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Authors: Dominik Havsteen-Franklin, Vicky Karkou, Suzanne Haeyen, Claire Grant

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A Systematic Review Using Thematic Synthesis of Arts Therapies Therapeutic Actions and Perceived Benefits in the Treatment of People with a Diagnosis of Cluster B Personality Disorder

Author names and affiliations

Prof. Dominik Havsteen-Franklin[1,5] Prof. Vicky Karkou[4,6], Suzanne Haeyen [2,3,4], PhD, Claire Grant[5]

[1] College of Arts and Humanities, Gaskell Building, Brunel University London, Kingston Lane, Uxbridge, Middlesex, UB83PH

[2] GGNet, Centre for Mental Health, Scelta, Expert Centre for Personality Disorders Apeldoorn, PO Box 2003, 7230 GC, Warnsveld, The Netherlands

[3] HAN University of Applied Sciences, PO Box 6960, 6503 GL Nijmegen, The Netherlands

[4] KenVaK, Research Centre for the Arts Therapies, PO Box 550, 6400 AN, Heerlen, The Netherlands

[5] CNWL NHS Foundation Trust, 350 Euston Road, London, NW13JN

[6]Edge Hill University, St Helens Rd, Ormskirk L39 4QP

Corresponding author

Prof. Dominik Havsteen-Franklin

dominik.havsteen-franklin@brunel.ac.uk

Postal address

College of Arts and Humanities, Gaskell Building, Brunel University London, Kingston Lane, Uxbridge, Middlesex, UB83PH

E-mail addresses co-authors

s.haeyen@ggnet.nl

karkouv@edgehill.ac.uk

claire.grant1@nhs.net

Highlights:

- The significant findings from this thematic synthesis clearly describe overarching areas of arts therapies therapeutic actions for arts therapies treatment of people diagnosed with Cluster B personality disorder.
- *Processing interpersonal experiences* and *processing emotions* were the most commonly reported types of therapeutic action and perceived effect for the patient.
- The themes based on coded extracts are drawn from definitions and understandings of therapeutic action and perceived effects as described in the literature that spans art, drama, music and dance movement psychotherapy.

Abstract

The objective of this study was to thematically synthesize literature about arts therapies specific in-session therapeutic actions occurring with this client population and the perceived effect of engaging in arts therapies. Using systematic review methods, qualitative and mixed method studies, reporting on arts therapies treatment for people with a diagnosis of personality disorder (Cluster B) were searched in Embase, Medline, PubMed and grey sources until June 2017. The search yielded 167 records. 32 studies were included in the analysis. Data synthesis was conducted by using extracts from the literature search which were coded and then subject to a thematic analysis and synthesis. The codes were then discussed and agreed by the research team. The thematic analysis and synthesis resulted in seven overarching themes: (1) Processing interpersonal experiences (2) Processing emotions (3) Developing agency (4) Symbolising (5) Structuring experience (6) Cognitive reappraisal (7) Developing a shared experience. This thematic synthesis provides some evidence that according to the arts therapies literature available regarding patients with a diagnosis of personality disorder, there are thematic similarities in terms of primary areas of therapeutic action and the relationship between the therapeutic action and the perceived effects of engaging in arts therapies. Our findings suggest that literature about in-session therapeutic actions focus mostly on processing interpersonal experiences and the largest frequency of coded excerpts concerning the perceived effect of engaging in arts therapies was in the area of processing emotions.

Introduction

Personality Disorders (PD) are a class of psychological illness that have a strong relational element with presenting symptoms which are understood as caused or exacerbated by the immediate or recent relational context (Tyrer, Reed, & Crawford, 2015). As a relational set of issues, PD becomes apparent during the course of interacting with others where there can be profound misjudgements of intentions producing emotional instability and impulsive behaviours (Luyten, 2016). The fifth edition of the diagnostic statistics manual (DSM5) categorises PD within three clusters of which cluster B includes identity disturbance, affect dysregulation and cognitive misunderstandings in relation to intentionality, as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture. This pattern is manifested in two or more of the following areas—cognition, affectivity, interpersonal functioning, impulse control' (American Psychiatric Association, 2013). Recommendations have been made by the National Institute for Clinical Excellence (Kendall et al., 2009) for treating presenting issues such as emotional instability, identity disturbance, cognitive rigidity and interpersonal conflict through psychosocial treatment such as psychodynamic, cognitive behavioural and arts therapies approaches. Relevant research studies in this area (e.g. by Bateman & Fonagy, 2009; Blum et al., 2008; Gullestad et al., 2012; Levy et al., 2006; Leichsenring, Leibing, Kruse, New, & Leweke, 2011) also provide evidence for the value of different treatment options for PD. However, details of how the different arts therapies (for example, dance movement, drama, music and art therapy) in particular work with this client population remain essentially unexplored. Furthermore, at the time of conducting this study (June 2017), there were no randomised controlled trials (RCT) for arts therapies treatment of patients with a diagnosis of PD (cluster B).

According to Karkou and Sanderson (2006), good outcomes are achieved through specific agents of change in the therapeutic process that they describe as the participatory uses of the arts; play and creativity; engagement with imagery; symbolism and metaphor and; fostering non-verbal experiences, all of which place the arts at the centre of the therapeutic work as well as the value placed on the development of a safe therapeutic relationship. In their survey of practitioners in the UK and in Europe, six therapeutic approaches were identified across arts therapies: humanistic, psychoanalytic/psychodynamic, developmental, artistic/creative, active/directive and eclectic/integrative (Karkou & Sanderson 2006; Karkou, Martinsone, Nazarova, & Vaverniece, I. 2011; Zubala, MacIntyre, Gleeson, & Karkou 2013). Although these studies have indicated that the different arts therapies have enough in common to be studied together, the relevance of these approaches to the therapeutic action of arts therapies with people diagnosed with a PD remains unclear.

Recent literature suggests that arts therapists working in mental health contexts are regularly referred people with a diagnosis of PD (S. Haeyen et al., 2015; Havsteen-Franklin, Jovanovic, Reed, Charles, & Lucas, 2017; Springham, 2015). This paper is also a response to emerging evidence that suggests that engagement in the arts in therapy or treatment programmes involving arts therapies may have an impact on primary diagnostic features of PD (Bateman & Fonagy, 2009; Franks & Whitaker, 2007; S. Haeyen et al., 2015). It is also notable that since this systematic review has been completed, significant progress has been made with developing approaches in drama therapy for PD, with disordered offenders (Keulen-de Vos, van den Broek, Bernstein, Vallentin, & Arntz, 2017) as well as with Cluster C type PD such as patients with a diagnosis of avoidant or dependent PD (Doomen, 2017). In addition to this there has been a significant study examining the effectiveness of art therapy with patients with a diagnosis of PD (S. W. Haeyen, Hooren, van der Veld, & Hutschemaekers, 2018) which demonstrates the outcomes of art therapy with a Cluster B and C population.

To determine the need for a systematic review, an initial literature search for qualitative reviews was conducted. This revealed five systematic and general reviews of literature carried out in recent years. The first by Haeyen, van Hooren and Hutschemaekers (2015) was focusing on perceived effects of visual art therapy for people diagnosed with a PD. The review did not focus on specific therapeutic actions during the process of the treatment or the relationship to other arts therapies. A second systematic review with a subsection on arts therapies working with patients with a diagnosis of PD by Van Lith (2016) also focused on art therapy. Whilst Van Lith (2016) makes a significant contribution to the field, through providing a summary of arts therapies approaches in terms of diagnosis specific general therapeutic actions and a theoretical framework she does not go so far as to synthesise the findings or defining specific therapeutic actions. The third summary is a literature review (Springham, 2015) that examines art therapy publications and promotes a 'teleologically sympathetic process' based on theory and observation. However, how the methodology results in the findings is unclear. In music therapy Odell-Miller, (Odell-Miller, 2016) offers an overview of literature for PD which includes therapeutic actions and perceived effects. However this literature review does not provide more detail about the quality of the papers or the method of synthesis employed. Röhricht (2015) has also given an overview of body psychotherapy practice for severe mental health issues, however given the paucity of literature in this area about the treatment of PD only a few paragraphs refer to the treatment of this population. Studies with this client population are also notably absent from the meta-analysis completed by Koch et al (2014) in dance movement therapy. These publications offer some insight into differences in orientations amongst arts therapists previously described by Karkou and Sanderson (2006). However, with the exception of Haeyen et al. (2015), none of these reviews were both systematic as well as exclusively about PD in relation to an arts therapies modality.

Within the arts therapies professions, researchers are increasingly identifying the need to systematically summarise clinical practice in a meaningful way (Edwards & Kaimal, 2016; Gabel & Robb, 2017; Gruber & Oepen, 2018) and to develop methods that help to integrate learning across the arts therapies (Zubala and Karkou 2018; Havsteen-Franklin et al., 2017). Edwards and Kaimal (2016 ,p30) state, 'Greater understanding of the procedures undertaken in metasynthesis of qualitative studies, will assist in further transferability of qualitative research findings into creative arts therapy practice.'

Kazdin (2001, 2009) has argued that the first step of understanding the effectiveness of any therapeutic action should be understanding the estimated change mechanism as being comprised of the therapeutic action, mediator and outcome. Likewise, this study aimed to examine the domains of arts therapies therapeutic actions in preparation for future research and how the clinical application of these therapeutic actions compared to existing therapeutic practices. The following questions guided the process of identifying arts therapies literature focusing on arts therapies practice for patients with a diagnosis of PD:

1. What are the overarching themes that describe in-session therapeutic actions and perceived effects in literature describing arts therapies treatment of patients with a diagnosis of PD?

Sub questions:

a. What is the quantity and type of coded extracts that refer to types of therapeutic action and perceived effects?

b. Are the themes that describe therapeutic action similar to the themes that describe perceived effects?

c. How do the quantities of therapeutic actions and perceived effects compare?

In-session therapeutic actions are defined by the authors as actions that have an intended outcome associated with a given strategy. For example, Greenberg (Greenberg, Haviland-Jones, & Feldman Barrett, 2008) suggests that there are 'in-session therapeutic actions' for exploring, facilitating and regulating emotions. Perceived effects' (S. Haeyen et al., 2015) refers to the immediate effects that the patient's engagement with the arts process has as perceived by the patient. In this study we are referring to patient, therapist or researcher views depending on data from the selected publication. Perceived effect and in-session therapeutic actions were selected because they are observable elements of the therapeutic process that give an indication of effectiveness and there is currently not sufficient published quantitative research indicating outcomes for these patients.

We sought to answer the research questions through a systematic review of current practice

which can also help to inform our understanding of shared frames of reference amongst arts therapists, clinical actions and perceived effects of engaging in arts therapies therapeutic actions. It was anticipated that the findings from this study could provide a platform for understanding the constructs that can enable model development and support the process of manualization in preparation for research focusing on effectiveness with this client population.

Methodology

Using a thematic synthesis approach to systematic reviews (Thomas & Harden, 2008), the research team, comprising of arts therapists and researchers discussed questions relevant to in-session therapeutic actions and perceived effects with this population. The following methodology was employed allowing for rigour and reproducibility (Edwards & Kaimal, 2016) as will be described in greater detail in the following sections. The team developed a search and screen protocol to identify relevant papers (See Figure 1). A quality appraisal was then conducted on all of the selected papers that included practice examples (See Table 1). The final screened papers were then uploaded into the *dedoose* software package to enable reliability of quantifying coding by the first author. The coded data was then exported into excel format and analysed by looking at the similarity of themes and cross-referenced with their meanings in their original context (See Tables 2 and 3). On this basis the codes were synthesised by establishing overarching themes as interpreted by the researchers. The method utilised thematic synthesis to construct novel meanings from the data that integrated extracts as amounting to '…integrations that are more than the sum of parts, in that they offer novel interpretations of findings' (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004, p.3). In practice this means that the final high-level themes are intended to encapsulate a shared meaning for each group of similar extracts. Therefore, thematic synthesis was chosen to allow for an interpretation of the text resulting in eliciting overarching meanings rather than pre-determined definitions or being solely reliant on the terms used within the extracts. The final themes were checked for validity by ensuring that there was unanimous agreement by the lead researchers, thereby triangulating expert opinion with the data source and professional contexts (Denzin & Lincoln, 1994).

Data Sources and Search Strategy

We searched EMBASE; MEDLINE; PsychINFO, conducted grey literature searches by hand, including book chapters and journal searches. The search was conducted between the dates of 24th February and to the 23rd June 2017.

The terms used for the HDAS database search were: (personality disorder*.ti,ab OR exp "PERSONALITY DISORDERS"/ AND art therap*.ti,ab OR exp "CREATIVE ARTS THERAPY"/ OR art psychotherap*.ti,ab OR music therap*.ti,ab OR "MUSIC THERAPY"/ OR drama therap*.ti,ab OR PSYCHODRAMA/ OR dance movement psychotherap*.ti,ab OR dance therap*.ti,ab OR "DANCE THERAPY"/ OR "MOVEMENT THERAPY"/ OR art.ti,ab OR

music.ti,ab OR drama.ti,ab OR dance.ti,ab OR body movement.ti,ab OR improvis*.ti,ab OR exp ART/ OR MUSIC/ OR DRAMA/ OR IMPROVISATION).

Grey literature was sourced through (1) grey literature databases, (2) customized Google search engines, (3) targeted websites, and (4) consultation with experts.(Godin, Stapleton, Kirkpatrick, Hanning, & Leatherdale, 2015).

Eligibility Criteria

The selected publications needed to refer to art therapy/art psychotherapy, music therapy, dramatherapy/psychodrama, dance movement psychotherapy/body psychotherapy and PD. Papers also needed to include a reference to diagnostic criteria based on the DSM-5 definitions for PD as a primary characteristic of the text. Publications referring to interviews with patients, practice descriptions, case studies or vignettes, qualitative studies on process and mixed methods studies were considered for inclusion. After an initial collation of papers all papers were subject to exclusion criteria (see Figure 1.)

Papers were excluded on the basis of:

(i) providing no evidence of the diagnostic criteria for PD;
(ii) the model of practice was not relating to standard models of arts therapies practice as described by professional and registration bodies (Alperson, 1977; Case, 2006; Cattanach, 1994; Odell-Miller, 2016; Waller, 1991);
(iii) not providing practice descriptions; and
(iv) not being available in the English language.

Screening Process

Using the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) (Thomas, Harden, & Newman, 2012) we screened all papers at a title and abstract level in the first instance. The papers that passed this first screening process were read fully to check eligibility criteria as described in the PRISMA diagram (see Figure 1).

Quality Appraisal

Quality appraisal of all the papers included in this review was conducted in order to weight studies for the purposes of the systematic thematic synthesis. We used Critical Appraisal Skills Program (CASP) (Singh, 2013) criteria for qualitative papers and ranked them according to whether the dimension was included and took note of the quality of that dimension. Each member of the research team rated a selection of papers according to the CASP criteria where (1) meets the criteria fully, and (/) partially meets the criteria. Generating the themes from the data was weighted according to the CASP rating. For example, although this rarely happened in practice, where there was significant uncertainty about

a code, and the CASP rating was very low, the extracts taken from higher ranked papers were prioritised.

Data Analysis and Synthesis

Thomas and Harden (2008) argued that the process of synthesising findings across a given domain allows for heterogeneity and configures the data to form new meanings. The method of synthesis chosen was a thematic synthesis due to the primary aim of generating hypotheses (Lucas, Baird, Arai, Law, & Roberts, 2007) about models of practice that can be further researched. The process follows careful coding and thematic analysis with final synthesis of findings.

In this study, all included papers were loaded onto the *Dedoose 7.6.13* software package. Then the following three steps were conducted:

In the first step the paper was read as a whole and descriptions of therapeutic actions or perceived effect directly related to engagement with arts therapies therapeutic actions were highlighted.

In the second step, free codes were applied using *Dedoose 7.6.13* that closely followed the meaning of the extracts.

During the third step, the codes were grouped and interpreted in terms of meaningful themes. The resulting themes were checked and discussed by senior arts therapists for their accuracy and validity.

Results

The search led to 167 potential relevant records, as is shown in Figure 1 'Prisma Diagram'. After the removal of duplicates and screening of Title/Abstract 45 publications were selected to be relevant for synthesis. Following this, a further 14 publications were excluded based on the aforementioned exclusion criteria. Finally 32 publications were included in the synthesis.

Most studies included were based on the therapist/ researcher's perceptions of therapeutic actions and change processes which usually did not attend to some important aspects defining high quality research (DeNora & Wigram, 2006; Dokter & Winn, 2010; Gilroy, 2006; Meekums, 2010), including the therapist/researcher reflecting on their own potential biases in terms of how they understood their own role, or the limitations of their study and sampling methods. This meant that the validity and transferability of the clinical process to other contexts was in question.

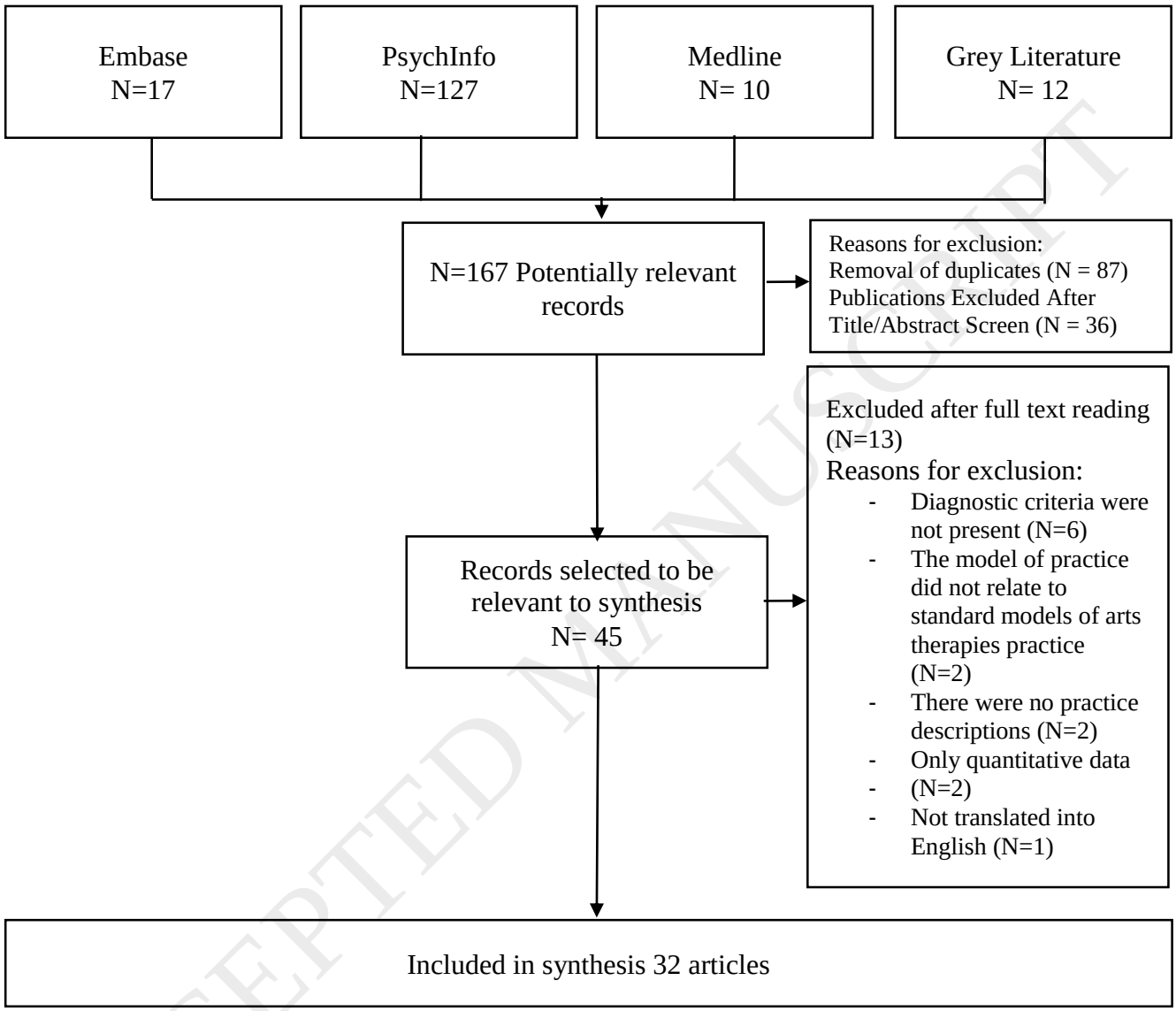
In terms of diagnosis, several papers referred to multiple PD (dissociative identity disorder) (Fuhrman, 1988; M. Jacobson, 1994; M. L. Jacobson, 1993; Mills, A, 1995; Spaletto, 1993; Zigmund, 1986) which were excluded on the grounds that the case examples did not refer to the primary criteria for PD. Two papers (Levens, 1990, 2002) referred to eating disorder patients which were included on

the grounds that there was a clear definition of a 'borderline organisation' that closely resembled the DSM-5 criteria for Cluster B PD. Whilst it was possible to find English translations for most papers, one paper (Maaz, 2007) was excluded because there was no English translation available at the time.

Characteristics of Included Studies

As shown on Table 1, most studies were from the UK (18/32) whilst two studies were from Brazil, and Denmark and three from Germany and the USA. Other countries produced one paper each (Australia, Netherlands, Norway, Turkey). The majority of papers were focusing on art therapy (17/32). There were five music therapy papers, two psychodrama papers, two dance movement/body psychotherapy papers and five papers that were cross modal, including practice descriptions drawn from two or more arts therapies. We included 17 qualitative explorative studies, five case studies, five mixed method studies, one survey and four summaries of literature or systematic reviews.

Figure 1. PRISMA Diagram



Characteristics of Selected Papers							
First author and date of study	**Country**	**Modality**	**Aim**	**Characteristics of participants**	**Methodology (as reported by authors)**	**Duration of treat-ment**	**CASP rating (0-10)**
Collier 2015	UK	Art	Illustrate the use of art psychotherapy to contain trauma and acting out	N=1 (patient) Diagnosed with BPD	Qualitative case study	Not known	5
Cukier 2016	Brazil	Psycho-drama	Exploring methods of working with BPD using psychodrama	N/A	Qualitative explorative study.	N/a	5
Eastwood 2012	UK	Art	To examine the diagnosis of borderline PD	N=4 (patient)	Qualitative case study	> 3 years	6
Eren 2014	Turkey	Art	To investigate the changes in the beginning and termination phases of psychotherapy in terms of psychosocial, symptomatic, diagnostic and personality qualities	N=17 (patient) Diagnosed with PD	Mixed method: quantitative and case example	4-10 years	9
Figusch, 2006	Brazil	Drama	Exploring methods of working with BPD using psychodrama	Insert number/characteristics?	Qualitative explorative study.	N/a	3
Franks 2007	UK	Art	Exploring a mentalisation based	N=3	Mixed Method: Quantitativ	N/a	7

			approach to group work		e and case study		
Haeyen 2015	Nether-lands	Art	To provide insight into the perceived effects of art therapy	N=29 (patients) Diagnosed with bpd	Systematic review (grounded theory)	3 - 12 months	9.5
Hannibal 2016	Denmark	Music	To provide an overview of music therapy research	Varies Diagnosed with bpd	Mixed Method: Qualitative & quantitative literature review	Varies	7
Havsteen-Franklin 2017	UK	Art/ music/ drama/ dance move-ment	Understanding therapist descriptions of practice	N=14 (arts therapists) Diagnosed with bpd/ schizophrenia/major depression	Qualitative Study (Personal construct psychology)	N/a	9
Johns 2004	Norway	Art	To provide guidelines for art therapy treatment	N=1 (patient) Diagnosed with bpd (with reference group work)	Qualitative case study	18 weeks	6
Kreisman 2010	USA	Art/ music	Understanding bpd	Varies Diagnosed with bpd	Qualitative explorative study	N/a	3
Lamont 2009	Australia	Art	To review 11 art therapy sessions	N=1 (patient) Diagnosed with bpd	Qualitative explorative study	11 sessions	6
Levens 1994	UK	Art/ psycho-drama	Explorative study of dynamic therapy model for eating disorders	N/a Eating disorders with borderline organisation	Qualitative explorative study	> 15 weeks	3

Levens 1990	UK	Art/ psycho-drama	Explorative study of dynamic therapy model for eating disorders.	Varies Primary diagnosis of eating disorder with 'borderline organisation'	Qualitative explorative study	N/a	2.5
Lefevre 2004	UK	Arts	Understanding impact of sexual abuse on the treatment	N=1 (patient)	Qualitative case study	< 2 years	6
Manford 2014	UK	Dance Movement Psycho-therapy (DMP)	Exploring attachment based model of DMP	n/a	Qualitative case study	N/a	7
Morgan 2012	UK	Art	To provide an in-depth exploration of the 'lived experience' of receiving therapy	N=4 (patients)	Qualitative explorative study.	Not known	5
Moschini 2005	USA	Art	Exploring methods to treat 'the difficult client'	Varies Diagnosed with bpd	Qualitative explorative study.	Varies	3
Odell-Miller 2011	UK	Music	Overview of music therapy practice for the treatment of PD.	N=1	Qualitative explorative study.	N/a	6
Odell-Miller 2016	UK	Music	Overview of music therapy practice for the treatment of PD.	N/a	Literature review	N/a	6
Pool 2011	UK	Art	To explore the relationship between aggression and	N=1 (patient) N=3 (music	Explorative qualitative study	10 weeks	9

			creativity in music therapy.	therapists) Diagnosed with bpd			
Röhricht 2015	UK	Body Movement Psycho-therapy	Overview of body movement psychotherapy practice for the treatment of mental health conditions.	n/a	Qualitative explorative study.	N/a	7
Springham, 2012a	UK	Art	Guideline development	N=30 (art therapists)	Qualitative explorative study. (Delphi cycle)	N/a	6
Springham, Findlay, Woods, & Harris, 2012	UK	Art	To evaluate mentalization focused art therapy	Bpd Co-written with patients	Mixed Method (Quantitative outcome measures and Delphi Technique)	N/a	6
Springham, 2015a	UK	Art	Survey of clinical procedures	N=250 (art therapists)	Survey	N/a	5
Springham & Whitaker, 2015b	UK	Art	To define a practice based and theoretically coherent model of practice.	n/a	Literature review	N/a	6
Strehlow 2007	Germany	Music	Exploring psychodynamic model of music therapy	N=1	Qualitative explorative study.	N/a	5
Strehlow, 2013	Germany	Music	Exploring psychodynamic model of music therapy	N=1	Qualitative explorative study.	N/a	6

Strehlow 2016	Germany	Music?	Exploring psychodynamic model of music therapy	n/a	Qualitative explorative study.	N/a	6
Teglbjaerg 2009	Denmark	Art	To understand how artistic expression may affect psycho-pathology	N=10 (patients) Two groups: schizophrenia and depression/PD)	Qualitative explorative study. (interview and case examples)	1 year	6
Thorne 2016	UK	Art	Explorative study of mentalization focused therapy model	N=7 Diagnosed with BPD	Mixed Method	Not known	6
Van Lith 2015	USA	Art	Aims to develop a bridge between what art therapists know and what they do	N/a Section dedicated to PD	Systematic review	N/a	7

Table 1. Characteristics of Selected Papers

Quality of Included Studies

CASP is considered to be an effective method to demonstrate that the author has taken into account a range of factors that give some evidence of the reliability and validity of their findings (Singh, 2013). The questions that were asked in the qualitative review demonstrated good quality across most domains. Anderson (2010), follows a similar evaluation to the CASP checklist when she states that the quantity of data must be sufficient to offer a credible finding and that the theme that offers an interpretation of the findings is reliable and aligned to the data as well as there being relevant clinical material to the proposed study. Anderson (2010) suggests that these criteria can be elucidated more explicitly through the CASP rating process providing a basis for discussing the transferability to other contexts.

Because of the content of the selected papers being mostly case study based offering an illustration of good practice, in many of the papers ethical issues were not mentioned. For example, it was rare that consent or potential harm to patients was considered. The rigour of the analysis was often dependent upon the author's voice as expert without reference to a method of verification.

However, the strengths of the selected papers were that they often provided a clear statement of the aims of treatment, the method chosen to illustrate good practice was appropriate to researching those aims and on this basis the findings were valuable to the profession. The majority of papers were qualitative exploratory studies, usually in the form of a case study, and the authors had not indicated that they were conducting research that addressed a hypothesis or question. For the purposes of this study, the selected papers where valuable on the grounds that they did include perceptions of change and therapeutic action.

Coding Data

In the first step of the coding process free coding of the primary data of 32 papers produced 727 code applications to the text that described types of therapeutic action and 770 coded extracts for perceived change making a total of 1497 coded extracts. These segments were explored with the research team and coded producing 16 codes for the perception of effect and 20 codes for the types of therapeutic action that closely adhered to the text. These codes were then organised into themes which resulted in 23 themes for types of therapeutic action and 18 themes for perceived effects. The codes are recorded (see figure 2) with the number of times that they appeared in the text. The original text was repeatedly returned to in order to verify the specific meaning of the code.

From Coding to Themes

The process of producing themes was based on the Thomas and Harden (2008) method of line-by-line close coding of the text based material. This produced 45 codes for therapeutic actions and 29 codes for perceived effects, totalling 74 codes. The codes were generated from the selected extracts rather than having predetermined codes. This meant that interpretation of the codes was required to formulate meanings that were accessible to arts therapists, were context specific and related to the population and aims of the therapy as described by the arts therapists in the selected extracts.

Tables 2 and 3 describe the relationship between mid-level themes and the original 45 in-session therapeutic action codes and 29 perceived effects in relation to engagement with the arts. These mid-level themes were synthesised according to an essential meaning that encapsulated the author's intended communication (also described in Tables 2 and 3). It is notable that the original text was referred to repeatedly throughout the process to ensure that the themes captured and surmised the essential contextual meaning that was intended by the author, rather than a dictionary or conceptual meaning that was developed independently of the literature being reviewed.

In-Session Therapeutic Actions CODE (applied to text)	MID LEVEL THEME	HIGH LEVEL THEME
Interpretation	Interpretation	**COGNITIVE REAPPRAISAL**
Enhancing Validation Affirmation Marked mirroring Copying and matching	Validating emotional experience	**DEVELOPING AGENCY**
Grounding	Facilitating engagement in the here and now	**DEVELOPING SHARED EXPERIENCE**
Facilitating engagement in the here and now		
Observing		
Joint attention		
Regulating emotions Communicating the embodied emotional situation Careful engagement Adapting personal boundaries Regulating interpersonal proximity Establishing/ maintaining personal boundaries	Emotional Responsiveness/ Regulation	**PROCESSING EMOTIONS**
Monitoring countertransference	Monitoring countertransference	
Affective/ sensitive / thoughtful attunement/ adaptation to emotional presentation Empathising Authentic response Personal disclosure Giving permission Clear verbal communication	Unconditional emotional attunement	
Make implicit meaning explicit	Make implicit meaning explicit	**SYMBOLISING**
Work with meaning implicitly	Work with meaning implicitly	
Explore/ reflect on emotional patterns Explore impact of past relationships Facilitate group relationships/ interactions Facilitate reflecting on/ exploring external relationships	Explore relational patterns	**PROCESSING INTERPERSONAL EXPERIENCES**
Improvisation/ arts response	Improvisation/ arts response	
Reconstruct narrative/ story	Reconstruct narrative/ story	

Facilitate reflexivity	Facilitate reflexivity	
Reflecting on self-other intentions Use role reversal 'Doubling' Explore/ tolerate interpersonal perspectives	Explore/ tolerate interpersonal perspectives	
Challenging/ directing behaviour	Challenging/ directing behaviour	
Being curious	Being curious	
Clarifying events	Clarifying events	
intersubjective participation	Intersubjective participation	
Apology	Apology	
Using arts as a container Using a structured exercise/ game Establishing consistent/ reliable environment Establishing boundaries	Facilitate reliable context/ procedures	**STRUCTURING EXPERIENCE**

Table 2. In-session Therapeutic Action

Perceived Effects Of Engaging With The Arts In Arts Therapies

CODE	MID LEVEL THEME	HIGH LEVEL THEME
Differentiating between emotions and thoughts Structured thoughts and fantasy Thinking Thoughtful expression	Thoughtful expression	**COGNITIVE REAPPRAISAL**
cognitive reappraisal	cognitive reappraisal	
Imaginative / creative response	Imaginative / creative response	**DEVELOPING AGENCY**
Bodily awareness/ articulation	Bodily awareness/ articulation	
Developing and accepting a cohesive sense of self	Developing and accepting a cohesive sense of self	
Personalised aesthetic experience	Articulate agency/ autonomy	
Self-control		
Confidence/ self-esteem		
Mirroring/ validation	Mirroring/ validation	
Being in the here and now	Being in the here and now	**DEVELOPING SHARED EXPERIENCE**
Emotional regulation	Emotional regulation	**PROCESSING EMOTIONS**
Expression/ embodiment/ processing emotions Processing feelings Emotional release/ acting out	Expression/ embodiment / processing emotions	
Symbolisation	Symbolisation	**SYMBOLISING**
Reflexivity	Reflexivity	**PROCESSING INTERPERSONAL EXPERIENCES**
Perspectives on self Mind-mindedness Shift from self to other Social functioning Providing a transitional object Reflecting on relationship with therapist	Social interaction/ exploring perspectives	
Communication	Communication	
Continuity/ narrative Story construction	Continuity/ narrative development	
Safety/ containment/ boundary	Safety/ containment/ boundary	**STRUCTURING EXPERIENCE**

Table 3. Perceived Effects Of Engaging With The Arts In Arts Therapies

High Level Themes

The overarching themes for therapeutic actions and perceived effects of engaging in the arts were: (1) processing interpersonal experience; (2) processing emotions; (3) developing agency; (4) symbolising; (5) structuring experience; (6) cognitive reappraisal and; (7) developing a shared experience. Whilst the focus of arts therapies work in terms of number of extracts coded (see Figure 2) is clearly in the area of processing interpersonal experience (510/1475) and processing emotions (371/1475), these are closely followed by developing agency (273/1475) and symbolising (169/1475) and lastly structuring experience (60/1475), cognitive reappraisal (54/1475) and developing a shared experience (38/1475). Whilst there are clearly overlaps between the themes they sufficiently represent domains of in-session therapeutic actions and perceived effect. The themes remain conceptually aligned to the original data and offer salient focal areas based on the priority given to these areas in literature.

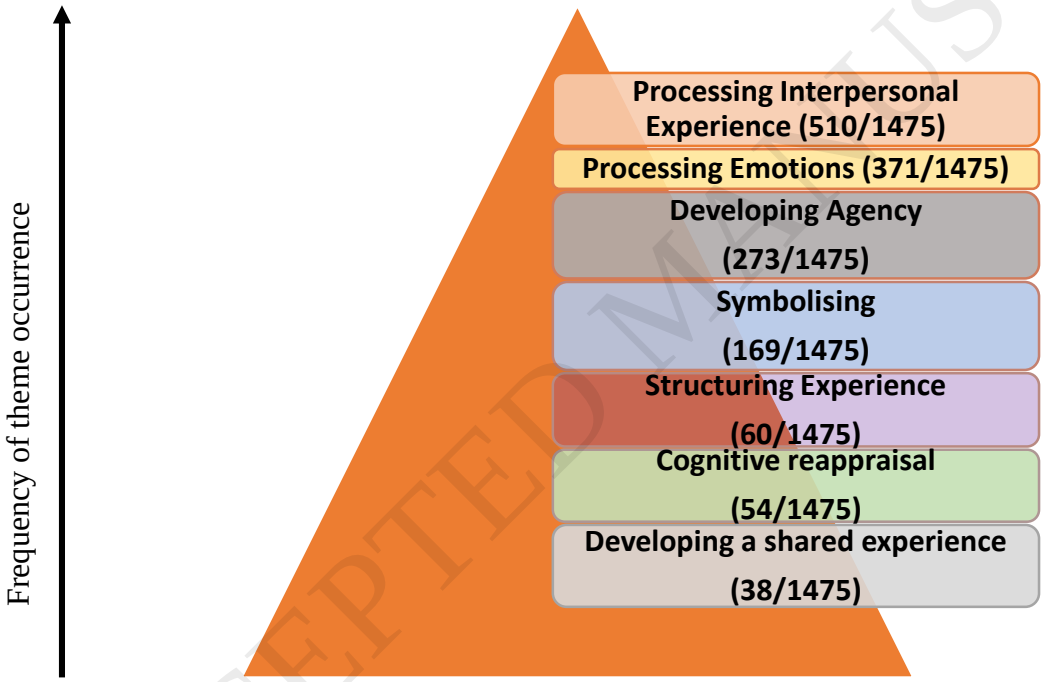


Figure 2. Occurrence of High-Level Themes in the Literature

IN-SESSION THERAPEUTIC ACTIONS AND PERCEIVED EFFECTS

The following section aims to clarify the relationship of the original data to the high-level themes in order to verify the premise upon which the final hypotheses will be established. Each of the following headings comprises a high level theme with example definitions salient to the original text.

Processing Interpersonal Experience

Facilitating a therapeutic experience and exploration of self within an interpersonal context was

described within a large number of extracts as happening more through types of therapeutic action (330/678) than through the arts (160/980) (See Figure 2.). Types of therapeutic action included: 'psycho-(bio)-dramatic role playing' (Röhricht, 2015); using props to maintain the therapeutic alliance (Manford, 2014); 'improvising together' (Odell-Miller, 2016) and; finding ways of becoming present to the patient through the arts form (Strehlow & Piegler, 2007). In terms of reflecting on relationships,) it is suggested that engaging in the arts enables relational patterns to be repeated (re-enactments) (Strehlow & Piegler, 2007), establishing 'a new and reparatory relational model' (Cukier & Marmelszetjn, 1998), for example through enabling curiosity and interest in the patient (Springham, Findlay, et al., 2012), facilitating group curiosity and understanding interpersonal conflicts (Johns & Karterud, 2004). In terms of improving relationality, this is described as happening through facilitating 'accompaniments, enhancements or contrasts' (Strehlow & Lindner, 2016), 'mutual cooperation' (Levens, 2002), externalisation through the arts to reveal interpersonal intentionality (Johns & Karterud, 2004), for example to 'identify typical interaction patterns' (Hannibal, 2016) and confronting fixed ideas about self and other (Lefevre, 2004).

Processing interpersonal experiences were described in a number of different ways in the extracts. For example, Thorne (2016) states that 'The therapist takes an active stance in promoting the process of self and group mentalizing' through 'modelling the application of inquiry'. From the extracts, there is a clear relationship between the way that the therapist focuses attention on differentiating and clarifying relationships, people's intentions and the development of a more authentic collaborative relationship where both parties can be open to each other's experiences and exploration of thoughts and feelings.

Processing Emotions

The extracts content suggest that emotions are considered as being central to the therapeutic processes of the therapist and the patient. In terms of the number of extracts it is notable that there are two themes for emotionally focussed therapeutic actions: emotional responsiveness / regulation (52/732) and unconditional emotional attunement (80/732). The high number of extracts in this theme suggests this is particularly significant to the arts therapies process and includes a range of sub-themes such as 'embodied empathy' (Röhricht, 2015), 'emotional examination' (Strehlow & Piegler, 2007), 'sensitizing' (Cukier & Marmelszetjn, 1998) 'attunement' (Lefevre, 2004), responsiveness, warmth and genuiness' (Lefevre, 2004), being 'judgement free' (Pool & Odell-Miller, 2011) and having a 'therapeutic attitude of empathy' (Manford, 2014). However, (Gabbard, Miller, & Martinez, 2006) suggest that the emotional attention and quality of experience extends into psychobiological processes intimately bound to our sense of self and other and therefore, whilst many explicit statements refer to emotions, there is often a clear overlap with interpersonal experiences. This is represented in the patient experience of emotions where as a result of engaging in the arts, patients were reported to regulate emotions. Examples of this include using arts to: 'cope with threatening feelings' (Strehlow

& Lindner, 2016); reduce the intensity of the relationship (Morgan, Knight, Bagwash, & Thompson, 2012); 'distract from distress' (Lamont, Brunero, & Sutton, 2009);'stay with feelings' (Levens, 1990) and; expand on the range of feelings experienced (Pool & Odell-Miller, 2011).

From the extracts taken across the arts therapies extracts there appears to be a clear relationship between the therapeutic action and the effect in the domain of emotions. The therapist is able to process their own emotions as well as the patient's emotional experience to enable a genuine and attuned approach to facilitating a safe and containing environment that demonstrates and guides validation, recognition and regulation of emotional states.

Developing Self-Agency

Developing self-agency in terms of clarification, integration and development appeared to be mostly described in terms of engaging in the arts form (199/715) rather than the therapeutic actions (53/732). The therapeutic actions were described as: helping the patient to 'recognise emotions' and develop a personal narrative (Strehlow & Piegler, 2007); being 'validating and warm' (Cukier & Marmelszetjn, 1998) and; mirroring (Hartwich & Brandecker, 1997).

In terms of the wide range of self-experiences for the patient these include: 'feeling safe' (Odell-Miller, 2016); having 'a sense of how I feel inside… self worth… and a stable sense of identity' (Odell-Miller, 2016);feeling present and less judged (Odell-Miller, 2016); 'ego-maturation' (Röhricht, 2015); 'connecting with body feelings' (Manford, 2014); 'authenticity' (Manford, 2014); 'pride and self-confidence'(Springham, Findlay, et al., 2012); an 'intrinsic sense of personal value (Cukier & Marmelszetjn, 1998); '…coherent, stable self-image and more self-acceptance…personal integration' (S. Haeyen et al., 2015); engaging with a personalised aesthetic that 'promoted his individuality' (Pool & Odell-Miller, 2011) and; 'body awareness….improved self-awareness, improved self-perception, improved reflective abilities and self-insight' (Haeyen et al., 2015).

However, the sense of self appears to be supported by a range of attributes that come through becoming more able to be articulate through the arts medium. Haeyen et al. (2015) highlight that patients, 'experience positive effects on self-acceptance, [and] higher self-esteem' all of which appear to emerge from the validation of self-experience from a 'deepening' (Pool & Odell-Miller, 2011) experience of self which leads to reformulation (S. Haeyen et al., 2015; Levens, 1990; Morgan et al., 2012; Strehlow & Lindner, 2016), self-control (Pool & Odell-Miller, 2011) and self-constancy (Johns & Karterud, 2004). There is also psychodynamic theory applied with reference to Winnicott (1971) for example, (Cukier & Marmelszetjn, 1998; Lefevre, 2004; Levens, 1990, 2002; Manford, 2014; Moschini, 2005; Pool & Odell-Miller, 2011) suggest that developing agency does not exist independently of the other and the arts can have a transitional object function.

From the literature, it appears that there is a relationship between the therapeutic actions of creating a holding and safe space, where the therapist can mirror, validate and reflect the patient's

experience in a way that enables confidence in the relationship and the arts process. The impact of this process appears to include a range of helpful outcomes; from positive self-perceptions to self-articulation that can be understood in the context of developing self-agency.

Symbolising

Symbolising is a complex process of psychological perception changing from concrete to second-order representations of experience (Johns & Karterud, 2004). In the literature symbolisation was frequently referred to (73/715) but far less so than emotional and interpersonal themes. The themes of symbolised experience helped to form meaningful representations of the arts about personal narrative and personal or interpersonal experiences. This was referred to both as a verbal process (Strehlow & Lindner, 2016) and a private arts based process (Franks & Whitaker, 2007). The process of engaging in arts as a way of developing symbolisation that could remain implicit to the process and not verbalised is an idea shared by many of the authors (for example, see Eren et al., 2014; Johns & Karterud, 2004; Levens, 2002; Pool & Odell-Miller, 2011). However, the majority of extracts described how the therapist intervened to either interpret the work (Cukier & Marmelszetjn, 1998; Johns & Karterud, 2004) or assist in making an implicit meaning in the arts more explicit (Haeyen et al., 2015; Havsteen-Franklin et al., 2017; Springham et al., 2012) through the use of clarifying and deepening an understanding of the arts form and what it might represent. In this way the arts form was usually considered to form a foundation for enabling symbolisation to assist with developing a symbolic language where 'one object or idea is employed to represent another' (Moschini, 2005). The arts based pre-symbolisation process is described both as 'illusion' (Franks & Whitaker, 2007) and a 'transitional' object (Levens, 1990; Moschini, 2005; Pool & Odell-Miller, 2011). In psychodrama, music and art, the arts object was perceived to have an implicit symbolic meaning based on mental representations (Levens, 2002), affect (Cukier & Marmelszetjn, 1998) or personal communication (Johns & Karterud, 2004; Levens, 1990; Strehlow & Lindner, 2016). The impact of the symbolisation process related to; the patient's capacity to articulate their experience both verbally and nonverbally (Strehlow & Piegler, 2007); the facilitation of imaginative engagement (Levens, 1990); creativity and spontaneity (Lamont et al., 2009); reflexivity (Johns & Karterud, 2004) and; object constancy (Levens, 1990).

The relationship between the impact of symbolisation and the therapeutic action appears to be that the arts are often facilitated in collaboration with the therapist. Whilst the content of the arts form was not always perceived as being the primary agent of change, the development of a nonverbal language was often described as the initial stage to forming a symbolic representation of the patient experience. Further to this facilitation of meaning-making, where the therapist either directly interprets the work or takes a more explorative approach was often described as a way to help the patient formulate a symbolic language through verbal means.

Structuring Experience

Attending to the structural elements of the arts form and context was referred to considerably less (56/689) than other therapeutic actions. 'Structuring experience' in arts therapies refers to three areas; providing some structure within the session through coordinating an exercise which requires a sequence of steps to be followed; by establishing a clear timeframe to the session or lastly; through exploring a way of giving a sense of order to intra/ interpersonal events. It was stated that a range of artistic and verbal competencies, are needed for these structuring techniques. When referring to body movement psychotherapy, Röricht (2015) stated that 'the therapist possesses a great deal of experience and structuring ability'.

The types of sequential structure can be seen in the composition of music or being 'task-orientated' (Odell-Miller, 2016), having 'artistic assignments' (S. Haeyen et al., 2015) or 'using a structured exercise or game' (Havsteen-Franklin et al., 2017). The arts form is also described as having a containing function (Manford, 2014) and appeared to be considered as facilitated primarily by the therapist offering specific arts materials or arts responses. For example Levens (Levens, 1990) states, 'the development of line and form, as an external structure enabling the development of a more stable internal structure' or Röhricht (2015) describes body movement psychotherapy as 'vessel-forming, containment orientated'.

Attention to structure is also about procedural issues such as 'structural parameters…(e.g. integrating new members and terminating treatment)' (Johns & Karterud, 2004) as well as the time boundaries, 'maintaining the frame' (D. Thorne, 2016) or the 'safe and facilitating environment' within which the arts are conducted (Odell-Miller, 2016).

Springham (2015) also refers to the 'consistency' of the approach suggesting that there is some predetermined ideology and conduct which has an implicit structure which responds to an 'explicit formulation' of the patient's presentation. This, he suggests, also facilitates a wider structure within the organisation to inform and develop the patient's care-package.

From the literature, the focus on structure for arts therapists covers 4 areas: the containing function of the service context, secondly, the time frame of the session, timings and the approach taken. The third area is the use of arts as a response or as an object to structure emotional experience and lastly using the arts in a more systematic way, where there are sequential steps to take during a directed task.

Cognitive Reappraisal

Cognitive reappraisal includes focusing on thinking as a way of making sense of experience. The majority of extracts suggest that the arts are a vehicle for emotional expression, processing experience or finding a way to communicate, however there is also reference to the use of arts as both a 'precursor to self-reflective thinking' (Strehlow & Lindner, 2016), and in its final form '…when it is being re-looked at, after its completion' (Levens, 2002) an idea shared by other authors, (S. Haeyen et

al., 2015; Lamont et al., 2009; Pool & Odell-Miller, 2011). Cognition appears to be intimately linked with the process of improvised externalisation through the arts form (Manford, 2014; Odell-Miller, 2011; Springham, Findlay, et al., 2012; Van Lith, 2016) where the arts form has a content that can be thoughtfully reflected upon rather than be emotionally overwhelming. This approach is considered by authors to enable thinking through the explorative interpretation that helps to link together events and experiences through the co-construction of the arts form. In the extracts, cognition rarely exists as being independent of other mental functions and the therapeutic action of cognitive reappraisal described in the extracts commonly aims to link cognition with emotions (S. Haeyen et al., 2015; Manford, 2014; Odell-Miller, 2011; Springham, Findlay, et al., 2012) as well as physical sensations (Manford, 2014; Odell-Miller, 2016). The impact of cognitive reflection is referred to as a way of structuring experience (Lamont et al., 2009; Levens, 1990; Springham, Findlay, et al., 2012) naming emotions and experiences(Eastwood, 2012; S. Haeyen et al., 2015; Lamont et al., 2009; Springham, 2015) and developing new ways of seeing relationships (Gabbard et al., 2006; Manford, 2014; Strehlow & Piegler, 2007).

Whilst cognitive reappraisal is not referred to as often as most of the other domains, this appears to be integral both in the way that the arts therapist reflects on the arts form as well as how cognition is developed, particularly through externalisation of experience and in collaboration with the therapist to develop new ways of understanding relationships.

Developing a Shared Experience

Shared experience was considered to be based on moments where there was an explicit statement regarding a *similar* experience of a relationship, action or perception in an embodied rather than intellectual way. The explicit focus on shared experience does not frequently appear in the literature although is a significant theme that runs across the arts therapies (21/689). Whilst it is probable that there are a greater number of moments in the therapeutic situation that are shared, these are not explicitly referred to in the written material. The perceived effect of shared engagement in the arts appeared to be evident in those moments where there was increased explorative reflexivity about relationships and in every case emphasis was given to these moments prior to introducing therapeutic actions that would highlight or challenge self-other perceptions.

The act of developing a shared experience was described as being four different types of therapeutic action. The first of these is engaging in arts together in such a way that there is a sense of co-creation where both patient and therapist understand the arts form from a shared perspective. For example, Levens (1990) suggests this can be done 'non-verbally, by participating in a joint picture'. Alternatively, a shared experience can be encouraged through shared musical engagement, the therapist 'enhancing' or 'accompanying' the patient's music and, as Springham et al. (2012) state, '…the service user's own resources are reflected in the art object so that they can be jointly considered.' Springham et al. (2012) describe the second way that a shared experience of the work

can be understood, as the moment where there is a nonverbal observing of the arts-making act where the patient experiences the therapist as emotionally attuned, containing and psychologically available to the arts-making process. This is commonly referred to as 'joint attention' (Springham et al., 2012; Thorne, 2016) or 'joint observation' (Strehlow & Piegler, 2007). The third area of shared experience relates to the process of being 'in the here and now'(Cukier & Marmelszetjn, 1998; Havsteen-Franklin et al., 2017; Lefevre, 2004; Morgan et al., 2012; Springham et al., 2012; Teglbjaerg, 2011). Lastly, treating the group as a whole with some similarity of perspective can influence the sense of a shared experience within 'the viewing mind of the group' (Franks & Whitaker, 2007).
In conclusion, the domain of shared experience appears to be facilitated by the therapist through assisting the patient to be in the here and now through the use of the arts, an attuned approach to observing the arts-making process and an increased bodily awareness associated with an experience of being more 'grounded'. This also happens within the group context where ideas, themes or experiences are brought together and identified as a shared group experience.

Comparing Number of Extracts Relating to Perceived Effect of Engaging in the Arts and Therapist's Actions

The number of extracts relating to perceived effects of engaging in the arts on the one hand and therapist's actions within each theme were compared with each other (Figure 3). The reason for this was because the moments of engaging in the arts in the context of being with a therapist may have a relationship to the intended impact of the therapeutic action of the therapist. The results support our hypothesis that the patient uses both the arts therapist and the arts form to achieve similar aims. However, the literature relating to the arts form is weighted more towards processing emotions and developing agency whereas processing interpersonal experience, structuring experience and developing a shared experience were referred to a greater number of times in terms of the therapist's therapeutic actions. This comparison of data suggests that the main area of therapeutic congruency between arts therapies is likely to be in the domain of processing interpersonal experience. It appears that there is a causal hypothesis that change for the patient is primarily motivated by the explicit therapeutic actions conducted by the arts therapist and that this impacts on the patient's capacity to use arts to process emotional experiences.

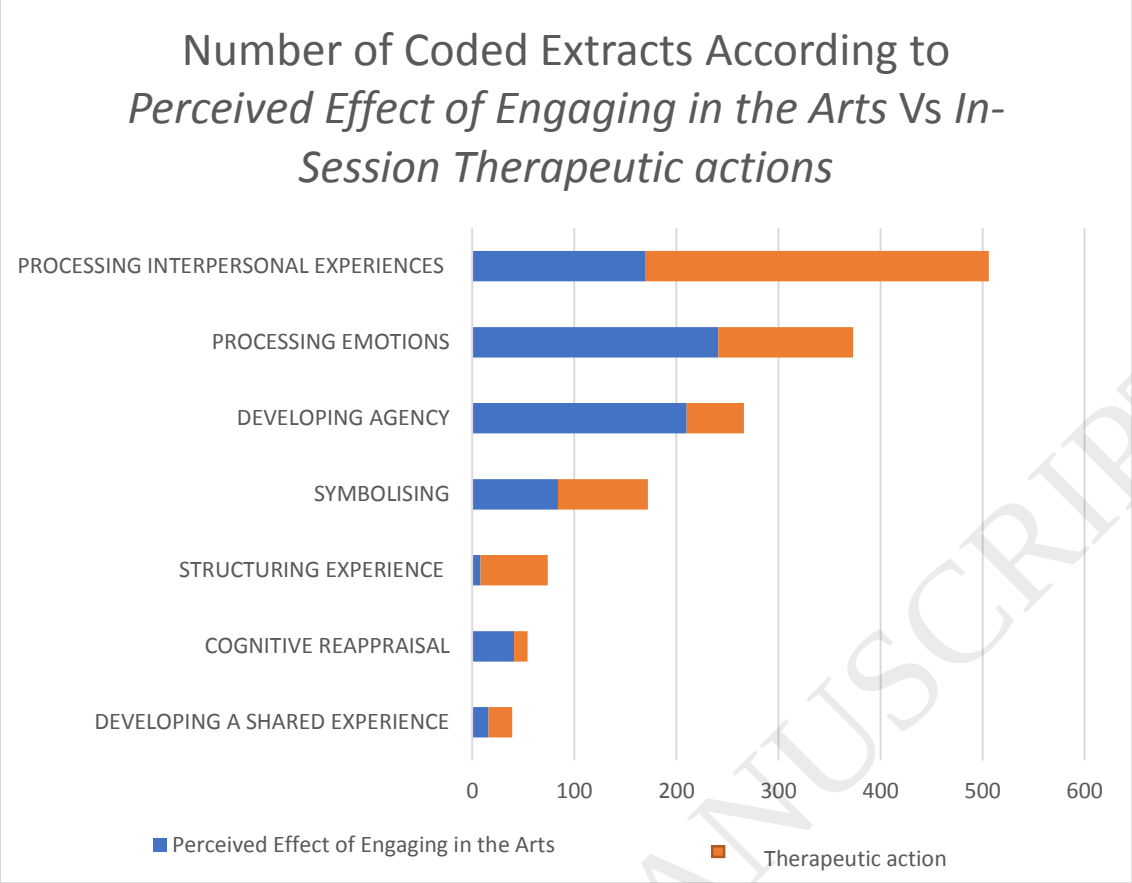
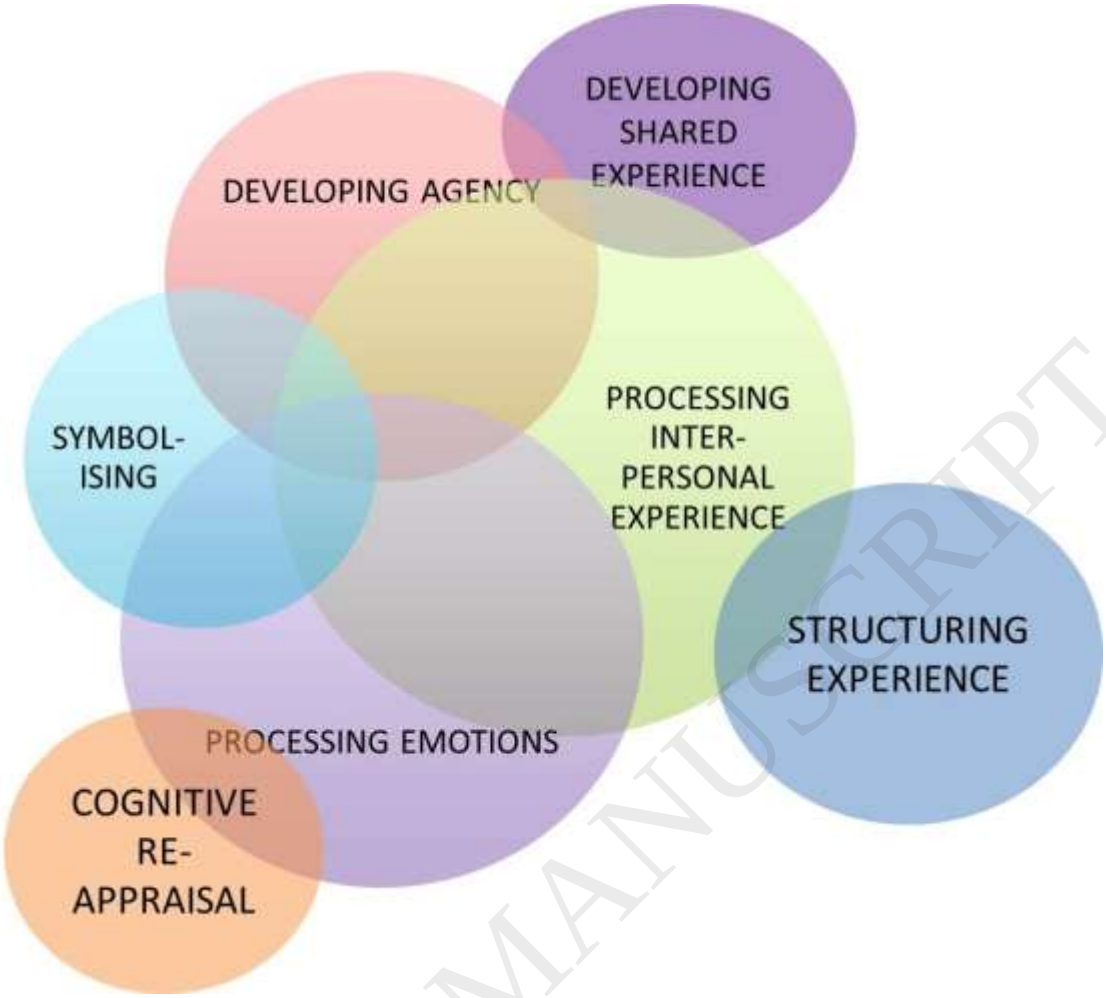


Figure 3. Number of Coded Extracts According to Perceived Effect of Engaging in the Arts vs In-Session Therapeutic Actions

Co-occurrence of Themes

The high-level themes were analysed in terms of their co-occurrence which revealed that many of the high-level themes had a greater co-occurrence of 20% (see figure 4). This finding indicates that there was a high degree of overlap of themes, particularly between symbolisation, processing emotions, processing interpersonal experience and developing agency. Shared experience only co-occurred more than 20% relative to processing interpersonal experience, which is consistent with this concept being a passive or active interaction between people. Lastly, there was a 74% co-occurrence of cognitive reappraisal and processing emotions. Whilst these are significantly different themes in terms of their conceptual meaning, the extracts often described clinical scenarios that involved seeking to thoughtful grasp and make sense of emotional experiences. Whilst processing interpersonal experiences had the highest number of extracts, processing emotions co-occurred with more themes. This finding suggests that most arts therapies therapeutic actions may be linked with processing emotions within an interpersonal focus.



INSERT FIGURE 4 HERE

Figure 4. Co-occurrence of High-Level Themes Topological Map. (Sizes of circles are indicative of number of codes applied in each theme)

Discussion

The results show that there are seven overarching themes that can describe a conceptual framework for arts therapies that are about how arts therapists practice. These themes are: (1) processing interpersonal experiences (2) processing emotions (3) developing self-agency (4) symbolising (5)

structuring experience (6) cognitive reappraisal (7) developing a shared experience. The data suggests that there is an emergent model of practice across the arts therapies that whilst underpinned by an intrapersonal theory, is predominantly focused on working through complex emotional experiences in a safe way and that this happens primarily through engaging with the form. What appears to facilitate this method is a focus on the interactional nature of the work, providing different and new perspectives on how people relate and how the patient can form new relationships safely. Whilst there are clearly some other mechanisms that are referred to such as how the sessions are structured, the symbolic value of the communication or how new ways of thinking can happen, according to the data these are not the dominant principles of practice.

In the analysis there were complex conceptual issues to do with the overlap of themes as is prevalent within all qualitative research, and the authors have explored and tested the themes to give sufficient primacy to the final high-level themes. However, it is also acknowledged that there are a range of themes that are not explicitly stated in the extracts but are implicit to the process. For example, 'continuum / narrative development' was often described and this also implies that there is a capacity to cognize experience, to link events together and to form a representation of experience and therefore to symbolise. However, if these themes are not explicitly linked and concurrent in the data we can only infer that one benefit would necessarily be closely linked with another and therefore if there were other data collection methods included such as interview with patients and arts therapists we would expect to see higher co-occurrence of concepts. However, in terms of reliability of specific themes, previous research conducted by Havsteen-Franklin et al. (2017) included in this study shows a high covariance in results, and whilst previous research did not include such high-level themes there are clear correlations between the therapist actions previously defined by Havsteen-Franklin et al. (2017) and the data collected for this study. It should also be noted that the researchers for this study came from art, music and dance movement backgrounds from a European context and that this is a limitation given that a significant proportion of the data referred to drama and was from outside of Europe. Nonetheless, by cross referencing the themes the authors triangulated the findings to ensure reliability whilst also acknowledging potential limitations.

The data also revealed that there is still a lot to be understood about cause and effect in arts therapies. In this paper, we have examined extracts recorded from patients, therapists and researchers to examine the relationship between therapeutic actions of the therapist and some of the perceived effects of engagement in the arts. There is a theoretical correlation about a causal hypothesis that engaging in arts produces a range of perceived effects as listed in tables 1 and 2. However, 'engagement in the arts' may also contain the outcome. For example, bodily articulation and emotional expression can be intrinsic to any arts-based process, inseparable from the act of making an image, a musical or dramatic response. Therefore, identifying what motivates and mediates change for the patient, and in particular the therapist and wider factors requires some clarification which is often

not explicitly available in current research. The key issue is that the how, when and why engagement with the arts has an effect in these different domains has yet to be researched in relation to specific therapeutic actions. At best, we can say that these perceived effects appear to have a correlation with arts engagement. Second to this, this study simply describes the actions and perceived effects, without any quantitative evidence that would support research into effectiveness. Without quantitative evidence, we are left with practice and event descriptors rather than the quantifiable effect. Therefore, this study would also benefit from further studies that could falsify or verify the hypothesised correlation between perceived effect and therapeutic action. Further to this, one of the limitations of this study is that the literature only identified perceived patient effects that were usually observed following an in-session therapeutic action. Future research should be conducted examining the change mechanisms in arts therapies in short, intermediate and long-term arts therapies treatment.

Conclusions

Critical and collective dialogues across the arts therapies about shared principles of practice for arts therapists working with PD remain scarce and many of the competencies and skills revealed through the data, whilst based on dynamic, interpersonal, arts-centred and humanistic schools of thought according to this study appear to have a similar basis of therapeutic action in practice. Whilst this study described extracts drawn mainly from case study research, there appears to be adaptations made to practise that links process and outcome. To better understand how we can train, research and manage arts therapies, the authors recommend that developing a shared conceptual framework based on these themes is required as a premise for understanding the needs for professional development. Furthermore, if it is the case that there are clear practice overlaps, further inquiry could be conducted concerning the main influence on this convergence. For example, has this happened through inter-professional dialogue, supervision, collective approaches to treatment, management direction being evidence focused or simply a pragmatic response to trial and error? The authors recommend that these high levels themes are used as a basis for considering domains of professional development to understand how we can safely and effectively improve practice to meet patient need based on the available evidence.

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XXXX – Music Therapist

XXXX – Music Therapist

XXXX – Art Psychotherapist

XXXX – Dance Movement Psychotherapist

XXXX – Learning Resources Advisor

XXXX – Learning Resources Lead

XXXX – Honorary Researcher

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