conflictual Relationship Theme (CCRT).

The level of completeness of relationship episodes given by Adam ranged from 0.5 to 3.0 with 83% being rated below 2.5 as incomplete. The *wish* statements were judged from 55% explicit statements and 45% moderately inferred statements. There was no overall agreement between judges regarding selection of standard category scores for *wish* statements from Adam's relationship episodes at the start of treatment, therefore all *wish* statements are shown with equal value. There was agreement between judges for *wish* statements at the end of therapy but there was no overall dominant theme (see Table 7.9).

At the start of therapy Adam saw others as being "helpful", he was "happy", and his wish was "to achieve". There are no negative responses at the start of therapy. At the end of therapy negative *responses of self* and *others* are present. This includes a response that *others* "don't trust me" and a *response of self* of being "uncertain". At the end of therapy there were no *wish* statements matching those stated at the start of therapy. There is a *wish* to be "distant from others" and a *wish* "to be close to others". The pervasiveness score for the presence of the CCRT interpersonal schema at the start of therapy was 50% reducing to 37.5% at the end of therapy.

Table 7.9

Core Conflictual Relationship Theme (CCRT) Interpersonal Schemas

CCRT at start.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
*Are helpful; are supportive; give to me; explain.		***Feel happy;** feel excited; feel good; feel joy; feel elated.		***To achieve;** to be competent; to win. ***To be independent**; to be self-sufficient; to be self-reliant; to be autonomous. ***To not be responsible or obligated;** to be free; to not be constrained. ***To be stable;** to be secure; to have structure.

CCRT at end.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
*Are helpful; are supportive; give to me; explain.	**Don't trust me;** don't believe me; are suspicious of me.	***Am open;** express myself. **Am independent;** make my own decisions; am self-directed; am autonomous.	**Am uncertain;** feel torn; am ambivalent; feel conflicted,	***To be distant from others;** to not express myself/my feelings; to be left alone. ***To be close to others;** to be included; not to be left alone; to be friends.. ***To be helped;** to be nurtured; to be given support; to be given something valuable; to be protected. ***To better myself;** to improve; to get well.

Note: *= most frequent recurring theme in relationship episodes.

7.4.3 Therapist Observation Rating Scales

For therapeutic engagement Adam was rated by the therapist to be "genuine but guarded" in 11 out of the 20 therapy sessions. This was interspersed with sessions when he presented himself as "open". Lower scores for "reluctantly engaged" are given by the therapist for sessions nine and 10, and at the end of therapy in sessions 19 and 20. No higher level scores for being seen to be "open and trusting" are given by the therapist during the course of treatment (see Figure 7.6).

For participation and motivation Adam is rated as having "participated satisfactorily without prompting or encouragement" in 11 sessions. In the nine other sessions he was seen to have had a "self-motivated attempt to participate" (see Figure 7.7).

Adam achieves higher scores for his attitude towards image-making within therapy, with four sessions rated as having an "active and focused response to image-making" (see Figure 7.8).

Therapist Observation Rating Scales

Fig. 7.6 Therapeutic engagement for Case 3 (Adam)
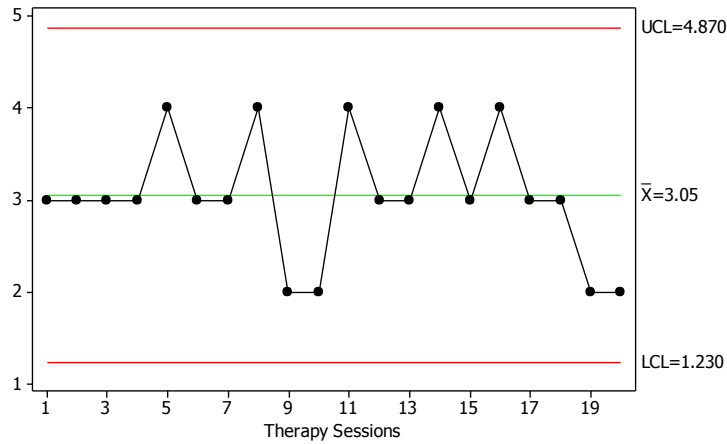
Note. 1=did not engage, 2=reluctantly engaged, 3=genuine but guarded, 4=open, 5=open and trusting,

Fig. 7.7 Participation and motivation for Case 3 (Adam)
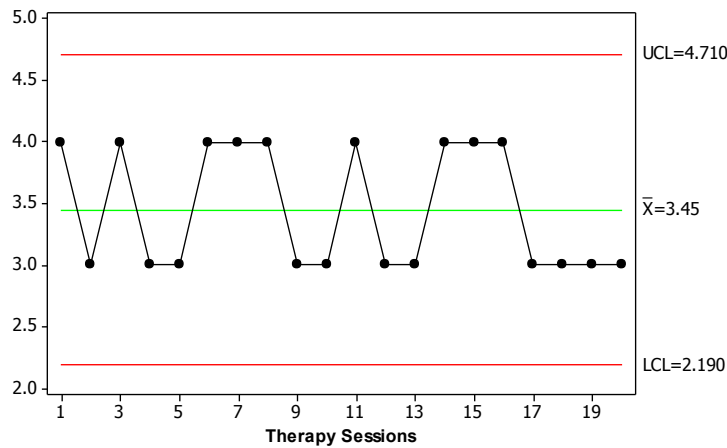
Note. 1=did not participate in session even when prompted and encouraged, 2=participated in session with prompting and encouragement, 3=participated satisfactorily without prompting or encouragement, 4=a self-motivated attempt to participate and 5= full and active participation throughout.

Fig. 7.8 Attitude towards image making for Case 3 (Adam)
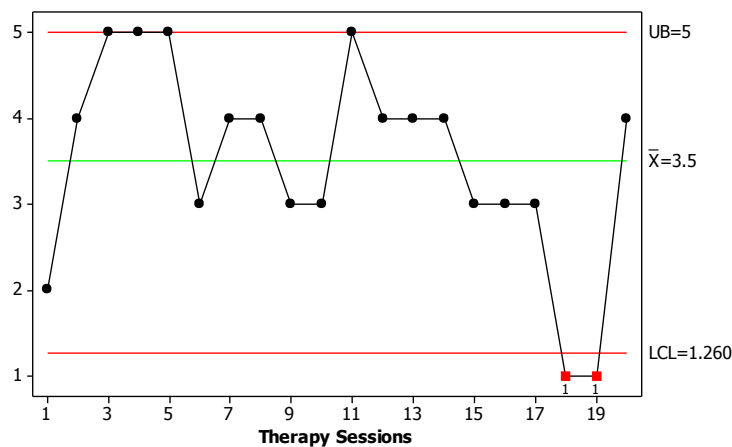
Note. 1= No image or art object made in the session, 2=required encouragement and prompting to attempt image-making, 3=mixed response to image-making, 4=positive response to image-making, 5=active and focused response to image-making.

7.4.4 Participant's most important image or object.

Adam selected a picture of a riding stable which he had worked on in a number of sessions. Work in progress can be seen in Figure 7.10 from session seven when Adam told the therapist that he found making art "peaceful and calm". The final version of the picture can be seen in Figure 7.11. Adam did not give a specific reason why he chose this picture as his most important image.

7. 5 Retrospective Attribution

7.5.1 Change Interview (adapted).

At the post-therapy interview Adam reported that he was having fewer nightmares, was feeling more settled, and was being more sensible and helpful to others.

7.5.1.1 Having less frequent nightmares.

What changed? "Probably I can't say something about it… I'm having less dreams about young girls."

What helped? "Aye, telling [therapist's name] about my dreams."

Attribution: Adam attributed having fewer nightmares to events in therapy. From the interview transcript Adam appears to have been initially reluctant to disclose this information to the interviewer. Therapy session records show that Adam had sexually deviant dreams about young girls. No extra-therapy events were identified as supporting this change.

7.5.1.2 Feeling more settled.

What changed? "And I feel a lot more settled."

What helped? "Probably doing that art therapy, talking out my problems with [therapist's name]. She's given me some advice, what to do. Speaking to her about what's happening, I feel more settled."

Attribution: Adam attributes feeling more settled to talking with the therapist. No extra-therapy events were seen as contributing towards this change.

7.5.1.3 Being more sensible and helping others.

What changed? "More sensible." "Helping people out." "Doing more jobs around".

What helped? No example given.

Attribution: Adam said that he had noticed he was doing more jobs and trying to be helpful when speaking about changes. These were general comments about changes and Adam did not give specific details about how therapy helped these changes.

7.5.2. Attributed Changes.

When asked what the art therapy was like for him Adam replied, "It was quite interesting". Adam spoke about early sessions: "the first time I started I was quite nervous". When asked what he was nervous about Adam replied, "probably talking about my dreams".

When asked how much he thought things had changed since doing art therapy Adam said, "probably quite a bit". Helpful things within the sessions described by Adam were, "probably writing things down, probably drawing things, painting it". Adam said that the things that helped were "…talking, drawing…feeling sad, feeling happy. All different things". He found talking to be the most useful part of therapy. One difficult area was that he did find it hard to explain the pictures he had made in the session. "A little bit difficult

for me to do with explaining what's happening in the picture." Adam later clarified this in the interview and said that he had difficulty "expressing my feeling".

Adam gave mixed statements about his therapy. He said that he thought six months of therapy was "too long". Adam also said that making artwork in therapy was "probably relaxing". He did think that art therapy would be useful for other patients in the hospital, but with fewer sessions.

7.5.2.1 Corroboration of the participant's retrospective attribution with a nursing account of change.

An interview with Adam's named nurse was not carried out at three months follow-up due to their being absent from work on long term sick leave.

Figure 7.9 Therapy Session 2 "3D window".

Figure 7.10 Therapy Sessions 7 & 8 "Riding stable".
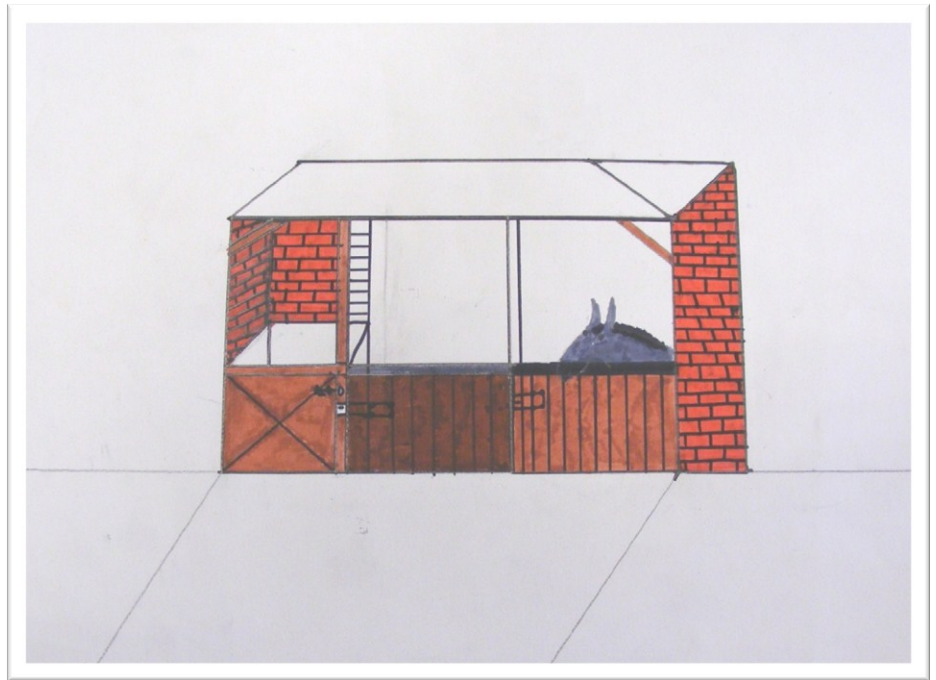
Figure 7.11 Therapy Session 10 "Riding stable".

Figure 7.12 Therapy Session 6 Image of dream, "two streets and two families".
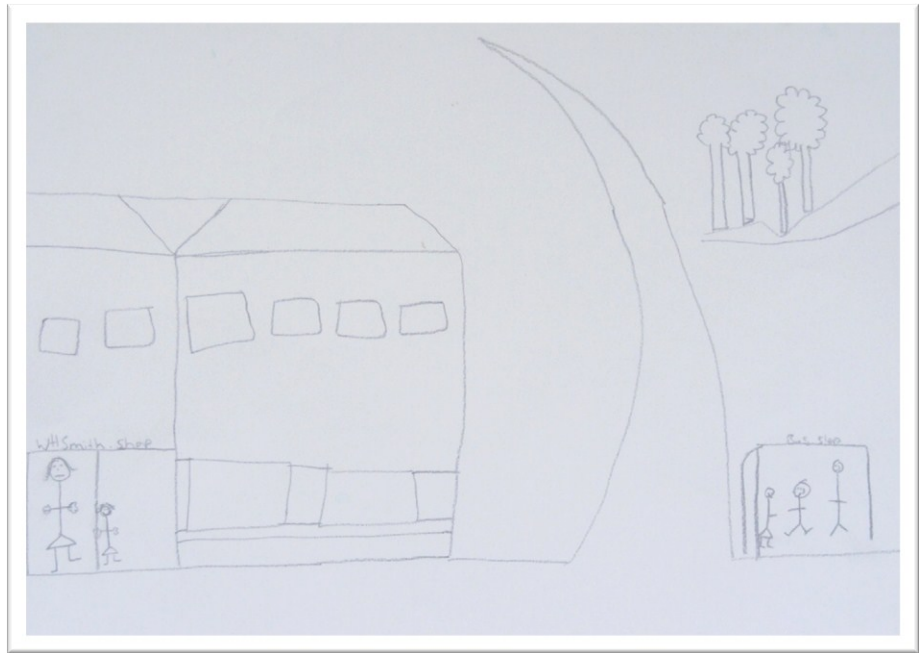
Figure 7.13 Therapy session 6 detail of picture "some at WH Smith".
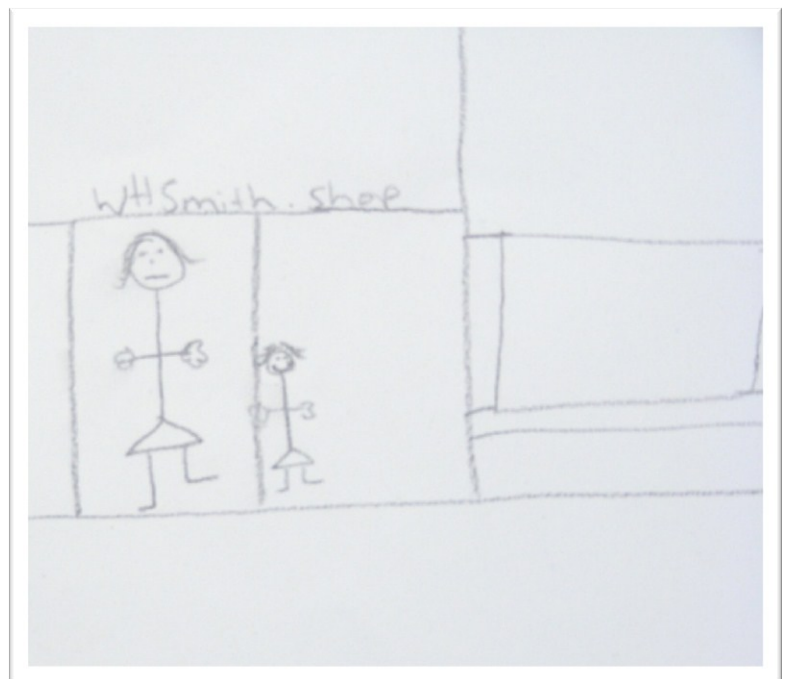
Figure 7.14 Therapy session 6 Detail of picture "…there is me looking for underage girls".
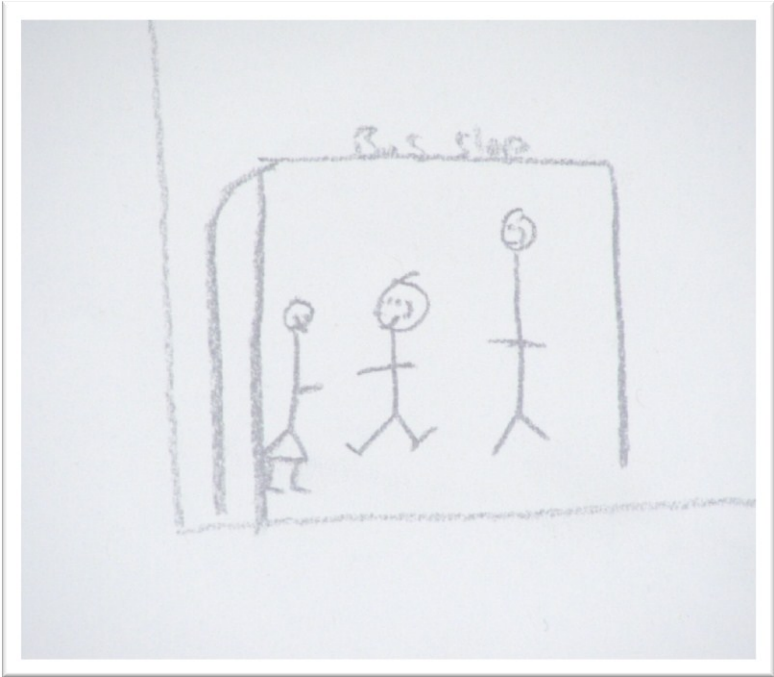
Figure 7.15 Therapy Session 11 "Dream catcher".

7.6 Evaluation of Explanations for Change Related to Therapy

    7.6.1 Process outcome mapping.

Adam's post-therapy retrospective attribution towards therapy can be seen to correspond with events taking place during therapy. Adam's difficulties in expressing himself verbally are reflected in the interview responses. His specific communication problems with processing and understanding new information may have limited some of his responses. He did identify some events within therapy as supporting personal change.

In the second session Adam told the therapist that he found that making artwork in the session helped him feel peaceful (see Figure 7.9). Adam also spoke about having nightmares in this session "I might speak it out, yesterday night, I had a bad dream. If I'm living in my own place or with staff, some people were knocking on the door and make threats to me…because of my index offence."

After this session Adam told the therapist that his nightmares were going away. This changed again in session six when he informed the therapist that they had started again. Adam's nightmares appeared to cause him a degree of distress at different times. His nightmares were mainly related to his offence, both in terms of fears about being threatened by people who knew about his offence and dreams with violent or sexual content.

Adam drew images of the dreams within this session (see Figures 7.12, 7.13 and 7.14). He described these images to the therapist. "Those are people on the street and two families. One at WH Smiths and one at the bus stop. That is me there, looking for underage girl. I followed her around off on that road there, and kidnapped her."

The week before this, in session five, Adam had started to draw a picture of a horse in a riding stable (see Figure 7.10). It is likely that Adam's interest in horse-riding was associated with his interest in pre-pubescent girls. Adam continued to speak about his disturbing nightmares in session six. His nightmare was related to the image of the horse.

"Most dreams are very dangerous for me, to going…one dream I had, probably last week or this week - probably last week now - a farmer slaughtered a horse. We were getting that horse better, and he slaughtered me not the horse…I saved the…Before the horse had been slaughtered…I saved the horse. The farmer was not looking and he slaughtered me."

In session eight Adam continued to discuss his dreams with the therapist. Adam said that he thought the increase in having disturbing dreams was related to his thoughts about being on a waiting list for a sex offender treatment programme within the hospital. He was feeling increasingly anxious about the start of this treatment which was due to take place at some point in the future. Adam brought his written dream records to the therapy session to discuss with the therapist. In session 17 the content of his dreams included violent sexual fantasies about young girls. He also spoke about being attracted to a female patient he had seen in the hospital. His attraction to her was not reciprocated and the content of his dream record included a fantasy account of carrying out a violent sexual assault on the female.

Within session 18 the therapist prompted Adam to review all the images he had made during therapy. When looking at all the pictures together Adam commented that some of the places in his dreams and nightmares were in his pictures and he said that this felt "weird". He said, "I think I have achieved something, working with art". Within this session Adam identified one of his pictures as resembling a "dream catcher" (see Figure 7.15). At this time Adam told the therapist that he was not having any more bad dreams and that he thought it was probably to do with his art therapy sessions.
At post-therapy interview Adam reported having fewer nightmares with violent and sexual content. This retrospectively attributed outcome can be plausibly related to processes taking place within therapy.

Adam also reported "feeling more settled" as a result of art therapy. Within process notes the therapist described Adam's attention and focus on art-making within the sessions.

In session three Adam drew an image of a battleship, and described how he could become "submerged" in the artwork. Within session four Adam reported that he was feeling a lot more settled and related this to attending therapy. Within session seven the therapist noted that Adam had spent a large portion of the session, 25 minutes, working on his picture of a horse in a stable (see Figure 7.10). At the end of the session Adam commented that he had felt "peaceful and calm". In therapy session 11 Adam made a similar comment when he was painting a picture: "This is relaxing maybe I made the right choice today" (see Figure 7.15). Within session 16 Adam told the therapist, "I think I have enjoyed sessions last couple of months". He related his enjoyment to "painting as being relaxing" and "thinking about pictures, what to do".

Retrospectively Adam attributed "feeling more settled" to art therapy and said that this was related to talking to the therapist. It is also clear that Adam spoke about feeling settled and relaxed within the process of therapy when making artwork.

Adam's other post-therapy attribution was "being more sensible and helping others". He did not give a specific example in relation to events or processes within therapy that helped this change. From the therapy record it is clear that Adam had considerable difficulties relating to other people. When he was asked specifically to give accounts of his interaction with others the therapist noted that Adam appeared to lack any real sense of relationships or interactions and that he gave rather stilted and brief comments. The therapy process record shows that general relationships with others formed the content of some therapy sessions, but examples of specific discussion about helping others appears to be limited. Adam had rated "relationships" as a difficult problem in the Personal Problem Scale (see Table 7.8).

There is evidence to suggest that Adam's post-therapy outcomes for having fewer nightmares and feeling more settled correspond with events and processes taking place within therapy.

7.6.2 Change in stable problems.

There is some indication of change in stable problems in Adam's case but results are mixed. GAS-ID anxiety scores fell below the clinical cut-off following treatment but gains were not maintained. Trend for continuous measures did not provide evidence of change in daily self-rated anxiety scores. Improvement in the Personal Problem Scale, such as being bothered by "having nightmares", and positive retrospective attribution for having less frequent nightmares provide evidence of change in one longstanding problem.

7.6.3 Event-shift sequence.

Process outcome mapping adequately describes post-therapy change linking with events in therapy. There are few clear examples of event-shift sequences within therapy process due to a number of negative extra-therapy events. Negative extra-therapy events obscure the possibility of identifying positive sustained gains in self-rated anxiety scores as a result of therapy.

At the start of therapy there is a slight increase in self-rated anxiety scores with variation below the mean (see Figure 7.1). It is plausible to relate this increase in anxiety scores to the start of treatment. Adam described himself as being nervous about having one-to-one therapy with the female therapist at this time. After the second session, anxiety scores increased above the mean for three days. In this early session Adam discussed having graphic nightmares. After this, lower level anxiety scores are attributed until day 103 (see Figure 7.1).

A higher rated score for anxiety coincides with Adam's care programme approach meeting (CPA) and being told by his responsible clinician that plans for him to be included in the hospital sex offender treatment programme had been put on hold. Plans for him to go ahead with the treatment were then reviewed and implemented at a later date in post-treatment phase C.

Sessions seven, eight, and nine included an intensive period when Adam worked on the image of the horse in the stable (see Figures 7.10 and 7.11). He also discussed being disturbed by nightmares with the therapist and continued to express anxiety in anticipation of the sex offender treatment programme. Anxiety scores reduce for an extended period of 56 days with the exception of day 126 which coincides with therapy session 10. In session 10, after having chosen to work on the picture of the stable for a number of weeks, he told the therapist that he was getting bored with the picture. It is interesting to note that this conversation led to Adam saying that he felt "lonely". He also told the therapist that he was "feeling stressed" about dental surgery he was expecting to have. Adam acknowledged that it had been difficult for him to raise his concerns with the therapist but he said he had felt better after "getting things off my chest and thinking". The therapist observed Adam to be "reluctantly engaged" during this session (see Figure7.6). Therapy session observations rated by the therapist are more positive in session 11 (see Figures 7.6, 7.7 and 7.8). In sessions 12, 13, and 14 Adam reports that doing artwork in these sessions was relaxing. Low trend in self-rated anxiety scores are interrupted following therapy session 14 (day 154, week 22) by a cluster of six days rated above the UCL (starting on day 160) (see Figure 7.1). This pattern in the data is assignable to a special cause, also seen in week 24 in Figure 7.2. High anxiety scores at this time correspond to Adam having dental surgery and therapy sessions were cancelled during this period.

One further negative extra-therapy event corresponds with high anxiety scores being rated on day 188 (week 27) (see Figure 7.1). At this time Adam was told that his birth mother did not wish to have contact with him. Adam had asked his social worker to try and re-establish contact with her.

Some therapy sessions precede stable runs of low daily self-rated anxiety, which appear to be interrupted by negative extra-therapy events accounting for high scores. As

has been described in process outcome mapping, work related to disturbing and sexually deviant nightmares precedes Adam reporting improvement in this area.

7.6.4 Specific change processes.

Specific elements of the process helping Adam to change can be taken from his post-therapy interview responses. Adam gave limited responses to questions at post-therapy but he provided enough information to identify the key areas of the therapy process that he found helpful.

1. Adam said that he was a bit nervous at the start of therapy. His nervous feelings were also related to opening up to the therapist. "The first time I started I was quite nervous, probably talking about my dreams."

2. Adam described being involved in therapy sessions. "It was quite interesting." "Painting, drawing, talking."

3. Adam identified that speaking and explaining himself to the therapist was difficult for him. "Going over the pictures and talking about it." "A little bit difficult for me to do with explaining what's happening in the picture."

4. Adam reported that he was able to speak to the therapists and that this helped. "…doing that art therapy, talking out my problems with [therapist]. She's given me some advice, what to do. Speaking to her [about] what's happening and I feel a lot more settled."

5. Adam was able to be open with the therapist about his feelings and found therapy relaxing. "Expressing my feeling." "Probably relaxing."

7.7 Change Process Theory

A number of complexities are presented in Adam's case, such as his diagnosis of Klinefelter's syndrome (XXY condition), a diagnosis of autistic spectrum disorder (ASD), and deviant sexual fantasies and nightmares. These factors will be considered sequentially

giving a context for processes taking place within therapy. There is a small amount of literature relating to the reduction of nightmares in psychotherapeutic work with people who have intellectual disabilities, for example, reductions in "highly disturbing nightmares" are demonstrated as an outcome in psychodynamic-interpersonal psychotherapy (Kellett & Beail, 1997).

7.7.1 XXY Condition.

Klinefelter's syndrome is considered a sex chromosome variation (SCV), also referred to as XXY condition due to an extra X chromosome. The condition is the most common genetic cause of male infertility and it can occur as frequently as 1 in 500 in male births, although not all develop features associated with Klinefelter's syndrome. Insufficient testosterone is produced, commonly treated with hormone replacement therapy. Typically XXY males can present as being socially quiet and shy as children. Associated literacy problems, language difficulties, problems with verbal processing speed, auditory processing, and deficits in verbal memory can persist into adulthood (Boone, et al., 2001; Geschwind, Boone, Miller, & Swerdloff, 2000). This can adversely affect the ability of some men with this syndrome to express their thoughts and put emotions into words. Behavioural abnormalities also seen in this population include poor judgment, impulsivity, failure to consider consequences of one's behaviour and deficits in social skills (Boone, et al., 2001)

7.7.1.1 XXY males and offending.

Examples of detailed case reports relating to the psychosexual development and sexually deviant behaviours of XXY males can be seen in the literature dating back to 1953 (Hoaken, Clarke, & Breslin, 1964). Early studies in sex chromosomal abnormalities were commonly based in secure hospitals and penal units (Craft, 1984).

Money and Lamacz (1989) described seven different cases with "sexological disorders" and paraphilia, including sadomasochism and paedophilia. Epps (1996) reports on the sexual preferences, behaviour, and fantasies of an adolescent boy with the 48-XXYY syndrome. Some authors have sought to establish a link between Klinefelter's syndrome and sexual offending (Hummel, Aschoff, Blessmann, & Anders, 1993; Lachmann, et al., 1991; Raboch, Cerna, & Zemek, 1987). Other studies provide counter-evidence supporting the hypothesis that Klinefelter's syndrome is associated with lower levels of sexual activity in comparison with peers (Raboch, Mellan, & Starka, 1979; Sorenson, 1992).

Griffiths and Fedoroff (2009) cite Langevin's (1992) findings that endocrine disorders were apparent in 10% of sexual assault cases and evident in cases involving paedophilia. Whilst there is a range of historic case reports and studies of offender populations with chromosome and endocrine conditions there is no known correlation with paraphilia (Gooren & Kruijver, 2002).

7.7.2 Autism Spectrum Disorder and offending.

Hare, Gould, Mills, and Wing (2000) reported an over-representation of individuals with autistic spectrum disorders in English high secure special hospitals. O'Brien et al. (2010) found rates of ASD at 10% in a study covering three health regions in the UK, which included 477 people with intellectual and developmental disabilities. Offending behaviour was not found to be over-represented among individuals on the autism spectrum.

Tantam (1988) identified 46 people with ASD in a sample of 60 patients with "lifelong eccentricity and social isolation". Nearly a quarter of the subjects had committed a criminal offence with two of the subjects detained in a special hospital. Antisocial behaviour is also reported in the sample with six subjects being identified with "morbid fascination for violence" of which three went on to act upon their interests and carry out

violent assaults. Two of the men had violent sexual fantasies which included designing sadistic experiments on women, and violent fantasies. Both men carried out attacks on girls after writing explicitly about their aggressive feelings (Tantam, 1988).

Berney (2004) suggested that some forensic presentations in ASD, in particular Asperger syndrome, can include obsessive harassment (stalking), inexplicable violence, computer crime, and offences arising out of misjudged social relationships.

In a brief commentary on offenders with autism spectrum disorders Murphy (2010) highlights the presence of dysfunctional and restricted coping strategies: "many people with autism include a profound alienation from other adults and maladaptive coping strategies (such as developing vivid and controlling daydream worlds) for dealing with emotional regulation and interpersonal anxiety" (Murphy, 2010, p. 45). There is also a clinical view that individuals with autism can find the experience of inpatient treatment and offence-related interventions anxiety-provoking. Symptoms of anxiety may be seen to worsen for some patients with autism during treatment, and close monitoring is recommended (Taylor, Lindsay, & O'Brien, 2011).

7.7.3 Deviant sexual fantasies and offending.

The role of fantasy in leading to an offence has generated a wide range of theory, and differing opinion. Daleiden, Kaufman, Hilliker, & O'Neil (1998) consider that it might be the absence of normal sexual fantasies in sex offenders rather than the presence of deviant ones that stimulates offending. Howitt (2004) proposes that offenders' fantasies are more reflective of themes associated with their own history. The role of deviant sexual fantasies and internet pornography leading to contact offences has also been considered. In a study comparing the psychological profile of contact sexual offenders with internet sexual offenders, under-assertiveness was found to be predictive of internet offences (Elliott, Beech, Madeville-Norden, & Hayes, 2009). A conclusion from this study was that

child pornography was used due to its lack of face-to-face contact. General rates of offenders reported to go on to commit contact offences after using pornography vary from 40% (Wolak, Finkelhor, & Mitchell, 2005) to 86% (Wilcox, Sosnowski, Warberg, & Beech, 2005).

7.7.4 Process change theories relating to reduced nightmares.

Willner (2004) reports a case study of a man with mild to moderate intellectual disabilities experiencing two recurrent nightmares, one of which was accompanied by congruent post-traumatic daytime ruminations. The 29-year-old man had committed a sexual offence and disclosed that he had been sexually assaulted. He also reported urges to re-offend which were associated with periods of personal distress. The recurring nightmares were addressed in a single therapy session including use of a relaxation technique, telling the story of the dream and then changing the ending of the story from a negative to positive outcome. This revised dream story was then rehearsed several times in the session and support staff were asked to monitor the man's dreams for a week. Reduction in nightmares and daytime ruminations were also linked to a reduction in the man's urges to offend and an increase in victim empathy. At six and 12 month follow-up only one repeat of a nightmare had taken place with no resurgence of urges to offend. Kroese and Thomas (2006) report two case studies describing the treatment of chronic nightmares for sexual assault survivors with an intellectual disability. The technique of imagery rehearsal therapy (Krakow, Kellner, Oathak, & Lambert, 1995) was applied in both cases with the addition of using drawing to help both client and therapist to illustrate the dream sequence. Both cases were reported to have had reduced frequency in nightmares which was reported to have been maintained at six-month follow-up.

7.7.4.1 Therapy processes.

Adam reported that nightmares were a personal problem for him at the start of therapy which improved by the end of therapy (see Table 7.6). At three-month follow-up he reported that events within therapy had helped him feel less distressed by nightmares. He identified that processes taking place within therapy led to a reduction in his specific nightmares about young girls, such as the ones reported to the therapist in session six. Within this session Adam drew and described stalking and kidnapping a young girl (see Figures 7.12, 7.13, and 7.14.). He also described dreams to the therapist which placed him as a potential victim related to his own fears about being targeted in the community because of the offence he had committed. Specific components of therapy involved Adam in retelling dream scenarios, drawing imagery from recurring dreams and reflecting upon the content of these pictures with the therapist. In session 11 Adam drew a "dream catcher" image associated with a reduction in his nightmares (see Figure 7.15). Adam's self-report that he experienced a reduction in the frequency of recurring nightmares involving specific offences against young girls appears to be plausible.

Other potential alternative influences may have been present and will be considered briefly. Alternative explanations for the improvement Adam reported could include hormonal fluctuation, a general reduction in stressful extra-therapy events, the use of a diary, and the possibility that the art-making activity in itself promoted relaxation, leading to reduced night-time distress.

Some studies have identified positive outcomes of testosterone treatment for men with Klinefelter's syndrome (Nielsen, Pelsen, & Sorensen, 1988). Whilst testosterone can influence the threshold of occurrence of erotosexual imagery and sexual activity it does not appear to change the content of imagery (Gijs & Gooren, 1996; Gooren & Kruijver, 2002; Money, 1986). Hormonal influences may offer a potential alternative explanation but this remains unclear in Adam's case.

Adam related his nightmares to periods of increased stress. There is evidence that periods of stress increased during the treatment as a result of a number negative extra-therapy events. Increased levels of self-reported anxiety would suggest that there might have been an increase in the frequency of nightmares reported rather than a decrease.

Adam kept a diary of dreams which he said helped him not to think about the nightmares during the day; he brought the diary to the therapist for discussion. If left unchecked, Adam's written fantasies could be associated with heightened risk. It is not possible to assess if use of a dream diary on its own had a positive therapeutic influence. The additional influence of discussing the dreams and fantasies with the therapist (as opposed to self-correction processes) appears to provide a plausible explanation for change.

A contributory rather than alternative explanation could be linked to Adam experiencing art-making as a form of relaxation within therapy; Adam reported this to the therapist. This may have also supported a reduction in night-time distress during the treatment phase.

It remains plausible that in addition to Adam's report of finding therapy sessions relaxing his experience of depicting and discussing his nightmares and deviant sexual fantasies supported a reduction in their frequency.

Imagery rehearsal therapy (Krakow, et al., 1995) was not applied within the art psychotherapy. A study that adapted imagery rehearsal therapy for adults with intellectual disabilities to include drawing dream imagery has shown some benefits (Kroese & Thomas, 2006). Elements of Adam drawing explicit and deviant sexual dreams within therapy and discussing this with his therapist may have contributed to change. Adam's post-therapy reports, that specific events in therapy supported a reduction in the frequency of his nightmares, appears to provide a plausible and likely therapy outcome.

7.8 Evaluation of Alternative or Competing Explanations for Change

7.8.1 Trivial or negative change.

For repeated measures BSI-18 and GDS-LD scores deteriorate between pre- and post-test; change is negative. GAS-ID scores improve between pre- and post-test, falling below the clinical cut-off, but gains are not sustained. RSES (adapted) self-esteem reduced following treatment. Continuous measures of self-rated anxiety do not show improving change in trend.

7.8.2 Relational and expectancy influences.

There is no evidence of Adam reporting changes as a result of making a superficial attempt to please the therapist. He expressed some dissatisfaction during session 10, albeit reluctantly, and at post-therapy interview he said that he would have preferred a shorter duration of therapy. It is difficult to fully assess whether Adam's responses at post-therapy interview were influenced by relational or expectancy issues. Adam did attribute "being sensible and helping others" towards his participation in therapy but he was not able to give a specific and detailed account of events within therapy relating to this change. Adam's responses at post-therapy interview were, at best, measured.

7.8.3 Self correction processes.

The potential influence of the self-correction processes of Adam keeping a dream diary have been discussed. No other potential self-correction processes have been identified within the therapy process record or at post-therapy interview.

7.8.4 Extra-therapy events and psychobiological influences.

Adam did not identify any positive extra-therapy events supporting changes. There is strong evidence within continuous self-rated measures that negative extra-therapy

events account for heightened anxiety scores in treatment phase B. No psychobiological influences were identified.

7.8.5 Apparent changes can be attributed to reactive effects of research.

Potential research effects are difficult to gauge. The main outcome in Adam's case is related to a reduced frequency of nightmares. Adam did not discuss having nightmares with the study assessors until post-therapy interview. This suggests that a potential therapeutic influence of research procedures on this change is unlikely.

7.9 Conclusion

7.9.1 Did therapeutic change take place during or as a result of art psychotherapy?

In-treatment measures show important changes in the Personal Problem Scale for "having nightmares", an improvement that was reported to have been sustained at three month follow-up.

Adam's CCRT interpersonal schema changes from being wholly positive at the start of therapy to including negative and ambivalent components at the end. Whilst this may not be fully identified as having been influenced by therapy there is a potential explanation for this change. Adam's negative CCRT response at the end of therapy that others "don't trust me" is related to his telling the therapists and subsequently the nursing staff about the content of his dreams. An increase in his openness about his deviant sexual fantasies and awareness that others perceive them as being related to risk can be seen as a positive outcome in forensic services.

7.9.2 Is there a plausible link between therapy and outcome?

As described in process outcome mapping and change process theory, a plausible link between therapy process and outcome can be made. There is evidence to suggest that specific events in therapy, including dream image-making, and discussions with the therapist about fantasies and nightmares, supported change.

Alternatively a number of outcomes were measured to be negative or trivial. Relational influences have not been shown to account for changes that have been reported. No positive extra-therapy events have been identified as offering a potential therapeutic influence upon outcome in Adam's case. No clear reactive effects of research have been identified in Adam's case.

7.9.3 Is there congruence between the outcomes, processes, and broad psychotherapeutic theory?

Despite the limited and idiographic nature of the outcome, in Adam's case it is possible to identify very specific links between therapy and outcome. The case is interesting given the range of complex factors; there are examples, albeit limited, of psychotherapeutic approaches and techniques being used with people who have intellectual disabilities that have been shown to reduce the frequency of nightmares. Within this study art psychotherapy does appear to have supported a reduction in the frequency of Adam's nightmares.

CHAPTER 8: CASE 4

8.1 Background Information

8.1.1 Hospital admission.

"Richard" is a twenty-eight year old man with mild intellectual disability who had been in hospital for eight years two months prior to his participation in the art psychotherapy study. At the start of the study he had been living in low secure wards for approximately six years. From this low secure setting Richard had potential to move to a forensic community placement.

Shortly after arriving in the hospital Richard had spent some time in the medium secure unit within the hospital. At that time he had repeatedly attempted to breach security and abscond. He had also made verbal and physical threats to staff and frequently damaged property.

Richard's day-to-day interactions with staff were generally good; he did however show a degree of volatility and disgruntlement towards staff members. He was also reported to have tried to play nursing staff off against each other; this sometimes undermined treatment plans that were intended to help him progress. One hospital report suggested that Richard seemed unaware that staff would talk to each other about the different conversations he had with them. Members of the nursing team tried to provide consistent responses to Richard's demands which frequently resulted in him being caught out. This particular behaviour was considered to be "egocentric", reflecting his lack of maturity. This problem was managed by allocating Richard to a contact nurse each day to minimise his tendency to ask different staff members the same question. There was also a concern that having spent all his adult life within forensic services he had become quite institutionalised and regarded all negative incidents to be of equal seriousness.

As part of his treatment pathway within the hospital, Richard had completed sex offender and anger treatment programmes. The level of risk he presented was considered to

have reduced during his admission. He was closely monitored within the low secure unit but he continued to test the boundaries of his treatment and not comply with basic rules. Richard was treated with a small stable dose of Risperidone which remained unchanged for the duration of the study period. In his first therapy session he reported experiencing low mood and a lack of motivation at times. "I'm always down as soon as I get out of bed, I hate getting up. Hate going to work. I'd rather just stay in bed." Despite this Richard was seen to engage well in activities in the work and education programme at the hospital and was generally well regarded by day staff. He had achieved some educational qualifications and was able to go to the hospital club, access ground leave and go on supervised community outings.

Many of Richard's longstanding difficulties were considered to be the result of a high degree of relationship instability and a lack of awareness of appropriate social boundaries. Richard's speech was clear and easily understood, and he had basic literacy skills and was able to use a wide vocabulary in conversation. He was able to hold a balanced conversation and respect others' opinions but would often stick to subjects which were closely related to his own personal interests. Despite this he did not always respond appropriately to everyday communication and often miscommunication and misunderstandings would be a source of frustration.

8.1.2 Family relationships.

Richard did not have contact with many members of his family but he did have occasional contact with his brother.

8.1.3 Peer relationships.

Richard described having minor arguments and disagreements with other patients on the ward. His interactions with other patients did not escalate into aggressive incidents

but he did say that he would often spend time in his room on his own. Richard had a girlfriend, and this relationship was observed by staff to have a particularly destabilising effect on him. Richard had known this girlfriend since he was 15 years old when they met in a hospital at an adolescent treatment unit. At the time therapy started they lived within the same hospital grounds in wards which operated as separate units but were next door to each other. Richard continued this "on and off" relationship with his girlfriend throughout therapy. Her discharge from hospital coincided with the end of treatment.

8.1.4 Childhood and adolescence.

Richard's history and background is described in reports as having been highly dysfunctional. Concerns were raised when he was seen to exhibit sexual behaviour at age four. He started attending special school at the age of eight years old. At age 10 Richard was placed on the child protection register as a result of physical and sexual abuse from his father. He was exposed to inappropriate sexualised material from an early age and was then placed in the care of his grandfather who also went on to sexually abuse Richard and his siblings. This led to Richard being made a ward of court at 11 years. Following this he was placed in a number of successive foster placements. At the age of 13 he had sexual intercourse with young children in his extended family. This resulted in his being placed in institutional care at the age of 14. Incidents reported at this time include aggression, verbal abuse and inappropriate sexual behaviour. At the age of 18 he transferred from a specialist adolescent unit and was placed in a secure forensic hospital as a result of public protection concerns.

8.1.5 Forensic history.

Richard's offending history included numerous allegations of sexual assault on very young children. His status as a schedule one offender was as a result of one

conviction for indecent assault on a minor. He was considered to present a risk to female staff following reports of his touching some staff inappropriately. Within the hospital this behaviour was closely monitored and supervised and a "no touch" policy had been put in place.

8.1.6 Participation in the study.

Richard completed 20 one-to-one art psychotherapy sessions with a female therapist. Sessions were conducted in a designated art therapy room on the hospital site. A male staff escort would routinely sit outside the room.

8.2 Repeated Measures

8.2.1 Brief Symptom Inventory (BSI-18).

Global Severity Index (GSI) scores are on or above the clinical cut-off. There is a reduction in GSI post-test scores but they remain within the clinical range (see Table 8.1).

Table 8.1

BSI-18

Item	Screen	Pre	Post	Follow-up	Pre-Post Diff.	Pre-Follow-up Diff.
Somatisation	64	73	70	75	-3	+2
Depression	65	62	63	61	+1	-1
Anxiety	50	72	60	65	-12	-7
GSI	63	71	66	68	-5	-3
Percentile	90th	98th	95th	96th	-	-

Note. GSI=Global Severity Index. The BSI-18 clinical cut-off is 63 (Derogatis, 2000) for a forensic inpatient ID maximum-security hospital sample (*n*=45) clinical cut-off is 64 (Kellett, et al., 2003).

8.2.2 Glasgow Anxiety Scale (GAS-ID).

Total scores for anxiety remain above the clinical cut-off. Total anxiety scores increase at post-test with no change being measured between pre-test and follow-up (see Table 8.2).

Table 8.2

GAS-ID

Items	RCI	Screen	Pre	Post	Follow-up	Pre– Post Diff.	Pre-Follow-up Diff.
Worries	-	10	10	13	9	+3	-1
Fears	-	3	6	5	2	-1	-4
Physiological	-	12	9	10	14	+1	+5
Total	6.20	25	25	28	25	+3	0

Note. GAS-ID clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Mindham & Espie, 2003).

8.2.3 Glasgow Depression Scale (GDS-LD).

Depression scores are above the clinical cut-off at each test point. Improvement is seen between pre- and post-test but change is not above the RCI minimum (see Table 8.3).

Table 8.3

GDS-LD

Item	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Depression	4.27	20	25	23	23	-2	-2

Note. GDS-LD clinical cut-off is 15. Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Cuthill, et al., 2003).

8.2.3.1 Bayesian analysis of Glasgow scales: Comparison of difference between case and controls.

Post-test GAS-ID scores place 82.10% of the local forensic control sample and 95.75% of the non-anxious community sample below Richard's score (see Table 8.4). Post-test GDS-LD scores place 89.54% of the local forensic control sample and 99.98% of the non-depressed community sample below Richard's score (see Table 8.5).

Table 8.4

Bayesian point estimate of percentage of the control population falling below the participant's GAS-ID score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	73.06	62.44	82.24	73.06	62.44	82.24	82.10	72.55	89.71	73.06	62.44	82.24
**Community ID	92.94	79.92	99.02	92.94	79.92	99.02	95.75	85.48	99.67	92.94	79.92	99.02

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GAS-ID total scores as compared to a male forensic IDD sample (n=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 19 (SD=9.4). **Participants GAS-ID total scores as compared to a male and female non-anxious community ID sample (n=16) with a mean age of 34.9 (SD=10.4) and a mean score of 9 (SD=10) (Mindham & Espie, 2003).

Table 8.5

Bayesian point estimate of percentage of the control population falling below the participant's GDS-LD score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
* Forensic IDD	79.98	70.12	88.04	93.69	87.48	97.62	89.54	81.70	95.14	89.54	81.70	95.14
** Community ID	99.99	99.13	100.00	99.99	99.98	100.00	99.98	99.89	100.00	99.98	99.89	100.00

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants GDS-LD scores as compared to a male forensic IDD sample (*n*=51) with a mean age of 31.2 (SD=9.4) (see Appendix 8) and a mean score of 14 (SD=7). **Participants GDS-LD scores as compared to a male and female non-depressed community ID sample (*n*=19) with a mean age of 39.11 (SD=9.31) and a mean score of 9.29 (SD=2.94) (Cuthill, et al., 2003).

8.2.4 Rosenberg Self-Esteem Scale (adapted).

The highest overall self-esteem rating is at the screening assessment point and the lowest score is at follow-up. The statements "I feel I am a good person, as good as other people", "I feel there are a lot of good things about me", "I am able to do things as well as other people", and, "sometimes I think I am no good at all", are all rated consistently by Richard across repeated tests as being "sometimes true" (see Appendix 16d). There are no changes in self-esteem scores between pre- and post-test (see Table 8.6).

Table 8.6

Rosenberg Self−Esteem Scale (adapted)

	RCI	Screen	Pre	Post	Follow-up	Pre-post Diff.	Pre-Follow-up Diff.
Total score	6.25	22	20	20	18	0	-2

Note. Maximum score = 30 (highest self-esteem), minimum score = 6 (lowest self-esteem). Least change RCI 95% confidence (1.96sd) is based upon test-retest reliability (Dagnan & Sandhu, 1999).

8.2.4.1 *Bayesian analysis of RSES (adapted): Comparison of difference between case and controls.*

At pre- and post-test 33.12 % of the local forensic control sample and 19.95% of the community sample would fall below Richard's score. When compared with both control samples at follow-up Richard's self-esteem is low with 19.21% of the local forensic control sample and 9.24% of the community sample falling below his score (see Table 8.7).

Table 8.7

Bayesian point estimate of percentage of the control population falling below the participant's RSES (adapted) score

Sample	Screen			Pre			Post			Follow-up		
	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL	Point	95% LL	95% UL
*Forensic IDD	49.97	38.25	61.72	33.12	22.48	44.90	33.12	22.48	44.90	19.21	10.80	29.82
**Community ID	36.13	25.21	48.00	19.95	11.37	30.54	19.95	11.37	30.54	9.24	3.80	17.32

Note. Point=Bayesian point estimate of percentage of the control population falling below the participant's score. LL=Lower credible limit, UL=Upper credible limit. *Participants RSES (adapted) total scores as compared to a male forensic IDD sample (*n*=43) with a mean age of 32.2 (SD=9.1) and a mean score of 22 (SD=4.5) (see Appendix 8).**Participants RSES (adapted) total scores as compared to a male and female community ID sample (*n*=43) with a mean age of 31.1 (SD=10.2) and a mean score of 23.44 (SD=3.99) (Dagnan & Sandhu, 1999).

8.3 Continuous Measures

At the screening assessment point Richard gave the following self-rating scores: "feeling tense, panicky or stressed" = 10 (not much), "feeling poorly or unwell" = 15 (a little bit), "feeling low, down or sad" = 25 (a bit), and "feeling cross or angry" = 14 (a little bit) (see Appendix 10 for examples of all self-rating scales). Richard completed daily self-rated low-mood scores for the duration of the study.

8.3.1 Self-Rated Low Mood.

Self-rated scores for low mood span 293 days. Pre-therapy phase A includes 88 days, the period of therapy in phase B includes scores across 134 days and the post-therapy phase C includes 71 days. There is a small amount of missing data for a total of 16 days so that 94.5% of days were rated across all phases (see Figure 8.1).

8.3.1.1 Self-rated low mood in phase A.

In pre-treatment phase A rating of low mood scores show a high degree of variability. The mean score (12.27) for phase A has been set across all phases. The longest stable run of scores falling below the mean occurs for a period of 16 days between day 35 and day 51. The highest possible score of 50, "the worst it can be", is present in phase A on day 59. Low mood is then rated as improved with scores falling below the mean or the LCL (6.68) between days 61 and 78. Days 79 and 84 are rated above the UCL (18.76) prior to treatment.

8.3.1.2 Self-rated low mood in phase B.

After day 90, which is rated above the UCL, scores fall below the mean until day 110. This initial period of phase B includes sessions one to four. From day 111 to day 117 consecutive higher scores are given above the UCL.

After the fourth session no further days are rated above the UCL for the remainder of phase B. Days 118 to 153 include sessions five to nine. Ten out of 35 days in this period are rated below the LCL including days 118, 123, 125, 129, 143, 144, 145, 146, 152 and 153.

Following the tenth session and continuing until the final session, from day 155 to day 221, a run of 64 scores fall below the mean and above the LCL (in control) with the exception of day 216 which is scored below LCL.

8.3.1.3 Self-rated low mood in phase C.

In the post-treatment phase C no scores are rated above the mean. At the start of phase C, immediately following the end of therapy, established trend is interrupted by scores falling below the LCL from day 226 to day 240. A stable run of scores is then established (within control) until the end of the observation period with only day 216 falling below the LCL.

8.3.1.4 Trend for self-rated low mood.

LOESS and linear trend lines for each of the separate phases of the study can be seen in Figures 8.2, 8.3, and 8.4. An improving trend can be seen in the pre-treatment phase A (see Figure 8.2). A stable flat trend is established in the second half of the treatment phase B (see Figure 8.3). Trend lines in the post-treatment phase C showed that scores remain low with stable periods and few outliers (see Figure 8.4).

Fig. 8.1 Self-Rated Low Mood for Case 4 (Richard)

A=Pre-Treatment; B=Treatment; C=Post-Treatment
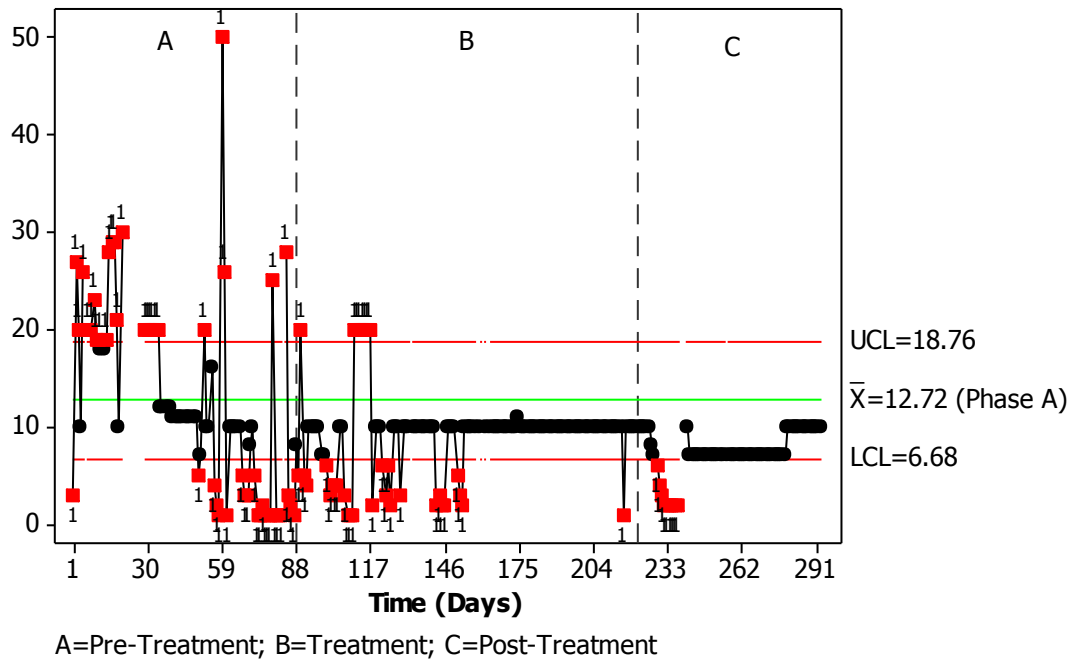
Fig. 8.2 Pre-Treatment (Phase A) Self Rated Low Mood for Case 4 (Richard)
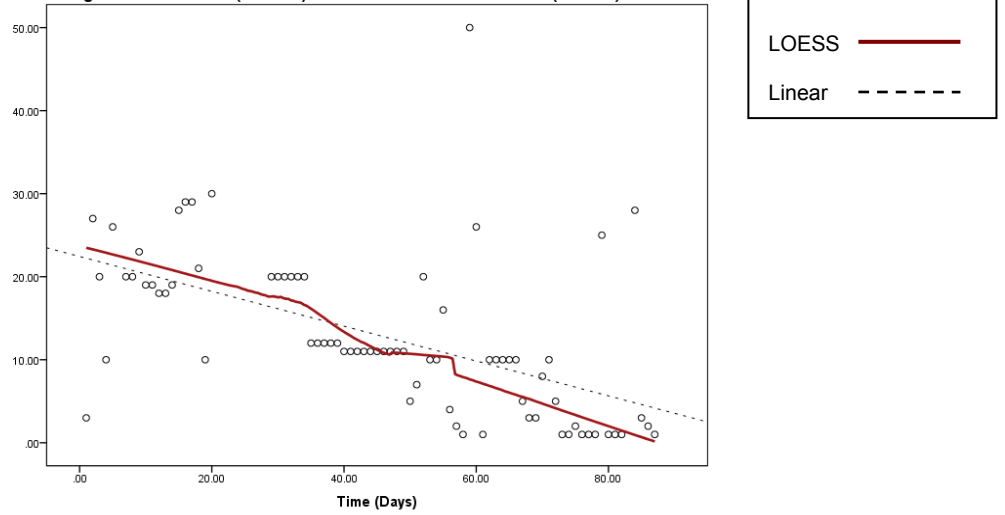
Fig. 8.3 Treatment (Phase B) Self Rated Low Mood for Case 4 (Richard)
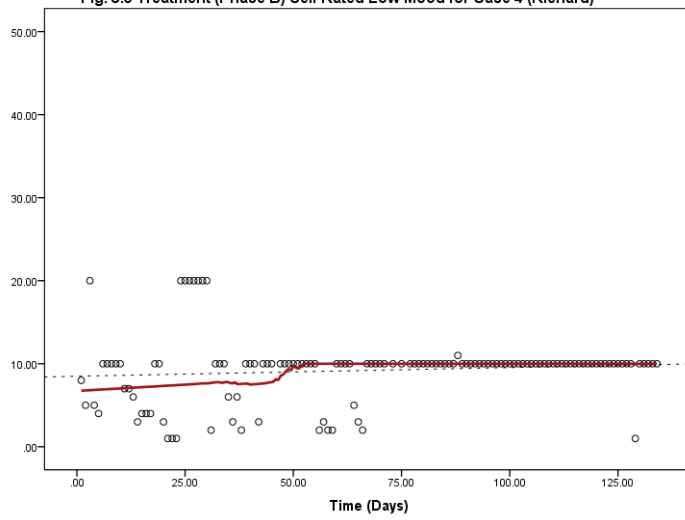
Fig. 8.4 Post-Treatment (Phase C) Self Rated Low Mood for Case 4 (Richard)
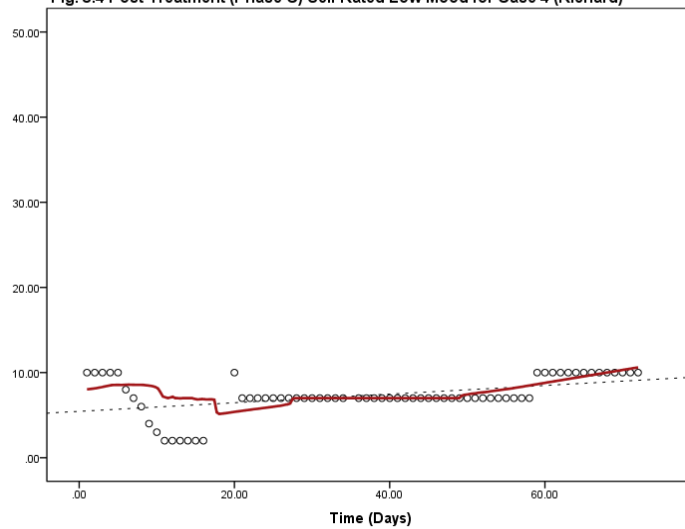
8.3.2 Modified Overt Aggression Scale (MOAS).

No MOAS scores were present for the duration of the study.

8.3.3 Serious Untoward Incidents (SUIs).

No SUIs were recorded during the twelve months prior to therapy starting, during therapy, or following therapy.

8.4 In-Treatment Measures

8.4.1 Personal Problem Scale (PPS).

Richard spoke about a number of problems in detail during his first session, but did not rate all problems as being severe or the worst that they could be (see Table 8.8). His three main stated problems were: (1) Richard had an "on and off" relationship with his girlfriend. In the first session he said "well, we're just not, we're just not seeing eye-to-eye. She says she loves somebody else, when she really doesn't, but she's just using the other person to get to me." Richard rated this problem as the midpoint in the scale with a score of three. (2) Richard also felt vulnerable about potentially being discharged from the hospital to a community placement, "Because I am wanting to go back in the community, but I'm thinking that they're moving me too fast because they're not giving me enough time in the community of getting my courage. They want me straight out and it's hard to explain." Despite this statement to the therapist Richard rated this problem as being near to the "best it can be" with a score of four. (3) Richard said that his third problem related to living with other patients on the ward. Richard gave a score for this problem which indicated that it was a superficial difficulty at the time.

When asked to score the same problems at the end of therapy, feeling upset about his ex-girlfriend had improved to "the best is can be", and worrying about moving to the community also improved slightly.

Table 8.8

Personal Problem Scale

Problem Statement	First Therapy Session	Last Therapy Session
Feeling upset by ex-girlfriend*	3	5
Worrying about being moved into the community	4	5
Arguments with patients at the tea table	5	5

Note. 1= worst it can be, 5 = Best it can be; * = most difficult problem.

8.4.2 Core Conflictual Relationship Theme (CCRT).

Richard was able to give accounts of many relationship episodes at the start and end of therapy. The completeness of the relationship episodes were scored for detail in each component, *response of others*, *response of self*, and *wish*. The completeness of relationship episodes Richard gave ranges from 1.0 to 3.0. A higher percentage of statements for the *wish* component, 66%, were rated as being moderately inferred, and 33% of statements were rated as an explicit *wish* (see Table 8.9).

The relationships Richard spoke about included staff, his ex-girlfriend, his brother and foster parents. The CCRT interpersonal schema found in relationship patterns at the start of therapy included experiencing *others* as "rejecting"; his *own response* was to be "happy" with an underlying *wish* "to be close to others" and "to be loved".

At the end of therapy Richard's relationship episodes include many of the same themes with some small but notable changes. He indicates that his negative *responses of self* change to feeling "angry" which is linked to relationship episodes when he spoke about feeling frustrated with some staff members. His *wish* "to be close to others" remained unchanged. At the start of therapy the CCRT pervasiveness score was 56% reducing slightly to 42% at the end of therapy.

Table 8.9

Core Conflictual Relationship Theme (CCRT) Interpersonal Schemas

CCRT at start.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
Like me; are interested in me.	*** Are rejecting;** are disapproving; are critical	***Feel happy;** feel excited; feel good; feel joy; feel elated.	**Am not open;** am inhibited; am not expressive; am distant.	***To be close to others;** to be included; not to be left alone; to be friends.
Are helpful; are supportive; give to me; explain.	**Are not trustworthy;** betray me; are deceitful; are dishonest.	**Am helpful;** am supportive; try to please others; am giving.	**Feel unloved;** feel alone; feel rejected.	**To be loved;** to be romantically involved.
Are happy; are fun; are glad; enjoy.			**Hurt others;** am violent; act hostile.	
Loves me; is romantically interested in me.				

CCRT at end.

Positive responses of others (PRO)	Negative responses of others (NRO)	Positive responses of self (PRS)	Negative responses of self (NRS)	Wish (W)
*Are helpful; are supportive; give to me; explain.	**Are hurt;** Are pained; Are injured; Are wounded.	***Feel happy;** feel excited; feel good; feel joy; feel elated	**Feel angry;** feel resentful; feel irritated; feel frustrated.	***To be close to others;** to be included; not to be left alone; to be friends
Are accepting; are not rejecting; approve of me; Include me.				

Note: *= most frequent recurring theme in relationship episodes.

Therapist Observation Rating Scales.

Therapeutic engagement (see Figure 8.5) is scored by the therapist for each session. Attributed scores can be considered as reflective of the quality of a working or therapeutic alliance as perceived by the therapist. For 65% of therapy sessions the therapist has rated Richard as being "genuine but guarded". The pattern of scores indicates the therapist experienced him as being "open" within sessions 2, 7, and 12. The highest scores attributed by the therapist occur within sessions 8 and 9, when Richard is rated as being "open and trusting". His lowest scores are given towards the end of therapy in sessions 18 and 19 when he is observed to be "reluctantly engaged".

The therapist's rating of Richard's overall participation and motivation (see Figure 8.6) shows that 50% of scores are attributed to him for having "a self-motivated attempt to participate". The highest score for showing "full and active participation throughout" occurs in session 8. From sessions 9 to 13 Richard is consistently rated as having a "self-motivated attempt to participate". Lower scores are given at the end of therapy in sessions 19 and 20.

Therapist scoring for Richard's attitude towards image-making can be seen in Figure 8.7. Richard was rated by the therapist as having "a mixed response to image-making" within 61% of sessions with 27% rating him as showing a "positive response". His lowest score was given in session eight when he "required encouragement and prompting". Richard's highest score was in session 18 towards the end of therapy when he was considered to have an "active and focused response to image-making".

Therapist Observation Rating Scales

Fig. 8.5 Therapeutic engagement for Case 4 (Richard)
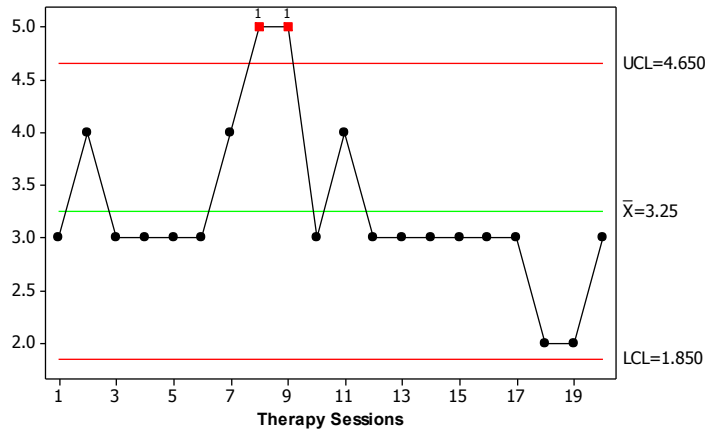
Note. 1=did not engage, 2=reluctantly engaged, 3=genuine but guarded, 4=open, 5=open and trusting,

Fig. 8.6 Pariticipation and motivation for Case 4 (Richard)
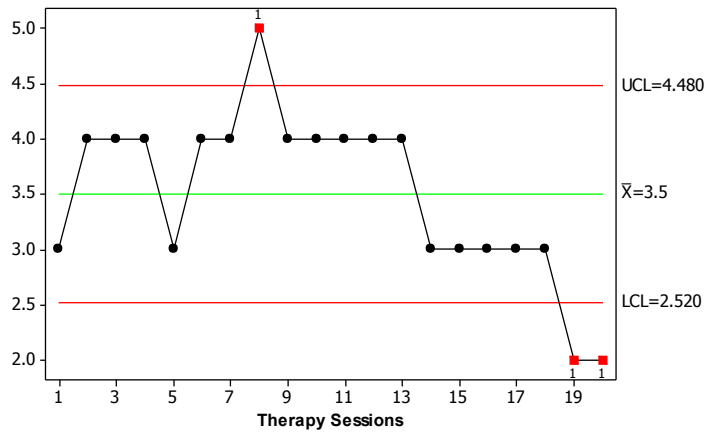
Note. 1=did not participate in session even when prompted and encouraged, 2=participated in session with prompting and encouragement, 3=participated satisfactorily without prompting or encouragement, 4=a self-motivated attempt to participate and 5= full and active participation throughout.

Fig 8.7 Attitude towards image making for Case 4 (Richard)
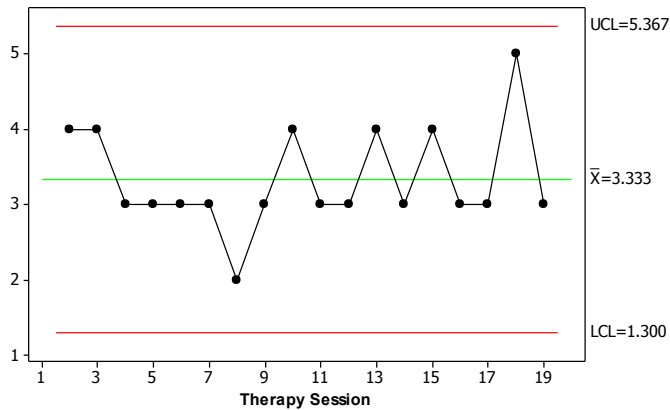
Note. 1= No image or art object made in the session, 2=required encouragement and prompting to attempt image-making, 3=mixed response to image-making, 4=positive response to image-making, 5=active and focused response to image-making.

8.4.4 Participant's most important image or object.

Richard did not identify a specific picture or model that he said was important for him at the end of therapy but made a general comment that everything that he had made about his girlfriend/ex-girlfriend was important. Examples of models which include this subject can be seen in Figure 8.11, "My family", from session nine when Richard spoke about wishing to have a family with his girlfriend. "Ex-girlfriend as an angel" (see Figure 8.13) was made in session 10 when Richard described his girlfriend as the love of his life. In this session he also spoke to the therapist about feeling wrongly blamed and angry about an incident involving him inappropriately touching a member of staff. In session 13 Richard represented his "Ex-girlfriend as a witch" (See Figure 8.14). In this session he said he had split up with his girlfriend and also spoke about feeling worried about his family. A photograph including all the models made can be seen in Figure 8.15.

8.5 Retrospective Attribution

8.5.1 Change Interview (adapted).

Three months following the end of therapy Richard said that some areas of his life had changed. His explanations of change included improved self-motivation to do jobs in his flat on the ward, improved relationships with other patients, and improved relationships with staff members. Richard also spoke about having more contact with his brother. He had indicated that he felt less upset by his ex-girlfriend at the end of therapy in the Personal Problem Scale (see Table 8.8) but at post-therapy interview Richard's retrospective attribution about this change was less clear.

8.5.1.1 Relationship with ex-girlfriend.

What changed? "I'm finding it a bit hard at the minute because most of the conversations was about my ex-lass, and she's no longer here."

What helped? "A little bit, sometimes didn't". "It was mostly about [ex-girlfriend's name] and relationships we'd fallen down on."

Attribution: Richard gave a mixed response in relation to this issue at post-therapy interview. He did identify that he had spoken about his relationship with his ex-girlfriend a lot within therapy but was not clear during the interview how helpful this was.

8.5.1.2 Self-motivation to do jobs.

What changed? "...I hated my jobs but I tried doing them as much as I did, and tried to help as much as I could." "Yeah, I get on with them straight away now."

What helped? "The conversations opened my mind a bit more, talking, as what I like to do." "It would have stayed the same before the art therapy. But then with the art therapy it helped me."

Attribution: Richard did not attribute this change to anything outside the therapy.

8.5.1.3 Relationship with other patients.

What changed? "I get on with everybody in the flat [ward]. Yeah, it's like I always used to ignore them. I've built up a bit to talk to them all the time now."

What helped? "The art therapy. It was because I used to get bullied a lot before the art therapy and since I've been talking more about things, it's helped me to open my eyes more to how people aren't trying to bully me, they're trying to help me."

Attribution: Richard said that his therapy had helped change the way he thought about other people. This change was not attributed to any extra-therapy events.

8.5.1.4 Relationships with staff.

What changed? "I try to get on with other staff, but some of the staff I don't get on with. But I treat them all equally." "Because they're only here to help us and not to be enemies."

What helped? "The art therapy because we used to talk about staff and because, like, art therapy would only run if we had staff and with the staff taking me over, I got into more talking to them."

Attribution: Richard partly attributes his change in attitude to events taking place within therapy and speaking with the therapist about his interactions with staff. He also identifies a related extra-therapy event contributing to this change as he thought that staff had been helpful by escorting him to therapy sessions.

8.5.1.5 More contact with a family member.

What changed? My brother is coming up on… Tomorrow. But that's the first time he's been up in four weeks or something."

What helped? "It was because we used to talk about my brother all the time in art therapy and it was because we always wanted to know what he was up to. Then the time I tried ringing him because I've got his mobile number."

Attribution: Richard attributed having more contact with his brother to talking within therapy and initiating the contact. He did not identify any extra-therapy events related as to this change.

8.5.2. Attributed changes.

Richard said his overall experience of therapy had been helpful although he had felt nervous initially. "I was sometimes getting a bit nervous with going in, with strange people." At the start he also said, "Sometimes it was ok and sometimes it was boring." "I was keeping my mind occupied with the stuff that we had", meaning the art materials.

When asked if he enjoyed therapy he said, "little bits", "not all the time". When asked what he thought was good about the art therapy Richard said it was doing artwork. "Because when I get something on my mind, I want to draw." When asked specifically if he enjoyed the art-making because it was keeping him occupied he replied, "No it was helping us as to what to talk about".

Richard said that he did not find anything within his therapy sessions difficult to speak about and that he "...tried to open up all this time". He also said, "…because staff were sitting outside that made us uncomfortable". Richard thought that art therapy would be helpful for other patients within the hospital. "Because they'll be able to talk about things that they can't talk to other people about." "Because it's one-to-one and you can open up more than what you can to the staff. I can open up to the staff, but I opened up more to [therapist's name] than I did with these."

The main positively attributed changes were in Richard's perception of others, including the way he viewed patients whom he had previously seen as bullying. Richard also changed his attitude towards staff whom he had previously described as "enemies".

8.5.2.1 Corroboration of the participant's retrospective attribution with a nursing account of change.

Comments made by Richard's named nurse identify that escort arrangements had an impact upon his attitude towards therapy. "At first he was quite reluctant to participate in it. Even though, sort of, when [therapist's name] came and talked to him about it he was quite enthusiastic. But for about the first couple he didn't, like, really want to go and I think there was issues over escort status. Because I think where it took place we had to send a male member of staff, to like sit outside the room. Because I think he didn't like that more... Well he didn't like the idea of somebody sitting outside when he thought it was going to be just him and [therapist]. But afterwards he seemed to... well, he says that he got a lot out of it and he's actually asked, like, for it to continue."

Richard's attribution that his relationships had improved is supported by the nurse's observation. The improvement in his relationships is also partly attributed to his ex-girlfriend moving out of hospital. "I think he's been able to address his relationships a lot more with other people. Relationships were always a problem for Richard and from what I gather he's talked quite a lot about relationships and... I mean, the start of the art therapy tied in with when he had a girlfriend [in the hospital]. But she was actually discharged and so all the problems that, like, were caused were around her but obviously now she's not in the hospital. That's kind of stopped and it's all coincided with the art therapy time. But he's able, he's definitely sort of talks more openly about the relationships with people."

One-to-one sessions were seen to have helped Richard to be more open. "I do. Like I say I think he's enjoyed the one-to-one interaction and he's definitely talked with [therapist's name] stuff which he hadn't sort of spoken to us [nursing staff] much about. He seems to sort of confided in her a lot more than he maybe

would, like, ward staff. Even though he knew, obviously, [therapist's name],

possibly, like, if she had to, like, tell us things he was saying. Because he seems to

have, like, benefitted from that."

Comments made by Richard's named nurse do corroborate with Richard's

own post-therapy attribution that he felt able to speak more openly with the therapist.

Figure 8.8 Therapy Session 1 Doodle (Sample image has been cropped).

Figure 8.9 Therapy Session 2 Pattern.

Figure 8.10 Therapy Session 4 Doodle "love" (Sample image has been cropped).
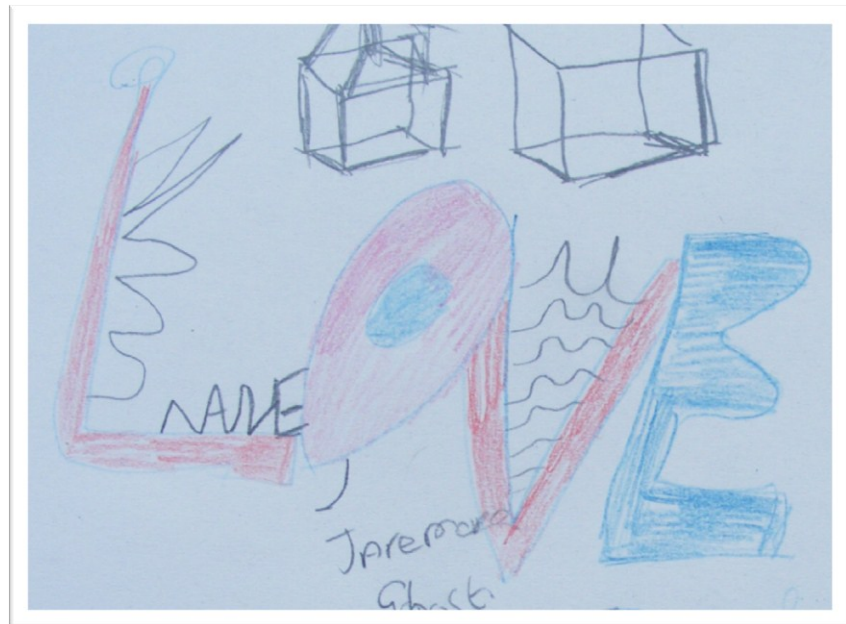
Figure 8.11 Therapy Session 9 "My family".
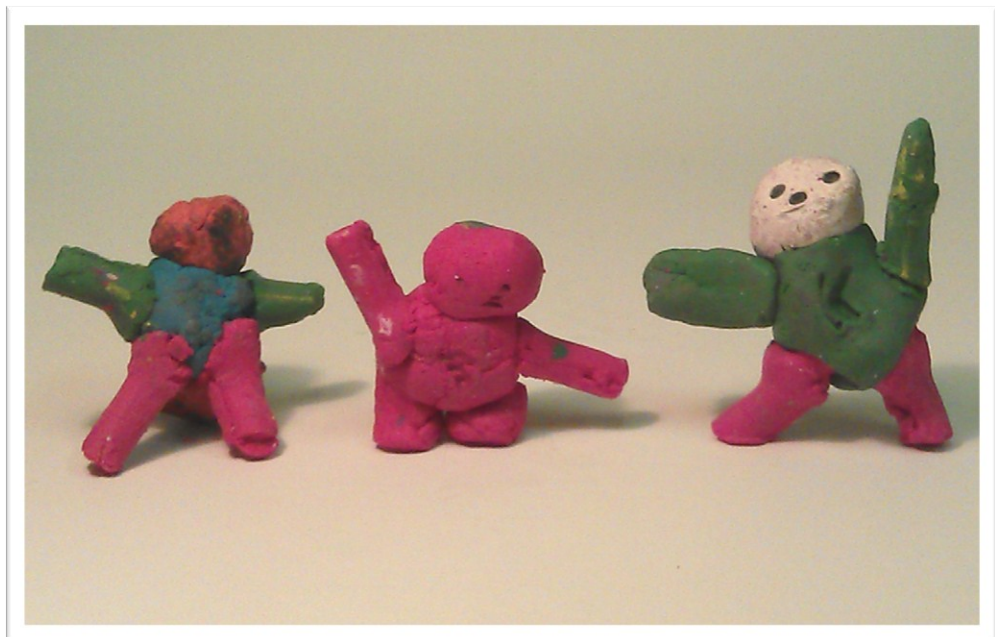
Figure 8.12 Therapy Session 10 "Ex-girlfriend as an angel".

Figure 8.13 Therapy Session 13 "Ex-girlfriend as a witch".

Figure 8.14 Therapy Session 15 "Robin red breast".
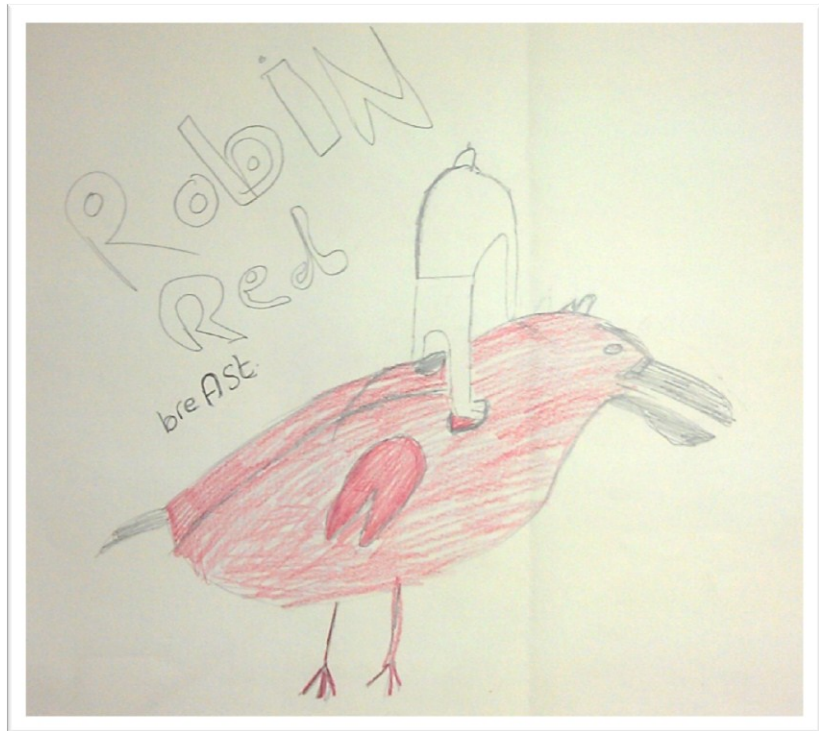
Figure 8.15 Therapy Session 20 All models together.

8.6 Evaluation of Explanations for Change Related to Therapy

8.6.1 Process outcome mapping.

A number of Richard's attributed post-therapy changes can be related to events which took place in therapy. The main areas where process within therapy can be linked to outcomes are relational in nature and indicated by a shift in his relationships and perception of others.

Richard had a difficult relationship with his ex-girlfriend and the timing of her leaving the hospital also coincided with the end of therapy. Richard discussed his relationship with his ex-girlfriend in every session. He rated that feeling upset by his ex-girlfriend had improved at the end of therapy within the Personal Problem Scale (see Table 8.8). At follow-up interview Richard gave a mixed response about speaking about his ex-girlfriend.

Another outcome identified in the change interview was that Richard was more motivated to do jobs and chores. Richard relates this to therapy. Richard's low mood was discussed in sessions 1, 7, 8, and 9. Most notably, in session seven Richard's therapist discussed the support that Richard had in place and ways he could cope when feeling low in mood.

Richard also had a mixed relationship with staff. "I don't talk to staff very much. I just keep my comments to myself. I don't talk to many of the staff." At the start of the first session Richard also expressed regret that a male supervisory escort was required to be present outside the room. Richard raised this issue quite often in subsequent sessions and he felt highly frustrated by an increase in his level of supervision and escort arrangements. This had been put in place due to a re-assessment of his risk to females prior to therapy starting. Within Richard's RAP (interview) conducted by the therapist near the end of therapy in session 19 he expressed that he was annoyed about the confusion that he felt had occurred over the

session start time, and changes to work sessions he had attended: "It's not my fault, it's the way they go it's really annoying me. It's making me look like a fool"; "That's why I think everybody [staff] is starting to get to me now. Starting to do things like that [change session times] because they know I haven't got a good memory. Well, I have got a good memory, but it's just I pick things up wrong, and that's what they're doing this all the time to me now."

Richard's relationships and interactions with staff were discussed in sessions 1, 6, 9, 19 and 20. In his post-therapy interview Richard said that his attitude towards staff had changed. "Because they're only here to help us and not to be enemies."

Other relationships were also discussed in therapy. The relationship between Richard and his brother was raised in sessions 1, 3, 4, 5, 6, 9, and 13. At post-therapy interview Richard said that he had decided to make contact with his brother again after speaking about him in a therapy session.

Process outcome mapping indicates that post-therapy changes reported by Richard relate to specific events taking place within therapy.

8.6.2 Change in stable problems.

A longstanding problem can be considered to be Richard's variability and instability of mood as shown in the pre-treatment phase A (see Figure 8.1). An improving trend can be seen in Figure 8.2 pre-treatment phase A, but the variability of scores is reduced and brought within control as a stable trend during treatment phase B.

Richard's longstanding relational difficulties are well documented. The CCRT positive *response of others* component becomes a more dominant theme at the end of therapy (see Table 8.7) and Richard's retrospective attribution that he had a more positive attitude towards his relationships with others shows change.

Relational changes were identified by Richard's named nurse as having taken place during the study.

8.6.3 Event-shift sequence.

It is possible to identify specific events taking place within therapy that precede a measurable change. Three areas or types of events can be seen to have had a cumulative influence upon process and outcome: (1) There is the change in higher scores for self-rated low mood following sessions one to four. (2) There is increasing stability in self-rated low mood starting in session 11, preceded by sessions seven to 10. (3) Process and outcome changes link with the therapist's interventions within sessions. The primary intervention being used by the therapist had been in making reflective statements.

8.6.3.1 Change in higher scores for self-rated low mood.

In the first session Richard "doodled" a picture while he was speaking to the therapist (see Figure 8.8). The session included discussion between Richard and the therapist about many issues that were then revisited in subsequent sessions. Richard spoke about the difficulties he was experiencing in relation to his ex-girlfriend and expressed the true extent of his feelings for her: "She means everything to me, but there is nothing I can do about it at the minute." He said that his relationship had gone "downhill again". Richard then said that he was feeling angry and hurt and found it hard to express his feelings to his ex-girlfriend. "Well I would rather both of us just be friends instead of mucking each other about." "I have tried talking to her but she does listen to me on occasions, but not all the time. It just depends on her fettle."

Richard spoke about difficulties in family relationships including his brother whom he had not seen for some time. He also mentioned not having any contact with his sister and mother.

In this initial therapy session Richard also spoke about his relationship difficulties with other patients. "They're [other patients] always arguing at the table and it does annoy me a little bit." "They argue about teas and coffee. It's so childish, but it's the way it is. That does upset me a bit." He added "…I don't talk to them. I'm usually in my room". "I go to my room, the other day I spent nearly all day in my room. If I'm not at work or I'm not at the club, I'm in my room, watching my TV."

Richard described his feeling of social awkwardness and concerns that he might offend women. "My relationships were never very good." "Mine's [relationships] always a downfall, because I try and build up courage with people and I find it hard sometimes." "Because I'm frightened in case I say something and it offends the other person. I try not to speak to many of the lasses in the hospital."

Within the second session Richard spoke briefly about people he had known who had died, and about his general anxiety about things going wrong in his life. Richard also spoke about his ex-girlfriend leaving the hospital in the future and "facing up to her leaving". Within this session Richard drew and coloured in a pattern (see Figure 8.9).

The content of session three shows that Richard revisited issues related to family relationships and feelings of social awkwardness. He discussed the confusion that he sometimes felt in his relationship with his brother, his sister not speaking to him, and finding it hard to know what to say in some social situations. Issues about maintaining personal boundaries were raised by the therapist after Richard asked her

personal questions. He also started to express some regret about his current situation, wishing he was young again and wanting to re-live his life.

Themes of regret continued within session four. Richard remarked about still being locked up at age 28 years and he said that he wished to go back home and have his own place. He spoke about love which is reflected in the image he drew (see Figure 8.10). He spoke about being understood and misunderstood in conversations with others and mentioned that he had no contact with his father.

Therapy sessions one to four precede a change in Richard's scoring patterns for self-rated low mood with no scores being rated above UCL from this point onwards (see Figure 8.1).

8.6.3.2 Increasing stability in self-rated low mood.

Richard's scoring of low mood within a stable trend is preceded by sessions seven to 10 and can be seen to start on day 155 in Figure 8.1.

Preceding this change, in session seven, Richard expressed his frustration about the cancellation of a previous session due to lack of a staff escort. Richard's low mood was also discussed alongside possible supportive coping strategies. He said that he had been in the care system since he was six years old, "locked up" since this time.

Within session eight Richard raised a number of difficult personal issues with the therapist. This included mentioning an older sister who had been adopted and whom he had never met, speaking about a breakdown in a foster care placement at age sixteen, and having been sexually abused by his grandfather. Richard associated these past events as leading towards or resulting in his current admission to hospital (due to the inclusion of names in the picture which Richard drew in this session, the image has not been reproduced). In session nine Richard had been rated by the

therapist as presenting himself as "open and trusting". Richard spoke about his wish to move on from hospital and he also complained that his social worker had "knocked him back". He said that he felt like a criminal and wanted to be given a chance. Richard made model figures of himself and his ex-girlfriend with a baby which he described wistfully as "my family" (see Figure 8.11).

Within sessions eight and nine Richard was observed by the therapist as having a stronger level of therapeutic engagement, participation and motivation (see Figures 8.5 & 8.6). This change in Richard's presentation within therapy also precedes a trend related to his fluctuating mood. His level of engagement returned to being rated as "genuine but guarded" following session 11 but his mood scores remain stable until the end of treatment.

Figure 8.16 shows the convergence of weekly average self-rated low mood scores with higher ratings of engagement scores given by the therapist. Stability in self-rated low mood is seen to occur following the therapy mid-point. Engagement increases just prior to the midpoint, preceding trend in stable mood rating.

In session 10 Richard spoke about feeling angry and unjustly blamed for an incident involving him touching someone inappropriately and the need for a male staff escort to be present outside the room as a result of this. Richard also told the therapist that his "on and off" relationship with his girlfriend was now getting stronger and he made a model figure of her which he called "an angel".

Stable trend in mood starts in week 11 of phase B (see Figure 8.3). Stability of trend in self-rated low mood appears to be detached from the on-going instability that Richard reported in his relationship.

In session 13 during a period of stable trend in self-rated low mood Richard continued to speak with the therapist about his relationship with his ex-girlfriend. In

contrast to session 10 he said that he had now split up again with his girlfriend and portrayed her as a "witch" (see Figure 8.13).

Following session 10 and continuing until the end of therapy self-rated low mood scores show a stable trend.

Fig. 8.16 Weekly Low Mood & Therapeutic Engagement for Case 4 (Richard)
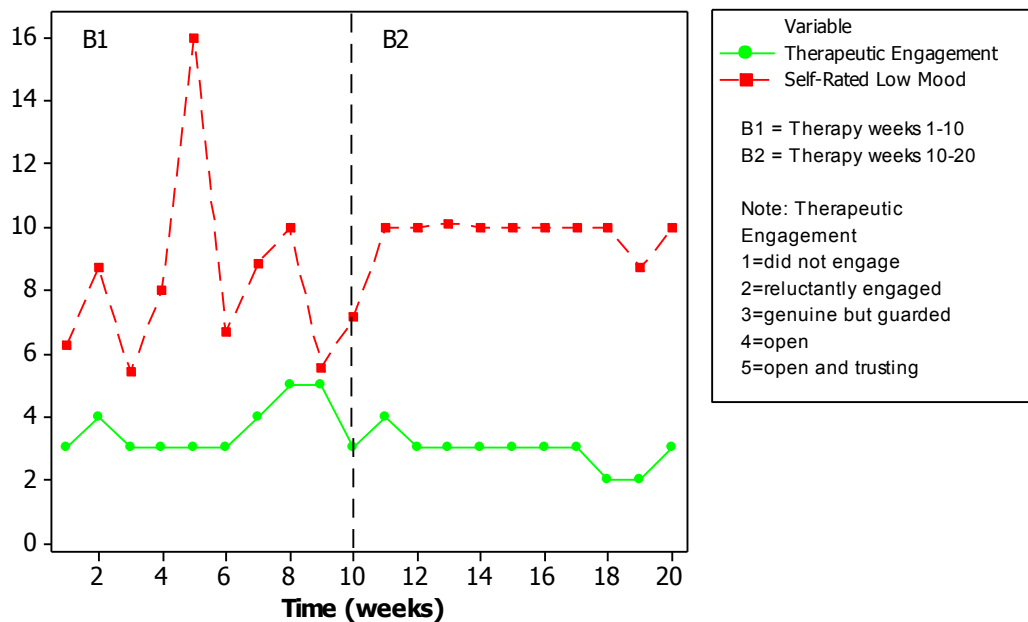
8.6.3.3 Process and outcome changes link with the therapist's interventions within sessions.

Reflective statements were made by the therapist in response to Richard's comments, his presentation and the content of the images and artwork he made. After reviewing the therapy process record it is possible to see that a reflective and empathic approach was frequently used by the therapist. She used reflective statements to summarise, make connections, respond to affect, and provide a means of introducing alternative possibilities or ideas into the therapy session. The profile of reflective statements being used as an intervention can also be corroborated with

event-shifts in trend for self-rated low mood and changes in Richard's perception of others in relationships.

The therapy process record shows that the therapist's use of reflective statements as a specific intervention increased dramatically as therapy progressed. This can be most clearly seen in sessions one to three where the therapist's intervention consisted of frequent questioning to elicit information but no direct reflective statements. Overt reflective statements started to be made by the therapist in sessions five to 10. From the therapy process record the number of reflective statements made by the therapist within these sessions ranged from 3 to 6 per session.

From sessions 11 to 14 the number of reflective statements made by the therapist increases again, ranging from 10 to 12. In session fifteen the number of reflective statements drops, reducing to 3. In this session therapy process notes report that Richard was more focused upon making an image and drawing. There is evidence of a collaborative and problem-solving approach being used by the therapist within this session which is related specifically to making art. Richard struggled at first to achieve making a picture he was satisfied with but he found that he could adapt and change the drawing to arrive at something with which he was happy. In response to the artwork, the therapist introduced the theme of "changing through a process" but few other reflective statements were made.

From sessions 16 to 20 the number of reflective statements increases with the exception of session 17. The number of reflective statements made by the therapist ranged from 12 to 22 with an average of 14.

Examples of the type and style of reflective statements, questions and comments made by the therapist have been transcribed from the audio recording of session 18 to illustrate the "reflective style" used in therapy. Verbatim dialogue

between the therapist and participant has not been reproduced but the beginnings of the therapist's statements and comments give an indication of the approach that was used within the treatment.

"What you're saying is…"

"I wonder if…"

"Is that what you are saying…?"

"Sounds like you might…"

"What about…?"

"It seems like…"

"Perhaps it might be…"

"It might be… but it might also be…"

"No, I know it is not an easy thing…"

"Maybe thinking about yourself is hard…"

"Perhaps you want me to understand…"

"I imagine that…"

"But I think when we talked about it before it seemed like you recognised that…"

"Well, perhaps things felt a bit…"

"I am wondering how you are feeling right now."

"You didn't want…can you say why?"

"I wonder if it's because it gives you space to get in touch with your feelings…"

"I think you had been saying you anticipated … and that's maybe when you need a bit more support…"

"Do you mean…?"

"You give the impression…"

"Do you think…?"

"I was thinking about…"

There is evidence that these types of "interventions" were also used flexibly and sensitively in response to the participant's presentation within the session. Early sessions in which the therapist predominantly employed questioning and listening, also coincided with change in trend for self-rated low mood. The use of reflective statements as a specific intervention started to be actively used from session five onwards. The profile of use shows that the therapist increased this approach from session 10 onwards. This coincides with an increase in the therapist observation rating for engagement at the midpoint and precedes stabilisation in self-rated low mood scores despite Richard's continued relationship instability.

8.6.4   Specific change processes.

The role of therapy in change process can be considered using post-therapy interview accounts. Richard described aspects of his experience of therapy process at post-therapy interview and these statements are placed in sequential order.

1.   Initially Richard reported that he felt nervous about meeting the therapist. "I was sometimes getting a bit nervous with going in with strange people."

2.   "That was my other favourite thing I did, doodling, just drawing on a little piece of paper and just drawing loads and loads of stuff."

3.   Talking to the therapist was also supported by the artwork which helped. "It was to talk about the things that I've made." "…was helping us as to what to talk about".

4.   This process appeared to help Richard become more open. "The

conversations, to open my mind a bit more, talking, as what I like to do."
"Sometimes I didn't draw, I just talked." "Because it's one-to-one and you can open up more than what you can to the staff. I can open up to the staff, but I opened up more to [therapist's name] than I did with these [staff]."

5. A specific area that changed was Richard's perception of relationships. "It was because I used to get bullied a lot before the art therapy and since I've been talking more about things, it's helped me to open my eyes more to how people aren't trying to bully me, they're trying to help me."

8.7 Change Process Theory

8.7.1 CCRT Interpersonal schema and therapeutic alliance.

Concepts and theory relating to the therapeutic alliance and its influence in psychotherapy is wide-ranging and can be seen as pantheoretical (Messer & Woltizky, 2010). There is a multitude of models and descriptions of phenomena encompassing the therapeutic working relationship or alliance between the therapist and patient/client. In essence, the therapeutic alliance can be defined as the mutual collaboration of patient and therapist in therapeutic tasks (Muran & Barber, 2010). Some authors suggest that the alliance between the patient and therapist has therapeutic benefit in its own right (Zuroff & Blatt, 2006). The actual level of impact of the therapeutic alliance upon outcome is considered to provide a positive but moderate influence (Martin, et al., 2000). Patients with good interpersonal relations and positive object representation form a stronger alliance and perceive their lives to be better in a variety of spheres (Messer & Woltizky, 2010).

Reviewing therapists' ratings of alliance in-therapy must be done with the cautionary understanding that patients often see the alliance to be more stable over the course of therapy than their therapists (Martin, et al., 2000). The therapist's

observation scale used in this study was devised as a way of capturing process description. It cannot be considered an accurate measure of therapeutic alliance but it does indicate the therapist's assessment of a participant's level of engagement and participation. This information has been corroborated with the therapy process record and outcome data in order to consider possible links between process observed within Richard's case and theory related to therapeutic working alliance.

Beretta et al. (2005) used the CCRT to assess 60 patients' (37 women and 23 men) interpersonal schemas and their possible influence upon the therapeutic alliance. This work was carried out in an adult community psychiatry service with patients who were seeking treatment for anxiety and mood disorders, including depressive episodes, social and specific phobias and generalized anxiety. A smaller proportion of patients presented with eating or sexual disorders. Just under half of the patients (44%) had a personality disorder including dependent (16%) and avoidant (16%) personality disorders.

This work was based upon the hypothesis that a patient's interpersonal problems are linked to difficulties in the establishment of early alliance within therapy. The development of early alliance with the therapist is influenced by the patient's internalized relationship schemas (core beliefs). Beretta et al. (2005) also assert the view that a patient's interpersonal problems can be exacerbated by maladaptive internalized schemas, as "relationship schemas modulate one's ability to think of one-self, to think of others, and to sense and be present with others" (p. 14). This in turn can influence the patient's representation of the therapist as either a good or bad object and determine the nature of the therapeutic relationship.

Patients within therapy who had a low alliance were more likely to perceive others as "unhelpful", "hurtful", or "untrustworthy". Somewhat surprisingly, the study also found that patients who had a low alliance were more likely to have a *wish*

to be "close to others and accept others" expressed in their relationship episodes. Those patients who viewed others to be untrustworthy or hurtful had a lower quality alliance despite wanting to be more connected. Conversely, patients were shown to have had a better therapeutic alliance if they saw others as helpful, co-operative, and trustworthy from the outset. The study also concluded that the degree of pervasiveness of the relationship schema did not influence the alliance (Beretta, et al., 2005).

8.7.1.1 Therapy processes.

Richard's engagement in therapy is rated to be genuine but guarded for five out of the first six sessions. The highest level of engagement, being open and trusting, only occurs in sessions eight and nine which constitutes a brief period within the therapy (see Figure 8.5).

Richard's CCRT at the start of therapy included a perception that others are rejecting, disapproving, critical, not trustworthy, betraying, deceitful, and dishonest. His *response of self* is mixed with positive and negative themes such as being happy, feeling excited, feeling good, feeling joy, feeling elated, and not being open towards people, being inhibited, not being expressive, and being distant. Richard's underlying *wish* was to be close to others, to be included, not to be left alone, and to be friends. Another *wish* was to be loved and romantically involved (see Table 8.9).

One positive outcome for Richard is a shift in his internalised relationship schema CCRT at the end of therapy. This shift is noteworthy as there is movement from seeing people as rejecting and not trustworthy towards a positive *response of others* being seen as helpful, supportive, giving, and explaining things. His changed perception towards others as being helpful is also maintained in his retrospective attribution given at post-therapy change interview three months following the end of

therapy. Change in Richard's CCRT can be seen as a positive outcome which can be linked to signs of therapeutic alliance.

> From a clinical standpoint, if patients with low alliance have an underlying wish to be close to others while simultaneously perceiving them in an overall negative manner, the therapeutic alliance could in and of itself constitute the focal point of treatment. In this manner, the patient-therapist bond can be utilized to expand, differentiate, ameliorate, and add flexibility to the patient's object representations. (Beretta, et al., 2005, pp. 18-19)

8.7.1.2 Signs of therapeutic alliance.

It is important for patients with long term relationship difficulties to strengthen their alliance with the therapist during the course of therapy. It is possible to identify signs of a strengthening alliance in Richard's case. Evidence of seven signs of alliance within therapy process (shown in italics below) are taken from what is now considered to be a classic work on the subject (Luborsky, 1976, 2000).

- *The patient experiences the therapist as providing the help: The patient believes that the therapy is helping.* In session six Richard said that as a result of attending therapy he felt that he was getting less bad tempered and "starting to think before acting".

- *The patient feels changed since the beginning of treatment, or he / she* [sic] *is considered to be better.* In his final therapy session Richard told the therapist that he had learnt things he had not known, like how to talk to people without

getting embarrassed. Richard also attributed changes he had made to events within therapy.

- *The patient feels a rapport with the therapist, and feels understood and accepted.* It is difficult to fully establish Richard's response towards the therapist during therapy, or whether he felt understood and accepted. He was able to speak to the therapist and made disclosures about many personal issues including describing situations he found himself in, his emotions and his relationships. There is some evidence that Richard agreed with statements that the therapist made, for example in session 14. Richard agreed with his therapist when she reflected that that he had felt "humiliated" by his ex-girlfriend. Richard also reported in his post-therapy interview that he could "open up more" to the therapist.

- *The patient feels optimism and confidence that the therapist and treatment can help.* It is not possible to establish if Richard felt confidence in his therapist solely from the therapy record. In session 14 Richard told the therapist that the intervention had helped him.

- *The patient experiences the treatment as working together with the therapist in a joint effort, as part of the same team.* There are many incidents within therapy sessions which include mutual exchanges and collaboration. There are concrete examples of the therapist and participant working together to solve problems in relation to the art-making process.

- *The patient shares with the therapist similar conceptions of the etiology of the problems.* Evidence of this is harder to establish. There is a record of the therapist discussing relationship patterns and past experiences with Richard.

There is no clear information related to Richard having a shared understanding with the therapist about the origins of his problems and current circumstances.

- *The patient demonstrates qualities that are similar to those of the therapist, especially in having the tools for understanding.* This is also harder to quantify in Richard's case. He did demonstrate that he had capacity to reflect upon his difficulties and he did attribute events taking place within therapy as contributing towards some areas of positive change.

8.7.1.3 The therapist's role in developing a therapeutic alliance.

In further support of change process theory aspects of the therapist's presentation are also linked with a positive therapeutic alliance. Numbers have been added to the following quote to clearly delineate the different factors which are seen to support therapeutic alliance. "In brief, to enhance the therapeutic alliance, psychodynamic therapists should [1] adjust their interventions to patients' defences, [2] explore interpersonal themes, [3] develop specific goals, [4] facilitate affect, and [5] attend to patterns and past experiences" (Messer & Woltizky, 2010, p. 111).

There is evidence within the therapy process record that the therapist attended to areas suggested by Messer and Woltizky (2010). A comprehensive review of the therapist's detailed process notes, discussed previously in this chapter, showed signs of: (1) A build-up and adjustment in the level of reflective statements made by the therapist. (2) The exploration of interpersonal themes took place including the therapist identifying Richard's confusion about relationships and his responses towards other people. (3) Goal-setting took place at the start of therapy. (4) The therapist has been shown to have responded empathically and made comments about the participant's mood, for example, when he appeared to look tired

and low in mood. (5) Richard's uncertainty and lack of confidence in some of his interactions with others, described as needing "courage" when speaking to people, and repetitive patterns in his relationship with his girlfriend, were also discussed.

The CCRT at the start of therapy indicates that Richard's pre-existing representation of the therapist may have been influenced by a negative view of others as being rejecting and not to be trusted. There is evidence, congruent with theory, that there were signs of a strengthening therapeutic alliance (Luborsky, 1976, 2000). Interventions made by the therapist can also be seen to have had an influence upon working alliance (Messer & Woltizky, 2010). Post-therapy change was seen in Richard's maladaptive CCRT interpersonal schema. His retrospective attribution, that his relationships with staff, peers, and a family member had improved, have corroborated with observations made by a member of the nursing team.

8.8 Evaluation of Alternative or Competing Explanations for Change

8.8.1 Trivial or negative change.

For repeated measures such as the BSI-18, GAS-ID, and GDS-LD there is no improvement between pre- and post-treatment scores and no changes in the RSES (adapted) measure pre- and post-treatment.

8.8.2 Relational and expectancy influence.

Whilst relational and expectancy influences cannot be ruled out there is no strong evidence to suggest that they had an influence on the changes reported in Richard's case. There is evidence of differentiation in Richard's post-therapy retrospective attribution. He gave detailed examples of events taking place within therapy that can be corroborated with the therapy process record. When in-treatment measures were repeated at the end of treatment his therapist considered Richard's

engagement to be "reluctant", requiring him to be prompted to participate in the sessions. When the in-treatment measures were completed this appears to be an unlikely condition for Richard to give overly positive responses to his therapist.

8.8.3 Self-correction processes.

There is no strong evidence of Richard using self-help strategies within the treatment period. Given his longstanding relationship difficulties it appears unlikely that improvement is a response to self-correction or a short-term easing of a temporary problem.

8.8.4 Extra-therapy events and psychobiological influences..

Richard's insecure and sometimes volatile relationship with his ex-girlfriend can be considered an influential extra-therapy event. It is possible that his girlfriend's move from the hospital at the end of therapy influenced Richards's post-therapy report of change. As it happens Richard gave a mixed response about the helpful aspects of therapy at three-month follow-up. There is also evidence that his mood stabilised during treatment despite the continuing instability of his relationship.

A further extra-therapy event is Richard's retrospective attribution that he developed his relationship with staff whilst they escorted him to therapy sessions. This is an interesting post-treatment change as there is substantial evidence in the therapy process record that Richard had been frustrated by his escort arrangement during the course of therapy. No changes in psychobiological influences have been identified.

8.8.5 Apparent changes can be attributed to reactive effects of research.

Baseline linear trend (see Figure 8.2) shows reduction for self-rated low mood providing a possible explanation that self-monitoring could have contributed towards this. When seen in conjunction with other data (see Figure 8.1) scoring patterns for self-rated low mood do not come within control until treatment phase B.

Given Richard's difficulties in interpersonal relationships and social situations it is not possible to fully exclude the influence of relational components during the research assessments and interview. No reports of unusual behaviour, for example overly positive or overly negative responses towards the assessors, arose during the study. There is no evidence that reactive effects of research influenced outcomes to a degree that would displace therapy as being a plausible explanation for change.

8.9 Conclusion

8.9.1 Did therapeutic change take place during or as a result of art psychotherapy ?

Results are mixed. Repeated symptomatic measures indicate clinical levels of psychological distress at the screening assessment point which are unresponsive to therapy. Continuous measures show some reduced variability in self-rated low mood scores to have occurred during treatment phase B. Richard's in-treatment Personal Problem Scale did show some improvement for "feeling less upset by his ex-girlfriend" but this was not sustained at his post-therapy follow-up interview. A positive shift in one CCRT interpersonal schema component, *response of others*, is seen between the start and end of therapy. Improved relationships and attitude towards others is reported at post-therapy interview.

8.9.2 Is there a plausible link between therapy and outcome?

A number of links between therapy and outcome have been considered. Events taking place within therapy, including the therapist's interventions, precede periods of stabilising trend in self-rated mood scores. There is some evidence that post-therapy improvement in relationships can be linked to events and processes in therapy.

Alternative explanations for change have been considered. No change was measured in symptoms of psychological distress. Relationship and expectancy influences and self-correction are considered to be unlikely alternative explanations for change. One extra-therapy event, primarily an end to Richard's relationship with his girlfriend, does provide a potential influence. The influence of staff escorts supporting Richard's changed perception towards their being helpful appears to have occurred following therapy as he reported his dissatisfaction with the arrangement throughout and up until the end of treatment. The influence of the research process does not appear to provide a strong plausible alternative explanation for change.

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8.9.3 Is there congruence between the outcomes, processes, and broad psychotherapeutic theory?

Specific change processes reported by Richard show his engagement in the therapy to have had an active effect during and following therapy. Richard's attribution to therapy was that his perception of others changed from being negative to positive. Signs of therapeutic alliance have been assessed and shown to have been present during the therapy process. Positive shifts in CCRT interpersonal schemas are considered to be a good therapeutic outcome for patients who have a *wish* to be close to others whilst holding a dominant pre-existing negative view of others (Beretta, et al., 2005). Richard's change in his perception of (non-romantic)

relationships between the start and end of therapy do appear to have been supported

by processes identified as occurring within treatment.

CHAPTER 9: COMPARISON OF RESULTS FROM SINGLE-CASES

9.1 Introduction

Within this chapter the findings from each single-case will be reviewed and compared. The comparison of cases will also assess whether the research hypothesis (see Page 7: 1.2) has been adequately answered.

Findings from each case will be systematically compared following the structure established in each individual case study, and comparing repeated measures, continuous measures and in-treatment measures. An analysis of retrospective attribution which combines the responses of each participant will also be used to emphasise processes taking place within therapy.

9.2 Comparison of Findings in Each Case

The four participants in this study represent the broad range of patients in an intellectual and developmental disability forensic service. The participants had very different backgrounds, ages, forensic histories, and length of detention. All participants were assessed to have an IQ within the mild intellectual disability range.

Inclusion and exclusion criteria for this study did not specify that participants should have a particular index offence. As it happens, all participants recruited to the research study did have convictions for sexual offences, and all had a background history of violence within institutional settings. Participants from the medium secure unit showed continuing signs of aggressive behaviour at the start of treatment. Participants were at different stages in the hospital treatment pathway. Case 1 - John, case 2 - Stuart, and case 3 - Adam had not completed a sex offender treatment programme. Case 4 - Richard had completed sex offender treatment prior to participating in the study and had had a longer period of detention.

Table 9.1 summarises post-test improvement in scores for repeated measures, continuous measures, and in-treatment measures for each case.

9.2.1 Repeated measures.

The treatment was not targeted at a specific area of psychological distress or psychiatric symptoms. Change in repeated symptomatic measures differed for each individual case in terms of general psychological wellbeing.

At the screening assessment point Stuart and Richard were above the clinical cut-off for the BSI-18 and John and Adam were just below the clinical cut-off. John showed no change, Stuart and Richard showed slight improvement, and Adam showed an increase (deterioration) in scores. With the exception of Adam, the participants did show some easing of general psychological distress at follow-up.

For GAS-ID scores John showed post-treatment deterioration in anxiety. Stuart showed improvement between pre- and post-test, but this was not within reliable margins. Adam's anxiety scores improved and reduced below the clinical cut-off post-treatment and Richard's scores remained within the clinical range throughout the study.

For the GDS-LD measure, three cases scored within the clinical range for depression with reliable improved change seen between pre- and post-test for Stuart.

Judging what constitutes a therapeutic change in self-esteem in an offender population is complex. John's case indicates that stability in post-treatment rating of some RSES (adapted) items, rather than an increase in the total self-esteem scores, may point towards positive therapeutic change. Stuart showed improved self-esteem post-treatment. Adam showed a reduction in self-esteem and Richard showed no change.

9.2.2 Continuous measures.

Improved trend was shown in daily self-rated scores in three cases. The exception was Adam, where negative extra-therapy events appear to have overshadowed measurement of potential treatment effects. There is evidence of reduced self-rated anger for both John and Stuart, participants from the medium secure unit. Richard showed improving trend of stabilising mood scores.

Improving trend in MOAS scores for aggression was shown in two cases, John and Stuart. Changes in aggression have been linked to events and processes taking place within their sessions. Reduced aggression towards others is also consistent with corroborated findings that show improvement in interpersonal relationships.

Improved trend in reduced SUIs for use of PRN medication was recorded as having occurred during the treatment phase for Stuart.

9.2.3 In-treatment measures.

All participants reported improvements in items identified and rated in the Personal Problem Scale between the start and end of treatment. CCRT interpersonal schema profiles at the start of therapy show that John, Stuart, and Richard shared dominant themes in their *wish* "to be close to others" and also share a schema that others "are not trustworthy", that is, they "betray me, are deceitful, are dishonest" or "rejecting". The presence of these closely shared CCRT components in three cases is an interesting and unexpected finding. The three participants who share CCRT schema components for *wish* and *response of others* had committed contact offences, in contrast to Adam who had committed a non-contact offence. Adam did not have any dominant themes for negative *response of others* at the start of therapy and his awareness that others "do not trust me" at the end of therapy may show increased

awareness of his own risk, demonstrated through *responses of others*. Each participant provided a relationship episode at the end of treatment with the dominant theme that others "are helpful". This theme was present for Adam at the start of therapy. Experiencing others as "helpful" rather than "not to be trusted" can also be linked to measurable behavioural change in the other three participants. Reduced pervasiveness scores in maladaptive CCRTs and positive shifts in interpersonal schemas in three cases for *response of others* could be suggestive of specific treatment effects.

Therapist observation rating scales have provided valuable process data. There are similarities in the profiles of John and Stuart with "rupture-repair" sequences in the first half of therapy. This includes sessions rated positively followed by sessions rated as "not engaged". The similar profile in engagement and participation for John and Stuart could have been influenced by the same therapist conducting and rating each case. Therapist factors may have influenced both John and Stuart's engagement in the treatment, for example the therapist having a similar style of dealing with "rupture markers" during the course of therapy. It is also noteworthy that both John and Stuart shared some similar features, such as having longstanding interpersonal difficulties with others. They were also both convicted rapists, and Stuart in his late 30s had a diagnosis of APD, while John in his early 20s exhibited signs of a conduct disorder. It is most likely that therapist factors and the longstanding interpersonal difficulties that John and Stuart presented culminated in similar "V"-shaped engagement profiles seen in both cases (see Figure 5.9 and 6.10).

Therapist, contextual factors and variables may also be considered as influencing participant engagement. Adam and Richard, who also shared the same therapist, show rising and falling engagement profiles within treatment (see Figure 7.6 and 8.5).

It is possible that engagement profiles derived from therapist session rating scales provide an insight into the repeated patterns of relating to others represented in the interactions with the therapist. This may also indicate that the relationship with the therapist offers opportunities to some offenders with intellectual disability to learn about and seek resolution for interpersonal problems. Therapy had shown limited influence on engagement profiles for Adam which suggests that treatment effects observed in other participants are not present. This raises an interesting hypothesis, that the impact of relational components in some psychotherapy approaches may be limited in patients with pervasive developmental disorders such as ASD.

All participants showed an "active and focused response to image-making" at some time within the therapy. Despite some participants expressing scepticism about creating art in therapy sessions all participants gave positive post-therapy feedback about this process.

Table 9.1 *Post-test improvement in scores for each case.*

Measure	Case 1 (John)	Case 2 (Stuart)	Case 3 (Adam)	Case 4 (Richard)
The Brief Symptom Inventory – 18		X		X
Glasgow Anxiety Scale (ID)		X	X*	
Glasgow Depression Scale (LD)		X*		X
Rosenberg Self-Esteem Scale	X	X		
Daily Self-Rating Scale	X	X		X
Modified Overt Aggression Scale	X	X	-	-
Serious Untoward Incidents	-	X	-	-
Personal Problem Scale	X	X	X	X
Core Conflictual Relationship Theme - Pervasiveness Score	X	X	X	X

Note. X = improved pre- and post-test scores are shown; * = the change in scores is within reliable margins (where measurable); - = not identified as a pre-existing problem.

9.2.4 Retrospective attribution.

Retrospective attribution of participants towards their experience of therapy three months following the end of the treatment has identified important events allowing corroboration of process description. Combined retrospective attribution for all four cases can be seen in Table 9.2

The range of changes that participants have retrospectively attributed to the influence of therapy encompasses relational, emotional, and behavioural gains. Adam's post-therapy attribution does not include any relational components. He did say that he was "helping people out more" linked to doing more jobs, a change also identified by Richard. The absence of relational changes for Adam is likely to be due to limitations in communication and interpersonal skills associated with his diagnosis of ASD and XXY condition. He also identified difficulties in "thinking and talking about relationships" in his Personal Problem Scale at the start of therapy.

John, Stuart, and Richard identified positive changes in their relationships with staff and family. Stuart and Richard also attributed improvements in their relationships with other patients to the influence of therapy. Improvement in relationships with staff and patients is an important outcome within inpatient forensic intellectual and developmental disability settings given the high levels of contact patients have with each other in communal areas.

Adam reported a reduction in his personal distress caused by deviant sexual fantasies and nightmares. This is an unexpected finding which has been explored within "change process theory". At three-month follow-up Adam continues to report having fewer dreams with specific content.

Table 9.2 *Retrospective attributions given to the influence of therapy*

Attributed Change	Case 1 (John)	Case 2 (Stuart)	Case 3 (Adam)	Case 4 (Richard)
Improved relationship with staff	X	X	-	X
Improved relationship with patients	-	X	-	X
Improved relationships with family	X	X	-	X
Making progress	X	X	-	-
Feeling settled, calmer or more relaxed	X	X	X	-
Feeling less anger	X	X	-	-
Feeling happier	X	-	-	-
Fewer nightmares	-	-	X	-
Helping people out / doing more jobs	-	-	X	X

Note. X = attribution present in post-therapy interview, - = attribution not present in post-therapy interview.

9.3 Therapy Processes

There are clear links between therapy process and outcome in each case. Specific events taking place within therapy correspond with measured and attributed outcomes for participants. The corroboration of mixed sources of data for each case provides detailed process description. There is evidence within the cases of specific events within therapy preceding shifts or improvement in outcome. Findings within each case are further supported by broad process theory related to current understanding in psychotherapeutic practice. Specific change processes described by participants at post-therapy interview can be compared with process-based descriptions of art psychotherapy given in the introductory chapter (British Association of Art Therapists, 2012; Edwards, 2004).

9.3.1 Process outcome mapping.

Each of the participant's post-therapy narrative descriptions of therapy is suitably detailed and specific enough to have enabled corroboration with the therapy process record. Corroborated evidence from a mixture of data sources provides plausible accounts of the causal relationship between therapy process and post-therapy outcome. Selected examples include case 1 – John, where he linked bereavement work with feeling happier, case 2 – Stuart, where techniques supporting emotional self-regulation in therapy supported reduced use of PRN medication, case 3 – Adam, where specific work on dreams and fantasies supported his reduced distress in relation to his dreams, and case 4 – Richard reported a change in his perception that people were trying to help him rather than bully him.

9.3.2 Change in stable problems.

Background information and baseline measures indicate that change in longstanding problems did occur. Continuous measures indicate positive change in trend for self-rated anger and observed aggression during the treatment phase with sustained gains in improved trend post-treatment. There is evidence of mood stabilisation for Richard occurring during treatment. Change in CCRT interpersonal schemas indicate a shift in central relationship patterns demonstrated within the narratives that participants report about their relationships and interactions. Shifts in narratives (relationship episodes) given at the end of therapy show changes in patterns of relating to others in all cases. Relational difficulties and instability can also be considered problems of long duration in all cases.

9.3.3 Event-shift sequence.

There is evidence within the cases to suggest that specific therapist interventions within treatment preceded measurable change. Events in therapy preceding and related to therapeutic outcomes include use of specific techniques, development of working alliance and use of a reflective approach within the treatment. Other events supporting change include relational work focusing on families, work on issues of personal identity, loss/bereavement work, work looking at past histories of criminal behaviour, and work focused upon early adverse events.

9.3.4 Specific change process.

All participants gave examples of specific change processes within therapy. Within post-therapy interview all of the participants identified key stages in therapy which can be closely related to the aims of art therapy (Edwards, 2004) quoted in the introductory chapter. This quote is reinserted below with added numbers

corresponding with processes identified by participants in the study, shown in Table 9.3.

In practice, art therapy involves both the process and products of image making (from crude scribbling through to sophisticated forms of symbolic expression) and the provision of a [1] therapeutic relationship. It is within the supportive environment fostered by the therapist-client relationship that it becomes possible for individuals to [2] create images and objects with the explicit aim of exploring and [3] sharing the meaning these may have for them. It is by these means that the client may gain a [4] better understanding of themselves and the nature of their difficulties or distress. This, in turn, may lead to positive and enduring [5] change in the client's sense of self, their current relationships and in the overall quality of their lives. (Edwards, 2004 p4)

In the first session participants consistently identify that they were either nervous, found therapy hard, or struggled with trusting the therapist. This initial stage (1) is the provision of a therapeutic relationship and shows a range of responses. It is important to acknowledge the difficulties that some patients in intellectual and developmental disability forensic services have in engaging with professionals. At the start of therapy the working relationship may have to overcome a number of obstacles in order to strengthen. All participants describe finding (2) the drawing or image-making in the therapy session positive, and saw this element of treatment as making things easier, interesting, or a "favourite activity". Making artwork in the session then bridged into (3) talk with the therapist and "exploring and sharing meaning", for example John said "…we used to talk about what the picture

was about and how it was". This discussion provided an opportunity for collaborative reflection (4) developing understanding and self-efficacy in relation to problems, for example Stuart said "…if you draw pictures and you see it from a bit of paper that you've drawn it on, then it makes a lot more sense than what it is in your head". The final stage is defined by (5) personal change.

Specific change process accounts provide evidence that the participants in the study experienced similarities in the delivery of the therapy by the two different therapists. Therapists can be seen to have conducted the sessions in line with the structure, principles, and aims of art therapy described by Edwards (2004).

Table 9.3 *Specific Change Processes*

Process	Case 1 (John)	Case 2 (Stuart)	Case 3 (Adam)	Case 4 (Richard)
1. Start of a therapeutic relationship	"I found it a bit hard at first. Because we were like talking about my family and that, and what happened and who was I close to and stuff."	"Well, I didn't trust him. Trust's a big thing with me. You know if I don't trust a person I won't be with them or speak to them or anything."	"The first time I started I was quite nervous, probably talking about my dreams."	"I was sometimes getting a bit nervous with going in with strange people."
2. Drawing / art making	"I found the drawing part easy. A lot easier to get it out in the open and show what I was doing with my cousin and stuff like that. It was just getting easier through some of it."	"Once you got into it, drawing the pictures and trying to get the images of what you wanted to draw, it started to like sort of get a bit easier like."	"It was quite interesting." "Painting, drawing, talking."	"That was my other favourite thing I did, Doodling, just drawing on a little piece of paper and just drawing loads and loads of stuff."
3. Drawing bridging into talking (sharing meaning)	"Before I could think what I was going to draw. We used to have a little chat then and then… I'd at least go, 'Right, I've got one that I want to draw now.' And he goes, 'Right.' And then I used to get on with my drawing and do it. And we used to talk about, after we drawn the picture, we used to talk about what the picture was about and how it was."	"The thing that I found helpful was… talking about it. Talking about things and like… You know, when you drew a picture, you know, you can sort of look at it and see like what's it… you know, what's it represent and that."	"Going over the pictures and talking about it." "A little bit difficult for me to do with explaining what's happening in the picture."	"It was to talk about the things that I've made." "It was helping us as to what to talk about."
4. Developing understanding	"Because drawing pictures of good times that we had with my cousin. It was what we'd done... Because my cousin, like, being on… Having fun and that made me realise that's what I want in life. To have my fun with my brother and that. And stuff, so… And that's made me realise what I want."	"…if you draw pictures and you see it from a bit of paper that you've drawn it on, then it makes a lot more sense than what it is in your head."	"…doing that art therapy, talking out my problems with [therapist]. She's given me some advice, what to do. Speaking to her [about] what's happening and I feel a lot more settled."	"The conversations, to open my mind a bit more, talking, as what I like to do". "Sometimes I didn't draw, I just talked."
5. Personal change	"Well, just getting the stuff out in the open, what I've been keeping inside for a long time… Talking and drawing pictures.	"We talked about it because like we… I wanted to know where I was going and what I was doing and that."	"Expressing my feeling" and "Probably relaxing."	"…it was because I used to get bullied a lot before the art therapy and since I've been talking more about things, it's helped me to open my eyes more to how people aren't trying to bully me, they're trying to help me."

9.3.5 Change process theory.

It has been possible to link outcomes and processes within the separate cases to theory developed in psychotherapeutic work. John's case included the theory of aggression being linked to self-esteem defined as "egotism" (Baumeister, et al., 1996). The potential influence of self-image, self-esteem or egotism in maintaining maladaptive and aggressive behaviours in some patients has potential to be more widely applied in forensic settings.

Theory related to patterns of engagement in treatment has also been highlighted in Stuart's case. Common patterns of engagement in relationships or treatment can appear to be repeated in some individuals. This can be evident in patients with antisocial personality disorder. The therapist's role in anticipating and managing the effects of a patient's style of engagement appears to be an important part of work within forensic settings. A suggestion that better outcomes can be seen for patients who experience rupture-repair sequences in working alliance (Safran, et al., 2001; Stiles, et al., 2004) is relevant to therapeutic work with forensic patients.

Characteristics of ASD, XXY condition, internet crime, and deviant sexual fantasies and nightmares have been explored in Adam's case. It has been important to consider findings in Adam's case in relation to the complex interactive effects of his conditions and his response to therapy. Single-case studies of this kind are valuable as they highlight areas of difference and provide the opportunity to identify specific components of treatment that may have a therapeutic value.

The other three participants were shown to have had positive shifts in their CCRT interpersonal schemas. End-of-therapy changes in participants' pre-existing negative perceptions of others, seen at the start of therapy, were also witnessed in their improved post-treatment behaviour towards others. The apparent link between the influence of a developing therapeutic alliance and the CCRT interpersonal schema (Beretta, et al., 2005) was shown in Richard's case. The link between a therapist's role in developing a working

alliance, and the patient's responses towards others, could be explored further as a clinical micro-theory in forensic work with men who have intellectual and developmental disabilities.

9.3.6 Evaluations of alternative or competing explanations for change.

Elliott (2002) identified eight areas that may provide competing or alternative explanations for change in psychotherapy research. These areas have been applied within each case. It has been possible to rule out some influences but others have been seen to be partially or completely plausible as competing explanations for change. It has been important to incorporate design features and recommendations for single-case experiments that increase confidence in judgements about causal relationships (Haynes & O'Brien, 2000; Kazdin, 2011)

9.4 Art Psychotherapy Supports Change in Adult Offenders with Intellectual and Developmental Disabilities

All of the single-case experiments conducted in this study show some evidence of positive change taking place for participants. In all cases specific and sometimes multiple outcomes of therapeutic change can be plausibly attributed to treatment. Alternative explanations for change in most instances did not challenge the evidence of treatment effects to such a degree that rendered each of the study findings implausible. This series of case studies provides evidence that art psychotherapy supported positive therapeutic benefits for four male patients with mild intellectual and developmental disabilities within a medium-low secure forensic hospital. Participants provided post-therapy relationship anecdotes that had positive shifts in the CCRT interpersonal schemas. There is evidence of positive behavioural changes in participants' responses towards others. This is also demonstrated in post-therapy self-reports of improved relationships with staff, patients, and

family members. One participant with ASD and XXY conditions reported a reduction in the frequency of nightmares with violent and sexual content.

CHAPTER 10: DISCUSSION

10.1 A Study of Art Psychotherapy Treatment Effectiveness

The current study is the first systematic evaluation of art psychotherapy with adult offenders with intellectual and developmental disabilities in the UK. The completion of this study demonstrates that systematic single-case studies can be carried out successfully to investigate art psychotherapy within a forensic clinical setting. The study design has allowed the treatment to be delivered in a manner which remains close to current practice in routine care conditions. Systematic use of qualitative and quantitative measures, use of multiple assessments of change over time, the use of multiple cases, and the assessment of change in previously chronic or stable problems adhere to principles of good practice in single-case investigation (Kazdin, 2011). Measures of process and post-therapy interviews with participants have provided a rich and detailed insight into the relationship between process and outcome for this treatment (Elliott, 2002). The results of this exploratory study develop the art psychotherapy literature in this area from its current position (anecdotal case-reports of treatment) by using an experimental design to provide process and outcome results.

Improvement in symptoms of anxiety and depression do not appear to have been strongly influenced by treatment consistently across cases. One study using brief verbal psychotherapy has shown that reduced CCRT pervasiveness scores at the end of treatment correlate with symptom reduction (Lunnen, et al., 2006). Whilst all participants show some improvement in reduced pervasiveness of core conflicts in relationship themes, symptom reduction is not measured in all cases.

Case 3 – Adam, who had a diagnosis of ASD and XXY condition, shows important idiographic response to treatment. Gains in improved relationships are not reported in this case, which appears to be strongly related to predisposing factors linked to ASD, and less

likely to have been related to treatment being applied differently or to the influence of therapist factors. Art psychotherapy process indicates that Adam was able to sustain a one-to-one relationship with his therapist and make use of creative processes within sessions.

Findings based upon treatment outcome show positive change in trend for continuous measures in three out of the four participants, with all participants reporting a reduction in personal problems identified at the start of therapy. Problems of long duration such as heightened levels of anger, general levels of aggression, mood fluctuation, interpersonal difficulties, and frequency of deviant sexual fantasies, were positively influenced by treatment. It is of interest that for the two participants who showed reduced levels of aggression during treatment, issues related to traumatic events and parental violence were a feature in the treatment process. Processes in which the participants from the medium secure unit re-evaluated their self-image in therapy can be linked with a post-treatment reduction in their aggressive styles of interacting with others.

Rates of aggression are consistently measured to be higher in institutional rather than community settings (Taylor, et al., 2005). Studies have reported that post-admission incidents of physical violence recorded among detained offenders with intellectual disabilities in specialist forensic services can be as high as 47% (Novaco & Taylor, 2004). Exposure to interparental anger in child development has been linked to an increased risk of adjustment difficulties. Novaco and Taylor (2008) found that parents' anger and aggression was related to patients' anger and aggression in a population of male forensic patients with developmental disabilities. There is some indication that understanding anger "dysregulation" can be enhanced by inquiry into parental models associated with "volatile parents or caretakers who inculcate aggression-infused schemas or scripts" (Novaco & Taylor, 2008, p. 391). The association between the therapeutic exploration of early adverse events and exposure to family violence related to reducing levels of aggression warrants further investigation.

The treatment had a general effect upon relational outcomes and responses towards others for the three participants without ASD. Exploration of participants' feelings of loss and regret in some instances led to their re-evaluating their priorities and goals for the future and improving their motivation to achieve.

Participation in the treatment appears to have had personally important outcomes for those taking part. Treatment has had an impact upon interpersonal schemas held by participants at the start of therapy. This led to behavioural change towards others resulting in improved relationships, improved personal motivation and positive outlook reported at three-month follow-up. Both participants who received treatment in the medium secure unit were transferred to a low secure unit within 20 weeks of completing treatment. Three of the four participants also reported improvement in family relationships as a positive outcome retrospectively attributed to therapy.

The assessment of CCRT interpersonal schemas revealed an unexpected finding that dominant themes in three of the participants' narratives at the start of therapy were similar. John, Stuart, and Richard had two dominant themes in their *wish* "to be close to others" and yet saw others as predominantly "not trustworthy" or "rejecting". Similarities between these participants included chronic and on-going examples of relationship instability and background histories which include being both victims and perpetrators of sexual abuse. It is possible that schema change arose from opportunities to address interpersonal difficulties both through direct engagement with the therapist, a relationship in the "here-and-now", and the process of collaborative reflection upon ruptures and violations in past relationships.

It is plausible that this process within therapy supported change from predominantly seeing others as "not trustworthy" to starting to view others as "helpful". This internal shift may have enabled participants to act upon their *wish* to "be close to others". This possible explanation linked with shifts in an individual's pattern of *responses*

to others may explain decisions made by participants to either increase efforts to make contact with family members, "to be close to others", or accept the efforts of others to renew contact with them.

In three of the four participants, the CCRT component for *wish* changed at the end of treatment. Studies of CCRT pervasiveness during dynamic psychotherapy have shown that negative *responses of others* and negative *responses of self* become less negative, but the *wish* component is not seen to change (Barber & Crits-Christoph, 1993). Additional themes in narratives for *wish*, in case 1 – John, and case 2 – Stuart, reflect a change in motivation at the end of therapy "to achieve", "to be respected" and "to better myself". In case 3 - Adam has narrative themes which indicate some ambivalence, such as a *wish* "to be close to others" and "to be distant from others", whilst a *wish* "to be helped" is also present. The development of Adam's apparent ambivalence about relating to others at the end of treatment is interesting and actually indicates that he had attempted some engagement in relationships, beyond seeking advice and reassurance. At the start of therapy Adam's CCRT interpersonal schema contained themes which indicated his motivation and his *wish* to be free from the influence of others, "to achieve", "to be independent", "to not be responsible or obligated" and "to be stable". This subtle shift in CCRT components between the start and end of therapy may indicate that there was a positive change in Adam's desire or *wish* to relate to others, albeit expressed ambivalently at the end of therapy. In case 4 – Richard's CCRT *wish* remained stable between early and late therapy sessions with improvement in negative *responses of others*.

Beckley (1998) suggests that maladaptive behaviours are underpinned by schema activation, whilst there is a "trait"-like quality to enduring features of personality; there is a view that there is some flexibility in "state-like", changeable presentations of schemas, as "self-states" and coping strategies. The high level of childhood disturbance within forensic patients, and particularly in personality disorder patients, can result in an "increased

likelihood of early relational patterns being repeated within care-giving relationships"
(Liebmann, 1998, p. 174). Within institutional forensic settings treatments which can
influence the outward manifestation of patterns of maladaptive interpersonal schemas have
some benefits. One tentative conclusion demonstrated in this study is that "in-therapy
process" including the therapist's response to the participant's material, such as adverse
events and maladaptive relationship patterns, supported improvement in their relationships
with staff. This conclusion is further supported by the participant's retrospective attribution
towards therapy corroborated with staff interview responses. Gains in improved
relationships with staff have potentially important implications for clinical management of
offenders. Relational security can be operationalized both quantitatively and qualitatively.
In quantitative terms, it is the staff-to-patient ratio and amount of time spent in face-to-face
contact. Qualitatively relational security is the balance between intrusiveness and
openness, trust between patients and professionals (Kinsley, 1998). The development and
maintenance of therapeutic rapport is important in terms of general relational security
(Kennedy, 2002). Studies suggest that offender rehabilitation programmes need to
incorporate a focus on relationship issues to help develop fully informed discharge plans
and maintain safe community integration (Ward, 2002).

10.2 Relationship Variables in Sex Offender Assessment and Treatment

Given that all four participants included as single-cases in this study had a
background which included committing sexual offences, some consideration will be given
to relationship variables for this group.

Whilst there is a body of literature supporting theory, treatment, and risk
assessment of sex offenders regarding patterns of relating to others and attachment style, it
must also be recognised that offenders are not a homogeneous group. There is little
literature considering the relationships between sex offenders, attachment and intellectual

disability (Craissati, 2009). A number of theories have been explored in relation to "attachment", both in childhood and adulthood, linked to sex offender assessment and treatment (Craissati, 2009; Marshall, 1989, 1993; Smallbone, 2006). The childhood experiences of offenders have also been hypothesised as having an enduring influence on adult relationships and psychological problems in offenders. Craissati, McClurg and Browne (2002) assessed 178 convicted child sex abusers over a seven-year period to look at different characteristics between offenders who were sexually victimised, and those who were not. One key variable included the presence of emotional abuse/neglect as a child with the whole sample reporting high levels of childhood maltreatment. A difference in the level of enduring psychological problems was also identified in sexually victimised perpetrators being "...more likely to experience enduring psychological problems associated with disturbed emotional development" (Craissati, McClurg, & Browne, 2002, p. 235). Findings from this study led to speculation that increasing an offender's emotional awareness of their own victim experiences and impoverished parenting may enhance victim empathy work in treatment.

Theories related to styles of attachment in offenders link the lack of early satisfactory attachments with an inability to form stable adult relationships. Instability in adult relationships is thought to increase the likelihood of some offenders being more susceptible to pursuing intimacy in maladaptive ways (Craissati, McClurg, & Brownea, 2002). The reporting of a lack of satisfaction in intimate relationships has been found in sex offenders and intimacy deficits are one of a range of dynamic variables employed in risk assessment (Hanson & Harris, 2001). Relationship instability is also considered as a dynamic risk factor. The Northgate Offender Risk Assessment Package (NORAP) is a comprehensive risk assessment for offenders with intellectual and developmental disabilities incorporating the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997) and SVR-20 (Boer, Hart, Kropp, & Webster, 1997). Relationship instability is identified as a risk

factor for violence in the HCR-20, and the SVR-20 identifies relationship problems as a risk factor for sexual offending behaviour. Sex offender perceptions of early interpersonal relationships have also been explored in relation to adult attachment style. In a study of 55 men who had committed a range of sexual offences including rape and nonsexual nonviolent offences, 75% reported insecure attachment against a normative sample where a majority rated themselves as securely attached (55-65%) (McCormack, Hudson, & Ward, 2002).

Sex offender treatment programmes for patients with intellectual and developmental disabilities include components which consider attachments and relationships (Hatton, 2002). Within the context of sex offender treatment programmes the aim of supporting pro-social relationships is included. Whilst a balance of consideration is given to risks and benefits of promoting engagement in some types of relationships in sex offender treatment there is an underlying recognition that "low risk" relationships improve quality of life. There is an added factor in supporting offence avoidance through increased motivation to maintain valued relationships (Hatton, 2002).

Relationship variables in sex offenders, including attachment, childhood experiences, and relationship instability, are described in the literature. There is also evidence that component elements of these areas are being addressed in sex offender treatment programmes with offenders who have intellectual and developmental disabilities (Beail, 2003). However, it is difficult to place findings for the single-cases investigated within this research neatly into the intellectual and developmental disabilities sex offender literature. There is some evidence within the case-studies that art psychotherapy supported the therapeutic aim of reducing the risk of recidivism in some of the ways that treatment programmes also seek to do: that is, they support pro-social behaviour, promoting the development of low risk relationships, and the maintenance of valued relationships. Inclusion of sex offenders within this study was not a specific requirement. While there

may be outcomes from art psychotherapy which do support therapeutic benefits for sex offenders with intellectual and developmental disabilities further research is required to identify specific treatment effects showing positive offence focused outcomes or risk reduction.

10.3 The Role of the 'Art' in Art Psychotherapy

In case 3 - Adam demonstrated that he was able to make associations with the art work he produced and, despite having communication difficulties, he was able to discuss and describe his artwork with the therapist. He said that the art-making process and talking to his therapist was "relaxing". It is possible that the sessions did have some direct therapeutic benefit in "here-and-now" reduction of anxiety. The depiction of his deviant sexual fantasies within therapy had a dual effect of highlighting potential risks within the multi-disciplinary team and providing therapeutic benefits in reducing personal distress.

There is evidence within this research that the artwork made in therapy supported participants in articulating problems and difficulties, describing events, and expressing potentially subtle internal concepts such as ambivalence or ambiguity within relationships. A clear example of this was Richard's model-making of his girlfriend as an angel followed by portraying her as a witch. Supporting these processes, sometimes creating physical representations of conflicts in their internal world, may have some value for people who have intellectual and developmental disabilities and associated communication problems. The exploration of personal material using artwork appears to have had a supportive role both in terms of developing a relationship with the therapist and helping participants "make sense" of themselves and be self-reflective. This may have been brought about as artwork produced by the participant becomes an object of interest for the therapist and the work of the participant is shown to have immediate acceptance and value. In addition to this, value is placed upon the meaning of the work, devoid of any aesthetic judgement.

Participants reported that drawing made the therapy "easier", "interesting" or helped them decide what to talk about (see Table 9.3). The process of collaborative reflection with the therapist when looking at artwork made in the therapy sessions also provides an inherent flexibility when exploring meaning. For example, a picture can be drawn with one intended purpose or meaning, but images can provide a starting point for discussion and meaning that can be developed through alternative suggestions or associations. This is clearly demonstrated in case 2-Stuart, who expressed surprise at his own image of a wall and could not think of what was on the other side (Figure 6.15). In the following session the therapist revisited the picture with him and asked Stuart if he had thought any more about the other side of the wall. Stuart then drew a table and chairs representing a meeting with staff to discuss his future (Figure 6.16).

10.4 Engagement in Treatment

All participants completed treatment and attended up to 20 therapy sessions. One concern raised during the study was that two participants, John and Stuart, considered ending treatment before they had completed 10 sessions. One possible scenario is that therapist factors contributed to engagement patterns for both patients who shared the same male therapist in the medium secure unit. The therapist rated their engagement to be high in the session prior to their raising concerns about the treatment. It is also possible that longstanding interpersonal relationship problems were played out in the early course of therapy before a stronger working alliance was established.

It is interesting that both participants, John and Stuart, shared a small number of features including having similar index offences, frequent aggressive outbursts, persistent interpersonal difficulties, opposition to ward staff, and hostile-dominant interpersonal styles. The results of these studies indicate that these participants made greater gains as a result of therapy than the participants who did not have disrupted engagement profiles. For

these participants, with controlling styles of relating to others, often observed in APD or conduct disorders, it is also possible that the "composed" response given to them when they spoke about considering dropping out of treatment was helpful in supporting them to re-engage. This may have been an inadvertent influence of the research process, whereby participants were reminded of their right to terminate treatment at any time without prejudice.

These participants also reported that they had found discussing difficult issues in therapy hard in early sessions. For example John referred to feeling disturbed after speaking about the violent murder of his cousin. Stuart also disclosed a deep "hatred" for his mother despite his difficulty trusting the therapist and expressing doubts about the treatment. The introduction of the RAP (adapted) interview in early therapy sessions may have also had the effect of eliciting personal disclosure at an early stage in therapy.

Three out or the four participants did say that they found certain aspects of therapy difficult but also reported that they felt supported at these times. At the post-therapy three-month follow-up interview each participant was asked if they thought art therapy could be helpful for other patients. All participants responded positively to this question and said that other patients in the hospital could benefit from the treatment.

10.5 Limitations of the Study

The study can be considered as largely practice-based and experimental in its design. Due to the paucity of current literature demonstrating expected outcomes for this treatment the selection of specific outcome measures for use in the study has been based upon a "best guess" approach. Some adaptation of other measures and development of study-specific measures have been included. The decision to use a range of measures has been driven by the expected and inherent limitations of stand-alone measurement of change, and an expectation that corroborated evidence gives greater confidence to the

plausibility of findings. A range of limitations is considered for each of the component areas of the research.

10.5.1 Management of qualitative process information and post-therapy interview data.

Qualitative process and interview data have been used to add richness to each case record. Although quotes of participant change interview data have been chosen selectively, careful attention has been given to the inclusion and editing of transcript information. A preference has been given to including as much of each of the participant's complete dialogue as possible. In fact, differentiation and detail in the participant's attributions towards therapy are considered necessary for testing the plausibility of post-therapy accounts of change (Bohart & Boyd, 1997). In the majority of quotes from participants the questions from the interviewer have been removed after additional contextual information has been provided in the text. In this way an attempt has been made to preserve the original meaning and integrity of a participant's comments made in therapy and in interview without quoting the entire conversation. This said, it is clear that the process is selective and therefore inherent bias cannot be ruled out. Within the qualitative data collection and analysis there has been clear acknowledgment of the existence of a "double hermeneutic" (Smith & Osborn, 2003), the therapist/researcher making sense of the participant/patient making sense of themselves.

10.5.2 Repeated Measures.

Although attempts were made to compare individual participant's BSI-18 scores with BSI scores from a forensic sample, the procedure for converting and comparing scores was considered unreliable and was not included in the results. The BSI-18 was chosen for use in this research due to the reduced number of questions for the participant to

answer. On reflection, this decision has limited the reporting of results as a longer version of the measure, the BSI, would have offered opportunities to compare individual test scores with an intellectual and developmental disability forensic sample (Kellett, et al., 2003). Comparing individual GAS-ID, GDS-LD, and RSES (adapted) test scores with a local forensic control sample has provided a clinically relevant and meaningful assessment of changes in the participant's symptoms and self-esteem during the study.

10.5.3 Continuous measures.

Self-rated measures were generated specifically for this study and have not been validated. During the study, comparison of staff scores with self-rated scores using a weighted kappa test for one case, John, showed very good rater-agreement. Testing for floor and ceiling effects in scores for self-rated measures was not carried out prior to the study being conducted, however these effects were not identified in the study data. Continuous measures have been the central measure of process and outcome within this study and have been shown to have sensitivity in being able to identify significant events or a "special cause" (Callahan & Barisa, 2005). An improvement in the study design would have been to identify pre-therapy events which would have had a potential influence on baseline trend.

10.5.4 In-treatment measures.

The Personal Problem Scale is study specific and has not been validated. Its use in the study indicates that participants rated both major and minor personal changes between the start and end of therapy. The influence of relational and expectancy effects for participants' in-treatment measures cannot be ruled out as the test was administered by the therapist.

Studies using the Relationship Anecdote Paradigm (RAP) with people who have intellectual and developmental disabilities have not been found. The RAP (adapted) is a unique format and has only been used in this study. As the interview is designed to elicit personally-generated anecdotes this interview was included as an in-treatment measure rather than being administered by an assistant psychologist prior to therapy. The interview required the participant to give simple accounts of relationship episodes including conversations or events that had taken place between himself and others. Results show that the interview was a useful tool for collecting personal narratives from participants with mild intellectual and developmental disabilities. Within the context of therapy, the interview led to meaningful areas of the participant's relationships and personal histories being brought to the attention of the therapist early on. This in turn supported the therapeutic process and treatment aims. Whilst the RAP (adapted) interview was included as an in-treatment outcome measure it is also possible that it contributed to treatment effects. The interview may have hastened the extent and intensity of personal disclosures being made by participants at an earlier stage in therapy. The information elicited in the interview went on to form the basis of the psychotherapeutic interventions carried out in subsequent sessions.

The therapist observation rating scale was generated for the purposes of the research. This measure was created and included in the study to add to the therapy process record and corroborate the therapist's observations with other measures used in the study. The descriptive value of the therapist's session-by-session observation and rating of the participant's engagement has been evident. In the corroboration of data the therapist observation rating scale has been used to indicate components of strengthening or weakening of the working alliance by plotting engagement profiles. An improvement to the study would have been to include a validated working alliance measure.

10.5.5 Retrospective attribution.

Assessment of the plausibility of post-therapy accounts of change have been tested against Bohart & Boyd's (1997) eight indicators supporting the assessment of the plausibility of participant post-therapy self-report and retrospective attribution. This assessment has been made by the principal investigator. Applying the assessment criteria for plausibility of post-therapy accounts is straightforward. Use of a second judge to assess that the content of post-therapy accounts of change had met plausibility criteria would have provided independent verification. An additional feature in the studies included repeating the change interview with each of the participant's named nurses, which was successful in three cases.

10.6 Treatment Integrity

A treatment manual was not followed in this study. Both therapists were experienced in working with offenders with intellectual and developmental disabilities and also worked within the same therapies team. Post-therapy interview revealed that all participants gave similar descriptions of the structure of therapy sessions and key components comprising treatment, also fitting with Edwards (2004) aims of art therapy. In the reporting of results, when specific therapist factors appear to provide a plausible alternative explanation for differences or similarities in findings, this has been stated. It is possible that following treatment plan manuals could have added to the integrity of treatment delivery during the study. However, as has been discussed in previous chapters, variability in individual therapist factors cannot be eradicated even when treatment manuals are followed. Audio recording of all therapy sessions was carried out. A study with greater resources may have been able to assess the extent to which the therapist's delivery of treatment varied.

10.7 Alternative Explanations for Change

Where a plausible account of a therapy-change relationship has been identified within cases, alternative explanations for apparent change have also been considered. Not all variables have been controlled or accounted for. As a practice-based investigation the study design had been chosen as it seeks out non-therapy influences in an attempt to present a credible account of a therapy-change link. The study has relied upon the participant's post-therapy accounts of extra-therapy events and alternative attributions. It is possible that specific measures assessing the actual impact of a range of non-therapy influences could have been used alongside process/outcome measures.

10.8 Therapist/Researcher Bias

Recognition must be given to the fact that the principal investigator provided therapy in two cases. This has both the disadvantages of inherent bias and the advantages of dual (therapist/researcher) role. Advantages in a therapist/researcher approach are in the detailed knowledge of the case, including experiencing actual events in-therapy. It is important to recognise that one's preferred account can have potential to strongly influence the reporting of data. On a personal note I have attempted to be disciplined in following the "story" that the data tells in identifying significant events and outcomes. This has been a conscious choice rather than selectively including features within the case which are clinically interesting in their own right rather than linked to outcome. The difference in this approach is clear when contrasted with anecdotal case studies where the interests and observations of the therapist/writer are the only perspective. Process outcome mapping has helped in assessing the impact and importance of in-therapy events for participants. Preference has been given to events within therapy that have been important for each participant. In this sense editorial decisions in highlighting important elements in each case have been driven by post-therapy attributions and significant events identified via

collecting continuous data. I have found Elliott's (2002) principle for therapist/researchers conducting single-case studies useful. Elliott's (2002) work is explicit in identifying researcher reflexivity, and recommends making a "good faith effort" to systematically search for evidence that brings one's preferred account, that therapy caused change, into question. The demonstration of this approach in art psychotherapy research is the logical next step from the rich anecdotal case studies which form the predominant literature in this area. The importance of anecdotal case-studies must not be underestimated in developing clinically-based theories. However, it must also be acknowledged that what is of interest to the therapist is not necessarily what is important to the client and may well be entirely unrelated to outcome or treatment effects.

10.9 Statistical Analysis

It has been possible to retrospectively collect accurate SUI data 12 months prior to and nine months post-therapy. The use of statistical process control (SPC) charts within this research, as outlined by Callahan and Barisa (2005), has proved to be a pragmatic and flexible tool in single-case evaluation of a psychotherapeutic approach. The benefits of routine use of SPC for self-rated or observational monitoring have potential for further exploitation in the pursuit of "evidence-based practice" (Callahan & Barisa, 2005).

10.10 Advantages and Disadvantages in Significant Events Studies

An advantage of significant events studies is the investigation of different lines of evidence in pursuit of a hypothetically important therapeutic process (Elliott, 2010). These approaches often employ mixed methods and can be used in theory-building case-studies. This study has sought to apply theory as a means of ensuring that the processes observed in cases are grounded in existing evidence related to psychotherapy outcome.

There is an inherent complexity in seeking to identify important events within therapy. This study has attempted to look for a causal relationship between moments of particular importance within the process of therapy supporting changes for the participants. The study has not set out to focus attention on or track one particular area of therapy process, for example "helpful events", across all four cases, but has sought to identify a range of potential therapy effects linked to individual participant outcomes. Statistical process control charts have been particularly effective in identifying important negative events or difficult phases in therapy as well as showing improving trend. In-treatment measures have supported strands of qualitative description and analysis of specific events. It has been important to give some theoretical explanation for change-process, but in reality multiple aspects of participant and therapist processes are involved. An important factor in significant events studies is in being able to tie in-session processes to post-session and post-therapy outcomes (Elliott, 2010). This has been achieved within the current study. Transcript excerpts from therapy sessions and post-therapy interviews have been used with the intention of keeping study findings clinically relevant.

The luxury of conducting the study within a PhD framework has enabled some level of engagement with the complexity of cross-referencing and corroborating different sources of data. The method of enquiry used in this study has been possible within a clinical setting. The time-consuming nature of analysing multiple rather than single factors within a case does not easily lend itself to being carried out in routine clinical practice-based research but it is an approach that shows potential.

The process of making judgements about the significance of events in the treatment and to some extent the degree of influence of non-therapy events is a challenge for a single researcher. The rationale behind development of single-case research methods using a small research team or "research jury", proposing a for-and-against case for change, does appear to be the logical next step in this approach (Stephen & Elliott, 2011). In practice an

alternative to this is in continuing to fine-tune the process of measurement with an increasing level of sophistication, whilst maintaining the principle of corroboration of multiple sources of data. This could also incorporate collecting a process record during the baseline control pre-treatment phase as an additional method of checking pre-existing influences on participants and using a multi-layered approach.

10.11 The Value of Art Psychotherapy with Adult Offenders who have Intellectual and Developmental Disabilities

The intention of this study was to demonstrate the effectiveness of art psychotherapy with adult offenders with intellectual and developmental disabilities in a medium-low secure hospital. The research has also attempted to demonstrate some internal validity, that the cause precedes the effect in time (temporal precedence); that the cause and the effect are clearly related (co-variation); and that there are no plausible alternative explanations for the observed co-variation ("nonspuriousness") (Haynes & O'Brien, 2000). In this study, an attempt to meet these criteria for assessing a causal relationship has been pursued with a balance of judgment being made about the plausible account (or otherwise) of change. The presence of a "logical mechanism" for the apparent change outweighing the plausibility of an alternative explanation for change has been considered in each single-case (Elliott, 2002; Kazdin, 2011).

Art psychotherapy provided as a treatment to four male patients in this study has been shown to have supported positive outcomes. It has also been an important finding that one participant with ASD made idiographic gains (Hackett & Archibald, 2010). The strongest effects seen within this research were reduced levels of aggression in MSU patients (Hackett, 2011a). Outcomes are relevant to the treatment of offenders within inpatient settings where dysfunctional aggression and maladaptive patterns of relating to others are seen. The art-making within art psychotherapy was viewed positively by the

participants at the end of treatment. The study has demonstrated a viable application of methods seeking to identify and link important events and processes taking place within art psychotherapy to outcomes for participants (Hackett, 2011c). The study does show that it is possible to collect relevant outcomes in clinical practice to evaluate art psychotherapy with this client group. Combining the use of a standardised symptom measure, the therapists rating of session observations (such as the therapists observation rating scale used in this study) and a post-therapy interview or questionnaire would provide helpful evidence of process and outcome in clinical practice for individuals.

10.12 Conclusion

The current study set out to investigate the effectiveness of art psychotherapy as a treatment for adult offenders with intellectual and developmental disabilities. While the limitations of the study are apparent there is plausible evidence to support a hypothesis that the treatment provided positive therapeutic benefits to participants. The nature and degree of positive change within each case can be seen to vary considerably. Individual case-studies also present a number of interesting in-therapy process factors which have been indicated to have had an influence upon treatment.

The conclusion of findings from this study can provide only one of two possible results, either the demonstration of a plausible account for therapy having a "causal relationship" to measured changes has been achieved, or no plausible account has been shown. Although notoriously there is always another possible explanation for events and findings the most plausible of alternative explanations for the change has been represented in the analysis within each case (Elliott, 2002). Limitations of the study have been presented in an attempt to be as comprehensive and as open as possible about inherent weaknesses. The experimental nature of the study design and methods may also be contributory or over-inclusive in being able to detect strong effects (Salkovskis, 1995).

However, despite such considerations it is possible to conclude that, on balance, the positive therapeutic influence of art psychotherapy has been measured within a limited number of four single-case studies.

At present no other studies, published or unpublished, investigating outcomes for art psychotherapy with adult offenders with intellectual and developmental disabilities, have been identified within the UK. This research demonstrates the possibility for further exploration and investigation into art psychotherapy with adult offenders with intellectual and developmental disabilities.

It is of interest that three out of the four participants (those without ASD) showed similar outcomes in their improved relationships. This may provide a tentative indication of areas of further study for art psychotherapy and could be the subject of further investigation. Limitations of the treatment upon improving areas of psychological distress such as anxiety and depression also need to be considered and may form a useful basis of further studies and improvement in the treatment.

The benefits of gathering a rich case record have given a considerable scope for investigation in each single-case study. This in itself is an important discovery when investigating the efficacy, and potentially the effectiveness, of psychotherapeutic interventions within complex client groups, in complex clinical settings. The influence of an overwhelming number of variables upon treatment requires some attempt at process observation during trials. The approach that has been used in this study addresses the reservations about some studies of causality raised in psychotherapy outcome research, for example (Bohart & Humphreys, 2000; Elliott, 2002). It is also clear that using a rich investigative approach does provide a platform for corroborating findings with existing theory in order to provide an additional layer of analysis. Studies of this kind can have potential to make a contribution to theory development and therefore initiate some conclusions which have a more general application.

The small number of participants in this study with mild intellectual and developmental disabilities and communication problems found that making images or models, as a precursor to discussion with the therapist, gave a supportive framework from which they could develop their thoughts about personally-generated material. Therapist factors and approaches which support participants in making sense of their own work are also seen to have an important influence upon treatment outcomes. The study included participants who had primarily committed sexual offences; further consideration should be given to the specific therapeutic benefits and components of treatment that art psychotherapy may offer this category of offenders. The role of art psychotherapy in supporting a reduction in sexually deviant nightmares for one participant with ASD is a tentative conclusion from the study and warrants further investigation. Outcomes showing that therapy had a positive influence in supporting gains in improving motivation, interpersonal relationships, and aggressive behaviour may have a more general application for the client group and further study is required.

Art psychotherapy has had diverse application in the NHS and while it remains available on a limited basis its value in supporting positive therapeutic gains for some client groups warrants further investigation and research. Studies which seek to demonstrate the efficacy and effectiveness of treatment, through testing the modality in experimental outcome research, will also benefit patients and therapists by developing practice-based evidence and theory. Art psychotherapy studies, if conducted with adequate rigour, have potential to inform other psychotherapeutic approaches, as well as developing the evidence within the modality.

Given the plethora of difficulties of many patients detained in specialist forensic services the use of a broad range of psychotherapeutic modalities, including art psychotherapy, could have value. Accessible and evidence-based approaches are required in this field. It is right that psychotherapeutic treatment such as art psychotherapy should

be given consideration and tested and evaluated in clinical settings. This can only lead to the positive development of art psychotherapy as an evidence-based approach used with greater discrimination and sophistication in pursuit of positive outcomes for patients.

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APPENDICES

Letter to the Responsible Clinician

[Insert Date]

Dear

Re: A multiple case series study of Art Psychotherapy with adult offenders who have learning disabilities

We are conducting a study to investigate the changes which may take place during the delivery of Art Psychotherapy as a supportive psychological therapy for people with learning disabilities within Medium and Low secure settings. An information sheet outlining the study is attached.

We are contacting clinical colleagues to ask you if any patients on your caseload might benefit from taking part in this study. We would be grateful if you could identify cases that are likely to meet the following criteria:

1. An inpatient within Northgate Hospital Learning Disability Forensic Service.
2. Have had a completed WAIS - Wechsler Adult Intelligence Scale indicating an IQ of between 55 and 75.
3. Age 18 to 60 years.
4. Able to give informed consent.
5. Able to complete standardised mental health questionnaires validated for a learning disability population.
6. Some presentation of difficulties with either anxiety symptoms, depressive symptoms, and / or interpersonal difficulties.
7. The individual's participation in the study is supported by clinicians within the Multi Disciplinary Team (MDT).
8. Is not receiving active treatment for psychotic symptoms.
9. Is not expected to be discharged within 12 months of the start of the study.
10. Is not currently requiring frequent / ongoing management in seclusion facilities.

If any of your clients or patients are likely to meet these criteria I would be grateful if you would discuss the project with them and ask them if they would be prepared to meet with one of the study therapists alongside their named nurse to talk about their possible involvement in this research.

Thank you for your kind attention and anticipated support of this study. Please do not hesitate to contact me if you require any additional information or would like to discuss this study further.

Yours sincerely

Simon Hackett
Head Art Psychotherapist - Psychological Services
Learning Disability Directorate

Study Information for Clinicians

A multiple case series study of Art Psychotherapy with adult offenders who have learning disabilities

What is the purpose of the study?
The aim of the study is to investigate and evaluate the delivery of Art Psychotherapy as a psychological therapy to support therapeutic change for people with learning disabilities in Medium and Low Secure settings. The study will use a wide range of measures to evaluate changes that occur during the course of therapy sessions. Art Psychotherapy has been demonstrated to have the same level o feffectiveness as verbal psychodynamic psychotherapy in some adult populations. This study has a small number of participants but takes multiple measures of changes that may occur before, during, and after the therapy.

Who should take part?
This study is taking place in Northgate Hospital NHS Forensic Learning Disability services. Four patients will be asked to take part in the study, two in Medium Secure accommodation and two in Low secure accommodation. Those included will meet age and level of learning disability criteria.

What will the research involve?
Assessment: A researcher / psychology assistant will complete a number of assessment measures for presenting symptoms with the client. Clients will complete these assessments on four occasions during an 11 month period. The assessments will be completed in order to establish a baseline, at pre-and post-intervention and 3 month follow-up. Clients will also be required to complete a simplified brief self-rated scale on a daily basis for the duration of the 11 month period.

Therapy: The therapy involves between 12 and 20 weekly Art Psychotherapy sessions over a 6 month period. Therapy will be delivered by an Art Psychotherapist qualified to Masters degree level with a minimum of 3 years experience of work in inpatient settings with people who have learning disabilities. The approach is non-behavioural, encouraging clients to engage in a therapeutic relationship using the production of art work as an additional means of expressive communication. Images completed within sessions are used for the purposes of assisting client engagement, generating discussion, and supporting personal reflection. The therapy has an overall goal of developing a constructive understanding and resolution in areas of personal and relational difficulties. Sessions are provided in a structured and time limited manner, taking place in a setting which can become familiar at a set time each week.

Will participation be voluntary and confidential?
Participants will be required to give informed consent and can withdraw from the study at any time without prejudice. Any information collected will be treated in confidence unless a participant or somebody else is considered to be at risk. Computer files will not include data that could identify individuals. To protect anonymity, participants will be assigned a study code number. Paperwork and the list linking participant's names to their code numbers will be kept securely by the Principal Investigator.

What will happen with the results of this study?
Study findings will be published in one or more academic journals and presented at professional conferences. Clients will receive an accessible version of written feedback describing the results of the study. Relevant clinical colleagues will receive a report at the end of treatment indicating their progress in treatment.

Who has reviewed this study?
The project has been reviewed by the Northumbria University School of Health, Community and Education Ethics Committee and the NHS Local Research Ethics Committee; local approval has been granted by Northumberland, Tyne & Wear NHS Trust R&D Department.

Who is the Principal Investigator/Contact?
Simon Hackett Head Art Psychotherapist – Psychological Services Learning Disability Directorate, Northgate Hospital, Northumberland, Tyne & Wear NHS Trust Tel: 01670 394886; e-mail: **simon.hackett@nap.nhs.uk** Under the academic supervision of Professor John Taylor, Head of Forensic Psychological Therapies and Research.

Research Consent Procedure

A multiple case series study of Art Psychotherapy with

adult offenders who have learning disabilities

Chief Investigator: Simon Hackett**,** Head Arts Therapies Team & Art Psychotherapist

Psychological Services - Learning Disability Directorate

Tel:

Mobile:

Email:

Academic Supervisor: Professor John Taylor

Consent Procedure: The Consent procedure will be completed within a period of 4 weeks from the initial approach / Invitation to take part from their psychiatrist (and or named nurse). Within this period participants will have a further meeting with a member of the research team (and named nurse) and information on 'understanding research and consent', 'information sheet', and 'consent form' will be discussed. A follow up meeting with the participant after a period of 4 days will be arranged at which formal consent will be sought.

i. Potential participants will be approached by people they know (psychiatrist−RMO or named nurse) and asked if they would like to speak to a member of the research team and a meeting will be arranged.

ii. Consent procedures for this study will be informed by guidance and recommendations from a recent 'understanding research' consent project within the Kenneth Day Medium Secure Unit at Northgate Hospital (Cook 2007). To facilitate informed consent, each component of the consent process will be broken down into its constituent parts with the individuals taking part.

iii. Information will be verbally presented in accessible language, accompanied by accessible, easy−read written material (including symbols) concerning the treatment, confidentiality issues, and the participant's right to decline involvement without prejudice to their current or future treatment. The participants understanding of each component will be checked carefully using the 'Empirical Assessment of Capacity to Consent' (Arscott 1998) designed for people with learning disabilities.

iv. The consent procedure will be allowed to take place within a period of 4 weeks from the initial contact with the participant.

Please contact Simon Hackett if you have any further questions.

Participant Information sheet 1

Understanding Research

Information about research

We would like to invite you to take part in a research study.

Before you decide to take part in research you need to fully understand why this research is being done and what you are being asked to do.

You will have time   to decide   whether or not you wish to take part in this research.

- We will explain the research study and go through the information pack . You can keep a copy.

- We will then ask you to sign a consent form   to show you have agreed to take part.

- You can stop talking about research at any time.

What is this research about?

This research is trying to find out if Art Therapy can help people feel better about themselves.

What will I be asked to do for this research?

You are being asked to have an Art Therapy meeting with a Therapist every week for six months.

The Art Therapy meetings will take from 30mins to 1 hour. .
You will have a chance to draw a picture and speak to your Therapist.

You will be asked to fill in a simple chart   every day.

All of the Art Therapy meetings will be recorded   to check how you and your therapist are getting on. Some of the information from the recordings will be used in the research. People reading about the research will not be able to know the information is about you.

You will be asked questions   by an assistant psychologist at two meetings before you start Art Therapy and again at two meetings after you have completed all of your Art Therapy.

Information about you will be kept confidential
You will get a copy of the research report when it is done.

Research Consent

Part of consent is deciding whether you want to agree to take part in the research.

You are now being asked to decide whether to say Yes or No to taking part in the research.

Informed consent means that you should fully understand what the research is about.

In the consent form you will be asked to say Yes or No to important questions.
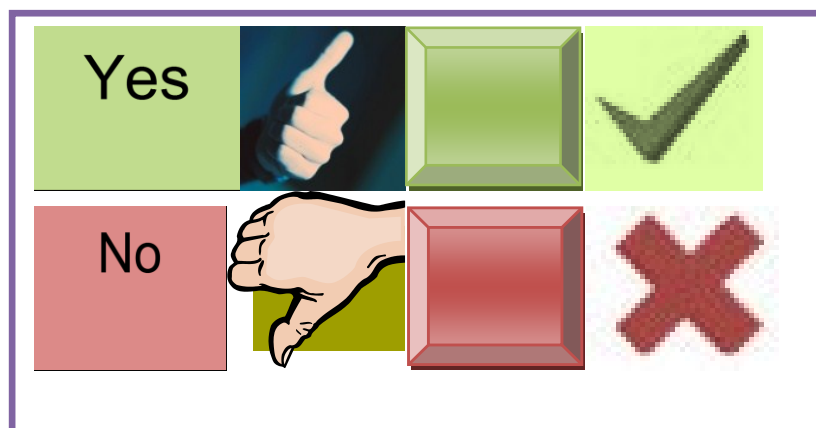
It is important to check that these questions have been answered before you consent to doing the research.

I have read and understand the information about this research?

Yes

No
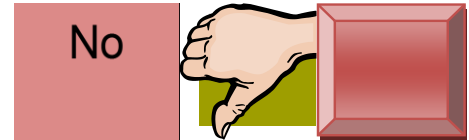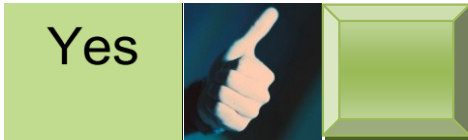
I have had a chance to ask questions about this research which have been answered?

Yes

No
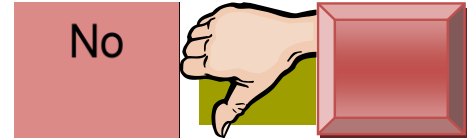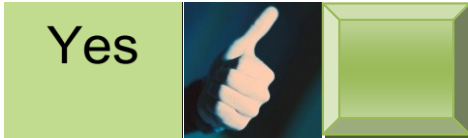
I understand it's OK to change my mind and stop taking part in the research at any time?

Yes

No
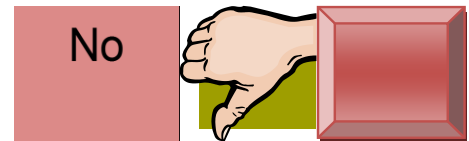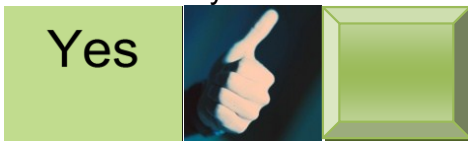
I am happy to take part in this research?

Yes

No
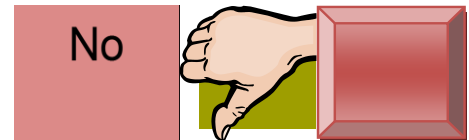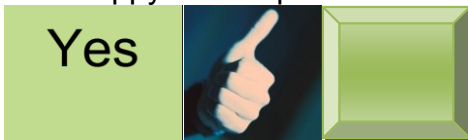
If <u>any</u> answers are 'no' or you don't want to take part, don't sign your name on the consent form!

Information based upon; Cook, T., & Inglis, P. (2008). Understanding research, consent and ethics: a participatory research methodology in a medium secure unit for men with a learning disability. London: Department of Health.

Participant Information Sheet 2

Art Psychotherapy to help me feel less distressed by things that are bothering me, like thoughts, feelings or relationships.

Who am I?
My name is Simon Hackett. I am an Art Psychotherapist at Northgate Hospital and my job is to help people feel less distressed or bothered by things that they are finding difficult in their life; like thoughts, feelings or relationships.

What are we doing?
We are trying to find out if Art Therapy can help people change and be less bothered by things that they are finding difficult like thoughts, feelings or relationships. Art Therapy sessions take place every week for between 30mins to 1 hour, you will be able to come to Art Therapy sessions every week for up to 6 months. You will have a chance to do some art work and speak to your therapist during the meeting.

Do I have to take part?
If you do not want us to talk, just say no. This will not affect the way you are treated in the Hospital now or in the future. If you say yes, but then you change your mind, that's OK. You can stop at any time; just tell me 'I want to stop'.

What happens next if I do take part?
An Assistant Psychologist will come to ask you questions on two occasions about how you are feeling at the moment, this will include things that might be bothering you or causing you some distress. Then I will come to talk with you for about an hour each week for around six months. You will also be asked to fill in a form every day for eleven months, the form asks how bothered you are by things on each day.

What happens when the treatment finishes?
At the end of treatment sessions we hope that you will feel better about things like difficult thoughts, feelings or relationships with others. The Assistant Psychologist will visit you twice to ask questions and check how you are getting on.

What happens to the information I give to the Art Therapist?
In sessions you don't have to talk about anything that you don't want to. What you tell me is confidential. That means I won't tell people what you say to me. However, if you tell me that you or someone else is in danger now or in the past, I may have to tell ……………………… (*named person*). All of the therapy sessions you will have will be recorded, this will be used to see how the therapist is working with you, nothing you say in therapy sessions will be shown to people outside the research team. This information will be kept locked-up in a safe place.

I will let your Consultant Psychiatrist know how you are getting on with treatment by sending reports in the normal way. You can see the reports if you would like to.

We will look at how you and the other patients who are having this treatment are getting on. We will let you know the results of the research if you would like to know. The results will not mention your name or any other personal information about you.

Thank you for letting me talk to you about this study. I will give you some time to think about whether you would like to take part and have this Art Therapy treatment. If you do not want me to come back, just tell me know.

If you would like further information please can you ask your named nurse ……………………..(name person).

Simon Hackett
Head Art Psychotherapist
Chief Investigator

EMPIRICAL ASSESSMENT OF CAPACITY TO CONSENT

A multiple case series study of Art Psychotherapy
with adult offenders who have learning disabilities.

Instructions

Go through the Participant Information sheet once to the participant and then say:

'To do this work with me I need to be sure you understand what I'm asking you to do. If it's ok, I'll just ask you some questions about what we've just read'.

Carry out the following questions.

Questions
1. Read the following part of the Information sheet: 'We are trying to find out if Art Therapy can help people change and be less bothered by things that they are finding difficult like thoughts, feelings or relationships.'
➢ **Ask the participant**: '**What will art therapy try and help you with?**'
    Score 2 if the person gives a clear and accurate answer such as to 'to help change things', be less bothered by thoughts', 'to help me with my feelings', 'get on better with people'.
    Score 1 if the person gives an answer that is similar to but less clear than above response(s).
    Score 0 if the answer is vague and/or irrelevant (e.g. 'Say hello').
2. Read the following part of the Information sheet: 'What you tell me is confidential – this means I wont tell anybody what you say'
➢ **Ask the participant: 'What does confidential mean?'**
    Score 2 for a clear and accurate answer such as 'You won't tell anybody what I say' or 'What we talk about is private'.
    Score 1 if the person gives an answer that is similar to but less clear than above response(s).
    Score 0 if the answer is vague and/or irrelevant.
3. Read the following part of the Information sheet: 'If you tell me (in our sessions) that you or someone else is in danger now or in the past I may have to tell……………….. (named person)'
➢ **Ask the participant: 'What will I do if you tell me that you or somebody else is in danger?'**
    Score 2 for a clear and accurate answer similar to 'you will have to tell……… (named person)'
    Score 1 if the person gives an answer that is similar to but less clear than above response.
    Score 0 if the answer is vague and/or irrelevant.
4. Read the following part of the Information sheet: 'The results will not mention your name or any other personal thing about you'.
    Ask the participant: 'Will your name or personal details be included in results?'
    Score 1 if the answer is 'No'.
    Score 0 if the answer is 'Yes'.
5. Read the following part of the Information sheet: 'If you say yes, but then you change your mind that's OK. You can stop the sessions at any time, just say "I want to stop".'
➢ **Ask the participant: 'What will you do if you change your mind?'**
    Score 2 for a clear and accurate answer such as "I want to stop".
    Score 1 if the person gives an answer that is similar to but less clear than above response.
    Score 0 if the answer is vague and/or irrelevant.
    Overall Scoring
    If the participant scores 0 to any of the questions 1, 3, 5 or 6 then consider carefully whether the participant has the capacity to consent to participating in the study.

    This protocol is based on the procedure described by:

Arscott, K., Dagnan, D., & Kroese, B.S. (1998). Consent to psychological research by people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities, 11(1)*, 77-83.

Participant Consent Form 1

Art Psychotherapy to help me feel less distressed by things that are bothering me, like thoughts, feelings or relationships.

Follow Empirical Assessment of Capacity to Consent before completing this form.

<u>**Participant to complete:**</u>

I have read, or had read to me, an information sheet explaining the research	Yes/ No
I have had the project, and the meaning of confidentiality explained to me by: _____ (Therapist) and _____ (nurse)	Yes/ No
I have been given a copy of this consent form.	Yes/ No
I agree to take part in the research project	Yes/ No
I understand that the details of what is talked about in the treatment sessions are confidential	Yes/ No
I understand that if I talk about situations where I or someone else is in danger now or in the past nursing staff will be told	Yes/ No
I understand that therapy sessions will be recorded on an audio tape recorder	Yes/ No
I have been told that I can stop doing the treatment sessions at any time, without giving a reason, and that this will not affect my treatment in hospital in future **Patient Signature**: _____	Yes/ No

<u>**Witness and Researcher to complete:**</u>

I have witnessed that _____ has orally consented
to take part in this research and has been given adequate information and time to answer
questions about it.

Witness Name: ....
Signature: ....
Date: ....
Job Title: ....
Address and/or contact ....
number:

....

Researcher Name: ....
Signature: ....
Date: ....

Participant Change Interview Consent Form

Statement	Initial
I have read, or had read to me, the information sheet explaining the 'change interview'	
I understand that this meeting will be recorded	
I understand that the details of what is talked about in the 'change interview' are confidential	
I understand that the meeting will be recorded and that the audio tapes will be destroyed within 3 months.	
I understand that all information will be securely stored on hospital computers, and any paper copies of information will be stored in a locked filing cabinet in a secure office at Northgate Hospital.	
I understand that if I talk about situations where I or someone else is in danger nursing staff will be told about this	
I agree to take part in the 'change Interview'	
I agree that my Named Nurse can be asked questions about how they think I have got on in Art Therapy in a separate interview.	
I understand that I can ask for information from the interview with my named nurse if needed.	
I have been told that I do not have to take part in the change interview and can stop at any time without giving a reason, and that this will not affect my treatment in hospital in future **Signature**: _____	

Witness and Researcher to complete:

I have witnessed that _____ has orally consented to take part in this research and has been given adequate information and time to answer questions about it.

Witness Name: ………………………………………………………………

Signature: ………………………………………………………………

Date: ………………………………………………………………

Job Title: ………………………………………………………………

Address and/or contact: ………………………………………………………………

Staff Change Interview Consent Form

A multiple case series study of Art Psychotherapy with adult offenders who have learning disabilities.

If you would like to take part in this interview please sign below after you have read the following statements.

Statement	Initials
I understand that the research participant has agreed that I can share information about them with the researcher.	
I understand the reason for this interview and that information I give will be used as part of the research into Art Psychotherapy.	
I understand that the information I provide will be confidential and will remain anonymous.	
I understand that the research participant is entitled to request information I give in the interview and that there is a procedure for this.	
I understand that the interview will be recorded and will take up to forty mins.	
I understand that taking part in this interview is voluntary and that I can withdraw my consent to participate at any time.	
I give my consent to take part in this interview.	

Print Name...

Signed .... Date...

Witness and Researcher to complete:

I have witnessed that _____ has consented to take part in this research and has been given adequate information and time to answer questions about it.

Witness Name: ....
Signature: ....
Date: ....
Job Title: ....
Address and/or contact number: ....
                              ....

Assessment Schedule and Information

**A multiple case series study of Art Psychotherapy
with adult offenders who have learning disabilities**

Chief Investigator: Simon Hackett, Head Arts Therapies Team & Art Psychotherapist
Psychological Services - Learning Disability Directorate

Tel:

Mobile:

Email:

Academic Supervisor: Professor John Taylor

Background Information: The study investigates Art Therapy / Psychotherapy as a psychological therapy to support beneficial changes for people with learning disabilities who are treated within a specialist hospital. Art Psychotherapy is shown to have the same level of effectiveness as verbal psychotherapy in some adult populations with mental health problems. Patients attend between 12 and 20 weekly Art Psychotherapy sessions over a 6 month period and are encouraged to engage in a therapeutic relationship.

Within therapy sessions artwork helps generate discussion and supports personal reflection. The therapy has an overall goal of developing a constructive understanding and resolution of personal difficulties. This study is designed to look at changes that can occur in patients with complex needs regarding their psychological / mental health, criminal behaviour and learning disability. Because of the highly complex and individual needs of this patient group there is limited value in using research methods which rely on large numbers of participants.

This innovative approach to research uses many measures to evaluate changes occurring during therapy in a small number of people. The study uses a mixture of methods including statistical measures and also looks at processes taking place in therapy sessions as well as artwork. The interpretative approach called 'Hermeneutic Single−Case Efficacy Design' also calls into question the data to assess if change can be attributed to the therapy. Participants in the study will complete standard mental health measures at set points before and after therapy. This will establish a baseline of 'no treatment', a before and after measure of treatment, and a follow up measure to check if changes are sustained. Participants act as their own control (having no treatment is measured) and changes which occur during treatment will be carefully considered. The patient's experience of therapy is integrated with all of the data to form a holistic case study.

Assessment: Each participant will be interviewed / assessed on 4 occasions throughout the study.

1. **Baseline** - Following completed consent procedure
2. **Pre** - At 8 weeks after baseline (therapy to begin immediately following this)
3. **Post** - After 6 months or completion of all therapy sessions (between 12 & 20)
4. **Follow up** – 12 weeks from post-.

- The Brief Symptom Inventory-18 (BSI-18)
- Glasgow Depression Scale for people with a Learning Disability (GAS-LD)
- Glasgow Anxiety Scale for people with an Intellectual Disability (GAS-ID)
- Rosenberg Self−Esteem Scale (adapted)

Procedure: The meetings will take place in a private meeting room on the ward or unit where the participant is residing. The assistant psychologist will be trained and experienced on the unit in administering standardised mental health questionnaires which have been validated for a learning disability population.

i. The Responsible Clinician (RC) has been informed about the participant's requirement to complete standardized mental health questionnaires validated for a learning disability population. The ability of the participant to complete standardized mental health questionnaires is listed in the inclusion criteria.

ii. The participant has been given an invitation to attend the meeting via their Named Nurse. (Each of the participants' named nurses will have attended a meeting with the chief investigator before and after the consent procedure has been completed).

iii. Questionnaires will be administered during a one hour meeting with an assistant psychologist who is approved as competent and experienced with patients from the unit. The assistant psychologist will explain the procedure for completing each of the questionnaires to the participant and offer support and breaks should this be required.

iv. Should the participant become distressed at any time during the meeting the assistant will stop the meeting and request immediate support for the participant from nursing staff. The assistant psychologist will then inform the chief investigator before any further action is taken.

Please contact Simon Hackett if you have any further questions.

GDS-LD Total Scores	GAS-ID Total Scores	RSES (adapted) Total Scores
M=14 (SD=7)	*M=19 (SD=9.4)*	*M=22 (SD=4.5)*
28	44	30
26	44	30
25	39	30
25	37	30
25	36	28
24	35	27
23	31	26
22	31	26
22	27	26
22	27	25
21	26	25
20	26	25
19	26	25
19	24	25
19	21	25
18	21	24
18	21	23
17	21	23
16	21	23
16	21	23
16	20	23
16	20	22
15	20	22
15	20	22
15	19	21
15	19	21
14	19	21
14	18	20
13	18	20
13	18	20
11	17	20
11	17	20
11	16	20
10	16	20
10	16	19
9	13	19
9	13	18
9	12	18
9	12	18
8	12	18
8	11	16
7	10	13
6	10	8
6	9	
5	9	
5	9	
4	9	
4	7	
3	7	
3	3	
2	2	

Appendix 8

Local forensic hospital control sample

Note: Table of total scores from two local control samples.

GDS-LD & GAS-ID local control sample of 51 male patients in forensic units with IDD had a mean age of 31.2 (range 20.9-58.8) (SD=9.4).

RSES (adapted) local control sample of 43 male patients in forensic units with IDD had a mean age of 32.2 (range 21.1-59.6) (SD=9.17).

Rosenberg Self-Esteem Scale (Adapted). Sample of questions 1 to 3 (not including questions 4-6)

Name: _____Administered by: _____ Date: _____

1. I feel I am a good person, as good as other people.	1 Never true	2 Hardly ever true	3 Sometimes true	4 Often true	5 Always true
2. I feel there are a lot of good things about me.	1 Never true	2 Hardly ever true	3 Sometimes true	4 Often true	5 Always true
3. I am able to do things as well as other people.	1 Never true	2 Hardly ever true	3 Sometimes true	4 Often true	5 Always true

1. I feel I am a good person, as good as other people.
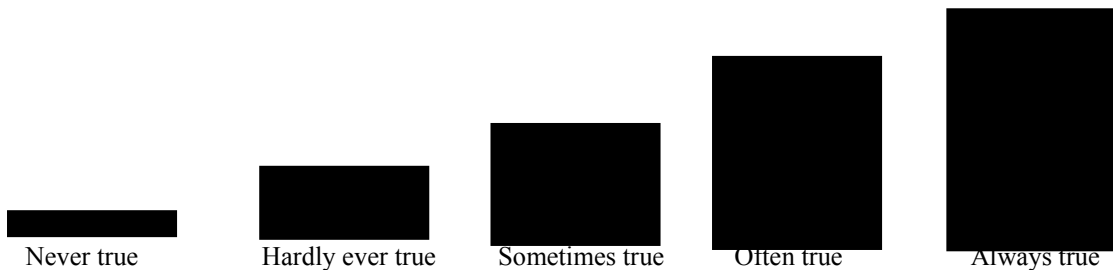
Never true   Hardly ever true   Sometimes true   Often true   Always true

2. I feel there are a lot of good things about me.

Never true   Hardly ever true   Sometimes true   Often true   Always true

3. I am able to do things as well as other people.

Never true   Hardly ever true   Sometimes true   Often true   Always true
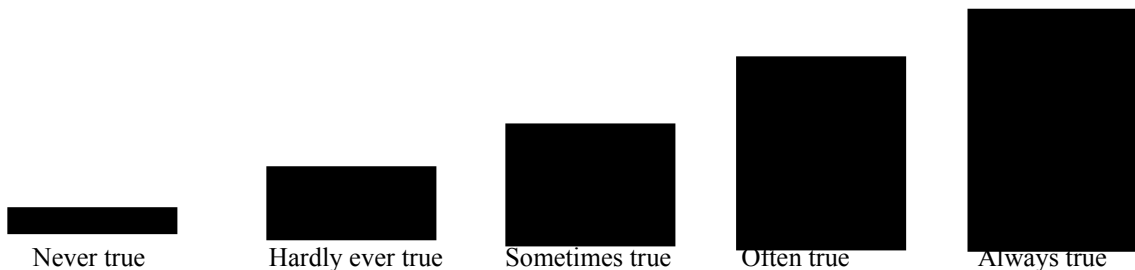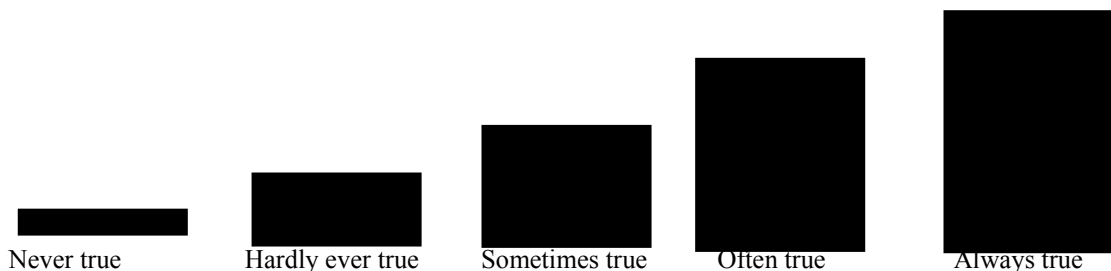
Daily Self-Rating Scale (Study Specific)

Today

How much have you been feeling cross or angry?

Choose a number.

1 is the best it can be.

50 is the worst it can be.

Name:

Date:

50
49
48
47
46
45
44
43
42
41

40
39
38
37
36
35
34
33
32
31

30
29
28
27
26
25
24
23
22
21

20
19
18
17
16
15
14
13
12
11

10
9
8
7
6
5
4
3
2
1

A LOT

QUITE A BIT

A BIT

A LITTLE BIT

NOT MUCH

Today

How much have you been feeling tense, panicky or stressed?

Choose a number.

1 is the best it can be.

50 is the worst it can be.

Name:

Date:

50
49
48
47
46
45
44
43
42
41
40
39
38
37
36
35
34
33
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1

A LOT

QUITE A BIT

A BIT

A LITTLE BIT

NOT MUCH

Today

How much have you been feeling low, down or sad?

Choose a number.

1 is the best it can be.

50 is the worst it can be.

Name:

Date:

50
49
48
47
46
45
44
43
42
41
40
39
38
37
36
35
34
33
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1

A LOT

QUITE A BIT

A BIT

A LITTLE BIT

NOT MUCH

Today

How much have you been feeling poorly or unwell?

Choose a number.

1 is the best it can be.

50 is the worst it can be.

Name:

Date:

50
49
48
47
46
45
44
43
42
41
40
39
38
37
36
35
34
33
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1

A LOT

QUITE A BIT

A BIT

A LITTLE BIT

NOT MUCH

Completing a Modified Overt Aggression Scale.

What is it being used for? The MOAS scale is being used as part of a research project and needs to be completed weekly, so that accurate data can be collected for the study. The MOAS measures incidents and severity of aggression and needs to be collected every week in the study (approximately 11 months) to have any statistical value. Thank you for completing the form.

Who should complete the form? Any qualified member of the nursing team can complete the form based upon a review of the nursing notes and observations in the previous 7 days.

Please rate types of aggression seen in the previous 7 days.

1. Write the name and date at the top of the form.

2. Read through the list of levels from the first to the last; if all levels are absent for the type of aggression then circle 0 for absent.

3. Identify each of the four types of aggression (verbal aggression, physical aggression against objects, physical aggression against self and physical aggression against others)

   Which of the severity levels have occurred during the course of the week for the individual?

   You can have more than one severity level for each type of aggression during a week for an individual.

   It is possible for an individual to exhibit almost all severity levels in the four types of aggression in a week. Or an individual could have only one or two severity levels for the week.

4. If a particular severity level was present for the individual during the week then circle the corresponding number of 1, 2, 3 or 4.

5. Circle if the type of aggression occurred less than ‹10 times per week or ›10 and more times per week. The right column is greater than and equal to 10 times.

Note: Do not calculate the total MOAS Severity score as this is done using a specific formula.

Sample – MOAS not including categories for "physical aggression against self" or "physical aggression against other people".

MOAS	NAME		NO		DATE		
CATEGORY	**SEVERITY LEVEL**					**FREQUENCY (past week)**	
VERBAL AGGRESSION	Absent			0			
	Makes loud noises, shouts angrily			1		<10	>10
	Yells mild personal insults, e.g. "You're stupid!"			2		<10	>10
	Curses viciously, uses foul language in anger, makes moderate threats to others or self			3		<10	>10
	Makes clear threats of violence toward other or self ("I'm going to kill you") or requests to help control self			4		<10	>10
PHYSICAL AGGRESSION AGAINST OBJECTS	Absent			0			
	Slams doors, scatters clothing, makes a mess			1		<10	>10
	Throws objects down, kicks furniture without breaking it, marks the wall			2		<10	>10
	Breaks objects, smashes windows			3		<10	>10
	Sets fires, throws objects dangerously			4		<10	>10

TOTAL MOAS SEVERITY SCORE

Personal Problem Scale (PPS) (Study Specific)

Start/End

Name :

Date :

a) Think of 3 things you would like to feel less distressed or bothered by at the moment, this can be things like thoughts, feelings or relationships.

1.	$1 - 2 - 3 - 4 - 5$
2.	$1 - 2 - 3 - 4 - 5$
3.	$1 - 2 - 3 - 4 - 5$

b) How bothered are you by each of these things if 1 is the worst it can be and 5 is the best it can be?

c) Which one of these things would you most like to feel better about?

Therapist:

Relationship Anecdote Paradigm (Adapted) Interview Schedule

Preparation: Tape/audio recorder, pens & pencils, large sheet of A1 paper.
Time: Up to 60mins
Note: This session needs to be recorded. The participant is free to speak about any incident about any people. It can be an event which was important to them or was a problem to them. It is desirable that there is some variety among the people chosen. It is useful if the narratives are from past and present. Each narrative should be about a specific incident, not a generalised amalgam of several incidents. Within each specific incident narrative you should aim to establish -

- a) Who the person is and their relationship to the participant
- b) Some of what the participant and the person they are talking about said or did
- c) What happened at the end
- d) When it happened

You should aim to support the participant to give up to ten or more narratives in this interview. At the start you may wish to speak about the confidentiality of the session and/or explain that the reason for asking the questions is to help gain a better understanding of the participant's relationships.

STEP	INSTRUCTION	DESCRIPTON
1.	**Explain:**	"This session focuses on talking about things that have happened between you and other people. This can be talking about things that have happened between people in your family, friends, people in hospital, or people you have met."
2.	**Explain:**	"I will ask you to speak about something that happened between each of the people you choose".
3.	**Question:**	Ask the participant to think of people he/she can speak about, then ask them to start to draw the people and/or write their names on the paper. (Prompt the participant to identify five or more people).
4.	**Question:**	Ask, "which person would you want to talk about? (Establish their relationship to the participant, i.e. mother, brother, friend, staff member…)
5.	**Question:**	Ask the participant to think of one thing that happened between them and the chosen person (specific incidents).
6.	**Question:**	Use questions, "Tell me about what happened?" Use prompts, "what did you say?", "what did they say?", Establish, "how did it end?" and "when did this happen?" For participants who are being too brief, use prompt: "Could you tell more about that?"
7.	**Question:**	Ask, "Have you got another story about this person from a different time (past or recent)?"
8.	**Repeat:**	Repeat step '6' for the same person or move onto another person (aim to have one past and one recent narrative for each person although this can vary)
9.	**Complete:**	Repeat steps 4 to 8 with all the people who have been identified by the participant on the paper or until you are confident that you have 10 or more specific narratives from different people and different time periods.

1. **READ TRANSCRIPT**: session notes taken from tape recordings.
2. Insert the date in the relevant section on the Relationship Theme Record Form.
3. **IDENTIFY THE OTHER PERSON:** A main other person must be identified, e.g. other patients, parents, staff, therapist, groups of people (family, friends, organizations).
4. Insert the name of the other person on the Relationship Theme form.
5. **IDENTIFY RESPONSES FROM THE OTHER PERSON:** A response from other should be scored only with respect to the main other person. Only when the other person in a Relationship Episode actually performs an action or responds in some way does the rater score a Response from the Other Person.
6. Indicate on the transcript the start and end of each Response from the Other Person using //.
7. At the start and end of each Response from the Other Person write RO.
8. On the Relationship Theme Record Form write the responses you have marked in the 'Response from Others' Transcript notes box.
9. **CATEGORISE RESPONSES FROM OTHERS USING STANDARD CATEGORIES:** Standard categories have been created to enable quantitative comparison between individuals and a common language to be used. There are 30 standard categories for Responses from Others.
10. Read through the 'Responses from Others Standard Category form.
11. Choose the best-fitting and the second best-fitting statements for each Response from others (RO) from the transcript notes section in the Relationship Theme Record form.
12. Write in the codes which best fit in section 1 and 2 on the Relationship Theme Record form.
13. **CALCULATE THE FREQUENCY OF RESPONSE FROM OTHERS CATEGORIES:** Write in the most frequent code and the number of times it has been used in the frequency section on the Relationship Theme Record form.
14. **IDENTIFY RESPONSES OF THE SELF:** Responses of the Self (individual): Narratives about the patient's interactions with the patient's own self. Most of the patient's references to self tend to be self-descriptions and therefore do not qualify as developed Relationship Episodes about the Self. Characteristic of the Responses of the Self (individual) narrative if a patient's recollection of a specific interaction with the self that included feelings or thoughts about themselves. Responses of self (individual) should also include the patient's symptoms when these are evident.
15. Read through the transcript and identify the Response from Self.
16. Mark at the start and end of each response from the Self (individual) with //.
17. At the start and end of each Response of the Self write RS.
18. Using the Relationship Theme Record form write the responses you have marked in the 'Response from Self' transcript notes box.
19. **CATEGORISE RESPONSES FROM SELF USING STANDARD CATEGORIES:** Standard categories have been created to enable quantitative comparison between individuals and a common language to be used. There are 31 standard categories for Responses from Self.
20. Read through the 'Responses from Self Standard Category form'.
21. Choose the best-fitting and the second best-fitting statements for each Response from self (RS) from the transcript notes section in the Relationship Theme Record form.
22. Write in the codes which best fit in section 1 and 2 on the Relationship Theme Record form.
23. Write in the most frequent code and the number of times it has been used in the frequency section.
24. **CALCULATE THE FREQUENCY OF RESPONSE FROM SELF CATEGORIES**: Write in the most frequent code and the number of times it has been used in the frequency section on the Relationship Theme Record form.
25. **IDENTIFY WISHES:** *Wishes: the wishes, needs or intentions of the individual.*
26. Read through the transcript.
27. Indicate on the transcript the start and end of each Wish //.
28. At the start and end of each Wish write W.
29. Insert on the Relationship Theme Record Form write the responses you have marked in the 'Wish of individual' Transcript notes box.
30. **CATEGORISE WISHES USING STANDARD CATEGORIES**: Standard categories have been created to enable quantitative comparison between individuals and a common language to be used. There are 35 standard categories for Wishes.
31. Read through the 'Wishes of individual'.
32. Choose the best-fitting and the second best-fitting statements for each Wish (W) from the transcript notes section in the Relationship Theme Record form.
33. Write in the codes which best fit in section 1 and 2 on the Relationship Theme Record form.
34. Write in the most frequent code and the number of times it has been used in the frequency section.
35. **CALCULATE THE FREQUENCY OF INDIVIDUAL WISHES CATEGORIES:** Write in the most frequent code and the number of times it has been used in the frequency section on the Relationship Theme Record form
36. **CREATE A RELATIONSHIP THEME:** The Relationship Theme is the central relationship pattern, script, or schema that each person follows in conducting relationships, i.e. blueprint for relationships. It is the highest frequency of each of (i) Responses from others (ii) Responses from self and (iii) Wishes.
37. On the Relationship Theme Record form in the bottom section of the form write the most frequent code in the code section.
38. On the Relationship Theme Record form write in the corresponding code description from the standard category sheets.

CCRT - RELATIONSHIP EPISODE RECORD FORM - To be completed by trained CCRT Rater / Judge.

Participant ID: ……………………….…   Other Person … ………………………Number of Relationship Episode:

Date………………………….   Judge:…………………………………..

Relationship Theme	Transcript notes	Standard category code 1	Standard category code 2	Most frequent code	Frequency
Response from others					
Response of self					
Wish of individual					
Relationship Theme	Code	Code description			

CCCRT Standard Categories for "Others, Self, & Wish"   Appendix 13d

RESPONSES OF OTHERS STANDARD CATEGORY	EXAMPLES
1. ARE UNDERSTANDING	Are empathic; are sympathetic; see me accurately
2. ARE NOT UNDERSTANDING	Are not empathic; are unsympathetic; are inconsiderate
3. ARE ACCEPTING	Are not rejecting; approve of me; include me
4. ARE REJECTING	Are disapproving; are critical
5. RESPECT ME	Treat me fairly; value me; admire me
6. DON'T RESPECT ME	Don't treat me fairly; don't value me; don't admire me
7. DON'T TRUST ME	Don't believe me; are suspicious of me
8. ARE NOT TRUSTWORTHY	Betray me; are deceitful; are dishonest
9. LIKE ME	Are interested in me
10. DISLIKE ME	Are not interested in me
11. ARE OPEN	Are expressive; are disclosing; are available
12. ARE DISTANT	Are unresponsive; are unavailable
13. ARE HELPFUL	Are supportive; give to me; explain
14. ARE UNHELPFUL	Are not comforting; are not reassuring; are not supportive
15. HURT ME	Are violent; treat me badly; are punishing
16. ARE HURT	Are pained; are injured; are wounded
17. OPPOSE ME	Are competitive; deny/block my wishes; go against me
18. ARE COOPERATIVE	Are agreeable
19. ARE OUT OF CONTROL	Are unreliable; are not dependable; are irresponsible
20. ARE CONTROLLING	Are dominating; are intimidating; are aggressive; take charge
21. GIVE ME INDEPENDENCE	Give me autonomy; encourage self-direction
22. ARE DEPENDENT	Are influenced by me; are submissive
23. ARE INDEPENDENT	Are self-directed; are not conforming; are autonomous
24. ARE STRONG	Are superior; are responsible; are important
25. ARE BAD	Are wrong; are guilty; are at fault
26. ARE STRICT	Are rigid; are stern; are severe
27. ARE ANGRY	Are irritable; are resentful; are frustrated
28. ARE ANXIOUS	Are scared; are worried; are nervous
29. ARE HAPPY	Are fun, are glad; enjoy
30. LOVES ME	Is romantically interested in me

RESPONSES OF SELF STANDARD CATEGORY	EXAMPLES
1. UNDERSTAND	Comprehend; realise; see accurately
2. DON'T UNDERSTAND	Am confused; am surprised; have poor self-understanding
3. FEEL ACCEPTED	Feel approved of
4. FEEL RESPECTED	Feel valued; feel admired
5. LIKE OTHERS	Am friendly
6. DISLIKE OTHERS	Hate others
7. AM OPEN	Express myself
8. AM NOT OPEN	Am inhibited; am not expressive; am distant
9. AM HELPFUL	Am supportive; try to please others; am giving
10. HURT OTHERS	Am violent; act hostile
11. OPPOSE OTHERS	Am competitive; refuse/deny others; conflict with others
12. AM CONTROLLING	Am dominating; am influential; manipulate others; am assertive; am aggressive
13. AM OUT OF CONTROL	Am irresponsible; am impulsive; am unreliable
14. AM SELF-CONTROLLED	Am responsible
15. AM INDEPENDENT	Make my own decisions; am self-directed; am autonomous
16. AM DEPENDENT	Am submissive; am passive
17. AM HELPLESS	Am incompetent; am inadequate
18. FEEL SELF-CONFIDENT	Am or feel successful; feel proud; feel self-assured
19. AM UNCERTAIN	Feel torn; am ambivalent; feel conflicted
20. FEEL DISAPPOINTED	Am not satisfied; feel displeased; feel unfulfilled
21. FEEL ANGRY	Feel resentful; feel irritated; feel frustrated
22. FEEL DEPRESSED	Feel hopeless; feel sad; feel bad
23. FEEL UNLOVED	Feel alone,; feel rejected
24. FEEL JEALOUS	Feel envious
25. FEEL GUILTY	Blame myself; feel wrong; feel at fault
26. FEEL ASHAMED	Am embarrassed; feel abashed
27. FEEL ANXIOUS	Feel scared; feel worried; feel nervous
28. FEEL COMFORTABLE	Feel safe; am or feel satisfied; feel secure
29. FEEL HAPPY	Feel excited; feel good; feel joy; feel elated
30. FEEL LOVED	
31. SOMATIC SYMPTOMS	Headache; rash; pain

WISHES STANDARD CATEGORY	EXAMPLES
1. TO BE UNDERSTOOD	To be comprehended; to be empathised with; to be seen accurately.
2. TO BE ACCEPTED	To be approved of; to not be judged; to be affirmed.
3. TO BE RESPECTED	To be valued; to be treated fairly; to be important to others
4. TO ACCEPT OTHERS	To be receptive to others
5. TO RESPECT OTHERS	To value others
6. TO HAVE TRUST	Others to be honest; others to be genuine
7. TO BE LIKED	Others to be interested in me
8. TO BE OPENED UP TO	To be responded to; to be talked to
9. TO BE OPEN	To express myself; to communicate
10. TO BE DISTANT FROM	To not express myself/my feelings; to be left alone
11. TO BE CLOSE TO OTHERS	To be included; not to be left alone; to be friends
12. TO HELP OTHERS	To nurture others; to give to others
13. TO BE HELPED	To be nurtured; to be given support to; to be given something valuable; to be protected
14. TO NOT BE HURT	To avoid pain and aggravation; to avoid rejection; to protect/defend myself
15. TO BE HURT	To be punished; to be treated badly; to be injured
16. TO HURT OTHERS	To get revenge; to reject others; to express anger at others
17. TO AVOID CONFLICT	To compromise; not to anger others; to get along; to be flexible
18. TO OPPOSE OTHERS	To resist domination; to compete against others
19. TO HAVE CONTROL OVER OTHERS	To dominate; to have power; to have things my own way
20. TO BE CONTROLLED BY OTHERS	To be submissive; to be dependent; to be passive; to be given direction
21. TO HAVE SELF-CONTROL	To be consistent; to be rational
22. TO ACHIEVE	To be competent; to achieve; to win
23. TO BE INDEPENDENT	To be self-sufficient; to be self-reliant; to be autonomous
24. TO FEEL GOOD ABOUT MYSELF	To be self-confident; to accept myself; to have a sense of well-being
25. TO BETTER MYSELF	To improve; to get well
26. TO BE GOOD	To do the right thing; to be perfect; to be correct
27. TO BE LIKE OTHERS	To identify with other; to be similar to other; to model after other
28. TO BE MY OWN PERSON	Not to conform; to be unique
29. TO NOT BE RESPONSIBLE OR OBLIGATED	To be free; to not be constrained
30. TO BE STABLE	To be secure; to have structure
31. TO FEEL COMFORTABLE	To relax; to not feel bad
32. TO FEEL HAPPY	To have fun; to enjoy; to feel good
33. TO BE LOVED	To be romantically involved
34. TO ASSERT MYSELF	To compel recognition of one's rights
35. TO COMPETE WITH SOMEONE FOR ANOTHER PERSON'S AFFECTION	

CCRT Standard catagories from,
Barber, J. P., Luborsky, L. & Crits-Cristoph, P. (2003) 'A guide to the CCRT standard categories and their classification', in *Understanding Transference: The Core Conflictual Relationship Theme Method. 2nd Edition.* Washington: American Psychological Association, pp. 43-54

Therapist Observation Scale (Study Specific)   **Appendix 14**

Therapists Name...Participant ID:.......................

To be completed immediately following each therapy session. Enter score and date.

1. Image Making				
1	2	3	4	5
No image / art object Made	Required encouragement and prompting to attempt image making	Mixed / ambivalent response to image making	Positive response to image making	Actively focussed on image making
1)	5)	9)	13)	17)
2)	6)	10)	14)	18)
3)	7)	11)	15)	19)
4)	8)	12)	16)	20)
2. Participation				
1	2	3	4	5
Did not participate in session, even when prompted / encouraged	Participated in session with prompting / encouragement	Participated satisfactorily	Motivated attempt to participate	Active participation
1)	5)	9)	13)	17)
2)	6)	10)	14)	18)
3)	7)	11)	15)	19)
4)	8)	12)	16)	20)
3. Therapeutic Relationship Development				
1	2	3	4	5
Resistant	Reluctantly engaged	Genuine, but guarded	Open	Open and trusting
1)	5)	9)	13)	17)
2)	6)	10)	14)	18)
3)	7)	11)	15)	19)
4)	8)	12)	16)	20)

Client Change Interview Schedule (9/99) (Elliott 2008)   **Appendix 15a**

After each phase of treatment, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. This interview is tape-recorded for later transcription. Please provide as much detail as possible.

2. General Questions:

1a. What medication on you currently on? (researcher records on form, including dose, how long, last adjustment, herbal remedies)

1b. Review Release of Recordings form

1c. What has therapy been like for you so far? How has it felt to be in therapy?

1d. How are you doing now in general?

2. Self-Description:

2a. How would you describe yourself? (If role , describe what kind of ____? If brief/general, can you give me an example? For more: How else would you describe yourself?)

2b. How would others who know you well describe you? (How else?)

2c. If you could change something about yourself, what would it be?

3. Changes:

3a. What changes, if any, have you noticed in yourself since therapy started? (For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?) *[Interviewer: Jot changes down for later.]*

3b. Has anything changed for the worse for you since therapy started?

3c. Is there anything that you wanted to change that hasn't since therapy started?

Client Change Interview, p. 2

4. Change Ratings: (Go through each change and rate it on the following three scales:)

4a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)

(1) Very much expected it

(2) Somewhat expected it

(3) Neither expected nor surprised by the change

(4) Somewhat surprised by it

(5) Very much surprised by it

4b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)

(1) Very unlikely without therapy (clearly would not have happened)

(2) Somewhat unlikely without therapy (probably would not have happened)

(3) Neither likely nor unlikely (no way of telling)

(4) Somewhat likely without therapy (probably would have happened)

(5) Very likely without therapy (clearly would have happened anyway)

4c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)

(1) Not at all important

(2) Slightly important

(3) Moderately important

(4) Very important

(5) Extremely important

5. Attributions: In general, what do you think has caused these various changes? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)

6. Helpful Aspects: Can you sum up what has been helpful about your therapy so far? Please give examples. (For example, general aspects, specific events)

7. Problematic Aspects:

7a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

7b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?

7c. Has anything been missing from your treatment? (What would make/have made your therapy more effective or helpful?)

8. Suggestions . Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?

Client Change Interview, p. 3

9. Review Personal Questionnaire (PQ)

Instructions: Compare pre-therapy (screening) and post-therapy to current PQ ratings with client, noting number of points changed for each problem. Tell client: We are trying to understand how clients use the PQ, and what their ratings mean.

9a. In general, do you think that your ratings mean the same thing now that they did before therapy? If not, how has their meaning changed? (Sometimes clients change how they use the PQ rating scale; did that happen for you?)

9b. Identify each problem that has changed 2+ points:

(1) Compare each PQ problem change (2+ points) to the changes listed earlier in the interview.

(2) If the PQ problem change is not covered on the change list, ask: **Do you want to add this change to the list that you gave me earlier?**

•If yes -> go back to question 5 and obtain change ratings for this change.

•If no -> go on:

(3) For each PQ problem change (2+ points), ask: **Tell me about this change: What do you think it means? Do you feel that this change in PQ ratings is accurate?**

10. Review Pretherapy Self-description (only if pre-treatment self-description has been obtained)

•Show client self-description summary from screening; ask:

•**How does this compare with how you see yourself now?** (What is similar? What is different? How do you understand these similarities and differences?)

Elliott, R. (2008) *Client Change Interview Protocol (CSEP, 9/99).* [Online]. Available at: www.experiential-researchers.org/instruments/elliott/changei.html

Change Interview (Adapted) (based upon Elliott, 2001, 2008)   **Appendix 15b**

Note: This session needs to be recorded and should be conducted in a suitable venue. The aim of this interview is to gather rich data on the changes that the participant feels have taken place since starting therapy and to establish if this is related to their Art Therapy sessions or other factors. You are able to prompt the interviewee, rephrase questions if necessary and clarify what they are saying throughout the interview. To elicit more information from the participant you can use phrases like, '*can you tell me a bit more about that?',* or *'can you think of anything else?'*

The interview should cover
- Any changes they have noticed since the start of their Art Therapy
- What they believe may have brought about these changes (including non therapy reasons)
- Helpful and unhelpful aspects of the Art Therapy

Explain
- The main purpose of this interview is to allow you to tell us about the Art Therapy you had in your own words.
- This information will help us to understand how the therapy works and is part of the research you have been participating in; it may also help us to improve the therapy.
- This interview is tape-recorded for research about your Art Therapy; please let me know if you have any questions about this?

Warm up questions
- *When did you start Art Therapy?*
- *When did you finish Art Therapy?*
- *Do you remember how many sessions you had?*
- *Who was your therapist?*
1) **What was Art Therapy like for you?**

2) **How has it felt to be in therapy?**
3) **Changes:** The next set of questions will ask about changes that have happened since you started your therapy *[Interviewer: Make a list of changes to refer to during the interview]*
a. How are you doing now?
b. What changes if any, have happened since the beginning of the year (i.e. general or specific circumstances and relationships)?
c. What changes have you noticed (in yourself) since you began Art Therapy (at the start of this year)?
d. What kind of things did you **speak about** in your Art Therapy sessions (i.e. feelings, family, past events)?
e. Have you noticed anything different in the way you are **doing things** since finishing Art Therapy?
f. Have you noticed anything different in the way you are **thinking** since finishing Art Therapy?
g. Have you noticed anything different in the way you are **feeling** since finishing Art Therapy?
h. Have you noticed if there is anything different about your **relationships** with people since finishing Art Therapy?
i. What **specific ideas**, if any, have you got from therapy so far, including ideas about yourself or other people?
j. Has **anyone else** thought that you have made changes?
k. Has anything changed for the **worse** for you since your therapy started?

4) **How much have things changed for you since starting Art Therapy?**

5) **Attributions:** *(Interviewer: refer to the list of changes, go through them one by one and ask a, b, c & d for each)*
a. What do you think has **caused** this change? (what do you think might have brought them about?)
b. What things **outside of therapy** do you think have helped bring about this change?
c. What things **in the therapy** itself do you think have helped bring about this change?
d. Could this change have happened if you **did not** have Art Therapy?

6) **Helpful factors**
a. Can you sum up what has been **helpful** (good) about the Art Therapy you had? Please give examples. *(Prompt the participant to give both general and/or specific events)*
b. Can you put into words what made these things helpful to you?

7) **Has Art Therapy been helpful for you?**

8) **Problematic factors**
a. Was there anything about the therapy which was **unhelpful**?
b. Were there things in the therapy which were **difficult** to speak about or think about?
c. How was it to speak about **difficult** things in therapy?
d. How did your therapist **respond** when you spoke about difficult things?

9) **Art Therapy specific questions**

a. What was it like having therapy for six months?
(Was it long enough? Too short? Too long?)
b. What was it like to be asked to draw pictures in your sessions?
c. Did making pictures help you in the sessions?
d. Do you think that Art Therapy could be helpful for other patients at Northgate Hospital (and why)?

10) **Suggestions.**
a. Do you have any **suggestions** for us, regarding the research in the therapy?
b. Do you have **anything else** that you want to tell me?

Rosenberg Self−Esteem Scale (Adapted) for Case 1 (John)

Statement	Screen	Pre	Post	Follow-up
"I feel I am a good person, as good as other people"	Sometimes true	Never true	Sometimes true	Sometimes true
"I feel there are a lot of good things about me"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
"I am able to do things as well as other people"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
"I feel I have not done anything worthwhile"	Sometimes true	Hardly ever true	Often true	Sometimes true
"I like myself".	Always true	Never true	Sometimes true	Sometimes true
"Sometimes I think I am no good at all"	Never true	Hardly ever true	Sometimes true	Never true
Total score.	22	16	17	20

Note. Level of agreement with each statement, "Never true", "Hardly ever true", "Sometimes true", "Often true", "Always true". Max score=30, Min score =6.

Rosenberg Self−Esteem Scale (Adapted) for Case 2 (Stuart)

Statement	Screen	Pre	Post	Follow-up
"I feel I am a good person, as good as other people"	Hardly ever true	Never true	Sometimes true	Sometimes true
"I feel there are a lot of good things about me"	Sometimes true	Sometimes true	Sometimes true	Often true
"I am able to do things as well as other people"	Often true	Sometimes true	Sometimes true	Sometimes true
"I feel I have not done anything worthwhile"	Sometimes true	Always true	Never true	Sometimes true
"I like myself".	Hardly ever true	Sometimes true	Sometimes true	Sometimes true
"Sometimes I think I am no good at all"	Sometimes true	Sometimes true	Never true	Never true
Total score.	17	16	22	21

Note. Level of agreement with each statement, "Never true", "Hardly ever true", "Sometimes true", "Often true", "Always true". Max score=30, Min score =6.

Rosenberg Self−Esteem Scale (Adapted) for Case 3 (Adam)

Statement	Screen	Pre	Post	Follow-up
"I feel I am a good person, as good as other people"	Always true	Sometimes true	Sometimes true	Often true
"I feel there are a lot of good things about me"	Often true	Always true	Often true	Often true
"I am able to do things as well as other people"	Often true	Often true	Sometimes true	Always true
"I feel I have not done anything worthwhile"	Often true	Sometimes true	Sometimes true	Sometimes true
"I like myself".	Always true	Sometimes true	Sometimes true	Often true
"Sometimes I think I am no good at all"	Never true	Never true	Hardly ever true	Often true
Total score.	25	23	20	22

Note. Level of agreement with each statement, "Never true", "Hardly ever true", "Sometimes true", "Often true", "Always true". Max score=30, Min score =6.

Rosenberg Self−Esteem Scale (Adapted) for Case 4 (Richard)

Statement	Screen	Pre	Post	Follow-up
"I feel I am a good person, as good as other people"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
"I feel there are a lot of good things about me"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
"I am able to do things as well as other people"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
"I feel I have not done anything worthwhile"	Never true	Never true	Never true	Sometimes true
"I like myself".	Always true	Sometimes true	Sometimes true	Sometimes true
"Sometimes I think I am no good at all"	Sometimes true	Sometimes true	Sometimes true	Sometimes true
Total score.	22	20	20	18

Note. Level of agreement with each statement, "Never true", "Hardly ever true", "Sometimes true", "Often true", "Always true". Max score=30, Min score =6.