Empirical Chapters

Developing an evidence base for the use of Art Psychotherapy within an inpatient perinatal mental health service

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

Ethical approval for the conduct of this research is confirmed as follows:

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List of Abbreviations

AIR – Audio Image Recording
BAAT – British Association of Art Therapists
GDPR – General Data Protection Regulation
GCSE – General Certificate of Secondary Education
HCPC – Health and Care Professions Council
IRAS – Integrated Research Application System
JBI – Joanna Briggs Institute
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
PCR - Polymerase chain reaction test for Covid-19
PPE – Personal Protective Equipment
PQN - Perinatal Quality Network
ReQoL – Recovering Quality of Life
RCP – Royal College of Psychiatrists
SPSS – Statistical Package for the Social Sciences
WEMWBS – Warwick Edinburgh Mental Wellbeing Scale
WHO – World Health Organisation

Terminology

Art Psychotherapy

Art Psychotherapy shall be defined within this research in alignment with the British Association of Art Therapists (BAAT) definition of “the use of art materials for self-expression and reflection in the presence of a trained Art Therapist. The overall aim of its practitioners is to enable a client to effect change and growth on a personal level using art materials in a safe and facilitating environment” (British Association of Art Therapists, 2014).

‘Art Therapy’ concerns itself with the relationship between the image and the client while separately addressing the perceived relationship between the therapist and the image. ‘Art Psychotherapy’ focuses primarily on the therapeutic relationship between client and therapist. ‘Analytical Art Psychotherapy’ considers interactions between the trio of client, therapist and image to carry equal significance in the therapeutic process. (BAAT, 2014, Schaverien, J. 2000)

Patient

Individuals engaging in Art Therapy sessions are referred to as patients, similarly the term ‘patient group’ is used to describe the clinical category of patients. This decision was informed by the preferences conveyed by a panel of experts by experience, consulted within the NHS Trust. Unless making reference to a term adopted by a specified alternate text, generalisations shall be made under the title ‘mother’ rather than ‘parent’ in order to provide clarity regarding which care-giver is being referenced.

Perinatal

The perinatal period, defined as the period of time from the point of conception through to 12 months after birth, is widely understood to be a time of intense transition with perinatal mental illness affecting up to 27% of new and expectant mothers who experience a wide range of conditions such as stress, anxiety, depression or psychosis during the perinatal phase (NHS England, 2023).

Perinatal Mental Health Unit

During the course of the research design, implementation and analysis, the term Mother and Baby Unit began to be replaced within clinical settings with a preference for the term Perinatal Mental Health Unit. A Perinatal Mental Health Unit offers care to patients who present with acute mental health problems during pregnancy or up to twelve months after giving birth, a unit allows patient and infant to remain together within the clinical setting for the duration of treatment. The researcher makes reference to “Mother and Baby Unit” within early research documents but alters to “Perinatal Mental Health Unit” or “the unit” interchangeably within the thesis. To further preserve anonymity of patients, the individual name and specific geographic location of the unit will not be identified within the research, the research site being referred to as a

Perinatal Mental Health Unit within the East Midlands. N.B. Perinatal Mental Health Unit is intentionally capitalised when used as a title of the place, the service or the staff team but remains lower case when referring to a generalised patient group.

Researcher / Patient-Oriented Clinician-Researcher

The researcher discusses the duality of her roles in depth within section 4.8.12. In summary, a Patient-Oriented Clinician-Researcher is an individual who prioritises patient outcomes over academic enquiry while acting as both a clinician (practicing Art Psychotherapist in this instance) and academic researcher in one setting. For the purposes of brevity within the thesis, the term “researcher” will be employed throughout while acknowledging the context of the duality of the role.

Acknowledgements

To the patients, past, present and future, thank you for being willing to engage in our sessions together, in spite of nearly every single one of you ensuring me that you are “no good at art”. I wholeheartedly appreciate the power of everything that you have chosen to share with me, spoken and unspoken.

To the staff team at the unit, your boundless hard work and dedicated to the patients leaves me awestruck. Thank you for all that you do.

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To my little family unit, the glue that has kept me together throughout this PhD, thank you. To my children, throughout this PhD process I have tried to model for you what it is to be tenacious and to follow your passions even when things stand in your way, never let anyone put out your bright light. My darling daughter, Sorcha, you have such glorious power in you and a wonderful belly laugh, never ever change. My wonderful son, Teddy, you are a magnificent orange in a world made for apples, that is your superpower; remember, what would David Bowie do? My husband, our source of love, playfulness, security, strength, talker of talks and keeper of equipment for all extreme sports; I see you. I am back now, no more need for ‘daddy’s special breakfast’ of re-heated chicken nuggets!

Binks and Mouse, my feline typing companions who managed to abide by the ‘no standing on the keyboard’ rule 52% of the time, while dedicating their days to snoring softly by my side or chattering to the birds from the windowsill.

The Hive: thanks must go to Nicki Power for her boundless generosity in being second reviewer for the Systematic Review. Lydia and Nicki, thank you for your proofreading superpowers. Kelly, thank you for your support and modelling of how to get through this thing in one piece. You have all been my cheerleaders and I know that the power of our hive mind will continue to flourish!

The FHT crew at Crossfit Nottingham, thank you for pushing me to exercise my body as well as my mind. You good? Good.

Acknowledgement must be given to my PhD fuels; truffle, burrata, crisps of all varieties (I do not discriminate) and lastly, time spent in the safe haven of my garden hammock.

Dedication

Throughout the ongoing, undulating challenges of my own journey as a mother, I have been both buoyed and soothed by the following piece of music, the original meaning of which was to pay tribute to Martin Luther King. Much like the experience of art, the meaning held within music can remain fluid in interpretation, providing a mouldable

container for the expression of a range of potent emotions. As such, I wish to share the lyrics to this piece of music, by way of dedication of this thesis.

This thesis is dedicated to mothers.

Up to the mountain; MLK song, (Patty Griffin, 2005)

I went up to the mountain
Because you asked me to
Up over the clouds
To where the sky was blue
I could see all around me
Everywhere
I could see all around me
Everywhere

Sometimes I feel like
I've never been nothing but tired
And I'll be walking
Till the day I expire
Sometimes I lay down
No more can I do
But then I go on again
Because you ask me to

Some days I look down
Afraid I will fall
And though the sun shines
I see nothing at all
Then I hear your sweet voice, oh
Oh, come and then go, come and then go
Telling me softly
You love me so

The peaceful valley
Just over the mountain
The peaceful valley
Few come to know
I may never get there
Ever in this lifetime
But sooner or later
It's there I will go
Sooner or later
It's there I will go

Abstract

A variety of acute mental health symptoms and resulting diagnoses can be experienced by mothers during the perinatal period. This study seeks to determine the feasibility, appropriateness, meaningfulness and clinical effectiveness of an Art Psychotherapy intervention with this patient group, via the delivery of individual sessions in the context of a randomised control trial with wait-list control group in an NHS inpatient Perinatal Mental Health service.

The thesis provides a summary of the literary, professional, academic and clinical contexts to the research, followed by a mixed methods systematic review which seeks to identify and analyse the existing evidence base for the intervention with the perinatal mental health patient group. Evidence gaps in the provision of rigorous, mixed methods research which aligns with clinical expectations in the field are identified within the systematic review which in turn informs the research methodology, detailing the researcher position, ethical considerations and the intended approach to the collection and analysis of qualitative and quantitative data. The subsequent presentation of a rich qualitative case series is followed by a thematic analysis of qualitative data, identifying 5 master themes relating to both the patient and therapist experience of the Art Therapy intervention. The master themes noted within the data are therapeutic process, the revealing image, mothering of others, mothering of self and control. Master themes identified are assessed for indications of treatment acceptability, the results of which demonstrate that the intervention can be considered to be clinically feasible, appropriate, meaningful and effective for use with the perinatal mental health patient group.

The researcher returns to the research questions to offer concluding answers drawn from the data while highlighting challenges faced during the research phase. Recommendations are provided to inform future research in the field with the aim of enhancing the existing research findings. This is followed by a closing discussion of the ongoing intentions of the researcher to establish a spectrum of Art Psychotherapy provision for perinatal mental health patients.

1 Introduction

1.1 Chapter overview

This chapter establishes the research questions and intentions of the research project while identifying the contribution of the research to the field of Art Psychotherapy interventions within Perinatal Mental Health. Additionally, the chapter acknowledges the impact of the Covid-19 pandemic upon the patient group and the research process.

1.2 Aim

To identify whether Art Psychotherapy is a feasible, appropriate, meaningful and clinically effective intervention for the perinatal mental health patient group, focusing upon delivery of the intervention in an inpatient Perinatal Mental Health unit. To develop / contribute to a wider evidence base for the use of Art Psychotherapy in Perinatal Mental Health.

1.3 Scope

The thesis considers the population of the perinatal mental health patient group, defined as mental health diagnoses and symptomatology experienced during pregnancy and the first postnatal year. It can be characterised by either an existing mental health issue or a condition that arises during pregnancy or related to pregnancy.

1.4 Primary Research Questions

The following research questions were determined in the early phases of the PhD by the researcher based upon professional experience as an Art Psychotherapist and knowledge of the existing research in the field. The research questions have been structured in accordance with the JBI Model of evidence-based healthcare (JBI, 2016) which considers healthcare practices and seeks to employ the FAME scale to determine the feasibility, appropriateness, meaningfulness and effectiveness of a practice (this is expanded upon within the Systematic Review chapter). This process enables evidence to be presented in a consistent and clear format for the use of clinical decision makers and commissioners (JBI, 2016).

1. What is the existing evidence base within this patient group for the feasibility, appropriateness, meaningfulness and clinical effectiveness of an Art Psychotherapy intervention?
2. Is Art Psychotherapy a feasible intervention with perinatal mental health patients?
3. Is Art Psychotherapy an appropriate intervention for use with perinatal mental health patients?
4. Is Art Psychotherapy a meaningful intervention to perinatal mental health patients?
5. Is Art Psychotherapy a clinically effective intervention with perinatal mental health patients?

1.5 Emerging Research Questions

The following research questions emerged during both the research and subsequent analysis phases, they are based upon the researcher's reflections on the research process and relevant outcomes.

6. Can the research provide commissioners with the rigorous evidence (aligning with accepted clinical standards) required to enable future funding of Art Psychotherapy interventions with the patient group?
7. What are the barriers to conducting Art Psychotherapy research with this patient group within the NHS?
8. What are the barriers to engaging with an Art Psychotherapy intervention for patients within the Perinatal period?

1.6 Gap

Thorough, well documented research into Art Psychotherapy intervention outcomes with the perinatal mental health patient group. Research which delivers evidence within the upper levels of the hierarchy of evidence (is credible and able to assist commissioners in making an informed choice), while ensuring ethical conduct (within bounds of IRAS etc, quality intervention by qualified Art Psychotherapists).

1.7 Main Argument

The research hypothesis is that Art psychotherapy intervention within the perinatal mental health patient group will contribute toward improvements in wellbeing and in mother-infant attachment. Additionally, that the existing evidence may have been impacted by barriers faced by researchers seeking to rigorously evidence a qualitative intervention while addressing boundaries around conducting research within NHS services.

1.8 Contribution

A piece of research which is credible, and which serves to broaden the evidence base for Art Psychotherapy within Perinatal Mental Health. Recommendations made for further research, paving the way for future researchers.

1.9 Impact of Covid-19

In 2020 the world experienced the Covid-19 pandemic, a global outbreak of an infectious disease by the name of Coronavirus. The Leicester Central Health Research Authority Research Ethics Committee issued ethical approval for the research project on 16th March 2020; on the same day, the then Prime Minister of the United Kingdom announced that all non-essential travel and contact should be ceased, lockdown measures were legally introduced on 26th March 2020 (Institute for Government Analysis, 2023). As a result of this the host site, an inpatient NHS Perinatal Mental Health unit, put Covid-19 protection measures in place which, in conjunction with challenges in the NHS administration of a research passport and honorary contract for the researcher, delayed the commencement of recruitment to the research until 16th June 2021.

During the 15-month period between ethical approval and the research recruitment phase, the researcher attempted to adapt by proposing a revision of the research methodology to an online delivery of an Art Psychotherapy intervention. This became an impossibility due to the process and timescales involved in securing an ethics amendment to allow this adaptation to the research.

It became clear in July 2021 that the recruitment of participants was being impacted by a number of factors (see discussion chapter for further expansion on this), predominantly related to Covid-19, therefore the total number of research participants was anticipated to be far fewer than the initial estimate of 35. In response to this, the researcher sought contact with a potential second NHS site, a Perinatal Mental Health Unit in a different NHS Trust, in order to offer the intervention and inclusion in the research phase via a transferable research passport. The researcher pursued the administration of this possibility with the NHS Research Compliance department within the Trust until December 2021 at which point the remaining duration of the research passport no longer allowed the addition of a second site to be a feasible option.

The impact of the Covid-19 pandemic upon the perinatal mental health patient group manifested itself in a number of ways, observed by the NHS unit as a “reduction in admission rates to the inpatient unit, alongside an increase in acuity of patients” who were admitted to the unit (correspondence with the Perinatal Clinical Lead, 2021). Additionally, the functioning of the unit was impacted by the sick leave and ongoing compulsory isolation timeframes of the staff team.

The NHS Covid-19 measures remaining during the research phase led to research participants who were outpatients being asked to return for Art Psychotherapy sessions in an NHS location which was external to the Perinatal unit in order to avoid cross-contamination; however, this involved patients attending sessions in an unfamiliar space which was situated within an adult inpatient unit which included acute male patients. Additionally, the researcher delivered the intervention in line with the changing measures by providing patients with their own individual pack of art materials which limited exploration of a wider selection of materials, the researcher acted in accordance with regulations by wearing varying levels of PPE as required and by conducting PCR tests prior to every visit to the unit.

1.10 Thesis structure

The thesis begins by introducing the personal and academic origins of the research project, the history of the profession of Art Psychotherapy and the development of clinical guidelines which are applicable to the perinatal mental health patient group. This is followed by a brief exploration of existing research and literature in the field and

the emerging themes of barriers to the research within them, leading into a formal systematic review which presents and analyses the relevant research and literature published between the time period of 2000 – 2022 while seeking to determine whether Art Psychotherapy is a feasible, appropriate, meaningful and clinically effective intervention with the patient group. The methodology of the doctoral research project is then established, detailing ontological and epistemological positions of the researcher, ethical considerations and the collection and analysis of data. The thesis then moves into a first-person narrative for the duration of the empirical chapters, presenting and analysing the gathered data in the form of a case series of individual patient experiences of the Art Psychotherapy intervention within the research project. The discussion section then reflects upon the findings of the research project before recommendations are made for future research as the thesis is drawn to a close within the conclusion section.

1.11 Chapter Summary

This chapter has introduced the aim of the research and set out a series of research questions while delivering a preliminary context to the research and the impact of the Covid-19 pandemic. The chapter has also provided the reader with a roadmap with which to navigate the thesis structure. Further academic and professional context to the research shall be explored within the following chapter.

2 Context of the Research

2.1 Chapter Overview

Following on from the previous chapter in which research the foundation of research questions and contributions were established, this chapter examines the interplay of the wider academic, clinical and professional contexts for research within the field of Art Psychotherapy interventions in Perinatal mental health, situated alongside the researcher's personal rationale. A synopsis is provided of the development of relevant clinical guidelines which relate to the provision of the specific intervention in the setting identified. This is followed by a brief overview of the existing research and literature in which themes and gaps are identified and a summary is given regarding how these gaps informed the design of this research project.

2.2 Academic Context

In 2015, the Director of Studies for this PhD and Art Therapist, Dr Jamie Bird began discussions with an NHS Trust in the East Midlands with the aim of establishing a link between the Trust and the University of Derby. The intention was to create an opportunity for the Trust to host Art Therapy placement students within the clinical setting of the inpatient Perinatal Mental Health Unit. The Trust was unable to host Art Therapy placement students, citing that there was insufficient evidence of the efficacy of Art Therapy interventions, thus highlighting a gap in the research and the evidential literature.

In response to this, Dr Bird began seeking funding to facilitate the completion of a PhD to address the evidence base. In 2017, the College of Health and Social Care within the University of Derby agreed to fund a PhD studentship to assist in the generation of a local evidence base for art therapy and to help develop an art therapy service within the Trust. The recruitment process for the PhD studentship was meticulous and competitive with four applicants being interviewed for the post.

The overarching research aim addressed by the PhD research was informed by clinical teams within the NHS Trust itself. During an informal interview between the Perinatal Clinical Lead within the Trust, and the researcher, an open written response was provided regarding the issue of the Perinatal Mental Health unit being previously unable to justify allocating funding to an Art Psychotherapy intervention;

> *“Historically funding has not been allocated for the provision of arts psychotherapy. Funding was prioritised to achieve the Perinatal standards set by The Royal College of Psychiatry. Sufficient evidence was not available to support the efficacy of the intervention.” (Perinatal Clinical Lead, 2022)*

From the point of identification of a lack of evidence by the Trust to the point of completion of the research and ultimately the establishment of an Art Therapy intervention within the Trust has been an approximately 9-year process. The origin of need and timeframe for the evolution of these developments appears to correlate with

the numerous challenges faced by the researcher. However, had the process been straightforward, the Trust would have been able to host placement students and commission the intervention directly in 2015 without the need for the research.

2.3 Professional Historical Context

It is the intention of this section of the thesis to offer a brief introductory context to the historical development of the Art Therapy profession, to situate the research within an acknowledgement of the professional grounding.

In 1938, during a lengthy period of convalescence from tuberculosis in King Edward VII Sanatorium, Adrian Hill discovered that returning to his former practice of making art enabled him to "occupy his mind and emotions" (Waller, 1991). As Hill's condition improved, he was prompted by the medical team within the sanatorium to engage fellow patients in similar art making practices, as such the term 'art therapy' was coined and the subsequent establishment of Hill's work within the National Health Service (NHS) led to the "formation of the British Association of Art Therapists (in 1963) of which he was the first Vice-President and later President" (Waller, 1991).

In 1946, Edward Adamson who had previously worked alongside Adrian Hill as an art therapist in a tuberculosis sanatorium, was appointed as 'art master' at Netherne Hospital, Surrey following his involvement with the British Red Cross Picture Library which served to introduce artwork into hospital settings. Written publications documenting Adamson's work at Netherne significantly raised the profile of the profession of Art Therapy and led to his being proclaimed as "a significant pioneer of art therapy" (Hogan, et al., 2001, p. 180)

The profession of Art Psychotherapy may be considered to have been shaped by three distinct chronological periods of developmental influence (Wood, 2011). Wood (2011, p.23) observed that the first historical period held a knowing of the therapeutic power of being "found in expression" whereas within the second period, Art Therapists developed a desire to address the perceived "alienating effects of psychiatric institutions by providing in their studios an 'asylum within an asylum'". Edward

Adamson sought to develop offerings of “painting on prescription” within a series of therapeutic community settings such as psychiatric social clubs.

During the 1980’s-1990’s, Wood (2011) notes a transition to Art Therapists delivering interventions within the community rather than in an asylum, with a newfound willingness to adapt previously formulaic Art Therapy approaches to the needs of individual patient groups, therefore prompting increased importance of factors such as “theory, practice and technique” to determine “more rigorous explanations for the therapeutic relationship within psychodynamic approaches” in Art Therapy.

Wood (2011, introduction) indicates that the three foundational periods of Art Therapy development have come together to form the contemporary period in which there is an “increasing concern to produce systematic evidence for the practice” of Art Therapy. Wood (2011) concludes that the common thread of strength throughout the historical influences upon the development of the profession of Art Therapy is that of the unique “art making and a therapeutic relationship” and simultaneous awareness of the influence of “socio-economic circumstances of the client’s life and the therapeutic setting”.

The professional title of “Art Therapist” became a protected title in 2004 when it was accepted as a registered profession with the Health and Care Professions Council (HCPC), as such, registered Art Therapists must adhere to the HCPC standards of proficiency for practice. The protection of this professional title in United Kingdom Law ensures that only those holding HCPC approved qualifications as Art Psychotherapists and upholding registration with the HCPC may deliver an intervention of Art Therapy / Art Psychotherapy within the United Kingdom.

The profession of Art Psychotherapy appears to have faced a series of obstacles which have hindered or perhaps continue to hinder attempts to evidence the feasibility and acceptability of the intervention within clinical settings such as the NHS, this was observed by Westrhenen & Fritz as follows.

> *“The often unstructured nature of the therapy, which depends on the pace of the client and the severity of symptoms, as well as systemic influences,*

> *challenges the execution of clean and controlled experimental designs." (Westrhenen, N. & Fritz, E. 2014, introduction)*

Similarly, Eaton et al., 2007 indicate that the lack of empirical research in the profession may be attributed to a lack in research training of arts therapists, therefore resulting in a fundamental issue when attempting to measure the abstract creative process of creative therapy interventions.

An All-Party Parliamentary Group on the Arts, Health and Wellbeing (APPGAHW) was formed in 2014 and conducted an inquiry into practice and research in the arts in health and social care. The intention of the inquiry report, published in 2017 was to make a series of recommendations for improvements in policy and practice in the field, three primary areas of discussion within the report are summarised below due to their relevance to this research project; the question of evidence base versus proof, a shift from the reliance upon quantitative research methodologies to an acceptance of creative forms of analysis and finally a discussion of economic value in contrast with value in real life terms.

The inquiry held sixteen round table consultations with external experts such as service-users, academics, and people working in the arts and health care, during this phase of the inquiry, Professor Paul Camic observed that "an obstacle to the commissioning of arts organisations in the health sector seems to be that the 'burden of proof' forces them to justify the impact of creative approaches as compared to biomedical alternatives" (Camic in APPGAHW, 2017, p.34); thus there is a pervasive confusion regarding a desire for evidence equating to a desire for proof. Further to this observation, Professor Ray Pawson stated "there is no such thing as evidence-based policy… Even its most enthusiastic advocates are inclined to prefer the phrase 'evidence-informed policy' as a way of conveying a more authentic impression of research's sway" (Pawson in APPGAHW, 2017, p.42). In response to this consultation, APPGAHW (2017) recommend that a change of belief is required within the commissioning system, such that political and institutional motivations for change must be of equal consideration as the desire for evidence. Such declarations may allow space within the Art Therapy profession for a relaxation of the pressure to obtain direct

proof of intervention efficacy, instead encouraging commissioners to indulge in a broader consideration of the feasibility and acceptability of an intervention.

A prior insistence upon quantitative methodologies within clinical intervention research could be making way for what APPGAHW (2017, p.36) refer to as “more rigorous sampling”, resulting in the use of arts-based qualitative methods to capture a “descriptive exploration of individual and shared experiences” via semi-structured interviews, participant observation and case series presentations. Professor the Baroness Finlay of Llandaff (APPGAHW, 2017, p.37) advised the inquiry that creative research methods are “effective for uncovering hidden perspectives, adding empathic power and strengthening participants’ voices”. In light of these observations within the inquiry, commissioners and stakeholders may be encouraged to give greater credence to the acceptability of data gathered via creative, qualitative research methodologies when considering Art Therapy interventions in health care.

In orienting the decision-making environment around the judgement of feasibility and acceptability of Art Therapy interventions, APPGAHW (2017, p.38) note the shortcomings of the tendency of commissioning bodies to make decisions based upon cost-benefit analysis when in contrast to this, “the difference that arts participation makes to people’s lives often transcends economic value”. Further to this, APPGAHW align themselves with the recommendation from the All-Party Parliamentary Group on Wellbeing Economics (APPGWE), that a wellbeing approach which prioritises direct benefits to individual patients offers a strong alternative to traditional focussed economic analysis by capturing the true value to society of arts-based interventions (APPGWE, 2014).

2.4 Clinical Context

The University of Oxford prepared a report entitled “Saving Lives, Improving Mothers’ Care” (University of Oxford, 2022) on behalf of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACE-UK). The report seeks to review the clinical care received by women who died during and after pregnancy in 2018-2020 and make recommendations for improvements to mental health care. The report states that in spite of pregnancy ordinarily being considered to

be a protective factor for death by suicide, “in 2020, women were three times more likely to die by suicide during or up to six weeks after the end of pregnancy compared to 2017-19” (University of Oxford, 2022, p.13). It was noted that at least half of the women who died from suicide had multiple adversity such as a “history of childhood and / or adult trauma, as a result of this, presentations could be complex with mental illness, substance misuse and physical health symptoms, such as chronic pain” (University of Oxford, 2022, p.5). In light of the data analysis, the report drew several conclusions which will continue to inform perinatal mental health care provision, particularly around recognising the significance of a patient’s trauma history when assessing risk, requiring the involvement of specialist perinatal mental health teams in the event of significant involvement with secondary mental health services.

The acute inpatient perinatal mental health unit in which the research was hosted accepts referrals from general practitioners, psychiatrists, obstetricians, crisis teams and the perinatal community mental health team. Referrals are accepted for individuals who are experiencing puerperal psychosis, severe postnatal depression, severe anxiety disorder, significant disorders of bonding or a relapse of existing mental health problems such as schizophrenia, major depressive disorder or bipolar disorder. The timeframe for admission to the unit is from 32 weeks antenatally or postnatally with infants up to the age of 12 months. The unit can accommodate up to 6 patients and their infants and offers treatment from a consultant psychiatrist, psychiatric nurses, nursery nurses, healthcare assistants, occupational therapy and psychology services. The unit has been awarded a Royal College of Psychiatrists, kite mark which recognises the high quality of care offered to patients.

2.5 Brief Review of Clinical Standards

2.5.1 Overview of the development of relevant Perinatal Quality Network (PQN), Perinatal Inpatient Standards.

The Royal College of Psychiatrists’ (RCP) College Centre for Quality Improvement (CQCI) works with 90% of mental health service providers in the UK with a focus on four primary areas; quality networks, accreditation, national clinical audits and research and evaluation (RCP, 2023). The CQCI has specialist quality networks for a

variety of sectors, the Perinatal Quality Network (PQN) sets core standards for facilities, treatment and care within inpatient perinatal mental health services as part of their commitment to promote perinatal mental health. The standards are determined via a consultation process involving several groups of experts in the field, such as patients and carers, members of the PQN and staff teams within inpatient perinatal mental health services. The PQN then engages further with perinatal mental health unit staff teams in the United Kingdom and undertakes clinical audits to ensure that the core standards are developed and maintained.

The transition in PQN standards regarding care and treatment, carrying relevance to the provision of Art Psychotherapy, for inpatients of perinatal mental health services have undergone several transitions since the publication of the first Standards for Mother and Baby Inpatient Units in 2008 (Perinatal Quality Network, 2008). The researcher has undertaken a review of the development of the PQN standards and has summarised the standards that are relevant to Art Psychotherapy as follows:

Table 1: Overview of relevant PQN Perinatal Inpatient Standards

Guideline	Relevant guidance
Standards for Mother and Baby Inpatient Units First edition January 2008	"All units have access to a range of therapeutic interventions focussing on mother and baby… creative therapies." - Allocated category "desirable" "Wherever possible the treatment provided is evidence-based, treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance." - Allocated category "essential / legal requirement"
Standards for Mother and Baby Inpatient units Second edition September 2008	All units have access to a range of therapeutic interventions focussing on mother and baby… creative therapies." - Allocated category "desirable" "Wherever possible the treatment provided is evidence-based, treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance and any deviations are documented." - Allocated category "essential / legal requirement"

Standards for Mother and Baby Inpatient units Third edition 2011	All units have access to a range of therapeutic interventions focussing on mother and baby… creative therapies." - Allocated category "3" – standards that an excellent ward should meet or standards that are not the direct responsibility of the ward. Wherever possible the treatment provided is evidence-based, treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance and any deviations are documented." - Allocated category "1" Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
Service Standards for Mother and Baby Units Fourth edition 2014	"All units have access to a range of therapeutic interventions focussing on mother, baby and family… creative therapies." - Allocated category "2" – standards that an accredited ward would be expected to meet. Wherever possible the treatment provided is evidence-based, treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance and any deviations are documented." - Allocated category "1" Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
Service Standards for Mother and Baby Units Fifth edition 2016	"All units have access to a range of therapeutic interventions focussing on mother, baby and family… Patients have access to art / creative therapies." - Allocated category "2" – standards that an accredited ward would be expected to meet. "Patients are offered pharmacological and psychological interventions in accordance with the evidence base and good practice." - Allocated category "1" Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
Standards for Inpatient Perinatal Mental Health Services Sixth edition 2018	"All units have access to a range of therapeutic interventions focussing on mother, baby and family… Patients are offered art/creative therapies." - Allocated category "2" – standards that an accredited ward would be expected to meet. "Patients are offered pharmacological and psychological interventions in accordance with the evidence base and good practice." - Allocated category "1" Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
Standards for Inpatient Perinatal Mental Health Services Seventh edition 2019	"The unit comprises a core multi-professional team with specialist skills and knowledge… There is dedicated sessional input from creative therapists." - Allocated category "3" – standards that an excellent ward should meet or standards that are not the direct responsibility of the ward. "There is a broad programme of care and treatment appropriate for the needs of the mothers and their babies… Patients begin evidence-based interventions, which are appropriate for their bop-psychosocial needs, within four weeks of admission. Any exceptions are documented in the case notes." - Allocated category "1" Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
PQN Quality Standards for Inpatient Perinatal Services Eighth edition 2022	""The unit comprises a core multi-professional team with specialist skills and knowledge… There is dedicated sessional input from arts or creative therapists." - Allocated category "3" – criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service. "There is a broad programme of care and treatment appropriate for the needs of patients and their babies… Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs." - Allocated category "1" Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment.

In summary of Table 1, the progression of recommendations for the use of creative therapies / Art Therapy within the PQN Perinatal Inpatient Standards begins with the first edition in January 2008 which calls for creative therapies as a desirable addition to perinatal inpatient care, but that an evidence base is a legal requirement “wherever possible” for treatments provided (PQN, January 2008). The third edition of the standards, published in 2011 states that the provision of creative therapies would indicate that a ward was meeting “excellent” standards of care, however an evidence base for such interventions was still a requirement in order to avoid “threat to patient safety, rights or dignity…” (PQN, 2011). In 2016, the fifth edition of the standards states that an accredited ward would be expected to facilitate patient “access to art / creative therapies” in accordance with the “evidence base and good practice” to avoid “threat to patient safety, rights or dignity…” (PQN, 2016). The eighth and most recent edition of the standards, published 2022 indicates that it is “desirable” for Perinatal Inpatient units to ensure that “there is dedicated sessional input from arts or creative therapists” with a requirement for therapeutic interventions to be evidence-based (PQN, 2022).

It is therefore apparent that the development of the PQN Inpatient Perinatal Standards between 2008 and 2022 has evolved from a brief acknowledgment of creative therapies to a statement that specific sessions delivered by arts therapists are desirable within the services. The evolution of the requirement for evidence-based interventions has only slightly altered, suggesting at points that there is scope for inclusion of interventions that do not have an evidence base, as long as “deviations are documented” (PQN, 2011) before returning to the addition that an evidence base for interventions is required in relation to “patient safety, rights, dignity, the law…” (PQN, 2022). As such, the progression of the standards points clearly to the gap in the evidence base for Art Therapy interventions which was similarly encountered by the NHS Trust that initially approached the University of Derby to seek research in establishing an evidence base in this field (see section 2.2, academic context).

2.5.2 Overview of relevant NICE (National Institute for Health and Care Excellence) Guidelines:

The National Institute for Health and Care Excellence (NICE), established in 1999 is funded by the United Kingdom, Government Department of Health and Social care. NICE gathers independent committees to assess evidence, informing the publication of clinical guidelines and quality standards which aim to provide practitioners and commissioners with the guidance necessary to "get the best care to patient, fast, while ensuring value for the taxpayer" (NICE, 2023). NICE guidelines and quality standards cover a range of clinical areas from the management of particular medical conditions to the selection of evidence-based interventions while ensuring that patients have access to the most clinically and cost-effective treatments available (NICE, 2023).

The researcher has undertaken a review of the relevant guidelines published by NICE and has summarised the standards that are applicable to Art Psychotherapy with the perinatal patient group as follows:

Table 2: Overview of relevant NICE guidelines

Guideline	Subsection	Relevant guidance
Antenatal and postnatal mental health: clinical management and service guidance Clinical guideline [CG192] Published: 17 December 2014 Last updated: 11 February 2020	1.7 Providing interventions in pregnancy and the postnatal period	1.7.2 All interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions practitioners should: • receive regular high-quality supervision • use routine outcome measures and ensure that the woman is involved in reviewing the efficacy of the treatment. • engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate. [2014]
	1.8 Treating specific mental health problems in pregnancy and the postnatal period	1.8.3 Interventions for depression: For a woman with moderate or severe depression in pregnancy or the postnatal period, consider the following options: • a high-intensity psychological intervention defined as: A formal psychological intervention usually delivered face to face (either in a group or individually) by a qualified therapist who has specific training in the delivery of the intervention. [2014]

		1.8.9 Interventions for anxiety disorders: For a woman with an anxiety disorder in pregnancy or the postnatal period, offer a low-intensity psychological intervention (for example, facilitated self-help) or a high-intensity psychological intervention (for example, CBT) as initial treatment in line with the recommendations set out in the NICE guideline for the specific mental health problem and be aware that: • only high-intensity psychological interventions are recommended for post-traumatic stress disorder • high-intensity psychological interventions are recommended for the initial treatment of social anxiety disorder • progress should be closely monitored and a high-intensity psychological intervention offered within 2 weeks if symptoms have not improved. [2014]
		1.8.18 Interventions for severe mental illness: Consider psychological interventions (CBT or family intervention) delivered as described in the section on how to deliver psychological interventions in the NICE guideline on psychosis and schizophrenia in adults, for a woman with psychosis or schizophrenia who becomes pregnant and is at risk of relapse arising from: • stress associated with pregnancy or the postnatal period • a change in medication, including stopping antipsychotic medication. [2014]
	1.10 The organisation of services	1.10.5 Specialist perinatal inpatient services should: • have available the full range of therapeutic services [2007]
Psychosis and schizophrenia in adults: prevention and management. Clinical guideline [CG178] Published: 12 February 2014 Last updated: 01 March 2014	1.4.4 Psychological and psychosocial interventions	1.4.4.3 Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings. [2009]
		1.4.4.4 Arts therapies should be provided by a Health and Care Professions Council registered arts therapist with previous experience of working with people with psychosis or schizophrenia. The intervention should be provided in groups unless difficulties with acceptability and access and engagement indicate otherwise. Arts therapies should combine psychotherapeutic techniques with activity aimed at promoting creative expression, which is often unstructured and led by the service user. Aims of arts therapies should include: • enabling people with psychosis or schizophrenia to experience themselves differently and to develop new ways of relating to others. • helping people to express themselves and to organise their experience into a satisfying aesthetic form helping people to accept and understand feelings that may have emerged during the creative process (including, in some cases, how they came to have these feelings) at a pace suited to the person. [2009]

		1.4.4.5 When psychological treatments, including arts therapies, are started in the acute phase (including in inpatient settings), the full course should be continued after discharge without unnecessary interruption. [2009]
		1.4.4.6 Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with psychosis or schizophrenia. However, take service user preferences into account, especially if other more efficacious psychological treatments, such as CBT, family intervention and arts therapies, are not available locally. [2009]
	1.5 Promoting recovery and possible future care	1.5.1.1 Continue treatment and care in early intervention in psychosis services or refer the person to a specialist integrated community-based team. This team should offer the full range of psychological, pharmacological, social and occupational interventions recommended in this guideline [2014]
		1.5.4.4 Psychological interventions: • Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms. [2009]

Table 2 demonstrates that NICE clinical guidance regarding the antenatal and postnatal mental health patient group (2020) specifies that a range of therapeutic interventions should be available to patients, with all interventions delivered in accordance with each practitioners governing body code of conduct, ensuring regular supervision and employing outcome and efficacy measures. Additionally, the guidance states that high-intensity psychological interventions (delivered by a qualified therapist as a long-term intervention) are preferable for treatment of depression, anxiety or post-traumatic stress disorder. Therefore, when acting in accordance with the Health and Care Professions Council (HCPC) standard of proficiency for Arts Therapists (2023), Art Therapy interventions of between 6 and 20 sessions in length with this patient group would meet the NICE (2020) guidelines for a high-intensity intervention for the treatment of anxiety and depression within the antenatal and postnatal mental health patient group.

NICE issued guidance regarding the prevention and management of psychosis and schizophrenia in adults (2014); this can be considered to be relevant to the perinatal mental health patient group due to there being a 21.6% incidence of admissions to the inpatient Perinatal Mental Health unit, host site in 2019 (data provided by Head of Performance within the Trust, 2019) in which the patient was diagnosed with puerperal psychosis, mania with psychotic symptoms and acute or transient psychotic disorders. NICE state that inpatient settings should consider offering arts therapies interventions

to all people with psychosis, particularly in patients with negative symptoms, with the aims of the therapy being to facilitate the patient in experiencing “themselves differently and to develop new ways of relating to others… accept and understand feelings that may have emerged during the creative process” (NICE, 2014). The guidelines also indicate that the arts therapist should be registered with the HCPC and have previous experience of working with patients with a diagnosis of psychosis.

In summary, the 2014 NICE guidelines related to psychosis in adults makes a recommendation for the inclusion of an arts therapies intervention for the patient group, the term “arts therapies” being inclusive of all creative modalities within psychotherapy including art, drama or music. However, it is apparent that this recommendation is not mirrored within the most recent NICE clinical guidance for antenatal and postnatal mental health clinical management and service guidance (2020), therefore perhaps leaving commissioners and practitioners with scope for uncertainty around the provision of this intervention for the patient group.

2.6 Research Background

2.6.1 Research Rationale

After qualifying as an Art Psychotherapist in 2012, the researcher worked with children and young people in a variety of settings such as the McGuinness Unit, an acute inpatient adolescent psychiatric service, Queen Elizabeth Hospital Teenage Cancer Trust and a range of schools and pupil referral units. An interest in the field of Perinatal Mental Health and Birth Trauma developed alongside the growth of the researchers own personal family unit.

The opportunity arose to examine the efficacy of an Art Psychotherapy intervention in the field of Perinatal Mental Health via PhD research with the University of Derby, this aligned with the researchers aim to identify and broaden the evidence base for the intervention with this patient group. In questioning the existing evidence base, the researcher intended to design their own research intervention, gather data and make recommendations. Thus, informing commissioning bodies of the existing and emerging evidence base, with the intention of enabling them to commission Art Psychotherapy

interventions for availability to a greater number of Perinatal Mental Health service users within the NHS.

Existing literature in the field of Art Therapy and Perinatal Mental Health shows that evidence does exist to indicate the effectiveness of psychotherapeutic interventions within perinatal care, however the evidence is found only within the low levels of the hierarchy of evidence due to the study design, limited numbers of participants or the sole use of qualitative approaches to analysis. As a result, bodies such as the National Institute for Health and Care Excellence (NICE) have been unable to base their recommendations for treatment solely upon it.

The need for a hierarchy of evidence is explained by Orthop (2007) who identifies that when examining a range of evidential literature, the multiple sources of evidence can be integrated by determining the level of evidence quality from low to high. The determination of position within the hierarchy of evidence is based on a number of factors such as study design, a case report approach being low level and a randomised control trial being allocated to the higher level of the hierarchy of evidence Orthop (2007). This demonstrates the importance of the aim of this PhD study being to achieve a collection of high-quality quantitative data, complimented by the addition of qualitative outcome measures, in order to capture both the numerical outcomes of medical changes in participants and the creative and descriptive experience of Art Therapy.

By aiming to produce stringent evidence for the use of Art Therapy with this client group, future service users may benefit from access to Art Therapy interventions as they begin to be commissioned with wider availability. Research participants will benefit from being given the opportunity to access Art Psychotherapy in addition to the standard unit care plan. Through the process of engaging in the research, participants will have their therapeutic experiences honoured by capturing and presenting their “voices” as service users anonymously and respectfully within the research via the end of therapy interview. Additionally, the profession of Art Psychotherapy will benefit by being able to present quality evidence demonstrating that the professional skill set is applicable and beneficial within the field of perinatal health.

2.6.2 Context of existing literature / research

Research within the field of Art Psychotherapy interventions with a perinatal mental health patient group has been conducted and published, however themes within the literature suggest that the research has been hindered by several significant factors. In summarising the existing research, this section of the thesis will explore the emerging themes of challenges faced by researchers in the field. Literature included in this chapter is considered to be relevant to the professional context of the research however, the papers were not eligible for inclusion in the systematic review due to the stringent inclusion and exclusion criteria. It is the specific intention of this section of the thesis to briefly explore literature presenting observations of research challenges faced by the Art Therapy profession, when seeking to evidence Art Therapy interventions within perinatal mental health.

2.6.3 Qualified Art Psychotherapists

Within the research report for The Birth Project, Hogan (2018) summarised that the project which worked with groups of mothers, midwives and a birth worker showed “overall improvement in self-reported wellbeing measures with a significant increase in the overall scores for both of the arts interventions with the mothers (37%). This is such a substantial improvement that we believe it will have long-term consequences for both the mothers and for their infant’s development.” (Hogan, 2018, p. 3). The Birth Project was undertaken via four group facilitators from backgrounds within the arts, two of whom were practicing Art Psychotherapy with group participants. The project served to provide an insight into the birth process and transition into motherhood from the perspective of mothers, fathers and birth professionals. The work has produced observations and data which has been presented via a wide range of artistic and academic mediums. It is evident within the report that The Birth Project (Hogan, 2018) has shown improvements in self-reported wellbeing, however there are limitations to the outcomes and implications of this research project for the patient group and Art Therapy profession since the intervention was not conducted solely by qualified Art Psychotherapists whose practice is regulated and held to account by governing

bodies. Instead, this finding highlights the benefits of a far broader intervention; that of arts interventions delivered by group facilitators.

Dreamtime Arts (2022) conducted three studies, investigating the impact of arts-based activities (not undertaken by Arts Therapists) within groups of perinatal mental health patients. The data gathered was included in the All-Parliamentary Group on Arts, Health and Wellbeing, Inquiry Report (Marmot Review 2017) report which stated that local authorities must consider communicating the observed “health and wellbeing benefits of arts participation” to professionals within Perinatal services. The aim of this dissemination of the observations being to convey the perceived meaningfulness of the activities to the service user and the appropriateness of the intervention within the setting, to encourage provision of arts participation within all local authorities. However, similarly to the case of The Birth Project (Hogan, 2018), the Dreamtime Arts (2022) studies can have limited impact within the quest to secure an evidence base for presentation to commissioners due to the activities being delivered by group facilitators rather than Art Psychotherapists.

2.6.4 Research Design

Following the facilitation of a small non-directive art therapy group for parents and their children, Hosea (2006), determined that art therapy brought individuals physically closer while fostering attunement and emotional connection, demonstrating the impact of the intervention on wider wellbeing. Hosea (2006) observed that the art therapist's ability to provide containment was vital in avoiding overwhelming responses to the artwork; this draws upon the feasibility and appropriateness of the intervention in this setting and provides an example of the importance of establishing any Art Therapy intervention with the use of strong professional boundaries in order to keep the patient group safe. Hosea (2006) employed the approach of using video recordings of parent infant interactions which Hosea then reflected upon to draw themes from the work. This qualitative analysis approach allowed parents to engage in a reflective opportunity of their own, however this approach to analysis and recording of any post-therapy outcome would be found within the lower levels of the hierarchy of evidence due to the subjective nature and purely qualitative technique.

Similarly, Coates et al. (2015) conducted a qualitative study of new mothers' need for support during the postnatal period. The in-depth interviews conducted showed that participants were asking for support to be normalised and made available universally. The work also identified that current classifications of Post Natal Depression "may not adequately address the range or combination of emotional distress experienced by mothers" (Coates et al. 2015, p.121). However, the purely qualitative approach to evidence gathering within this study may serve to limit the impact of the study findings.

2.6.5 Participant numbers

Ponteri (2001), undertook an eight-week directive art therapy group, focussed upon the quality of mother infant interaction, maternal image and self-esteem with depressed mothers and their children. Ponteri (2001) found that the intervention produced benefits in wellbeing, improved self-esteem and lasting improvements in mother-infant interactions. Therefore, this study demonstrates positive impacts within the wellbeing of the patient group and the capturing of the participant experience feeds into the evaluation of the meaningfulness of this intervention for the patients within this setting. The notable limitations of the Ponteri (2001) study are that it was a brief intervention with a small client group (four participants), during which no measurements were taken regarding levels of depression or other influencing mental health factors. The absence of psychological pre- and post- measures taken and the limited number of participants within the study indicate that the data gathered would be deemed to be at a low level within the hierarchy of evidence.

2.6.6 Standardisation of the intervention

Fancourt (2019) undertook a scoping review of evidence for the role of the arts in improving health and wellbeing for the World Health Organisation (WHO) and found that the growing evidence should be acknowledged by "supporting research in the arts and health, particularly focussing on policy-relevant areas such as… studies that explore the feasibility, acceptability and suitability of new arts interventions." (WHO:

Fancourt & Finn, 2019, p.8). While working to create an evidence base for the intervention of Art Therapy, several researchers have set out to standardise the intervention approach.

Havsteen-Franklin (2016) undertook a study entitled The Horizons Project, examining the practice of six Arts Psychotherapists (all modalities) working with severe mental health inpatient and community services in London, not limited to perinatal mental health patients. The study aimed to explore the common elements between the practice of arts psychotherapies and other interventions with pre-existing evidence to establish evidence for and a discussion around the efficacy of arts psychotherapies. However, the initial observations of the study echoed Patterson et al. (2011) who proposed that that arts psychotherapies practitioners had not reached a generalised approach to practice or alignment with theory, therefore Havsteen-Franklin (2016, p51) stated that it was not possible to reach a "consensus about why arts psychotherapies are effective". The Horizons Project therefore focussed upon categorising therapists' actions which were found across all arts psychotherapies modalities and subsequently concluded that there is a close correlation between approaches to arts psychotherapy interventions and that of evidence-based practice interventions such as mentalisation-based therapies. This highlighted an opportunity for arts psychotherapies practice approaches to inform other practices which rely predominantly upon verbal dialogue, by transferring arts psychotherapists expertise in working with a patient to enable them to express themselves via creative means, therefore opening the possibility of a verbal exchange following a period of regulation (Havsteen-Franklin, 2016).

In line with Havsteen-Franklin (2016) findings, de Witte et al. (2021) noted that models of therapeutic factors exist for the majority of Creative Arts Therapies, therefore this can be considered to be a starting point for standardising research of the impact of each intervention. Within the field of Art Psychotherapy, Czamanski-Cohen (2016, p.1) proposes a Bodymind Model as a means of providing a framework to support research which aims to "test the key theoretical mechanisms through which art therapy benefits clients", the model considers several mechanisms such as tactile engagement, levels of emotional awareness, acceptance of emotion and reflective stance. However, Czamanski-Cohen (2016) simultaneously acknowledges that the Bodymind Model is

unable to capture all mechanisms of Art Therapy therefore it is to be considered a “work in progress” prompting further research to test the mechanisms proposed. Further to the RCPsych College Centre for Quality Improvement: CQCI making a formal recommendation that Art Therapy is made available within services for perinatal families, The Royal College of Psychiatrists (RS Psych) Perinatal Quality Network instructed an evaluation of an art therapy service within an outpatient perinatal mental health facility (Bruce 2021). With the use of questionnaires, Bruce (2021) was able to collate the views and experiences of nine mothers who were experiencing mental health issues and engaged with the art therapy service with their babies; 4/8 patients indicated it to be “very true” that “art therapy provides... me with an alternative way of communicating” while 6/8 patients marked “very true” against the statement that “art therapy is helping... me to understand myself and my problems better”.

Bruce (2021, p.111) summarised that the results of the study indicated that mothers who engaged with art therapy provision experienced the intervention as helpful and attributed positive outcomes relating to perinatal mental health; however, it was also proposed that further research is required in order to better understand the "mechanisms of change and to test the clinical effectiveness” of the intervention. As Bruce (2021) identifies, the current clinical climate and expectations of commissioners requires that interventions demonstrate an ability to align with the JBI Model of Evidence-based Healthcare (JBI, 2016), addressing the feasibility, appropriateness, meaningfulness and effectiveness. Similarly, Hogan et al. (2017, p.175) undertook a literature review of Art Therapy provision within antenatal and postnatal care which highlighted the “small evidence base emerging” which suggests that there are benefits of Art Therapy engagement during this perinatal period, however further research is required including rich qualitative data with a focus upon patient experience and cost effectiveness in order to feed into the sense of the meaningfulness and feasibility of the intervention.

Crane et al. (2021) conducted an integrative review of research in the field of art-based interventions with women during pregnancy; six studies with a total of 195 participants met the particularly stringent inclusion criteria and limited range of keywords, a thematic analysis of which determined three key impacts of the interventions: “art-based engagements supported women to express complex emotion, fostered a sense

of connection and strengthened personal resourcefulness" (Crane et al. 2021, p.325). The review focuses upon the specific 9-month period of pregnancy rather than the full perinatal term and states inclusion criteria of "women with an uncomplicated pregnancy" undergoing an intervention of either an "art therapy program facilitated by art therapists or an art-based intervention facilitated by allied health (…) professionals" (Crane et al. 2021). Following analysis of resulting literature, Crane et al. (2021) suggested "…that facilitated art-based programs are valuable for pregnant women. Art-based experiences offer women a unique opportunity to explore the full dimensionality of the transition to motherhood which can contribute to improved health and wellbeing. These findings suggest that art-based programs may serve to complement existing antenatal care models." (Crane et al. 2021, p. 325.)
This indicates that the art-based interventions have demonstrated feasibility within the setting defined as "public health" alongside the observation that such interventions have been considered appropriate in prompting "the release of deep and complex emotion (…) made more accessible through creative expression" (Crane et al. 2021). As Crane et al. (2021) note, the transition to motherhood often involves significant upheaval alongside a range of personal and social challenges, therefore indicating that the meaningfulness of a chosen intervention can be considered to be a vital element in connecting with this client group; "care that recognises the importance of psychosocial experiences may offer more effective support for childbearing women". When considering the clinical effectiveness of art-based interventions within the research, Crane et al. (2021) conclude that such programs lead to an improvement in factors such as self-expression, "attachment quality between infant and parent" and a decrease in "distress associated with postnatal mental health conditions". The Crane et al. (2021) review presents positive emergent findings yet also acknowledges that research and literature should be subject to further review in order to solidify findings around whether art-based programmes positively impact the client group; specifically focusing upon the recommendation to create consistency in understanding the intervention with the use of an "art therapy protocol" and the use of "mixed-method data collection".

2.7 Conclusion

> *"There is a very small body of literature addressing the use of the arts or art therapy in postnatal care, and much of it is qualitative, including some rich and complex data which are worthy of discussion and consideration. Overall, it points to a promising use of supportive and therapeutic arts in this area." (Hogan, 2017, p. 169)*

As Hogan (2017) summarises, within the existing literature in the field of Art Therapy and Perinatal Mental Health, evidence does exist to indicate the potential feasibility, appropriateness, meaningfulness and clinical effectiveness of psychotherapeutic interventions within perinatal care, however the evidence is problematic due to obstacles in clearly defining the intervention approach, the study design (limited numbers of participants) or the sole use of qualitative approaches to analysis (data which is descriptive and conceptual). As a result, bodies such as the National Institute for Health and Care Excellence (NICE) appear to have been unable to base clinical guidance for treatment solely upon the existing evidence.

In conclusion, the overview of existing research in the field suggests that the profession of Art Therapy is somewhat lagging in the production of methodically conducted research and quality evidence for the use of the intervention with the perinatal mental health patient group. It is possible that this can be attributed to the challenge of capturing the qualitative nature of the experience and the impact upon Art Therapists and intervention designs of using the rigorous quantitative research methods that are more widely employed within health and social care research.

This demonstrates the importance of the intention of this research to address the topic via a synthesis of quantitative and qualitative methods, in order to assess the feasibility and appropriateness of the intervention while capturing the influence of both the numerical outcomes of changes in mental health and wellbeing of participants demonstrating clinical effectiveness and the meaningfulness conveyed via the relaying of the creative and descriptive experience of Art Therapy. Additionally, the existing research indicates that data collection and comparison of intervention experiences and

outcomes may be aided by standardising the design and delivery of Art Psychotherapy interventions.

Additionally, the researcher has drawn from the aforementioned context to the research and sought to address the gaps identified by attempting to ensure that the research intervention was conducted by a qualified Art Psychotherapist (the researcher), employing validated pre- and post- measures of intervention outcome and by seeking to engage an adequate number of participants, allowing statistical significance to be achieved within the data analysis. The influence of the setting on the work was also a factor for consideration during data analysis, as the aforementioned studies were undertaken within informal community settings rather than an inpatient, NHS unit. In comparison, the research was pinned to the Art Therapy approach with emphasis on tightly controlled quantitative and qualitative data gathering techniques and approaches to measuring outcomes. The researcher's experience as an Art Psychotherapist acted as a supportive measure in establishing this as the researcher has prior experience of designing and delivering interventions within NHS settings.

2.8 Chapter summary

This chapter has provided an exploration of the personal and wider professional contexts for the research. Additionally, the development of relevant clinical guidelines has been examined and gaps within the research have been identified via existing literature. This preliminary investigation of the literature is furthered in a structured manner within the following systematic review chapter.

3 Systematic Review

3.1 Chapter overview

The clinical, academic and professional context of the research was provided in the previous chapter. Further to this, the following systematic review seeks to identify and explore the quality of research within the field of Art Psychotherapy in Perinatal Mental Health. Searches are undertaken, qualitative and quantitative data is analysed and themes are identified within the resulting literature, in a bid to examine the experiences

of both patients and clinical teams and determine the feasibility, appropriateness, meaningfulness and clinical effectiveness of the intervention.

3.2 Introduction

The therapeutic intervention of Art Therapy is used by qualified Art Psychotherapists to work with patients in Perinatal Mental Health settings, in order to work with factors such as mental wellbeing and bonding with the infant. The purpose of this systematic review is to review reports of interventions of this nature and to examine research that has been published in this field between the time period of 2000 – 2022. The systematic review considers the methodology, the specificities of the population under study and the setting in which the intervention took place by extracting information from included reports using the Template for Intervention Description and Replication (TIDieR, Hoffmann et al. 2014) data extraction tool followed by an assessment of the design and delivery of the intervention with the use of an Intervention Assessment Tool (IAT) designed by the researcher. Additionally, the review analyses the reliability and quality of research findings included and reported within literature with the use of a Mixed Methods Assessment Tool (MMAT, 2018). This systematic review was registered in advance of completion with Prospero under registration number CRD42022151947 on 12th July 2022.

A qualitative thematic synthesis of included reports is undertaken followed by a narrative summary of quantitative data, observations then undergo a secondary mixed method synthesis via configuration of findings before a sensitivity analysis is conducted to provide transparency and demonstrate the weight of conclusions drawn. Finally, gaps are identified within the existing research and evidence base for the intervention, alongside recommendations for future research in the field of Art Psychotherapy with the perinatal mental health patient group.

3.1 Background

The perinatal period is widely understood to be a time of intense transition; Dennis et al. (2017) conducted a systematic review of studies of over 200,000 women across 34 countries and determined that up to 20% of women experience clinically significant

mental health impairment such as stress, anxiety, depression or psychosis during the perinatal phase.

As a result of the positive impact of arts based activities (not undertaken by Arts Therapists) within groups of perinatal mental health patients across three studies conducted by Dreamtime Arts (2022), the All Parliamentary Group on Arts, Health and Wellbeing, Inquiry Report (Marmot Review 2017) report stated that local authorities must consider communicating the observed “health and wellbeing benefits of arts participation” to professionals within Perinatal services, in order to convey the perceived meaningfulness of the activities to the service user and the appropriateness of the intervention within the setting to encourage provision of Arts participation within all local authorities.

In support of the FAME scale (JBI, 2016), Fancourt (2019) undertook a scoping review of evidence for the role of the arts in improving health and wellbeing for the World Health Organisation (WHO) and found that the growing evidence should be acknowledged by:

> *“Supporting research in the arts and health, particularly focussing on policy-relevant areas such as… studies that explore the feasibility, acceptability and suitability of new arts interventions.” (WHO: Fancourt & Finn, 2019, p.8)*

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The Horizons Project therefore focussed upon categorising therapists' actions and subsequently concluded that there is a close correlation between approaches to arts psychotherapy interventions and that of evidence-based practice interventions such as mentalisation-based therapies. This highlighted an opportunity for arts psychotherapies practice approaches to inform other practices which rely predominantly upon verbal dialogue, by transferring arts psychotherapists expertise in working with a patient to enable them to express themselves via creative means, therefore opening up the possibility of a verbal exchange following a period of regulation (Havsteen-Franklin, 2016).

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Further to the Royal College of Psychiatrists, College Centre for Quality Improvement: CQCI making a formal recommendation that Art Therapy is made available within services for perinatal families (RCP, 2018), The Royal College of Psychiatrists (RCPsych) Perinatal Quality Network instructed an evaluation of an art therapy service within an outpatient perinatal mental health facility (Bruce 2021). With the use of questionnaires, Bruce (2021) was able to collate the views and experiences of nine mothers who were experiencing mental health issues and engaged with the art therapy service with their babies; statements rated by patients as "very true" regarding their experience of art therapy included:

> *“Art therapy provides… me with an alternative way of communicating (4/8 patients rated as ‘very true’). Art therapy is helping… me to understand myself and my problems better (6/8 patients rated as ‘very true’).” (Bruce, 2021, p.118)*

Bruce (2021) summarised that the results of the study indicated that mothers who engaged with art therapy provision experienced the intervention as helpful and attributed positive outcomes relating to perinatal mental health; however, it was also proposed that further research is required in order to better understand the "mechanisms of change and to test the clinical effectiveness” of the intervention. As Bruce (2021) identifies, the current clinical climate and expectations of commissioners requires that interventions demonstrate an ability to align with the JBI Model of Evidence-based Healthcare (JBI, 2016), addressing the feasibility, appropriateness, meaningfulness and effectiveness. Similarly, Hogan et al. (2017) undertook a literature review of Art Therapy provision within antenatal and postnatal care which highlighted the “small evidence base emerging” which suggests that there are benefits of Art Therapy engagement during this perinatal period, however further research is required including rich qualitative data with a focus upon patient experience and cost effectiveness in order to feed into the sense of the meaningfulness and feasibility of the intervention.

Crane et al. (2021) conducted an integrative review of research in the field of art-based interventions with women during pregnancy; six studies with a total of 195 participants met the particularly stringent inclusion criteria and limited range of keywords, a thematic analysis of which determined three key impacts of the interventions: “art-based engagements supported women to express complex emotion, fostered a sense of connection and strengthened personal resourcefulness” (Crane et al. 2021, p.325). The review focuses upon the specific 9-month period of pregnancy rather than the full perinatal term and states inclusion criteria of “women with an uncomplicated pregnancy” undergoing an intervention of either an “art therapy program facilitated by art therapists, or an art-based intervention facilitated by allied health (…) professionals” (Crane et al. 2021). Following analysis of resulting literature, Crane et al. (2021) suggested;

> *"…that facilitated art-based programs are valuable for pregnant women. Art-based experiences offer women a unique opportunity to explore the full dimensionality of the transition to motherhood which can contribute to improved health and wellbeing. These findings suggest that art-based programs may serve to complement existing antenatal care models." (Crane et al. 2021, p.325)*

This indicates that the art-based interventions have demonstrated feasibility within the setting defined as "public health" alongside the observation that such interventions have been considered appropriate in prompting "the release of deep and complex emotion (…) made more accessible through creative expression" (Crane et al. 2021). As Crane et al. (2021) note, the transition to motherhood often involves significant upheaval alongside a range of personal and social challenges, therefore indicating that the meaningfulness of a chosen intervention can be considered to be a vital element in connecting with this client group; "care that recognises the importance of psychosocial experiences may offer more effective support for childbearing women". When considering the clinical effectiveness of art-based interventions within the research, Crane et al. (2021) conclude that such programs lead to an improvement in factors such as self-expression, "attachment quality between infant and parent" and a decrease in "distress associated with postnatal mental health conditions". The Crane et al. (2021) review presents positive emergent findings yet also acknowledges that research and literature should be subject to further review in order to solidify findings around whether art-based programmes positively impact the client group; specifically focusing upon the recommendation to create consistency in understanding the intervention with the use of an "art therapy protocol" and the use of "mixed-method data collection".

Ponteri (2001), undertook an eight-week directive art therapy group involving four mother and child pairs, focussing upon the quality of mother infant interaction, maternal image and self-esteem with depressed mothers and their children. Ponteri (2001) found that the intervention produced benefits in wellbeing, improved self-esteem and lasting improvements in mother-infant interactions. Therefore, this study

demonstrates positive impacts within the wellbeing of the patient group and the capturing of the participant experience feeds into the evaluation of the meaningfulness of this intervention for the patients within this setting. The limitations of the Ponteri (2001) study are that it was a brief intervention with a small client group, during which no measurements were taken regarding levels of depression or other influencing mental health factors.

Following the facilitation of a small non-directive art therapy group for parents and their children involving between 3 and 6 families per group, Hosea (2006), determined that art therapy brought individuals physically closer while fostering attunement and emotional connection, demonstrating the impact of the intervention on wider wellbeing. Hosea (2006) observed that the art therapist's ability to provide containment was vital in avoiding overwhelming responses to the artwork; this draws upon the feasibility and appropriateness of the intervention in this setting and provides an example of the importance of establishing any Art Therapy intervention with the use of strong professional boundaries in order to keep the patient group safe. The work of Hosea (2006) appears lacking in the employment of credible outcome measures and doesn't appear to consider the influence of parents as both male and female entities upon the group work.

In summary of the existing literature in the field of Art Therapy and Perinatal Mental Health, evidence does exist to indicate the potential feasibility, appropriateness, meaningfulness and clinical effectiveness of psychotherapeutic interventions within perinatal care, however the evidence is found predominantly within the low levels of the hierarchy of evidence due to obstacles when clearly defining the intervention approach, the study design (limited numbers of participants) or the sole use of qualitative approaches to analysis (data which is descriptive and conceptual). As a result, bodies such as the National Institute for Health and Care Excellence (NICE) have been unable to base their recommendations for treatment solely upon it.

This demonstrates the importance of the aim of this review to address the topic via a synthesis of high quality quantitative and qualitative studies, in order to assess the feasibility and appropriateness of the intervention while capturing the influence of both the numerical outcomes of changes in mental health and wellbeing of participants

demonstrating clinical effectiveness and the meaningfulness conveyed via the relaying of the creative and descriptive experience of Art Therapy.

3.2 Objective

The objective of this systematic review was to evaluate existing research and evidence in order to determine the feasibility, appropriateness, meaningfulness and clinical effectiveness of Art Psychotherapy interventions when utilised with perinatal mental health patients. The systematic review employed a Mixed Methods Review approach in order to allow the synthesis of qualitative and quantitative data. Therefore, focussing upon capturing qualitative creative aspects of the intervention alongside the experiences of the patient and clinical team, supported by quantitative data, demonstrating any impact / lack of impact of the intervention upon the client group.

The systematic review addresses the following questions within the context of patient / clinical team experience and changes observed in patient mental health and wellbeing:

- Is Art Psychotherapy a feasible intervention with perinatal mental health patient group?
- Is Art Psychotherapy an appropriate intervention for use with perinatal mental health patients?
- Is Art Psychotherapy a meaningful intervention to perinatal mental health patients?
- Is Art Psychotherapy a clinically effective intervention with perinatal mental health patient group?

Art Psychotherapy can be classed as a complex intervention, requiring commissioners to synthesise a wide range of data in order to appropriately consider whether the intervention may offer benefit to a client group or patient setting; therefore, this Mixed Methods Systematic Review aims to aid the commissioning process by offering a comprehensive synthesis of available qualitative and quantitative data.

In evaluating Art Psychotherapy as an intervention with this patient group, this review employs the structure of the FAME scale as devised by the Joanna Brigg's Institute (JBI, 2016) in order to ensure that evidence review findings are of relevance to

clinicians and policymakers. The JBI Model of Evidence-based Healthcare aims to ensure that clinical decision makers have access to globally disseminated, quality evidence about an intervention, concerning four key elements which allow influence from research outcomes and clinician experiences alongside the voices and experiences of service users.

Pearson, et al. (2005) offer definitions of feasibility, appropriateness, meaningfulness and effectiveness, summarised as follows; feasibility considers whether or not an activity or intervention is physically, culturally or financially practical or possible within a given clinical context. Appropriateness is the extent to which an intervention fits with or is apt in a setting, in addition taking into account the way in which the intervention relates to the context of the wider clinical care team provision. Meaningfulness is defined by the way in which an intervention is experienced by the patient, relating to the “personal experience, opinions, values, thoughts, beliefs and interpretations of patients or clients.” (Pearson, et al. 2005, p. 210) Effectiveness addresses whether an intervention achieves the intended effect and what relationship exists between the intervention and clinical or health outcomes (Pearson, et al. 2005).

Where available within the selected studies, the aforementioned FAME scale approach to evaluation of Art Psychotherapy interventions in this setting was employed to examine a range of qualitative and quantitative data. This included qualitative approaches to recording patient and clinician experiences and quantitative data such as intervention uptake, attrition rates and outcome measures addressing changes in the area of mental health and wellbeing.

3.3 Systematic Review Methodology

Studies selected for inclusion in the systematic review were required to meet the following eligibility criteria, structured within the PICOS framework:

3.3.1 Population

Women who have received a mental health diagnosis within the perinatal period. For the purposes of the review, the perinatal period shall be determined as being from conception to one year after birth. Exclusion criteria were not applied in relation to pre-existing conditions or particular diagnoses.

3.3.2 Intervention

Individual or group sessions of Art Psychotherapy delivered by a qualified Art Psychotherapist (refer to Methodology section for definition of eligible Art Psychotherapy interventions) in inpatient, outpatient or community settings. Privately funded, reimbursed via health insurance companies or provided via NHS. The discussion of the intervention is expended upon within section 3.1.1.

3.3.3 Comparator

All types of comparator groups were considered for inclusion; care as usual (within an NHS setting) or any alternative active interventions such as creative groups run by a lay person.

3.3.4 Outcomes

Primary Outcome: Examine available quantitative data reflecting the feasibility and appropriateness of the intervention within the patient group, such as intervention uptake or attrition rates. Determine the meaningfulness of the intervention via the analysis of qualitative approaches to recording patient and clinician experiences. Identify the clinical effectiveness of the intervention by analysing any changes in mental health, as recorded by qualitative and quantitative outcome measures.

Secondary Outcome: Identify any changes noted by patient via self-reporting method regarding wellbeing, confidence or bonding with child.

Tertiary Outcome: Identify any additional outcomes gathered via available qualitative and quantitative methods such as observations of patient interactions with art materials or unforeseen themes emerging within the included studies data sets.

3.3.5 Setting

All inpatient and outpatient settings dedicated to the perinatal period, e.g., inpatient perinatal mental health units or community teamwork.

3.3.6 Study

All study designs were eligible for inclusion, including but not limited to Randomised Control Trials, Experimental Trials, Case Studies, qualitative, quantitative and mixed methods studies. Only studies published in or after the year 2000 and up to the search date of September 2022, published in English were eligible for inclusion.

3.1 Search Strategy

Table 3: Search criteria

Inclusion:	Art Therapy, Art Psychotherapy, Inpatient, Outpatient, Group intervention, One to one intervention, NHS funded, privately funded, Perinatal client group
Exclusion:	Pre 2000 publication date, in any language other than English
Search Terms:	(“Mother*” or “Maternal” or “Perinatal Mental Health" or "Post Natal Depression" or “perinatal” or “Birth Trauma” or "Post-Partum Psychosis”) AND ("Art Therap" or "Art Therapy" or "Community Arts" or "Art Psychotherapy" or "Arts in Health" or “Arts-Based")
*NOT	“HIV” or “AIDS” or “Antiretroviral Therapy”

EMBASE, EBSCO Host (combining Cinahl, AMED, PsychInfo), Web of Science, Pubmed, ProQuest Central, NICE Evidence, Turning Research Into Practice (TRIP) and Scopus databases were searched using the above search terms, search operators, publication date criteria and language restriction (Table 3). Search operators were tailored to the requirements of each database and Rayyan was used for management of search records and results. Citation chaining was undertaken within all selected articles, searches were conducted within grey literature such as

government reports and Prospero, in addition a hand search was undertaken of relevant journals such as the International Journal of Art Therapy. Direct contact was made with authors in the event that literature of relevance was identified yet was unpublished in the public domain. Contact was made with colleagues in the field of Art Therapy and Perinatal Mental Health to enquire about their knowledge of any relevant unpublished studies. The Boolean Operator “NOT” was included due to the prevalence of articles about Antiretroviral Therapy (ART abbreviation) within scoping searches.

The screening process conducted by the lead reviewer (AS) involved the removal of duplicates, screening of titles and abstracts using the stated inclusion and exclusion criteria followed by a screening of the full text of remaining literature against the same criteria. A portion of screening at each stage was cross-checked by an additional member of the review team. Any results that did not clearly fall within the inclusion and exclusion criteria at either title and abstract or full text screening stages were cross-checked by a second member of the review team (NP) in order to ensure eligibility for inclusion or exclusion and to reduce bias during screening; any disagreements would have been resolved by involvement of a third member of the research team (JB or RS), however this step was not necessary in practice.

The searches, screening and selection process were recorded via PRISMA (2020) study flow diagram for transparency. This search strategy was devised in collaboration with a specialist librarian within Health, Psychology and Social Care at the University of Derby.

3.1.1 Art Psychotherapy Intervention

This review examines the intervention titled Art Psychotherapy to the exclusion of all other interventions. Art Therapist and Art Psychotherapist are legally protected titles within the United Kingdom, therefore any individual using these titles to describe themselves or the intervention being facilitated must be listed on the Health and Care Professions Council (HCPC) register.

All approaches to Art Therapy practice were eligible for inclusion in the review, as defined by the aforementioned British Association of Art Therapists definition (BAAT, 2014) and additionally by Joy Schaverien (2000):

‘Art Therapy’ concerns itself with the relationship between the image and the client while separately addressing the perceived relationship between the therapist and the image. ‘Art Psychotherapy’ focuses primarily on the therapeutic relationship between client and therapist. ‘Analytical Art Psychotherapy’ considers interactions between the trio of client, therapist and image to carry equal significance in the therapeutic process.

In response to the Czamanski-Cohen Bodymind Model of Art Therapy (2016) which focuses upon clinical mechanisms of the intervention, the reviewer devised an Art Therapy Intervention Assessment Tool which determines the delivery approach of an intervention and categorises it alongside basic pre-requisites for safe practice, in order to establish whether the intervention qualifies as an Art Therapy intervention (Table 4). The face validity of the Art Therapy Intervention Assessment Tool was reviewed by the supervisory team and by members of the Art Therapy profession. It was ascertained that by including a summary of the clinical mechanisms of the interventions detailed within the Czamanski-Cohen Bodymind Model of Art Therapy (2016), the Art Therapy Intervention Assessment Tool may be considered to be relevant to the profession and may therefore be adequate in providing opportunity for succinct summary and assessment of Art Therapy interventions. It is acknowledged that the determination of face validity offers a subjective approach to the assessment of validity, therefore it is proposed that future study is undertaken in order to determine the content validity of the Art Therapy Intervention Assessment Tool.

Every piece of literature describing an intervention was scored using the Intervention Assessment Tool with a maximum available total score of 30. Only those with a score of 15 or above were eligible for inclusion in the next round of screening. The lead reviewer assessed 20% of the included results using the Intervention Assessment Tool, the same 20% was then cross-checked by a second member of the review team (NP) and the agreement rate between the reviewers was calculated using inter-rater agreement, Cohen’s Kappa in order to ensure quality and eligibility of the intervention and to reduce bias. Any disagreements arising would have been resolved via

involvement of a third member of the research team (JB or RS) however this situation did not arise. The remaining 80% of included results was then assessed by the lead reviewer alone.

It is noted that a conflict of interest is present within the systematic review team; Amy Stanhope, Nicki Power and Jamie Bird are HCPC registered Art Therapists, however any influence of this conflict may be considered to be mitigated by measures taken to ensure reduction of bias such as the use of an inter-rater agreement.

Table 4: Art Therapy Intervention Assessment Tool

Paper title						
Art Psychotherapy Criteria	**Agree**	**Somewhat agree**	**Somewhat disagree**	**Disagree**	**Unclear / Unspecified**	**Notes**
Score	**3**	**2**	**1**	**0**	**0**	
Designed and delivered by a qualified / state registered Art Psychotherapist (e.g., HCPC / American Art Therapy Association), therefore assumed to hold professional insurance and undergo regular clinical supervision as per professional body regulations.						
Aims to facilitate self-awareness and meaning-making (Flanagan, 2004; Kalaf and Plante, 2019).						
Aims to facilitate non-verbal and verbal self-expression and reflection through the process of art making and artwork (Orkibi 2020).						
Takes place within the safety of a carefully established therapeutic environment.						
Boundaries are established, e.g., confidentiality and safeguarding.						
A clearly documented consent and assessment phase is undertaken.						
A therapeutic alliance is established between therapist and patient.						
A variety of structured and unstructured art materials are made available.						

Artwork created is stored securely and confidentially by the therapist until the end of the period of therapy.						
Therapist works in liaison with the wider care team around the patient.						
Total score						

3.1.2 Critical Appraisal

As this review includes both qualitative and quantitative or mixed methods studies, literature in which the intervention meets the Art Psychotherapy Intervention Assessment Tool criteria was then scored for quality using the Mixed Methods Appraisal Tool (MMAT, 2018) (see Appendix 9.16).

MMAT has been designed for use in appraising the quality of empirical studies within five categories of study design: qualitative, randomised control trial, nonrandomised, quantitative descriptive and mixed methods studies. Within each of the categories of study design, the methodological quality of the study is appraised against five core criteria using a scale of 'yes' (criterion is met), 'no' (criterion is not met) or 'can't tell' (insufficient information within the paper to judge whether criterion has been met) (Hong, 2018). The MMAT guidance suggests that it is inadequate to solely allocate a numerical score to each appraised paper, instead a combination of score and accompanying brief description / observation of any problematic sections of the paper is created and included or excluded from the review in accordance with the reviewers resulting perception of quality.

The selected literature was then cross-checked by a second member of the review team (NP) in order to ensure quality and eligibility and to reduce bias; any disagreements were resolved by involvement of a third member of the research team (JB or RS). Inter-rater reliability of the use of the MMAT was measured using Cohen's Kappa co-efficient statistics (Cohen, 1968).

The Mixed Methods Review approach was selected for the purpose of this review due to it facilitating the synthesis of both quantitative and qualitative data, allowing wider

observations to be drawn from the available data and eliminating the limitations of reliance upon a singular research method, therefore meeting the intended outcomes of this review. Harden (2010) observes the ability of a MMSR to combine the quantitative observations of an intervention's benefit or harm within a patient group, while also demonstrating the qualitative understanding of the impact upon patient's lives. Policy makers and practitioners turn to systematic reviews for a succinct overview of the data available in a specific field in order that it can inform their decision making and commissioning, however this becomes challenging if the individual is first required to digest each individual synthesis of qualitative and quantitative data in turn.

> *"Decision-makers who use systematic reviews increasingly argue for a more comprehensive synthesis of the evidence than that currently offered by single method reviews (Dixon-Woods et al., 2005, p.46)*

Dixon-Woods observes therefore that such professionals are increasingly turning to Mixed Methods Reviews in order to address this issue and to streamline the decision-making process while ensuring a thorough understanding of the wider real-life context of a research question via the use of multiple methods of analysis. This is particularly pertinent in the case of policy making around complex interventions such as Art Psychotherapy, which present a variety of data.

3.1.3 Data Extraction

Data was extracted from the selected studies in accordance with the elements stated within the Art Therapy Intervention TIDieR (Table 5), the Microsoft Excel extraction table template was compiled by the researcher, informed by the Template for Intervention Description and Replication (TIDieR) (Hoffmann et al. 2014).

The aim of the Template for Intervention Description and Replication (TIDieR) is to improve the reporting of interventions within trials and studies; for the purposes of this

review, TIDieR was employed in order to standardise the observations of a variety of intervention-based studies.

Table 5: Art Therapy Intervention TIDieR

Study	
Reference	
Intervention	
Name	
Delivery method (in person / group etc)	
Setting	
Quantity and duration	
Time span	
Aims / Outcomes examined	
Facilitator	
Who provided the intervention?	
What is known about their title / qualification?	
Training / approach	
Participant	
Inclusion criteria	
Exclusion criteria	
Demographic data, e.g., age, gender	
Diagnoses / Clinical Presentation	
Recruitment	
Method	
Consent process	
Participant journey	
Assignment / randomisation method	
Qualitative baseline measures (measure used and data provided)	
Qualitative outcome measures (measure used and data provided)	
Quantitative baseline measures (measure used and data provided)	
Quantitative outcome measures (measure used and data provided)	
Debrief / follow-up	

The lead reviewer (AS) extracted all relevant study data, 25% of the selected literature was then screened for extraction by a second member of the review team (NP) in order to ensure quality and eligibility and to reduce bias; should any disagreements have arisen, they would have been resolved by involvement of a third member of the research team (JB or RS).

3.1.4 Data Synthesis

The review adopts a Segregated approach to mixed-methods synthesis, in accordance with the method described by Sandelowski et al (2006) which maintains that there is a vital distinction between qualitative and quantitative research. Therefore, requiring primary synthesis of qualitative and quantitative data sets individually, followed by a secondary mixed-methods synthesis of the combined data (Figure 1). By pursuing a Segregated Methodology, the review aims to acknowledge the validity of quantitative approaches while also widening the synthesis to encompass the elements of a complex intervention such as Art Psychotherapy, which may only be captured via qualitative research. The phases of data synthesis are discussed within the following subsections.

3.1.5 Primary Synthesis of Qualitative Data

The primary synthesis of qualitative data within this review takes the form of thematic synthesis, conducted by the lead reviewer (AS). Coding of emergent themes within the included literature was undertaken in accordance with Boyatzis (1998) definition of the key elements of a theme, as such the reviewer sought to establish a label for the theme and present a discussion of what the theme relates to within the reports.

> *"… thematic synthesis emphasises the development of theory from a starting point of open questions and few secure initial concepts. It makes no inferential claims based on statistics, but aims to enlighten decision making through the creation of new theory." (Thomas, 2012, p.7)*

The aim of the thematic synthesis within this review was to firstly identify and code themes identified within reports, collate themes and draw observations about how they may relate to and influence one another followed by a final process of returning to the review questions to examine whether the themes can propose a response to the questions posed.

3.1.6 Primary Synthesis of Quantitative Data

This review approaches quantitative data via the analytic framework of statistical meta-analysis within a combined aggregative and configurative mode of synthesis. Aggregation of data ordinarily takes place when working with quantitative data by adding all data together in order to answer the review question, whereas a configurative approach to synthesis aims to address the review question by organising both qualitative and quantitative data alongside one another. Effect size can be defined as a result drawn from a study of intervention effect, for example what effect does an Art Psychotherapy intervention have upon the size and direction of a quantitative measure of wellbeing either pre- and post- or throughout the duration of the intervention. The aim being that the resulting statistics gathered during quantitative synthesis enables the reviewer to return to the review questions to propose answers as an indication as to the impact of the intervention upon perinatal mental health patients.

In the event of the systematic review predominantly gathering continuous outcome data for synthesis in the form of a variety of outcome measures (such as Recovering Quality of Life, ReQol, Keetharuth et al. 2018) representing a scale of wellbeing / quality of life before, after and during an Art Therapy intervention; when calculating effect sizes, the reviewer would have employed the Standardised Mean Difference approach to calculating effect sizes with the use of a Hedges G calculation. Synthesis of studies involving lower levels of heterogeneity would have been conducted via a Fixed Effect Model.

The quantitative data to be synthesised represented multiple effect sizes from multiple measures (e.g., wellbeing, engagement with baby, etc), therefore a Random Effect Model of synthesis was utilised to account for dependence between the outcomes.

3.1.7 Secondary Synthesis

The secondary synthesis shall take the form of a configuration, set of recommendations or narrative conclusions. As Sandelowski (2006) describes, a configuration of the findings is the means via which an argument or suggestions of

relationships between differing data elements are formed, rather than an assimilation whereby the differing data sets come together seamlessly to inform an outcome.

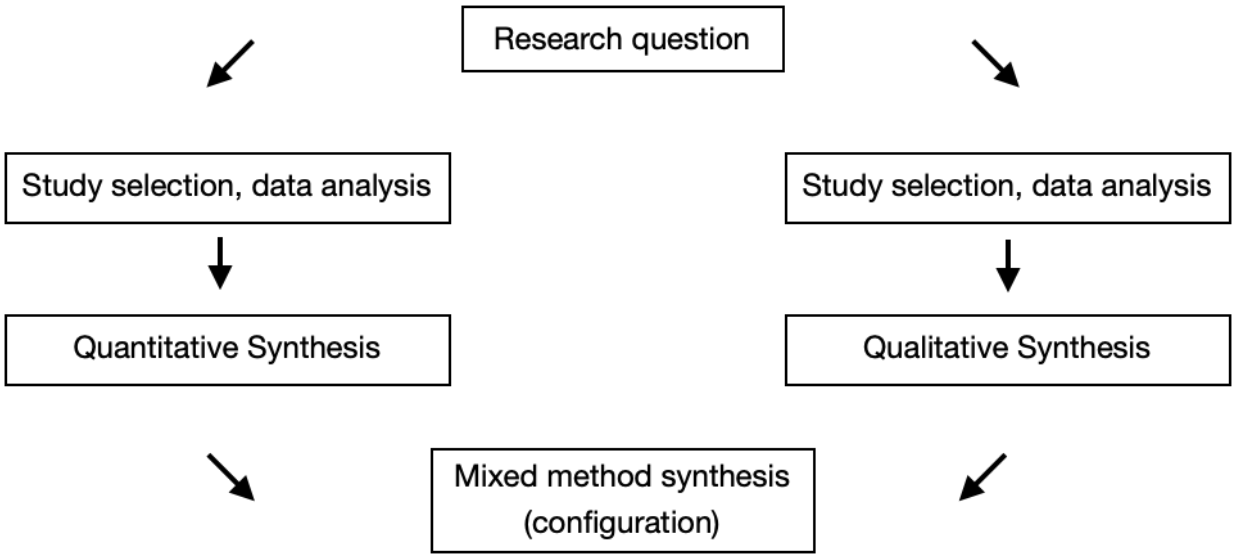


Figure 1: Segregated Methodology (JBI, 2014)

3.1.8 Sensitivity Analysis

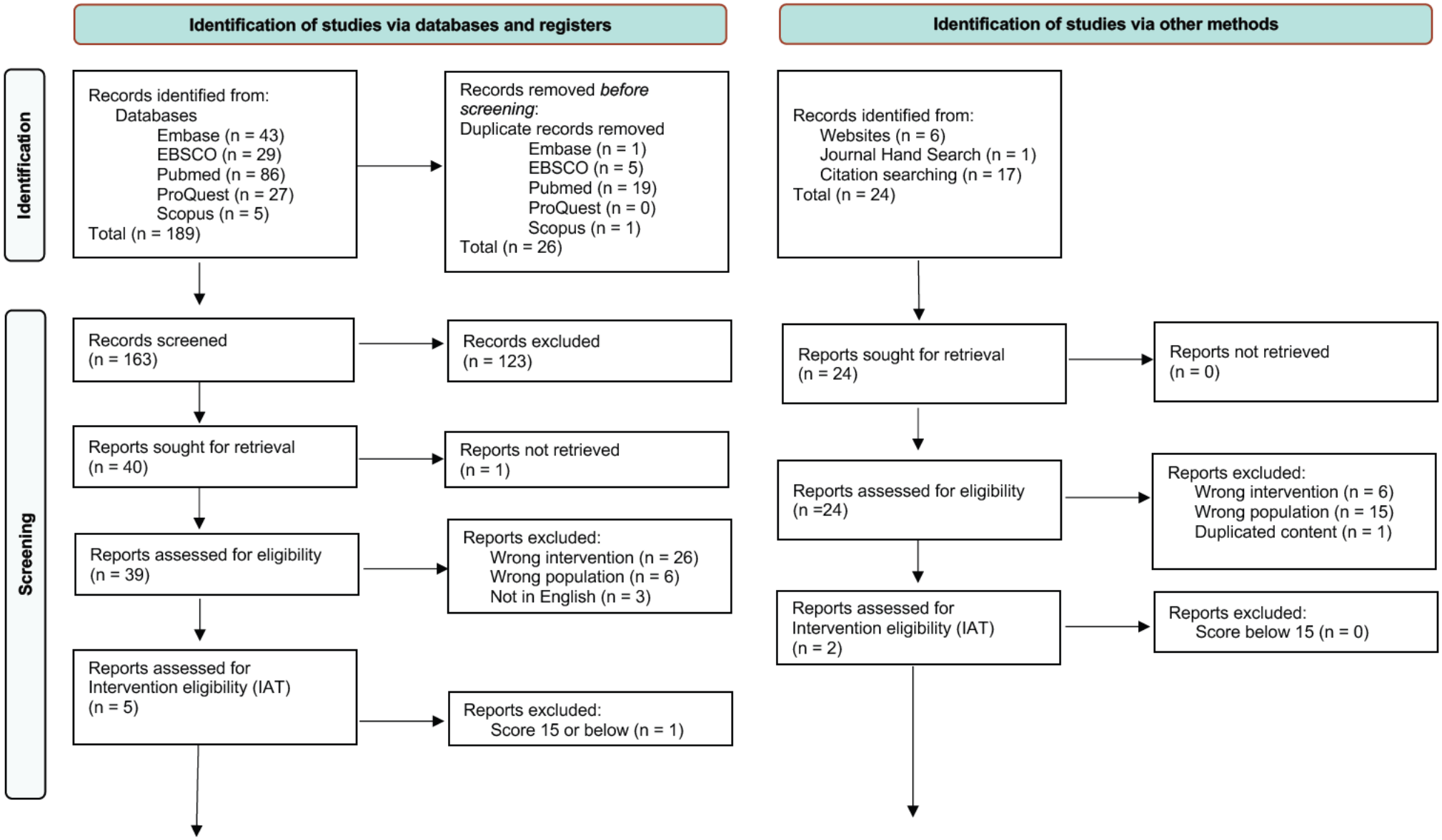
Thomas et. al. (2017) observe the importance of conducting a Sensitivity Analysis following data synthesis, therefore prior to drawing conclusions about the results of the synthesis of extracted data, the review process was checked for robustness via formal peer review among specialists within the field of Art Psychotherapy and systematic review conduct. This was aided by the compilation of a thematic codebook, detailing the themes which were drawn from each paper in order to demonstrate and critically consider whether themes were congruent across several papers or whether conclusions lean heavily on a limited number of papers.

The process of sensitivity analysis in line with the suggestion of Thomas et. al. (2017) critically reflects upon the review process and considers questions such as whether the translation of findings between studies has been consistent and coherent, the

weighting within the synthesis of the included studies in relation to their quality, how well the results answer the review questions and whether the results would vary in application to differing contexts.

3.2 Results

Figure 2 provides an overview of the systematic review search process. Initial searches returned 189 records, further searches of websites, hand searching of journals and citation chaining returned 24 additional articles, 26 duplicate records were removed. Screening of 163 abstracts resulted in the exclusion of 122 records. 65 reports were sought for retrieval with 1 report determined as being irretrievable, therefore full text screening was undertaken on 64 reports. During full text screening, 32 reports were excluded on the basis of their being related to the wrong intervention, 21 reports were excluded due to the discussion of the wrong population, 3 were excluded due to the original report not being written in English and 1 report was excluded on the grounds of it being duplicated content. 7 reports were eligible for assessment with the Intervention Assessment Tool (IAT), 1 report was ineligible due to being a literature review, 1 report was excluded at IAT assessment stage due to receiving a score of 15 or below. 5 reports were eligible for assessment with the Mixed Methods Assessment Tool (MMAT), 1 report was ineligible due to being a literature review. A final collection of 6 reports were included in the systematic review.


Identification of studies via databases and registers
Identification of studies via other methods
Identification
Screening
Records identified from:
Databases
Embase (n = 43)
EBSCO (n = 29)
Pubmed (n = 86)
ProQuest (n = 27)
Scopus (n = 5)
Total (n = 189)
Records removed *before screening*:
Duplicate records removed
Embase (n = 1)
EBSCO (n = 5)
Pubmed (n = 19)
ProQuest (n = 0)
Scopus (n = 1)
Total (n = 26)
Records identified from:
Websites (n = 6)
Journal Hand Search (n = 1)
Citation searching (n = 17)
Total (n = 24)
Records screened
(n = 163)
Records excluded
(n = 123)
Reports sought for retrieval
(n = 24)
Reports not retrieved
(n = 0)
Reports sought for retrieval
(n = 40)
Reports not retrieved
(n = 1)
Reports assessed for eligibility
(n =24)
Reports excluded:
Wrong intervention (n = 6)
Wrong population (n = 15)
Duplicated content (n = 1)
Reports assessed for eligibility
(n = 39)
Reports excluded:
Wrong intervention (n = 26)
Wrong population (n = 6)
Not in English (n = 3)
Reports assessed for
Intervention eligibility (IAT)
(n = 2)
Reports excluded:
Score below 15 (n = 0)
Reports assessed for
Intervention eligibility (IAT)
(n = 5)
Reports excluded:
Score 15 or below (n = 1)

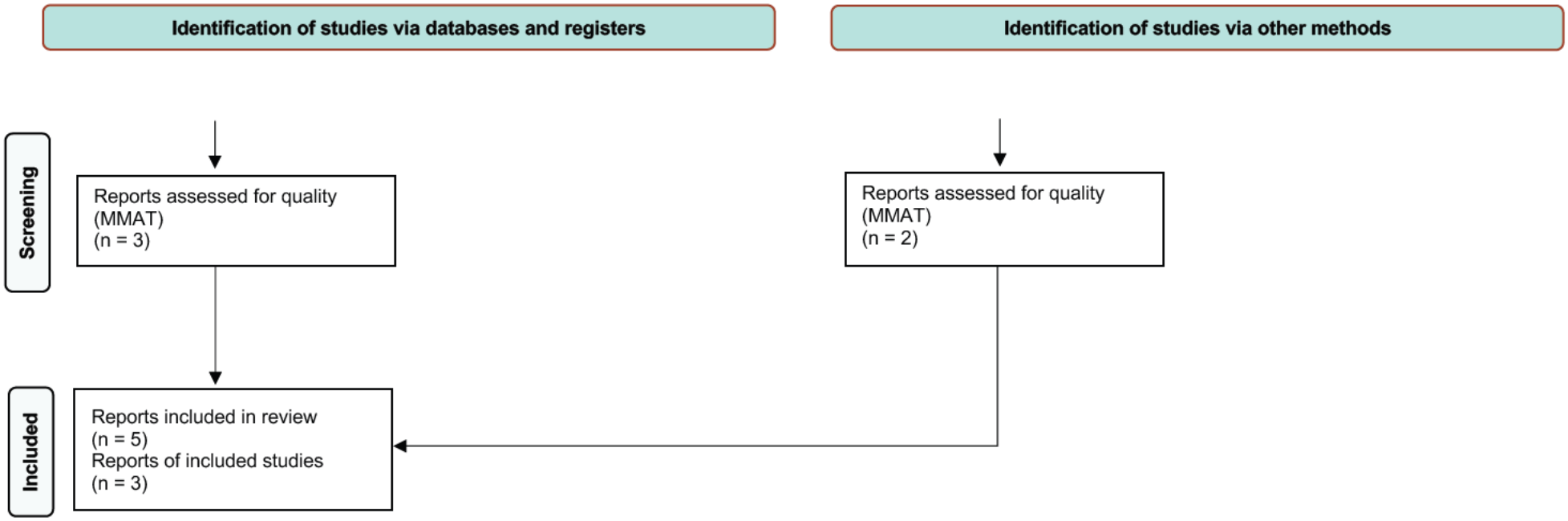


Figure 2: PRISMA flow diagram, (template attributed to Page et al., 2020)

3.2.1 Summary of reports

For the purpose of standardising the extraction of data from the studies included within the reports, the TIDieR template adapted by the researcher for the purpose of extracting data about Art Therapy interventions (further discussion in section 3.6.3), was completed for each report and is included within this summary section alongside the discussion of any additional relevant information. The first reviewer conducted a TIDieR extraction with all applicable reports, followed by an additional extraction of 25% of reports by the second reviewer; upon reflection, data extracted by both reviewers was found to be similar therefore demonstrating a consistent and transparent use of the TIDieR tool.

"Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention" Armstrong, Victoria Gray, and Rosie Howatson, (2015)

Armstrong & Howatson (2015) (Table 6) published an article in the Infant Mental Health Journal, discussing the effectiveness of an in-person Art Therapy group intervention for parent-infant dyads whom they deemed may have been experiencing possible postnatal depression or attachment difficulties. The article presents both quantitative and qualitative data gathered from the evaluation of two 12-week Art Therapy groups held in community spaces within the United Kingdom, delivered by an Art Psychotherapist and co-facilitator, using a standardised early intervention model of approach to the intervention defined as "Create Together" (Armstrong & Howatson, 2015). A total of 12 mothers and infants engaged in the intervention with quantitative data being drawn from a pre- and post- intervention questionnaire devised by the researchers, showing an overall improvement of 8.2% in the mothers' responses about being a parent and the relationship with their child. Four qualitative themes were drawn from feedback questions posed by the therapist and co-facilitator; 'modelling' in relation to the modelling of positive exchanges between mother and infant, 'containment' found within the boundaries of the group, 'attunement' found within the relationship between mother and infant and finally the theme of 'mentalization' was found within the ability for mother and infant to interpret emotional cues. Armstrong & Howatson (2015) presented the data in a bid to support the continued provision of creative therapies within local authorities.

Art Therapy Intervention TIDieR

Study	
Reference	Armstrong, Victoria Gray, and Rosie Howatson. “Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention” Infant mental health journal 36.2 (2015): 213–222.
Intervention	
Name	Art Therapy
Delivery method (in person / group etc)	In person, groups
Setting	Community spaces
Quantity and duration	12
Time span	12w
Aims / Outcomes examined	Work with feelings about being a parent and relationship with child
Facilitator	
Who provided the intervention?	Art Therapist and person-centred counsellor as co-facilitator
What is known about their title / qualification?	Unknown
Training / approach	Unknown
Participant	
Inclusion criteria	Parent-infant dyads, parents of infants under 3 years of age with difficulties in relationships and secure attachments. Happy to include fathers if they are primary care giver, though none were referred.
Exclusion criteria	Unknown
Recruitment	
Method	Referrals from health visitors and community nursing teams
Consent process	Assessment and consent session
Participant journey	
Assignment / randomisation method	N/A
Baseline measures	Qual questionnaire, self report.
Outcome measures	Qual questionnaire, self report.
Debrief / follow-up	Unknown

Table 6, TIDieR: Parent-infant art psychotherapy - a creative dyadic approach to early intervention

"Before and after: A Mother and Infant Painting Group"
Arroyo, Carl, and Neil Fowler, (2013)

Arroyo and Fowler (2013) published an article in the International Journal of Art Therapy, detailing their use of patient reported measures of postnatal depression, self-esteem and changes in relationships with infants to determine the impact of a 20-week art therapy, in person painting group for mothers who were identified by health visitors as experiencing postnatal depression and low self-esteem. The intervention was delivered by Art Psychotherapists and held within Sure Start centres in the United Kingdom. In the context that this may be considered to be a small-scale study with four participants, it was observed that the art therapy painting groups intervention resulted in "reduced levels of postnatal depression" and a "strengthening of the attachment relationships between mothers and infants", Arroyo and Fowler (2013, p.106) continued to propose that practice-based evidence of feasibility, appropriateness, meaningfulness and clinical effectiveness is vital in demonstrating demand for the availability of such an intervention within the perinatal client group while simultaneously supporting the need for funding in this area. Arroyo and Fowler (2013) were limited by the small-scale nature of this 4-participant study, however quantitative analysis involved pre- and post- measures of the Edinburgh Post Natal Depression Scale (cited in Arroyo and Fowler, 2013) and therapist observations of the self-esteem and relationship with infant indicated an overall reduction in measures of postnatal depression with an increase in self-esteem (70%) and improvement in parent infant relationships (63%). However, Arroyo and Fowler (2013) state that the low participant numbers resulted in a t-test indicating that the quantitative differences in relationship with child and postnatal depression, pre- and post-intervention were not statistically significant.

Art Therapy Intervention TIDieR

Study	
Reference	Arroyo, Carl, and Neil Fowler. “Before and after: A Mother and Infant Painting Group.” International journal of art therapy 18.3 (2013): 98–112.
Intervention	
Name	Art Therapy
Delivery method (in person / group etc)	Group, in person
Setting	Sure Start centre
Quantity and duration	Weekly, 20 sessions
Time span	20w
Aims / Outcomes examined	Psychological support and improve quality of mother/infant relationship, giving long term benefit to both mother and infant.
Facilitator	
Who provided the intervention?	Arroyo & Fowler
What is known about their title / qualification?	Art Therapists
Training / approach	Non-directive, integrative and systemic approaches.
Participant	
Inclusion criteria	Mothers identified by health visitors as experiencing PND and low self-esteem
Exclusion criteria	Unknown
Recruitment	
Method	Health visitor referral
Consent process	Unknown
Participant journey	
Assignment / randomisation method	N/A
Baseline measures	Self report questionnaires assessing postnatal depression, self-esteem and relationship quality with infants.
Outcome measures	Self report questionnaires assessing postnatal depression, self-esteem and relationship quality with infants.
Debrief / follow-up	Unknown

Table 7, TIDieR: Before and after: A mother and infant painting group

“Developing art therapy practice within perinatal parent-infant mental health”
Diane Bruce & Simon S. Hackett (2021)

In 2021, Bruce & Hackett published a paper within the International Journal of Art Therapy, examining the introduction of a parent-infant Art Therapy intervention in an NHS perinatal parent-infant mental health outpatient facility, a six-month service evaluation of which took place in 2017, leading to the publication which includes qualitative data gathered from nine mothers who engaged with the service. Engagement of patients varied in length from 6 weeks to 12 months of 90 minute, in person, individual sessions. Referrals of mothers were made to the service from a multidisciplinary professional team in light of varying presentations ranging from generalised depression, postnatal depression, birth trauma to domestic violence. Two mothers were antenatal and seven were postnatal. The aim of the intervention was to work with presenting emotions such as anxiety or depression while seeking to enhance parent infant relationships. Two self-reporting qualitative questionnaires were employed to gain insight into patient experiences of the intervention with eight out of nine mothers completing the questionnaires. Qualitative data collected indicated that all mothers found that their views and concerns had been taken into account, while six out of eight mothers conveyed that Art Therapy had aided self-understanding and comprehension of challenges. Bruce & Hackett (2021) indicate that the data may have been influenced by engaging in other treatments simultaneously to Art Therapy, particularly mood changes that may have been attributed to the influence of prescribed medication.

Art Therapy Intervention TIDieR

Study	
Reference	Diane Bruce & Simon S. Hackett (2021) Developing art therapy practice within perinatal parent-infant mental health, International Journal of Art Therapy, 26:3, 111-122.
Intervention	
Name	Art Therapy
Delivery method (in person / group etc)	In person, individual sessions
Setting	Perinatal Parent-Infant Mental Health Department, NHS
Quantity and duration	90 minute, intervention length from 6 weeks to 12 months
Time span	Intervention length from 6 weeks to 12 months
Aims / Outcomes examined	Explore emotional difficulties such as anxiety in pregnancy or postnatal depression. Improving relationships between parents and babies up-to 24months.
Facilitator	
Who provided the intervention?	Art Therapist
What is known about their title / qualification?	Qualified AT
Training / approach	Post-grad qualifications in infant mental health, systemic parent-infant art therapy approach
Participant	
Inclusion criteria	Women and babies referred to the
Exclusion criteria	Men - offered therapy and referred to a
Recruitment	
Method	Referrals from professionals.
Consent process	Consent and assessment process
Participant journey	
Assignment / randomisation method	N/A
Baseline measures	Unknown
Outcome measures	Qualitative service user experience questionnaires
Debrief / follow-up	Unknown

Table 8, TIDieR: Developing art therapy practice within perinatal parent-infant mental health

“And if the bough breaks: Individual art therapy in a perinatal mental health service” Grant, Bridget (2020)

Grant (2020) published a chapter in a book exploring the use of therapeutic arts in the perinatal period (Hogan, 2020). The chapter details Grant’s (2020) delivery of an Art Therapy intervention in a perinatal mental health service in Scotland as a registered Art Therapist. Referrals to the service are made for parents with a child under the age of two and are made via self-referral or via professional teams. Referrals are accepted for both mothers and fathers, however for the purposes of the article the author discusses only mothers experience of the intervention. On-site childcare is provided while the parent receives one to one, in person sessions. A single patient qualitative case study is presented, detailing 12 sessions of patient engagement with Art Therapy, the duration of the intervention for other patients is not stated. The aims of the intervention are to facilitate recovery and growth from perinatal presentations such as postnatal depression, anxiety and birth trauma. Themes of containment and anxiety around maternal failure are explored within reflections on the patient artwork and experience of Art Therapy. The processing of traumatic experiences is discussed within the work. In discussion of the experience of maternal failure within the patient group, Grant (2020) proposes the metaphor of the nursery rhyme, ‘rock-a-bye baby’ within which the blowing wind becomes the pressures and expectations placed on mothers, leading to the question of who will catch baby and mother if the bough breaks, and they begin to fall.

Art Therapy Intervention TIDieR

Study	
Reference	Grant, Bridget (2020), 'And if the bough breaks: Individual art therapy in a perinatal mental health service', in Hogan, S (ed.) *Therapeutic Arts in Pregnancy, Birth and New Parenthood.* Routledge, London, pp 210-227.
Intervention	
Name	Art Therapy
Delivery method (in person / group etc)	Individual sessions, in person
Setting	Perinatal Mental Health Service
Quantity and duration	12 sessions with one patient given in case study, session duration unknown
Time span	Unknown
Aims / Outcomes examined	Facilitation of recovery and growth from perinatal distress such as PND, anxiety and birth trauma.
Facilitator	
Who provided the intervention?	Bridget Grant
What is known about their title / qualification?	Art Therapist
Training / approach	Psychodynamic theory, somatic and body-work approaches, interpersonal neuroscience, physiology of trauma and Focussing Oriented Art Therapy.
Participant	
Inclusion criteria	Women using a Perinatal Mental Health Service, parents with children under age of 2.
Exclusion criteria	Men, for the purposes of this article.
Recruitment	
Method	Self-referral to the service or health-visitor referral
Consent process	Unknown
Participant journey	
Assignment / randomisation method	Patient elected to engage in available sessions
Baseline measures	Unknown
Outcome measures	Unknown
Debrief / follow-up	Ending session, patient instigated ending, discussion of intentions for artworks created.

Table 9, TIDieR: And if the bough breaks: Individual art therapy in a perinatal mental health service

“Inner city blues: best practice in Bradford”
Walsh, et al. (2006)

Walsh et al. (2006) published a brief service review in the Healthcare Counselling & Psychotherapy Journal, detailing the provision of an Art Therapy intervention which was established in 2002 in Bradford, United Kingdom. The service has two qualified Art Therapists in post, seeking to provide therapeutic interventions for patients experiencing a range of mental health issues, however the relevant material is the discussion of an in person, group Art Therapy provision for women who are struggling to transition to motherhood and whose infants are 12 months old or less. The aim of the group titled the “Just Had a Baby” group was to provide a chance for mothers to express themselves while working with feelings of isolation and failure. The group runs a rolling programme of 12 weekly sessions with group members able to begin and terminate their engagement with the group at any time, though a commitment of at least six weeks is requested. Anecdotal evidence is summarised within the report which states that mothers found the group to be effective in working with feelings of isolation and failure while normalising their experiences.

Art Therapy Intervention TIDieR

Study	
Reference	Walsh, et al. 'Inner city blues: best practice in Bradford' (2006) *Healthcare Counselling & Psychotherapy Journal*, 6(1), pp. 36–39.
Intervention	
Name	Art Therapy
Delivery method (in person / group etc)	Group, in person
Setting	Dedicated art room
Quantity and duration	Weekly
Time span	Minimum six weeks, maximum twelve weeks
Aims / Outcomes examined	Working with feelings of isolation and failure
Facilitator	
Who provided the intervention?	Art Therapists
What is known about their title / qualification?	Unknown
Training / approach	Unknown
Participant	
Inclusion criteria	Women struggling to transition to motherhood, baby born within 12 months
Exclusion criteria	Unknown
Recruitment	
Method	Wider professional team referrals
Consent process	During initial assesment
Participant journey	
Assignment / randomisation method	N/A
Baseline measures	Unknown
Outcome measures	Unknown
Debrief / follow-up	Unknown

Table 10, TIDieR, Inner city blues: best practice in Bradford

	Scoring notes:	Agree: 3	Somewhat agree: 2	Somewhat disagree: 1	Disagree: 0	Unclear / Unspecified: 0
	Art Psychotherapy Criteria	Designed and delivered by a qualified / state registered Art Psychotherapist (e.g. HCPC / American Art Therapy Association), therefore assumed to hold professional insurance and undergo regular clinical supervision as per professional body regulations.	Aims to facilitate self-awareness and meaning-making (Flanagan, 2004; Kalaf and Plante, 2019).	Aims to facilitate non-verbal and verbal self-expression and reflection through the process of art making and artwork. (Orkibi 2020)	Takes place within the safety of a carefully established therapeutic environment.	Boundaries are established, e.g. confidentiality and safeguarding.
Paper citation	**Total score**					
Grant, Bridget (2020), 'And if the bough breaks: Individual art therapy in a perinatal mental health service', in Hogan, S (ed.) *Therapeutic Arts in Pregnancy, Birth and New Parenthood.* Routledge, London, pp 210-227.	**27**	3	3	3	3	3
Diane Bruce & Simon S. Hackett (2021) Developing art therapy practice within perinatal parent-infant mental health, International Journal of Art Therapy, 26:3, 111-122.	**27**	3	3	3	3	3
Arroyo, Carl, and Neil Fowler. "Before and after: A Mother and Infant Painting Group." International journal of art therapy 18.3 (2013): 98–112.	**24**	3	3	3	3	3
Walsh, et al. 'Inner city blues: best practice in Bradford' (2006) *Healthcare Counselling & Psychotherapy Journal*, 6(1), pp. 36–39.	**27**	3	3	3	3	3
Armstrong, Victoria Gray, and Rosie Howatson. "Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention" Infant mental health journal 36.2 (2015): 213–222.	**30**	3	3	3	3	3

Table 11, Intervention Assessment Tool (IAT), results table, section 1

	Scoring notes:	Maximum available score is 30, any record receiving 15 or below was excluded from the review.				
	Art Psychotherapy Criteria	A clearly documented consent and assessment phase is undertaken.	A therapeutic alliance is established between therapist and patient.	A variety of structured and unstructured art materials are made available.	Artwork created is stored securely and confidentially by the therapist until the end of the period of therapy.	Therapist works in liaison with the wider care team around the patient.
Paper citation	**Total score**					
Grant, Bridget (2020), 'And if the bough breaks: Individual art therapy in a perinatal mental health service', in Hogan, S (ed.) *Therapeutic Arts in Pregnancy, Birth and New Parenthood.* Routledge, London, pp 210-227.	**27**	0	3	3	3	3
Diane Bruce & Simon S. Hackett (2021) Developing art therapy practice within perinatal parent-infant mental health, International Journal of Art Therapy, 26:3, 111-122.	**27**	3	3	3	0	3
Arroyo, Carl, and Neil Fowler. "Before and after: A Mother and Infant Painting Group." International journal of art therapy 18.3 (2013): 98–112.	**24**	0	3	3	0	3
Walsh, et al. 'Inner city blues: best practice in Bradford' (2006) *Healthcare Counselling & Psychotherapy Journal*, 6(1), pp. 36–39.	**27**	3	3	3	0	3
Armstrong, Victoria Gray, and Rosie Howatson. "Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention" Infant mental health journal 36.2 (2015): 213–222.	**30**	3	3	3	3	3

Table 12, Intervention Assessment Tool (IAT), results table, section 2

3.2.2 Intervention Assessment Tool

The reviewer devised an Art Therapy Intervention Assessment Tool (further discussion in section 3.6.1) which seeks to determine the clinical mechanisms of the intervention employed within a study, assessing the intervention against a series of basic pre-requisites for safe practice, thus determining whether the intervention can be categorised as an Art Psychotherapy intervention. Tables 11 and 12 demonstrate the results of the IAT assessment of reports of interventions included in the review.

In line with protocol, 20% of included reports were assessed by the lead reviewer (AS) using the IAT followed by an assessment of the same 20% of reports by the second reviewer (NP), the remaining 80% of reports were then assessed by the lead reviewer alone. Cohen's Kappa inter-rater reliability was calculated by the researcher via SPSS (IBM Corp, 2021) to analyse the level of agreement between first and second reviewers. The Kappa value was determined to be 0.2 which can be interpreted as demonstrating 'slight agreement' in accordance with the Kappa statistic interpretation scale established by Landis & Kock (1977). This low indication of interrater reliability is considered to have been influenced by the low number of reports assessed (2 reports per reviewer) with a total of only 10 numerical categories in relation to each.

In light of the indication of low interrater agreement, the first and second reviewer held several online meetings to resolve any disagreements in rating via discussion. The reviewers discussed views on each paper assessed and respectful debate ensued in the instance of a disagreement. In all cases, the debate and discussion led to one reviewer revising their selection or opinion of the paper in line with the other reviewer. Rather than being a laborious process, this was approached as an engagement in critical discussion of the reports. In the event that the reviewers had been unable to reach an agreement at this stage, the necessary protocol step would have been to default to the supervisory team to oversee a final decision about the piece.

One report was excluded during this phase of screening due to scoring 15 on the IAT, this was primarily due to the intervention not being delivered by a qualified Art Psychotherapist; both first and second reviewers concurred with this decision. In the instance that a category score of zero has been awarded, reviewers made notes to

document the reasoning, on all occasions the score indicates that the report did not specify sufficient information to determine an accurate score for the category therefore it was marked as ‘unclear / unspecified’. This may be considered as a recommendation for the transparent and consistent reporting of Art Therapy interventions within future research, particularly around the consent and assessment phase and storage of artwork.

As displayed within tables 11 and 12, each of the 5 interventions assessed within the included reports were allocated a score of between 24 and 30, indicating that each of the interventions can be classed as an Art Psychotherapy intervention conducted in line with what the researcher has determined to be the basic requirements for safe standards of practice.

3.2.3 Mixed Methods Appraisal Tool

The Mixed Methods Appraisal Tool (MMAT, 2018) was employed to assess the quality of the remaining included reports, Walsh et al. (2006) and Grant (2020) were excluded from the MMAT (2018) assessment due to their being a service review and a description of practice respectively, therefore not reporting study data.

Analysis of all applicable reports was conducted by both first and second reviewers. In line with the process of resolving disagreement described in section 3.7.2, reviewers met online to resolve rating disagreements via discussion. The Kappa value was determined to be 0.692 which can be interpreted as demonstrating ‘substantial agreement’ in accordance with the Kappa statistic interpretation scale established by Landis & Kock (1977).

Table 13 represents a summary of the MMAT (2018) scoring of the three reports which were eligible for the MMAT assessment of quality. In line with the MMAT reporting guidance (MMAT, 2020), standalone numerical scores are not relevant therefore a score within each applicable category of the quality criteria (detailed in appendix 9.16) was given and then rated as a percentage of the available quality criteria met. Two reports were deemed to be mixed method studies therefore were scored across a total of three categories, the percentage score being calculated in accordance with the

lowest scoring category, the remaining report was classed as a qualitative report therefore requiring scoring in one category only. Scoring was represented by '-' being 'can't tell', '1' being 'yes' and '0' being 'no'.

The Bruce & Hackett (2021) report was found to represent quality across all criteria for qualitative studies, including "findings adequately derived from the data" and "interpretation of results sufficiently substantiated by the data" therefore was allocated a score of 100% of quality criteria met. The Armstrong & Howatson (2015) report was allocated a score of 80% of quality criteria met, with two criteria being marked as 'can't tell', one being insufficient information being represented around any possible "divergences and inconsistencies between qualitative and quantitative results". Similarly, the Arroyo & Fowler (2013) report was marked as 'can't tell' within two quality criteria and 'no' in one criteria, namely "is the sample representative of the target population", rated as such due to the low number of participants in the study.

Studies	Criteria from the Mixed Methods Appraisal Tool																									
	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	Percentage of quality criteria met
Diane Bruce & Simon S. Hackett (2021) Developing art therapy practice within perinatal parent-infant mental health, International Journal of Art Therapy, 26:3, 111-122.	1	1	1	1	1																					100%
Armstrong, Victoria Gray, and Rosie Howatson. "Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention" Infant mental health journal 36.2 (2015): 213–222.	1	1	1	1	1											1	1	1	-	1	1	1	1	-	1	80%
Arroyo, Carl, and Neil Fowler. "Before and after: A Mother and Infant Painting Group." International journal of art therapy 18.3 (2013): 98–112.	1	1	1	1	1											1	0	1	-	1	1	1	1	-	1	60%

Table 13, Mixed Methods Appraisal Tool (MMAT), results table

3.2.4 Qualitative synthesis

The researcher conducted a thematic synthesis of qualitative data found within the 6 reports included in this systematic review. The thematic synthesis involved a process of identification of codes within individual reports, followed by a collation of codes into themes which were represented within all qualitative review data. Finally, a sensitivity analysis was conducted by the researcher in line with the Cochrane Handbook for Systematic Reviews of Interventions, version 5.1.0 (Higgins et al, 2023), in order to provide transparency around the development of themes, demonstrate robustness and illustrate the prevalence of themes within the data.

151 codes were drawn from the data which were collated into a series of 6 themes; therapeutic processes, intervention delivery, outcomes, patient presentation, mother-infant relationship and intervention assessment were themes identified within all 5 of the reports included in the review.

The repetition of codes was considered to indicate a weighting within themes, therefore this influence upon the synthesis is indicated with the use of a pie chart for each theme. Figure 3 demonstrates the formation of the most prominent theme, therapeutic processes from 46 codes, within which the most prevalent codes were that of ‘communication of feelings and experiences’ and ‘experimentation with art materials’ which were both found within all 5 reports and ‘containment’ which was present within 4 out of 5 reports. This is a clear representation within the reviewed literature, of the potent ability of Art Therapy to offer patients an alternate, creative means via which to express emotions within the containing bounds of a therapeutic relationship.

Figure 4 provides an illustration of the coded components of the next most widely recorded theme of patient presentation which is comprised of 24 codes. The codes bearing the most weight within this theme are ‘postnatal depression’ found within all 5 reports and ‘birth trauma’ which was identified within 2 reports. In maintaining the researcher’s approach to seek to maintain a wider view of patient experience than

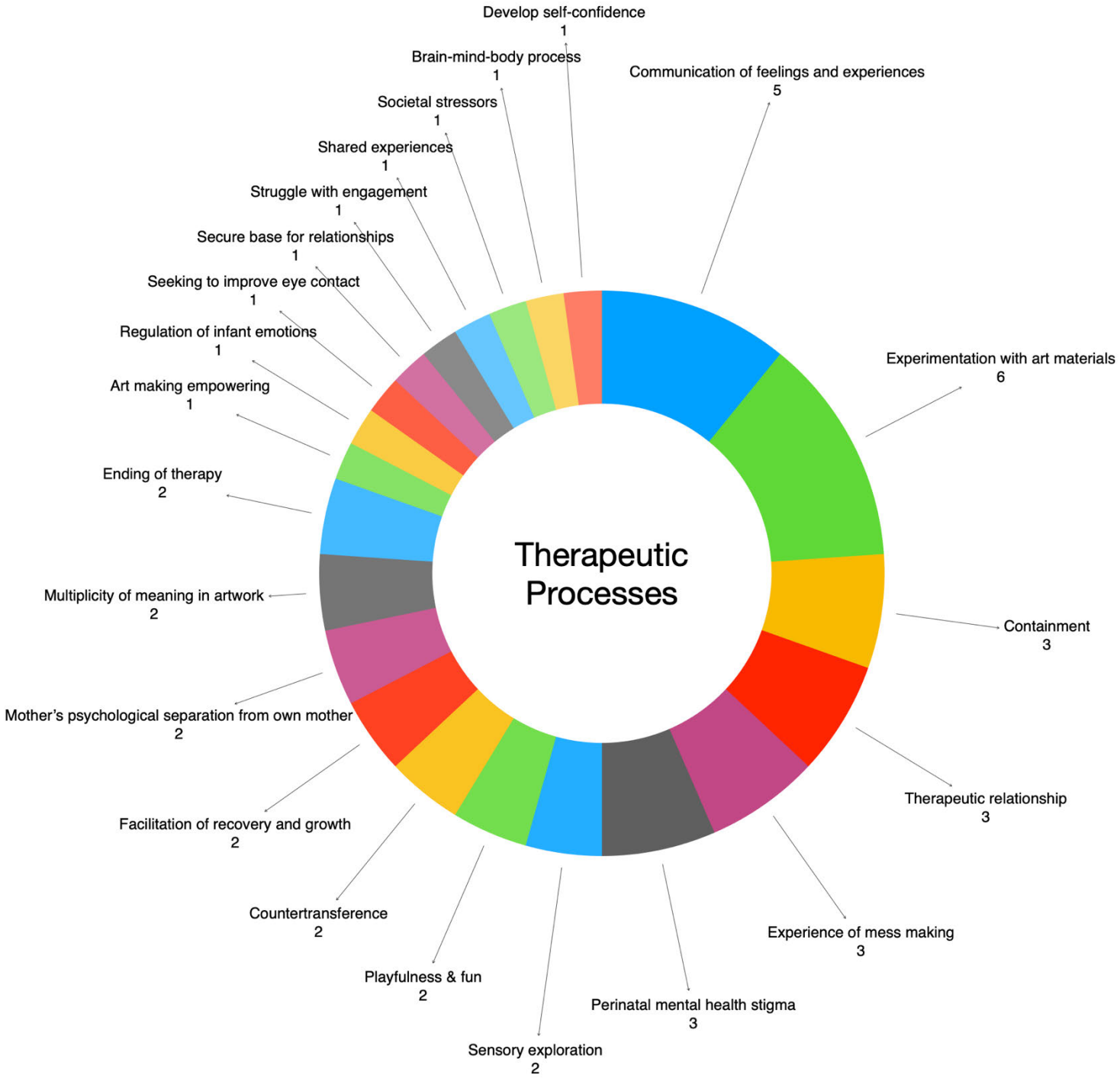


Figure 3, Thematic sensitivity analysis: Therapeutic Processes

Figure 4, Thematic sensitivity analysis: Patient Presentation

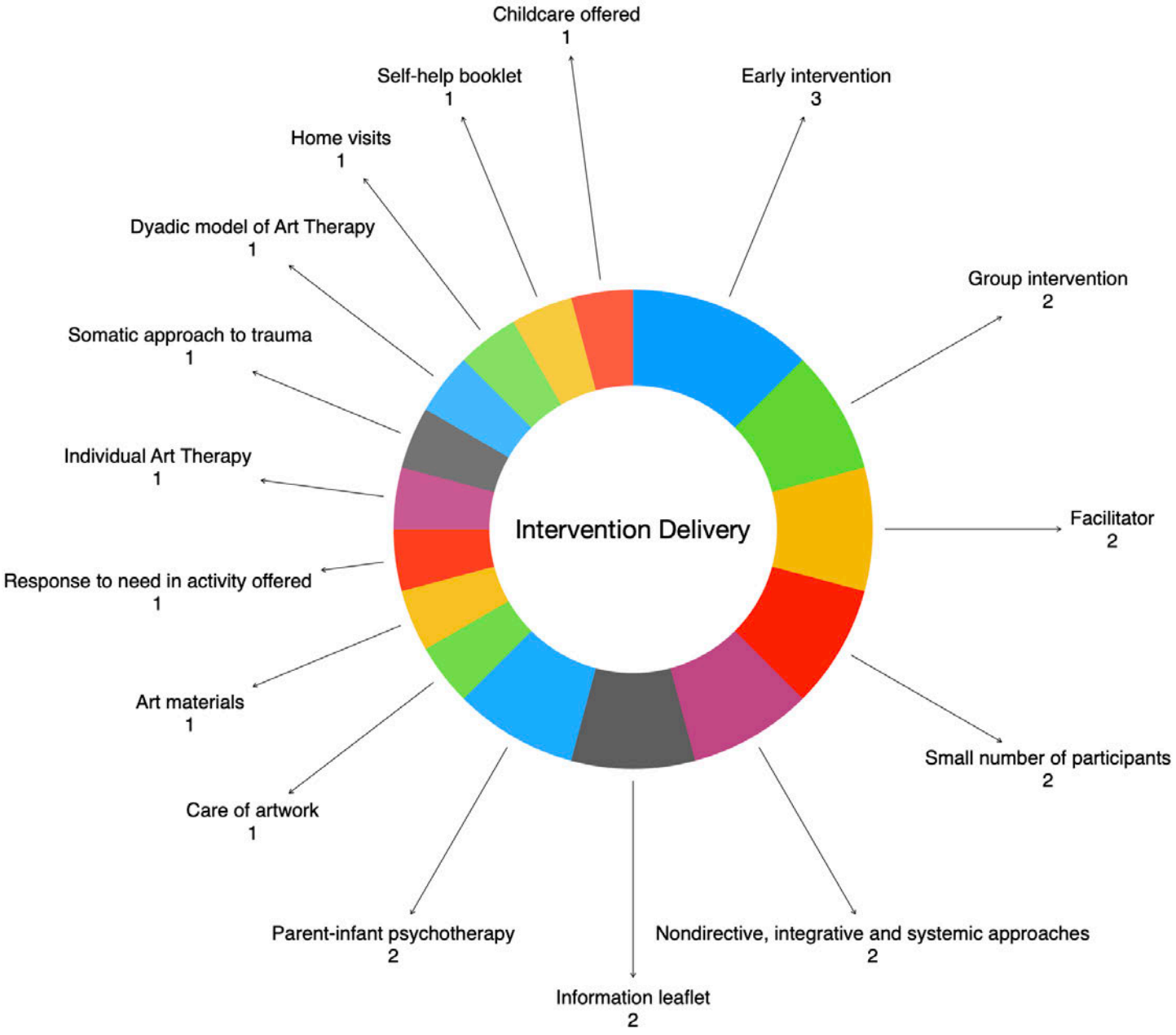


Figure 5, Thematic sensitivity analysis: Intervention Delivery

that of their diagnoses, the researcher considers the two primary coding groups to represent the gravity of the experience of the transition to motherhood and the societal pressures that are intrinsically linked to the perinatal period.

Comprised of 19 codes, the theme of intervention assessment (Figure 5) can be found to be primarily influenced by the codes of ‘research required to test clinical effectiveness of intervention’ found within 4 out of 5 reports and ‘future provision of rich qualitative data’ which was found to be present within 3 out of 5 reports. The weight of this theme can be found within recommendations for future research which identify the need for rigorous research in the field in order to establish a strong evidence base for the clinical effectiveness of Art Therapy to enhance clarity and accessibility for intervention commissioners. In addition, the emphasis within 4 reports was upon the value of communication of the depth of patient experience via the collection and presentation of qualitative data.

Figure 6 represents the theme of intervention delivery, which was drawn from 24 codes, identified by the researcher within the reviewed reports. The overriding code within this thematic group was that of ‘early intervention’ via which each of the 3 relevant reports communicated the importance of expediency when establishing the provision of an Art Therapy intervention for the perinatal mental health patient group.

The theme of outcomes (Figure 7) was formed by 20 codes, the primary code being that of ‘mothers nurturing selves’ which was found to be present in 3 out of the 5 reviewed reports. As such, the reports suggest an innate therapeutic aim of Art Therapy interventions with this patient group; to encourage and empower mothers to heed and subsequently tend to their own needs, rather than sacrificing them for the perceived benefit of others.

Figure 8 provides an illustration of the final theme, mother-infant relationship which was drawn from a total of 22 codes. In spite of being formed from the lowest quantity of codes, the codes with the predominant influence are found across the majority of reports reviewed. ‘Mentalisation between mother and infant’ and ‘attunement between

mother and infant' was present within all 5 reports while 'mother-infant relationship' was present within 4 reports and 'attachment between mother and infant'

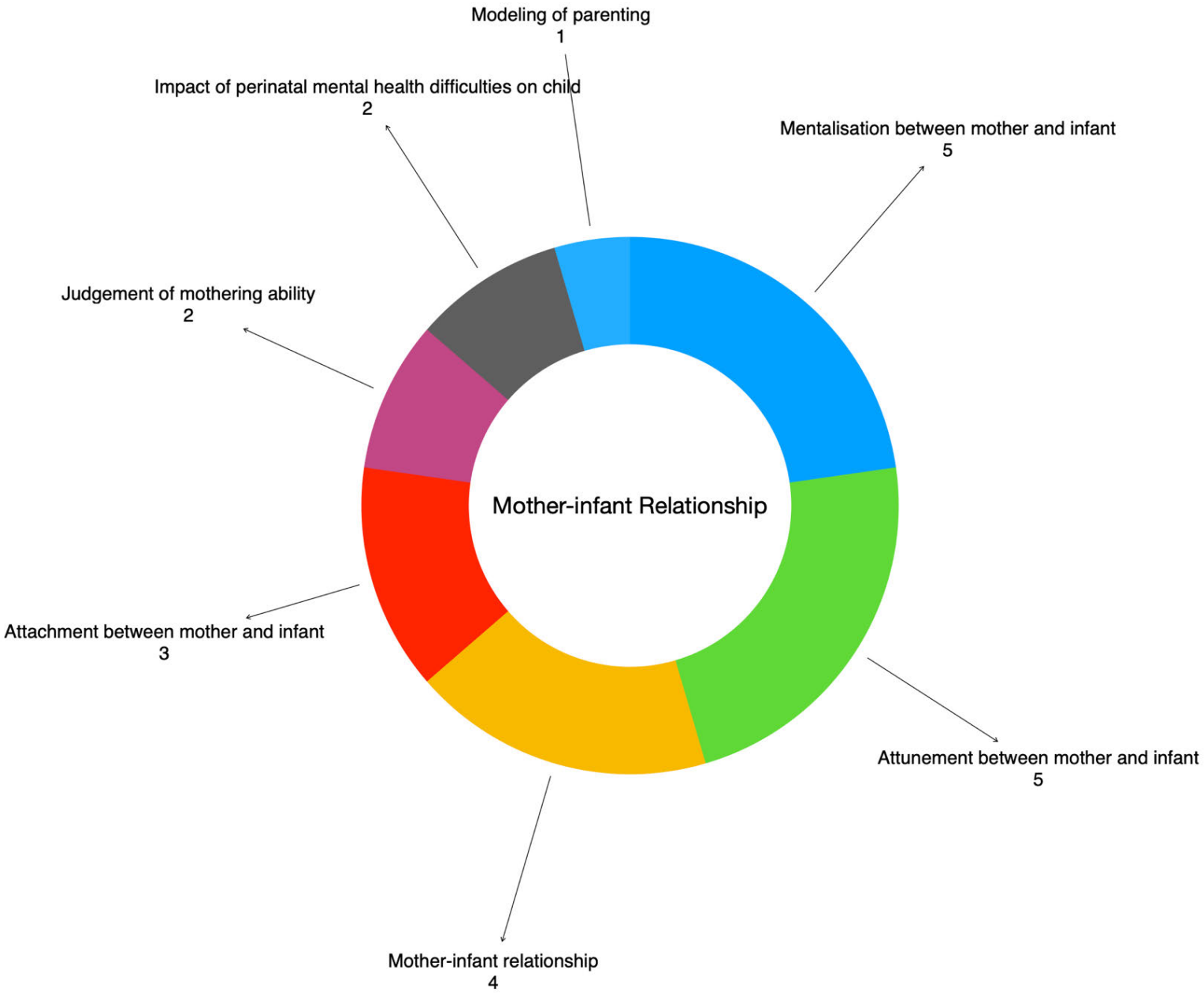


Figure 6, Thematic sensitivity analysis: Mother-infant Relationship

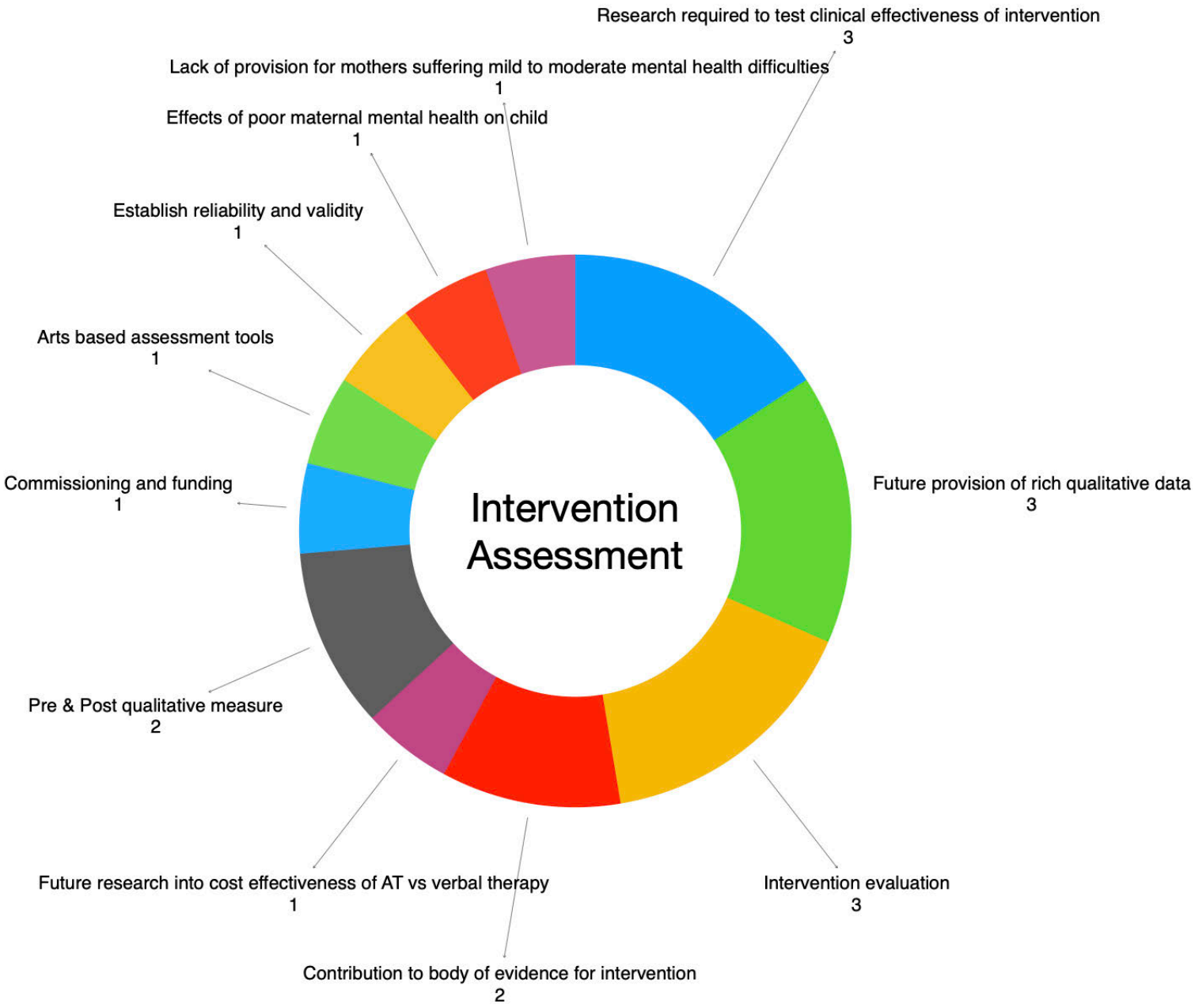


Figure 7, Thematic sensitivity analysis: Intervention Assessment

Figure 8, Thematic sensitivity analysis: Outcomes

was determined as a code within 3 reports out of 5. The strong presence of these codes may indicate the relevance of this theme within the reports reviewed, as such that these codes appear to form the cornerstones of the therapeutic approach within the studies reported on within this review.

3.2.5 Quantitative Synthesis

2 out of the 5 reports included in the review included quantitative study data: Armstrong & Howatson (2015) and Arroyo & Fowler (2013). The standardised mean difference meta-analysis proposed within the review protocol could not be employed in analysing the gathered quantitative data due to the variance between outcomes measured, i.e., attendance, depression, self-esteem, relationship etc. Similarly, the fixed effect model of synthesis was not applicable due to the presence of more than one source of data sampling across two studies. A random-effects model of meta-analysis would have been the chosen method of meta-analysis, however due to the data being gathered by unvalidated means within both reports, a meta-analysis was not conducted by the researcher. The quantitative data is still considered to be of some value in addressing the systematic review questions however, therefore the researcher has provided a narrative summary of the quantitative data.

Armstrong & Howatson (2015) gathered quantitative data, via a pre- and post-intervention questionnaire, from the 12 participants who attended two Art Therapy groups (further information discussed in section 3.7.1). The pre- and post- measure, designed by Armstrong & Howatson themselves in consultation with an unnamed external researcher, was comprised of 10 qualitative statements representing a combination of positive and negative inference. As a result of this questionnaire design method, it is evident that the questionnaire is not a validated outcome measure therefore this has been taken into account for the purposes of this systematic review.

Armstrong and Howatson (2015) note that the study was not subject to approval by an ethics committee, therefore they employed the RESPECT code of practice (Dench et al. 2004) as recommended by the British Association of Art Therapists (BAAT, 2014). Group participants were asked to rate the statements on a Likert (1932) scale of

‘never, strongly disagree to always, strongly agree’. Statements are examples such as “I feel confident as a parent”, “being a parent can make me feel tense or anxious” (Armstrong & Howatson, 2015). Questionnaire responses were given a numerical interpretation by the researchers, whereby a score of 5 was given for strongly agreeing with a positive statement or for strongly disagreeing with a negative statement etc, thus providing a measure of change for the group as a whole. The quantitative data was then presented as figures illustrating group pre, post and percentage change, as pre, post and percentage change for individual group members and finally as pre, post and percentage change within categories of participant presentation at the point of referral.

Upon drawing observations from the quantitative data, Armstrong & Howatson (2015) observed a positive change in 9 out of the 10 statements pre- and post- measures, however the pre- and post- scoring for the statement “being a parent can make me feel tense of anxious” demonstrated an increase in participant alignment with this statement. Armstrong & Howatson, (2015) noted an overall improvement in pre- and post- scores across the entire questionnaire of 8.2% with the statements demonstrating greatest improvement for participants were linked to parent ability to think about their infant and ability to interpret infant emotions and needs. When considering the data in relation to participant presenting diagnosis / difficulty, the researchers noted that the participants with the greatest improvement in ratings were those who presented with symptoms / a diagnosis of postnatal depression, with an improvement of 30% between pre- and post- measures. “A paired samples t test confirmed that on average, questionnaire responses were significantly more positive after the intervention ($M = 43.6$, $SD = 8.5$) than they were before it ($M = 40.3$, $SD = 7.8$), $t(9) = -2.7$, $p = .025$” Armstrong & Howatson, (2015).

Arroyo & Fowler (2013) undertook a study of four Art Therapy group participants (further discussion in section 3.7.1) during which, quantitative data was gathered about group attendance and with the use of quantitative pre- and post- measures of the Edinburgh Post Natal Depression Scale (EPNDS, cited in Arroyo and Fowler, 2013) alongside therapist observations and self-reporting evaluations of self-esteem and relationship with infant. The EPNDS is a validated outcome measure which was developed to aid detection of postpartum depression in mothers (Cox et al., 1987). The

data gathered via therapist observation is anecdotal in nature and self-reporting evaluations were presented as being quantitatively scored data drawn from “basic evaluation tools” (Arroyo & Fowler, 2013); in the absence of further explanation of the evaluation tools employed, it must be assumed that the evaluation tools were not validated.

Participant attendance at the Art Therapy group varied from 60% to 90% with an average of 77.5% attendance across the 4 participants. Therapist evaluations indicated an overall reduction in measures of postnatal depression with an increase in self-esteem (70%) and improvement in parent infant relationships (63%) (Arroyo & Fowler, 2013). Data gathered via EPNDS demonstrates an overall reduction of 14% in indicators of postnatal depression with a pre-intervention average rating of 18.25 and a post intervention rating of 15.5, representing a medium effect size of 0.56 which t-test indicated was not a significant difference ($t(3) = 0.949$) (Arroyo & Fowler, 2013). The researchers indicate that the t-test should be interpreted with caution as a power analysis revealed that detection of a medium effect size of 0.56 would require a minimum of 22 participants.

The evaluation of self-esteem resulted in a mean pre-intervention rating of 2.5 and post intervention rating of 4.5 therefore indicating a large effect size of 1.02 which a t-test demonstrated was significant ($t(3) = -2.459$, $p = 0.046$) therefore, Arroyo & Fowler (2013) concluded that the group participants experienced an increase in self-esteem.

The evaluation of parent relationship with infant indicated a pre- rating of 6.25 and post intervention rating of 8.5 therefore representing a large effect size of 0.98, t-test revealed that this was not significant ($t(3) = -2.029$) which again the researchers indicate should be considered with caution following a power analysis which notes that a minimum of 8 participants would be required to detect a large effect size of 0.98 (Arroyo & Fowler, 2013).

Arroyo & Fowler (2013) conclude that in gathering data across groups run in 2009, 2010 and 2011 (unpublished reports, cited in Arroyo & Fowler, 2013), averages were observed of 55% improvement in parent self-esteem and 30.5% improvement in relationships between parents and infants.

3.2.6 Mixed Method Synthesis

Of the reports that were analysed using the Intervention Assessment Tool (IAT), 1 report was excluded due to scoring 15 which was the predetermined cut off for exclusion of the report from the systematic review, 3 reports scored 27 out of a possible 30, 1 report scored 27 and 1 report scored 30. The conclusion was drawn that the reports of Armstrong & Howatson (2015), Arroyo & Fowler (2013), Bruce & Hackett (2021), Grant (2020) and Walsh et al. (2006) discuss interventions which can be considered to meet the researchers determined basic requirements for safe delivery of an Art Psychotherapy intervention.

A Mixed Methods Analysis (MMAT) of reports including the discussion of study data indicated the percentage of quality reporting criteria met within each report; Armstrong & Howatson (2015) meeting 80% of the MMAT quality criteria, Arroyo & Fowler (2013) met 60% and the Bruce & Hackett (2021) report met 100% of the quality criteria.

As a result of the IAT and MMAT assessments of reports, the classification of the interventions as safe Art Therapy practice and the individually indicated quality of the reports will be considered in line with the weighting that each report bears upon the Mixed Method configuration of findings.

6 master themes and an additional theme of influence were drawn from 151 codes identified across all 5 reports included within the systematic review during qualitative synthesis; the themes defined and their presence within reports (in order of prevalence, left to right) alongside a summary of quantitative observations are demonstrated within table 14. Grey boxes indicate a report within which a theme was not present or a report which did not include quantitative data.

The most commonly represented theme within the reports was that of therapeutic process which placed emphasis upon the patient experience of communication of feelings and experiences and experimentation with art materials, this was central to the coding presentation of the three reports which were assessed for quality using the MMAT. The second most commonly represented theme of patient presentation was found primarily within Bruce & Hackett (2021) which bears significance as the top-rated paper for MMAT analysis of quality, within this theme the key codes were those

of postnatal depression and birth trauma. The sixth master theme of mother-infant relationship was represented primarily within the second and third rated reports for quality within the MMAT, Armstrong & Howatson (2015) and Arroyo & Fowler (2013) thus demonstrating a focus upon the main codes of mentalisation and attunement between mother and infant.

In line with the summary and prevalence of codes within the context of report quality, it can be recognised that several of the foundational elements within the intervention of Art Therapy with this patient group are mirrored within the quantitative data presented in the reports of Armstrong & Howatson (2015) and Arroyo & Fowler (2013). The aforementioned data consists of positive indications that patients presenting with postnatal depression will benefit from a reduction in symptoms, an increase in self-esteem and an improvement in the mother-infant relationship. The context of this summary however, must consider that the aforementioned quantitative papers are perceived to be of lesser quality within the MMAT analysis than the Bruce & Hackett (2021) paper which presented qualitative data.

	Therapeutic Processes	Patient presentation	Intervention delivery	Mother-infant relationship	Intervention Assessment	Outcomes	Quantitative observations summary
Armstrong, Victoria Gray, and Rosie Howatson. "Parent-Infant Art Psychotherapy: A creative dyadic approach to early intervention" Infant mental health journal 36.2 (2015): 213–222.	10	2	9	7	3	3	12 participants. Overall improvement between pre & post measure scores of 8.2%. 30% improvement for those who presented with postnatal depression.
Arroyo, Carl, and Neil Fowler. "Before and after: A Mother and Infant Painting Group." International journal of art therapy 18.3 (2013): 98–112.	11	2	3	5	6	3	4 participants. Average 77.5% group attendance. 70% increase in self-esteem and 63% improvement in parent infant relationships in 2011 group. Average of 55% improvement in self-esteem and 30.5% improvement in relationships between parent and infant across 3 groups.
Grant, Bridget (2020), 'And if the bough breaks: Individual art therapy in a perinatal mental health service', in Hogan, S (ed.) *Therapeutic Arts in Pregnancy, Birth and New Parenthood.* Routledge, London, pp 210-227.	14	7	3	5	-	2	-
Diane Bruce & Simon S. Hackett (2021) Developing art therapy practice within perinatal parent-infant mental health, International Journal of Art Therapy, 26:3, 111-122.	6	9	3	4	8	8	-
Walsh, et al. 'Inner city blues: best practice in Bradford' (2006) *Healthcare Counselling & Psychotherapy Journal*, 6(1), pp. 36–39.	4	4	6	1	1	2	-
Code quantity	45	24	24	22	18	18	

Table 14, Mixed Method Synthesis

3.3 Discussion

In summary of the systematic review's answers to questions stated at the beginning of this systematic review, it can be concluded that the review was able to draw upon a small amount of quantitative data in examining the feasibility and appropriateness of the intervention with the patient group; determining that there were positive indications of clinical feasibility and perception of appropriateness found within the included studies. Markers of clinical feasibility were evident within interventions, for example practical measures to enhance engagement such as childcare, flexible group attendance and self-referral to the intervention. Attendance data and participant numbers were explored in relation to the study outcomes, indicating a high level of engagement in sessions offered but with low numbers of participants hindering the weight of conclusions drawn from the studies. The meaningfulness of the intervention for patients and clinicians was found within all reports included within the review and is evident within the formation and analysis of qualitative themes. The clinical effectiveness of the intervention with the patient group can be determined via the quantitative data gathered which demonstrates reduction in symptoms and increase in positive measures such as self-esteem, additionally the qualitative data demonstrates the potency of the therapeutic experience held within the work. Self-reported patient outcome measures are included in several instances within the reports and serve to provide insight into the cathartic and confidence building nature of the patient experience of Art Therapy. Finally, the dominance of the theme of mother infant relationship within the reports may be considered to be indicative of a wider impact of the intervention upon not only the mother in receipt of Art Therapy but upon the child, therefore broadening the scope of potential benefit of the therapeutic approach.

The intention of this review is to aid the future design and delivery of Art Psychotherapy research within inpatient and outpatient Perinatal Mental Health settings. By identifying gaps in literature and evidence within this field, it is hoped that the review may guide further research therefore benefitting the profession of Art Psychotherapists by enabling them to gather quality evidence, demonstrating that the intervention can be considered to be applicable and beneficial within the field of perinatal health.

It can be noted that the review only represents papers that have been published in the English language, therefore this may have been a limiting factor to the scope of the review. Additionally, reports of Art Therapy interventions as mother-infant dyad work and within the patient group experiencing perinatal death were excluded in the majority of cases due to the absence of communicated perinatal mental health diagnoses within the mothers represented within the studies.

The systematic review process was somewhat hindered due to reports providing limited information around the details of intervention delivery and due to the use of unvalidated outcome measures. The final 5 reports analysed within the review were comprised of, 3 service evaluations and 2 intervention studies, as such this is indicative of where the evidence base can currently be found within the profession and the quality of data available regarding intervention delivery with the perinatal mental health patient group.

Considering the limitations identified within the reports selected for inclusion within the systematic review, it has become evident that there are gaps within the evidence base. These gaps can be addressed by the design and delivery of rigorous Art Therapy research with the perinatal mental health patient group, which provides detailed reports of the intervention delivery in a thorough and consistent manner, using validated measures which are accessible and backed by commissioners and which is undertaken with ethical clearance. In addition to this, the evidence base is lacking in studies which are enhanced by a large, mixed method data set, gathered from a statistically significant number of participants.

In light of the methodological flaws influencing the potential impact of Art Therapy studies included within the systematic review, an observation made by Westrhenen & Fritz (2014) in relation to the use of Art Therapy as a treatment for child trauma, is mirrored within this review, in order to further the scientific foothold of the profession of Art Therapy to be advanced and secured, “researchers and Art Therapists need to work more closely together in future to establish a higher standard for the research in this field and to develop comprehensive theoretical frameworks” (Westrhenen & Fritz, 2014, p.533).

The findings of this systematic review echo the conclusions drawn by Hogan et al. (2017) during a brief literature review of the value of Art Therapy in antenatal and postnatal care. The literature review structure provides a literary context for postnatal depression, trauma, the impact of maternal mental health upon child development, social support for mothers, arts-based interventions with pregnant women and new mothers and finally offers reflections upon maternal wellbeing. Hogan et al. (2017) determined that the existing body of literature in the field was predominantly comprised of qualitative reports with a summarised indication that the use of therapeutic arts with this patient group is promising. The review concludes that art therapy groups have been shown to “improve women’s self-confidence and self-esteem in ways that allow them to mediate the other stressors associated with new motherhood” Hogan et al. (2017, p.175). The review noted that efforts to draw conclusive data about the cost-effectiveness of Art Therapy interventions had been as yet unsuccessful, therefore recommendations were made for future studies to report on cost-effectiveness measures as indicated by the National Institute for Clinical Excellence (NICE). Additionally, the review called for greater understanding of the impact of the emotional processes involved in an Art Therapy intervention and the resulting impact on the well-being of mothers and their children.

3.4 Chapter summary

The systematic review chapter provided insight into rigorous search, data extraction and analysis processes undertaken by the researcher as an examination of the research in the field of Art Psychotherapy in Perinatal Mental Health. Conclusions were drawn regarding the influence of the literature identified and a statement of suggested treatment acceptability was made. The systematic review has provided a thorough context to inform the following explanation of the research methodology of this study.

4 Methodology

4.1 Chapter Overview

The systematic review has provided a critical literary context to the research, identifying a number of blind spots within the evidence base. The researcher responds to the gaps identified by setting out the methodology for this study which intends to contribute to the evidence base in question. The researcher employed the CONSORT (2010) guideline to inform the structure of the methodology chapter in order to ensure transparency of reporting. The methodology begins with an explanation of the researcher's orientation within the research followed by an overview of research intentions and actions taken to secure them. The ethical considerations of the research are established and discussed in detail before the approaches to data collection and analysis are presented.

4.2 Ontological and epistemological positions

The researcher has pursued a relativist ontology, which is grounded in the philosophy that "reality is constructed within the human mind… reality is 'relative' according to how individuals experience it" (Moon & Blackman, 2017, ontology section). This philosophy aligns with the approach of Art Psychotherapy as enabling a patient to construct their own reality whereby "the emphasis is on the client expressing themselves, and the image provides a supplementary text, an alternative discourse to that which is spoken" (Hogan, 2015, p.63).

Similarly, the researcher identifies with a subjectivist epistemology, the philosophical foundation of which suggests that reality can be "stretched and shaped" (Moon & Blackman, 2017, ontology section) to accommodate the needs of each individual in order that they may then understand the world via their own interpretation. As such, this approach highlights the value of observing the way in which a participant's experience informs their perception of the world.

4.3 Positivism and interpretivism

Thomas (2013) stated that a positivist approach to research follows the belief that the "social and psychological world can be observed, measured and studied scientifically" without room for interpretation or influence from the researcher; whereas the contrasting approach of interpretivism encourages the researcher to become immersed in the research, to capture the minutiae of human behaviours and the way in which people think and relate to the world around them. The researcher elected to pursue a combined approach to the research, with the use of a mixed methods (quantitative and qualitative) approach to data collection to seek to achieve a balance between analysing the intervention of Art Psychotherapy scientifically in order to determine feasibility while also retaining the power of the patient's unique therapeutic experience.

4.4 Research paradigms

Fardet et al (2021) observed that the field of scientific research primarily follows two research paradigms; that of the empirico-inductive approach which seeks to collect both quantitative and qualitative empirical data which is then utilised as a source from which to draw theory in a holistic manner and that of the hypothetico-deductive (Popper, 1959) approach in which the validity of a pre-determined hypothesis is tested under research conditions. The researcher has pursued both empirico-inductive and hypothetico-deductive components to create a complementary research paradigm with a view to achieving rigorous research, aligned with internationally accepted research standards and a more complete understanding of the topic. Additionally, the researcher contributed to a wider movement within the profession which aims to situate Art Therapy research within the realm of meticulously produced clinical research conducted within the NHS (Bruce & Hackett, 2021). The dual research paradigm can be summarised as follows:

4.4.1 Empirico-inductive

The researcher sought to deliver an Art Therapy intervention for and collect mixed-methods data within the perinatal mental health patient group to determine whether the data shows any impact or themes which could be attributed to the use of the intervention.

4.4.2 Hypothetico-deductive

The researcher created a series of research questions based on their experience as a qualified Art Psychotherapist and in light of the existing literature in the field. The researcher sought to explore the research questions via the collection of mixed-methods research data.

4.5 Intervention

The researcher is a qualified Art Psychotherapist and has employed a non-directive, client centred approach to the use of the intervention with the patient group, thus enabling patients to lead interactions with the art materials. This simultaneously ensures that space is available for themes to arise organically and with subtlety, therefore increasing the likelihood of the themes being strong and dynamic in their therapeutic relevance (McNeilly, 1983). Art Therapists are governed by the British Association of Art Therapists and the Health and Care Professions council who each set standards of professional therapy delivery and requirements for clinical supervision. The researcher established and facilitated a safe therapeutic provision (detailed below via the use of the Intervention Assessment Tool) of weekly individual Art Therapy sessions for those patients of the Perinatal Mental Health inpatient unit who consented to take part in the research (see 4.8.1, consent section for further information). The researcher worked closely with the unit staff team in order to introduce and create a shared understanding about the therapeutic intentions of the Art Therapy provision; that the intervention contributes to improvements in patient wellbeing and in mother-infant attachment.

Approaches to Art Therapy interventions can vary greatly due to a variety of influencing factors such as the source of the therapists qualifying training, professional experience and individual beliefs of the therapist. During the process of the Systematic Review, the researcher devised an Intervention Assessment Tool (see 3.6.1) as a method of capturing the key elements of an intervention and summarising them in a standardised manner. For the purposes of transparency and congruence with the approach of the Systematic Review, the researcher situates their therapeutic approach to the intervention as follows with the application of the Intervention Assessment Tool:

Art Psychotherapy Criteria	Agree	Somewhat agree	Somewhat disagree	Disagree	Unclear / Unspecified	Notes
Score	**3**	**2**	**1**	**0**	**0**	
Designed and delivered by a qualified / state registered Art Psychotherapist (e.g., HCPC / American Art Therapy Association), therefore assumed to hold professional insurance and undergo regular clinical supervision as per professional body regulations.	☑					Registration held with HCPC and the British Association of Art Therapists. Professional insurance held and minimum monthly clinical supervision maintained.
Aims to facilitate self-awareness and meaning-making (Flanagan, 2004; Kalaf and Plante, 2019).	☑					Conversations around metaphor and themes are had during each session.
Aims to facilitate non-verbal and verbal self-expression and reflection through the process of art making and artwork (Orkibi 2020).	☑					Yes. Patients are facilitated to access materials as a means of expression alongside the additional option of communicating verbally.
Takes place within the safety of a carefully established therapeutic environment.	☑					Yes. One to one basis in a private room, therapist employs the same room set up each week to retain security and reduce the unknown.
Boundaries are established, e.g., confidentiality and safeguarding.	☑					Yes, established during assessment session and reinforced at multiple points throughout therapy.
A clearly documented consent and assessment phase is undertaken.	☑					Yes, as approved by NHS ethics committee.

A therapeutic alliance is established between therapist and patient.	☑					Yes.
A variety of structured and unstructured art materials are made available.	☑					Yes. Any requests from patients for additional specific art materials were met.
Artwork created is stored securely and confidentially by the therapist until the end of the period of therapy.	☑					Yes.
Therapist works in liaison with the wider care team around the patient.	☑					Yes, patient handovers undertaken with medical staff team and attendance at relevant team meetings.
Total score	**30**					

Table 15, Intervention Assessment Tool for the study

An initial assessment session was undertaken with each participant, 50 minutes in duration, during which overt observations were made about the patient's style of interaction with art materials. These observations were made utilising the Hyland Moon (2010) approach of categorising art materials as high or low structure based on their properties. Hyland Moon (2010) summarises the consideration of materials within Psychodynamic Theory; high structure materials such as colouring pencils or crayons are at the "resistive end of the spectrum" of materials, being easy to control they may aid the patient in maintaining boundaries. In contrast to this, low structure materials such as paint or inks being more fluid in nature "promote playful exploration" and are categorised as being at the "fluid" end of the materials spectrum (Hyland Moon (2010, p.12). The differing art making experiences and patient interactions that these varying art materials can produce were valuable in gaining an insight into the clients functioning, in order to facilitate an assessment of the appropriateness of the intervention within the context of the presentation and diagnoses of each patient.

Following assessment, both the client and the therapist had the opportunity to either withdraw from the research and the intervention or consent to continuation of the intervention. Should the therapist have determined following assessment that Art

Therapy was not appropriate for the patient, for example in the instance that the unit staff team noted a change in the patient's capacity to consent, that the patient's physical behaviour may have posed a risk to the therapist or the patient, or that the level engagement with the intervention (in spite of consent previously given) was so lacking that a continued offering was not sustainable, then the patient would have been withdrawn from the research. In this instance, a letter would have been provided to the patient, inviting them to return for a re-assessment for Art Therapy sessions, at such point as they felt ready to do so at a future point after a minimum period of two weeks had elapsed since prior assessment.

The length of each patient's engagement with the Art Therapy sessions, i.e., number of sessions provided, varied due to the nature of the population. At the point of research design in 2018, the average stay for a patient within the unit was 42 days. Patients would be eligible for inclusion in the research from the point of admission, subject to consent and recruitment procedures. The intention was to offer a series of five sessions of therapy following assessment. Should the patient be discharged prior to the end of therapy, the option was offered of returning to the unit for the remaining sessions as an outpatient.

The use of qualitative and quantitative data collection methods accounted for capturing the complexity of the intervention and aimed to provide evidence which sits within the higher levels of the hierarchy of evidence. The provision of this intervention within the unit was over and above the unit's "care as usual" plan as an Art Therapy provision did not exist in the setting at the time of the research design phase.

4.5.1 Care as usual

Care as usual within the unit is a clinical pathway that is created in response to the individual clinical presentation of each patient; a range of interventions are available within the unit such as psychiatric assessment and treatment, psychology assessment and treatment, social care support, occupational therapy, structured patient home leave and discharge planning alongside involvement of GP's, nationwide community perinatal teams and community psychiatry teams to ensure continuity of care.

4.6 Study Design

The research was designed as a Randomised Control Trial with a wait-list control group and a therapy intervention group. As previously discussed within the research rationale section, Randomised Control Trials are considered to be the most rigorous, gold-standard study design when seeking to determine the effectiveness and clinical feasibility of an intervention (Hariton E, Locascio JJ, 2018); this can be predominantly attributed to the reduction in bias afforded by the element of participant randomisation. In spite of the research benefits of randomisation, it should be noted that in the case of this study a wait-list control group may introduce the influence of patients having improved from their baseline measures prior to receiving the intervention due to receiving "care as usual" within the unit during the six week wait-list period.

Inclusion Criteria	Exclusion Criteria
• Inpatient of the Perinatal Inpatient Unit • Patients over the age of 18	• Refusal to consent to the intervention. • Unit staff determine that the patient does not have capacity to consent. • Patients who are not fluent English speakers, for the purposes of ensuring informed consent.

Table 16, Inclusion and exclusion criteria for the study

In accordance with the participant timeline (Figure 9), following admission to the unit, consenting patients who met the inclusion criteria for the study were randomised to an intervention group which had access to a total of 1 assessment session and 5 Art Therapy sessions with immediate effect, or to a wait-list control group for a minimum of six weeks with intervention commencing no more than two weeks following the patient's discharge from the unit. The intervention group members received the Art Therapy intervention immediately, while the wait-list control group were fully aware of the research and waited to receive the intervention at a later date. The participant timeline (Figure 9) is a versioned research document containing information which has been redacted in order to preserve patient anonymity.

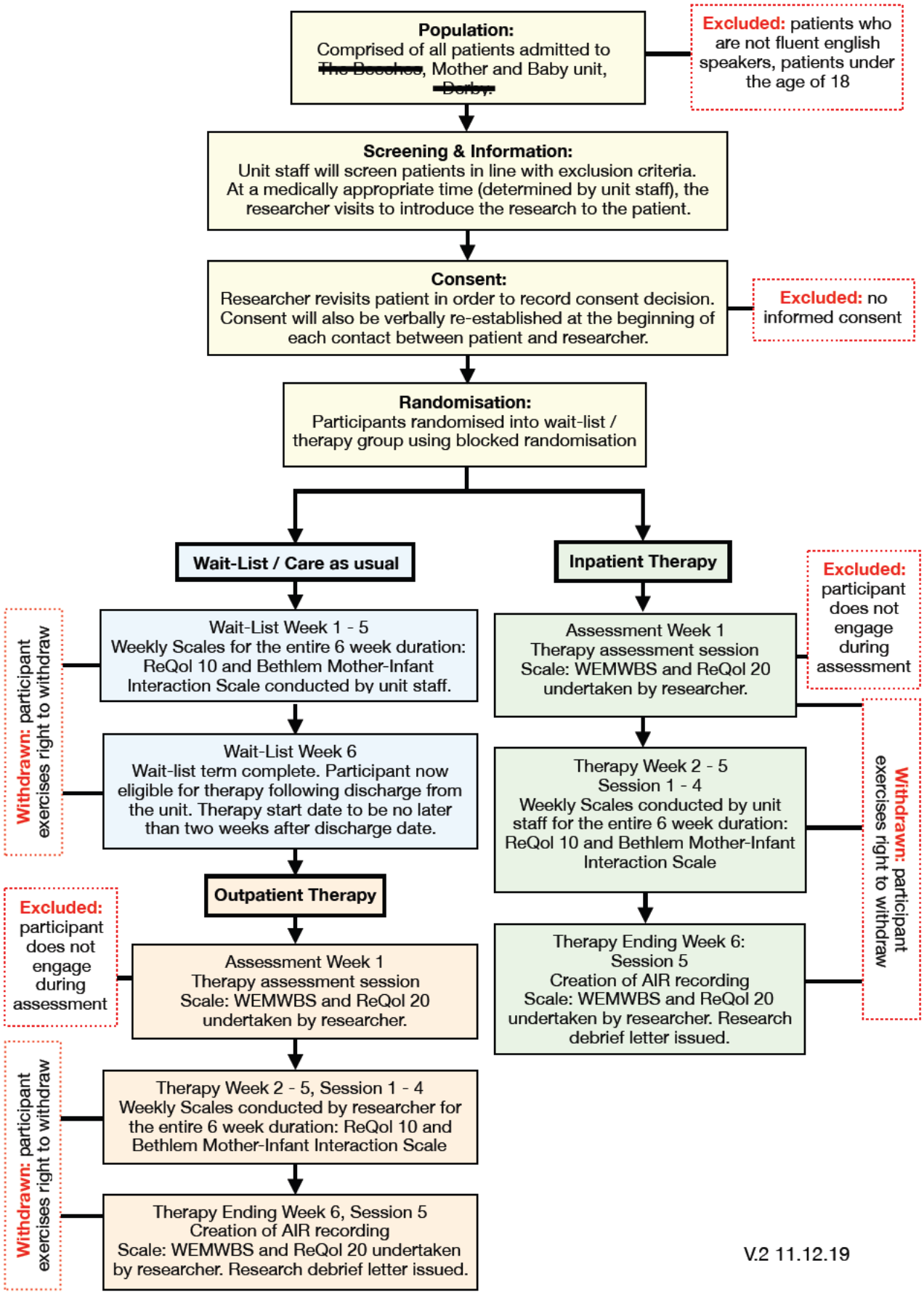


Figure 9: Participant timeline

Wait-list participants were made aware that they would not receive the intervention and would be withdrawn from the research in the event that they were discharged prior to completion of the six-week wait-list term as inpatients; this measure was in place in order to minimise the impact of outside influences on participants outcome measures, for example, should returning to the family home cause an improvement in symptoms, that would in turn impact the therapy outcome measures. Similarly, upon completion of the six-week wait-list term as inpatients, the intervention must begin no later than two weeks after the discharge date in order to limit the impact of outside influences. The maximum six-week wait-list term specified is based upon the six-week average duration of patient stay within the unit; the average length of stay was taken from data provided by the Head of Performance within the NHS Trust in 2021.

In order that the population of participants were randomly, yet evenly allocated into wait-list and treatment groups, a blocked randomisation process was applied with block sizes of 4 and 6. This was conducted via Sealed Envelope (www.sealedenvelope.com), a website facility which can be customised to produce a list of participants and their randomly allocated group. In addition, the website allocated each participant with a randomly generated code consisting of two letters and one number, ensuring that no participant code within the list would be repeated. Participant codes were used in place of names on all questionnaires, the Audio Image Recording (AIR, see 4.9.2) audio file and all data records in order to preserve anonymity. The allocation concealment mechanism within the randomisation process was that the randomisation list was produced and held by the Director of Studies, Dr. Jamie Bird.

Each time a participant completed the introduction and recruitment process and gave consent to be involved in the research, the clinician-researcher then obtained from the Director of Studies the next available participant code for that individual and established whether they had been allocated to the wait-list or treatment group. Throughout the study, all participants remained anonymous to the Director of Studies who also did not receive any identifying information about participants. A record of participant names and the randomisation log of codes was recorded in the site file, which is stored in an encrypted electronic format and is only accessed by the

researcher. In addition to this, including the varying size blocked element within the randomisation process adds another layer of allocation concealment as the clinician-researcher is unable to predict the next allocation outcome.

The wait-list approach allowed the participants to be randomised and their clinical presentation measured in comparison to a control group to isolate the effect of the Art Therapy intervention as the independent variable. Additionally, this approach is considered to be ethically preferable to a control group which denies participants access to an intervention for the entirety of a research study.

The research design was informed by discussions with the perinatal mental health unit managers, staff team, research and development team, good clinical practice training and University of Derby supervisors. The primary aim was to establish high quality evidence by collecting rigorous qualitative and quantitative data while ethically enabling access to a safe and relevant therapeutic intervention for the client group.

4.7 Sample Sizes

The study sample was determined by the population of the perinatal unit, therefore inclusion criteria was that of all patients admitted to the unit who were able to speak English and were deemed to be capable of providing informed consent, by the unit staff team. The perinatal unit's operating criteria is based upon the availability of six bed spaces for mother and her child. The unit confirmed that they have an average of 43 admissions to the inpatient unit each year, therefore on this basis and given the complexity of the population, the researcher anticipated being able to work with approximately 35 individuals within a period of 1 year. The end of trial date was signified by the completion of a minimum term of one full year of data collection, following which the researcher began analysis of the data and write up of findings.

4.8 Ethical Considerations

Ethical clearance for the research project was initially obtained via the University of Derby, College of Health, Psychology and Social Care Research Ethics Committee

under application number ETH2021-0134. Subsequently, IRAS application 272551 was made to seek ethical approval from the NHS Health Research Authority and following the researcher's attendance at the ethics panel, ethical approval and clearance to begin the research was confirmed by the East Midlands, Leicester Central Research Ethics Committee in March 2020. A summary of the ethical considerations discussed within the application are discussed as follows:

4.8.1 Consent

Participant informed consent form can be viewed within Appendix 9.1 alongside participant recruitment pack documents; Participant Information Sheet (Appendix 9.2), Art Therapy Leaflet (Appendix 9.3) and Audio Image Recording Protocol (Appendix 9.4). A secure record was kept of all consent given along with how and when it was recorded. Consent was verbally re-established at the beginning of each therapy session in order to establish whether the participant was willing to continue their engagement with therapy and the study process, or whether they wished to withdraw. The response was then recorded in the patient's medical records within the brief record of the session.

4.8.2 Wait-list

Randomised Control Trials can raise ethical concerns regarding the participant experience of being randomised to a control group (Ovosio J, et al, 2017), particularly in instances whereby the control group do not access an intervention at all, for example an intervention group versus 'care as usual' or placebo control group. With this in mind, the researcher designed the study to ensure that all research participants would have an opportunity to engage with the Art Therapy intervention, either straight away as an inpatient or after a wait-list period as an outpatient with travel costs subsidised by the University of Derby.

4.8.3 Debriefing

Upon conclusion of their engagement with the research, participants were given an opportunity to ask questions and discuss the research intervention and any findings

with the researcher. In addition to a research-based debriefing, participants underwent a thorough therapeutic debriefing, connected to the end point of each participant's therapy provision.

4.8.4 Withdrawal from the investigation

Participants were free to withdraw from the research at any time. Upon receipt of the withdrawal request, therapy sessions would cease and the collection of new questionnaire score data would cease, however any anonymous data gathered up until the point of withdrawal would still be included in the research, as made clear to patients within the PIS and consent forms. The client would be offered a debrief session to explain and reassure them that the withdrawal process had been undertaken and signpost them to further contact details of my Director of Studies for support with any further queries regarding withdrawal. The client would have the opportunity to either keep or securely dispose of any images and artwork made to date.

In the event that a participant failed to attend two sessions out of the five therapy sessions on offer, a meeting would be had with the participant in order to state that if they fail to attend another session, they would be withdrawn from the study in order to ensure the integrity of the research. In this instance, they would be offered one final therapy session in order to bring the therapy provision to a close.

4.8.5 Confidentiality

Participants retained anonymity by being allocated a randomised code which was formed of two letters and a number for use within all documents or publications. This ensured both anonymity of the participant and that the data is traceable by the researcher for the duration of the study. The researcher abided by the University of Derby’s Records Retention Policy (2013), Data Code of Conduct and the NHS computer record keeping policy within the perinatal unit.

4.8.6 Protection of participants

Participants welfare and dignity were respected at all times. Engagement in a therapeutic intervention can raise challenging issues for participants, this was taken into account and carefully managed via supervision in accordance with the guidelines publish by the British Association of Art Therapists as accepted ethical Art Psychotherapy practice.

Entries in patient medical records were brief and only indicated basics such as attendance, level of engagement with session and the art materials, e.g., X attended 50-minute art therapy session today, engaged with art materials and was able to reflect upon the art making process. Research notes only include copies of scales data, consent forms and AIR recordings, which are held as anonymised digital files of voice recordings (voice recordings were edited such that the tone and speed of the participants voice is altered so as to avoid identifying the participant) and images of artwork.

Research data was gathered throughout the project and from a number of participants, all of whom remain anonymous throughout the research data. Participants name and signature is only recorded on the researchers consent forms which are stored in an encrypted electronic file, only accessible by the researcher. The unit care team were made aware of the participants engagement in the research.

The content of Art Therapy sessions remained confidential between the therapist and the participant, only brief summaries of attendance and engagement with materials were detailed within the participant's medical record. Unless the therapist had a concern about the safeguarding and wellbeing of the participant and those around them (such as a family member), in which case the therapist's professional duty of care overrides confidentiality and the therapist raised their concern with the unit care team in writing and within the participants medical record, in order to ensure that appropriate support / follow up is provided to the participant. The participant was always made aware should a breach of confidentiality be necessary. In the event that a safeguarding risk or concern for wellbeing was noted during the early stages of wait-list allocation or Art Therapy assessment phase, the therapist liaised carefully with the unit care team in order to re-establish the participants capacity to consent.

4.8.7 Giving advice

In collaboration with the ward staff team and the perinatal unit provision, onward referrals were made for patients where necessary. Any ongoing support needs from a mental health perspective which became evident to the therapist through the course of assessment or therapy or at the point of withdrawal (reports or evidence of self-harm / suicidal ideation for example, or low scores on the ReQol or WEMWBS scales), were flagged with the unit care team in order that formal onward referrals to relevant professionals (psychiatrists for example) could be made within the NHS unit or to external providers as necessary under their standard NHS care pathway.

4.8.8 Data Protection (GDPR considerations)

The university guideline is for raw data to be kept for a minimum of 6 years within NHS Derwent Shared Services, a secure deep storage facility within which data will be stored via a box coding system, maintained by their on-site archivist. Data can be accessed via the facility as required. The data storage process will be reviewed actively within the storage period in order to ensure that it is in keeping with current GDPR legislation. In accordance with the University of Derby Data Code of Conduct, electronic data is stored on an encrypted device and a record will be made of the date and method of secure deletion of electronic data records and of the destruction of any paper documents or physical items. A sealed record of the encryption code is held by the Director of Studies, he would only be unblinded to the code in the event of an emergency which renders the lead researcher incapable of retrieving the data.

4.8.9 Storage of artwork

During the formal period of therapeutic intervention with clients, all artwork was stored securely on site within the Perinatal Unit and was treated as confidential material. At the therapy end point, the artworks that clients did not wish to keep themselves were disposed of in the same way as any confidential material (shredding, etc.).

4.8.10 Digital Media

Following consultation with guidance issued by the British Association of Art Therapists and the Information Commissioners Office, Data Protection Act 1998 surrounding digital media and the concept of "Bring Your Own Device", the following practices were abided by during the digital elements of my research.

Digital media is considered sensitive material and is treated in the same way as all other confidential material. In accordance with the University of Derby Data Code of Conduct, electronic data is stored on an encrypted device and a record will be made of the date and method of secure deletion of electronic data records and of the destruction of any paper documents or physical items.

An Audio Image Recording (AIR) is an art therapy practice research tool devised by Neil Springham (2013), involving a structured “Reflect Interview” of the patient, led by the therapist in which the therapist asks the patient to discuss three pieces of chosen artwork created in therapy. The audio of the interview is recorded and then edited together with photographic images of the chosen patient work, the resulting edited video production can serve as a transitional object within therapy and as a way of honouring the work undertaken. Consideration was given to the fact that digital media created during the Audio Image Recording (AIR) process could contain identifying features such as the clients voice and stylistic elements within the client’s artwork. These identifying elements were removed or altered to ensure anonymity, voice recordings were edited such that the tone and speed of the participants voice is altered to avoid identifying the participant. Any identifying features in artwork such as family name / home location / portraits etc were either blurred out within the image, or a recreation of the artwork was made by the therapist to eliminate those elements but retain the theme of the work.

Any digital files recorded or captured via a personal password protected device such as camera, audio recorder or smartphone were stored within encrypted files which were separate from the remainder of the devices content. The files were only stored on personal devices for a short amount of time until they were able to be transferred to a central device as the secure, permanent storage location following the completion of the therapy session.

4.8.11 Observation research

Observational research was undertaken on an overt basis only and took place solely during therapy sessions with clients. Observations made were in accordance with guidelines published by the British Association of Art Therapists as accepted ethical Art Psychotherapy practice. Observations were made on an informal basis (not written) as per standard Art Therapy practice and only included elements such as:

- Patient's interactions with art materials: are they hesitant to explore, reluctant to get messy for example.
- Patient's demeanour: are they able to engage in eye contact, are they relaxed or anxious in their body language, are they silent or engaging in conversation.
- Patient's ability to reflect upon artwork: describing their emotional processes while making the work, linking it to experiences or events, ability to explore the work with gentle discussion led by the therapist.

4.8.12 The role of patient-oriented clinician-researcher

The decision to have the researcher as both the lead researcher and clinician within this research project was not taken lightly. By providing an Art Psychotherapy service and direct therapeutic intervention to participants while conducting research relating to the provision of that intervention in the setting of a perinatal mental health unit, the researcher has adopted the role of patient-oriented clinician-researcher. The patient-oriented clinician-researcher can act as a bridging element between the research and practice communities therefore facilitating both the development of quality clinical research alongside the dissemination of treatments into clinical services (Yanos 2006). Additionally, the continuing thread through the research via this approach is that of the participants voice which is a valuable source of lived experience. The researcher has experience of working with clinical staff teams and can therefore disseminate research approaches and findings to teams with the use of layperson terminology rather than academic terminology. Yanos (2006) observed that the patient-oriented clinician-researcher role can represent a benefit in terms of research participant experience by

gaining the trust of patients who have a clear understanding of the role within the familiar context of the service team rather than solely in an abstract academic setting.

Edwards, M. & Chalmers, K. (2002) noted that the patient-oriented clinician-researcher may experience a tension between the clinical responsibility to act in a patient's best interests versus the academic desire to seek quality evidence. The researcher worked closely and openly with their managerial supervisor within the unit, the director of studies, academic supervisors and clinical supervisor in order to ensure that their actions were not being influenced by this tension. For clarity, Dr. Jamie Bird and Dr. Reza Safari, employees of the University of Derby are academic supervisors who oversee the researchers conduct as a PhD student. A clinical supervisor was appointed by the researcher following a process of careful selection to ensure professional conduct and relevant specialisms, they have overseen the researchers conduct as an Art Psychotherapist in order to protect both patients and the researcher by warding against any malpractice. All clinical supervisors are governed by both the supervision contract and supervisory practices; therefore, the supervisor maintains confidentiality accordingly. No sensitive materials (such as patient notes or original artworks) were presented during supervision sessions.

The relative power of the role of a patient-oriented clinician-researcher in comparison to the vulnerability of the patient can carry a risk that patients may feel coerced into agreeing to become research participants; the patient may feel a sense of duty or a fear of jeopardizing the patient-caregiver relationship by declining to take part (Edwards, M. & Chalmers, K. 2002). In the case of this research project however, as the intervention only began alongside the research project, participants did not have any pre-existing relationship with the therapist, as they meet for the first time at the point of the introduction of the therapist, research project and Participant Information Sheet (Appendix 9.2). In addition to this, the patient had an opportunity to decline having any contact with the patient-oriented clinician-researcher, as they were first approached by unit staff to discuss whether they were willing to meet with the researcher to introduce the research to them.

The researcher worked to maintain integration of their roles and identity within the research project by ensuring that their ethical responsibility to both the individual patients and the profession within an academic context was fulfilled.

4.9 Outcome Measures

4.9.1 Quantitative

Table 17: Table of measures

	Frequency	Score source	Therapy Patient	Wait-List Patient
ReQol20	Once during assessment, once at end of therapy	Researcher to use with patient	☑	☑
ReQol10	Weekly	Therapy patient: score to be obtained from medical records Wait-list patient: researcher to conduct weekly measures for outpatients.	☑	☑
Bethlem Mother-Infant Interaction Scale	Weekly	Therapy patient: score to be obtained from medical records Wait-list patient: researcher to conduct weekly measures for outpatients.	☑	☑
Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	Once during assessment, once at end of therapy	Researcher to use with patient	☑	☑

Each quantitative measure was selected with the intention of supporting the researcher's aim to test the research questions around feasibility, appropriateness and effectiveness (research questions 2, 3 & 5). The question of feasibility addresses whether the intervention can be considered to be "physically, culturally or financially

practical or possible" within the clinical setting while appropriateness considers whether the intervention "fits or is apt" within a setting; clinical effectiveness questions "what relationship exists between the intervention and clinical or health outcomes" (Pearson, et al. 2005, p. 210).

4.9.2 ReQol20 & ReQol10

ReQol20 and ReQol10 (Keetharuth et al, 2018) are patient reported outcome measures, used to assess the quality of life for people with a variety of mental health conditions. The ReQol20 scale includes 20 questions and was completed by the patient under supervision of the therapist once during the one-week assessment period and once at the end of the five-week therapy engagement. The ReQol10 scale includes 10 questions and was intended for use by unit staff on a weekly basis for the duration of the patient's engagement in therapy and during the wait-list period. Both the ReQol20 and ReQol10 measures were found to have "excellent face and content validity and desirable properties in terms of reliability, construct validity and responsiveness" (Keetaruth et al, 2018, further research) when assessed with a group of patients experiencing mental health diagnoses.

4.9.3 Bethlem Mother-Infant Interaction Scale

The Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) assesses disturbances of mother-infant interaction by recording observations from medical staff about seven areas of the mother-infant relationship including eye contact, physical contact, vocal contact, maternal mood, routine, risk to baby and baby's contribution to interactions. This scale was intended for use by unit staff weekly for the duration of the engagement in therapy and during the wait-list period. The Bethlem Mother-Infant Interaction Scale has been determined to have "good inter-rater, test-retest and inter-item reliability, correlations of the scale items with psychiatrist's ratings and changes in scoring over time suggest reasonable validity, despite some design problems with individual items." (Stocky et al, 1996, results). The research protocol indicates that the researcher would conduct Bethlem measures with wait-list patients who became outpatients, in fact this measure should only be used by nurses who engage in daily

interactions with patient and infant, however this situation did not arise within the research period.

4.9.4 Warwick-Edinburgh Mental Wellbeing Scale

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS, University of Warwick 2006) records 14 items which are sensitive to changes in mental wellbeing at the level of the patient. This scale was used once during the one-week assessment and once at the end of the five-week therapy engagement and was completed by the patient under supervision of the therapist. WEMWBS was deemed to show good content validity, “correlated with criterion scales to the expected extent and in the expected direction” and showed sensitivity to “change in evaluations of diverse public health interventions... and psychiatric populations” (Stewart-Brown et al, 2011, introduction).

4.10 Adaptations to data collection

4.10.1 Weekly Quantitative Measures

Data collection points and procedures are detailed within the participant timeline (Figure 9). Weekly questionnaires, ReQol10 (Keetharuth et al 2018) and Bethlem Mother-Infant Interaction Scale (Kumar & Hipwell, 1996) were to be administered by the unit care team as part of their standard care plan, the researcher requested permission from the patient (within the patient consent form) to access the patient’s medical records to extract the weekly scores from these questionnaires, for anonymous inclusion within the research data. This avoided patients being asked to complete weekly duplicates of these questionnaires that they were already completing with the unit care team. The researcher was authorised to access patient medical records under the terms of the honorary contract as provided by the NHS Trust, in order to record brief therapy notes. Those participants who were allocated to the wait-list and then were subsequently discharged from the unit were to have weekly questionnaires completed during weekly therapy sessions with the researcher.

WEMWBS and ReQol20 questionnaires were completed by the participant, once during the Art Therapy assessment session and once at the end of the five-week

therapy engagement. The completion of the questionnaires was undertaken within the private therapy room and in the company of the therapist in order that the therapist can safely support the participant should any challenging emotions arise in response to sensitive questions.

Due to staffing issues within the perinatal mental health unit, the weekly measure of ReQol10 was not completed with any of the research participants during the research project. Similarly, the Bethlem Mother-Infant Interaction Scale was conducted sporadically rather than weekly. This was not communicated to the researcher until the opportunity for the data collection had passed. Additionally, due to participant numbers being lower than anticipated and the impact of covid restrictions and discharge processes, the researcher was not able to collect data at intended post-intervention points due to patient's becoming uncontactable. This deviation from protocol is expanded upon within the discussion chapter.

4.10.2 Qualitative Measure

The researcher intended to conduct the qualitative measure of an end of therapy Reflect Interview with each consenting participant, using a templated set of semi-structured interview questions (Appendix 9.5) as written by the researcher and AIR (Audio Image Recording), as developed by Neil Springham (Springham N. & Brooker J. 2013) as a way of commemorating and bringing an end point to the series of Art Therapy sessions while allowing the client to fully express their lived experience of therapy.

The Reflect Interview was to be conducted between the participant and the therapist during the final fifth therapy session, within the privacy of the therapy room. The editing of the AIR recording was to be a collaborative process between participant and therapist by way of working to reduce the bias / outside influence on the final piece; the collaboration would have taken the form of the participant being given an opportunity to state at the end of the interview whether they wished for the researcher to remove or add sections of audio. The intention was that this qualitative measure would explore the research question of meaningfulness of the intervention, defined as the way in which an intervention is experienced by the patient based on their "personal

experience, opinions, values, thoughts, beliefs and interpretations" (Pearson, et al. 2005, p. 210). By working with the patient experience and voice as a source of qualitative data, the intention was that the creative element and any wider qualitative impacts of the intervention could be used to test the hypothesis.

Due to participant numbers being lower than anticipated and the impact of covid restrictions and discharge processes, expanded upon within the discussion chapter, the researcher did not reach the fifth therapy session with any of the research participants, as a result the researcher was unable together qualitative data via the means of a Reflect Interview and Audio Image Recording. As a result of this deviation from protocol, the researcher adapted the source of qualitative data. By recognising the wealth of qualitative observational data innately collected via the researchers processes as an Art Therapist, the qualitative data was subsequently gathered into a case series of patient and therapist experiences. A case series is defined as a qualitative research method which facilitates "in-depth analyses or experiential inquiries of a person or group in their real-world setting" and ordinarily involves greater than three individual patients (Sayre et al, 2017, abstract).

4.11 Data Analysis

4.11.1 Quantitative

The use of quantitative measures within research can allow for tests of validity and reliability to be conducted against the collected data to mitigate the risk of bias and the influence of the researcher on the research findings. The researcher intended to achieve this by undertaking statistical analysis of the quantitative data collected via IBM SPSS Statistics software, using Repeated Measures One-Way ANOVA to analyse the data collected from weekly questionnaires, alongside t-test and One-Way ANOVA analyses for measures used during the assessment phase and at the end of therapy engagement. However, in light of the challenges encountered during the research, the researcher was unable to reach statistical significance with the quantitative data collected therefore, summary discussions of measures taken will be included at relevant points within the patient case series.

4.11.2 Qualitative

In spite of the intended cohort being relatively small and the research timeframe being relatively short, the researcher anticipated that a large amount of pre- and post-intervention data may be produced which would have required statistical analysis in order to attempt to determine statistically significant change in the patient's presentation. The researcher intended to code all qualitative data gathered using the 6-step framework of reflexive thematic analysis devised by Braun & Clarke (2020), during which the interview transcripts would have been coded and both examined for the emergence of both semantic (overt, conscious meaning) and latent (concealed, subconscious) themes. Due to the volume of qualitative data anticipated in the form of AIR transcripts, the researcher intended to use professional and encrypted Nvivo software, provided by the University of Derby to aid the data analysis process.

In light of the AIR interviews not being conducted due to the participant journey being limited by a number of external factors (see discussion section), an interpretive phenomenological analysis (IPA) approach has been employed in order to create a case series structured reflection upon all available phenomenological participant data such as therapist observations around patient engagement with materials, body language, eye contact and both researcher and patient reflections on artwork and art making experiences. The ethical considerations of this approach to overt observation are discussed within the "ethical considerations" section of this chapter; the researcher seeks to employ the in-depth IPA approach in order to "give voice" (Larkin et al, 2006) to the therapeutic experience of each consenting participant.

The IPA approach enables the researcher to develop a greater depth of analysis within the available data in contrast to that achieved via reflexive thematic analysis with the aim of analysing the detail of each individual patient case study within the case series during primary analysis before conducting a secondary analysis of the overall case series presented as a whole. Within IPA, themes are developed from the codes identified by the researcher within the data, thus requiring the researcher to respond to the data in a reflexive manner by acknowledging their own assumptions and conditioning as a researcher and therapist and the impact that this may have upon the coding of the data.

IPA requires a primary phase of initial noting during which the researcher absorbs the detail of the data within each individual case study, staying close to the semantic terms and original meanings communicated by the patient, this then develops to include the influence of latent meaning, encapsulating the researcher's reflections on the patient's perception of the world and on metaphors used within the therapy. Following this, the researcher focusses upon coding of the emergent, subordinate (inductive) themes within each case study, while seeking to determine connections between the subordinate themes which then lead to the formation of superordinate themes (Braun and Clarke, 2020); the researcher then brings together the superordinate themes found within individual case studies to form master themes which provide an overview of the entire case series. This IPA methodology will be aided by the use of a codebook (spreadsheet) demonstrating transparency around the development of coding and themes while assisting in practical organisation rather than determination of themes (Byrne, 2021). Braun and Clarke (2020) acknowledge that there is no singular "hallowed method" of analysis, only an expectation that a researcher makes an informed choice regarding the method selected.

Meier et al (2008) propose an altered form of Braun and Clarke's (2006) thematic analysis, entitled Theme-Analysis, which is intended for use within psychotherapy research to measure change and identify themes during therapy sessions. However, the requirement for Theme-Analysis to have access to direct transcripts of all therapy sessions renders this approach to analysis unfeasible in the case of this research study and would involve significant allocation of researcher labour during data analysis if it were to be employed during future research.

A phenomenological approach provides the researcher with "a means of accessing subjective knowing and pure perception but is sufficiently rigorous and systematic to represent the lifeworld experiences of research participants with a high degree of accuracy." (Koopman, p1, 2015, abstract). By selecting this approach to the analysis of qualitative data, the researcher seeks to honour and document the experience of the research participants while acknowledging and retaining the impact of the researcher's subjectivity upon the data. Shaun McNiff (1998) identifies the process of art-based research which is rooted in an intrinsic "trust in the intelligence of the creative process and a desire for relationships with the images that emerge from it" (McNiff, 1998, p.25).

Suggested limitations of the IPA approach are examined by (Tuffour, 2017, p.4) in the discussion of the dependence of the IPA approach upon the use of language, offering the criticism of the approach as being elitist in its reliance upon a level of fluency between therapist and participant in order to communicate the nuance of the experience. Following the approach to analysis as discussed by Koopman (2015) and McNiff (1998), the researcher intends to unleash the value held within the patient artwork while simultaneously trusting the multi-layered communication held within the therapist's reflective artwork in order to inform a rich discussion of the therapeutic process.

The Theoretical Framework of Acceptability (v2), (TFA, v2), was devised by Sekhon et al, (2017) with the aim of presenting a rigorous method via which the acceptability of an intervention could be determined from the point of view of those delivering the intervention and that of the patient. In comparison with the TFA (v2), the JBI Model of evidence-based healthcare, FAME scale (JBI, 2016) was favoured for the methodology of this research project due to the established nature of the FAME scale's consistent, clear and reputable format sought by decision makers and commissioning bodies of entities such as the NHS. However, the TFA (v2) shall be referred to within the discussion of master themes identified within the patient work, by way of offering an additional test of intervention acceptability.

4.12 Chapter Summary

The methodology chapter has provided a transparent report of the researcher position, ethical considerations and research intentions. An in-depth presentation of approaches to data quantitative and qualitative data collection and analysis was included and the informing theory was highlighted. The methodology provides a thorough foundation for the expansion of the research phase within the following empirical chapters, in which the researcher demonstrates adherence to the methodology described.

5 Empirical Chapters

5.1 Chapter Overview

Following on from the methodology in which the researcher established the intention for the research conduct, this chapter presents an overview of the flow of participants through the recruitment and research phases while providing an immersive case series of participant data and researcher observations collected during the intervention.

5.2 Study Recruitment Summary

The researcher has employed the Consolidated Standards of Reporting Trials (CONSORT) flow diagram of study recruitment template to ensure compliance with the CONSORT statement of standardised approaches to reporting randomised trials, thus aiming to ensure transparency in the reporting of the research while aiding the readers critical appraisal and interpretation (Schultz et al. for the CONSORT group, 2010).

Figure 10 illustrates the flow of participants during the active twelve-month research phase; 26 patients were assessed for eligibility with 17 of those patients being excluded either due to failure to meet the inclusion criteria, declining to participate following the recruitment phase or being discharged prior to the completion of recruitment. 3 of the remaining 9 participants were allocated to the wait-list upon randomisation, only one of whom went on to receive the allocated intervention due to the remaining two participants being uncontactable or unable to travel. 6 participants were randomised to the intervention group, 4 of whom went on to receive the intervention while 2 were either uncontactable or unable to find childcare.

Upon the commencement of the intervention with the remaining 5 research participants, varying levels of data collection was achieved due to participant engagement; 2 participants elected to discontinue after receiving one session of Art Therapy due to being unable to travel or no longer wishing to be involved in the research, 1 participant engaged in four therapy sessions and then became limited by an inability to find childcare, 1 participant engaged in four therapy sessions and then became uncontactable, 1 remaining participant ceased engagement in therapy after two sessions due to an inability to travel. Further discussion of and expansion upon the

limiting factors impacting therapy engagement is presented within chapter 6 of the thesis.

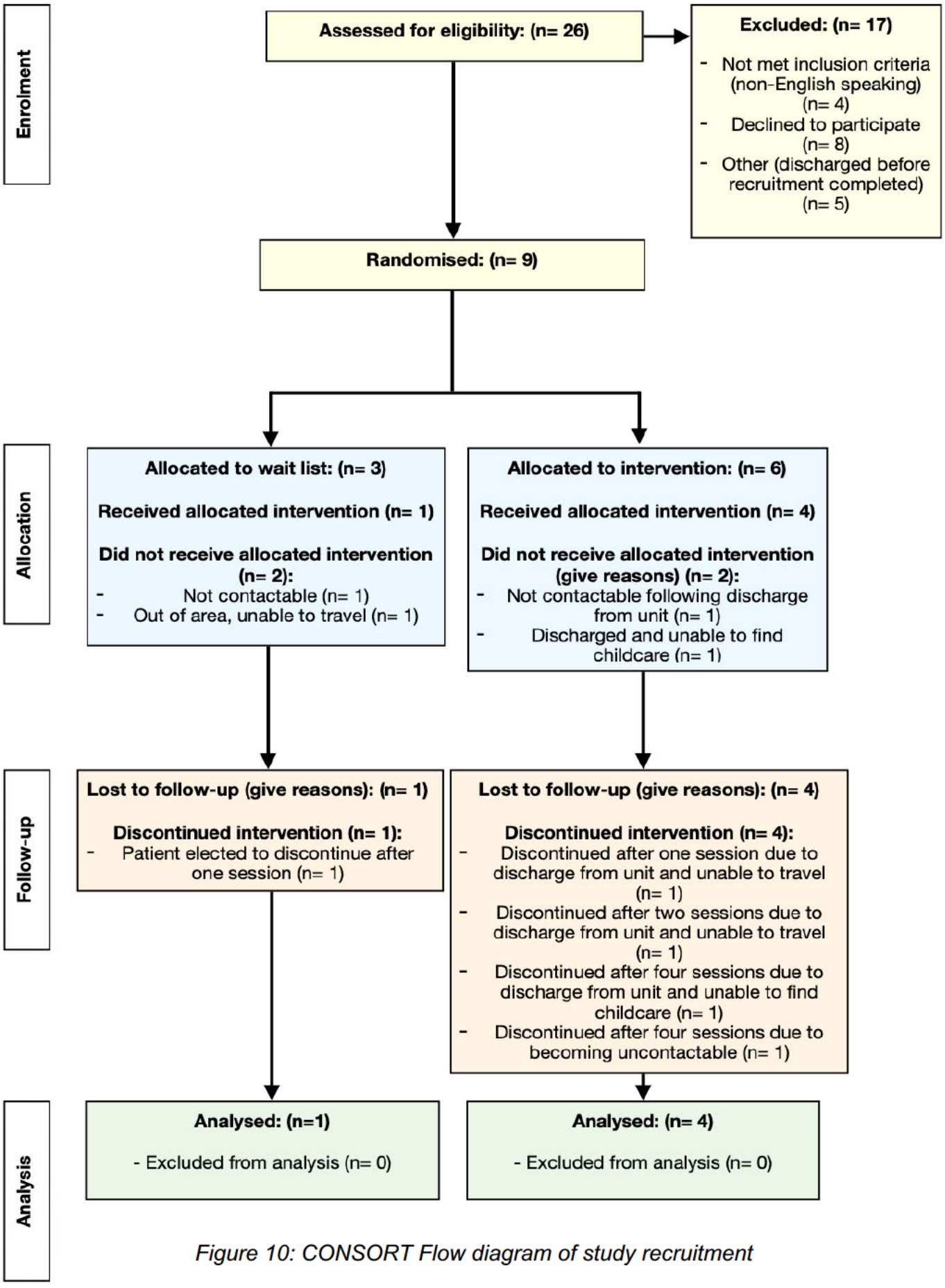


Figure 10: CONSORT Flow diagram of study recruitment

5.3 Quantitative Data Analysis

Figure 11 represents the timeline of quantitative data collected during the intervention phase; pseudonyms have been used to protect the anonymity of patients. The issues surrounding the collection of quantitative data are introduced within section 4.9.1 (quantitative outcome measures), illustrated in this section and further expanded upon within the discussion chapter (6). The charts demonstrate that all participants completed the ReQol20 (Keetharuth et al, 2018) and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS, University of Warwick 2006) baseline measures during the therapy assessment session with measures being taken by the researcher in line with protocol. These measures were due to be repeated, post intervention, however as a result of participants discontinuing the intervention for the various reasons displayed in Figure 10 and discussed within 5.2 Study Recruitment Summary, the researcher was not able to conduct the ReQol20 and WEMWBS measures at the post intervention point.

Figure 11 demonstrates that the ReQol10 (Keetharuth et al, 2018) measure which was due to be conducted weekly by unit staff was not conducted with any participants during the intervention phase. The unit staff did complete the Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996), however the completion dates were sporadic in nature rather than weekly as intended.

In light of the timing of measures conducted and limited nature of quantitative data collected, it has not been possible to conduct statistical analysis or draw conclusions based upon quantitative pre- and post- measures. However, the researcher has included the scoring and discussion of baseline measures and additional Bethlem Mother-Infant Interaction Scale scores at relevant points throughout the patient case series. Completed ReQol20 and WEMWBS measures are shared within the Appendices for transparency as indicated within the case series, however copies of the Bethlem Mother-Infant Interaction Scale have been withheld due to the identifying information held within them.

Figure 11: Participant session & measures timeline

5.4 Qualitative Case Series

As stated in the introduction section of this thesis, within the case series section, the researcher has elected to make a change in narrative from the objective third person to the reflective first person, this is an intentional act to aid the communication of the reflections and observations of the researcher in the role of therapist. This is mirrored within the observation of David Edwards (1999), that the use of case studies within the Art Psychotherapy profession carries a responsibility to undertake “story-telling” by conveying the meaning found within the therapeutic relationship, “Central to the success of such an approach to writing case studies is the creation of an authentic, believable voice: a voice the reader can trust. The writer must convince the reader of their integrity.” (Edwards, 1999, p.8).

The clinical context section of this thesis (2.4) details the clinical setting of the research and offers insight into the varying diagnoses of the inpatients admitted to the unit, ranging from puerperal psychosis, severe postnatal depression, severe anxiety disorder, significant disorders of bonding to a relapse of existing mental health problems such as schizophrenia, major depressive disorder or bipolar disorder. Each of the research participants were experiencing symptoms of one or more of the aforementioned diagnoses, however within this case series the researcher has determined to adopt the stance of the work of Professor Susan Hogan (2021, p.7) and her intention to “‘de-pathologise’ women’s experiences, while also acknowledging real distress, rather than add to a dominant rhetoric of women’s instability and inadequacy”. By not declaring each individual participants specific diagnosis(es) within the case series, the participant voice and experiences are amplified within the work while simultaneously negating the opportunity for the participant to be interpreted through the lens of a mental health diagnosis.

5.5 Suzie

5.5.1 Recruitment phase

This patient case study draws upon the Art Psychotherapy intervention conducted with an inpatient of the Perinatal Mental Health Unit who shall be referred to by the pseudonym, Suzie. During the initial recruitment phase, Suzie was initially particularly distanced and struggled with eye contact, looking predominantly at the floor. It was clear that Suzie understood the introduction to the research and was given the recruitment information pack, she was given a full week to consider the documents and discuss them with unit staff / family or friends. During the second recruitment discussion, Suzie was better able to engage with a moderate level of eye contact and asked questions about what would happen if she was randomised to the wait-list. Upon confirmation of understanding and informed consent, Suzie was randomised and allocated to the intervention group.

5.5.2 Assessment - Session 1

During the assessment session, boundaries were clearly established around the use of the room, materials, confidentiality, safety and the purpose of the sessions. The boundaries were mutually created between therapist and patient and were confirmed to be understood, Suzie reiterated her consent to engage in the research.

The baseline measures of ReQol20 (Keetharuth et al, 2018) and WEMWBS (WEMWBS, University of Warwick 2006) were completed by the patient under my supervision at this point during the session. The completed ReQol20 (Appendix 9.6) scored 23 out of a possible lowest score of 0 and the highest score of 80, with 80 indicating the highest quality of life. Suzie's score of 23 falls within the clinical range determined as being between 0 and 49, therefore indicating that a clinical diagnosis and treatment should be considered appropriate for the patient (ReQol, 2017). In summary of the pertinent sections of the completed measure, in reflection upon the last week, Suzie indicated that she often thought that her life was not worth living and felt anxious, unable to cope, had problems with sleeping and felt like a failure most or all of the time. The WEMWBS (WEMWBS, University of Warwick 2006) prompted Suzie to consider the last two weeks and was scored at 30 (Appendix 9.7), with a possible range of 14-70 with the higher score indicating high wellbeing. WEMWBS (WEMWBS, University of Warwick 2006) scoring guidance notes that the cut point for

indication of low wellbeing is 42. Within completion of the measure, Suzie indicated that none of the time in the last two weeks had she been feeling good about herself or confident.

Following the initial administration and introductory tasks of the session, Suzie showed a sense of excitement to explore her own allocated therapy art materials packet, which had been carefully curated by myself and kept in a sealed portfolio pouch in order to abide by the Covid-19 precautionary measures taken by the unit. Suzie's initial reaction was to immediately explore the watercolour set while explaining that she does not have time to paint or engage with art materials although she does "like to do it", Suzie cautioned that she did not take GCSE art because she "wasn't good enough", I re-iterated that Art Therapy does not require artistic ability nor does it encourage judgement of what is produced, only a willingness to explore the art materials. Upon reflecting the issue of time and creativity back to Suzie, she expanded to state that "it makes me feel guilty that it is something only for myself". The absence of engagement in creativity led me to recall the connection between creativity and play, discussed by Winnicott (1971), as being vital to the patient's experience and expression of self within psychotherapy.

> *"Psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist… if the patient can not play, then something needs to be done to enable the patient to become able to play, after which psychotherapy may begin. The reason why playing is essential is that it is in playing that the patient is being creative… it is only in being creative that the individual discovers the self." (Winnicott, 1971, p.73)*

As Winnicott suggests, the opportunity to allow and develop the ability to play is vital to both the nurturing and expression of one's sense of self; yet in the case of Suzie, she had been previously unable to indulge in setting time aside to engage with art materials. My response to this as the therapist is to reflect upon the societal expectations of the role of 'mother' and raises questions such as why has a mother been unable to prioritise time to tend to her own needs, desires and recovery process alongside the needs and desires of her child? What has informed that mother's decision to disregard her instinctive desire to play and to create until now? It is in

offering a mother an opportunity to play and to invest in tending to her own needs that the therapist is simultaneously asking the mother to become vulnerable to the scrutiny of society, questioning whether she is fulfilling the role of “good enough mother” Winnicott (1971).

Using the social constructivist model of material analysis proposed by Hyland Moon (2010) which proposes that observations are made from perspectives such as “developmental, psychodynamic, systems and relational perspectives” to analyse the use of materials within patient sessions; it was observed that Suzie elected to engage with watercolour painting, a wet material on the fluid end of the scale of art material qualities.

It could be noted that the use of watercolour as a medium allows a range of intensities of mark making, effectively enabling the patient to make choices about the dilution of the participant’s impact and metaphorical presence upon the paper. As such, Suzie created a selection of flowing watercolour shapes on thick, white watercolour paper; the shapes were overlaying a variety of stronger lines and other lines which she had carefully, almost cautiously, blurred by flooding them with water with controlled strokes of a water laden brush. By controlling the addition of water and dilution of the watercolour paint, Suzie appeared to take a fluid and seemingly unboundaried material and consciously control the flowing shapes to fit within her subconsciously required structures. Rather than playing with elements of the unknown and leaning into the organic evolution of mark making with a fluid material, Suzie displayed a firm desire for boundaries and safety within her cautious and controlled exploration of the material. Suzie’s brush hold mirrored the tentative sense of the art making practice, her fingertips wrapped around the brush in a delicate and seemingly fragile hold.

In considering Suzie’s art making from a relational perspective, one may reflect that the use of a brush is a passive interaction with the surface of the paper. Watercolour painting can be perceived as an act of stroking the paper with the brush as an extension of the hand and allowing the water and subtle watercolour paints to flow over it, a somewhat soothing sensory experience as opposed to indenting or embossing the surface with a more resistant art material. Within the range of art materials available, Hyland Moon (2010) observes that materials such as coloured pencils may carry an assumption for some patients that they are a “high status”

material linked with skilful artistic practice therefore carrying an implication of high expectations for the work produced; in light of this, it can be considered that watercolour paints carry a similarly high artistic status which may cause patients to feel trepidation about their engagement with them. In the case of Suzie, there was an almost childlike initial excitement about selecting this material which then transformed into a highly ordered and conscious interaction, perhaps a sign of the effects of such trepidation having set in.

In responding to the feel of the session and of the client's engagement, I began some neutral mark making with pastels while Suzie worked on her piece. During my mark making, I consciously mirrored some of the client's mark making movements while reflecting upon the atmosphere of the room which I felt to be calm and tentative with a sense of hopeful engagement. The session was predominantly silent while the mark making was taking place, I perceived that Suzie was comfortable with this. When prompted to discuss any feelings that had arisen during the art making process, Suzie was able to observe that it felt calming and that it "stops me thinking about things."

Suzie's completed artwork (Figure 12) evokes a sense of an organic map, the markings mapping out an imagined journey within a neutral space. The piece appears to hold an energy which is brimming over, somewhat frantic. London (1989) noted that "art can be said to be, and can be used as, the externalised map of our interior self". At an appropriate point, I gently voiced an observation that Suzie's brush strokes had moved from flowing marks with the use of pale colours to becoming thick, black lines, I wondered with Suzie about whether she had noticed a change in her mark making and whether this had aligned with any changes in her emotions or thought pattern. Suzie was able to note that she was feeling calm at first but then the black marks came as she began feeling frustrated that her mind had started to ruminate about things again.

Figure 12, Suzie's artwork, Session

Within Art Psychotherapy practice, transference is understood as a process whereby the patient transfers strong feelings onto the therapist, these feelings are often found to have their roots in the formative experiences and relationships of childhood; as Freud notes “a whole series of psychological experiences are revived, not as belonging to the past, but applying to the physician at the present moment” (Freud, 1905, p.116). In contrast to this, countertransference is considered in Art Therapy to be the therapist’s own emotional response to both the client and the image, with the image holding “the significance of feeling in that it acts as a receptacle for the phantasies, anxieties and other unconscious processes that are now emerging into consciousness for the client in therapy” (Case & Dalley, 1992, p.14).

By engaging with the patient’s distress, holding it, then reflecting it back to the patient via the therapist’s own artwork and countertransference, the therapeutic process links to the notion of the therapist providing a function of “maternal containment” (Bion 1959). In the same way that a mother will instinctively respond to the cry of her baby by attempting to identify and then meet the need of the child, similarly the therapist aims to accept the patient’s distress, modify the distress by containing and defining it before enabling the patient to accept the return of the experience within an altered, more psychologically comfortable form. In this sense, my artwork (Figure 13) made alongside the patient holds a series of mirrored shapes and brushstrokes. My piece bears a series of marks which appear to be emanating from or traveling toward a yellow epicentre, perhaps a subconscious attempt to soothe the patient’s perceived sense of desire for control and order.

By employing the skill of “binocular vision” (Bion, 1975), one of my aims as therapist is to bring together the elements of knowing and not-knowing within the patient work in order to reach understanding. However, inseparable from this process is the uncomfortable practice of sitting with uncertainty, requiring an element of vulnerability from both the patient and the therapist. This process can result in a deeper understanding, informed by a concoction of factors such as the artwork, patient presentation, ethnography, the sense of the space, an acknowledgement of both external and internal realities and an awareness of the influences of transference and countertransference.

Suzie's body language represented a sense of self-comfort and defence as she worked on her piece while leaning on the table in front of her, keeping her left arm supporting herself on the table while simultaneously positioning her arm in a self-hug across her torso. Suzie managed to engage in eye contact sporadically with a preference for looking down toward the floor after speaking.

The assessment session was cut short by approximately 5 minutes and had a rather rushed ending when Suzie heard her baby crying while in the care of the nurses in the unit, therefore she became immediately tense and distracted. I noted this observation with Suzie, giving her the space to act upon her apparent urge to leave, she subsequently requested to end the session in order that she could tend to her baby. A natural and instinctive response which again raises the question of the influence of instinct alongside societal expectations upon mothers, reminiscent of Badinter's (2012) observation that mothers are embroiled in a battle to attempt to find their place within a culture of "overzealous motherhood", requiring "obsessive levels of immersion and self-sacrifice" (Fernandez-Cao, 2021, p103).

Figure 13, Therapist artwork, Session 1

5.5.3 Session 2

Session 2 began with strong, well maintained eye contact and a positive tone of voice with which Suzie confidently stated that she would like to use coloured clay during the session. Suzie was comfortable with handling the clay and was able to notice that it felt warm and soft which was a sensation that she enjoyed. One piece was made on the plastic of the clay wrapper while another piece was made almost simultaneously on the surface of the table. Suzie rolled out several lengths of clay and the curled them up into spirals. This careful curling and spiralling of the clay was a recurring pattern in the work of the session, I noticed this aloud with Suzie who was able to identify and accept the observation. Suzie worked with the clay with an apparent sense of focus and was predominantly quiet while working.

In the final quarter of the session, Suzie suddenly declared that the piece (Figure 14) was “just a mess”, she recognised that she had put it together but that somehow, she felt that it did not really go together. Suzie perceived the piece to represent an animal which only had one wing (she pointed to the pink part on the side of the piece, Figure 14b). In the process of joining the pieces together, Suzie had made a flat platform for the main piece to sit on, the platform was firmly adhered to the surface of the table.

Figure 14, (left to right: 14a, 14b, 14c), Suzie's Artwork, Session 2

After referring to the piece as a mess, Suzie shared with me that she felt a desire to "squash it", we discussed this and how it might feel and after a period of lengthy silence, Suzie responded that this made her think of her father. Suzie explained that she would have been unable to do this with clay as a child because she was not allowed to "make a mess". Case and Dalley (1992, p.100) note that the use of clay "encourages a very physical involvement that aids release of the body tension which helps emotional release". Suzie took this moment of emotional release to continue speaking about her father and said that he would shout, throw things and hit her as a child yet upon disclosing this to her mother, she had not been believed. Suzie explained that her father would also accuse her of stealing things and that she was dismissed when she raised these false accusations with her mother**.** When asked whether Suzie's father was still present in her life, Suzie confirmed that he was, therefore I carefully explained that I would make the unit staff aware of this as a safeguarding risk which Suzie understood and agreed that it should happen. At that point, I reiterated the importance of being heard when a concern, risk or thoughts and feelings are expressed, Suzie noted that she felt as though she had been heard by me during our session.

In response to the potency of Suzie sharing something of the traumatic experiences of her childhood, I was led to recall Bessel van der Kolk's notion that "trauma is not the story of something that happened back then… it's the current imprint of that pain, horror, and fear living inside people" (van der Kolk, 2014, p.41) therefore it became vital to me to provide a sense of safety for Suzie by actively hearing and responding to the communication of her trauma. In employing trauma-informed practice within Art Therapy, Cathy Malchiodi (2020) explains that the patient can be provided with "meaning making experiences and ways to imagine new narratives post-trauma… to convey what is often unspeakable… to explore, restructure, reframe and re-story trauma". By engaging in the creation of this piece, Suzie appeared to have begun the process of navigating her experience of trauma within the bounds of the session timescale, thus allowing her to delve to a comfortable depth followed by a pause until such time as a revisitation to the imagining of the new post-trauma narrative felt possible.

I noticed at this point that during the assessment and session 2, Suzie had followed the Hyland Moon (2010) criteria of “messy / wet” category of materials having used watercolours during the assessment and clay during the second session. Suzie’s engagement with the clay was akin to a physical enactment of a mental process of rumination, her hands worked the clay repeatedly until each piece was perceived to meet the self-imposed standard. The artwork was being built from the table up, getting taller and taller but not from the top, just from the bottom. Suzie noticed this also but was unable to expand more on the observation. A variety of colours were used, the majority of which were clearly segregated from one another.

Suzie elected to preserve the piece and re-visit the desire to destroy it in our next session together. Due to the way in which Suzie had built the piece, the base was difficult for me to remove from the tabletop after the session without deforming the piece, I managed to carefully transfer the artwork onto a piece of card after making a photographic record of the original details and shape. Upon reflection during clinical supervision, I came to realise that Suzie had perhaps subconsciously transferred the battle between her desire to destroy the piece and the difficulty of doing so to me, leaving me to hold the weight of the simultaneous desire for destruction and preservation of the work.

Between the dates of session 2 and session 3, the unit staff undertook a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Suzie, the results of which were scored on a five point scale within subscales (discussed further within section 4.9.1), a score of zero would indicate appropriate interaction between mother and infant, a score of 3 would indicate a moderate disturbance of interaction and a score of 4 would indicate a severe disruption of interaction. Suzie scored 2 within the subscale of mood and eye contact, 1 within the subscale of physical and vocal contact and 0 within the subscale of general routine and risk to infant; thus, indicating that there was some disruption to specific categories of interaction between mother and infant, however some elements were within appropriate range.

5.5.4 Session 3

Suzie began the session by immediately and confidently stating that she wanted to "destroy" the clay piece that she had made in the previous session (Figure 14), I returned the piece to her and sat it on the table upon a piece of card. We sat quietly for a moment and then Suzie began methodically taking the piece apart, one section at a time, very carefully separating the pieces of clay into individual balls which she then positioned on the piece of card (Figure 15). The card picked up grease marks from the clay, a visual memory of the previous position of each piece of clay, which Suzie stated that she found interesting.

One piece of clay fell to the floor, Suzie retrieved it and then kept it separate from the other pieces, when I noticed this with her a moment later, Suzie explained that she felt it was important to separate it because it had been on the floor. Suzie expressed difficulty with the observation that one of the pieces of clay was made up of a combination of other pieces and mixed colours; she was unable to separate this mixed piece of clay and noted that she found this irritating and uncomfortable. A significant amount of time was spent on shaping and smoothing the other pieces of clay before Suzie began to make something with the mixed colour piece of clay, she appeared accepting as she began to make the piece flat, rolling it and then bringing it together into a circle like a donut (Figure 16c). The mixed shape was at the top of the board of all other shapes while all other pieces were placed separately below it.

Suzie stated that the blue ball and the green arch (centre of Figure 15) were the most comfortable and pleasing shapes because they looked like they had been "done well", in contrast to this, Suzie explained that she found the yellow piece and the black piece to be difficult to look at because they "didn't look very good". As I began to respond to Suzie, she immediately recalled our previous conversations around the understanding that the intention of art therapy sessions is not about judgement or a requirement to produce "good" pieces of work.

Figure 15, Suzie's Artwork, Session 3

Figure 16, (left to right:16a, 16b, 16c, 16d), Suzie's Artwork, Session 3

I elected not to make anything with the art materials during this session, only stayed quiet while Suzie made work as I sensed that there was a great purpose to this session which Suzie did not wish to be distracted from. Suzie worked with an intensity verging on fervour, she made several long sighs while working with the materials, I noted this and she explained that she was feeling tense but that this felt like a normal emotion for her.

Suzie's body language appeared to portray a sense of struggle when clay remnants became stuck to her fingers, therefore I offered her a piece of sturdy tissue which she accepted and used with water in order to wipe the clay from her fingers, she noted that this felt "very important". Suzie's experience of contamination with the clay and the irritation that she displayed in response to the pieces sticking to her fingers is reminiscent of Case and Dalley's (1992, p.106) observation of patients who encounter feelings of anxiety in response to mess or losing control of materials; "only by exploring the possibilities and risking losing control by using paint, mixing the colours and so on can the experience of regaining it be successfully negotiated." By observing Suzie's changes in response to the interaction with the materials, I was able to offer Suzie support in exploring the possibility of testing her boundary of control while also acting as an anchor point via which she could return to safety.

As the art making phase of the session drew to a natural close, I reflected with Suzie about the words that she had used regarding her desire to "squash" and "destroy" the piece of work and what the actions associated with those high energy words might look like. Suzie was able to explain that she didn't feel able to destroy the piece in a bold way because it would have been "messy and loud" which she explained would have felt difficult and cause her to feel uncomfortable. In contrast to this however, Suzie's material choices to date had included primarily wet materials such as watercolour and clay which may be commonly considered to be messy materials; perhaps in this instance it was the act of destruction itself rather than the mode selected which bore greater significance to the patient.

In discussion of object-relation theory within therapy, Winnicott (1971, p.120) notes that through the process of cathexis, namely the investment of emotion and meaning

in an object, a patient may relate to, destroy, and observe the survival of an object in order that it can subsequently exist within a reality outside of the patient themselves. Further to this, during a description of work with a patient, Casement (1985) observed the patient's discovery that;

> *"The other could exist and survive, as an entity in its own right, she was able to discover the possibility of a real separateness. She did not have to remain for ever merged… Nor did she always have to preserve the person she was relating to, and trying to be separate from, by constantly re-directing her destructive feelings onto others or against herself." (Casement, 1985, p.213)*

The observations of Casement (1985) lead me to reflect upon the apparent importance for Suzie of the cathected object not being entirely destroyed but surviving in a new, revised form; perhaps Suzie was engaged in a process of beginning to externalise her father. The object (the father) had been placed outside of herself and had survived, which in this context Winnicott (1971, p.122) interprets as the object did "not retaliate". As a result, Suzie was afforded a sense of control over an entity that may have previously felt uncontrollable.

Suzie agreed that I would photograph each piece in great detail and then preserve each piece securely in a box, the card would also be retained as a piece of process artwork due to the grease marks made on it. In taking the previous piece apart so carefully, Suzie noted that it felt important to ensure that the pieces of clay were entirely separate so that it could be re-used. I explored this further with Suzie and used it as an opportunity to remind her that her kit of materials could be replenished by me at any time, as required therefore there was no pressure to limit her consumption of materials. I was conscious at this point of the influence of my own countertransference, fuelling my desire to adopt the role of "nurturer and provider" within the therapy space, as identified by Malchiodi (2003, p.45), the therapist may be drawn to assume this role while assisting within the therapeutic space and facilitating the engagement with art materials. There was a lot of silence toward the end of the session as Suzie contemplated her work and our brief verbal interactions, the silence felt comfortable to me, and I believe this sense of comfort to have been mirrored by the client.

Between the dates of session 3 and session 4, the unit staff undertook a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Suzie, scoring 2 only within the subscale of mood, 1 within the subscales of physical, vocal and eye contact and 0 within the subscales of general routine and risk to infant; thus, indicating that there was a reduction in the level of disruption to specific categories of interaction between mother and infant indicated than in the previous measure completed 14 days previously.

5.5.5 Session 4

Suzie appeared calm upon commencement of the session, she was able to sustain eye contact and was confident in her selection of thick, white watercolour paper and a set of pastels. Suzie set about working in the bottom right-hand corner of the paper (Figure 17), a few moments later she stopped abruptly and stared at the dark blue shape for a moment before seemingly disregarding it and moving on to the opposite side of the paper. Upon my noticing this aloud with Suzie, she was able to explain that she had found herself beginning to think about her father which felt uncomfortable, therefore, she elected to stop working on it and to keep the shape separate from the rest of the drawing. During my reflection on this observation after the session, I was intrigued to note that it had felt challenging for me to witness Suzie's choice to continue working with the same piece of paper on which her subconscious had revealed a metaphorical representation of her father. I was able to acknowledge, yet restrain, my instinct in that moment to offer Suzie a fresh piece of paper. In a continuation of the previous discussion of Casement (1985) and Winnicott (1971), I pondered about the possibility that the previous process of externalising a representation of her father and testing the process of careful destruction had enabled Suzie to then tolerate the recurring presence of the father, represented within the image.

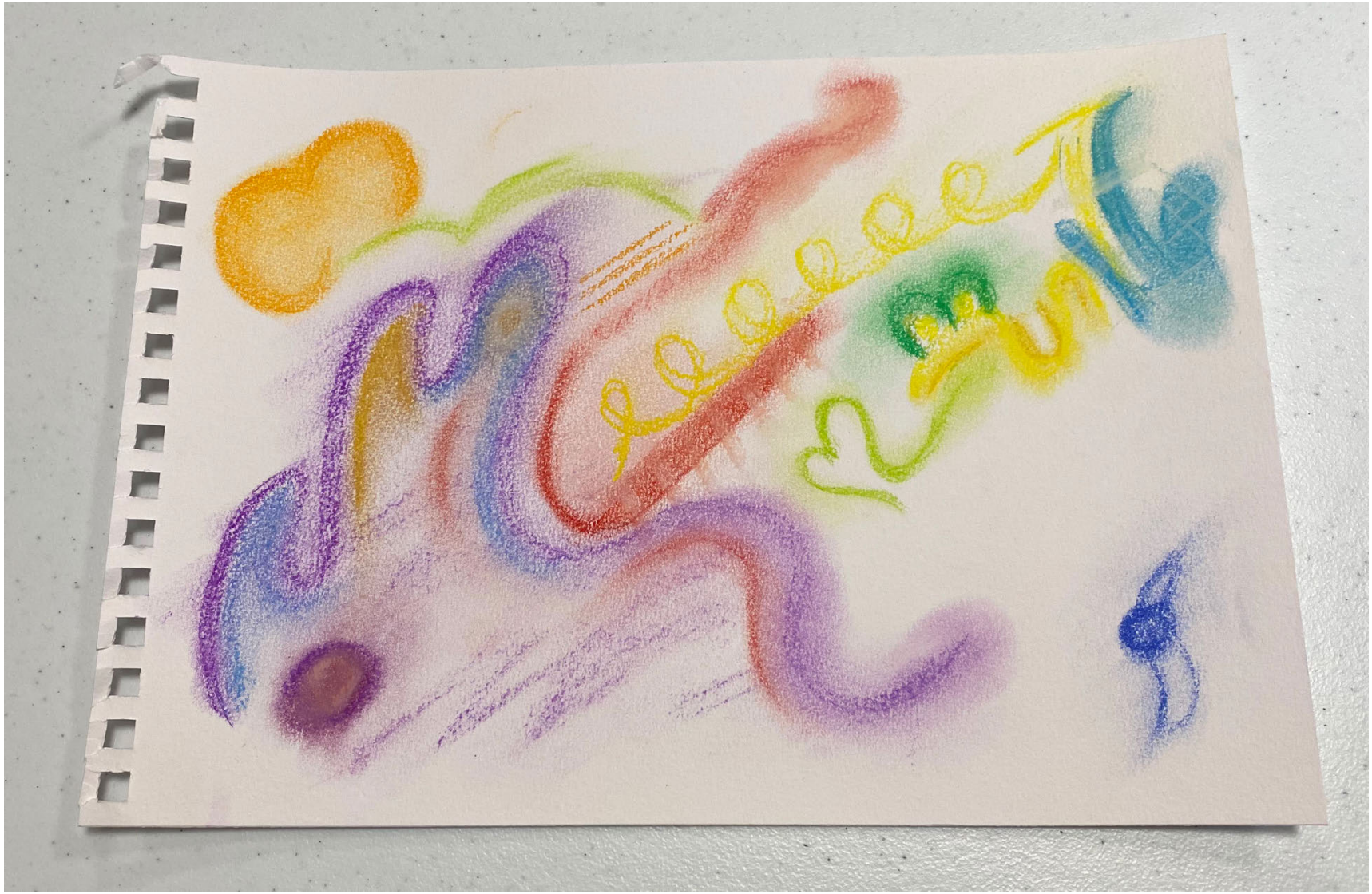


Figure 17, Suzie's Artwork, Session 4

As Suzie continued working on the piece, a selection of repeated soft, rounded shapes and marks developed, and Suzie appeared to soothe herself while engaging in an almost ritualistic process of smoothing the pastel dust with her fingers followed by blowing the dust gently off the paper and onto the table. In observing the power of breath within Art Therapy creative processes, Siegel (2019) notes that the “rhythm of breath speaks as a life force”, guiding the creation of the resulting artwork that contains it. The nature of pastels requires the patient to encounter dust as remnants of the art practice, resulting in a regulation of breath as the desire to blow the dust away is enacted. Suzie took time to reflect on the piece and concluded that the shapes and bright colours felt calming and cheerful to her.

As John Berger (1972) suggests, “although every image embodies a way of seeing, our perception or appreciation of an image depends also upon our own way of seeing” (Berger, 1972, p10). During Art Therapy sessions, I often prompt patients to consider their work from different angles in order to offer new perspectives in both literal and metaphorical sense. Upon turning the piece of work (Figure 17) around by a quarter turn (Figure 18), Suzie exclaimed that she had noticed a face with an eye and a mouth within the purple shapes in the bottom left corner of the piece, at first Suzie chuckled and was amused to see that the mouth appeared to have things “flowing out of it”. Upon discussing the observation of the face within the work that had previously felt calming, Suzie noted that she was now feeling some anxiety in response to the face. As we were nearing the end of the session, we sat silently together with this alteration in perception of the image for a moment; I held an unspoken sense that we may both have been considering the face and the purging of the shapes coming from the mouth while wondering about the toxin that had induced this bodily function in the entity, I felt assured that this would be revisited during my own clinical supervision.

Figure 18, Suzie's Artwork, Session 4 - Rotated

Following this session, the patient was discharged from the inpatient unit and subsequently did not attend a previously arranged session. Suzie became uncontactable via previously established methods; therefore, I sent a therapy debrief letter to Suzie's home address in accordance with the ethically approved patient protocol and participant agreement. Suzie did not make further contact with me and was withdrawn from the research.

5.5.6 Observations resulting from clinical supervision

In relation to the possibility of the presence of a 'vomiting face' within Figure 17 and 18, I recalled Casement's (1985) identification of the internal supervisor. As a result, I was able to internalise my historical experience of a clinical supervisory relationship, this then guided the observation and management of my countertransference response to this element of the work during the session. Upon sharing this during clinical supervision (while retaining patient anonymity), I was able to verbalise the sense of concern that I had felt in questioning my ability to contain what appeared to be an unspoken episode of purging within the artwork. In response to this, my supervisor prompted me to consider that the therapeutic space provided a sense of safety via which the client could freely express her subconscious; a type of cathartic purging in itself. In acknowledging this, I was prompted to return to the foundation of clinical supervision, to "sustain our capacity to think, to give attention and yet not be overwhelmed by the plight of our clients… cultivating thoughtful attention" (Wood, 2007).

The process of the therapy ending for Suzie was discussed at length during clinical supervision as it resulted in a number of responses for me. I was left with a sense of concern regarding the lack of closure for the patient in spite of the therapy debrief letter that we must assume was received by her. Additionally, that the lack of engagement with further sessions negated the possibility of conducting and Audio Image Recording (AIR) with Suzie, therefore the available qualitative data surrounding her experience of therapy had been reduced, thus doing the research a disservice,

and denying the patient an opportunity to create a transitional object which could support her transition from inpatient therapy to life in the community.

However, my supervision process provided me with the space to consider alternative narratives; that the patient had been in control of the ending and had chosen to cease engagement at a stage which felt right for her, and that Suzie had been empowered by being given the choice around whether to make use of contact details and resources from the unit which would afford her additional support.

5.5.7 Post discharge therapist reflective art making

Reflective art making practice differs from in session artwork made by the therapist due to the nature of being outside the therapy session, creating a piece that will not be seen by the patient, therefore affording the therapist a sense of freedom and privacy to use “art making to manifest what is just below the surface in order to deepen meaning and understanding” (Malchiodi, 2023, p.17) without the risk of breaching boundaries by accidentally revealing elements of the therapist subconscious.

In taking time to reflect on the entire duration of therapy with Suzie, I created a collage piece from a series of cuttings which captured something of the essence of our therapeutic relationship (Figure 19). While making the piece, I was drawn to the apparent tranquillity of the water and the reflection of a clear blue sky, prompting me to consider the metaphor of future calmer waters waiting for the patient. However, I noted a sense of foreboding being revealed with the addition of what I interpreted to be the talons of a bird of prey against a fiery sky; this image alongside the fish swimming in the water resulted in the introduction of a predator to previously safe waters. The wording included in the piece was quickly chosen with a sense of excitement due to the links with encouraging the nurturing of the patient and fostering her ability to communicate and meet her own needs. Although when considered in context with the images, the text caused me to reel at the overriding predatory nature of the artwork; perhaps reminiscent of the challenges expressed by the patient in allowing herself to be generous with materials while simultaneously experiencing and processing the trauma response regarding the threat posed by her father.

Figure 19, Therapist, Post Discharge Reflective Artwork

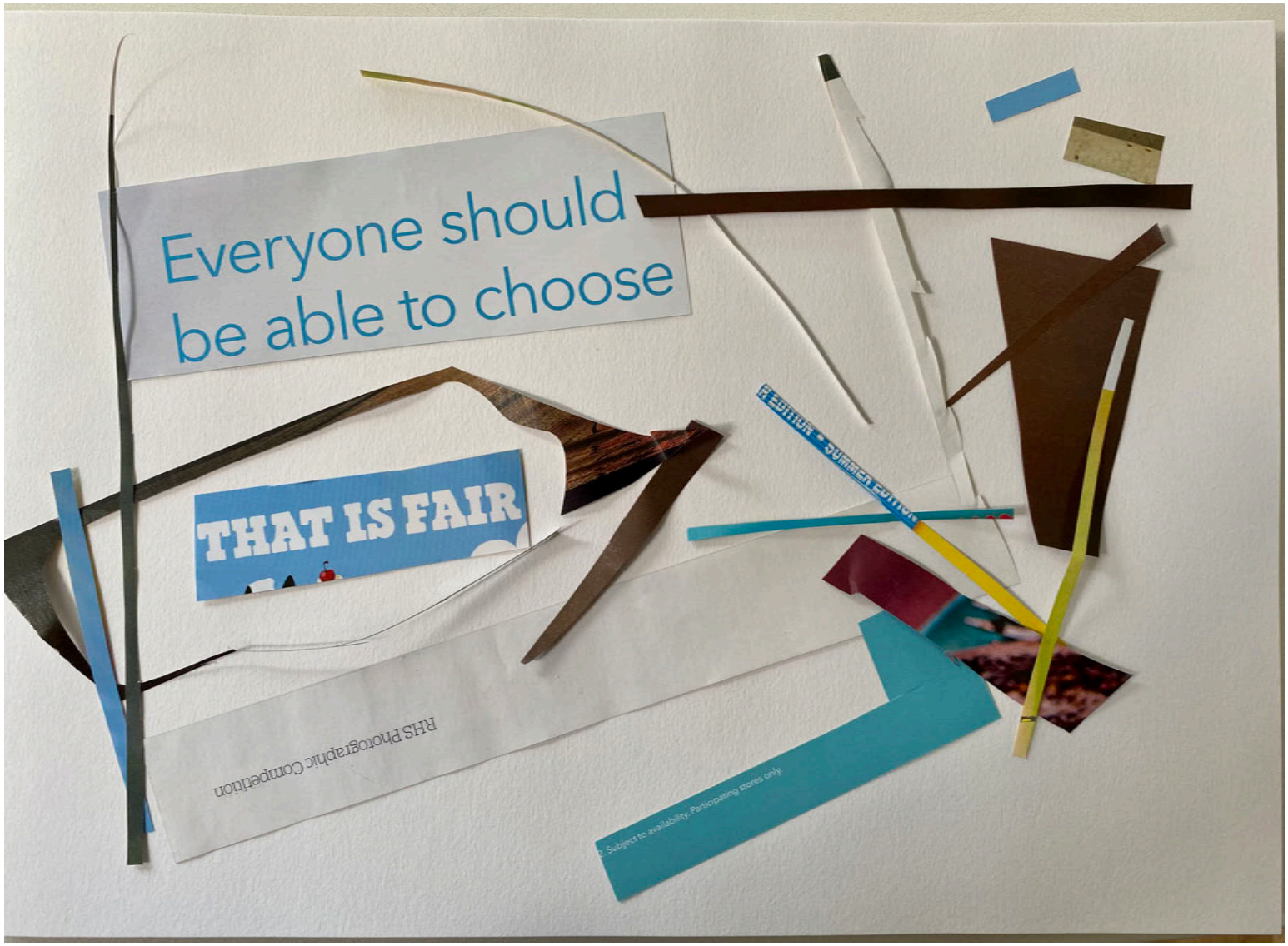


Figure 20, Therapist, Post Discharge Reflective Artwork, Piece 2

Upon concluding the artwork, I was drawn to create a record of the "waste" pieces that were created by the collage making process as I felt that they carried significance in relation to the therapeutic experience. On reflection, I am curious about whether this decision mirrors Suzie's apparent desire to avoid wasting or allowing herself to consume a large portion of materials. The jagged edges of the remnants (Figure 20) that were not initially intended for inclusion in the artwork are somewhat reminiscent of the destruction process that I had imagined Suzie might indulge in, namely the smashing and forcible breaking apart of an object in order to make way for the object's rebirth in an alternate form within the resulting debris.

5.5.8 Subordinate Codes and Superordinate Themes

Suzie	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Superordinate Themes	Control	Positive Emotional Catharsis	Negative Emotional Catharsis	Engagement	Outside commitments / pressures	Destruction vs preservation
Subordinate Codes	Desire for control	High energy	Struggle	Mess making	No time to tend to own needs / desires	Desire for destruction
	Control of materials	Self-comfort	Trauma	Spirals	Distraction due to concern for baby	Squash
	Separation of colours	Self-defence	Rumination	Smoothing	Perceived lacking artistic skill	Desire for preservation
	Separation	Soothing	Frustration	Rolling	Judgement of artwork	Careful
	Contamination	Intensity	Purging	Fluid materials		
		Breath	Distracted	Preference for soft materials		
		Being heard	Tense			
		Externalisation				

Table 18, Codebook, Suzie

In line with the interpretive phenomenological analysis (IPA) approach discussed within the methodology chapter of this thesis (4.10.2), I reflected on the Suzie's case study and coded my perception of the patient experience, resulting in the collation of a series of subordinate themes. The subordinate themes were then summarised by myself to provide a more concise overview with the use of superordinate themes, thus preserving the participant experience as observed by and communicated to me during

the intervention. For transparency, the codebook is recorded within the thesis (Table 16).

Superordinate themes were determined as control, positive emotional catharsis, negative emotional catharsis, engagement, outside commitments and destruction versus preservation. The theme of control was present within Suzie's pressing need to control her interactions with the materials, namely the separation of and avoidance of contamination of clay.

Catharsis can be understood as a discharge of emotion, "completing (some or all of) a previously restrained or interrupted sequence of self-expression. The expression is that which would have occurred as a natural reaction to some experience had that expression not been thwarted" (Nichols & Efran, 1985, p.55). Within the context of this thesis, I wish to discuss the observation of positive and negative emotional catharsis, determining the experience of the cathartic expression for the patient. Positive emotional catharsis was evident as a theme within the subordinate themes of Suzie's work, such as her expression of behaviours such as self-soothing and the externalisation of trauma experiences from her inner psyche. Negative emotional catharsis can be seen within the expressions of subordinate themes of tension, rumination and frustration.

The superordinate theme of engagement was found during Suzie's willing engagement with the art materials, selecting fluid materials with which she undertook smoothing and rolling. Suzie's judgement of her artwork and communication around a perceived lack of time to engage in such creative and playful activities informed a superordinate theme of outside commitments and pressures in her life. Finally, the discussion and resulting act of squashing and careful deconstruction of the work led to the inclusion of a superordinate theme of destruction versus preservation.

5.6 Abby

5.6.1 Recruitment phase

This patient case study tells the story of an Art Psychotherapy intervention conducted with an inpatient of the Perinatal Mental Health Unit who shall be referred to by the pseudonym, Abby. During the initial recruitment phase, Abby was enthusiastic and was given a one-week period for consideration of the recruitment information pack and the explanation of the research. During the second recruitment discussion, Abby expressed a keen desire to be involved with the intervention and the research, indicating some understanding of creative practices due to her chosen profession. Upon confirmation of understanding and informed consent, Abby was randomised and allocated to the intervention group.

5.6.2 Assessment - Session 1

At the beginning of the assessment session, boundaries were clearly established around the use of the room, materials, confidentiality, safety and the purpose of the sessions. The boundaries were mutually created between therapist and patient and were confirmed to be understood, Abby reiterated her consent to engage in the research.

The baseline measures of ReQol20 (Keetharuth et al, 2018) and WEMWBS (WEMWBS, University of Warwick 2006) were completed by the patient under my supervision at this point during the session. The completed ReQol20 (Appendix 9.8) scored 14 out of a possible lowest score of 0 and the highest score of 80, with 80 indicating the highest quality of life. Abby's score of 14 falls within the clinical range determined as being between 0 and 49, therefore indicating that a clinical diagnosis and treatment should be considered appropriate for the patient (ReQol, 2017). In summary of the pertinent sections of the completed measure, in reflection upon the last week, Abby indicated that she felt anxious, terrified, lonely, felt like a failure and felt that her life was not worth living most of the time, additionally the measure indicates that she often felt unable to cope. The WEMWBS (WEMWBS, University of Warwick 2006) prompted Abby to consider the last two weeks and was scored at 21 (Appendix 9.9), with a possible range of 14-70 with the higher score indicating high wellbeing. WEMWBS (WEMWBS, University of Warwick 2006) scoring guidance notes

that the cut point for indication of low wellbeing is 42. Within completion of the measure, Abby indicated that none of the time in the last two weeks had she been feeling confident or that she could think clearly.

Following the introduction to the session, Abby began by talking about the way in which she sought to separate the part of herself which represented her professional practice and training from the other part of herself that was unwell. Abby explained that the professional part of herself was confident and was capable of engaging enthusiastically with babies. In contrast to this, Abby felt that it was important for me to understand her sense that this was the only way in which she could provide for her own baby, through his enjoyment of activities that she sets up for other babies in the unit, as outside of that exchange her baby felt like a stranger to Abby. Abby continued by relaying her sense that she did not “want to be here anymore” in life but that she understood that her children needed her and that this sense of hopelessness had arisen and then passed before. In light of the fact that the written unit handover information had already referenced a discussion between patient and staff around suicidal ideation, I felt assured that it was not necessary to raise an additional formal concern with the care team in this instance. There was a sense of urgency in Abby’s delivery of this information which may have been influenced by a clinical presentation referred to as pressured speech, experienced as a high energy level, racing mind and an urge to share a constant stream of thoughts (McCray, 2022). I experienced the pressured speech as a form of spilling out, in line with Bion’s (1959 cited in Case & Dalley, 1992, p.63) notion of “projective identification” from patient into the therapist, during which intolerable feelings are projected by the patient into the therapist in order that they may act as a “maternal container”, receiving, holding and modifying the acute feelings in order that they can be understood by the patient.

Abby spoke at length about one of the other inpatients in the unit. When prompted, Abby was able to recognise that it felt exhausting to be constantly thinking of how other people may be feeling around her, expressing surprise that I had been the first person to acknowledge that this might feel draining. This led me to wonder whether the projection that I had received from Abby was that of a history of other people spilling out onto her, bringing expectations about her emotional resources while drawing on her seemingly innate desire to scoop them back up again; the therapeutic space had

perhaps given Abby an opportunity to release that responsibility for containment of others and to begin to ask for the holding and containment of her own emotions.

Abby continued to explain that she spent a great deal of time each day helping other babies who were in the unit as this helped her to “keep her hands busy”. Abby had been able to identify that when she was overwhelmed with anxious feelings, she would find herself repeatedly scratching the backs of her hands, therefore being diverted to other tasks helped her to avoid this. In response to this I began by noting aloud that it sounded like Abby spent a lot of her time helping others, upon hearing this Abby acknowledged that she understood the purpose of being in the unit was to help herself and not to help others. In discussions with the unit staff around this general topic, I was able to feel assured that appropriate boundaries were being held between staff roles and the involvement of patients.

Abby relayed her perception that she was constantly assessing, analysing and thinking about things, in response to this I was able to gently remind Abby that the therapy sessions were a dedicated space and time in which she was able to think solely about and to invest in herself. After a moments silence while Abby considered this, I used a soft voice to prompt Abby to notice that she had begun making quite busy, anxious movements with her hands, Abby thanked me for noticing this and I calmly asked whether it might feel helpful to open and explore her packet of art materials at this point; Abby appeared relieved and enthusiastically reached for the clay and began to work with it without hesitation.

The clay was packaged in separate, coloured sections from which Abby tore off two pieces, a bright purple and a brown colour which she proceeded to work together into a single blended piece which was deep purple in colour (Figure 21). Abby worked silently and calmly on the resulting piece of clay for the entirety of the remaining session time, around 30 minutes. Abby was entirely absorbed in repeatedly smoothing out the clay and stretching it, breaking it into two parts which would then become individual balls which were then worked together in her hands until two pieces were re-consolidated into one piece at which point the process was repeated. The resulting single piece was carefully placed upon a piece of card at the end of the session, to prevent it from sticking to the table. When asked if she noticed anything about the

piece, Abby stated that it reminded her of a beach pebble because it was smooth, she found that observation to be pleasing.

During the client's period of engagement with the materials, I took time to mirror the repetitive yet calm nature of Abby's art making processes with a set of coloured pencils and card (Figure 22). I began on the right-hand side of the card by allowing myself to free draw shapes that came to mind, in doing so I produced three boxes which were stacked on top of each other, each one filled with a flowing or swirling collection of marks. As I reflected on my brief drawing, I wondered whether something of the sense of pressure and desire for containment that I had perceived during the projective identification from the patient was being subconsciously represented within the stacked, full boxes. Upon this realisation, I diverted my mark making to the left-hand side of the page in order to ensure that I could continue with a more innocuous, neutral and abstract mark making process which mirrored the repetitive flow of her hand movements.

In recognising the time of transition during motherhood, Hayward (2019, cited in Grant, 2021, p.215) recognised that the process of engaging with art materials can be a grounding force, seeking to counteract the uncertainty that can be found within periods of transition, a process which can facilitate an ability to "play in the limbo while also providing a physical container". On reflection, in subconsciously providing an initial series of containers in my work, I was responding to the need being subconsciously communicated to me by the patient.

Between the dates of session 1 and session 2, the unit staff undertook a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Abby, scoring 0 within all subscales apart from 4 within the risk to infant subscale; thus, indicating that there was an appropriate level of interaction between mother and infant however that there was a significant risk to infant indicated due to the content of intrusive thoughts that Abby had communicated to staff.

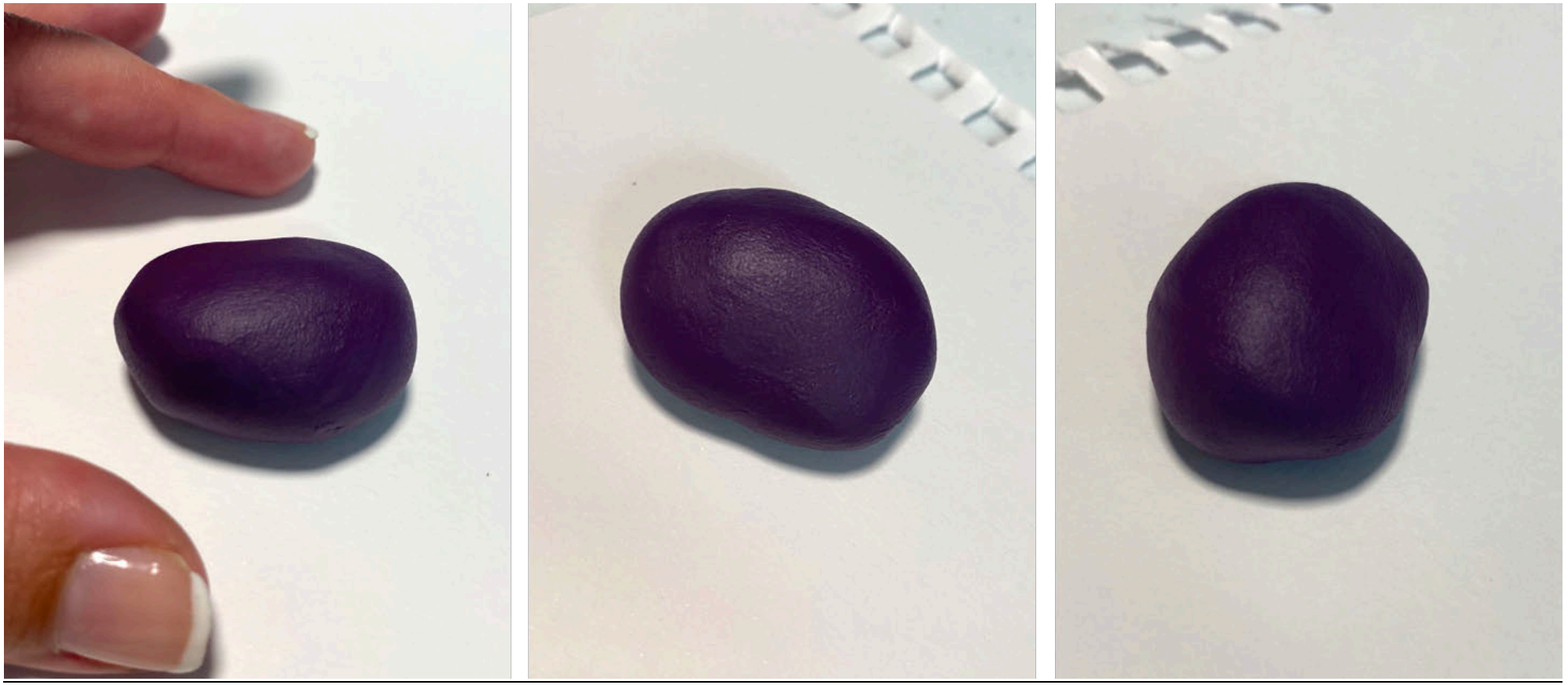


Figure 21, (left to right 21a, 21b, 21c), Abby's Artwork, Session 1

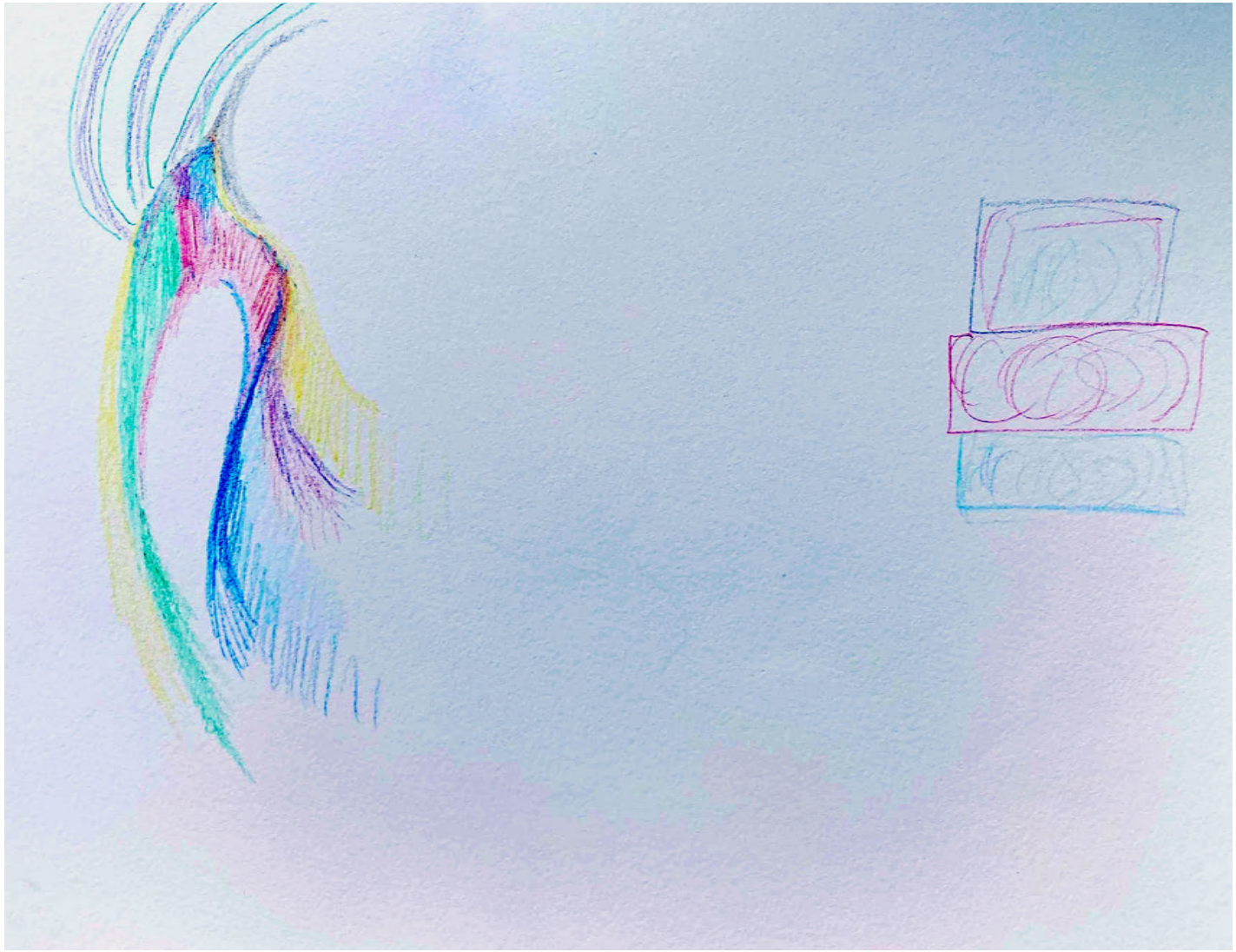


Figure 22, Therapist Artwork, Session 1

5.6.3 Session 2

Abby began the second session by declaring that she wanted to get to work immediately with the clay. Abby selected two colours, a light and a dark shade of blue, after pulling sections of each of the colours apart Abby began moulding two different colours together, leaving a single smaller piece of dark blue untouched on the piece of card. Abby worked with intensity on the mixed clay, she flattened it onto the tabletop with the palm of her hand, seemingly forcing the piece to become pliable by accepting the warmth of her skin, Abby then began rolling the piece so that it formed a long, thin string of clay. Abby was silent while making this and appeared to be entirely consumed by the process in contrast to her preference for prioritising verbal expression in the previous session.

Abby appeared to become satisfied after bringing the ends of the long piece of clay together to form a circle (Figure 23), she contemplated the shape for a moment and then began lightly pinching the piece while turning the circle repeatedly in her fingertips. Abby held brief eye contact with me while favouring a soft gaze upon the movement of the work. I suggested to Abby that it seemed as though the repetitive nature of her circular animation of the clay might feel somewhat mesmerising to her, Abby chuckled and replied that she “hadn’t really been thinking about very much at all”. Upon reflection, I was led to recall the concept of mimetic functioning, muted by Tinnin (1994) with the observation that mimicry is a vital human process which fuels communication and leads to the development of self-soothing. Tinnin (1994) explores the action of stroking a soft blanket, namely a transitional object which provides the mimicry of a comforting exchange with the mother, thus enabling a child to self-soothe in the mother’s absence. It struck me that Abby may have been drawn to the repetitive nature of smoothing, rolling and rotating the circle of clay between her fingertips due to the self-soothing feedback loop that it had activated in her brain.

With only ten minutes remaining of the session time, Abby turned her attention to the remaining single piece of dark blue clay that she had previously selected from the packet of clay; she began turning it in her fingers, squashing the sides together between finger and thumb until the piece resembled a cube. The cube underwent the

same repetitive process as the circle of clay until gradually the edges and corners began to soften. A few moments later, the piece was being rolled carefully and with great consideration between Abby's finger and thumb as a perfectly rounded, smooth ball. The session had been predominantly silent while the making took place, therefore I prompted some time for reflection on the work before the end of the session, Abby was able to note that she enjoyed making the pieces and that it was interesting that both were smooth in nature, much like the piece that was made in the previous week.

We spoke together about the relationship between the two items and whether it might be that they could sit together rather than individually on the piece of card, Abby discussed that she felt comfortable with the circle and ball being separate but that they were perhaps connected due to it appearing that the ball had come from within the circle. The unspoken remained held within this moment, the possibility that the two pieces represented mother and child, separate yet intrinsically as one. Within this exchange may be found the roots of Arne Jemstedt's (2000) concept that the "negative capability" of the therapist who sits comfortably with the unknown can lead to the provision of a wholeheartedly authentic therapeutic exchange in which the patient is empowered with the provision of space to formulate their own responses to the work.

The session came to a close with the understanding that both the artwork and the piece of card on which it sat would be preserved, due to the marks that had been transferred to the card, and that there would be an opportunity to return to the piece in the next session should she wish to do so.

Between the dates of session 2 and session 3, the unit staff undertook a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Abby, 7 days after the previous measure. On this occasion, the scale indicated a score of 1 within the subscale of mood and general routine and 0 within all other subscales; thus, indicating that there was deemed to be a significant reduction in the level of risk to the infant however that there was an increase in disruption within the subscale of mood and general routine.

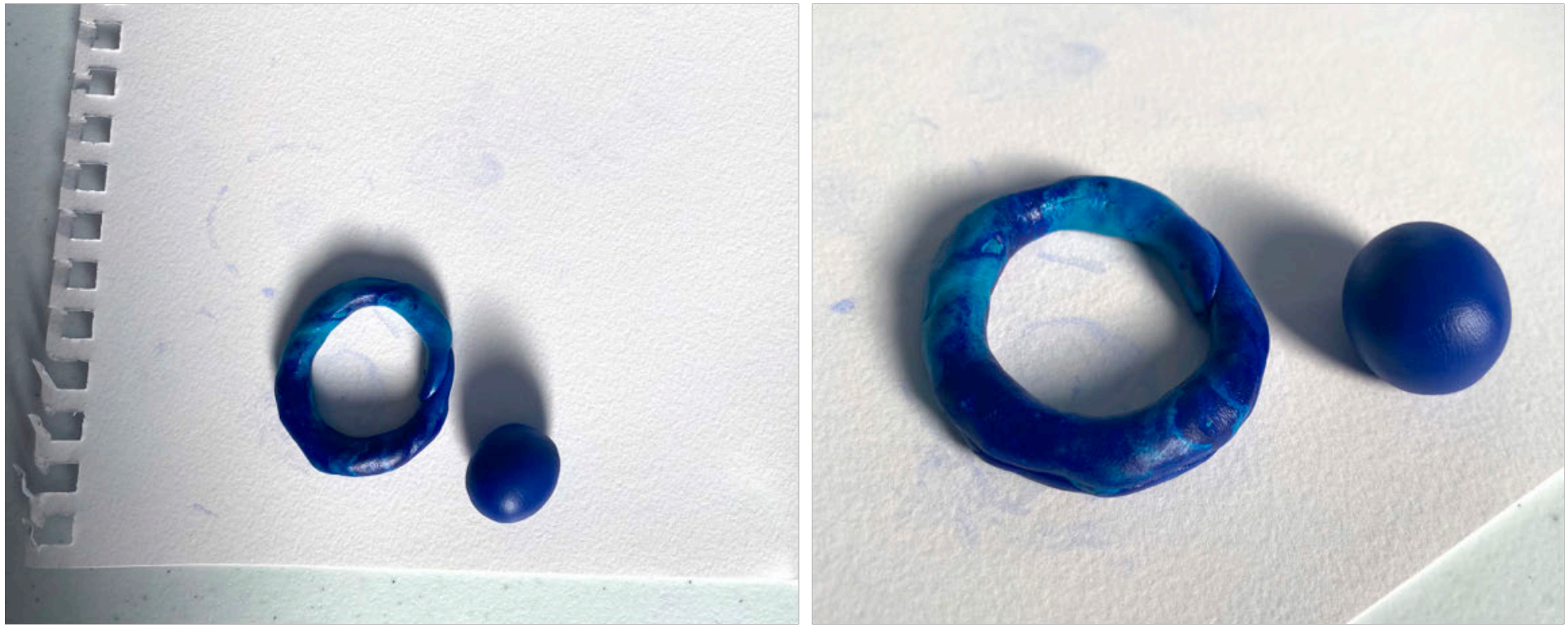


Figure 23, (left to right 23a, 23b), Abby's Artwork, Session 2

5.6.4 Session 3

The third session began with a sense of excitement, Abby relayed that she had been in discussions with a friend who had offered to support her in resolving challenges around accommodation and childcare ahead of any discharge being authorised from the unit. It was evident that Abby was somewhat in awe of the generosity that she was experiencing in the friendship, at this point I took time to mirror key sentences from Abby's dialogue back to her in order that she could hear all that was held within them.

As Abby began to settle into the session, I prompted her by offering whether she might wish to revisit last week's piece or to explore the art materials, Abby elected to return to the same material but to begin a new piece. Abby tore off two colours of clay, pale green and dark green, and began working with them. In previous weeks, Abby had moulded the clay together and warmed it in her hands, but this week she worked with the fragility of the cold clay straight from the packet. Abby positioned the pieces carefully, one on top of the other and then began to roll them up into a cylindrical shape (Figure 24), the piece was then held in Abby's hand above her lap as she sat back and tended to the 'seam' of the cylinder. Due to the nature of working with cold clay, cracks appeared in the piece as it was rolled into a cylindrical shape, these cracks were diligently tended to and smoothed over by Abby to maintain the appearance and strength of the shape. As the two ends of green clay met, Abby began working on them, smoothing and pulling material from one side onto the other, creating an almost imperceptible seam within the grooves of the piece.

Abby spent a large amount of time perfecting the smooth surface and ensuring the integrity of the piece. Upon my noting this with her, Abby was able to share that the piece felt significant, that it came about in an unexpected way, as had the offer of support from her friend. We wondered together about the coming together of two individual pieces to form a shape which appeared to be capable of providing a strong foundation, almost reminiscent of Corinthian columns found within Roman architecture; capable of supporting great weight yet simultaneously prepossessing. Abby commented that it felt as though she and her friend had come together to build a strong base for her own family unit.

Figure 24, (left to right 24a, 24b, 24c), Abby's Artwork, Session 3

While reflecting on Abby's evident preference for engagement with clay during her sessions, I was intrigued to discover the neurobiological effects of the use of clay in art therapy, also referred to as Clay Art Therapy (CAT). The outcomes of a randomised control trial indicate that the combination of the physical processing of clay alongside the simultaneous visual sensory input and cognitive processing, leads to the firing of a number of cortical regions; thus, resulting in improved emotion regulation and psychophysiological attunement (Nan & Ho, 2017).

Following the completion of the clay cylinder, in the final moments of the session, Abby sat the piece on the table and returned to a spare piece of the pale green clay that she had selected at the start of the session. She noted that this piece had been left untouched and that she disliked the idea of 'wasting it' yet Abby was aware that the session was about to draw to a close, in response to this Abby made a round ball by rolling the clay rapidly between her two flat palms, briefly inspected it and with a shrug of her shoulders, she placed the ball on top of the cylinder. This felt poignant to me, and I acknowledged this with Abby who was nonchalant about it. In holding the boundary of the session time, we drew to a close and agreed to meet in the following week.

During my reflection immediately after the session, I contemplated the last-minute addition of the ball of clay to the top of the cylinder and I felt a sense that the resulting combination of clay pieces felt tentative. Perhaps Abby had mirrored the previous session's piece (Figure 23) which held the possibility of an unspoken representation of the child and the mother, as yet unable to be together as one; yet in this session, Abby had been able to tentatively tolerate the risk of joining of the pieces but only by way of dismissing the significance of the act. Gabbard, (1982) determined that the "exit lines" of a psychotherapy session often carry the most potent exchanges, as the patient holds back what they perceive to be their most fearful or shameful communication, only to release it as their hand hits the door handle to leave the therapy room. Perhaps in this instance, the finite nature of the closing of the therapy session allowed Abby to safely enact the symbolic positioning of the two pieces of clay while also acknowledging the possibility of an underlying ambivalence about the union that she was not yet ready to expand upon within therapy.

Between the dates of session 3 and session 4, the unit staff undertook a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Abby, scoring 0 across all subscales, indicating that there was considered to be an appropriate level of interaction between mother and infant within all subscale categories.

5.6.5 Session 4

Session 4 began with a noticeably different atmosphere to previous weeks, Abby relayed that a plan for her discharge from the unit had been made and that she was to be going home later that day for a period of leave with discharge set for the following week. Abby presented this information with a sense of high energy, as she felt reassured that there was a clear plan for her future discharge. Arrangements were agreed between us regarding Abby's return to the unit as an outpatient for her remaining Art Therapy sessions.

Abby reached almost instinctively for the clay at the beginning of the session, she selected a dark green, a yellow and a red piece and began moulding them between her hands until the colours had blended into one single colour. As the clay came together into a ball shape between Abby's palms, she paused and began chuckling softly; Abby revealed that she had just noticed that the piece (Figure 25) "looked like poo". I mirrored Abby's chuckles with a gentle smile and Abby wondered aloud whether she was being childish, we sat in silence with this thought for a moment before I asked Abby whether the piece was sparking any feelings in her, Abby responded that she felt somehow uncomfortable with the piece, therefore she acted upon an urge to change it by adding in another colour of clay.

Scholt & Gavron (2006, p.69) identify that due to the "sensual and primary qualities of clay, which involve the client in procedural communication, clay-work allows and even invites regression processes that are crucial in therapy." Further to this, Scholt & Gavron propose that clay can bring about a "temporal regression" (Knafo 2002, cited in Scholt & Gavron, p.69, 2006) thus returning the patient to earlier phases of psychosexual development, resulting in a playful engagement with the notion of clay as faeces. As Abby worked to blend the additional clay into the piece, I began to reflect

upon the fact that we were nearing the end of her allotted six sessions of therapy, I mused that much like the process of eating during which the expelling of waste is a natural part of the process, perhaps it was possible that therapy may also result in the ejection of waste.

It was evident in Abby's body language that she began to feel significantly more comfortable when the colour of the ball of clay had completed the process of transformation, Abby observed the revised colour and reflected; "it is a rose colour, like rose tinted glasses, so perhaps everything will be ok after all".

Abby continued to roll the ball around between the palms of both hands as she began discussing the challenges involved in co-parenting a child, we noted together the similarities between a co-parenting relationship and the metaphor of the artwork; namely that two separate people had come together to mould and shape the life of a child, much like her hands upon the clay.

At the end of the session, Abby spoke about how helpful she was finding the Art Therapy approach, she felt that Art Psychotherapy enabled her to think things through at her own pace while using her hands, allowing her to expel energy while speaking whereas during other talking therapy sessions she described feeling left drained and somehow "undone".

Following this session, the patient was discharged from the inpatient unit and made contact with me in advance of the previously arranged session to inform me that difficulties with childcare arrangements were preventing her from being able to attend the planned session. We re-arranged the session date, which Abby then did not attend. At this point Abby became uncontactable via previously agreed methods, therefore following several unsuccessful attempts to make contact, I sent a therapy debrief letter to Abby's home address in accordance with the ethically approved patient protocol and participant agreement. Abby did not make further contact with me and was withdrawn from the research.

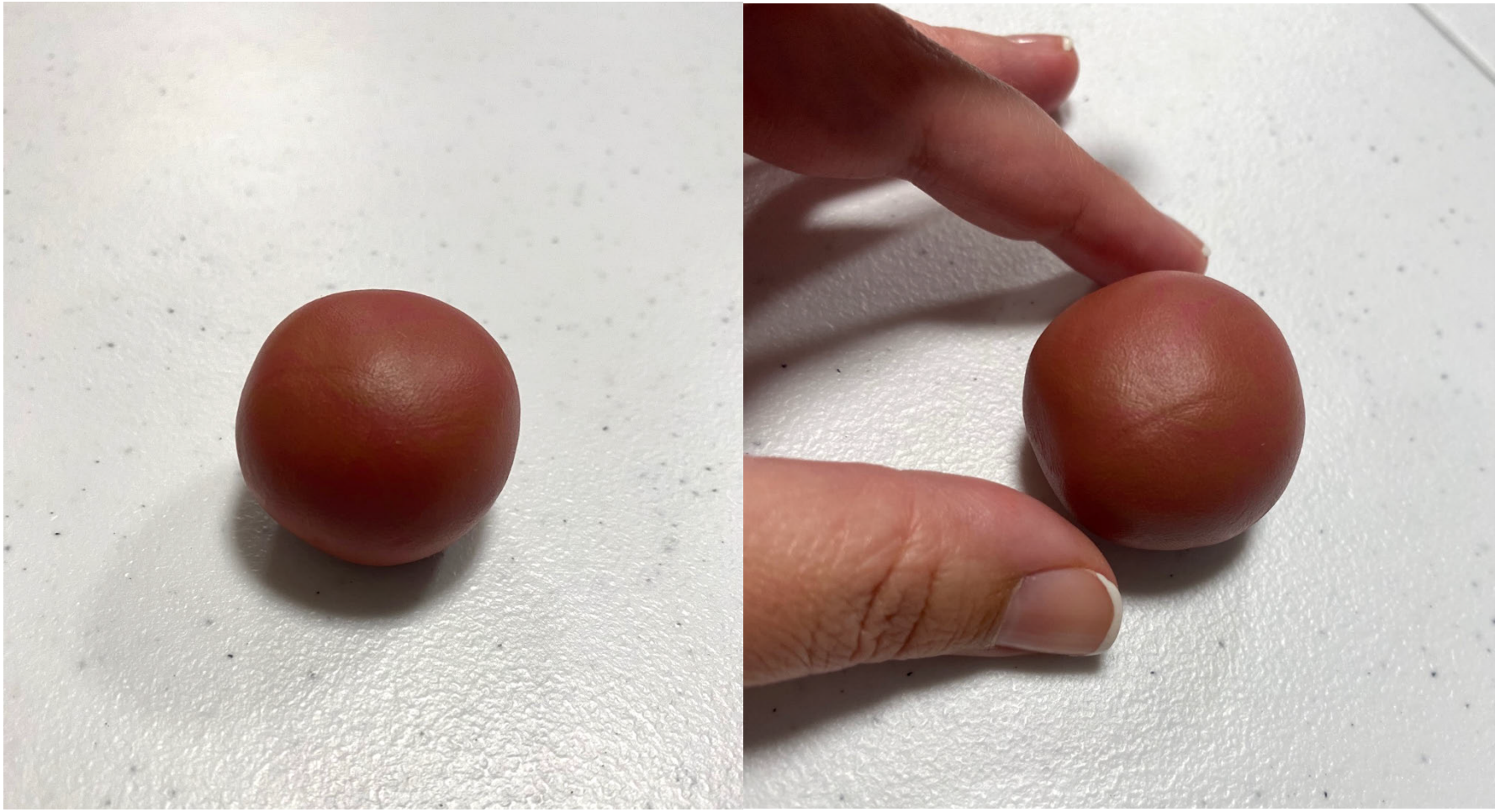


Figure 25, (left to right 25a, 25b), Abby's Artwork, Session 4

5.6.6 Observations resulting from clinical supervision

During my clinical supervision, I discussed feelings of frustration that had arisen within me following Abby's withdrawal from the research, the primary source being my speculation that the primary factor that had prevented Abby from returning for her remaining two sessions of Art Therapy was the absence of childcare. This stirred a deep sense of injustice within me regarding the apparent lack of support for women who assume multiple roles and responsibilities and consequently require childcare in order to tend to their own basic needs. As Susan Hogan (1997, p.19) discusses, an appropriate response to the "obvious fact that motherhood is frequently a socially isolating and stressful experience" would perhaps be to prescribe childcare rather than medication. This underlying issue was astutely identified within clinical supervision as being tied to many of my personal experiences as a mother, therefore I continued the exploration of this aspect of reflective response within my own therapy.

Additionally, I found that a sadness remained that Abby had not been able to conduct an Audio Image Recording, therefore she was left without a formal therapeutic transition and processing of the ending of therapy. My clinical supervisor prompted me to consider that perhaps the fourth session had been all that Abby had needed by way of an ending. It was possible that Abby's comments about how helpful she had found Art Therapy felt like a goodbye for her, particularly if she had been aware at some level that she would find it challenging to achieve the practicalities of returning for her final sessions.

5.6.7 Post discharge reflective art making

In light of the clear preference displayed by Abby for working with clay during her Art Therapy sessions, I found myself drawn to mirror this choice when beginning my personal reflective art making practice. I began with a strip of white clay which felt clean and untarnished by the other colours, yet the clay was simultaneously somewhat unpleasant in texture due to it being sticky and leaving a greasy residue on my fingers. The white clay had grooves embossed along the length due to the packaging, I felt

compelled to use the grooves as a guide to attempt to tear the clay into several long, thin strips yet in attempting this action, the clay revealed itself as being unexpectedly brittle and began to break into multiple small sections. After making a pile of the broken pieces (Figure 26a), I paused for a moment to consider their shapes. I was reminded of the children's game "pick-up sticks" in which a collection of thin sticks are allowed to overlap in a pile and one must carefully lift one stick at a time without disturbing the others; somewhat reminiscent perhaps of the process of therapy in which a sharing often takes place in a tangle and the therapist is tasked with the process of untangling without disturbing the security and integrity of the overriding structure.

It became important to me to create a vestibule in which the pieces could be contained, I noted that this idea may have formed in an attempt to counteract the sense of spilling out that I had been left with at times during my work with Abby. I selected a yellow piece of clay and began working it into a ball, the irksome sticky residue covering my fingers once again. I pressed the ball against the work surface with the flat of my thumb, attempting to spread it out on the page, to blur the boundaries in order that it could hold more of the pieces than the visual capacity suggested. The corners were folded together (Figure 26b & 26c) in a bid to provide the structure with integrity before I placed the pieces inside the container, one by one, noting within me a sense of dismay that I had appeared to make an inadequate container, incapable of holding all of the pieces.

Figure 26, (left to right, 26a, 26b, 26c), Therapist, Post Discharge Reflective Artwork

5.6.8 Subordinate Codes and Superordinate Themes

Abby	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Superordinate Themes	Self-soothing	Expenditure of negative energy	Desperation	Dedication to others	Moulding of self	Seeking change
Subordinate Codes	Enthusiasm	Hopelessness	Urgency	Responsibility for others	Moulding	Containment
	Regulation	Personal lack of confidence	Pressured speech	Helping others	Blending	Separation
	Self-soothing	Exhausting	Racing mind	Professional confidence	Smoothing	Desire for containment
	Strength	Overwhelmed	High energy		Colour mixing	Transformation
	Warmth	Anxious	Spilling out		Rolling	Expelling of waste
	Repetition of movements	Perfection	Concern about waste		Combining	
		Doubting ability as a mother			Circle	

Table 19, Codebook, Abby

Six superordinate themes were determined via coding of my observations and perception of the patient experience within Abby's case study (Table 17); self-soothing, expenditure of negative energy, desperation, dedication to others, moulding of self and seeking change. Regarding the theme of self-soothing, this was informed by the observation of Abby's desire to undertake several self-soothing behaviours within the work such as repetition of movements and revelling in the warmth of the materials. Malchiodi (2020, p.165) explains that self-soothing as an act of self-regulation is vital in establishing the capacity to sooth and calm one's stress response; "self-regulation is an initial critical competency that forms the basis of any future successful intervention".

Similarly, to the aforementioned superordinate theme of catharsis, I perceived that Abby underwent a process of releasing negative energy during the intervention, via expressions of feeling overwhelmed, hopeless and doubting her ability as a mother, this fed into a theme of desperation which was communicated via pressured speech, urgency and a sense of spilling out. Abby's portrayal of her perceived responsibility for others informed a theme of dedication to others while the repeated actions of blending, smoothing and mixing were summarised in the theme of moulding of self.

Finally, I felt it was evident within Abby's work that she was communicating a desire for containment with simultaneous separation in order to conduct a process of transformation, therefore the theme of seeking change was allocated.

5.7 Alice

5.7.1 Recruitment phase

This patient case study draws upon the Art Psychotherapy intervention conducted with an inpatient of the Perinatal Mental Health Unit who shall be referred to by the pseudonym, Alice. During the initial recruitment phase, Alice was cognisant of our conversation in spite of being was hindered by lethargy. It was clear that Alice had heard the introduction to the research and was given the recruitment information pack. During the second recruitment discussion after Alice had been able to consider the information with staff, family and friends for a week, Alice was better able to engage and asked appropriate questions about the intervention. Upon confirmation of understanding and informed consent, Alice was randomised and allocated to the intervention group.

5.7.2 Assessment - Session 1

In the two weeks prior to our first Art Therapy session, the unit staff completed the Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) on two occasions. The first with interaction being scored as 1 within the subscales of eye, physical and vocal contact along with mood and general routine, with scoring indicating a broad experience of low-level disruption. The second measure indicated that disruption to interaction between mother and infant had reduced to low-level disruption across only three subscales of physical contact, mood and general routine.

During the introduction of session 1, Alice completed the baseline measures of ReQol20 (Keetharuth et al, 2018) and WEMWBS (WEMWBS, University of Warwick 2006) under my supervision. ReQol20 (Appendix 9.10) was scored at 53 with statements rated to indicate that Alice often felt anxious but only occasionally felt lonely or felt like a failure, therefore it can be observed that the score for this measure

fell 3 points outside of the determined clinical range for diagnosis and treatment. Upon completion of the WEMWBS (Appendix 9.11), the measure was scored at 42 with statements ranked to convey that Alice had been thinking clearly and feeling confident some of the time in the previous two weeks, the clinical cut off for indication of low wellbeing is 42, therefore it can be observed that both measures demonstrate that Alice was experiencing emotions at the borderline of clinical range at this point.

Following the completion of measures and the establishing of mutually curated boundaries, Alice showed a keen interest in exploring the art materials. Alice was drawn to select the watercolour palette and noted verbally, while preparing the brush and a purple piece of thin sugar paper, that she would not ordinarily seek out engagement with watercolour because she "likes to control things… I mean actually, not control but make choices about things". Alice explained that she changed the wording of her observation because she was trying to consciously change the way that she spoke to include fewer negative inferences. Alice made what she described as "test marks" on the right-hand side of the paper with pastels.

As Alice worked on the piece (Figure 27), she spoke about having "grown up quickly" as a child aged 8-18 as a result of her mother being terminally ill and Alice being her mother's main carer due to her father's work commitments. Alice explained that she would go home to care for mother in the middle of school day and that her father expected her to hide her emotions and "just get on with it". Alice shared that when she was 18, her mother passed away and Alice went travelling in a bid to get away from the assumption that she would take on the mother role for her father and brother. Alice shared that while traveling, she felt resentment as a result of an arrangement that had been made by family friends who organised for Alice to chaperone their child and care for her additional needs during Alice's travels. Alice became quiet momentarily after sharing this and then elaborated that she had "never said this out loud before because it always felt wrong".

Figure 27, Alice's Artwork, Session 1

I wondered with Alice about the early experiences of caring for others, or mothering, that she had provided to her mother and the family friend. Alice reflected that she felt proud of the care that she gave to her mother, but that this was in stark contrast to the feeling of resentment that remained tied in with the experience of the family friend. When prompted to considering how mothering her own child felt in contrast to those previous caring relationships, Alice communicated a sense of excitement about having created a family unit with her child and husband. Alice was also able to identify that her choice of adult profession (withheld in order to preserve anonymity) was intrinsically linked to her instinct to mother and care for others. While reflecting on the multiple mothering roles within Alice's life, I was led to recall Alice Miller's (1995) observation that the majority of people working in helping professions have a childhood history of moderating their own emotional responses to avoid inconveniencing others, simultaneously experiencing a hypersensitivity to the perception of and urge to meet the needs of others. Miller (1995, p.17) continues that such people who have "been a little adult" from the beginning, can develop "a new empathy with her own fate, born out of mourning" when given the therapeutic space within which to do so. In providing Alice with this space, she appeared to have begun the process of revisiting these formative experiences and allowing herself to experience sensations of grief.

While Alice had been speaking, she had been carefully working on the paper with the watercolours, she had noted the risk that the paper might be prone to disintegrating should she have flooded it by adding too much water on the brush. Reminiscent of the therapeutic relationship, Alice was testing the physical boundary of the paper's / therapist's ability to contain the fluid art material / emotional content while acknowledging her choice to begin her mark making at the outer edge of the paper itself, already almost breaching the boundary of containment. Davis and Wallbridge (1991, p.143) discuss Winnicott's concept of boundaries by summarising that an individual has a need to establish secure boundaries, yet "once this security has become established within, there comes a need to take the risk of breaking out, of struggling against the boundary… to establish themselves as themselves".

The order of the formation of marks made on the paper by Alice were of note, over the duration of the session a tree was revealed on the paper; first came the trunk, Alice

then added branches, then followed a cloud over the tree with what Alice described as “sideways rain, storming over the tree” indicating a somewhat aggressive form of nourishment, followed by the formation of were. As Alice was speaking about her present-day experience of mothering her own infant, she began adding pink blossom to the tree, exclaiming that she had felt a sudden sense of excitement as she contemplated her future as a mother now. Toward the end of the session, when prompted to discuss the ground around the tree, Alice observed with a wry chuckle that the tree did not appear to have any stabilising roots; she was surprised by this observation and the metaphoric link to her childhood and declared that she would like to explore this further in our next session, but by revisiting the watercolours with thick watercolour paper.

In the closing moments of the session, I prompted Alice to reflect on how the session had felt for her, Alice responded that having not had the opportunity to play in her childhood, it felt somewhat difficult for her to be playful now within the creativity of Art Therapy sessions. Alice noted that she wanted to engage in the work, but also felt a sense of guilt which she understood was because she had “been taught not to care for her own needs”.

5.7.3 Session 2

Alice opened the second session with a discussion of what she perceived to be a regression in progress, she noted that her confidence had been knocked when dates were agreed with her care team for her to go on home leave, because she worried that it was happening too quickly. The leave and planned discharge dates were subsequently cancelled when Alice’s anxiety increased, and she began experiencing auditory hallucinations which she described as “constant negative voices which judge me” by making negative observations about her interactions with her infant. Alice explained that she was in an exhausting cycle of believing that she could hear staff making negative judgements about her ability as a mother, yet upon testing that reality by opening her door to check, she would realise that this was in fact the impact of the auditory hallucinations. Alice shared that the auditory hallucinations caused her to experience voices telling her that she is not able to be a good mother, while trying to interact with and care for her infant, as such she felt the weight of the judgement left

her feeling frozen and unable to interact when she was with her baby. In response to Alice's discussion of auditory hallucinations, I employed the service-user generated approach of the international Hearing Voices Movement (HVM), (Hearing Voices Network, 2023, cited in Wood, p.88, 2020) response pattern which acknowledges that patients may experience three phases of response to auditory hallucinations. Chris Wood (2020) summarises that the HVM acknowledges that the patient may experience a startling phase during which a therapist may respond by "establishing a sense of safety and human connection in relation to the shock of these sensations", followed by an organisational phase which can allow for exploration of links between the nature of the voices and any related life history for the patient, finally a stabilisation phase is encouraged which focuses upon understanding and establishing of resources for the patient, with advocacy from friends and family playing a vital role. The HVM moves away from the "illness model and prejudiced stereotypes; essentially the voices and the people who hear them are accepted and treated with respect" (Wood, 2020). During the therapy session, I responded to Alice by ensuring that I offered gentle reminders of the safety of our space and our therapeutic boundaries, by exploring themes of historical family relationships as they arose within the artwork and finally by encouraging Alice to seek advocacy for needs via trusted family members.

Alice appeared uncomfortable in her body language and explained that she felt embarrassed to say these things out loud because she had not felt able to share it previously. Alice appeared fixated on the question of whether she should discuss the frozen feeling with staff, she felt that she wanted to seek support from them with interacting with her baby however, simultaneously Alice felt it was important to avoid "being needy" with the staff. By mirroring the question softly to Alice, she appeared to feel able to take some time to ponder the response, resolving that she thought it was important to speak with the staff. Alice set out a clear verbal plan to speak with her partner about it first so that he could act as an advocate if she felt she needed it, I noted with Alice that this seemed particularly important in encouraging her not to minimise her needs when speaking with the staff.

I discussed with Alice whether there might be a link between the concept of being "needy" and the last session in which we discussed a time when her needs were not met as a child because she had to care for others. Alice took time to consider this and

responded that she could recognise a tendency in her to minimise her needs and emotions when communicating them to others. It felt timely to remind Alice at this point that the session time is solely for her and to encourage her to allow herself to be generous when using the materials as her material packet is there for her to use and will be replenished as required. Alice said that she found this to be a good reminder and immediately got a packet of clay out, I asked if she noticed a change in how she felt about approaching the clay, she was able to notice that she had planned to take a piece of clay from the section of the packet that was already open, but that in response to my reminder she felt able to open the film packet in a different area and instead selected the colour that she truly wanted to use. This exchange of nourishment between therapist and patient via the supply of materials served to embody Joy Schaverien's observation that by providing a plentiful selection of quality materials, the therapist demonstrates a respect, an "early affirmation and valuing of the work patient and therapist are about to embark on together" (Schaverien, 1999, p.83).

Shortly after opening the clay, Alice became stuck with her words and appeared to be lost in thought. After some time had passed, I softly prompted Alice with the offer of returning to the act of exploring the materials if she felt stuck with her verbal expression, Alice picked the clay up and immediately lowered her shoulders and set to work with the clay. Alice repeatedly pulled away multiple small sections of clay from the main piece and made each one into a small ball, the clay balls were formed into imperfect spheres, many still contained signs of folds through their centres, each being a slightly different shape and size (Figure 28a). Alice carefully placed each ball onto a piece of paper that I had provided for her so that the clay could be preserved after the session without the risk of it sticking to table. When prompted, Alice noted that she was inexplicably drawn to one particular shape which was close to her and was one of the largest balls (Figure 28b), Alice expanded upon this reflection in noticing that none of the shapes were touching.

As the end of the session neared, Alice explained that she had a scheduled psychology session after the previous session of Art Therapy session and was surprised to note that she felt "far less need to speak lots" with the psychologist due to the benefit that she had felt by having had our Art Therapy session earlier in the day. In response to this, I noted with Alice that this was an astute observation of the ways in

which therapy professions work in differing ways and that there may be occasions during which one approach, or a blend of approaches may be more appropriate for patients than others.

After Alice had left the room and I was able to move around the therapy room freely, I was struck by the sense that the positioning of Alice's artwork held some significance. It appeared to me that Alice had positioned the artwork such that it appeared to have been pushed toward me (Figure 29, showing the position of the artwork in relation with my chair), that the tip of the "wave" of clay is mirrored by the corner of the paper which was pointing toward my seat. I felt a sense of having been an unwitting collaborator in the creation of the piece without having touched any of the materials, rather than experiencing this non-consensual, subconscious creative involvement in a threatening sense, I was left with a feeling of being honoured to have been included as a non-threatening participant rather than be treated as a distanced observer. Winnicott's (1971, p.146) described the "potential space" between mother and infant and simultaneously between therapist and patient, in which there is "creative playing that arises naturally out of the relaxed state" and patient begins to move from "dependence to autonomy" by exploring the potential space as an "infinite area of separation" between the therapist and themselves. It is possible that Alice had felt the weight of the increasing possibility of home leave being scheduled, therefore feeling compelled to tentatively experience the potential space during the safety of the session by creating her artwork in the hinterland between us. When working with clay during the Art Therapy process, Sholt & Gavron (2006, p.71) observe a process of "procedural expression which can enable access to non-verbal representations of self, other and the relationships between self and other" thus facilitating a continuation of "their journey of becoming". Alice's artwork was built carefully with the measured addition of each ball of clay, or perhaps, each piece of herself; a process of testing the potential space with a gradual reveal of herself within it.

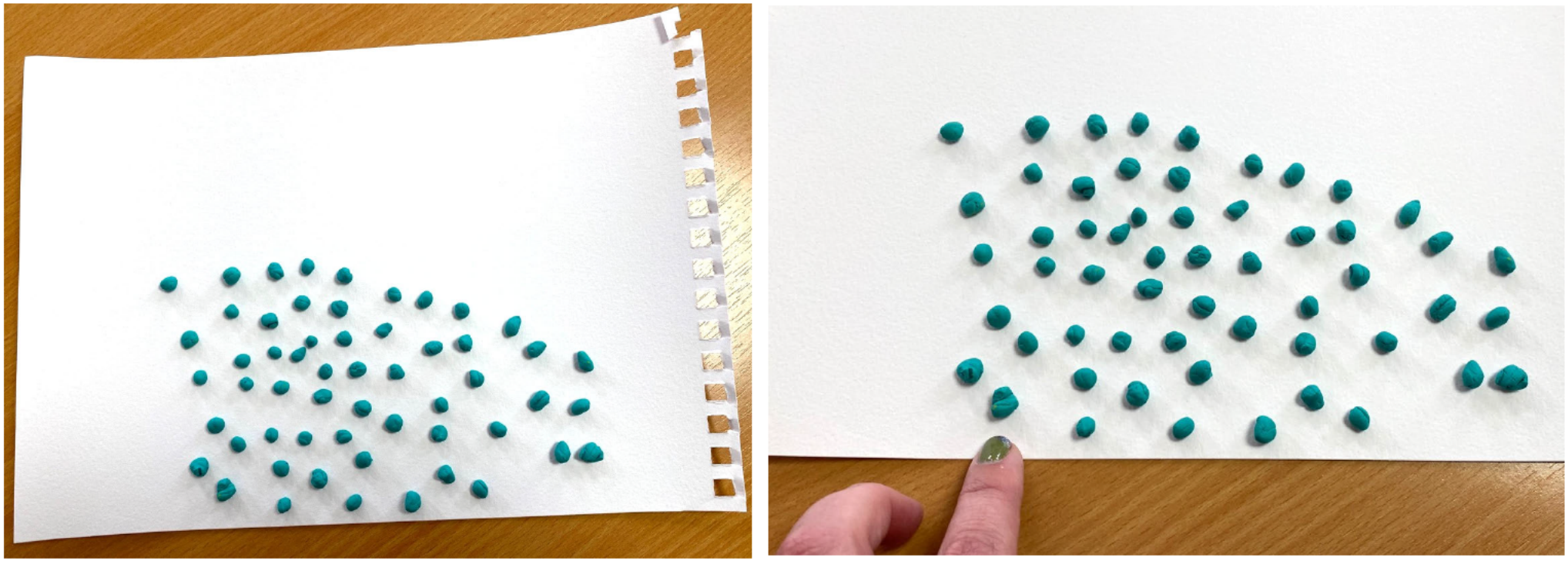


Figure 28, (left to right 28a, 28b), Alice's Artwork, Session 2

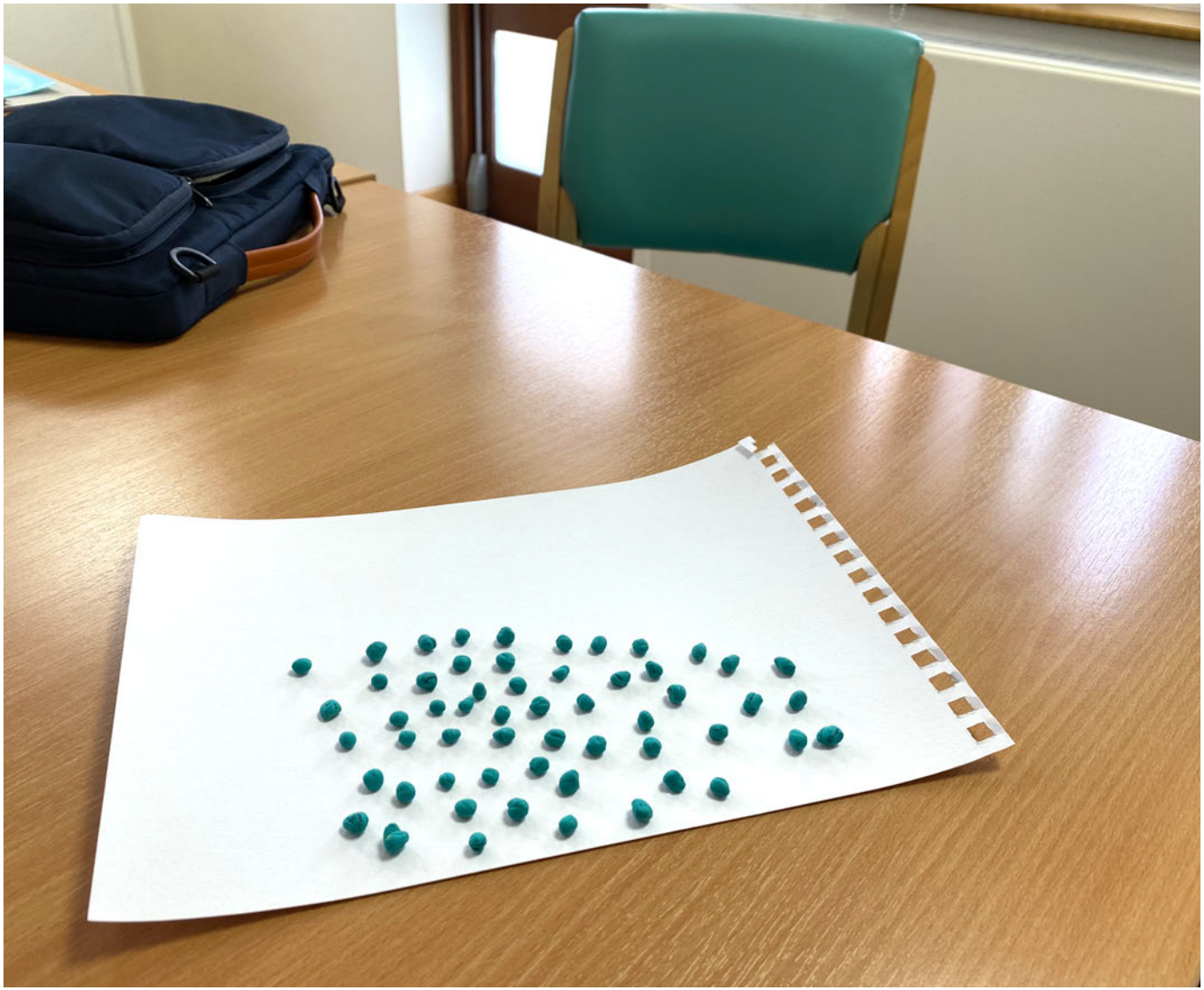


Figure 29, Alice's Artwork Positioning, Session 2

In the following week, I offered Alice her third session and she relayed that she was planning to go on home leave that same afternoon therefore she would rather go for a walk in the grounds instead, I acknowledged Alice's choice and we agreed that we would meet again in the following week when Alice had returned from leave. It was my sense in discussion with Alice and with unit staff that Alice may have made this decision, and an additional decision not to engage with the psychology team on this date, due to being fearful of the potential for therapy to cause an element of release or regression prior to her leave. Alice then commenced several long periods of home leave in an area which was not local to the unit and was subsequently discharged from the inpatient unit. Prior to discharge, I made telephone contact with Alice in which we both noted that it would not be possible for Alice to travel back to the unit for further Art Therapy sessions due to geographic distance; upon offering to arrange for delivery of Alice's artwork to her home address, Alice elected to leave her artwork with me and agreed that I would send her a therapy discharge letter.

5.7.4 Observations resulting from clinical supervision

After Alice was discharged from therapy, I found that I was left with a sense that in being asked to retain the artwork, I was holding parts of the patient that Alice had chosen to leave with me, yet which simultaneously existed in the now disrupted "potential space" (Winnicott, 1971, p.146) between us. I was prompted during clinical supervision to return to the Hearing Voices Movement (Hearing Voices Network, 2023, cited in Wood, 2020, p.88) approach in sitting with the possibility that each individual piece of clay that Alice placed on the paper may have been a careful and considered process of Alice practicing autonomy by leaving me with a representation of her auditory hallucinations, having perhaps felt a sense that I was capable of holding them without judgement, safely and respectfully, within the therapeutic relationship.

5.7.5 Post discharge reflective art making

French et al (2014) observe that the process of research requires the researcher to allow themselves to be vulnerable to the power of the process of truly seeing the story as it is revealed in front of them; "the experiential gaze is not an abstract perception

from the safety of the intellect: it is a fully emotional, lived gaze that requires an engagement of the whole person, which ultimately transforms the researchers identity" (French et al, 2014). In reflecting on my having allowed myself to be open to the therapeutic process undertaken with Alice, I felt compelled to create a three-dimensional piece of work (Figure 30), I began by selecting a soft, slightly crumpled piece of printed tissue paper which I carefully folded and rolled into a long tube. The tube was secured with tape, I then made cuts in the soft end of the tube which bore the unfolded tissue edges, at this point I was drawn to look through the piece. In bringing the tube to my eye, I became aware that I had created a telescope of sorts, a tool with which I became able to cast my gaze both literally and metaphorically upon the therapeutic work before me. The feathered edge of the telescope provided me with a sense of softening of the potentially intrusive nature of my gaze upon the subject. I noted that this tool afforded me the safety of distance from the subject thus avoiding overwhelm while simultaneously providing a zoom lens via which I could focus the cross section of my analytic, therapeutic and academic gazes.

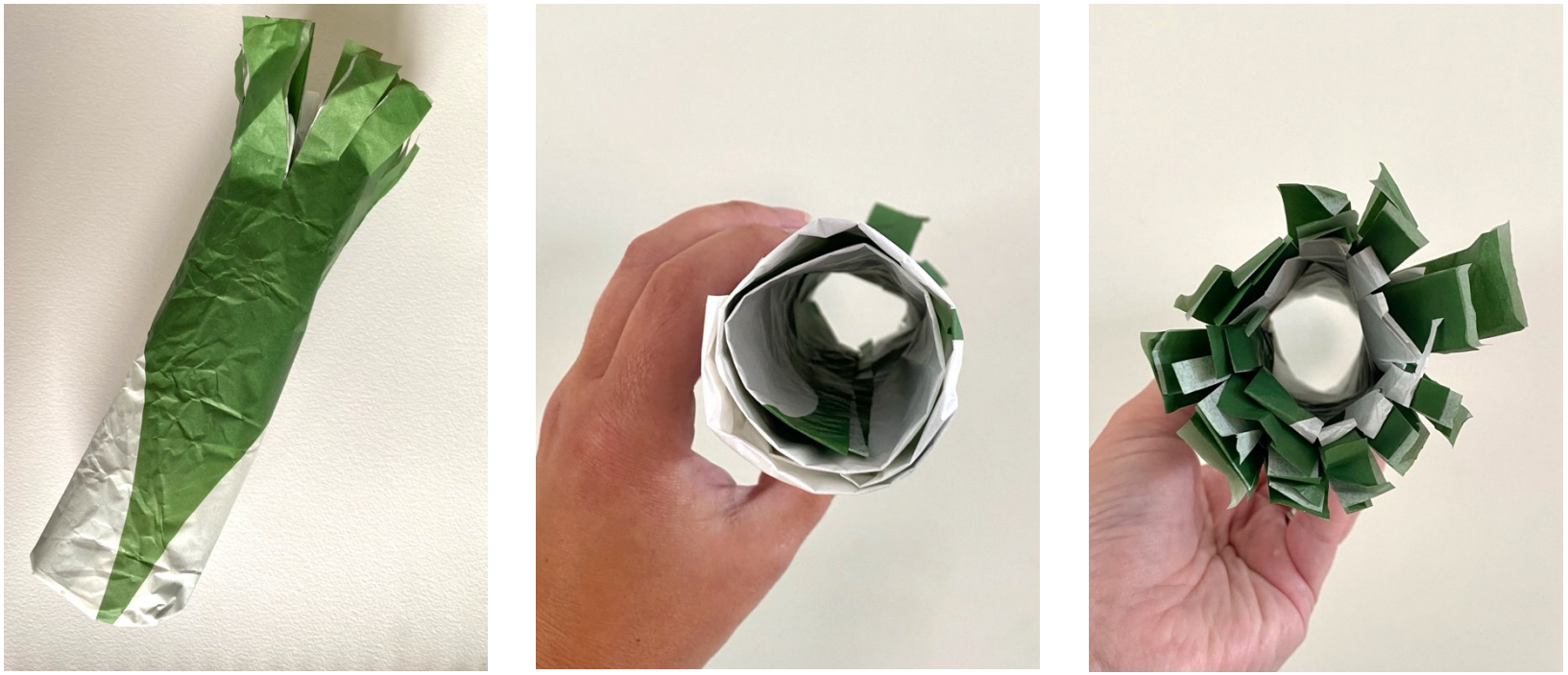


Figure 30, (left to right, 30a, 30b, 30c), Therapist, Post Discharge Reflective Artwork

5.7.6 Subordinate Codes and Superordinate Themes

Alice	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Superordinate Themes	Mothering / Caring role	Control	Negative Emotional Catharsis	Ability to mother self	Artistic catharsis	Judgement
Subordinate Codes	Premature maturation	Control	Resentment	Fearful of own perceived neediness	Flooding	Auditory hallucinations
	Caring for others	Testing out	Shame	Not instinctively generous with self	Disintegration	Negative voices
	Mothering of others	Careful wording	Grief	Fearful of release / regression	Spheres	Judgements
	Multiple mothering roles	Testing of capacity for containment	Lethargy	Lack of play	Nature	Frozen
	Nourishment	Secure boundaries	Struggle	Separation from self	Roots	
		Testing of reality	Regression			
		Collaboration	Anxiety			
			Unable to interact			
			Doubting ability as a mother			
			Imperfect			

Table 20, Codebook, Alice

Reflection upon Alice's case study and my observations of her experience of Art Therapy led me to present an overview of six superordinate themes (Table 18); mothering role, control, negative emotional catharsis, ability to mother self, artistic catharsis and judgement.

The mothering role theme was drawn from observations of the spoken and unspoken representations of the multiple mothering roles in Alice's sessions. The theme of control was repeating in this case study which was reminiscent of Alice's desire for control and testing of both boundaries and reality. Negative emotional catharsis, understood in relation to the explanation given in section 5.5.8, was observed within the expression of struggle, anxiety and Alice's doubting of her ability as a mother. In witnessing Alice's engagement with the art materials, I was particularly struck by the potency of the emotional release held within her work and artistic processes as she

experimented with disintegration and flooding, I therefore determined the theme of artistic catharsis.

Alice was greatly influenced by a sense of judgement of her abilities in all realms, particularly when considered in combination with the effects of her auditory hallucinations, this is reflected within the theme of judgement. Alice's approach to her own assessment of artistic adequacy was based seemingly upon the subconscious elements held within each image rather than the marks on the paper, as Schaverien (p56, 1999) notes "it can feel distinctly uncomfortable to see, in a picture, elements of one's imaginal world which it would have been preferable to deny".

5.8 Jane

5.8.1 Recruitment

This patient case study draws upon the Art Psychotherapy intervention conducted with an inpatient of the Perinatal Mental Health Unit who shall be referred to by the pseudonym, Jane. During the initial recruitment phase, Jane was able to engage in conversation with me. Jane explained that she would need time to consider the information that I had shared with her, as she felt the need to discuss it with her family. Jane was given a full week to consider the documents and discuss them with unit staff and family members. During the second recruitment discussion, Jane was accompanied by her mother who ensured that Jane had understood the research recruitment information. Upon confirmation of understanding and informed consent, Jane was randomised and allocated to the wait-list group.

5.8.2 Assessment - Session 1

Following her discharge from the unit, Jane returned six days later for her first Art Therapy session. The boundaries of the therapy were established between us, and baseline measures were taken. Jane indicated a reluctance to complete the baseline measures and explained that she found the wording difficult to understand and that the

questionnaires felt too long. In recognition of this, I offered to read the baseline measure statements out to Jane for her to consider and then rate accordingly.

Four weeks prior to our session, unit staff had completed a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with subscale scoring recording a 3 for vocal contact, 2 for eye contact, mood and general routine and 1 in the subscales of risk to baby and physical contact, therefore indicating a generalised, moderate disruption to interactions between mother and infant. Jane's completion of the ReQol20 (Keetharuth et al, 2018), (Appendix 9.12), was scored at 75, only 5 points away from the highest score indicating high quality of life, with statements indicating that Jane only sometimes felt unable to cope or found it hard to concentrate within the last week. After completion of the WEMWBS (WEMWBS, University of Warwick 2006) under my supervision, Jane scored the highest possible score of 70 (Appendix 9.13), indicating high wellbeing with statements indicating that Jane had been thinking clearly and feeling cheerful all of the time in the previous two weeks.

After introducing the set of art materials to Jane, she repeatedly emphasised to me that she was not good at art but that she enjoyed doing it, I reminded Jane that there is no judgement about the nature of the work produced in Art Therapy sessions. Jane appeared to be stuck with the large selection of materials available therefore I offered to make alongside her and picked out a small selection of paper and pencils, Jane elected to work with a white piece of paper and a lead pencil. I explained to Jane that I would simply start making marks on my piece of paper (Figure 31) without worrying about what they were and that she could begin doing the same if she felt able to do so. Jane appeared to be tense in her body language with hunched shoulders as she sat at the table, she explained that she was struggling to know what to draw therefore I suggested that she might wish to do some imagining and draw the first abstract shape that came to mind.

I began making marks on my piece of paper, organic lines and circles in response to the sense of intimidation and pre-occupation with artistic skill that I sensed was being conveyed by the patient. As I worked on my piece, I narrated some of my actions and thought processes by way of modelling the process of what art making in Art Therapy sessions might look like; "I think I will add a line here… yes I am going to find a

brighter colour now and try out swirling my pencil around on the page to see what happens". As we both worked on our separate pieces of paper, Jane repeatedly glanced at my paper and reiterated comments such as "oh, you are very good at art… haven't you done well". Despite my repeated reminders that the process of Art Therapy is not about making "good art", Jane appeared unable to pull away from her focus upon my work, therefore I chose to subtly cease working on my piece entirely in order to disrupt Jane's focus on my work and instead held the pencil at the side of the paper for a while, as though pausing in thought.

Jane appeared to gradually relax into the art materials and as she started drawing, she filled more and more of the page with pencil drawings (Figure 32a). Jane shared with me that she was thinking about her bed at home and that it felt good to be back at home with her cat following her discharge from the unit. In the closing minutes of the session, Jane drew an additional series of seemingly unrelated shapes (Figure 32b) while making in what felt like comfortable silence. When prompted to reflect upon the piece of work, Jane remained within the scope of literal observations, noticing that the thought of her bed made her feel happy and that she liked butterflies. Hogan (2021, p.2) observes the "strong cultural taboos preventing women from expressing their feelings, not least the fear that their children may be taken away from them", I was struck that these seemingly superficial observations may have been a defence mechanism to prevent the unwitting revelation of a deeper distress.

At the end of our session, I wondered with Jane whether she might feel more comfortable working directively, I suggested that we might work together next week on the same large piece of paper, taking turns in basic mark making, Jane smiled broadly and explained that this idea felt good and that it would help her to know what to do in the session. After Jane had left the therapy room, while reflecting on the session, I came to realise that after drawing the bed and the cat, Jane had then started to draw images while copying from the packaging of art materials that were on the table next to her.

Figure 31, Therapist Artwork, Session 1

Figure 32, (left to right 32a, 32b), Jane's Artwork, Session 1

Upon immediate reflection of the session, I was able to note the dynamic of the therapeutic relationship between patient and therapist, described by Joy Schaverien (2000) as the therapeutic alliance which is subject to the context of Schaverien's (2000) proposed triangular relationship between patient, therapist and artwork. I reflected that the triangular relationship within this session may have been disrupted due to Jane appearing to model the importance of paying compliments when regarding artwork and perceived artistic skill. I wondered whether Jane had felt rejected in response to my lack of compliments regarding her piece of work as I held the mutually agreed boundary of negating the need for appraisal of artistic skill or quality of artwork in Art Therapy sessions by not complimenting or reviewing the patient's artwork. Schaverien (2000) expands upon this dynamic by observing the activation of "aesthetic countertransference" at the point at which the therapist casts their gaze upon the patient's artwork, thus bringing the image to the centre of the triangular relationship. In describing this process within a clinical case study, Schaverien noted the patient's anxiety regarding the quality of her work, "her concern about whether the work was 'good enough' was also a concern about whether she would be acceptable when she revealed the extent of her distress" (Schaverien, 2000, p.80). This brings me to reflect upon whether the vulnerability of revealing herself within the artwork was too acute for Jane to bear, a continuation perhaps of Jane's response to the baseline measures which she may have experienced as an invasion, attempting to forcibly reveal her experience of mental distress.

Jane's mother made contact with me prior to the next arranged session date, she relayed that in spite of understanding the consent process and information pack, Jane had hoped that Art Therapy sessions would be more like art classes in which she could learn new creative techniques, therefore Jane wished to withdraw from Art Therapy. I thanked Jane's mother for advising me of this and sent a therapy debrief letter to Jane's home address.

5.8.3 Observations resulting from clinical supervision

Upon reflect of the experience of completing the baseline measures with Jane, I felt a sense that Jane may have been seeking to please me with the outcome of the measures and therefore perhaps did not feel fully able to represent her experiences

truthfully within them. This may tally with the experience of Jane seeking to continually compliment my artwork and perceived artistic skill.

Upon further reflection of the work, I was able to begin a questioning of the bed represented within the work; in noticing a single pair of thin legs, I wondered how stable it was and how comfortable it might be given the apparent lack of soft bedding or indeed perhaps the absence of a mattress. Similarly, I was struck by the angular nature of the cat which may ordinarily be expected to be experienced as a soft, organic shape. The process of clinical supervision allowed me to consider whether this had been an indication of Jane's experience of her surroundings being 'at odds' with societal expectations. This left me with a feeling of sadness at the possibility that Jane had not felt comfortable within the environment of our Art Therapy session.

In a bid to assuage feelings of guilt, I sought reassurance during clinical supervision that the research recruitment process had provided a description of Art Therapy sessions that was sufficiently clear in differentiating the experience of therapy from that of an art class. I was reminded at this point of the rigorous nature of the NHS ethical clearance processes which examined and carefully curated the thorough recruitment information pack.

5.8.4 Post discharge reflective art making

While reflecting upon the single session of Art Therapy with Jane, I was drawn to mirror Jane's approach to the materials by selecting one sharp pencil and a piece of paper. My instinct was to attempt a softening of Jane's representation of her bed, I began drawing a sturdy bed frame with rounded edges, pillows, a duvet, and the addition of Jane's cat at the end of her bed (Figure 33). As my marks came together, I was struck by how suddenly uncomfortable I had become with my artwork as I realised that I had found myself seemingly working to improve the patient's work, by recreating it as I felt it should have been. I sat with the unpleasant observation and battled with the resulting desire to destroy my piece of work. I returned to the piece some time later with a purposefully open mind and was reminded that my original intent was to provide a space for Jane, a soft, comfortable, safe, therapeutic space; in the absence of being

able to continue sessions with Jane, I was perhaps attempting to meet that desire to do so through my reflective work.

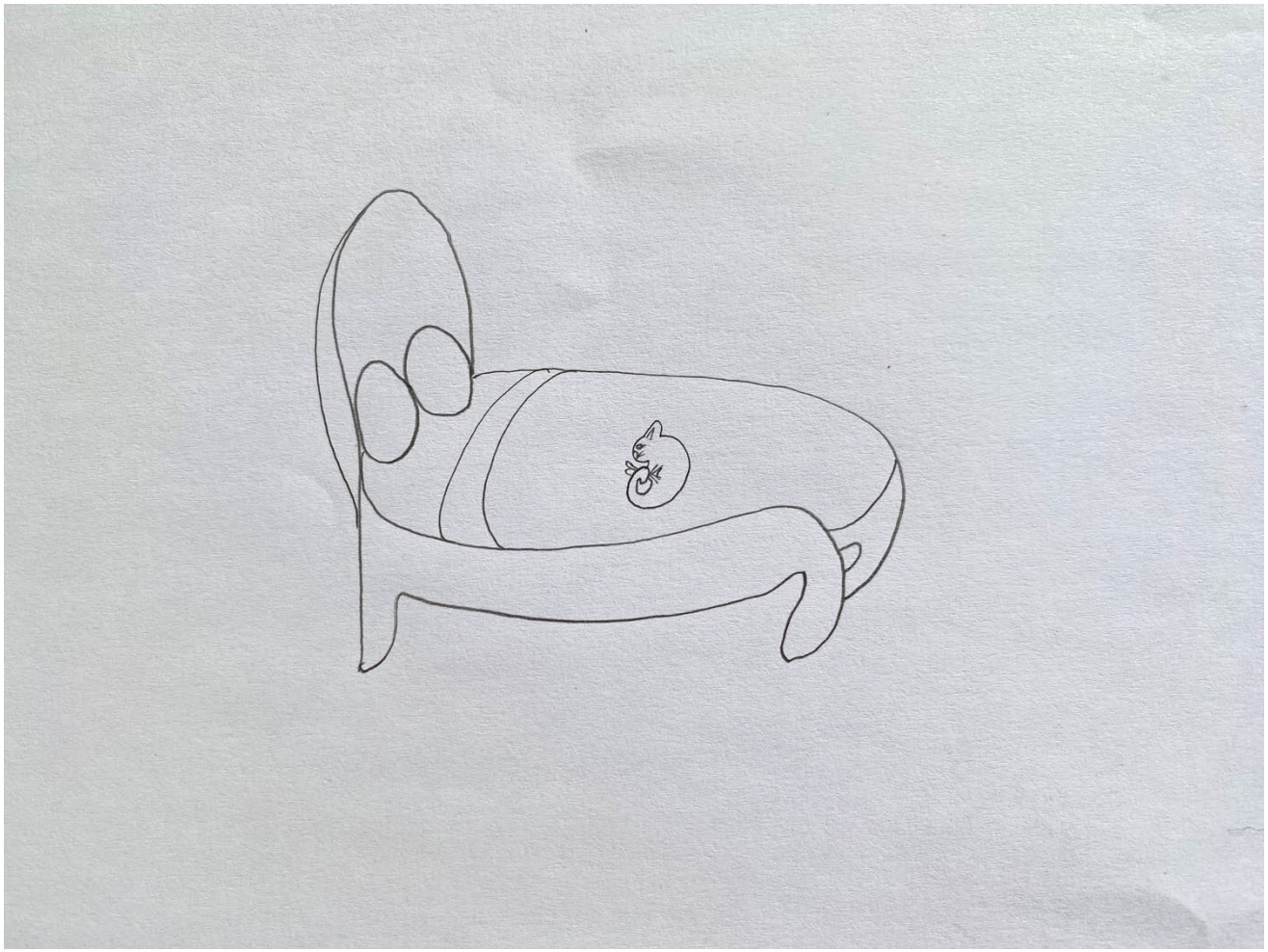


Figure 33, Therapist, Post Discharge Reflective Artwork

5.8.5 Subordinate Codes and Superordinate Themes

Jane	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Superordinate Themes	Uncomfortable vulnerability	Self-defence mechanisms	Dedication to others	Difficulty engaging	Self-neglect within artwork
Subordinate Codes	Perceived lacking artistic skill	Literal observations	Pleasing	Misunderstanding	Angular
	Fear of judgement	Superficial observations			Unsupported
	Copying	Reluctance			Sparse
	Stuck	Avoidance of vulnerability			

Table 21, Codebook, Jane

The coding of my observations around Jane's experience of the Art Therapy intervention resulted in the formation of five superordinate themes, that of uncomfortable vulnerability, self-defence mechanisms, dedication to others, difficulty engaging and self-neglect within the artwork (Table 19). The theme of uncomfortable vulnerability was rooted in observations of Jane's apparent fear of judgement and a desire to remain in the safety and comfort of replicating existing images. Jane remained within the safe bounds of literal observations about her work and displayed a reluctance to engage in measures which may be attributed to an avoidance of vulnerability, thus feeding into the theme of self-defence mechanisms. In light of Jane's attempts to please me with compliments about my work, the theme of dedication to others was identified. However, due to the misunderstanding recognised about the aims and content of Art Therapy sessions, I have allocated a theme of difficulty engaging.

Within Jane's artwork, I was struck by the observation of the sparse and angular nature of the images of otherwise organic subjects and the unsupported of representation of Jane's bed, as such the theme of self-neglect within artwork was noted. Within the development of this theme, I sensed a link with the learned repression of needs that is often experienced by women, as Martin (p174, 1997 Cited in Hogan, 1997) observes, there is a nurturing part of her that is "so ready to listen to the pain of others. My needy helper, she gives what she needs to receive. She hears the cry, can she learn to respond? Slowly and unsure at first, she contains and holds; I am learning to take care of my own needy child-self." Upon reflection, it is possible that

the foundation of the perceived self-neglect within Jane's work may lie within the repression of needs, therefore preventing her from tending to and providing comfort for herself in the form of a comfortable, supportive bed with soft, organic surroundings.

5.9 Meg

5.9.1 Recruitment

This patient case study tells the story of an Art Psychotherapy intervention conducted with an inpatient of the Perinatal Mental Health Unit who shall be referred to by the pseudonym, Meg. During the initial recruitment phase, Meg engaged in conversation with me about Art Therapy and was given a one-week period for consideration of the recruitment information pack. During the second recruitment discussion, Meg consented to taking part in the research and having Art Therapy sessions. Meg was randomised to the intervention group.

5.9.2 Assessment – Session 1

Upon confirmation of consent, collaborative curation of the therapy boundaries, and introduction to the art materials, I supervised the completion of baseline measures. Prior to the session, the unit staff had conducted a Bethlem Mother-Infant Interaction Scale (Kumar and Hipwell, 1996) with Meg, a score of 2 was given in the subscales of both physical and eye contact and mood, the remaining subscales of vocal contact, general routine and risk to baby were scored at 1, indicating a generalised, low to moderate level of disruption across interaction subscales. Baseline measures of ReQol20 (Keetharuth et al, 2018) and WEMWBS (WEMWBS, University of Warwick 2006) were completed, with a ReQol20 score of 22 (Appendix 9.14), falling within the pre-determined clinical range for clinical diagnosis and treatment and including statements that in the last week Meg had often felt anxious, unable to cope and like a failure. The WEMWBS (Appendix 9.15) was scored at 26, indicating low wellbeing and that none of the time in the previous two weeks had Meg been feeling relaxed or able to think clearly.

Upon completion of the measures, Meg engaged with the materials immediately, choosing to work with a large piece of brown card, explaining that she selected it because the corners were “slightly battered and bruised, a bit like my mind”. Meg was eloquent in describing that she felt daunted to make the first mark on the card, noting that her “body and mind have been marked by my experiences, so it feels strange to be the one in charge of marking something”.

Meg sat with her chosen materials as she spoke about her experience of control in relationships and that as a result, it felt scary to now be able to have her own control in small amounts, yet she was managing this with family input where required. I was struck by the maturity with which Meg communicated and was left with a sense that her voice had somehow been formed by something that was external to her.

The use of the therapeutic relationship as a mechanism for the reversal of societal control over women was discussed by Helene Burt (1997, p.100) “feminist therapists believe in acknowledging the power they have in helping a woman reconstruct her life while maintaining that the client is her own best expert and that the client’s perceptions are valid”. As such, by establishing an Art Therapy provision for Meg, I was aiming to validate Meg’s experiences and offer her a safe space within which she could feel empowered to test out her ability to take control of her choices and environment.

Meg’s body language, sitting with the paper held almost literally at arm’s length on the table, appeared to indicate that she was uncomfortable with making the first mark on the card. I held space for Meg to sit with that process for a while and then gently noticed aloud that it seemed as though it might be feeling challenging for Meg to take control the materials. Meg released a long breath and indicated that she had been caught up in ruminating about that feeling, Meg began marking out shapes on her piece of card (Figure 34) as she spoke, the outlines of which began on the left-hand side and continued to the right-hand side of the card. I observed with her that the shapes were initially sloping and then seemed to rise to a steeper gradient before flattening out again to a curve. Meg responded that the shapes were mountains, a series of peaks, she then added weather and a storm, explaining that “there are storms in life along the way but that storms cannot last forever”. Meg added that she

knows this in her rational mind, yet this becomes difficult to remember when she feels caught in a storm.

While making her piece of work, Meg made several observations such as “I’m drawing a cloud now, I know that it is not a perfect cloud, but I also know that that is okay” as though outwardly coaching herself. Upon expanding the discussion of storms and nature, we observed together that in nature, no one judges whether things are perfect or not. Meg spoke about waves and storms at sea, and we drew parallels between the peaks of the mountains and the peaks of the waves as they ebbed and flowed before flattening out, much like the mountains. Meg began adding pathways to the piece which reminded me of tributaries of a river, she explained that the different parts of the path would either be rough or smooth and that sometimes a path may lead to a dead-end, Meg discussed this representing the difficult parts of her life.

Snyder (2016) identifies that the use of metaphor within Art Therapy can enable mothers to safely explore and nurture a new self-image as ‘mother’, as such I was struck by Meg’s use of weather as a metaphor to allow cathartic processing and representation of emotion within her work. The rain and lightning storm rages until it eventually dissipates, making way for clearer skies under which the mountains remain stood, a stoic and unchanging presence.

Meg indicated that she had completed the piece of work and was able to reflect that making the artwork had helped her brain to regulate, she explained that she had always found regulation challenging but that the artwork helped her with that. In light of this observation, Meg suggested that she could make artwork in the unit between sessions and that she would ask staff for a book in which to make some art. I acknowledged the importance of this suggestion and supported Meg in wondering whether that would feel safe in the absence of the boundaries and safety of the Art Therapy session, she explained that she understood this and felt that she could keep herself safe by only making the work in the privacy of her room.

Arrangements were made for a further session with Meg in the following week, however following our session, Meg left for home leave which led into discharge two weeks later. I sent a therapy debrief and discharge letter to Meg’s home address.

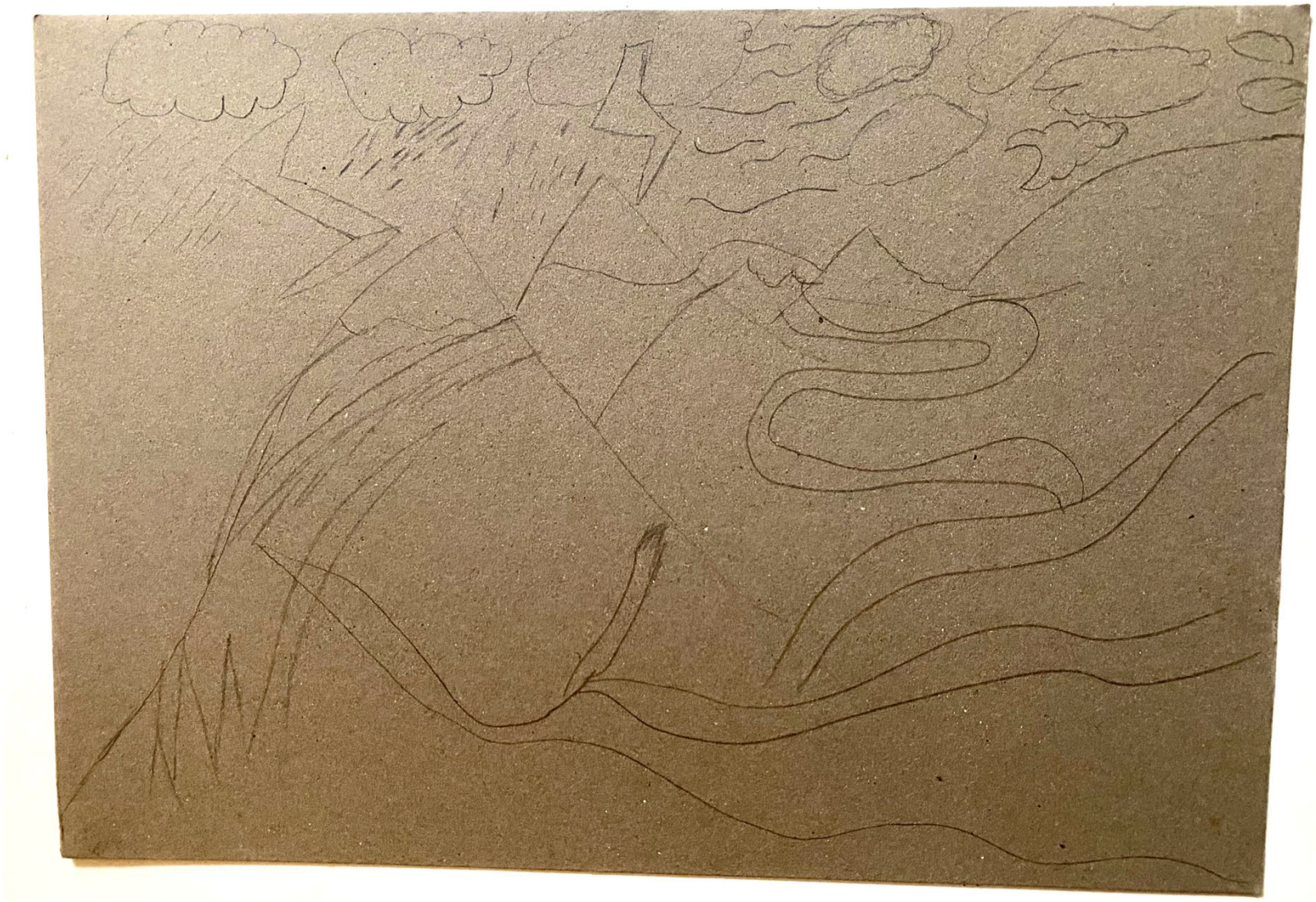


Figure 34, Meg's Artwork, Session 1

5.9.3 Observations resulting from clinical supervision

During clinical supervision, I explored a sense of dismay grounded within the reflection that the control over Meg's ending of Art Therapy had been removed from her as a result of the rapid processes of leave and discharge, thus resulting in an unplanned therapy ending. I had been hopeful that Meg's experience of ongoing Art Therapy could offer an opportunity for empowerment Meg, however I was reminded of the potential power that engagement with only one session of Art Therapy may hold for some patients. In the context of this abrupt ending, which was enacted by neither therapist nor patient, I took solace in Sanville's observation that life may be considered to be a "series of felt oscillations between connectedness and apartness… the quality of each phase of separateness being affected by the experience of the relationship out of which it emerged" (Sanville p123, 1982). The process of clinical supervision enabled me to consider that the brief therapeutic interaction that I had with Meg may have been 'good enough' within the bounds of the time available to us.

5.9.4 Post discharge reflective art making

I was drawn to reflect upon organic shapes found in nature while reflecting upon my session with Meg, I elected to explore this with the basic materials of pencil and paper. In considering the theme of nature and the storms within Meg's image, I began making quick, flowing marks which swirled around the paper (Figure 35). Some areas were made with a greater applied pressure whereas others were made with a far lighter touch of the pencil. While making the piece, I was struck by the mesmerising sound of my pencil as it brushed repeatedly over the rough surface of the paper, giving a sense of my being caught up in a swirling storm alongside Meg. In recognition of that experience, I changed the movements of my pencil in order to move out of the storm and into a calmer, smoother motion at the top of the page. On reflection, the marks made at the top of the page give a sense of a pressure system over the storm, perhaps indicating the impact of Meg's experience of controlling interactions, conveyed during her session.

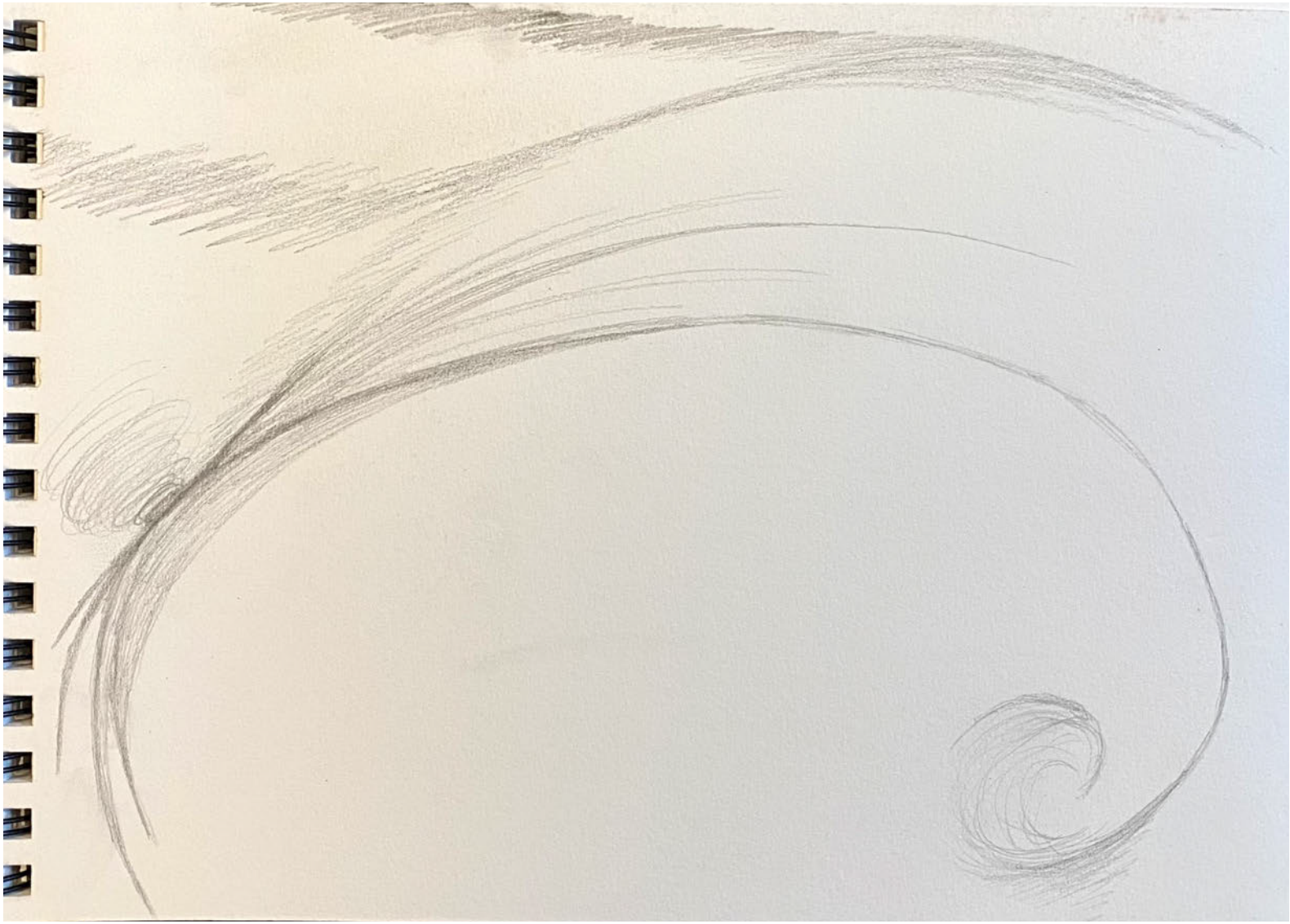


Figure 35, Therapist, Post Discharge Reflective Artwork

5.9.5 Subordinate Codes and Superordinate Themes

Meg	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Superordinate Themes	Control	Acceptance of imperfection	Natural elements	Artistic process	Emergence of self as a mother
Subordinate Codes	Daunted	Preference for imperfect materials	Weather	Cathartic	Transition
	Uncomfortable	Acceptance of imperfection in art	Nature	Regulation	Journey
	Control		Flow	Metaphor	
	Impact of others in her life				

Table 22, Codebook, Meg

A total of five superordinate themes were drawn from my observations of Meg's engagement with the therapeutic intervention (Table 20), namely control, acceptance of. Imperfection, natural elements, artistic process and emergence of self as a mother. Control was perceived within the daunted and uncomfortable experience of asserting control upon the art materials within the context of Meg's previous experience of being under the control of others in her life.

Meg demonstrated a preference for imperfect art materials (selecting a damaged piece of card) and a comfortable response to imperfection within the aesthetics of her art making, as such I established the superordinate theme of acceptance of imperfection. An ability to tolerate imperfection within the image during Art Therapy may be perceived as a testing out of the experience of the patient accepting the sense of their own imperfections in a safe, boundaried way within the function of the frame of the artwork which, as Case and Dalley (p136, 1992) determine, can provide the function of "holding and symbolising past, present and future aspects of a client, linking unconscious to conscious imagery".

Further to Meg's inclusion of several representations of weather and nature in her work, I have included the superordinate theme of natural elements. The emotional release that was prompted in Meg while she made her work and the resulting experience of regulation that she described has led me to define a theme of artistic process. Finally, a theme of emergence of self as mother has been determined due to Meg's exploration of transition to motherhood and the process of journeying within her work.

5.10 Interpretive Phenomenological Analysis

Following the coding of the subordinate codes and superordinate themes within each of the patient case studies, I reflected on the superordinate themes as a combined group in order to determine master themes which were found across the entire case series. Table 21 demonstrates that a total of 132 subordinate codes informed the development of 28 superordinate themes within the 5 case studies which in turn led to the identification of 5 master themes, capturing the entire case series.

	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Master Themes	**Therapeutic processes**	**The revealing image**	**Mothering of others**	**Mothering of self**	**Control**
	Positive Emotional Catharsis	Destruction vs preservation	Outside commitments / pressures	Moulding of self	Control
	Engagement	Seeking change	Dedication to others	Self-soothing	Control
	Negative Emotional Catharsis	Artistic catharsis	Mothering / Caring role	Ability to mother self	Control
	Expenditure of negative energy	Self-neglect within artwork	Dedication to others	Self-defence mechanisms	
	Desperation	Natural elements	Emergence of self as a mother		
	Negative Emotional Catharsis	Artistic process			
	Judgement	Acceptance of imperfection			
	Uncomfortable vulnerability				
	Difficulty engaging				

Key:
Meg
Jane
Alice
Abby
Suzie

Table 23, Superordinate and Master Themes Codebook

As discussed in section 4.10.2, the intention in conducting this process of Interpretive Phenomenological Analysis (IPA) was to capture the essence of each individual patients experience of the intervention and their sense of whether the intervention was

meaningful for them. This in turn facilitated the formation of master themes which seek to provide a broader overview and an insight into the wider potential responses of the perinatal mental health patient group to the provision of an Art Therapy service. Thus, explicating the individual participant experiences and creating an overview of how those experiences connect with both the participant group and patient group as a whole. Regarding the power of themes within case series, it has been observed that "the relevance of one or more person's experience to others in a similar situation can be a key way that case studies gain validity" (Hogan, 1997 cited in Carr & Crocker, 2021).

The root of the initial coding of the case studies was formed by a combination of patient quotes, patient physical actions and interactions with art materials; this was complimented by the addition of my own observations as therapist around the wider sense of patient engagement via a number of factors such as eye contact, body language, selection and use of art materials. In pursuing Heidegger's (1962) hermeneutic phenomenological approach to the analysis of the qualitative data, I have been able to permit the combination of the patient experience with my own observations in a bid to develop a global understanding of the patient's "importantly this meant that the sociocultural context… could also be explored and therefore part of the analysis" (Crocker & Carr, p157, 2021). However, much like the awareness that a therapist holds of outside influencing factors and the effect of countertransference, I have been conscious of the need to employ "bracketing" (Giorgi, 1992, Cited in Crocker & Carr, p157, 2021) of any judgement or the influence of previous knowledge such as patient diagnoses upon the analysis of the data.

Master themes and the superordinate themes which inform them are presented within Table 21, with a colour coded key representing each patient indicating the case study source of each superordinate theme. Master themes are determined as therapeutic processes, the revealing image, mothering of others, mothering of self and control. In line with my intention to avoid the pathologisation of patients, I am mindful of the weight that generalised observations of a patient group may carry; therefore, in order to retain transparency, each master theme shall be discussed in relation to the relevant portion of the research participants to whom it applies.

5.10.1 Therapeutic processes

Upon revisiting the case series in order to ensure that the codes and resulting themes felt appropriate, I observed a number of subordinate codes and superordinate themes that pointed to the patient experience of the process of engaging with the Art Therapy intervention. The master theme of therapeutic processes was drawn from 9 superordinate themes found within 4 out of the 5 case studies and were established as positive emotional catharsis, negative emotional catharsis (duplicated as present within 2 case studies), expenditure of negative energy, engagement, desperation, judgement, uncomfortable vulnerability and difficulty engaging.

The master theme of therapeutic processes can be defined as a number of interactions, releases and responses that are rooted within the patient as a result of their experience of the therapeutic environment; “if the Art Therapist maintains the safe space for the client, then the therapeutic process will become established. This refers to the sequence of integrating energies released in a patient as a result of her interaction with the therapist” (Cox 1978, cited in Case & Dalley p59, 1992).

As defined within section 5.5.8, catharsis may not ordinarily be defined within the separate categories of positive and negative catharsis, however I believe this separation to encompass a sense of all acts of catharsis being a productive release for patients when conducted within a safe therapeutic setting. Cathartic experience can be observed within both negative and positive aspects of expression, such as the negative cathartic experience of struggle and shame found within Alice’s work (section 5.7) and the positive cathartic experience of externalisation and acts of self-defence within Suzie’s work (section 5.5).

I determined that the superordinate theme, expenditure of negative energy, was distinct from the process of catharsis due to it being a release but did not appear to be associated with therapeutic progression, this was observed within Abby’s therapeutic experience as a presentation of anxiety and hopelessness (section 5.6).

Engagement was demonstrated during Suzie’s (section 5.5) sessions as an eagerness to engage with the art materials and an enthusiasm for doing so in a variety of ways. In contrast to this, the superordinate theme of difficulty engaging held roots within Jane’s

session (section 5.8) and the difficulty that she experienced in undertaking the measures and in her desire for Art Therapy to be more akin to art lessons. Jane's work also resulted in the addition of a superordinate theme of uncomfortable vulnerability due in part to Jane's apparent desire to remain within the more literal realm of reflections upon her work.

The superordinate theme of desperation was evident within Abby's presentation (section 5.6) of high energy, pressured speech and a pervasive sense of 'spilling out'. Finally, judgment was experienced as a theme within Alice's work (section 5.7) in light of her experiences of negative voices and negative assumptions about her choices and actions within the artwork.

In reflecting upon the foundation of this master theme, I note that the therapeutic processes of patients who engaged in the intervention did not appear to be acutely intolerable due to their being sufficiently supported within the bounds of the therapeutic, safe space of each session. As such, this suggests a broad acceptability of treatment, thus offering a positive insight in consideration of research question 2 (section 1.4) regarding the feasibility of the intervention for the patient group.

5.10.2 The revealing image

The second master theme of the revealing image, taken from the seminal Art Therapy book of the same name (Schaverien, 1999), was formed from 7 superordinate themes that were found within all 5 out of 5 patient case studies, namely, destruction versus preservation, seeking change, artistic catharsis, artistic processes, self-neglect within the artwork, natural elements and acceptance of imperfection.

The image within Art Psychotherapy practice can be considered to be a product of two distinct processes, that of the creation of the image and that of the therapeutic processes centered around the image once it has come to fruition; "these are the life *in* the picture and the life *of* the picture respectively" (Schaverien, p80, 1999). Schaverien (p101, 1999) continues with a distinction between types of images, that of the "embodied image" which symbolises the unconscious processes within the therapeutic exchange, in contrast to this is the "diagrammatic picture" which invites exploration and

may result in the evocation of the unconscious as a result of the resulting associations and interactions with the therapist.

An example of the superordinate theme of destruction versus preservation is seen within the case study, Suzie (section 5.5) and the “embodied image” (Schaverien, 1999) of the clay figure that was created followed by the battle between the desire to destroy yet simultaneously preserve the work. It could be noted that the outward, verbal analysis of this piece was scant during therapy as it felt that there was an accepted unspoken understanding that the piece held a fragile potency which could have been interrupted by the process of eliciting conscious meaning.

The superordinate theme of seeking change can be observed within the case study of Abby (section 5.6) in which this is expressed via a desire for transformation and containment within the therapeutic process in order to allow Abby to experience the safe expulsion of waste products within the artwork.

The superordinate themes of artistic catharsis and artistic processes remain distinct in a continuation of the observations of the experience of catharsis within Art Therapy. Artistic catharsis can be found within Alice’s work (section 5.7) during the testing of the physical boundary of the piece of paper while flooding the work yet also anticipating the paper’s resulting disintegration. In contrast to this, artistic processes can be observed within Meg’s work (section 5.9) in the use of the artwork as a regulatory factor by exploring the use of metaphor held within the piece.

Self-neglect within the artwork was evident within Jane’s work (section 5.8) as she delivered a representation of her own bed with what appeared to be insufficiently supportive legs and the absence of a mattress or soft furnishings.

The acceptance of imperfection and natural elements as superordinate themes can be found within the therapeutic experience of Meg (section 5.9) in which a “diagrammatic picture” (Schaverien, 1999) was created which sparked discussion about and a period of revelling in the metaphor of weather and the personal relevance of storms transforming above rocky ground. Meg shared a verbal narrative while making her

work, one of comfortable acceptance that her representations of elements within the work could not be considered to be perfect.

5.10.3 Mothering of others

Mothering of others was formed as the third master theme as a result of 5 superordinate themes which were found within 5 out of 5 of the case studies, therefore this theme was represented continuously across the entire case series. The contributing superordinate themes are outside commitments / pressures, dedication to others (duplicated as found to occur within 2 case studies), mothering / caring role and emergence of self as a mother.

In discussion of the outside commitments or pressures experienced and communicated within the patients therapeutic process, this was witnessed during interactions with Suzie (section 5.5) and her acknowledgement that she does not feel that she has time to tend to her own needs or desires, this then became evident when Suzie became distracted from her work by a desire to tend to her crying infant which was in the care of unit staff.

The superordinate theme of dedication to others was found within two case studies, within Abby's therapy (section 5.6) it was present as a desire to take responsibility for and to help others, similarly in Jane's case study (5.8) I observed that there was a sense verging on desperation for Jane to achieve the mission of pleasing others.

Evidence of the superordinate theme of the mothering or caring role was clear within the experience conveyed during therapy of Alice's (section 5.7) premature maturation in order to meet the demands of the dedication to multiple mothering roles within her life.

In discussing the topic of emergence of self as a mother, the final contributory superordinate theme, Winnicott (1987, cited in David & Wallbridge p91, 1991) observes "she was a baby once, and she has in her memories of having been a baby; she also has memories of having been cared for, and these memories either help or

hinder her in her own experience as a mother". As such, Meg's work (section 5.9) bears witness to the transition and journey undertaken as she morphs into motherhood. As Winnicott (1987) suggests, this is a vast undertaking, over which the mother herself is unable to have full autonomy due to the influences of the modelling of motherhood that has been undertaken in her own childhood.

5.10.4 Mothering of self

The combination of 4 superordinate themes, moulding of self, self-soothing, ability to mother self and self-defence mechanisms, served to create the fourth master theme of mothering of self which was found to be applicable in 3 out of 5 patient case studies.

Regarding the moulding of self and self-soothing, these superordinate themes were found within Abby's case study (section 5.6), grounded in the experience of moulding of self during clay work which involved the blending, smoothing and rolling of the clay alongside self-soothing, which was found in the repetition of movements as she worked and the regulation which she found within the art making process.

Alice's case study (section 5.7) informed the superordinate theme of ability to mother self as it manifested itself in the perceived inability to tend to her own needs, a difficulty in being generous with herself, a lack of playfulness and a fear of her own self-defined neediness.

The final informing superordinate theme is that of self-defence mechanisms which was found in the case study of Jane (section 5.8) and her seemingly determined avoidance of vulnerability within the therapeutic work.

Research question 4 (section 1) addresses the meaningfulness of the intervention for the patient group; as such it is my belief that the master theme of mothering of self-recognises the capacity of the intervention to provide patients with an opportunity to explore the potency of taking time to care for oneself and to bolster one's self-defences. Therefore, providing a meaningful opportunity to patients as they embark upon the role of motherhood within the safe bounds of the therapy room.

Stern (p171, 1995) devised the term “motherhood constellation” to describe the extremely mentally taxing process that a mother undergoes, particularly upon the birth of her first child, by passing “into a new and unique psychic organisation” which serves to revise all previously known “tendencies, sensibilities, fears and wishes”. Stern continues to define three key discourses which inform the “motherhood constellation”, that of the “mother’s discourse with her own mother, her discourse with herself and her discourse with her baby” (Stern, p172, 1995). Within the case series, I have observed that the meaningfulness of the therapeutic intervention for patients can be found within the intersection of the therapy and the multiple discourses identified by Stern (1995), as such Art Therapy can provide the mother with the opportunity to tend to unmet needs, to nurture herself and to consider the process of re-mothering of her own inner child in order that she may begin to tolerate her newly adopted role of mother.

5.10.5 Control

The master theme of control was devised from 3 superordinate themes of the same name which was present in 3 out of 5 of the case studies. Control can be observed within the case study of Suzie (section 5.5) and her desire to maintain separation of materials within the work in order to avoid contamination. Alice’s experience of Art Therapy (section 5.7) demonstrated the necessity of the testing of reality in all realms and ensuring the capacity for containment within both the therapeutic relationship and the art materials. In contrast to the two previous instances of the superordinate theme, the foundation of control within Meg’s case study (5.9) indicated the impact of control from external relationships in her life resulting in an experience of discomfort when presented with the opportunity to assert her own control within the artwork.

The high prevalence of experiences of trauma within the patient group cannot be separated from the master theme of control, as Perry & Szalavitz (p134, 2017) describe “because trauma - including that caused by neglect, whether deliberate or inadvertent - causes an overload of the stress response systems, which is marked by a loss of control, treatment must start by creating an atmosphere of safety”. In reflecting on the notion of control, I am drawn to consider the way in which it might inform research question 3 (section 1) in relation to the question of appropriateness of

the intervention and the creation of such an atmosphere of safety as perceived by the patient group.

In capturing the duality of the experience of control within Art Therapy, the 3 relevant case studies have demonstrated that patients were able to tolerate the challenging notion of control of materials within the therapeutic boundaries while also exploring their ability to exert their own control. Therefore, in this instance I would deduce that the intervention provides patients with an appropriate means with which to feel held while exploring the notion of control and other accompanying emotional responses.

5.11 Overview of master themes

As discussed within section 4.9.1, the Theoretical Framework of Acceptability (v2), (TFA, v2), devised by Sekhon et al, (2017) specifies 7 components for consideration of the acceptability of a treatment from the point of view of a patient and as an intervention provider. The 7 components, a detailed description of which is shown in Figure 36, are affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness and self-efficacy.

In assessing the acceptability of the intervention, I returned to the qualitative data to determine whether the master themes linked to each of the 7 TFA (v2) components:

- Affective Attitude – anecdotal evidence of conversations between patients and therapist and private conversations between patient and unit staff indicate that patients found Art Therapy sessions to provide them with a helpful alternative means of communication, a safe space for reflection and patients were eager to engage in further sessions, with 3 out of 5 patients engaging in more than one session. This component is mirrored within the master theme of therapeutic process, reflecting a willingness to engage in a resulting productive process of therapeutic catharsis.
- Burden – Initial assessment sessions carried a slightly higher burden due to the use of baseline measures, however only one patient indicated that this was challenging. The master theme of control is relevant to this component as the

patients were given overriding control of and support with determining their level of engagement in any burdensome aspects of the intervention.

- Ethicality – Patients were given autonomy via the collaborative creation of therapeutic boundaries, additionally patients were empowered with elements of choice and control available to them within the therapeutic space. This component can also be found in the master theme of control, patients were facilitated in the curation of their own experience of control.
- Intervention Coherence – Patients underwent a rigorous, ethically approved recruitment process providing a rich information pack and multiple opportunities to ask questions about the intervention prior to consenting to their involvement. 1 patient out of 5 indicated a misunderstanding about the intervention and was subsequently withdrawn from the research at their request. The master theme of therapeutic process can inform this component, as it is the start point of the outcome of the standardised recruitment process.
- Perceived Effectiveness – Patients indicated anecdotally that the intervention had been helpful in identifying and processing challenging emotions and had contributed to a feeling of improved wellbeing, with end of session conversations between patients and myself relaying their thanks, a sense of release and expressions of surprise of “this really works, doesn’t it”. I believe that this component can be found within each of the 5 master themes as it encompasses the entire therapeutic experience that has been observed within the case series data.
- Self-efficacy – Patients expressed an initial concern regarding artistic ability, confidence was developed gradually with the support of the therapeutic boundaries, as such the master themes of mothering of self and the revealing image are applicable to this component as a reflection of the patient’s willingness to engage wholeheartedly in the therapeutic process of the artwork and allow the benefits of this to allow the self-mothering process to begin.
- Opportunity Costs – patients did not indicate either to the unit staff or to the researcher, that their engagement had led to a sacrifice of benefits in any other areas, therefore it can be concluded that this component does not apply to the intervention.

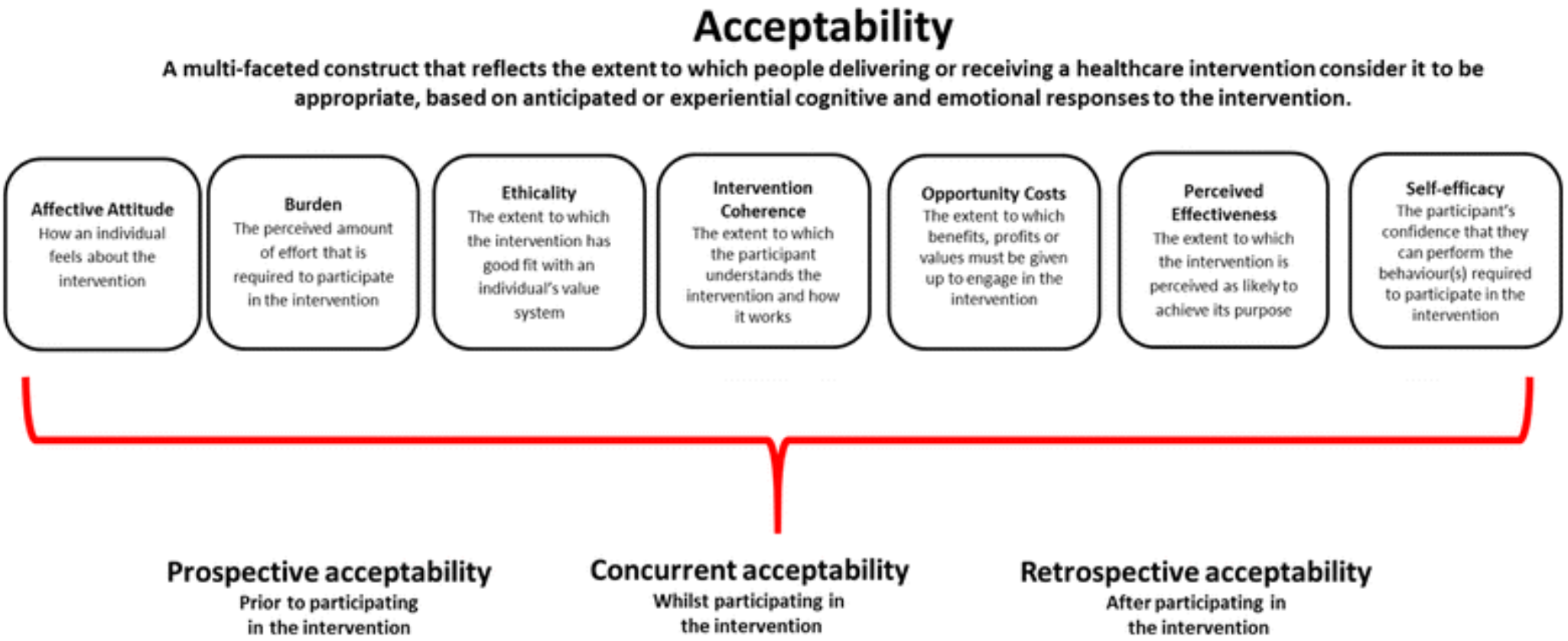


Figure 36, Theoretical Framework of Acceptability (v2), Sekhon at al. (2017)

In summary, 6 out of the 7 components of the TFA (v2) were found within the 5 master themes gathered from the patient experience and my own observations as therapist and researcher, therefore identifying that the Art Therapy intervention meets acceptability criteria for this patient group. The observations of the master themes and resulting assessment of acceptability have therefore indicated that the intervention of Art Therapy can be considered to be clinically feasible, appropriate, meaningful and effective for use with the perinatal mental health patient group.

The benefits to the patient group are additionally reflected within the following discussion of Art Therapy during matrescence; the descriptive term for the transitional process of becoming a mother which “serves to frame and reclaim this as a critical period in which mothers may need and would benefit from extra support. Art Therapy can nurture a re-imaging of mother while offering a safe space to explore all aspects of motherhood and be supported through matrescence” (Hogan, 2015; Snyder, 2016, cited in Lockhart Chilton, p75, 2021).

5.12 Chapter summary

The empirical chapter has presented an overview of the flow of participants through the recruitment and research phases while providing an immersive case series of participant data and researcher observations collected during the intervention. A thematic analysis has been undertaken, identifying a series of codes and resulting master themes in the work. The master themes have been analysed for treatment acceptability within the patient experience and conclusions were drawn. In order to return to a position of academic neutrality, the narrative shall now resume from the stance of the objective third person as the thesis proceeds with the discussion section.

6 Discussion

6.1 Chapter overview

This chapter offers an overview of the thesis via a return to the research questions that were set out within chapter 1. The discussion provides the reader with a summary of the research, challenges faced during the study, observations made as a result of data analysis and offers recommendations for future research. Finally, historical and future plans for dissemination of the research is presented before the thesis draws to a conclusion.

6.2 Research summary

In consideration of the aim of the research to identify whether Art Psychotherapy is a feasible, appropriate, meaningful and clinically effective intervention for the perinatal mental health patient group, following receipt of University and NHS ethical clearance, a randomised control trial with wait list control group and mixed methods data collection was undertaken to delivery an Art Psychotherapy intervention within an NHS inpatient Perinatal Mental Health unit. A systematic review was conducted with a view to identifying any existing evidence base for the intervention with the patient group, while the research was designed with the aim of developing or indeed contributing to a wider evidence base for the use of Art Psychotherapy in Perinatal Mental Health.

Following adjustments to the intended methodology, discussed within the ‘influencing factors’ section, data gathered during the research phase was presented by way of a narrative summary of quantitative data and a qualitative case series, which was subject to a process of interpretive phenomenological analysis (IPA) in order to determine influencing themes.

6.3 Research Questions

Research question 1 sought to examine and illustrate the existing evidence base for the feasibility, appropriateness, meaningfulness and clinical effectiveness the intervention of Art Therapy with the perinatal mental health patient group. The systematic review found within chapter 3 of the thesis answers this research question, a summary of which is that there is a limited evidence base in existence. However, the

evidence base is hindered by methodological issues resulting in studies from which conclusions may only be tentatively drawn, in the context of issues such as reaching statistical significance being impossible due to low participant numbers and methodological quality being reduced by the use of non-validated outcome measures.

The remaining primary research question asked whether Art Psychotherapy can be considered to be a feasible (research question 1), appropriate (research question 2), meaningful (research question 3) and clinically effective (research question 4) intervention with perinatal mental health patients; these research questions are addressed in part within the systematic review (chapter 3, particularly section 3.3). Additionally, the empirical chapters (found in chapter 5) present a qualitative case series via which research questions 2-4 are addressed throughout (summarised in section 5.11), therefore providing early indications that there is evidence within the qualitative case series expressed via the combination of patient voice and therapist observations, that the intervention may have been experienced by participants as feasible, appropriate, meaningful and clinically effective.

Research questions 5 and 6 emerged during both the research and the subsequent phases of data analysis, based upon the researcher's reflections on the research process and relevant outcomes. Research question 5 questions whether the research is able to provide commissioners with the rigorous evidence required to enable future funding of Art Psychotherapy interventions with the patient group. The experience of the researcher provides evidence in answer to this research question as the researcher utilised the research data collected to inform a personal bid for NHS Quality Improvement Funding in order to fund the continued provision of the Art Therapy intervention within the inpatient perinatal mental health service on a 1 day per week basis with a 1-year contract. The bid for the funding was successful and the researcher is now nearing the end of that 1-year contract. The NHS inpatient perinatal mental health service have subsequently confirmed that they wish to extend the Art Therapy provision via the next annual round of Quality Improvement Funding, however with an increase of 50% bringing the intervention delivery to 1.5 days per week, further discussion of this is held within section 6.8: dissemination of the research.

Research question 6 seeks to determine the barriers to conducting Art Psychotherapy research with this patient group within the NHS; this has been discussed in part within section 5.3 and shall now be answered fully within the following section, influencing factors.

6.4 Influencing factors

The impact of the Covid-19 pandemic upon the research is discussed at length in section 1.9 of the thesis. The following correspondence with the Perinatal Clinical Lead in 2021 was introduced within section 1.9 of the thesis, however it is considered pertinent to include the full correspondence at this point in providing further depth to the discussion of the impact of Covid-19 upon the research study;

> *"I can confirm that the impact of Covid impacted on ward clinical activity and processes which reduced the opportunity for the Art Psychotherapy sessions to take place as planned. A reduction in admission rates have been consistent throughout the pandemic and the discharge and leave pathway was amended to reduce the possibility of cross contamination on the unit. We also experienced an increase in acuity of patients which meant that interventions were not always appropriate." (Correspondence with the Perinatal Clinical Lead, 2021)*

As a direct result of the impact of Covid-19 upon clinical activity within the unit, quantitative measures were not conducted by the unit staff team in line with the agreed protocol. The collection of quantitative measures was not an element which was of additional burden to staff, the step was included in the protocol following collaboration with and approval of unit staff, due to the measures being included in the pre-existing standards of practice. The issue of the missing quantitative measures was not reported to the researcher until contact had ceased with the patients. Low numbers of participants were recruited to the research, this is considered to be as a result of the reduction in admission rates and increased acuity which subsequently impacted patient's capacity to consent. In light of these issues, the researcher was unable to reach statistical significance within the quantitative data.

The NHS ethical clearance for this study was secured by way of a full Randomised Control Trial (RCT) design, as such to alter the study design to that of a feasibility RCT in recognition of the limitations around participant numbers, would have required the processing of a major amendment via the NHS ethics committee. As such, due to the uncertainty of the ongoing impact of the Covid-19 pandemic and the related timescales, the researcher and supervisory team elected to proceed with the full RCT while evolving to align the focus of the study and data analysis in exploring the feasibility of the intervention.

Covid-19 measures meant that patients returning for sessions of Art Therapy in the unit following discharge had to attend sessions held within an unfamiliar side room, booked in a ward next door to the inpatient Perinatal Mental Health unit. The researcher observed that this change in the location of the therapy provision may have been unsettling for patients, particularly in combination with the intimidating element of being required to enter the room via the common recreation space for an adult inpatient ward which included male patients.

Upon recognising the evolving issue of low participant numbers within the research, the researcher sought an amendment to NHS ethical clearance in order to allow for the addition of a second site to the research. Upon receipt of this clearance and confirmation that the previously acquired NHS research passport is transferable between Trusts, a second site within a different NHS Trust was approached to seek permission for them to become a second host site. Following a 6-month pursuit of arrangements for a second research site, the request to establish a second site was withdrawn by the researcher, as the process had become unviable due to time consuming processes within the NHS research and design department of the second Trust.

Further to this, the researcher submitted a request for an extension to the NHS research passport within the original host site and secured permission to continue the research for an additional 3 months in an attempt to increase participant numbers via the original site. During this time the researcher underwent the recruitment process with a total of 4 patients, 1 of which went on to be randomised to the intervention group and is included within the case series. The extended 3-month research period covered

a timeframe which the unit described anecdotally as being unprecedented in terms of the 6-bed unit having a consistently high number of empty beds while the national waiting list for inpatient perinatal mental health unit beds was clear of patients. It is considered that this was a unique period of time which reflected the long-term impact of Covid-19, manifesting as a nationwide lack of referrals to inpatient perinatal mental health units.

In addition to the impact of Covid-19, the researcher has reflected at length upon the challenges faced during the intervention phase and has observed that sessions at which outpatients were marked as Did Not Attend (DNA) may have been impacted by the effect of the administration of the session arrangements. In arranging sessions with outpatients, the followed unit guidance to make contact with the patient via the unit telephone which showed as an ‘unknown number’ on the patient’s mobile phones. Subsequent conversations about this with outpatients indicates that this contact process was perceived to be anxiety inducing, the researcher reflects a sense of intrusion upon following guidance around this method contact. Future recommendations have been drawn from this experience within the following sections.

Recruitment of patients to the research was additionally observed by the researcher to have been impacted by the group dynamics of unit as patients transitioned between the stages of new admissions, patients on leave and patients being discharged to access the service as outpatients. A pattern was noted by the researcher of a period of approximately 8 weeks during which the presence of one patient who had declined to take part in the research appeared to be influencing the decisions of other patients who were approached during the research recruitment phase; this pattern ceased upon the discharge of the aforementioned patient.

The recruitment approach, as informed by the strict bounds of the NHS ethical clearance process was experienced by the researcher in practice to be lengthy and heavily reliant upon paperwork and written explanations. Upon reflection the researcher perceived the resulting recruitment process to be intimidating and overwhelming for patients during a period in which they were experiencing often severe symptoms of being unwell. Anecdotal responses from patients with regard to the quantitative pre-intervention measures often consisted of reluctance to continue

with the measure and a sense that the measure and recruitment process ‘got in the way’ of the intervention being offered. Future recommendations have been drawn from this experience and are discussed within the following sections.

In answer to research question 6 which seeks to determine the barriers that exist to conducting Art Psychotherapy research with this patient group within the NHS, the experience of the researcher indicates that aside from the previously discussed impacts of the Covid-19 pandemic, the following issues remain. The management of the administration of measures or research tasks undertaken by someone other than researcher, particularly NHS staff members who are already under significant professional pressure. The gatekeeping and administrative processes of NHS Trust Research and Design / Human Resources departments can be laborious and may ultimately be prohibitive to the conduct of research. A variety of unpredictable elements may directly impact upon patient numbers available for recruitment to the research at any point. NHS standardised methods of patient contact may be experienced as challenging for the patient. Patient group dynamics within a unit may influence the engagement in the research. The rigorous nature of the NHS IRAS ethical clearance process may inadvertently result in the formation of a recruitment process which is burdensome for patients. Physical space is at a premium in many NHS sites and there may be a link between the perception of value of the intervention within the NHS unit, and the allocation of space in which therapy is to be conducted; this may similarly impact storage space for art materials and confidential patient artwork. When conducting research within the NHS, the researcher may have to assume the role of peacekeeper when attempting to disarm a culture of defensiveness within an NHS setting, one may surmise that this stems from a systemic response to multiple instances of governmentally imposed threats to resources.

6.5 Observations

The systematic review conducted by the researcher for the purposes of this thesis indicated that significant gaps exist within the evidence base. These gaps can be addressed by the design and delivery of rigorous Art Therapy research with the perinatal mental health patient group. The evidence base requires research which

provides detailed reports of the intervention delivery in a thorough and consistent manner, using validated measures which are accessible and backed by commissioners and which is undertaken with ethical clearance. In addition to this, the evidence base is lacking in studies which are enhanced by a large, mixed method data set, gathered from a statistically significant number of participants.

In attempting to address the elements lacking within the existing evidence base for the intervention with the patient group, the researcher prepared a qualitative case series, capturing the patient experience of the intervention. Upon application of the Theoretical Framework of Acceptability (TFA, v2, Sekhon et al, 2017), the researcher determined that 6 out of the 7 components of the TFA (v2) were found within the 5 master themes gathered from the representation of patient experience and researcher / therapist observations, therefore identifying that the intervention of Art Therapy meets TFA (v2) acceptability criteria for this patient group. As such the researcher has suggested that the intervention of Art Therapy may be considered to be clinically feasible, appropriate, meaningful and effective for use with the perinatal mental health patient group. However, in light of the multiple challenges faced by the researcher, further research is required in order to sufficiently address the evidence base, as discussed within the following section: future recommendations.

6.6 Future recommendations

In light of the researcher observations regarding the patient experience of the recruitment phase of the research, in the event of revisiting the research in future, the researcher intends to prepare participant recruitment information in video format, including the voices of consenting former Art Therapy patients, reflecting upon their experience of Art Therapy. The aforementioned qualitative Audio Image Recording (AIR, Springham N. & Brooker J. 2013) data was gathered during Audio Image Recording processes which took place outside of the timeframe of this study, therefore the data was not eligible for inclusion in this thesis.

Regarding the administrative management of the arrangement of Art Therapy sessions with outpatients, future studies may wish to consider prior discussion with the patient and agreement of a preferred approach to contact prior to their becoming an

outpatient. Should resources allow, secretarial input may greatly support the resolution of this issue in order that communication between services and patient can be adequately recorded within NHS records.

Future versions of this research would seek funding to employ either an in person or telephone translator service in order to eradicate the possibility that potential Art Therapy patients are excluded based on being non-English speakers.

As indicated within section 2.2, a supportive relationship exists between members of staff within the NHS host site and the academic team for this study, in the even that this support could be broadened to become a service wide perception of the value of research within the NHS, then it is possible that the majority of the barriers around setting up an NHS research site and issues faced within the day to day conduct of the researcher, would be greatly reduced. Similarly, the issue of space in which to conduct the intervention may be alleviated, therefore allowing the Art Therapy sessions to be delivered in a consistent space, reinforcing the sense of therapeutic capacity for containment and safety.

In spite of the Theoretical Framework of Acceptability (TFA, v2, Sekhon et al, 2017), analysis indicating that the intervention is feasible, appropriate, meaningful and clinically effective with the patient group, the researcher acknowledges that the patient group, profession and commissioning bodies would benefit from further examination of the study hypotheses. This would allow for findings to be reinforced with greater weight via the completion of quantitative and qualitative measures with a greater number of participants.

Due to the existing relationship between the University, NHS Trust and the clinical team within the inpatient Perinatal Mental Health Team, the research was hosted purely by the inpatient specific section of the perinatal provision in the Trust. Future research however, may benefit from extension to include a wider provision of the Art Therapy intervention within community perinatal services. Similarly, a wider inclusion criterion would allow patients to access the intervention while outside of the specified perinatal period of up to 12 months after birth, also considering the inclusion of mothers who may not have received a specific Perinatal Mental Health diagnosis.

These changes could offer benefit to a broader patient group while also enabling the research to garner statistical significance as a result of greater numbers of participants and data collected, therefore ultimately benefiting the profession with the provision of a rigorous evidence base.

In the event of revisiting the research, the researcher would intend to seek funding to re-address the research questions while maintaining a randomised control trial approach, with the support of research assistants to support multiple points of data collection (rather than only pre- and post-intervention measures) with the use of measures throughout the intervention. Thus, allowing the research to achieve greater numbers of participant engagement while facilitating the ability to draw broad observations about the intervention. In addition, the researcher would seek to discover or design an alternative, validated quantitative measure which would allow the gathering of quantitative data to be brief and enables the therapist to verbalise the measure for the patient rather than relying upon the patient to interpret the written document.

In the event that it is not possible to secure funding to revisit the research, a single case experimental design (SCED) would be considered in order to test the efficacy of the intervention via the collection of repeated measures before, during and after the intervention while allowing the researcher to minimise the amount of researcher assistance required while achieving statistical significance with fewer participants.

In an expansion of the discussion (section 2.5.2) of relevant National Institute for Health and Care Excellence guidelines, NICE (2012) states that when commissioning reviews regarding the cost effectiveness, clinical impact, practitioner experience and patient experience of an intervention, the Centre for Public Health requires data gathered via qualitative research, case reports and observational studies. As a result, it may be considered that the value of qualitative research methods is becoming recognised in answering calls for evidence-based practice. Therefore, it is recommended that future research maintains the thread of qualitative data in capturing and conveying the patient experience. As such an expansion of the Theoretical Framework of Acceptability (TFA, v2, Sekhon et al, 2017), would be employed upon revisiting the research with the use of the recently published patient and clinical team

qualitative questionnaire, designed to establish treatment acceptability (Sekhon et al., 2022).

6.7 Anecdotal evidence

Further to the researcher's subsequent employment as an Art Psychotherapist within the inpatient Perinatal Mental Health service, outside the timeframe of the research, it is pertinent to note the following anecdotal evidence of an exchange with a senior member of the nursing staff team within the unit. Following a patient's disclosure to the therapist during an Art Therapy session that she was experiencing suicidal ideation alongside both auditory and visual hallucinations, the therapist underwent a process of safeguarding reporting with the staff team. Staff responded by providing immediate additional support to the patient. The patient then revealed to staff that she had not felt able to find the words with which to communicate these symptoms to the staff team since her admission to the unit, as it had felt too intimidating and confusing. The patient explained to staff that the experience of the Art Therapy session gave her the means with which to share the information, first via the artwork, then via verbal discussion. The staff team relayed their gratitude to the therapist, that the Art Therapy session had ultimately enabled the patient to communicate her experiences and symptoms with the care team, therefore allowing them to alter their clinical approach accordingly.

6.8 Dissemination of the research

The researcher was invited to co-author a chapter within The Bloomsbury Handbook of Creative Research Methods, edited by Helen Kara. The chapter was written collaboratively by the researcher and a group of three other Art Psychotherapists, titled; "ARTiculating an Ethical Position: A Group of art psychotherapists use a Collaborative Arts-Based (Research) Process to Set their Ethical Scene when Employing Creative Methods within Mental Health Research". The handbook is due for publication in January 2024 and includes a clinical vignette delivered by the researcher alongside discussion of approaches to research and delivery of an Art Therapy intervention within the perinatal mental health patient group.

The researcher was invited to deliver a presentation of the research and findings at an NHS Perinatal Stakeholders Conference in January 2023. Attendees included commissioners, external funding bodies, experts by experience and professionals within the field. 120 people were in attendance of whom the researcher asked two questions of the audience and recorded their responding votes. Audience members were asked to indicate whether they had a better understanding of the potential benefits of Art Therapy within Perinatal Services following the presentation, to which 86% of the audience indicated agreement. Audience members were then asked to respond regarding whether they would subsequently be more likely to consider seeking funding for or commissioning an Art Therapy intervention, 78% of the audience indicated a positive response. As a result of the presentation, the researcher was approached to prepare two further NHS bids for delivery of a mother-infant Art Psychotherapy group intervention for the Perinatal Mental Health community team and secondly for delivery of a dual Art Psychotherapy group intervention for mothers who are on the Tokophobia, Birth Trauma and Perinatal Loss pathways under the psychology team of the NHS Trust.

The researcher has been in discussions with the Royal College of Psychiatrists, Perinatal Quality Network (PQN) regarding the research findings, the PQN have subsequently requested a summary of findings for incorporation the 9th edition of the Perinatal Inpatient Standards which is due for publication in 2024.

As discussed within section 6.3, the research data collected was used to prepare a bid for NHS Quality Improvement Funding to support the continued provision of the Art Therapy intervention within the inpatient perinatal mental health service on a 1 day per week basis with a 1-year contract. The bid for the funding was successful and the researcher is now nearing the end of that 1-year contract. The NHS inpatient perinatal mental health service have subsequently confirmed that they wish to extend the Art Therapy provision via the next annual round of Quality Improvement Funding but with an increase of 50%, bringing the intervention delivery to 1.5 days per week. This extension has been requested by the service following their acceptance of the researcher’s proposal that the patient experience of transition from inpatient to outpatient / community services would be enhanced by the provision of a series of additional Art Therapy sessions made available to patients either online or in person,

depending on the patient's geographic limitations, during this transitional period. This would prevent the patient experiencing abrupt endings to therapeutic provision following rapid discharge to an 'out of area' NHS Trust or as a result of familial commitments which may prevent the patient from returning to the unit for the transitional, closing Art Therapy sessions.

As a result of the researchers experience of the patient group, their present aim is to establish a spectrum of Art Therapy provision, offering engagement with patients in a range of ways such as individual inpatient sessions, transition sessions for recently discharged patients, groups for specific pathways such as Perinatal Loss and mother infant groups within the community. As such, the researcher seeks to continually review and adapt their provision of the intervention in order to respond to the wide spectrum of need within the patient group.

7 Conclusion

The aim of the study was to undertake research of an Art Psychotherapy intervention delivered within an NHS, inpatient Perinatal Mental Health unit. Following the provision of literary, professional, academic and clinical contexts to the research, the researcher set out a clearly defined methodology via which the research was conducted. The researcher sought to gather qualitative and quantitative research in an attempt to identify whether Art Psychotherapy can be considered to be a feasible, appropriate, meaningful and clinically effective intervention for the perinatal mental health patient group. In addition, the researcher intended to identify and analyse the existing evidence base for the intervention with the patient group by undertaking a systematic review, therefore developing the research in order to provide a contribution to the further development of the evidence base within gaps identified by the review. A rich qualitative case series discussed the patient and therapist experience of the therapeutic intervention and supplied material for a thematic analysis of data, from which indications were drawn regarding the feasibility, appropriateness, meaningfulness and clinical effectiveness of the intervention with the patient group.

The discussion of findings within the thesis demonstrates that all research questions regarding the overall acceptability of the intervention have been explored via the data

gathered, in spite of numerous research challenges which were documented and overcome by the researcher. As such, it may be summarised that the study provides an original contribution to the research of Art Psychotherapy interventions with the perinatal mental health patient group. The research offers an original contribution to field of Art Psychotherapy in Perinatal Mental Health as it is the only study in this area to the knowledge of the research team to have been conducted at doctoral level, practicing under the exacting standard of NHS ethical clearance with a randomised control trial design. In addition to this, the researcher has undertaken the first systematic review of literature relating to Art Psychotherapy in Perinatal Mental Health. The researcher has detailed a series of recommendations (6.6) for future research within the field which may be of benefit to researchers considering embarking upon further engagement with research within similar NHS settings.

In brief, it is the intention of the researcher to re-visit the research in the near future, as detailed within the future recommendations section, in order to solidify the research findings by altering outcome measures employed and seeking engagement with a wider number of participants. Future research will undoubtedly be aided by the foundation of the researcher's established experience as an Art Psychotherapist, employed within an NHS Perinatal Mental Health service; an intervention provision which the researcher intends to continue to expand upon as a spectrum of Art Therapy provision for the perinatal mental health patient group.

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9 Appendices

9.1 Consent form

Research Ethics and Art Psychotherapy Consent Form
V.4. dated 28.02.2020

Project title: Establishing an evidence base for the use of Art Therapy in a mother and baby unit
IRAS project ID: 272551
Researcher: Amy Stanhope, Art Psychotherapist and Postgraduate PhD student in the College of Health & Social Care Research at the University of Derby. Contact: a.stanhope2@derby.ac.uk

This study was approved by the College of Health and Social Care Research Ethics Committee at the University of Derby.

Please initial box:

1. I confirm that I have read and understand the Participant Information Sheet [V.5 dated 28.02.2020] for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving reason. ☐
3. I understand that upon withdrawing from the study, therapy sessions and the collection of new questionnaire score data will cease, however any anonymous information gathered up until the point of withdrawal will still be included in the study. ☐
4. I agree to take part in the above study. ☐
5. I agree to allow the researcher and my therapist to access my medical records in order to record brief therapy notes and extract weekly results from two questionnaires for anonymous inclusion in the research data. ☐
6. I confirm that I have read and understand the Audio Image Recording (AIR) Protocol sheet [V.2 dated 08.11.19] and have had the opportunity to ask questions. ☐
7. I agree to the audio recording of an interview with the therapist, to create the AIR interview at the end of therapy. ☐
8. I agree to the use of anonymised quotes, clinical data, AIR interview content and artworks in professional and academic publications. ☐
9. I agree to the use of anonymised quotes, clinical data, AIR interview content and artworks in presentations and lectures for teaching purposes among professionals and students. ☐
10. I understand that I will be withdrawn from the research (be removed from the wait list / Art Therapy sessions will cease) should the unit staff team determine that my capacity to consent has diminished at any point. In this instance, anonymous data gathered during my engagement in the research up to that point will still be included in the study. ☐
11. I understand that the content of Art Therapy sessions will remain confidential, unless the therapist has a concern about the safeguarding or wellbeing of myself and those around me. I understand that I will always be made aware should a breach of confidentiality be necessary. ☐

Page 1 of 2

Name of Researcher	Date	Signature

Name of Participant	Date	Signature

9.2 Participant Information Sheet

UNIVERSITY of DERBY

NHS Derbyshire Healthcare NHS Foundation Trust

V.5 dated 28.02.2020

Project title: Establishing an evidence base for the use of Art Therapy in a mother and baby unit
IRAS project ID: 272551
Researcher: Amy Stanhope, Art Psychotherapist and Postgraduate PhD student in the College of Health & Social Care Research at the University of Derby. Contact: a.stanhope2@derby.ac.uk

You are being invited to participate in a research study. It is important that you understand what your participation would involve before reaching a decision about whether or not you consent to take part. Please take time to read the following information carefully, you will be given a minimum of 24 hours to consider the information fully. You may find it useful to discuss the following information with a relative or friend.

Who is the researcher?
Amy Stanhope is a fully qualified Art Psychotherapist and Postgraduate PhD student in the College of Health & Social Care Research at the University of Derby. As part of the PhD studies, Amy Stanhope is working with the full support of The Beeches, Royal Derby Hospital, to conduct research into the use of Art Therapy within perinatal mental health (with mothers who experience mental health diagnoses during pregnancy or up to a year after giving birth). This is the research that you are being invited to participate in.

What is the research?
The research is being conducted with the aim of establishing an evidence base for the use of Art Therapy in Mother and Baby Units such as The Beeches, Royal Derby Hospital. Evidence is needed so that Art Therapists can aim to provide access to Art Therapy for mothers in perinatal units on a wider scale.

The research has been approved by the University of Derby research ethics committee and the NHS ethics committee, this means that the research follows the standard of research ethics set by these bodies. Additionally, the research is being conducted with the support of The Beeches unit and staff. As an Art Psychotherapist, the researcher is governed by the British Association of Art Therapists and by the Health and Care Professions Council, therefore the therapy work will follow the standard of professional therapy set by these bodies.

The research is to be conducted via a wait-list control group, this is a widely used approach which means that there will be two groups to which people will be allocated on a random basis. One group will begin the Art Therapy sessions straight away, while the second group will be added to a waiting list for a minimum term of six weeks. The waiting list group will receive Art Therapy sessions at a later date as outpatients, to begin no later than two weeks after their discharge from the unit. Both groups will be part of the research and will be monitored for changes in mental health and wellbeing using the same set of questionnaires. Please see the "What is Art Therapy" leaflet for further information.

Consent process
You are being given this information so that you can make an informed decision about whether you wish to give permission to be involved in this research and to receive Art Therapy sessions. Should you wish to consent to involvement in the research and Art Therapy sessions, a separate consent form with further information has been provided for you to complete and return to the researcher. Alternatively, you are free to decline Art Therapy and involvement in the research, your standard care plan within The Beeches unit will not be affected.

Why have you been invited to take part in this study?
You have been invited to participate in the research because the researcher would like to work with people who have been admitted to The Beeches Unit during the perinatal phase (during pregnancy or up to a year after giving birth). Other mothers who have been admitted to the unit

information sheet included, for more detailed information about what an AIR is and how it is made.
- Please do not discuss your experience of Art Therapy sessions with other participants. This will ensure that those who are waiting for Art Therapy sessions will not be influenced by your experience of the therapy.

Funds are available to cover up to £10 per journey for wait list participants who will be asked to return to the unit as outpatients to receive Art Therapy sessions. Travel expense claims will be administered by the sponsor (University of Derby), please ask the researcher for further details about the claims process.

Your participation would be very valuable in helping to gather data and gain knowledge about the potential benefits of Art Therapy provision within perinatal mental health. In addition to this, the presence of the research project within the unit will enable you to access Art Therapy sessions as part of your care plan at The Beeches.

At the end of your participation, there will be an opportunity for you to discuss with the therapist whether you feel the need to access further support regarding any matters raised during your Art Therapy sessions. At this point, in discussion with the therapist, a further referral can be made to an ongoing provider as necessary.

What would happen to any information provided by you?
The University of Derby is the sponsor for this study, based in United Kingdom. The researcher and sponsor will need to use information from you and from your medical records for this research project. This information will include your name and contact details which will be held on consent forms and basic numerical results of wellbeing questionnaires which will be recorded within your medical records. People will use this information to do the research and to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. The researcher and sponsor will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you. Your name and signature would only be recorded on the researchers consent forms which will be stored in an encrypted (password protected) electronic file, only accessible by the researcher. The unit care team would be made aware of your engagement in the research. The data gathered will be comprised of participants engagement in therapy sessions, outcomes of questionnaires completed by participants, images made of any artwork created and extracts drawn from the AIR process. Research data and clinical vignettes (anonymous summaries of work with patients, which may have educational value or professional interest) will be included in professional and academic publications such as the researchers thesis and in workshops or teachings about the research. Should you wish to view a copy of the final published research upon its completion, please make contact with the Director of Studies (see contact details below).

During the therapy process, the art therapist will be writing brief therapy notes within your medical records and sharing information about your progress with your care team. Notes made in your medical records will include basic details such as whether you attended a session, whether you used any art materials and whether you gave your consent to continue with the sessions.

This data will be analysed by lead researcher and Art Psychotherapist, Amy Stanhope in conjunction with the Director of Studies and academic supervisors who are employed by the sponsor, using statistical methods which ensure reliability and anonymity. The researcher needs to manage your records in specific ways for the research to be reliable. This means that you will not be able to see or change the data that is held about you. Should you have any questions about the anonymous data that is being collected, please feel free to discuss it with the researcher or to make contact with the Director of Studies via the details provided below.

will also be given the opportunity to take part. The researcher is not looking for 'experts' on the research topic. You will not be judged in any way and you will be treated with respect.

What are the possible disadvantages and risks of taking part?
Art Therapy is a therapeutic process which can be challenging in terms of the emotions and content that you may bring to the sessions. You would be supported throughout the process by the therapist who is trained to safely facilitate the therapeutic process. Your involvement in the research and therapy process will require you to spend time attending the therapy sessions and on completing a series of brief questionnaires, as detailed clearly below.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence, then you may have grounds for a legal action for compensation against the sponsor (University of Derby) or the researcher (Amy Stanhope), but you may have to pay your legal costs. Professional insurance policies are in place in order to protect you, the sponsor and the researcher in the event of negligence during the research.

What are the possible benefits of taking part?
The possible direct benefits to you are of increased psychological wellbeing, developing future coping mechanisms, creative expression and increased emotional resilience and literacy.

The wider beneficial outcomes of the research are that it will further the provision of quality, evidence based research in the profession of Art Psychotherapy, supporting further work in the field of perinatal mental health

What would your participation involve?
Please also refer to the flowchart at the end of this document for a representation of a participants journey. If you agree to participate you will be asked to:

- Attend one to one Art Therapy assessment sessions within The Beeches unit at a mutually agreeable time.
- Following the period of assessment (one session of 50 minutes), should both the therapist and yourself feel that the Art Therapy approach is suitable for you, you will be offered a series of five, 50 minute, one to one Art Therapy sessions. Should you leave the unit before the duration of therapy has ended, you will be given the opportunity to return to the unit for the remaining sessions available to you, however it would be your responsibility to cover travel costs for this.
- You will be asked to complete four brief questionnaires which will gather data about and measure any changes in your mental health, wellbeing and your relationship with your child. Two questionnaires will only be completed twice, once at the beginning of therapy and once at the end of therapy; these will be completed by you with the support of your therapist and are being completed at this point for the specific purpose of gathering research data. Two other questionnaires will be completed once every week for the duration of your engagement in the study, while either on the waiting list or in active therapy; these will be completed with the support of the unit care team as part of your standard treatment plan.
  The weekly questionnaire results will be saved within your medical notes by the unit care team, the researcher is seeking your permission to view the results of those two questionnaires and include them anonymously in the research data. Please see the attached consent form within which you may indicate whether or not you wish to consent to this.
  The measures used within this study are no different to those used in standard care within the unit. The questionnaires will be multiple choice with tick boxes for your answers and vary in length, the shortest being ten questions long and the longest being twenty questions long. Questionnaires will include statements to help you record your thoughts and feelings in the past two weeks / week timeframe, either a member of the unit staff or the therapist will be present during questionnaire completion in order that you can be supported, should you find completion of the questionnaire challenging. Each questionnaire should take no longer than ten minutes to complete.
- At the end of the series of Art Therapy sessions, you will be offered the opportunity to create an Audio Image Recording (AIR) to honour your work and capture your experience of therapy. This will involve creating an audio recording of a discussion with the therapist about your experience of Art Therapy. The therapist will then combine the audio recording with photographs of three of your chosen pieces of work. The resulting edited video of the artwork and your voice is useful to the research but can also serve as a memento for you to take away. Please see the additional

The researcher will ensure that the research is of benefit to the public provision of healthcare services, by sharing findings about the research process, outcome and data. The intention is to submit reviews and reports to professional and academic journals, give lectures to Art Therapy students, speak at conferences for birth and mental health professionals during the course of the research and complete a thesis by August 2021.
You can find out more about how the researcher and sponsor will use your information by asking the researcher and data controller, Amy Stanhope or by visiting www.hra.nhs.uk/information-about-patients/

Clinical Supervision:
All Art Therapists are required by their governing body to undergo Clinical Supervision to ensure that the therapy is being undertaken in a safe way for both the participant and the therapist. This means that the content of the therapy sessions and photographs of artwork made will be discussed / shown on an anonymised basis (without revealing your name or any identifying features) within a confidential space with a qualified Clinical Supervisor who is bound by terms of confidentiality of the supervision contract and the practice guidelines of their own governing body (HCPC, Health and Care Professions Council).

Storage and ownership of artwork:
Participants will retain legal ownership of all artwork made by them during Art Therapy sessions. During the formal period of therapeutic intervention with clients, all artwork will be stored on site within the Perinatal Unit and will be treated as confidential material. When the therapy ends, participants will be invited to take work away to keep. Any artwork that participants do not wish to take away will be disposed of in an appropriately confidential manner.

The therapist will take photographs of any artwork made during your therapy sessions. This is to create a record of the work for additional safekeeping. In addition, your anonymised work (only work without identifying features) may be included in professional publications or teachings about the research.

The use of photographs and an audio recording device will be made available during the collaborative creation of an AIR recording, to mark the end of your therapy provision. Digital media will always be stored in an anonymised and encrypted (password protected) format.

Privacy, confidentiality and sharing information:
Your privacy and safety will be respected at all times. Participants will not be identified by name within the data collected, on any written material resulting from the data collected, or in any write-up of the research. Only the consent form will carry the participants name and signature, as referenced above. Where there is risk of a participant being identified through any artwork made during Art Therapy sessions, this will be carefully handled when referenced during the write up of the research so as to maintain anonymity. The research project will abide by the University of Derby's Records Retention Policy (March 2014), Data Code of Conduct and the NHS computer record keeping policy within the perinatal unit.

The university guideline is for raw data to be kept for a minimum of 6 years. The data storage process will be reviewed actively within the storage period in order to ensure that it is in keeping with current GDPR legislation. As a qualified therapist, my work is also informed by the GDPR guidelines of my governing bodies, The British Association of Art Therapists and The Health Care Professions Council.

The content of Art Therapy sessions will remain confidential between the therapist and yourself, only brief summaries of attendance and engagement with materials will be detailed within your medical record. Unless the therapist has a concern about the safeguarding and wellbeing of yourself and those around you, in which case the therapists professional duty of care will override confidentiality and the therapist will discuss their concern with the unit care team. You will always be made aware should a breach of confidentiality be necessary.

How could you withdraw from the study?
You are free to withdraw from the study at any point without explanation, disadvantage or consequence by contacting Art Therapist and researcher, Amy Stanhope using the details provided below. Upon receipt of the the withdrawal request, therapy sessions will cease and the collection of new questionnaire score data will cease. However, any information gathered up until the point of withdrawal including fully anonymised AIR recording extracts, images of artwork and clinical vignettes (anonymous summaries of work with patients, which may have educational value or professional interest) would still be included within the research study and any publications such as PhD thesis.

Should you miss two sessions out of the five therapy sessions on offer, a meeting will be arranged between yourself and the therapist in order to address any difficulties that you may be having in attending the sessions. Should you miss another session following this meeting, you will be withdrawn from the study in order to ensure the integrity of the research. In this instance, you will then be offered one final therapy session in order to bring the therapy provision to a close.

Contact Details
If you would like further information about the research or have any questions or concerns, please do not hesitate to contact the researcher on: a.stanhope2@derby.ac.uk

This study was approved by the College of Health and Social Care Research Ethics Committee at the University of Derby. If you have any questions or concerns about how the research has been conducted please contact the Director of Studies: Dr Jamie Bird, College of Health & Social Care Research Centre, University of Derby. Tel: 01332 594044, J.Bird@derby.ac.uk If you remain unhappy and wish to complain formally, you can do this by contacting the Centre for Research and Development on: 01332 623700.

Confidential support and advice about health related matters is available to all NHS patients, families and carers via the Patient Advice and Liaison Service (PALS),Your local office can be contacted via: 01332 623751.
Please take time to read the information included within this pack carefully before making your decision about whether you wish to participate in this research project. You will have an opportunity to discuss this information with the lead researcher in person.

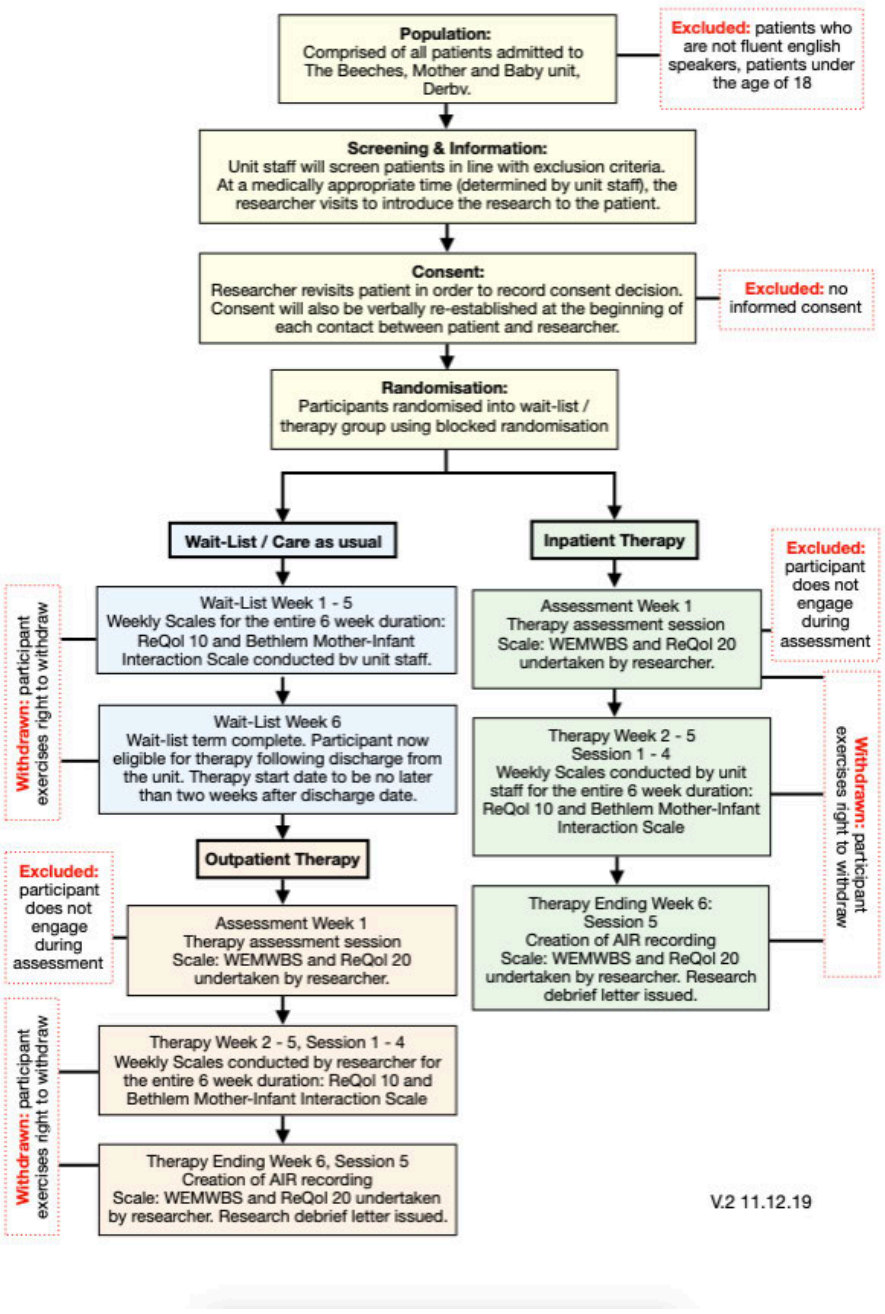
Thank you for taking the time to read this information,

[redacted]

Amy Stanhope
Lead Researcher
PGTA, PhD Student
University of Derby

Additional information included in this pack:
Patient consent form
Audio Image Recording information sheet and consent form
“What is Art Therapy?” information leaflet

Participant Timeline Flowchart:



9.3 Art Therapy Leaflet

What is Art Therapy?

Art therapy helps people to use art materials as a way of expressing themselves and can improve psychological wellbeing.

Further information

More information about Art Therapy is available via the British Association of Art Therapists: www.baat.org

This leaflet has been produced by Amy Stanhope, a qualified Art Psychotherapist, in order to support research within The Beeches, Mother and Baby Unit, Derby. Should you have further questions about the research, please refer to Participant Information Sheets provided for contact details.

Art Therapy is a type of Psychotherapy

Art Therapy sessions can only be offered by a qualified Art Psychotherapist. Art Therapy is not used as a way of diagnosing participants, but as a way of working with emotions and experiences.

What do service users say about Art Therapy?

"I had so many real lasting benefits, like a new way of doing things and different methods of coping. I got more from it than I ever thought possible."

"It's had a profound impact. I consider this to be the most successful thing that has happened in my mental health history."

www.baat.org

Can you keep your work?

After the final therapy session has finished, your therapist will offer you the chance to take home anything that you have made.

Why Art Therapy?

Art Therapy can be helpful as you can use the materials as a way of communicating, rather than relying on talking about something that might feel challenging.

Do I need to be good at art?

Art Therapy is not a recreational activity or an art lesson, although the sessions can be enjoyable. You do not need to have any previous experience or artistic skills and anything you make will not be judged. Art therapy will be provided as one to one sessions during which only yourself and the therapist are in the room.

How many sessions?

For the purposes of this research programme, six sessions of Art Therapy are available to you. This is made up of one assessment session and five therapy sessions.

Art materials

A selection of art materials are made available at each session. You are free to decide which materials you would like to use and in what way.

What is an Art Therapist?

Art Therapists are required to complete a Masters level qualification, undergo regular clinical supervision and are regulated by the Health and Care Professions Council and British Association of Art Therapists. This is in order to protect both the participant and the therapist by ensuring safe practice.

9.4 Audio Image Recording Protocol

Audio Image Recording (AIR) Protocol
V.2 dated 08.11.19

What is an Audio Image Recording (AIR)?
An AIR is an audio recording of voices as you have a discussion with your therapist, which is then combined with photographic images of your chosen pieces of artwork.

Why make an AIR?
Experiences and emotions are often difficult to put into words, but creative expression with art materials during Art Therapy sessions can be a helpful way of finding a new unspoken language to show what your emotions and experiences are and begin to process them. Art Therapists aim to give a voice to those who struggle to have one because of emotional, social or physical barriers. As someone who will have received a series of Art Therapy sessions, you are now an 'expert by experience'.

AIR's are a valuable tool within Art Therapy research, because they can capture an understanding of how the experience of Art Therapy was for you. An AIR also serves as a memento of your therapy journey and can therefore extend therapeutic benefits for you. Additionally, AIR's can help others by listening to someone else's experiences of Art Therapy, therefore reducing concern about their own future therapy encounters.

How is an AIR made?
At the end of your series of therapy sessions, your therapist will invite you to take part in recording a brief interview with your Art Therapist about your art work made during sessions and your experience of therapy.

1) You will be asked to select three pieces of your art work. Trust your instincts and select pieces which stand out for you as being significant and stayed with your throughout therapy. The elected art work will then be photographed by the therapist for inclusion in the AIR.
2) You will meet with the therapist to talk about your artwork and how things might have changed for you since you began therapy. The questions are standardised, a copy of the reflect interview questions have been included below. The therapist will make an audio recording of this conversation.
3) Your therapist will edit your recording to show your images while the recording of your conversation plays in the background. The AIR will not show your name, identifying features in your artwork or images of you at any time. You will be given an opportunity to listen to the edited AIR to ensure that you are happy with the content prior to it being used for research purposes.
4) You will be provided with a copy of your finalised AIR via encrypted electronic file for you to keep as a memento of therapy.
5) The AIR can then be used anonymously to show to others who may be interested in Art Therapy, for training of professionals and therapy students and to further academic research.

This study was approved by the College of Health and Social Care Research Ethics Committee at the University of Derby.

9.5 AIR Reflect Interview

AIR Reflect Interview
V.1 dated 13.06.19

Notes for therapist:

Pieces are to be in chronological order according to when they were made in the therapy journey. Can interject if appropriate with "I remember that at this point you spoke about feeling...."

Introduction:
We are creating an audio recording which will be made into a video alongside images of your chosen pieces of work, this is called an AIR and it will not reveal any identifying features about you to the listener. An AIR may be useful for you to reflect on in future, as it captures your experience of Art Therapy. An AIR is also of benefit to those who wish to learn about what it is like to have Art Therapy, so for future patients and professionals to listen to. You have consented to this AIR process and to the use of your AIR with professionals and other therapy candidates, please could you confirm whether you are happy to proceed?

1) Can you say a little about the reason why you have been offered Art Therapy / something about your time in The Beeches unit?

2) Can you say a few words about how you were feeling when you first started art therapy?

3) Please would you say a few words about your first chosen piece of work?

When did you make it?
Can you describe it please?
Did making this piece change the way that you were feeling or help you in any way?

4) Can you tell us about your second chosen piece of work?

How long had you been coming to art therapy sessions for when you made this piece?
Can you describe to the listener, how you made this?
How did making this piece make you feel?

5) Can you say what the difference was between the time when you made the first piece and when you made the second piece?

6) Can you tell the listener about your third chosen piece?

How long had you been coming to art therapy sessions for when you made this piece?
Can you describe to the listener, how you made this?
How did making this piece make you feel?

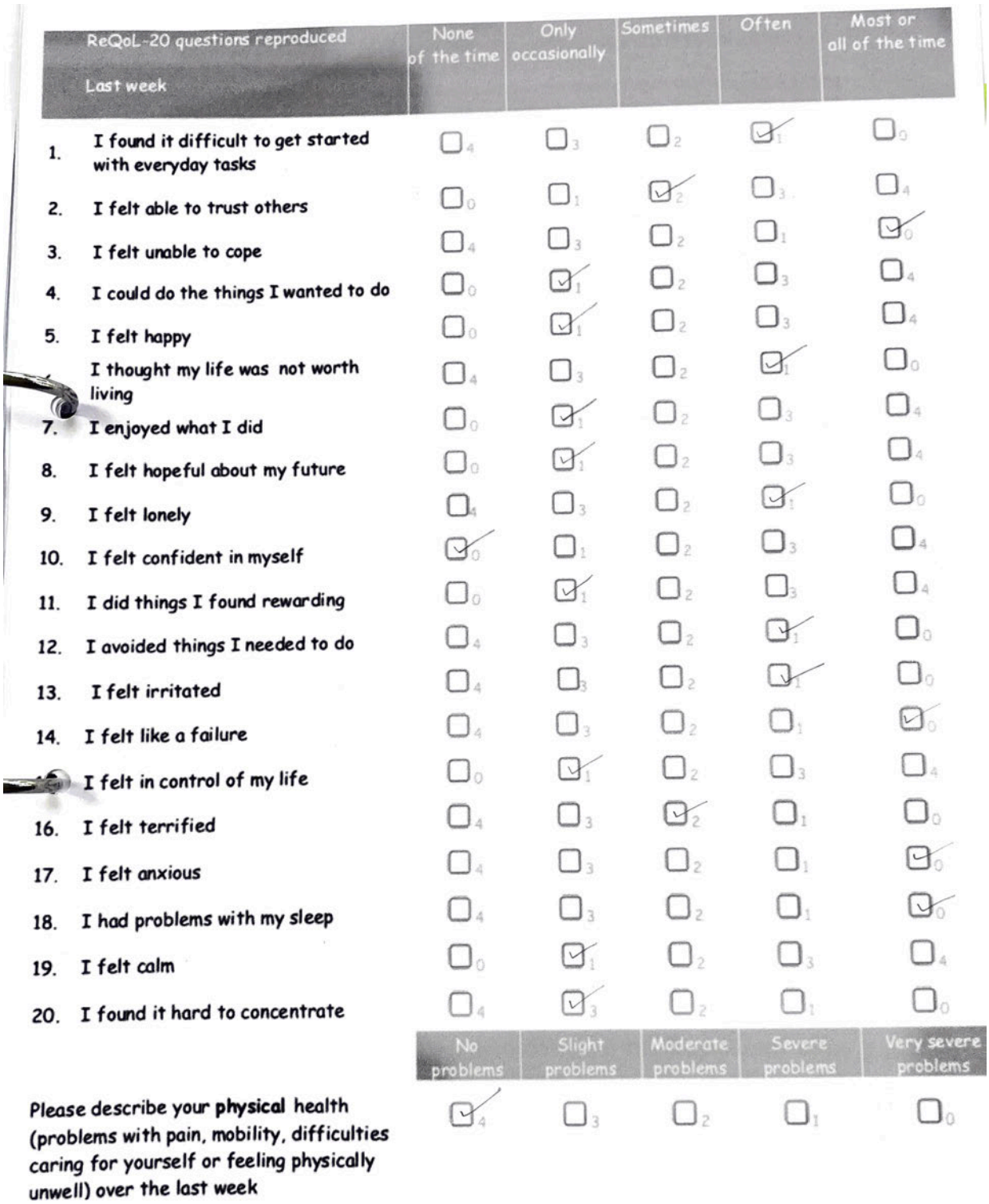
7) Can you say what the difference was between the time when you made the other pieces and then when you made the third piece?

8) Would you like to tell the listener anything else about what Art Therapy has been like for you?

9) Can you say a few words about how you were feeling now, at the end of your term of Art Therapy sessions?

Thank you for taking the time to create this Audio Image Recording.

9.6 ReQol20, Suzie, Session 1



ReQoL-20 questions reproduced Last week	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1. I found it difficult to get started with everyday tasks	☐4	☐3	☐2	☑1	☐0
2. I felt able to trust others	☐0	☐1	☑2	☐3	☐4
3. I felt unable to cope	☐4	☐3	☐2	☐1	☑0
4. I could do the things I wanted to do	☐0	☑1	☐2	☐3	☐4
5. I felt happy	☐0	☑1	☐2	☐3	☐4
6. I thought my life was not worth living	☐4	☐3	☐2	☑1	☐0
7. I enjoyed what I did	☐0	☑1	☐2	☐3	☐4
8. I felt hopeful about my future	☐0	☑1	☐2	☐3	☐4
9. I felt lonely	☐4	☐3	☐2	☑1	☐0
10. I felt confident in myself	☑0	☐1	☐2	☐3	☐4
11. I did things I found rewarding	☐0	☑1	☐2	☐3	☐4
12. I avoided things I needed to do	☐4	☐3	☐2	☑1	☐0
13. I felt irritated	☐4	☐3	☐2	☑1	☐0
14. I felt like a failure	☐4	☐3	☐2	☐1	☑0
15. I felt in control of my life	☐0	☑1	☐2	☐3	☐4
16. I felt terrified	☐4	☐3	☑2	☐1	☐0
17. I felt anxious	☐4	☐3	☐2	☐1	☑0
18. I had problems with my sleep	☐4	☐3	☐2	☐1	☑0
19. I felt calm	☐0	☑1	☐2	☐3	☐4
20. I found it hard to concentrate	☐4	☑3	☐2	☐1	☐0

	No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week	☑4	☐3	☐2	☐1	☐0

9.7 WEMWBS, Suzie, Session 1

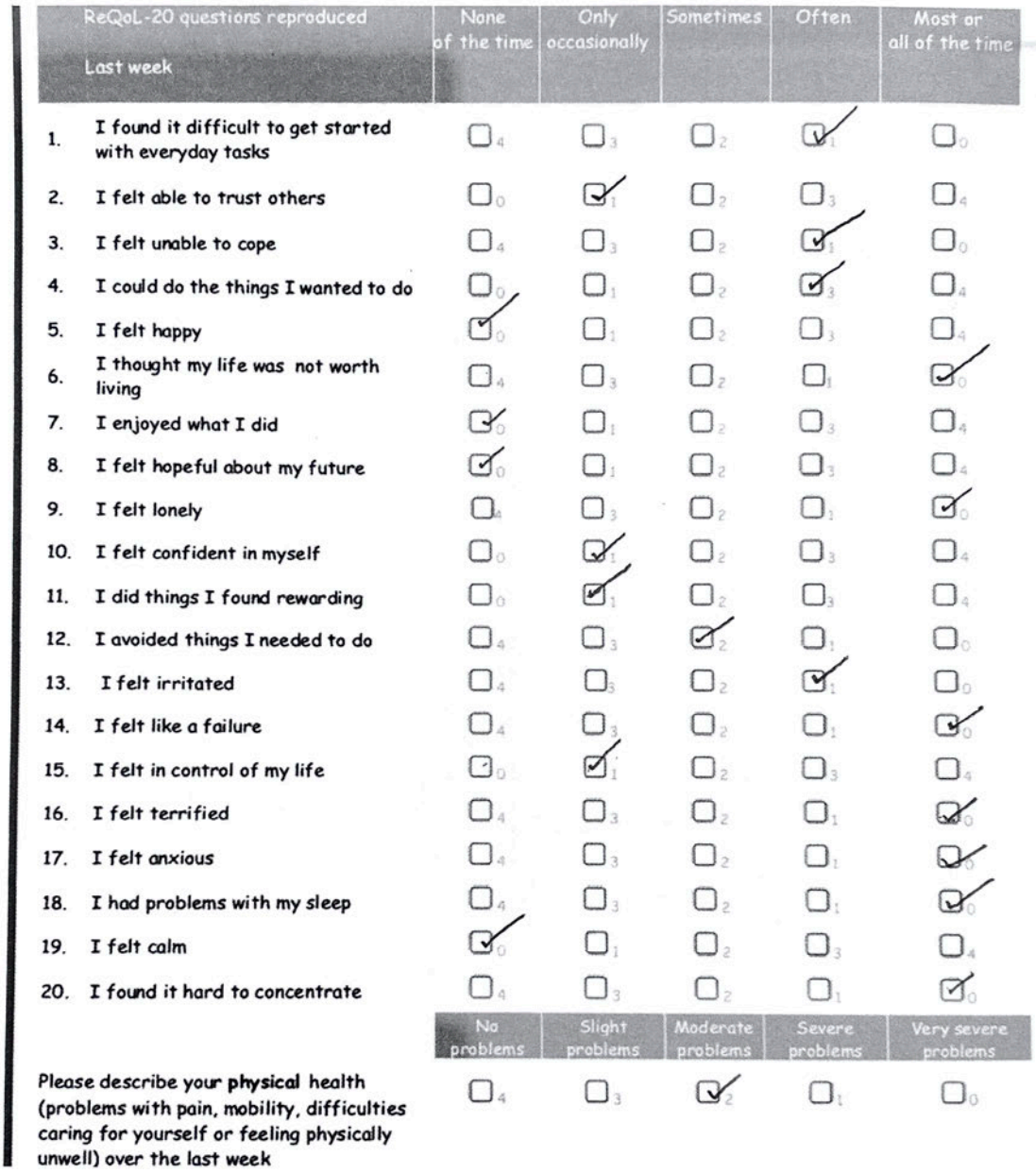
Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	✓ 2	3	4	5
I've been feeling useful	1	✓ 2	3	4	5
I've been feeling relaxed	1	✓ 2	3	4	5
I've been feeling interested in other people	1	2	✓ 3	4	5
I've had energy to spare	✓ 1	2	3	4	5
I've been dealing with problems well	1	✓ 2	3	4	5
I've been thinking clearly	1	2	✓ 3	4	5
I've been feeling good about myself	✓ 1	2	3	4	5
I've been feeling close to other people	1	2	✓ 3	4	5
I've been feeling confident	✓ 1	2	3	4	5
I've been able to make up my own mind about things	1	2	✓ 3	4	5
I've been feeling loved	1	2	✓ 3	4	5
I've been interested in new things	✓ 1	2	3	4	5
I've been feeling cheerful	1	2	✓ 3	4	5

© WEMWBS

9.8 ReQol20, Abby, Session 1



ReQoL-20 questions reproduced Last week		None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1.	I found it difficult to get started with everyday tasks	☐4	☐3	☐2	☑1	☐0
2.	I felt able to trust others	☐0	☑1	☐2	☐3	☐4
3.	I felt unable to cope	☐4	☐3	☐2	☑1	☐0
4.	I could do the things I wanted to do	☑0	☐1	☐2	☐3	☐4
5.	I felt happy	☑0	☐1	☐2	☐3	☐4
6.	I thought my life was not worth living	☐4	☐3	☐2	☐1	☑0
7.	I enjoyed what I did	☑0	☐1	☐2	☐3	☐4
8.	I felt hopeful about my future	☑0	☐1	☐2	☐3	☐4
9.	I felt lonely	☐4	☐3	☐2	☐1	☑0
10.	I felt confident in myself	☐0	☑1	☐2	☐3	☐4
11.	I did things I found rewarding	☐0	☑1	☐2	☐3	☐4
12.	I avoided things I needed to do	☐4	☐3	☑2	☐1	☐0
13.	I felt irritated	☐4	☐3	☐2	☑1	☐0
14.	I felt like a failure	☐4	☐3	☐2	☐1	☑0
15.	I felt in control of my life	☐0	☑1	☐2	☐3	☐4
16.	I felt terrified	☐4	☐3	☐2	☐1	☑0
17.	I felt anxious	☐4	☐3	☐2	☐1	☑0
18.	I had problems with my sleep	☐4	☐3	☐2	☐1	☑0
19.	I felt calm	☑0	☐1	☐2	☐3	☐4
20.	I found it hard to concentrate	☐4	☐3	☐2	☐1	☑0
		No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week		☐4	☐3	☑2	☐1	☐0

9.9 WEMWBS, Abby, Session 1

Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	✓ 1	2	3	4	5
I've been feeling useful	1	2	✓ 3	4	5
I've been feeling relaxed	✓ 1	2	3	4	5
I've been feeling interested in other people	1	2	✓ 3	4	5
I've had energy to spare	1	✓ 2	3	4	5
I've been dealing with problems well	1	✓ 2	3	4	5
I've been thinking clearly	✓ 1	2	3	4	5
I've been feeling good about myself	✓ 1	2	3	4	5
I've been feeling close to other people	✓ 1	2	3	4	5
I've been feeling confident	✓ 1	2	3	4	5
I've been able to make up my own mind about things	1	✓ 2	3	4	5
I've been feeling loved	✓ 1	2	3	4	5
I've been interested in new things	✓ 1	2	3	4	5
I've been feeling cheerful	✓ 1	2	3	4	5

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9.10 ReQol20, Alice, Session 1

ReQoL-20 questions reproduced Last week	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1. I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
2. I felt able to trust others	☐ 0	☑ 1	☐ 2	☐ 3	☐ 4
3. I felt unable to cope	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I could do the things I wanted to do	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
5. I felt happy	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
6. I thought my life was not worth living	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
7. I enjoyed what I did	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
8. I felt hopeful about my future	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
9. I felt lonely	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0
10. I felt confident in myself	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
11. I did things I found rewarding	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
12. I avoided things I needed to do	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
13. I felt irritated	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
14. I felt like a failure	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0
15. I felt in control of my life	☐ 0	☐ 1	☐ 2	☑ 3	☐ 4
16. I felt terrified	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
17. I felt anxious	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
18. I had problems with my sleep	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
19. I felt calm	☐ 0	☐ 1	☐ 2	☑ 3	☐ 4
20. I found it hard to concentrate	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0

	No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0

9.11 WEMWBS, Alice, Session 1

Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	✓ 3	4	5
I've been feeling useful	1	2	✓ 3	4	5
I've been feeling relaxed	1	2	✓ 3	4	5
I've been feeling interested in other people	1	2	✓ 3	4	5
I've had energy to spare	1	✓ 2	3	4	5
I've been dealing with problems well	1	2	✓ 3	4	5
I've been thinking clearly	1	2	✓ 3	4	5
I've been feeling good about myself	1	2	✓ 3	4	5
I've been feeling close to other people	1	2	✓ 3	4	5
I've been feeling confident	1	2	✓ 3	4	5
I've been able to make up my own mind about things	1	2	✓ 3	4	5
I've been feeling loved	1	2	3	✓ 4	5
I've been interested in new things	1	2	✓ 3	4	5
I've been feeling cheerful	1	2	✓ 3	4	5

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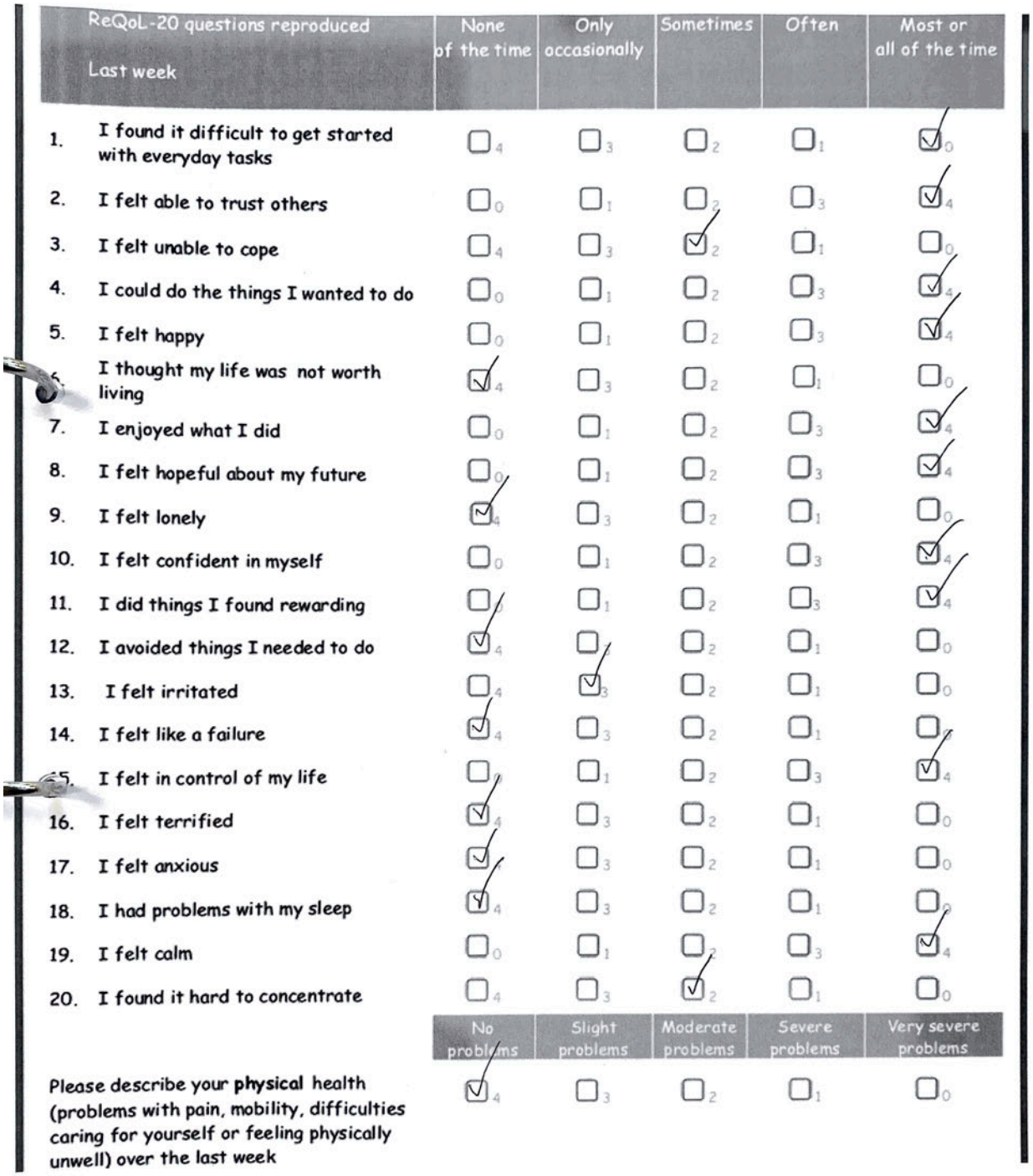
9.12 ReQol20, Jane



ReQoL-20 questions reproduced Last week		None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1.	I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☐ 1	☑ 0
2.	I felt able to trust others	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
3.	I felt unable to cope	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
4.	I could do the things I wanted to do	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
5.	I felt happy	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
6.	I thought my life was not worth living	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
7.	I enjoyed what I did	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
8.	I felt hopeful about my future	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
9.	I felt lonely	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
10.	I felt confident in myself	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
11.	I did things I found rewarding	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
12.	I avoided things I needed to do	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
13.	I felt irritated	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0
14.	I felt like a failure	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
15.	I felt in control of my life	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
16.	I felt terrified	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
17.	I felt anxious	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
18.	I had problems with my sleep	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
19.	I felt calm	☐ 0	☐ 1	☐ 2	☐ 3	☑ 4
20.	I found it hard to concentrate	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
		No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
	Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0

9.13 WEMWBS, Jane

Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5 ✓
I've been feeling useful	1	2	3	4	5 ✓
I've been feeling relaxed	1	2	3	4	5 ✓
I've been feeling interested in other people	1	2	3	4	5 ✓
I've had energy to spare	1	2	3	4	5 ✓
I've been dealing with problems well	1	2	3	4	5 ✓
I've been thinking clearly	1	2	3	4	5 ✓
I've been feeling good about myself	1	2	3	4	5 ✓
I've been feeling close to other people	1	2	3	4	5 ✓
I've been feeling confident	1	2	3	4	5 ✓
I've been able to make up my own mind about things	1	2	3	4	5 ✓
I've been feeling loved	1	2	3	4	5 ✓
I've been interested in new things	1	2	3	4	5 ✓
I've been feeling cheerful	1	2	3	4	5 ✓

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9.14 ReQol20, Meg

ReQoL-20 questions reproduced Last week	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1. I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
2. I felt able to trust others	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
3. I felt unable to cope	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
4. I could do the things I wanted to do	☐ 0	☐ 1	☑ 2	☐ 3	☐ 4
5. I felt happy	☐ 0	☑ 1	☐ 2	☐ 3	☐ 4
6. I thought my life was not worth living	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
7. I enjoyed what I did	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I felt hopeful about my future	☐ 0	☑ 1	☐ 2	☐ 3	☐ 4
9. I felt lonely	☐ 4	☐ 3	☐ 2	☐ 1	☑ 0
10. I felt confident in myself	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. I did things I found rewarding	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. I avoided things I needed to do	☐ 4	☑ 3	☐ 2	☐ 1	☐ 0
13. I felt irritated	☐ 4	☐ 3	☐ 2	☐ 1	☑ 0
14. I felt like a failure	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
15. I felt in control of my life	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4
16. I felt terrified	☑ 4	☐ 3	☐ 2	☐ 1	☐ 0
17. I felt anxious	☐ 4	☐ 3	☐ 2	☑ 1	☐ 0
18. I had problems with my sleep	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0
19. I felt calm	☑ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. I found it hard to concentrate	☐ 4	☐ 3	☐ 2	☐ 1	☑ 0
	No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical** health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week	☐ 4	☐ 3	☑ 2	☐ 1	☐ 0

9.15 WEMWBS, Meg

Below are some statements about feelings and thoughts.

Please tick (√) the box that best describes your experience of each over the **last 2 weeks**

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

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Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				

Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.