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Research Article

What makes us the same? What makes us different? Development of a shared model and manual of group therapy practice across art therapy, dance movement therapy and music therapy within community mental health care

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ABSTRACT

Arts therapies draw upon many theories and models of practice, but lack consensus in shared factors of their provision. In preparation for a randomised controlled trial involving art therapy, dance movement therapy and music therapy, we used experiential and practice-based methods to develop a model and manual for mixed diagnosis arts therapies groups in community mental health care. Six arts therapists met over the course of a year to explore commonalities and differences in art, dance movement and music therapy groups. Arts-based and consensus methods were used to develop practice principles, which were expanded through workshops with arts therapists working in mental health services. A model, manual, training and adherence guide were produced, which incorporated role-play and video-based reflection. The model is underpinned by transdiagnostic and contextual psychotherapy theories. The manual outlines ten core principles, alongside 19 practice principles. Fourteen scenarios where therapists commonly intervene informed ongoing therapist training and development. This is the first model to describe practice across three types of arts therapies for mixed diagnosis groups in community mental health care. Whilst overall manual utility (including adherence) and effectiveness is yet to be assessed, the development methods may be informative for wider arts therapies groups and clientele.

Introduction

The arts therapies are forms of psychotherapy that involve active participation in an art-form with an arts therapist to facilitate the therapeutic process through creative, non-verbal and verbal expression. Although in many countries arts therapies often have separate and varying training programmes, professional registration and recognition, they can also be regarded as sharing enough common characteristics to be part of joint clinical and research tasks (Karkou & Sanderson, 2006; Zubala, MacIntyre, Gleeson, & Karkou, 2014). Within the United Kingdom, art therapy, music therapy and dramatherapy are regulated by the Health and Care Professions Council (2013), while dance movement psychotherapists can achieve registration with the UK Council for Psychotherapy (UKCP, 2012). As with other forms of therapy, the arts therapies can be provided on an individual or group basis and there are many models of practice that have evolved from, and are tailored for different clinical groups and settings (Karkou & Sanderson, 2006). This diversity of practice enables the arts therapies to flexibly meet a range of

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health and care needs, but can make wider assessment and generalisation of their effectiveness challenging.

There is a rich body of arts therapies practice in mental health (Brooke, 2006; Hogan, 2001; Jones, 2007; McCaffrey, 2016; Nemetz, 2006). However literature tends to focus upon a single arts modality and in effectiveness studies, a specific diagnosis, which does not reflect actual provision (Fenner, Abdelazim, Bräuninger, Strehlow, & Seifert, 2017). Until relatively recently, there was also little consideration of the commonalities and differences of practice (Jones, 2020; Karkou & Sanderson, 2006) which limits our understanding of the factors shared across arts therapies and the practice principles that are important to apply in our work. This may be to some extent, historical. For example, within the United Kingdom, there were initial concerns of individual professions being grouped under one umbrella term of 'arts therapies' (Barrington, 2005) due to feared loss of identity and the notion that approaches were too different or poorly understood to be considered together (Karkou & Sanderson, 2006; Waller, 1991). Conversely, there are many examples of arts therapists collaborating and building a shared understanding across modalities (Colbert & Bent, 2018; Havsteen-Franklin, Jovanovic, Reed, Charles, & Lucas, 2017; Huet, 1997; Knill, 1994; Landy, 1995; Purdie, 1993; Sajnani, Marxen, & Zarate, 2017; Samaritter, 2018).

This paper presents developmental work to produce a model of group arts therapies practice for patients with different diagnoses (diagnostically heterogeneous) in community mental health care. The aim was to sufficiently identify, agree and describe core features of group arts therapies practice to produce a manual in preparation for a randomised controlled trial involving art therapy, dance movement therapy and music therapy (the ERA study, ISRCTN:88805048). Whilst the trial does not involve dramatherapy due to the logistics of the study design and local resources, we were keen to ensure the model could represent the full spectrum of arts therapies practice. Dramatherapists were therefore involved in the development process. In line with guidance for the development of complex interventions (Bleijenberg et al., 2018; Cotterill et al., 2018; Craig et al., 2006; Hoffmann et al., 2014; O'Cathain et al., 2019; Rousseau et al., 2019; Turner et al., 2019), our objectives were to (a) identify and agree upon theories that underpinned the intervention; (b) identify commonalities in the provision of art, dance movement and music therapy groups; and (c) develop a manual and set of principles to enable adherence rating in practice.

Considerations in manualising arts therapies

Treatment manuals can be thought of as a means to describe the core "conceptual and structural boundaries" of how a treatment is provided and works (Addis, Cardemil, Duncan, & Miller, 2006, p.132). Initially developed for research (Luborksy & DeRubeis, 1984), manuals are also adopted or developed for clinical practice (Addis et al., 2006). Within randomised controlled trials, the purpose of a manual is to sufficiently describe the aims, methods and hypothesised mechanisms of the treatment(s) under investigation (Grant et al., 2018). Manuals enable therapists to understand what is important to happen and how, and to monitor how far their practice aligns with this (Addis et al., 2006), whilst they enable researchers to check whether what is hypothesised to be of importance is actually provided across all participants (treatment fidelity) (Borrelli, 2011; Nelson, Cordray, Hulleman, Darrow, & Sommer, 2012). This enhances internal validity of the study, and enables future replication and comparison with different treatments (Nelson et al., 2012). The relative importance of practice elements to outcomes can also be better specified and understood (Kraemer, Wilson, Fairburn, & Agras, 2002; Nelson et al., 2012). As Rolvsjord, Gold, and Stige (2005) note, use of a manual does not "guarantee valid results, nor will all results of studies without therapy manuals necessarily lack validity" (p.22). Manualisation does not aim for or guarantee superiority over non-manualised treatments (Truijens, Zühlke-van Hulzen, & Vanheule, 2019; Tschuschke et al., 2015); nor are novel manualised procedures easily adopted in routine practice (Bitsika & Sharpley, 2006; Carroll & Nuro, 2002; Chorpita, 2006).

Most arts therapies research manuals draw upon existing psychotherapy approaches, or wider theories to develop new interventions for specific populations, with a focus on one single arts modality (Azoulay & Orkibi, 2015; Behrends, Müller, & Dziobek, 2012; Bryl & Goodill, 2019; Hackett, Taylor, et al., 2017; Parkinson & Whiter, 2016; Rolvsjord et al., 2005; Story & Beck, 2017; Zubala, 2013). Others have used intervention mapping (Bartholomew, Parcel, Kok, Gottlieb, & Fernández, 2011) as a development method (Aalbers et al., 2019; Haeyen & Heijman, 2020; Haeyen, van Hooren, Dehue, & Hutschemaekers, 2018). Those manuals that have incorporated practices across the arts therapies focus on a multi-modal arts approach with a distinct client population such as depression (Parsons et al., 2020), or dementia (Lyons, 2019). One intervention has been developed across different arts therapies with children in mainstream schools (Moula, Karkou, & Powell, 2019). However, none so far have developed manuals across different arts therapies modalities for diagnostically heterogeneous groups in mental health care. Within psychotherapy, there are a number of manuals for diagnostically heterogeneous groups. Notably, Barlow, Allen, and Choate (2004) developed a transdiagnostic "uniform treatment protocol" for a range of emotional disorders, including adaptations for group treatment (Bullis et al., 2015; Laposa, Mancuso, Abraham, & Loli-Dano, 2017). Karterud (2016) similarly published a manual for mentalization-based group therapy. Both share a focus on common factors of group treatment, whilst also highlighting specific aspects of the approach. Beyond research, a well-designed manual can also support therapists' self-monitoring, professional development (Addis et al., 2006; Luborksy & DeRubeis, 1984) and act as a map or toolkit for therapists (Bryl & Goodill, 2019; Taylor-Buck & Dent-Brown, 2014). As such, some arts therapies professional bodies have developed clinical guidelines using consensus based methods, such as nominal group or Delphi technique (Eyre, 2013; Hackett, Ashby, Parker, Goody, & Power, 2017; Havsteen-Franklin, 2014; Springham, Dunne, Noyse, & Swearingen, 2012; Taylor Buck, Dent-Brown, Parry, & Boote, 2014; Taylor Buck & Hendry, 2016; Wright & Holttum, 2020).

Despite the many manualised forms of psychotherapy, studies of how such manualisation is delivered in practice highlight the challenges in doing so. Manuals are not always accepted or understood by therapists, who may perceive them as challenging their professional identity, limiting therapeutic autonomy and creativity (Addis et al., 2006; Bergström, Ladd, Jones, Rosso, & Michael, 2019; Carroll & Nuro, 2002; Forbat, Black, & Dulgar, 2015; Truijens et al., 2019; Tschuschke et al., 2015). Implementation requires significant resource commitment (Addis et al., 2006; Chorpita, 2006) and if developed outside of the clinical context, may be limited in their external validity (Bitsika & Sharpley, 2006; Carroll & Nuro, 2002; Chorpita, 2006; Westen, 2002). Focus upon specific or novel factors of the manualised treatment can be to the detriment of known essential factors of therapy (e.g., therapeutic relationship) (Addis et al., 2006; Carroll & Nuro, 2002; Herman-Smith, Pearson, Cordiano, & Aguirre-McLaughlin, 2008); ignore the unique contribution of client and therapist (Addis et al., 2006; Rolvsjord et al., 2005) and focus upon technical execution to the detriment of training and supervision (Bein et al., 2000; Chorpita, 2006). This can have unintended and potentially negative consequences for both client outcomes (Henry, Strupp, Butler, Schacht, & Binder, 1993; Vakoch & Strupp, 2000) and therapists' practice (Forbat et al., 2015). Manuals can also fail to recognise the variation in therapist training, theoretical allegiance(s), experience, and competence (Crameri, Tschuschke, Koemeda, Schulthess, & von Wyl, 2020; Najavits, 1997; Tschuschke et al., 2015). For process-oriented therapies, the idea of following a predefined formula can be at odds with responding to the needs of the patient (Rolvsjord et al., 2005; Taylor Buck & Dent-brown, 2014; Vakoch & Strupp, 2000). Manuals may also challenge long-standing practice and require integration, building of confidence and skills (Najavits, 1997; Sholomskas et al., 2005). Research procedures and restrictions may also

impact upon therapists' performance and confidence (Gold, Erkkilä, & Crawford, 2012; Robb, Burns, Docherty, & Haase, 2011).

Manuals therefore require a fine balance of specification and flexibility. This includes careful consideration of common therapeutic factors (Beutler, 2006; Bradt, 2012; Rolvsjord et al., 2005; Waltz, Addis, Koerner, & Jacobson, 1993; Westen, 2002), practitioner involvement, clinical context (Bryl & Goodill, 2019; Carroll & Nuro, 2002; Chorpita, 2006; Forbat et al., 2015; Sidani & Braden, 2011; Westen, 2002) and therapist training and support (Butler, Henry, & Strupp, 1995; Carroll & Nuro, 2002; Gold et al., 2012; Robb et al., 2011). Studies of manual implementation have highlighted that therapists tend to work 'tacitly' or 'implicitly', responding to the person in the moment without thinking explicitly about the action being performed (Lee & Vakoch, 1996; Najavits, 1997; Vakoch & Strupp, 2000). Reber notes that within implicit learning "…not only is the learner unaware of the process of learning, the very knowledge itself is highly resistant to explication" (2001, p.15433). This may be even more important for arts therapists, given their frequent work within a non-verbal, implicit domain and the association of such processes with creativity (Gerge, Hawes, Eklöf, & Pedersen, 2019; McAleer, Bowler, Bowler, & Schoemann, 2020). Studies have also demonstrated that overarching principles are more likely to be understood and implemented rather than listing predefined techniques (Lee & Vakoch, 1996; Vakoch & Strupp, 2000). Accordingly, some arts therapists have based manuals on Waltz et al.'s (1993) framework of principles for practice, rather than rules or procedures (Bryl & Goodill, 2019; Rolvsjord et al., 2005). In order to have an effective learning experience, Lee and Vakoch (1996) suggest that implicit knowledge first needs to be made explicit. Therefore, techniques to explore the tacit/implicit way in which therapists work with groups are important to draw out in practice. Given their non-verbal and creative possibilities, the arts are an effective medium to achieve this. We therefore used a range of arts and practice-based methods in the manual development of this study.

Method of manual development

Manual development began with monthly meetings between six arts therapists: two each of art therapy, dance movement therapy and music therapy. The arts therapists each had backgrounds covering arts therapies practice, academic research and strategic or managerial positions within a range of NHS mental health trusts. Our initial meetings highlighted challenges in learning one another's separate arts therapies languages and finding a shared understanding in the theories, tools and techniques we used. These meetings informed development of the underpinning theory and model which enabled the group to explore practice. Subsequent meetings focused upon defining principles of practice according to Waltz et al.'s framework (1993). Each arts therapist listed principles for practice according to their discipline and the techniques that would be used to achieve this. These were discussed as a group and formed the basis of 10 core principles of the manual, 18 principles for practice and 15 proscribed principles (Table 1).

We then used nominal group technique (Boddy, 2012; Harvey & Holmes, 2012; Havsteen-Franklin, 2014; Taylor Buck & Hendry, 2016), facilitated by DHF and CC to explore common clinical scenarios encountered within community mental health arts therapies groups. The focus of this technique was to describe common scenarios in group arts therapy where the therapist would make an intervention (defined as an observable action made by the therapist). It was highlighted that interventions could be both to address a clinical need or deficit, or to promote, encourage or highlight strengths and resources. Each group member listed as many scenarios as possible, over the course of 20 min. These were written up and displayed on flipchart paper around the room. From a list of 90 scenarios, these were then grouped thematically, resulting in a list of 14 scenarios (Table 2). In a final step, group members individually ranked the importance of each scenario based on their experience in practice. Individual ranking scores were combined to produce an overall group ranking.

Wider arts therapist involvement and feedback

Once the ten core principles, principles for practice and clinical scenarios were developed, we ran a 1-day workshop in two NHS Trusts, with 19 arts therapists in total. Attendees were arts therapists who had expressed an interest in running arts therapies groups in the forthcoming ERA study. One person with lived experience of mental health problems advising on the study and two dramatherapists also participated.

Arts-based methods were used to explore therapists' stances towards the level of directiveness used in sessions and group boundaries (Brabender & Fallon, 2018; Dies, 1985). For this, we used a movement-based exercise, where therapists explored the space between two polarities (e.g., active vs passive) in the room and then discussed the reasons for positioning themselves where they did. This led to reflections on instances where greater activity from the therapist, or less might be appropriate. Therapists explored how they established safety in early sessions by working with a range of arts objects and materials (e.g., scarves, wooden blocks, paper and pens), and core principles from the ensuing discussion were recorded on a flipchart. Group processes were explored through a music drawing narrative exercise (Booth, 2005) facilitated by CC, resulting in artistic representations of common group processes and a written reflection by each therapist. The experience of this exercise was discussed as a group and core themes from this discussion were written down. The group then discussed the aims of group arts therapy, contributing drawings and written words to large pieces of paper. The group reviewed 14 clinical scenarios developed to date and broke into small groups to role-play one of these scenarios as they had experienced in their own practice. This role play was specific to each arts modality with participants taking turns in the role of therapist. As a final step, the arts therapists were asked to rank the importance of the 14 clinical scenarios, to provide additional feedback on the relevance of each scenario. Following these workshops, thematic analysis led to development of five core group aims and additional principles for practice (Table 1). The 10 core principles were unchanged, but were elaborated from workshop discussions to illustrate 'What this is' and 'What this isn't' (following Rolvsjord et al., 2005).

Refinement and selection of principles for practice

To refine the principles for practice, each principle was listed (20 from the main principles, 20 from promoted practices and 27 proscribed practices) and grouped thematically, forming 19 core areas. Core areas were then compared against existing group art, music and dance movement therapy literature in mental health and a group mentalization therapy adherence scale (Folmo et al., 2017; Karterud, 2016). In grouping the items, a number of principles shared amongst group therapies were identified. Where this was the case, the item naming, as entitled by Karterud (2016) was retained (items 1, 2, 6, 7, 8, 10). This formed the final structure for core principles and adherence rating.

Results

Underpinning theory

Transdiagnostic theory and contextual model of psychotherapy

We took as our starting point, transdiagnostic theories of mental illness (Bakker, 2019; Casey, Oliveri, & Insel, 2014; Sanislow, 2016). Whilst no single model exists, current theory suggests concepts of negative valence (e.g., acute threat/fear, loss), positive valence (e.g., motivation, reward), cognition, social processes, arousal and regulation are relevant to understanding shared features of mental illness (Cuthbert & Insel, 2013). There is particular interest in the transdiagnostic role of emotion regulation, with difficulties in using adaptive regulation strategies, intolerance of uncertainty and experiential avoidance as three

Table 1
Development of Practice Principles Through Initial Meetings and Therapist Workshops.

Initial meetings		Workshops	Final grouping
Practice principles	**Proscribed principles**		
Non-judgemental, validating attitude. **Empathy, unconditional positive regard, congruence of therapist, modelling for the group.**	Over-sharing. Therapist as a 'blank slate'.	Use of therapist self-disclosure as a means of building trust and sense of being understood.	**1. Engagement, interest and warmth.**
Modelling curiosity and interest in clients' experience of the modality (as opposed to interpreting).	Direct interpretation without checking client's understanding of events or ignoring client's communicated understanding of events.	Being with what is. Cultivating curiosity.	**2. Exploration, curiosity, not-knowing stance.**
Use of the art form and stance to meet the person/group where they are at.	Not intervening when expression is uncontained.	Letting go of tension. Safe space for feelings to be expressed.	**3. Active and dynamic attunement.**
Supporting self-regulation through containment and transformation of expression.		Therapist stance is more active in early stages. Therapist becomes less directive but is ready to resume directions if the group requires.	**4. Arousal regulation.**
The therapist adapts their stance and involvement with the group depending on whether the group is in early, middle or late stages.			**5. Developmentally informed group leadership.**
Importance of supportive and effective co-working.			**6. Cooperation between therapists.**
Modelling reliability and trustworthiness through actions.	Rigid adherence to boundaries without collaborating or seeking mutual understanding with clients.	Promoting safety. Elastic/flexible boundaries to be negotiated as a group. Fluidity. Boundaries as a group container and structure. Therapist responsibility.	**7. Managing group boundaries.**
Early stages focus on building trust, safety and cohesion. Later stages, group autonomy is promoted, with the therapist becoming more directive to prepare for group ending.	Not intervening/ being completely non-directive in the group. Therapist directs- does not give group opportunity to lead or direct.	Make changes led by client.	**8. Regulating group phases.**
Open and equal relationship to model safety and ways of relating in the group.	Once cohesion and trust are established, not challenging group to try out new things or take risks.	Group cohesion. Commonality of experience. Arts promote a sense of belonging – community and friendship.	**9. Active promotion of group cohesion.**
Encouraging sharing and helping between group members.	Contributions ignored or dismissed by therapist.		**10. Caring for the group and each member.**
Encouraging active participation, exploration and use of the art form.	Not assisting or intervening when the client is unable to use the art form.	Creativity. Enabling participation. Potential space, possibilities.	**11. Modelling use and potentials of art-form.**
Encourage self-expression and creativity.	Allowing the group to avoid or not use the art form.	Sharing of different cultures. Play, Enabling participation.	**12.Encouraging engagement and exploration of the art-form.**
Encourage exploration and new ways of using the art form.	Persisting in an activity which is not appealing or helpful to the group. Allowing long periods of talking or silence without any use of the art form.	Not dogmatic but coherent. Practice evolves with group life.	**13. Developing and expanding use of the art-form.**
Highlighting group interactions- encouraging clients to make their own meaning from this and try out new ways of relating.	Problem solving for the group.	Noticing patterns → changing patterns. Acknowledging trauma and working through. Exploration of differences.	**14. Focus on personal and group issues.**
Emotional involvement in the creative process.	Therapist over-involvement in emotional processes.	Working with what is within. Experiencing self differently.	**15. Focus on implicit experiences (arts-based, embodied, emotional).**
Relating all interactions in the sessions back to the here and now. **Develop relationships that are shared, equal, collaborative, respectful, mutually trusting.** **Use of transference to understanding evolving relationships within the group.**	Focus upon past events without connection to here and now of the group.	Making connections. Breaking isolation. Social contact. Peer support. Practising interactions. Shared experiences. Communication. Acknowledging diversity and difference.	**16. Focus on relationship between therapists and patients.**
Help service users to discover personal meaning and understanding from the arts process.		Therapist is dynamic and moves fluidly between verbal and nonverbal ways of relating.	**17. Encouraging integration of arts, implicit and relational experiences in the group.**

(continued on next page)

Table 1 (*continued*)

Initial meetings		Workshops	Final grouping
Practice principles	Proscribed principles		
		A place where emotions are ok. Integration. Connecting with different parts of self, integrating using creative means. Other ways of seeing self/others.	
Support service users to build on useful and helpful experiences of using the art-form within the group by identifying ways this can be continued in their day-to-day life.		Use of arts in own life outside of therapy for resilience/enjoyment.	**18. Integrating use of art-form inside and outside of sessions.**
Offering encouragement and facilitating/ fostering positive experiences.	Focus only on deficits or problems.	Building confidence and self-esteem.	**19. Acknowledging and encouraging strengths, preferences and positive experiences.**
Collaborating with group members regarding goals and methods of working. **Focusing upon group members' strengths and potentials, recognising clients' competence in the creative process and unique creative identity.**	Avoiding problems.	Resilience building.	

Table 2
Clinical Scenarios Where Therapists Make an Observable Therapeutic Action.

Item		Definition
1	Unmanageable affect	High / low affect that impacts upon ability to relate to or be with the art form/ others and is difficult to self-regulate
2	Power dynamics	Interpersonal dynamics, criticism, scapegoating, blame, dominance, boundaries, them and us
3	Collaboration	Empathy, attunement, relating, working with others, co-production of the art form
4	Ambivalence about using arts media	Difficulty using art form due eg. to lack of experience, current feeling state, self-consciousness in front of others
5	Using the arts for retreat/ distraction/avoidance	Avoiding contact with others by focusing solely on the arts medium, avoiding connection to feelings
6	Identity	Artistic biography, narratives, cultural associations, rites of passage, rituals
7	Linking arts process with personal relationships and community	Making connections between use of the art form and relationships within/outside the group.
8	Improvisation	Authentic, new artistic element, expression, play, creativity in use of art form in the moment
9	Incongruence between art form and feelings	Expression within the art-form does not match the presentation or stated affect of the group/group member
10	Concrete, rigid, stuck	Set ways of using the art-form, lack of flexibility, lack of connection to feelings and interpersonal process.
11	Sub-groups	Pairing, trios, quartets
12	Diverse uses of the arts forms	New ways of using the arts media eg. playing a chair with drumsticks, finding a different movement, different styles and genres of the art form introduced.
13	Over-compliance / need to 'fit in'	Taking a background role in the group, using the arts to hide from/avoid challenge by others. Working to please the therapist.
14	Pre-occupation with an 'aesthetic' or competence	Valuing the artistic product over and above the arts/group process. Focusing on ability/competence to use the arts without relating back to self and situation.

potential mechanisms (Aldao, 2012; Khakpoor, Bytamar, & Saed, 2019). Whilst the course and experience of mental illness is unique to each individual, within secondary mental health care, these transdiagnostic concepts are reflected in common challenges faced by patients in terms of managing and regulating mood and anxiety, maintaining motivation in daily life and becoming stuck in patterns of thinking, feeling or relating, with associated emotional and relational distress (Herrman, Saxena, & Moodie, 2005; World Health Organization, 2001). Relationships can be further affected through challenges in communicating experiences, thoughts and feelings making them difficult to develop or sustain (Brüne, Abdel-Hamid, Sonntag, Lehmkämper, & Langdon, 2009; France & Kramer, 2001; Kerns, 2007; Perlini et al., 2012; Sánchez et al., 2019). Many experience social isolation, stigmatisation and lack confidence to socialise and wider effects of disempowerment, loss of identity, role and self-esteem (Baker, Jodrey, & Intagliata, 1992; Goldberg, Rollins, & Lehman, 2003; Halford & Hayes, 1995; Thornicroft et al., 2016; Trompenaars, Masthoff, Van Heck, de Vries, & Hodiamont, 2007).

We then drew upon the contextual model of psychotherapy (Wampold, 2015; Wampold & Imel, 2015), which suggests that features shared across different types of therapy are the most important factors that account for clinical change. Determinants include the client's preference for, understanding and expectations of therapy and the therapist's experience, commitment and belief to the model of therapy provided, along with a positive working relationship (Wampold, 2015; Wampold & Imel, 2015). In line with the contextual model, a meta-analysis showed that for mental health patients, receiving a preferred treatment is associated with lower dropout from treatment and higher therapeutic alliance (Windle et al., 2020). A further meta-analysis across group therapies has demonstrated that common shared factors account for the greatest amount of change in therapy, rather than unique factors (Orfanos, Banks, & Priebe, 2015). These common group factors have been studied in various combinations, but include, at a meta-level; supportive factors (instillation of hope, acceptance, altruism, universality and cohesion); self-reflection (including self-disclosure, catharsis and secure emotional expression), psychological work (including interpersonal learning, self-understanding and awareness of relational impact) and social learning (including modelling, vicarious learning, guidance and education) (Mac Nair-Semands, Ogrodniczuk, & Joyce, 2010; MacKenzie, 1990; Yalom & Leszcz, 2005). On the basis of the above, we can assume that many of the important therapeutic factors in group arts therapies are those shared with wider forms of group therapy as a whole.

More recent research (Orfanos & Priebe, 2017) suggests that within closed community therapy groups, the first few sessions are most important in determining outcomes. Sessions where group members showed high cohesion in the first sessions predicted future engagement and greatest therapeutic gains. Reporting similar findings for different types of group psychotherapy, Tschuschke and Dies (1994) proposed that such early group integration promotes capacity for self-disclosure, which increases interpersonal feedback thus increasing opportunities for positive feedback from the group. Burlingame, Fuhriman, and Johnson (2001) highlight the importance of certain practices in developing cohesion, namely: Thorough preparation of members for the group experience, identification of useful processes early on in therapy, consistency in temporal and spatial features of the group, fostering member to member interaction, feedback to the group, a warm and caring therapeutic stance and ensuring members relate to each other in positive ways. Within the arts therapies, a positive association has also been identified between therapeutic alliance and symptom reduction (Heynen, Roest, Willemars, & van Hooren, 2017). The above suggests that important factors within group therapy are patient understanding and clear expectations of what will happen in therapy, patient and therapist shared commitment to working in a particular way and time to develop and establish a good working alliance. Within groups this highlights the importance of patient treatment preference, clear information on what to expect, fostering group cohesion in the initial phases and promoting active engagement quickly and early on in the therapeutic process.

The additional contribution of the arts in therapy

The defining factor of the arts therapies is emphasis upon the use of, and active participation in the arts during therapy. Koch (2017) suggests five factors specific to the arts therapies: aesthetics (beauty and authentic expression), hedonism (pleasure and play), meaning making (through non-verbal communication/symbolisation/metaphor), enactive transitional support in times of change, and generativity (creativity and creation). Inclusion of an active and creative arts-based process provides opportunities for embodied self-expression, creativity and a non-verbal means of relating with other people (Samaritter, 2018). The art form brings a third object- concrete (such as a recording or piece of art work), or experienced (such as movement or heard sound)- into the matrix of relations within the group (Karkou & Sanderson, 2006). Each person brings their own unique creative and cultural identity. This can be explored as part of the therapy with the potential to link and expand upon their personal relationship with, and use of the art-form as a 'helping resource' in their day-to-day lives (Ansdell & Meehan, 2010). Springham and Huet (2018) suggest art-work in art therapy may be considered a second order representation within psychological processes (representing alternative 'as if' scenarios, rather than reality). This provides a means of trying out different ways of relating to oneself and others in an imaginative and safe way. Arts therapies are therefore well placed to help patients identify difficulties and strengths through the use of the art-form in the varying group interactions. Use of the art-form can facilitate the experience and expression of emotions and discovery of personal meaning in creative activities, allowing experiences and learning through non-verbal and verbal communication (Gerge et al., 2019). In other words, through creativity, imagination and play, patients are helped to explore new or different emotional and cognitive experiences with support of both the group and the therapist. The production of a piece of art is often cited as a means of strengthening self-esteem by clients (Buck & Havsteen-Franklin, 2013; Grocke et al., 2014) and can provide access to personal and interpersonal resources which may be continued into wider daily and creative life (Ansdell & Meehan, 2010; McCaffrey, Edwards, & Fannon, 2011; McCaffrey, Carr, Solli, & Hense, 2018).

Historically, arts therapists have integrated wider psychotherapy theories including expressive, psychodynamic, person-centred, attachment and group-interactive models (Karkou & Sanderson, 2006; Odell-Miller, 2013; Springham & Huet, 2018; Zubala, MacIntyre, Gleeson, & Karkou, 2013). Principles from each of these informed our understanding, along with principles of resource orientation (Priebe, Omer, Giacco, & Slade, 2014; Rolvsjord, 2010, 2015) and recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; McCaffrey et al., 2011; McCaffrey, 2016, 2018; Solli, Rolvsjord, & Borg, 2013). The principles of person-centred therapy (Rogers, 2011/1967) are especially relevant to how the therapist models and interacts with members of the group involving a non-directive, empathic stance. The psychodynamic model (Montgomery, 2002) provides a means of understanding patterns of relating and emotional responses across unconscious and conscious levels, which facilitates understanding of non-verbal and implicit levels of communication. Resource and recovery-oriented approaches (Ansdell & Meehan, 2010; Buck & Havsteen-Franklin, 2013; McCaffrey et al., 2018; Rolvsjord, 2010) are informed by a move towards a collaborative, contextual and health-promotion focus rather than a deficit or treatment-based one. Principles include a shared, equal, collaborative process; focus on patients' strengths and potentials; acknowledging the patients' creative identity; being emotionally involved in the creative process and fostering positive emotions (McCaffrey et al., 2018).

Implications for the different arts modalities

Whilst we hypothesise that it is the shared, or common factors of group therapy that are associated with eventual change of health outcomes, each arts modality has specific multi-sensory and aesthetic properties which can provide unique opportunities within a group context (Malchiodi, 2005). Whilst in simple terms a single sensory modality is implied (art, the eye; music, the ear; dance movement, the body), a range of senses are activated, offering many different sensory and embodied modes of expression and experience (Gerge et al., 2019; McNiff, 1981). Malloch and Trevarthen's (2009) and Stern (2010) studies of human communication show how timing, shape and intensity ("vitality affects") are used to non-verbally communicate intention and regulate interaction from birth. The multi-sensory and multi-modal features of arts-based work can facilitate attunement and regulation of basic physical and behavioural experiences, such as relaxation, self-soothing, and building of healthy attachments (Behrends et al., 2012; Metzner et al., 2018; Springham & Huet, 2018).

In our model (Fig. 1), the importance of the art form is the appeal to the patient (their preferred type of arts therapy), the facilitation of active participation and emotional engagement in the use of the art form, the introduction of creativity, and the support of exchange and interactions. The final therapeutically effective processes however are non-specific to the art form and will benefit from the diagnostic heterogeneity of the group. Fig. 1 outlines how transdiagnostic theories of mental illness (orange), informed choice (yellow), common factors to group therapies (green), resource and recovery oriented theories (pink) and specific arts therapies processes (purple) relate within this model. We contextualise the arts-based processes within arts therapies groups as being an additional process to those that already occur within talking-based group therapy.

Manual

The manual encompasses five group aims, 10 overarching core principles, 14 clinical scenarios and 19 principles for therapist practice. The group aims relate directly to shared features of mental illness, whilst the overarching principles describe core features of how the groups should be managed over time. The clinical scenarios are used as a springboard for therapists to reflect on common features of running arts therapies groups. We purposefully did not define interventions for these scenarios as (a) many scenarios can unfold simultaneously and are not necessarily distinct; and (b) there are a multitude of ways that such scenarios might be addressed. Rather, we defined 19 principles for therapist practice which enable therapists to observe themselves and others when in action and form the basis of adherence rating for the ERA

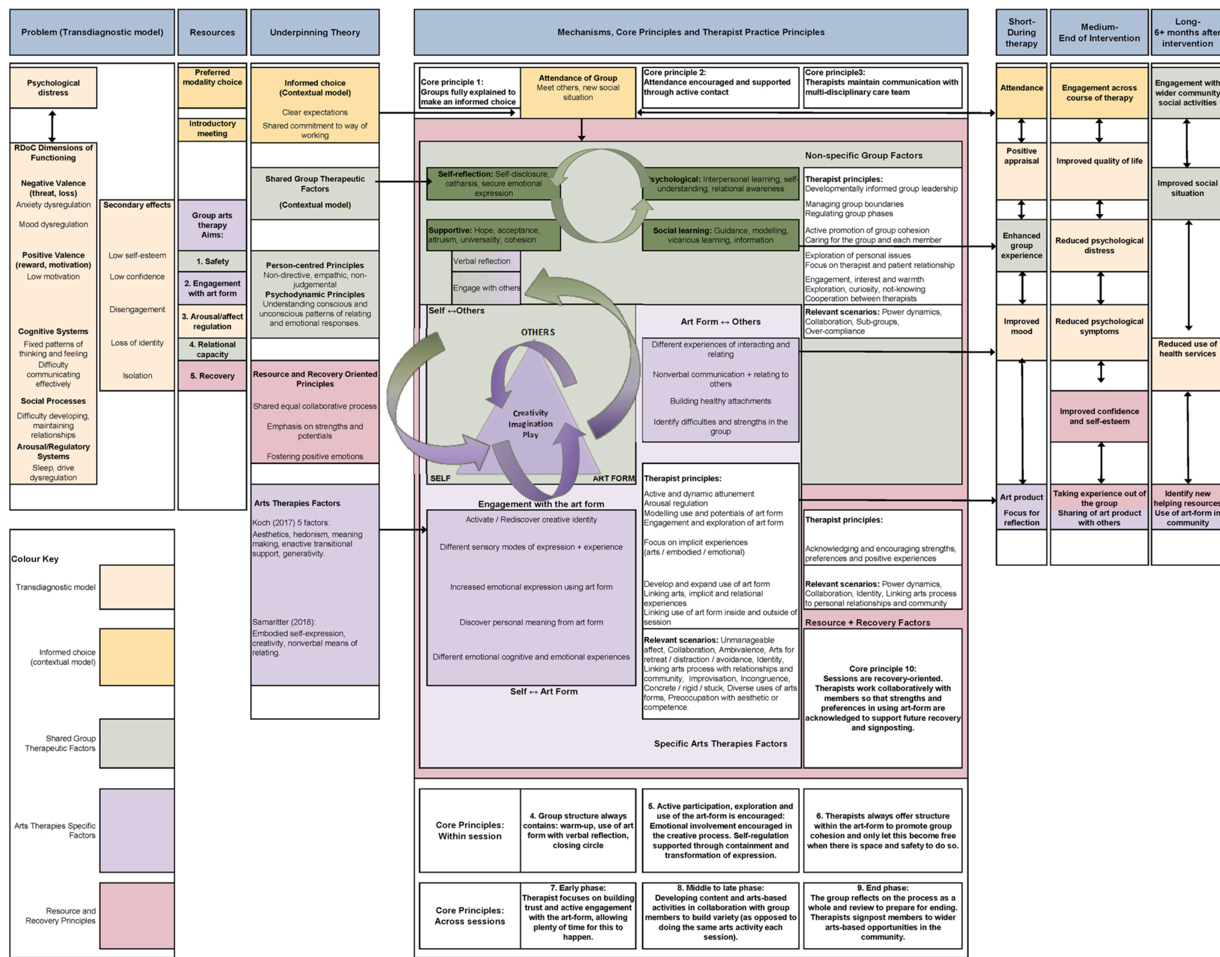

Fig. 1. Logic model summarising underpinning theory, group aims, core principles, therapist practice principles and related scenarios.

trial.

Group aims

Our discussions identified five core group aims of arts therapies groups for community mental health settings. Importantly, these aims incorporate both implicit (embodied, felt or lived) and explicit (verbal and reflective) relational experiences and build from basic pre-requisites for therapy and the individual, to wider relational and community goals:

1. To provide a safe space to be with others
2. To promote engagement with the art form to

explore ways of using the art form and its relevance to one’s own life;

explore inner creativity;

explore opportunities to extend and use the arts in daily life.

3. To provide regulation of arousal and affect to

explore ways of using the arts to aid self-regulation;

become aware of and find new ways of expressing and transforming emotions.

4. To offer opportunities to build upon existing relational capacity to

build awareness of self and others;

facilitate non-verbal engagement and expression with others;

explore new and different ways of relating to others;

break isolation and offer opportunities for support and socialisation.

5. Through the above, use the arts to build confidence, self-esteem, self-agency and autonomy in interactions with others and to further develop connectedness, hope, identity, meaning and empowerment (recovery) (Leamy et al., 2011).

Ten core principles

The ten core principles set the overall structure and format of groups over time. Items one to three highlight important actions to be taken by the therapist in preparation and support for the groups (such as non-attendance and team communication). Item four defines the general group structure for a single session, whilst items seven to nine describe the overall group task at beginning, middle and end stages of therapy. Items five, six and ten highlight the importance of active arts participation, the therapist’s role in supporting the group to become familiar with this and the importance of maintaining a collaborative and strengths-based approach, which is in keeping with a recovery focus.

1. The arts therapies groups are fully explained with information and video material so that patients can make an informed choice as to their preference

What this means: For the ERA study, potential members are shown video clips to aid decision making for the art-form that they most prefer. The videos explain what happens during an art therapy, dance movement therapy and music therapy session. Through the voices of service users, the videos cover what to expect, examples of activities during sessions and helpful and challenging features. Prior to the group start, an individual meeting is arranged with the therapists in the group therapy room, to provide a sense of what the space will look like. The meeting focuses upon introductions, the reasons for coming to therapy (including hopes and expectations) and explanation of the general aim, structure and process of group therapy. There is an opportunity to ask questions, agree ground rules and expectations, including the level of communication the person wishes to have. *What this is not:* Insisting upon a particular modality choice that negates the patients’ preference.

Declining to discuss arts therapies options or concerns.

2. Attendance is encouraged and supported through maintaining active contact with patients throughout the treatment phase

What this is: Strategies to support attendance are discussed and agreed in the initial meeting and can include text reminders, and agreed modes of communication for non-attendance. Within the group, therapists acknowledge group absences and ensure time to welcome and re-orient returning members and late arrivals.

What this is not: Persistent calls to demand why the person is unable to attend. Ignoring members' preferences for attendance support. Ignoring group absences and their impact.

3. The therapists ensure communication is maintained and held with the multi-disciplinary care team throughout.

What this means: Therapists ensure ongoing communication with the wider care team to inform them of arising issues or concerns and to ensure high quality of support and care. The level of communication is outlined and agreed in the pre-group meeting, including the nature of confidentiality and boundaries of what will be shared with the wider care team.

What this is not: Ignoring group members' preferences for team communication. Not sharing important information regarding risk, safeguarding or wider care support.

4. Group structure always contains: (a) an opening warm-up; (b) use of the art-form, with space for verbal reflection; (c) a closing circle to reflect upon the group experience.

What this means: Sessions have an element of predictability, giving space for individuals to share at the beginning and end of the group. The middle section is flexible and the amount of alternation between using the art-form and talking may vary across modalities. Opening and closing sections should be led by the therapist to start, but may be developed or expanded upon by the group as sessions progress. The amount of time given to each section will vary depending on the stage of the group (early/later on in the process) and how group members are on any given day.

What this is not: Rigid reliance on exactly the same opening and closing activity each week. Not following the lead of the group in when to transition from and to activities.

5. Active participation, exploration and use of the art-form is encouraged.

What this means: Therapists aim to begin using the art-form with group members as quickly as possible in sessions, particularly where members are reluctant, reticent or avoidant. Use of the art-form should be introduced sensitively, with a level of activity and degree of structure that fits the presentation of the group. The therapist should ensure that the group does not go for long periods of talking or silence, without any use of the art-form.

What this is not: Forcing members to use an art-form when they are not ready to do so – a single group member might not directly use the art-form themselves, but may watch attentively to the rest of the group's creations. Ignoring the current situation of a group member which may make use of the art-form difficult on that day.

6. Therapists always offer structure within the art-form to promote group cohesion and only let this become free when there is space and safety to do so.

What this means: Structure is always offered to begin to establish an atmosphere of safety and cohesion between members within the group. Time should be allowed for group members to explore the art-form within the safety of such structures so that self-agency and competency in using the art-form are established.

What this is not: Limiting the level of freedom and activity in sessions to rigid or predefined structures. Not varying the level of structure according to presenting needs.

7. Within the early phase of therapy (weeks 1–5), the therapist focuses upon building trust and active engagement with the art-form, allowing plenty of time for this to happen.

8. Middle to late sessions (weeks 6–17): Developing content and arts-based activities in collaboration with service users to build variety (as opposed to doing the same arts-activity each session).

9. End phase (weeks 18–20): The group reflects on the process as a whole and review to prepare for ending. Therapists signpost patients to wider arts-based opportunities in the community.

What this means: Within the ERA study, sessions will run for up to 90 min, twice per week over 20 weeks. The above phases (in weeks) are a guide and it is acknowledged that each group will have its own unique early, middle and ending processes. What is important is for the therapist to be aware of the phase of therapy in relation to overall group process, so that time is allowed for each of these stages whilst balancing group cohesion and offering opportunities to challenge or extend group activities.

What this is not: Ignoring the stage of the group and propensity to use the art form. Persisting in activities without collaborating with group members. Not returning to an earlier stage if the group requires. Ignoring the interests and needs of the group.

10. Sessions are recovery-oriented: Therapists work collaboratively with patients so that their strengths and preferences in using the art-form are acknowledged to support their future recovery and signposting.

What this is: Therapists work collaboratively with patients with a here and now focus, so that their strengths and preferences in using the art-form are acknowledged. Group members are supported to explore issues raised, with challenges acknowledged. The therapist models curiosity in understanding members' experiences but does not immediately interpret or suggest meanings for the group. Throughout the sessions, the therapists acknowledge these strengths and preferences in terms of supporting future recovery. Therapists signpost group members where appropriate to wider community services which may meet the strengths and preferences expressed in the group.

What this is not: Ignoring risks, problems or clinical issues. Minimising or ignoring the impact of events from the past upon group members. Referring group members onto services without exploring preferences and wishes to do so together first.

Clinical scenarios where a therapist would make an intervention

Table 2 summarises 14 scenarios where arts therapists would make an intervention or observable action within the group. The items are listed in overall ranked order with 1, being the scenario ranked as most important and 14, the least important.

Principles for practice and adherence rating

The 19 principles for practice (Table 3) encompass qualities the therapist displays in the group (items 1, 2, 10), and actions the therapist should take. Many are shared with other forms of group therapy but have the potential to also take an arts-based focus. For example, items 3 and 4 are especially important within arts therapies, where the art-form can be used jointly by the patient and therapist to aid connection to others (attunement) and change arousal state. Here, the role of the therapist is to support self-regulation through containment and transformation of expression. Items 11, 12, 13 and 18 are solely arts-based, whilst items 15 and 17 combine both common and arts group processes. Items 1, 2, 6, 7, 8 and 10 relate directly to common factors outlined by Karterud, and thus retained the original names (Folmo et al., 2017; Karterud, 2016). Items 4 and 15, whilst similar to Karterud (Regulation of tension level; Focus on emotions), were renamed to better align with the transdiagnostic focus, and acknowledge the wider range of possible implicit arts therapies experiences (bodily sensation, emotion, or as represented in the art form).

Discussion

Strengths and limitations

The manual addresses many of the challenges faced in defining a

Table 3
Therapist Principles for Practice.

Therapist principles for practice
1. Engagement, interest and warmth
The therapist conveys empathy, authenticity, positive regard, offers encouragement and is emotionally involved both during and outside the creative process.
2. Exploration, curiosity, not-knowing stance
Overall stance of the therapist in terms of active listening, modelling curiosity and interest and conveying a stance of 'not-knowing'.
3. Active and dynamic attunement
The therapist actively meets and attunes to the presenting internal state of each individual and the group as a whole through use of the art-form, body language and words.
4. Arousal regulation
The therapist uses attunement and interactions within relationships, primarily with the art-form, to help clients to regulate arousal levels, paying attention to under/over-arousal to establish a calm and reflective holding presence. The therapist later supports clients to carefully expand upon and return to different arousal states. The therapist only challenges the client/group once safety and cohesion are established.
5. Developmentally informed group leadership
The therapist's style of group leadership changes depending on the developmental level of the group with greater activity at the beginning and end of the group process.
6. Cooperation between therapists
The therapist and co-facilitator work together to establish a safe space, model relational capacity and cooperation through confident, transparent and open communication.
7. Managing group boundaries
Active and dynamic management of the physical space and group boundaries. Supporting and encouraging attendance, maintaining contact, modelling reliability and trustworthiness through actions.
8. Regulating group phases
The therapist is active in helping the group establish and move between beginning, middle and end stages of the session and process as a whole.
9. Active promotion of group cohesion
The therapist works actively to promote a sense of group wholeness and belonging through arts-based activities and discussion especially in early stages of the group.
10. Caring for the group and each member
The therapist provides a calm, reflective and holding presence; promotes shared, equal, collaborative and mutually trusting relationships. Actively addresses destructive behaviour or threats towards the group.
11. Modelling use and potentials of art-form
The therapist demonstrates ways to begin, and use the art-form.
12.Encouraging engagement and exploration of the art-form
The therapist supports members to overcome anxiety in use of arts materials and develop curiosity as to what is possible.
13. Developing and expanding use of the art-form
The therapist supports and begins to challenge members to play creatively to develop and expand their use of the art-form.
14. Focus on personal and group issues
The therapist supports group members to actively explore personal and group issues raised in the here and now of the group.
15. Focus on implicit experiences (arts-based, embodied, emotional)
The therapist draws attention to the embodied or felt qualities of using the art-form through arts-based or verbal responses.
16. Focus on relationship between therapists and patients
The therapist seeks to develop shared, equal, mutually trusting relationships, highlights group interactions and encourages clients to make their own meaning/try out new ways of relating; encourages clients to learn from one another.
17. Encouraging integration of arts, implicit and relational experiences in the group
The therapist encourages connection of bodily and arising emotional/felt states to the process of engaging with the art form and helps to make connections from the use of the arts to relationships within the group.
18. Integrating use of art-form inside and outside of sessions
The therapist promotes and explores connections between arts, group experiences and everyday life.
19. Acknowledging and encouraging strengths, preferences and positive experiences
The therapist nurtures positive experiences through collaboration and acknowledgement of the group's existing strengths and preferences.

single model of group arts therapy for diagnostically heterogeneous patients. The model has a clear theoretical basis and considers the pragmatic challenges of providing a standardised framework for three different arts modalities. Most importantly, we were able to reach agreement upon core aims and practice principles between therapists from different arts modalities and training backgrounds. Our development process followed current guidance for the development of complex interventions (Bleijenberg et al., 2018; Cotterill et al., 2018; Craig et al., 2006; Hoffmann et al., 2014; O'Cathain et al., 2019; Rousseau et al., 2019; Turner et al., 2019) and incorporated feedback from arts therapists. Experiential and practice-based methods enabled direct exploration and representation of diverse but context-specific practice. Core principles are clear and simple, whilst the practice principles accommodate a range of training backgrounds. The clinical scenarios provide the first comprehensive synthesis of situations considered important for arts therapists to act within a group.

Whilst the model is pluralistic in its wider approaches, this may pose challenges for arts therapists who have trained and practise in a defined therapy paradigm. For example, arts therapists working from a formal psychoanalytic model may be challenged by the more active and collaborative stance. Therapists with a strong person-centred leaning may be challenged by greater therapist directiveness early on in sessions. Whilst we believe that the manual encompasses current group arts therapy practice in community health care, it remains to be seen whether it has utility beyond the life of the study and within regular community-based practice. Feedback from arts therapists in the trial and further review by external bodies (for example, training providers) will assist further validation.

As the forthcoming ERA study encompasses only art, dance movement and music therapy, dramatherapists had limited involvement and thus, this model may not fully reflect aspects of dramatherapy practice. However, we hope that this may be examined separately from the ERA trial in collaboration with dramatherapists in the future. There was also limited service-user involvement, with only one service user attending the workshops. Further collaboration with and feedback from service users (both study participants and from a lived experience advisory panel) during the ERA trial will be important to understand the relevance of this way of working, including helpful and unhelpful factors.

The manual is necessarily transdiagnostic (Aldao, 2012; Cuthbert & Insel, 2013; Cuthbert, 2014; Khakpoor et al., 2019), and does not define diagnosis-specific actions or principles. However, it also does not contradict existing guidelines (Havsteen-Franklin, 2014; National Institute of Clinical Excellence, 2014; Springham et al., 2012; Wright & Holttum, 2020). Further work will be necessary to align where diagnosis-specific actions are indicated and required (Beutler, 2006).

Comparison to existing arts therapies practice

This manual differs to others developed so far, in that it seeks to identify shared aims and elements of practice across different arts therapy modalities and diagnoses. However, there is strong congruence between our manual and those practices outlined by specific arts therapists and professional bodies (Eyre, 2013; Hackett, Ashby, et al., 2017; Havsteen-Franklin, 2014; Parsons et al., 2020; Springham et al., 2012; Taylor Buck & Hendry, 2016; Taylor Buck et al., 2014; Wright & Holttum, 2020). In their study of therapist descriptions of in-session therapeutic constructs, Havsteen-Franklin et al. (2017), identified ten symptomatic events and 14 bipolar constructs. These events, whilst focusing upon only symptoms, have some similarities to the 14 scenarios identified by this group including: high and low affect, acute psychosis, ambivalent responses, concrete solutions to interpersonal problems and insight. Similarly, the bipolar constructs cover similar areas of attunement, boundaries, affect regulation, directiveness, curiosity and use of the arts. Samaritter's (2018) Delphi study of music and dance movement therapists suggests five core themes of embodied presence, somato-sensory engagement, emotional engagement, non-verbal communication and intercultural involvement. The 12 steps identified as arts related activities and procedures, follow a similar pattern to those described in our 19 principles for practice; from invitation and engagement to exploration, play and performance (Samaritter, 2018). Parsons et al. (2020) and Parkinson and Whiter (2016) also describe

similar aims, group structure and principles for depression and early intervention for psychosis.

The role of experiential and practice-based arts methods in training

Arts-based methods are gaining interest as a tool for creative exploration in clinical practice and research and were central to the manual development (Beer, 2016; Borgdorff, 2010; Geiger, Shpigelman, & Feniger-Schaal, 2020; Gerber et al., 2020; Ledger & McCaffrey, 2015; McCaffrey & Edwards, 2015; McCaffrey et al., 2020; Meltzer, 2020; Priebe et al., 2019; Sajnani, Mayor, & Tillberg-Webb, 2020; Springborg, 2020). As arts therapists, we recognised the value in working creatively with our colleagues to recognise the tensions and congruence across training traditions and art-forms. The workshops were lively and inclusive, enabling us to capture the essence of practice across arts modalities through our group reflections on the creative arts process. The workshops informed how we provide training of therapists for the trial itself. Initial feedback suggested that the arts therapists valued opportunities to reflect upon and explore their practice. We therefore built in a strong ethos for the training to promote therapist self-exploration of how their practice aligns with the model and manual principles, alongside regular opportunities for therapists to provide their ideas and feedback. Training is provided in three whole day workshops spread over a few months. Day one provides an overview of the ERA trial and the theory underpinning the intervention. Three core principles (7–9) are explored by therapist pairs leading an experiential session to demonstrate how these principles would be met in their arts modality. Therapists are asked at the end of this day to begin peer observation to become familiar in being observed for research and discussing practice with another. Day two involves feedback from therapists' experiences of peer observation and role plays based on one of the 14 clinical scenarios. Role plays are video recorded to give therapists a sense of how recording will feel when conducting sessions and for review in training day 3. Therapists are introduced to the adherence rating scale and encouraged to begin using this to assess their current practice. Introductory interviews and study procedures are also discussed. The final training day covers role play of introductory meetings, how to report adverse events and adherence rating. Therapists watch excerpts of videos from training day 2. Therapists from the modality in the video rate this excerpt, with the remaining group observing and later commenting upon the overall process. Excerpts are selected to ensure coverage of all 19 principles for practice and discussions focus upon the ways in which the principles can be observed in the videos and put into practice.

Conclusion

This is the first model of arts therapies group practice developed across three arts modalities for mixed diagnosis groups in community mental health care. Our emphasis on direct arts-based experience led to development of a rich corpus of practice. Most importantly, we were able to reach agreement of core principles between three different arts modalities. Such methods may be of wider value to arts therapists in clinical supervision and reflective practice, as well as wider clinicians and researchers. Whilst manual utility (including adherence) and model effectiveness is yet to be assessed, the methods may prove useful in developing models of practice for wider arts therapies groups and clientele.

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Declaration of Competing Interest

None

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