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AN INITIAL INVESTIGATION INTO THE EFFECTIVENESS OF GROUP THERAPEUTIC PUPPETRY WITH ADULTS WITH SEVERE MENTAL ILLNESS

Section A: The Role of Creative Arts Therapies in Assisting Recovery from Severe Mental Illness
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Summary of the MRP Portfolio

Section A explores the role of creative arts therapies (CATs) in assisting recovery from severe mental illness (SMI). It examines the congruence of CATs with recovery models, and critically reviews evidence for the effectiveness of art and drama therapy with adults with mental health problems. It then examines one form of CAT which combines art and drama therapy – therapeutic puppetry. Underlying theoretical models and the existing evidence base with adults with SMI are outlined and critiqued. The review concludes with a summary of proposed arguments and research recommendations.

Section B reports on a pilot investigation of group therapeutic puppetry with people with SMI. This mixed methodology study tested the hypotheses that group therapeutic puppetry results in improvements in mental wellbeing, self-esteem and body connection. It also investigated mechanisms of change, and service user acceptability and experience. Results indicated that participants can either decline or improve on standardised measures, but that service users experience the intervention as more consistently beneficial.

Section C is a critical appraisal of the conducted research, examining lessons learnt, identified training needs, changes to clinical practice and future research directions.

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Section A: The Role of Creative Arts Therapies in Assisting Recovery from Severe Mental Illness

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Abstract

This review explores the role of creative arts therapies (CATs) in assisting personal recovery from severe mental illness (SMI). It begins by examining definitions and proposed causes of SMI, before looking at associated difficulties. It then provides a brief overview of conceptual models of recovery with a particular focus on the distinction between clinical and personal recovery models. Having set the scene, it then explores the extent to which CATs are congruent with personal models of recovery. This is followed by a critical review of the evidence for the efficacy of art- and drama-based therapies in reducing symptoms of mental distress and enhancing positive factors associated with recovery. To illustrate and further expand on how CATs can be beneficial for people with SMI, the review then focuses on a psychotherapeutic intervention which combines both art and drama therapy – therapeutic puppetry. Theoretical models of therapeutic puppetry and the existing evidence base are summarised and critiqued. The review concludes with a summary of proposed arguments and makes recommendations for future research into the role of CATs in assisting personal recoveries from SMI.

Severe Mental Illness and Recovery

This review explores the role of creative arts therapies (CATs) in assisting personal recoveries from severe mental illness (SMI). It examines the concepts of SMI and recovery, critiques the psychodynamic model of CATs, and outlines the evidence base for their effectiveness for people with mental health difficulties. It then focuses on one form of arts-based intervention – therapeutic puppetry – which may be particularly relevant for people with SMI. Two systematic literature search strategies were utilised to identify empirical and conceptual literature relevant to CATs generally, and therapeutic puppetry specifically. In addition, searches of specific journals and online databases, and reference checking of key papers, was conducted to ensure search comprehensiveness (Appendix 1).

Severe Mental Illness

Definitions of SMI are complex, utilising a range of criteria including diagnosis, duration of illness, length and type of treatment, and functional impairment (Thornicroft & Strathdee, 1996). The National Service Framework for Mental Health (Department of Health, 1999) differentiates between SMI and common mental health problems. Examples of SMI include schizophrenia, bipolar affective disorder, severe anxiety disorders, severe eating disorders, severe depression, and severe panic disorder. This review will utilise a definition of SMI with two criteria: more than two years' history of mental illness or treatment, and impairment in social or occupational functioning (Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). An estimated 6 people per 1000 have a mental health problem severe enough to require long term care (Craig, 1992).

The Aetiology of SMI

SMI is controversial with a constellation of causative factors, including genetic, biological, social, and environmental. The stress-vulnerability model (Zubin & Spring, 1977) posits that associated impairments are a result of psychobiological vulnerability due to genetic factors, intrauterine environment, and conditions of birth. Stress and traumatic events impinge on this vulnerability, whilst effective coping and good social support can ameliorate the effects and build

resilience. This model is congruent with evidence demonstrating high rates of traumatic exposure amongst people with SMI. For example, 56% of people in the general population are exposed to some form of traumatic event during their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In comparison, and just considering interpersonal violence of a physical and sexual nature, lifetime estimates of exposure amongst people with SMI range from 43 to 81% (Carmen, Rieker, & Mills, 1984; Hutchings & Dutton, 1993; Jacobson, 1989; Jacobson & Richardson, 1987; Lipschitz et al., 1996). Childhood abuse, in particular, has been associated with the development of adult mental health problems (e.g. Bushnell, Wells, & Oakley-Browne, 1992; Christoffersen, Poulsen, & Nielsen, 2003; Mullen, Martin, Anderson, Romans, & Herbison, 1993), and shown to have a direct casual role in the development of psychosis and schizophrenia (Spataro, Mullen, Burgess, Wells, & Moss, 2004; Bebbington et al., 2004; Janssen et al., 2004).

Difficulties that may be associated with a SMI include suicidality and hopelessness, anxiety and depression, sleep disruption, unemployment and poverty, social isolation and stigma, and poor physical health (Wright, Turkington, Kingdon, & Basco, 2009). Despite extensive research into genetic and biological origins, as well as pharmacological interventions, little progress has been made in alleviating symptoms associated with SMI (Wright et al., 2009). For example, antipsychotic medication typically results in less than 20% improvement in the positive symptoms of schizophrenia when comparing repeated measurements across time on the Brief Psychiatric Rating Scale (Khan, Khan, Leventhal, & Brown, 2001). Attention has therefore partly turned to psychosocial models of recovery from SMI and the use of psychological therapies (Wright et al., 2009).

Models of Recovery from SMI

The concept of recovery from SMI resulted from longitudinal evidence which challenged the idea that SMI entailed inevitable deterioration (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987), as well as first person service user accounts of recovery (e.g. Houghton, 1982). A number of conceptual models of recovery have been developed, a review of which is beyond the scope of this thesis (see review by Bellack, 2006). Broadly, two types of recovery have been proposed: clinical

recovery and personal recovery (Slade, 2009). Clinical recovery developed from the system of mental health care and includes removal of symptoms and restoration of social functioning (Slade, 2009). In contrast, personal recovery refers to life lived despite the effects of SMI and includes developing meaning and purpose in life (Anthony, 1993).

Clinical recovery concepts have been critiqued for failing to explain the unequal progression and variable impact of SMI (Bellack, 2006). It has been suggested therefore that UK mental health services should orientate themselves around holistic well-being as opposed to clinical recovery (Slade, 2009). To help achieve this, a personal recovery framework based on service user accounts and core recovery concepts has been developed, and includes four domains of recovery:

- Hope: Belief that recovery is possible, acceptance of illness, commitment to change, focus on strengths rather than weaknesses, and looking to the future rather than the past (Jacobson & Greenley, 2001).

- Self-identity: Development of a positive and personally valued identity beyond that of a person with SMI (Slade, 2009). This is associated with the acquisition of socially valued roles and satisfying interpersonal relationships (Jacobson & Greenley, 2001; Repper & Perkins, 2003).

- Meaning: Development of a personally satisfying meaning of SMI within the individual's life as well as future purpose and goals (Slade, 2009).

- Personal Responsibility: Accepting responsibility for one's life, and learning to self-manage the symptoms of SMI (Slade, 2009). This is associated with the empowerment of people with SMI as a means of challenging the hopelessness and dependency which can be fostered by prolonged contact with mental health services (Jacobson & Greenley, 2001).

Conceptual models of recovery, clinical or personal, remain controversial and there is currently no single agreed-upon model to guide research and service development (Ralph & Corrigan, 2005).

This makes it difficult to know which, if any, psychosocial interventions for SMI are congruent with recovery models. However, one method of intervention which has been conceptualised within a personal recovery framework is CATs for people with SMI (Spandler, Secker, Kent, Hacking, & Shenton, 2007).

Creative Arts Therapies and Recovery from SMI

The importance of arts and creativity has been noted within individual accounts of recovery from SMI (Spandler et al., 2007). Arts and health has been defined as "arts-based activities that aim to improve individual/community health and healthcare delivery, and which enhance the healthcare environment" (Cayton, 2007, p.5). One example of arts-based activities in healthcare is creative arts therapies for mental health problems. This can include art, music, drama, and dance movement therapies; common to all four is creative self-expression and a strong therapeutic relationship which facilitates emotional expression. Although several psychological models are used to conceptualise CATs, psychodynamic models tend to predominate (Crawford & Patterson, 2007).

The Psychodynamic Model of Creative Arts Therapies

The psychodynamic model is based on the processes of projection, transformation, and internalisation. Projection involves parts of the self being externalised through artistic creations and creative play thereby revealing internal conflict and/or developmental impasse. These can then be worked through within the arts space allowing transformation and growth. Finally, the resolved conflict can be internalised and accepted into the self as a mature identification which corresponds to the external world but also has personal meaning for the individual (Johnson, 1998). These processes are made possible via the provision of a transitional (Winnicott, 1971) space in addition to the aesthetic, imaginal arts space, where inner and outer realities and the self and other are intermingled (Johnson, 1998).

The role of the creative arts therapist is to offer empathic listening, reflection, and attunement (Stern, 1985) with the client. Purposeful misattunement (Stern, 1985) is used to introduce discordant or novel elements into the arts space and propel the client towards

transformation and integration (Johnson, 1998). This role has been undertaken by therapists from a range of backgrounds including psychology, psychiatry, medicine and social work, in addition to those therapists specifically trained in CATs (Malchiodi, 2005).

The psychodynamic model of CATs is theoretically coherent with evidence drawn from clinical case studies. There is, however, little empirical validation of the model, although therapeutic processes are being tentatively linked to underlying brain structures (e.g. Buk, 2009).

Arts and Health, Creative Arts Therapies and Mental Health Services

The creative arts have been used extensively in physical and mental health care (Stickley, 2007), but have only recently received endorsement in government policy. The Prospectus for Arts and Health (Department of Health, 2007) found beneficial health outcomes from arts participation and recommended use across NHS and community settings. Similarly, Cayton (2007) concluded that arts should be integral to healthcare due to evidenced positive health outcomes and wider effects on social determinants of health via improvements in social capital and inclusion. More recently, the British Medical Association (BMA, 2011) concluded that a range of arts-based interventions, including story-telling, music, theatre, and drama, could be used to meet the social and psychological needs of patients in hospital.

There has, however, been a lack of government action (Clift et al., 2009) and dedicated funding. A recent survey examining the provision and practice of art therapy for people with schizophrenia, for example, concluded that this population had limited access to art therapy within the NHS (Patterson, Debate, Anju, Waller, & Crawford, 2011). This may in part be due to the lack of empirical validation of the psychodynamic theoretical model of CATs, but may also reflect inconsistencies in the evidence base for CATs for people with mental health problems.

Outcomes of Creative Arts Therapies for Adults with Mental Health Problems

Government policies regarding arts and health interventions in the NHS (Department of Health, 2007; Cayton, 2007) primarily draw on studies of physically unwell populations. Where interventions with mental health populations are included, there is lack of information about

participants, making conclusions about what is effective for whom difficult. There is also a lack of peer reviewed publications resulting from programme evaluations. Two Cochrane systematic reviews of art and drama therapy for schizophrenia or schizophrenia-like illnesses concluded that ongoing evaluation was required because of a lack of evidence for the harms or benefits of these therapies (Ruddy & Milnes, 2009; Ruddy & Dent-Brown, 2009). In contrast, the National Institute for Health and Clinical Excellence (NICE) recommends art therapy during the acute phase of schizophrenia and for promoting long term recovery (Department of Health, 2009). Similarly, Staricoff (2004) in a review of the medical literature concluded that arts in mental health improved communication between service users, carers and professionals, stimulated creativity and self-expression, and enhanced self-esteem. These contradictions are partly due to the types of evidence utilised. Cochrane reviews are limited to randomised controlled trials, whilst other reviews have included quasi-experimental research, case studies and qualitative research.

Existing research suggests a number of beneficial outcomes of CATs for adults with mental health problems that are congruent with personal models of recovery (Spandler et al., 2007). This research is reviewed and critiqued below, but is limited to art and drama therapy and does not include evidence relating to music and dance/movement therapies (for a comprehensive review see Staricoff, 2004). It is also limited to peer-reviewed publications in English language journals published after 1980. See table 1 for a list and brief details of each of the included studies.

Table 1
Effectiveness of art and drama therapy for adults with mental health problems

Quantitative studies

Study	Sample	Intervention	Research design	Duration	Benefits/outcomes
Colgan, Bridges, Brown, & Faragher, 1991	26 MH service users	Group art training	Quasi-experimental. Pre- and post-case data	Not stated	• Reductions in use of services • Reduced rate of relapse
Green, Wehling, & Talsky, 1987	47 MH service users	Group art therapy	Randomised controlled trial (RCT)	10 sessions	• Significant improvement in attitudes toward self • Therapists rated participants as significantly more able to 'get along with others'
Hacking, Secker, Spandler, Kent, & Shenton, 2008	62 MH service users	22 arts & MH projects	Quasi-experimental. Pre- and post-outcome measures and service use data	Not stated	• Statistically significant improvements on measures of empowerment, mental health needs and social inclusion • No change in service use, medication or occupational/ educational activity
Richardson, Jones, Evans, Stevens, & Rowe, 2007	90 MH service users	Group art therapy	Exploratory RCT	12 sessions	• Significant change in negative symptoms • No differences in quality of life or social functioning
Whetstone, 1986	15 MH service users	Social dramatics	RCT	8 sessions	• Improved social competence as rated by inpatient nurses

Quantitative and qualitative studies

Study	Sample	Intervention	Research design	Duration	Benefits/outcomes
Eades & Ager, 2008	59 MH service users	Time Being Arts Project	Quasi-experimental. Pre- and post-questionnaires, interviews, focus groups	Twelve weekly two-hour sessions	• 64% reported lower depression and anxiety • 69% reported improvements to social health • 64% reported greater self-esteem and self-confidence • 63% reported improvements in general health
Odell-Miller, Hughes, & Westacott, 2006	25 MH service users	Art, music and dance therapy	RCT and qualitative interview using grounded theory	Not stated	• No statistically significant improvements in personal issues, level of distress, severity of symptoms or functioning • Improved self-esteem and motivation • Exploration of difficult feelings and experiences • Improvements in mental and physical wellbeing • Improvements in relationships and social support/inclusion

Qualitative studies					
Study	**Sample**	**Intervention**	**Research design**	**Duration**	**Benefits/outcomes**
Heenan, 2006	40 MH service users	Art as Therapy module within recovery programme	In-depth interviews and focus groups using thematic analysis	Ten weekly sessions	• Improved self-esteem and self-confidence • Social support • Creation of safe space to explore MH issues • Empowerment and hope
Howells & Zelnik, 2009	10 MH service users	Community Arts Studio	In-depth interviews and participant observation using content analysis.	Not stated	• Personal transformation and new identities • Social support/inclusion • Self-validation
Spandler, Secker, Kent, Hacking, & Shenton, 2007	34 MH service uers	6 Arts & MH projects	Qualitative case studies.	Not stated	• Increased motivation • Purpose and meaning • Decreased hopelessness • Increased social and creative activities • Coping strategies for distress – grounding/distraction • Exploration of difficult feelings and experiences • Opportunity for self-expression • Development of positive self-identity and new social roles • Social support/inclusion • Increased sense of control
Stacey & Stickley, 2010	11 MH service users	'Arts We Can'	Research workshops and interviews using thematic narrative analysis.	N/A	• Coping strategy – escapism/distraction • Self-expression and achievement • Exploration of difficult feelings and experiences • Social support/inclusion • Creation of safe space to explore MH issues • Increased self-esteem and self-efficacy • Improved mood • Improved physical wellbeing
Stickley, Hui, Morgan, & Bertram, 2007	11 MH service users	Arts workshop days	In-depth interviews using narrative discourse analysis	Not stated	• Sense of achievement, hope and motivation to change • Coping strategies for distress – distraction/escape • Opportunity for artistic expression and mastery • Development of positive self-identity and new social roles • Social support/inclusion

All but one of the studies in Table 1 evaluated art-based interventions.

Improving mental health.

One RCT (Richardson et al., 2007) found improvements in the negative symptoms of schizophrenia. However, six other standardised outcome measures were used and demonstrated no statistically significant improvement, although the study was underpowered (Richardson et al., 2007). A further RCT also found no statistically significant improvements on standardised outcome measures of symptoms, distress and functioning, although analysis of qualitative data suggested improvements in mental and physical wellbeing (Odell-Miller et al., 2006). An RCT of social dramatics found no improvements in psychosis, irritability or depression (Whetstone, 1986).

Three quasi-experimental studies using pre- and post-measures found reductions in use of services and rates of relapse (Colgan et al., 1991), improvements in mental health needs (Hacking et al., 2008), and decreases in depression and anxiety (Eades & Ager, 2008).

Qualitative studies suggest possible mechanisms of change via exploring difficult feelings and experiences within a safe space and developing new coping strategies for managing distress (Heenan, 2006; Spandler et al., 2007; Stacey & Stickley, 2010; Stickley et al., 2007).

Developing coping strategies.

None of the included studies employed standardised or physiological measures of coping, although qualitative studies suggest that participants developed new coping strategies. Strategies included the grounding effects of expressive arts and the opportunity to distract and escape from life's difficulties (Spandler et al., 2007; Stacey & Stickley, 2010; Stickley et al., 2007).

Promoting self-esteem and confidence.

Two quasi-experimental pre-post studies found improved attitudes towards the self (Green et al., 1987) and greater self-esteem and self-confidence (Eades & Ager, 2008). This is further evidenced in three qualitative studies (Odell-Miller et al., 2006; Heenan, 2006; Stacey & Stickley, 2010). Participants

in Heenan's (2006) study described low levels of self-confidence and self-worth, using words such as "worthless" and "unable to function". Engaging in creative arts allowed them to challenge negative self-images, build confidence, develop new skills and knowledge, expand creative repertoires, and be more resilient in the face of negative influences on mental health.

Improvements in interpersonal relationships.

One RCT of social dramatics found improvements in social competence but not social interest (Whetstone, 1986). An RCT (Richardson et al., 2007) of art therapy found no improvement in social functioning, part of which evaluates quality of interpersonal relationships. A quasi-experimental pre-post study (Green et al., 1987) found that therapists rated participants as significantly more able to 'get along with others'. Interestingly, no participants in the qualitative studies spontaneously talked about effects on their interpersonal relationships.

Reducing stigma, promoting social inclusion and increasing social capital.

One quasi-experimental pre-post study found statistically significant improvements on measures of empowerment and social inclusion. However, this was not evidenced in improved levels of occupational/educational activity (Hacking et al., 2008). A further pre-post study found improvements to social health (Eades & Ager, 2008). All of the qualitative studies reported increased social support/inclusion and the development of new social roles (Heenan, 2006; Howells & Zelnik, 2009; Odell-Miller et al., 2006; Spandler et al., 2007; Stacey & Stickley, 2010; Stickley et al., 2007). Participants described developing new identities and social roles as 'artists', enabling them to gain recognition within wider society. Further, that art can both metaphorically and literally 'take people to other places', thereby decreasing social isolation and increasing support networks (Heenan, 2006; Stickley et al., 2007).

Finding purpose and meaning.

One RCT looked at changes in the quality of life of participants and found no significant improvements (Richardson et al., 2007). In contrast, participants in qualitative studies described creative expression as engendering hopefulness, purpose and meaning (Heenan, 2006; Spandler et al., 2007; Stickley et al., 2007). Arts participation broke the cycle of hopelessness and despair engendered by mental ill-health, allowing individuals to find new purpose and meaning (Stickley et al., 2007).

Summary of Evidence for Art and Drama Therapy in Mental Health

Both quantitative and qualitative studies of participation in art and drama therapy have found a number of benefits for adults with mental health problems. However, there are inconsistencies between studies and no set of agreed outcomes. Future studies should consider using standardised outcome measures and investigate a range of outcomes in addition to symptom reduction. Further information is also required on the processes by which creative arts participation engenders beneficial changes.

Having reviewed underlying theoretical models and existing evidence for the effectiveness of art and drama therapy for people with mental health problems, this review will now consider one form of CAT: therapeutic puppetry. This form of CAT was chosen as it has been described as particularly beneficial for people with SMI (Gerity, 1999) and because it represents an integration of art and drama therapy.

Therapeutic Puppetry

Therapeutic puppetry is the use of puppets to aid physical or emotional healing (Bernier, 2005). It can include puppet making, puppet play, interaction between puppet characters, and observation of, and reflection on, puppet shows. Therapeutic puppetry has been used extensively with children who are experiencing mental distress (Bernier, 1983; Butler, Guterman, & Rudes, 2009; Carter, 1987; Egge, 1987; Ekstein, 1965; Hawkey, 1951; Irwin & Shapiro, 1975; Kors, 1964) or physical health problems (Cassell, 1965; Linn, Beardslee, & Patenaude, 1986; Zahr, 1998). It has also been used for adults experiencing mental health problems (Gerity, 1999; Koppleman, 1984; Schuman et al., 1973; Vizzini, 2003).

Therapeutic puppetry has demonstrated a range of novel uses, including reducing stigmatising attitudes towards mental illness amongst elementary children (Pitre, Stewart, Adams, Bedard, & Landry, 2007), reducing family television time (Escobar-Chaves, Shegog, Markham, & Brehm, 2010), and as a method of social change and community participation (Smith, 2009). Considering clinical psychology specifically, puppets have been used as aids to therapy within cognitive behaviour therapy for children (e.g. Melfsen et al., 2011) and people with learning disabilities (Haddock & Jones, 2006).

Several theoretical frameworks have been used to conceptualise therapeutic puppetry. The core underlying model is object relations theory; however, other models have been utilised including attachment and narrative ideas, and theories of embodiment and play. It is important to note that all of the proposed models of therapeutic puppetry are hypothetical and based on clinical experience and individual case studies. Each of these proposed theoretical models will now be reviewed and critiqued.

An Object Relations perspective on Therapeutic Puppetry

The main theoretical framework for therapeutic puppetry is object relations theory as developed by Klein (1946, 1958), Bion (1967a, 1967b), Winnicott (1965, 1971, 1975), and Fairbairn (1994a, 1994b). Object relations is an interpersonal theory concerning 'objects' or internalised mental representations of external interpersonal relationships, which influence an individual's thoughts, feelings and ways of relating. Subsequent theoretical revisions have emphasised the object as the lens through which we perceive and conceptualise the self, others and the world (Ogden, 2004).

Klein distinguished between two forms of internal object relations which she labelled the 'depressive' (Klein, 1935) and 'paranoid-schizoid' (Klein, 1946) positions. These positions represent mental developmental stages which occur in response to experienced anxiety. Based on her observations of infants, Klein believed that the earliest developmental stage was the paranoid-schizoid position. At this stage, internal mental representations are split part-objects of a malevolent or idealised type developed in response to fear of annihilation by others. Infants progress from this

position to the healthier and more balanced depressive position, characterised by integrated patterns of internal relationships where others are perceived as separate and valuable individuals. Anxiety at this stage arises from the loss or harm of what is valued (Hobson, 2007).

Klein did not, however, see progression through these stages as a simple linear event, rather that individuals move between the two positions throughout life in response to experienced anxiety. She also believed that mental illness was a manifestation of being developmentally stuck within either the paranoid-schizoid or depressive position. Of particular importance here is Klein's understanding of schizoid type illnesses as representing individuals who were stuck in the nightmarish world of the paranoid-schizoid position. Individuals stuck in this position cope with the resulting anxiety through the defensive strategies of projection, splitting, denial, omnipotence, and idealisation (Klein, 1946). Splitting is crucial as it allows individuals to separate 'good' and 'bad' objects, with bad objects projected outside and good objects held safe in the internal world. This splitting, however, results in persecutory anxiety, as externalised bad objects are then perceived as attacking the self.

In order to developmentally progress and reduce the symptoms of mental illness, individuals therefore need to integrate their internal part objects, leading to decreases in persecutory anxiety and primitive defences and movement towards the depressive position. This is achieved by allowing individuals a safe space to experience and introject their anxieties in a more manageable form (Ogden, 2004). Once movement to the depressive position has been achieved, individuals begin the process of reparation (Klein, 1921/1975) whereby the child makes reparative gestures towards a world damaged by its external projections of aggressive and sadistic feelings. Clegg (1984, 1995) broadened this concept to include reparative acts directed towards the damaged self.

One way in which this developmental impasse can be bridged is through therapeutic dramatisation. This is an aesthetic method by which an individual uses imagery to enact a problematic aspect of their existence. Enactment itself can be helpful, but a cognitive, reflective process post-action

is also required to interpret the action and place it in the context of past and future experiences and in relationship to self and others (Landy, 1996). This potentially painful process is mediated by the use of distancing, which allows individuals to maintain a balance between separation and closeness. On an intra-psychic level, this also allows individuals to identify with, or separate from, roles, feelings, thoughts or physical self-images resulting from internal object relationships (Landy, 1996).

Scheff (1981) stated that distancing can be used within therapy to achieve catharsis - the ability to experience or express repressed emotions without becoming overwhelmed by them. This is achieved through balancing overdistance, or repression, and underdistance, or the return of repressed emotion. Overdistancing is a cognitive process where the past is remembered through adopting a passive observer role, whilst underdistancing is an affective process of re-experiencing a past event through an active participant role. Scheff (1981) stated that in order to handle and process painful repressed emotions, we must manipulate distance by simultaneously adopting and moving between participant and observer roles.

Therapeutic puppetry allows individuals to obtain participant-observer balance by establishing a clear separation between self (puppeteer) and non-self (puppet). However, the non-self, or puppet, also contains recognisable elements of the self which the puppeteer can identify with. Thus projection in puppetry can be seen to provide a 'margin of safety' manipulated by the puppeteer to achieve a balance between underdistance and overdistance, thereby allowing catharsis and therapeutic change (Landy, 1996).

Therapeutic puppetry has been described as particularly beneficial for adults who have experienced trauma in childhood at the preverbal level (Gerity, 1999) and who may therefore have difficulty working through these experiences using verbal forms of therapy. Therapeutic puppetry combines verbal and nonverbal modes of expression (Bernier, 2005) and uses projective and distancing techniques (Aronoff, 2005). As Aronoff (2005) states "Puppets project: what is expressed can be denied

and blamed on the puppet, so that inner emotional worlds are revealed in non-threatening ways." (p. 118). Core to this is the idea that puppets constructed or selected by clients are representations of parts of the self, and that clients use puppetry to re-create their internal object relations in 'live' form. In doing so, they are able to resolve 'splits' in their internal worlds leading to a more coherent sense of self (Gerity, 1999).

Like the psychodynamic model of CATs, object relations theory is theoretically coherent with evidence for key processes drawn from clinical observations and case studies. However, the model has been critiqued for its shaky epistemological foundations (Eagle, 1983) due to a lack of empirical validation. Furthermore, the foundations of object relations theory lie in Klein's clinical observations of children, making her generalisations to adult states of mind questionable. The review will now consider other theoretical models of therapeutic puppetry.

Puppetry and Autobiographical Competence

Attachment theory posits that infants enter the world with a predisposition to participative social interaction and expressed attachments with caregivers. These attachments provide the child with a 'secure base' from which it can safely explore the surrounding world (Bowlby, 1985). The security of this attachment is determined by the responsiveness and attunement of the caregiver to the child's needs. If the child experiences deprivation within this key relationship, insecure attachment of a disorganised, ambivalent, or avoidant type can result (Ainsworth, Blehar, Waters, & Wall, 1978). The child can also experience themselves as disjointed and incoherent because they lack autobiographical competence - the ability to develop a coherent narrative of their primary relationships. A key goal of attachment based therapy therefore is to develop a coherent narrative of the client's experience whereby difficulties are objectified and inner and outer experience linked (Holmes, 1993). Therapeutic puppetry may allow individuals to achieve this via the creation of stories that are metaphorical representations of their own lived experiences (Gerity, 1999).

Puppetry, Narrative, and Stigma

Narrative therapy (White & Epstein, 1990) suggests that clients need to 're-story' lives which have become populated by 'thin' descriptions as a result of unexamined and socially influenced preconceptions. This is analogous to the narrowing that can occur in peoples' experience of themselves and the world when they have a SMI. Narrowing results from the dominance of clinical models of recovery as well as societal stigma and discrimination (Repper & Perkins, 2003). Therapeutic puppetry may allow participants to create 'thick' descriptions which embody experiential knowledge and meaning and incorporate lost aspects of the self (Gerity, 1999). It may also assist in the creation of meaningful narratives about experienced loss and suffering which can contribute to mental health difficulties (Gerity, 1999).

Creation of Puppets and Healing the Body Self

Freud (1923/ 1951) stated that the ego is first and foremost a bodily ego. This body self is relational and formed through the mother's attunement to the child's sensorimotor experiences. It reflects a developmental hierarchy of experience and cognition which progresses from images, to words, to organising patterns, to superordinate abstractions and inferences that shape the experience of self (Krueger, 1988). The body self acts as a container for the development of the psychological self, and also provides the symbolic and linguistic abilities required to communicate internal experiences. It also allows for the development of effective self-regulation and self-empathy (Krueger, 2002).

If a child does not experience sensitive attunement and mirroring from the mother, or experiences significant childhood trauma and adversity, development will be warped, resulting in a fragmented body self and a psychological self which is incapable of recognising and distinguishing internal states. Consequently, a child may subsequently experience disembodiment, dissociation, somatisation of affect, an inability to self-reflect or create symbolic representations, and a sense of having an internal 'black hole'. This lack of a fully developed and unified body-psychological self is

manifested in the later development of mental health problems, and in particular, acts of self harm which can be seen as attempts to physically contain and shape the body (Krueger, 2002).

CATs are one way in which this developmental impasse can be bridged as they "offer more direct access to the unconscious and symbolic processes as well as to more basic experiences of the body self" (Krueger, 1989, p.162). This may be especially true for therapeutic puppetry as it can include puppet making; the physical act of shaping and creating puppet bodies can be representative of reparative acts towards a damaged body self. These acts can create an increasing sense of cohesion and safety within the body, reducing self-destructive acts (Gerity, 1999). Furthermore, puppet stories may allow for the creation of a metaphorical narrative about the development of body self, which also allows feelings of loss and grief to be processed. The combined effect of puppet making and performance may be a reconnection with body experience and development of a unified body-psychological self (Gerity, 1999).

Puppetry as Adult Play Therapy

Play has been defined as "a mental-physical activity that has normative, development-promoting functions" (Solnit, 1987, p.221). As development occurs throughout life, it has been proposed that play can serve the same functions in adult and childhood: providing stress relief (Colarusso, 1993), facilitating mastery by turning the passive into the active (Ostow, 1987), and offering a means of coping with conflicts and adverse life situations, developmental demands and loss (Solnit, 1987). It also allows people to expand their role repertoire and engage in cooperative socialisation and fun (Blatner & Blatner, 1997). Pretend play is particularly important as it allows experimentation with thoughts, feelings and behaviour without consequence, encouraging flexibility and expanding perspectives (Blatner & Blatner, 1997). The benefits of play may in part explain the beneficial outcomes of engaging in CATs. For example, self-esteem and confidence is enhanced as a result of increased mastery of self and the external world.

For those who have experienced trauma, therapeutic play allows for repetition and mastery of the trauma and its associated conflicts and affects via symbolic and metaphoric recreation within a safe space (Ablon, 1996). For people with SMI, who have often experienced traumatic life events, therapeutic puppetry may offer a way of engaging with, and experiencing mastery over these experiences (Gerity, 1999).

Reviewing the Evidence for Therapeutic Puppetry

Therapeutic puppetry has been used in various forms of psychotherapy for adults with mental health problems to facilitate the expression of difficult thoughts and feelings (Gerity, 1999; Koppleman, 1984; Schuman et al., 1973). Only one empirical study of the effectiveness of group therapeutic puppetry for adults has been conducted (Vizzini, 2003). The majority of the effectiveness literature constitutes descriptive case study evidence. Case studies are traditionally considered a weak form of evidence due to a lack of rigor (Yin, 2009), although they do provide more complex and rich detail than clinical trials (Greenhalgh, 2006). They are also useful in answering questions regarding how and why interventions are effective (Yin, 2009). The case studies used to illustrate therapeutic puppetry with adults are informative as they suggest possible outcomes and theoretical frameworks. However, they do not include service user accounts of the acceptability and experience of therapeutic puppetry.

The one empirical study of group therapeutic puppetry (Vizzini, 2003) evaluated the contribution of three puppet therapy sessions compared to three sessions of regular therapy in a 12-Step inpatient chemical dependency facility. Seventy-one participants were recruited and completed the State and Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) and the Client Satisfaction Questionnaire (Attkisson & Zwick, 1982), both of which have demonstrated good reliability and validity. Puppet therapy was evaluated significantly higher compared to regular therapy. Anxiety was also lower in puppet therapy groups compared to regular therapy groups. This study benefits from a large sample

size and the use of validated outcome measures. However, as an unpublished doctoral thesis it has not been subject to peer review.

Schuman, Marcus and Nesse (1973) described a group therapeutic puppetry intervention with psychiatric inpatients. No formal outcome measures were used and they provide no information regarding the size, composition or nature of the group (e.g. closed or open). However, they do describe how the puppets were used therapeutically via the safe expression of negative feelings, identifying ambivalent feelings, reaching out to others, experimenting with different methods of problem solving, and practicing new behaviours. They identified two key outcomes for participants: improved social functioning and enhanced sense of control.

Koppleman (1984) described a group therapeutic puppetry intervention with a "chronic schizophrenic socially withdrawn population" (p.283) attending a community support centre. Again, no formal outcome measures were used and no information was provided regarding the size or nature of the group. Suggested therapeutic mechanisms include: increased opportunities for creative self-expression, experimentation with new behaviours, and participating in a supportive group. Koppleman (1984) also suggested outcomes such as improved social functioning, increased personality integration, increased social judgement, and enhanced sense of control.

Gerity (1999) described five individual case studies of group therapeutic puppetry with adults with SMI attending a mental health day centre. The group was open to new members and not time-limited. No formal outcome measures were used. Gerity (1999) noted three key outcomes for participants: decreased personality fragmentation, decreased frequency of dissociation, and development of an embodied sense of self.

Summary of the Evidence for Therapeutic Puppetry

Although possible benefits of therapeutic puppetry include reductions in anxiety, improved social functioning, increased sense of control, increased personality cohesion, and enhanced body self,

there is a lack of empirical investigation of therapeutic puppetry for adults with SMI, with few studies resulting in peer-reviewed publications.

Summary

This review has demonstrated that CATs are congruent with personal models of recovery from SMI. Furthermore, that there is a growing evidence base for the beneficial outcomes of participation in CATs for adults with mental health problems. These benefits have resulted in a number of UK government publications recommending the use of CATs specifically, and arts and health based interventions generally, in mental and physical health care. There has, however, been a lack of action to achieve this.

Focusing on therapeutic puppetry as a particular form of CAT, several theoretical frameworks were reviewed and critiqued, concluding that underlying frameworks were tentative and had not been subject to empirical investigation. A review of the evidence for therapeutic puppetry concluded that there was a lack of empirical investigation with a heavy reliance on case study evidence. There were also no service user accounts of the experience and acceptability of therapeutic puppetry. This suggests a need for well conducted, controlled trials of therapeutic puppetry which utilise standardised outcome measures and have sufficiently long follow up periods. Such studies would ideally include both quantitative and qualitative methodologies to allow participants to voice their experiences of therapeutic puppetry and how it may have contributed to their personal recovery from SMI.

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Section B: Powerful Puppets, Powerful People: A Multiple Single Case Design Study of the Effectiveness of Group Therapeutic Puppetry with People with Severe Mental Illness

Word Count: 7977

Abstract

Background

Therapeutic puppetry is the use of puppets to aid emotional healing (Bernier, 2005). There is no published research investigating the effectiveness of therapeutic puppetry with people with severe mental illness (SMI).

Aims

A pilot investigation of group therapeutic puppetry with people with SMI tested the hypotheses that this intervention results in improvements in mental wellbeing, self-esteem, and body connection. It also investigated mechanisms of change, and service user acceptability and experience.

Method

This mixed methodology study utilised five single AB design case studies with time series data analysed using simulation modelling analysis (Borckardt et al., 2008). Qualitative data was collected via participant observation and participant interviews and analysed using thematic analysis (Braun & Clark, 2006).

Results

Three participants experienced statistically and clinically significant changes in either positive or negative directions during the intervention, with all participants describing therapeutic puppetry as powerful and beneficial.

Conclusions

Therapeutic puppetry is a potentially powerful medium which could be utilised by various mental health professionals. Service users find therapeutic puppetry acceptable and beneficial despite it being an occasionally difficult and intense experience.

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AN INITIAL INVESTIGATION INTO THE EFFECTIVENESS OF GROUP THERAPEUTIC PUPPETRY

Introduction

Attention is increasingly turning to the role of the arts and creativity in the promotion of health and wellbeing. A recent British Medical Association (2011) report concluded that patients in healthcare settings should have the opportunity to participate in creative therapies such as art, story-telling, music, theatre, and drama, to enhance their psychological wellbeing. These conclusions are based on a quite substantial evidence base which suggests that arts participation results in beneficial health outcomes, such as reductions in severity of perceived physical pain and improvements in mental health and empowerment (Department of Health, 2007). Wider effects on social determinants of health via improvements in social capital and inclusion have also been found (Cayton, 2007).

Despite this growing evidence base, there has been a lack of government action (Clift et al., 2009) and dedicated funding for arts-based interventions in the National Health Service (NHS). Considering mental health specifically, a recent survey examining the provision and practice of art therapy for people with schizophrenia found limited access within the NHS (Patterson, Debate, Anju, Waller, & Crawford, 2011). This is despite National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia recommending art therapy during the acute phase of schizophrenia and for promoting long term recovery (Department of Health, 2009). Access to arts and health interventions for this population may be particularly important due to the double disadvantage of having a mental health diagnosis and the stigma, discrimination and socially exclusion that can result (Repper & Perkins, 2003). The arts can also provide a psychotherapeutic means of working through underlying difficulties within an overarching recovery framework, fostering hope, creating a sense of meaning and purpose, facilitating new coping strategies, and rebuilding identities (Spandler, Secker, Kent, Hacking, & Shenton, 2007).

One form of arts intervention that has been suggested as beneficial for adults with SMI is therapeutic puppetry (Gerity, 1999; Koppleman, 1984; Schuman, Marcus, & Nesse, 1973). Therapeutic

puppetry is the use of puppets to aid physical or emotional healing and can include puppet making, puppet play, interaction between puppet characters and observation of, and reflection on, puppet shows (Bernier, 2005). Combining verbal and nonverbal modes of expression (Bernier, 2005), it may be particularly relevant for people with SMI who may have experienced early childhood trauma, often at a preverbal stage (Bebbington et al., 2004; Bushnell, Wells, & Oakley-Browne, 1992; Janssen et al., 2004; Mullen, Martin, Anderson, Romans, & Herbison, 1993), and who may therefore struggle to use verbal forms of therapy (Gerity, 1999).

Therapeutic puppetry can be used with individuals or groups as a psychotherapeutic intervention in and of itself (Vizzini, 2003) or as a therapeutic medium within diverse therapies such as cognitive behavioural therapy for social anxiety (Melfsen et al., 2011), narrative therapy (Butler, Guterman, & Rudes, 2009) and psychodynamic psychotherapy for adults survivors of childhood abuse (Gerity, 1999). Practitioners of therapeutic puppetry are similarly heterogeneous, coming from a range of professional backgrounds including art and dramatherapy but also clinical psychology, psychiatry, social work and occupational therapy.

Several theoretical frameworks have been used to conceptualise therapeutic puppetry, but these are hypothetical constructions with little empirical validation. The psychodynamic object relations model suggests that puppets constructed or selected by patients are representations of parts of the self. This allows patients to re-create their internal object relations in 'live' form and resolve 'splits' leading to a more coherent sense of self (Gerity, 1999). Projective and distancing techniques are core to this process (Aronoff, 2005). As Aronoff (2005) states “Puppets project: what is expressed can be denied and blamed on the puppet, so that inner emotional worlds are revealed in non-threatening ways.” (p. 118).

Attachment theory posits that therapeutic puppetry may allow patients to achieve ‘autobiographical competence’ (Holmes, 1993) via the creation of stories that are metaphorical representations of their primary attachment relationships and lived experiences (Gerity, 1999). Similarly,

narrative therapy (White & Epstein, 1990) suggests that therapeutic puppetry may allow participants to create 'thick' stories which embody experiential knowledge and meaning and incorporate lost aspects of the self, thereby challenging the 'thin' stories that can result from the stigma associated with mental ill-health. This may also assist in the creation of meaningful narratives about experienced loss and suffering, which can sometimes underlie mental health difficulties (Gerity, 1999).

Therapeutic puppetry can also be conceptualised as a form of adult play therapy with numerous benefits including: stress relief (Colarusso, 1993), mastery of traumas by turning the passive into the active (Ostow, 1987), increasing positive coping strategies (Solnit, 1987), expanding role repertoires and allowing experimentation with thoughts, feelings and behaviour without consequence, encouraging flexibility and expanding perspectives (Blatner & Blatner, 1997).

Where therapeutic puppetry includes the creation of puppets, it can also help to heal the body self (Krueger, 2002). The body self is the group of experiences and intellectual mechanisms that are used to regulate and conceive of the entire self-experience as expressed bodily through sensory-motor experiences, mentally as an internal body image, and emotionally as a container for affect (Krueger, 1988). This may be especially relevant for people with SMI who have often experienced early childhood sexual and physical abuse, resulting in interrupted development of the body self. The physical act of crafting puppets may create an increasing sense of cohesion and safety within the body, reducing self-destructive acts, and allowing re-connection with body experience and development of a unified body-psychological self (Krueger, 2002).

In contrast to the extensive conceptual literature, there are few empirical investigations of the effectiveness of therapeutic puppetry with adults with SMI. In an unpublished doctoral thesis, Vizzini (2003) evaluated the contribution of three puppet therapy sessions compared to three sessions of regular therapy in a twelve-step inpatient chemical dependency facility. Results included significant decreases in anxiety and higher service user satisfaction in the puppet group. The remaining studies of

therapeutic puppetry constitute descriptive case study evidence which can provide rich descriptions of interventions but little formal evidence of effectiveness (Greenhalgh, 2006). Schuman, Marcus and Nesse (1973) described a group therapeutic puppetry intervention with psychiatric inpatients and concluded that participants benefitted through improved social functioning and enhanced sense of control. Similarly, Koppleman (1984) described a group therapeutic puppetry intervention with community psychiatric patients and found improved social functioning, increased personality integration, increased social judgement, and enhanced sense of control. Finally, Gerity (1999) described group therapeutic puppetry with adults with SMI in the community and noted three key outcomes for participants: decreased personality fragmentation, decreased frequency of dissociation, and development of an embodied sense of self.

The existing evidence suggests a number of potential benefits of therapeutic puppetry for adults with SMI. However, these benefits have not been rigorously researched, making it difficult for practitioners to argue for the implementation of therapeutic puppetry with mental health settings. It would be beneficial, therefore, to evidence-base the effectiveness of therapeutic puppetry via well conducted, controlled trials that utilise standardised outcome measures and have sufficiently long follow up periods. Such studies would also ideally include both quantitative and qualitative methodologies to allow participants to voice their experiences of therapeutic puppetry and how it may have contributed to their recovery from mental illness.

The Present Study

The present study sought to evaluate the effectiveness of group therapeutic puppetry with adults with SMI attending a secondary care psychological therapies service. Due to the paucity of existing evidence, the feasibility of conducting effectiveness studies in this area needs to be established initially through a pilot study. A mixed methodology approach was adopted to allow for the evaluation of effectiveness and to assess the service user acceptability and experience of therapeutic puppetry.

This study used a mixed method multiple single case AB design (Yin, 2009), allowing for intra-case comparison with each participant acting as their own control (Robson, 2000). A range of standardised outcome measures, as well as qualitative methods, were chosen in an attempt to capture the diverse possible outcomes and processes of change suggested by the conceptual literature on therapeutic puppetry.

The study tested the following hypotheses regarding group therapeutic puppetry: (1) reduces symptom distress, (2) improves interpersonal relating, (3) improves social role functioning, (4) improves self-esteem and, (5) increases body connection. In addition, it sought to answer the following questions:

1. What changes do service users experience during group therapeutic puppetry?
2. What are the possible mechanisms of change when using puppets for therapeutic purposes?
3. What is the acceptability and service user experience of therapeutic puppetry?

Method

Participants

Four women and one man participated in the study with a mean age of 41 (SD= 4.66, range= 34-46). All participants described their ethnicity as white British and were living alone at the time of the study. Participants had received a range of psychiatric diagnoses, including depression with psychotic symptoms, bipolar disorder, and post traumatic stress disorder (PTSD); all participants were considered appropriate to receive support from secondary care mental health services. This is reflected in the group mean pre-intervention Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) (Evans et al, 2000) score of 62 (SD=28.48, range = 29 to 89) representative of moderately severe difficulties. All of the participants were taking long-term psychiatric medication.

Participants attended a mean of ten (SD = 1.92, range = 7-12) sessions of the intervention. One participant (P2) left the study prematurely after seven sessions due to physical ill health. This resulted in part of the intervention and all of the follow-up data being unavailable for statistical analysis.

Design

This mixed methods study utilised both quantitative and qualitative approaches. The overarching design comprises five AB design single case studies with each participant acting as their own control (Yin, 2009). Each single case study consisted of simple time series data (Morley, 2007) with quantitative measures administered at twenty separate time points. The baseline phase consisted of four time points, the intervention phase of twelve time points, and the follow-up phase of four time points.

All time series data were analysed using simulation modelling analysis (SMA) (Borckardt et al., 2008) as this method has more statistical power for short data streams than conventional time series analyses such as ITSACORR (Crosbie, 1993). Autocorrelation values for each overall data set were used as recommended by Borckhardt et al (2008) to reduce type 1 error. Bonferroni corrections were performed to control for multiple tests (baseline v intervention, intervention v follow-up, baseline v follow-up) on the same dataset resulting in a significance level of α=0.017.

Where suitable population norms and clinical cut offs were available, data were also tested for clinically significant and reliable change (Jacobson & Truax, 1991). This was achieved using mean baseline and follow-up scores for each participant and examining them for movement from a clinical to non-clinical population, and determining whether this change was reliable based on the magnitude of change.

Qualitative methods included: a research diary maintained by the author who acted as a participant-observer throughout the intervention, film and photographic data documenting puppet making and performance, and post-intervention interviews with participants.

Participant observation is inherently subjective, utilising the experience, thoughts and feelings of the research as a source of data, and recognising the inherent attention and memory biases. Validity of the analysis was achieved by including a clear audit trail of the research process, and triangulation of the research diary with interviews with participants (Dallos, 2006). The interviews were of a standardised open-ended type (Patton, 1987) to minimise variation in the questions asked to participants whilst providing sufficient flexibility for the exploration of participant experiences.

The research diary and participant interviews were analysed using thematic analysis (Boyatzis, 1998), with the author of the research diary considered as a participant in addition to the recruited participants. Thematic analysis was chosen because it allows for the exploration of both participant experiences and processes of change. A critical realist epistemological position underlay the analysis as it acknowledges that whilst individuals construct social realities through language; these constructions are shaped by possibilities inherent to the material world (Willig, 1999). Consequently, an inductive, semantic approach was adopted to allow themes to be identified from participants' responses (Braun & Clarke, 2006). The analysis was conducted in six stages as outlined by Braun and Clark (2006): familiarisation with data through repeated reading, generation of initial codes, collation of codes into unified themes, review of identified themes including creation of a thematic 'map', definition and labelling of emergent themes, and finally, report production. Participant interview transcripts were double-coded by the author and dramatherapist who delivered the intervention to increase trustworthiness of the analysis.

Standardised Measures

Standardised measures included three questionnaires, the Outcome Questionnaire (OQ) (Lambert et al., 1996), the Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965), and the Scale of Body Connection (SBC) (Price & Thompson, 2007). In addition, the CORE-OM (Evans et al., 2000) was used pre- and post-intervention (Appendix 7). Measures were chosen based on their psychometric properties

for people with SMI and the need to minimise participant burden during completion. However, only the OQ has been specifically designed for use on a weekly basis to measure therapeutic progress across sessions of psychotherapy.

The OQ (Lambert et al., 1996) is a brief 45-item self-report measure designed for repeated measurement of client progress throughout and following termination of therapy. A total score is generated as well as three sub-scale scores for symptom distress, interpersonal relationships, and social role functioning. It utilises a five-point Likert scale and contains some reverse score items. The questionnaire is scored by summing all items to produce a total score as well as summing the items contained in each sub-scale. Total scores are then divided by the number of items within each scale/sub-scale. Higher scores are indicative of greater distress and/or disability. Clinical cut offs and reliable change indices are available for each sub-scale and the overall total (Table 2), making the determination of clinically significant and reliable change possible. A highly reliable measure with good concurrent and construct validity, it discriminates between patients and non-patients as well as within patient samples with varying levels of severity (Umphress, Lambert, Smart, Barlow, & Clouse, 1997). It has also shown excellent sensitivity to change in studies of outpatient psychotherapy (Vermeersch et al., 2004).

Table 2
Clinical cut offs and reliable change indices for the Outcome Questionnaire

OQ Scale/ Sub-Scale	Clinical cut off	Reliable Change
Symptom Distress	36	≥10
Interpersonal Relationships	15	≥8
Social Role	12	≥7
Total Score	63	≥14

The RSE (Rosenberg, 1965) is a 10-item self-report measure of global self-esteem. Items are scored using a four-point Likert scale with some reverse scoring. Total score is the sum of individual item scores with higher scores indicating greater self-esteem. The scale demonstrates good reliability and concurrent, predictive and construct validity (Rosenberg, 1979). It has also shown good test-retest

reliability and internal validity when used with people with SMI (Torrey, Mueser, McHugo, & Drake, 2000).

The SBC (Price & Thompson, 2007) is a 20-item self-report questionnaire with two sub-scales: body awareness (BA) and body dissociation (BD). It utilises a five point Likert scale with some reverse score items. The two sub-scales are uncorrelated. A positive change on the BA scale represents an increase in bodily awareness and therefore positive change, whilst a negative change on the BD scale represents a decrease in bodily dissociation and therefore a positive change. The scale has good construct validity and reliability (Price & Thompson, 2007), and has been used with adult female survivors of childhood sexual abuse (Price, 2007).

The CORE-OM (Evans et al, 2000) is a 34-item self-report measure which assesses subjective well-being, symptoms, functioning, and risk. It utilises a five-point Likert scale with some reverse scoring of items. The questionnaire produces a range of scores but of relevance to the current study is the total score or sum of all items and the clinical score which is the mean item score multiplied by ten. Higher scores are representative of greater distress and/or difficulty. The clinical cut off is a total score of ten with scores above ten indicating clinical levels of difficulty. A change of five or more in the clinical score indicates reliable change. It has demonstrated good reliability and validity with people attending secondary care psychological therapy services (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005).

Where individual items were not scored due to participant error, a mean value for that scale/ sub-scale was calculated based on the other marked items and substituted for the missing value.

Qualitative Methods

Qualitative methods included the research diary (Appendix 9), maintained by the author, and participant post-intervention interviews which utilised an interview schedule designed specifically for this study (Appendix 8). The schedule was designed based on the research questions and study hypotheses.

Procedure

The study received ethical approval from a local NHS ethics committee (Appendix 2) and R & D approval from the host trust (appendix 3). Participants were recruited from a secondary care psychological therapies service. Participants were invited to an assessment with the group facilitator where their suitability for the group and interest in therapeutic puppetry could be determined. At assessment the author explained the study and provided a study information sheet and consent form (Appendix 4).

After consent was received, data were collected at twenty time points for the three main questionnaires – the OQ, RSE and SBC (Appendix 7). Baseline and follow up data were collected via questionnaire sessions, where participants completed the self-report measurements in a group with the facilitator and author present. Intervention phase data were collected prior to intervention sessions. In addition, the CORE-OM was administered pre- and post-intervention.

The author maintained a research diary (Appendix 9) of group observations and reflections throughout the intervention, and also documented puppet making and performance using film and photography (Appendix 14). Separate consent was collected for audio and video recording (Appendix 5). The video performance did not film the individual participant, only their puppet, so as to protect participant anonymity and confidentiality. At the penultimate questionnaire session, participants were invited to participate in an interview about their experience of therapeutic puppetry. Interviews were conducted by an independent interviewer to avoid researcher bias and were transcribed by a professional transcription service (Appendix 6).

The puppet group was facilitated by a qualified dramatherapist with extensive experience of delivering psychotherapeutic interventions to people with SMI. The group met weekly over a period of twelve weeks for ninety minutes. Each group session started with a ‘check-in’ exercise where participants could share their feelings and experiences of the past week. In the first session a group

agreement was developed which included principles of confidentiality, respect, and the maxim that 'everything is an invitation' and therefore not compulsory. The majority of the remaining sessions were then used for hand puppet construction. Clay was available for the sculpting of puppet heads along with a variety of underglazes and materials for decoration. Puppet bodies were made out of fabric and could be decorated with a variety of materials including buttons, sequins, and jewellery. Participants were given a brief demonstration of making procedures but were then free to create. The final two group sessions were used for puppet performance. This included a dramatherapy exercise – 'five questions' - where group members were interviewed as their puppets, and a final short performance to video which was developed and performed by the individual group member. Each session ended with a 'candle ceremony' where group members were invited to focus on their breathing, reflect on the session, and provide a final comment if they wished to. The sessions therefore provided the opportunity to engage in artistic creativity, drama and self-expression, and facilitated group support and social interaction.

Following termination of the study, participants were invited to join a group dramatherapy intervention.

Results

Complete data sets were available for four of the five participants, with the remaining participant completing eleven data collection points.

Quantitative Measures

SMA analysis was conducted for each participant using three separate phase comparisons – baseline v intervention, intervention v follow-up and baseline v follow-up. Mean change between phases was also calculated. For the OQ, clinically significant and reliable change was calculated using reliable change indices. Mean differences between phases and SMA analyses are presented by questionnaire in Tables 3-5, with statistically significant results indicated with an asterisk and clinically reliable results indicated with a double asterisk. All significant results are also highlighted in bold.

In addition, CORE-OM data are examined for clinically significant and reliable change only. Table 6 displays mean changes in CORE score pre- and post-intervention with clinically reliable changes indicated in bold. Insufficient data were available for calculation of statistically significant change.

Outcome questionnaire.

After controlling for autocorrelation present across time points, only two of the five participants experienced statistically significant changes on the OQ. Participant five experienced significant changes from baseline to follow-up in symptom distress (r=-0.96, p= 0.001), social role (r=-0.92, p=0.006) and total score (r=-0.96, p=0.001). The magnitude of change in both symptom distress (-17.5) and total score (-26.5) was sufficient to be considered a clinically reliable change, although participant five did not move from a clinical score to a non-clinical one. These results indicate that participant five experienced clinically and statistically significant improvements in their overall wellbeing as measured by the OQ during the course of the intervention (Figure 1).

Participant three experienced a negative and statistically significant change on the interpersonal relationships sub-scale from baseline to intervention (r=+0.81, p=0.002) and baseline to follow-up (r=+0.88, p=0.01), but neither was sufficient to be considered a clinically significant and reliable change. Participant three also experienced a clinically reliable increase in their total score (+15.75), but this did not reach statistical significance (r=+0.84, p=0.02). This indicates that participant three experienced a clinically reliable decline in their overall wellbeing as measured by the OQ over the course of the intervention (Figure 1).

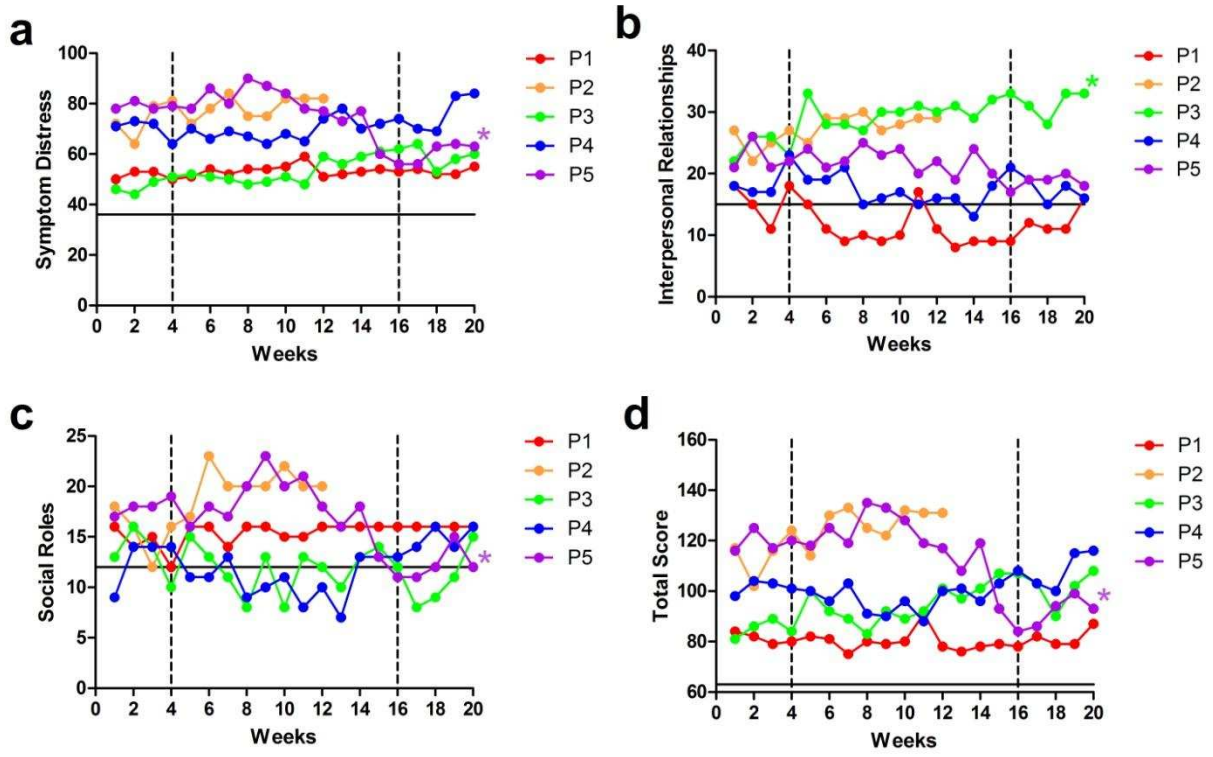

Figure 1: Outcome Questionnaire results. *a,* symptom distress, *b,* interpersonal relationships, *c,* social roles, and d, total score. In all plots, solid line indicates clinical cut off and dashed lines data collection phase. Statistically significant results are indicated with an asterisk.

Rosenberg self esteem scale.

After controlling for autocorrelation present across time points, no participants experienced a statistically or clinically significant change in levels of self esteem (Figure 2).

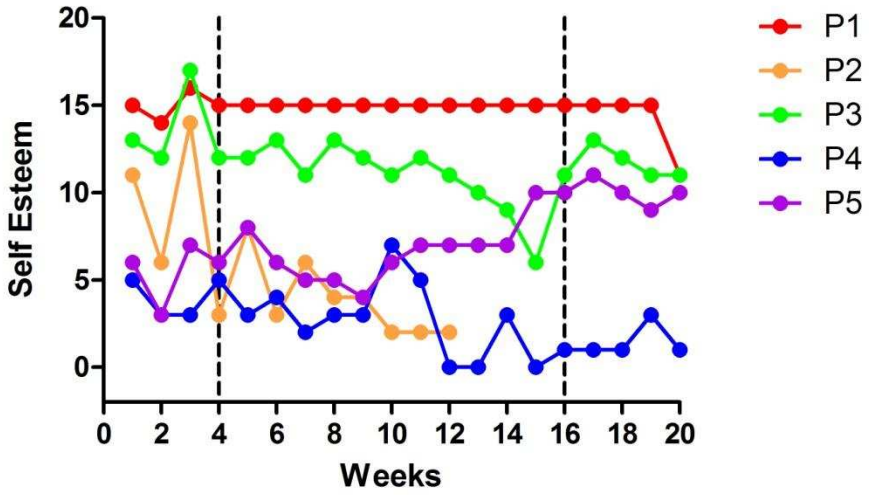

Figure 2: Rosenberg Self Esteem Scale results. Dashed lines indicate data collection phase.

Scale of body connection.

After controlling for autocorrelation present across time points, only one participant, number five, experienced a statistically significant change from baseline to follow up in body dissociation (r=-0.93, p=0.006). It was not possible to determine whether this change was clinically significant due to lack of population norms. This indicates that participant five experienced a statistically significant decrease in body dissociation during the course of the intervention (Figure 3).

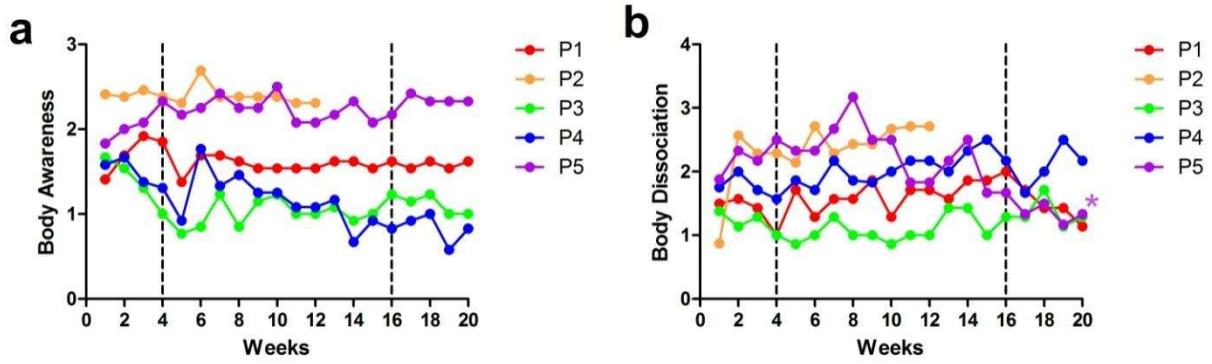

Figure 3: Scale of Body Connection results. *a,* body awareness, *b,* body dissociation. In both plots, dashed line indicates data collection phase. Statistically significant results are indicated with an asterisk.

Clinical outcomes in routine evaluation.

Only two participants experienced clinically reliable changes on the CORE-OM. Participant five experienced a clinically reliable change in their CORE clinical score from pre to post intervention (-6.2) and moved from a severe to moderate-to-severe classification as a result. Participant one also experienced also a clinically reliable change (+10.3) pre to post intervention, indicating movement from low level to moderate difficulties. This suggests that participant one's mental wellbeing as measured by the CORE-OM declined during the course of the intervention. No participants moved into a non clinical classification during the intervention (Figure 4).

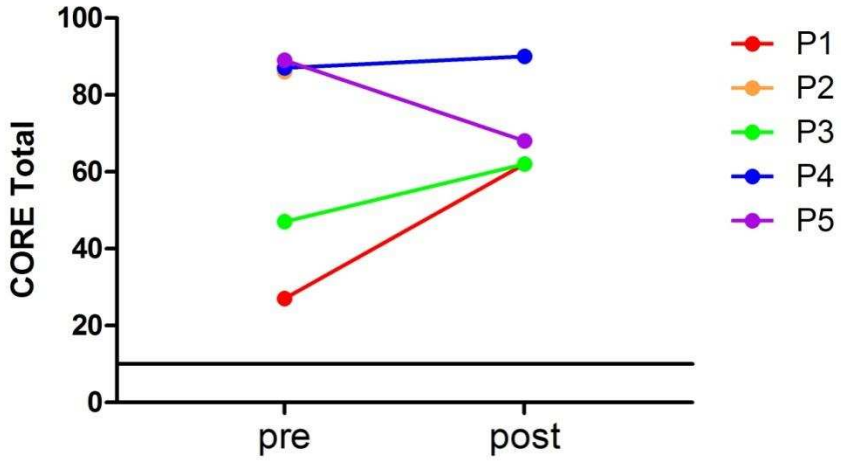

Figure 4: CORE-OM results pre and post intervention. Solid line indicates clinical cut off.

Table 3

Mean difference and SMA analysis of Outcome Questionnaire Results

Participant	**1**			**2**			**3**			**4**			**5**		
	Diff	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***
Symptom Distress															
Baseline v Intervention	+2	+0.41	0.15	+4.75	+0.40	0.26	+6.33	+0.52	0.23	-0.25	-0.03	0.93	-1.83	-0.09	0.83
Intervention v Follow Up	-0.25	-0.06	0.81	N/A	N/A	N/A	+4.92	+0.41	0.39	+6.75	+0.51	0.17	-15.67	-0.62	0.24
Baseline v Follow Up	+1.75	+0.53	0.08	N/A	N/A	N/A	+11.25	+0.86	0.03	+6.5	+0.51	0.37	**-17.5 ****	**-0.96**	**0.001***
Interpersonal Relationships															
Baseline v Intervention	-4.92	-0.62	0.04	+3	+0.64	0.09	**+5.92**	**+0.81**	**0.002***	-1.58	-0.27	0.41	-2.75	-0.14	0.58
Intervention v Follow Up	+1.92	+0.31	0.27	N/A	N/A	N/A	+1.08	+0.24	0.44	-0.17	-0.03	0.92	-0.75	-0.51	0.11
Baseline v Follow Up	-3	-0.51	0.14	N/A	N/A	N/A	**+7**	**+0.88**	**0.01***	-1.75	-0.75	0.06	-3.5	-0.75	0.06
Social Role															
Baseline v Intervention	+1.42	+0.56	0.03	+4.75	+0.77	0.05	-1.42	-0.28	0.27	-2	-0.40	0.20	-0.42	-0.06	0.89
Intervention v Follow Up	+0.33	+0.26	0.32	N/A	N/A	N/A	-1.08	-0.20	0.47	+4.25	+0.72	0.03	-5.08	-0.61	0.21
Baseline v Follow Up	+1.75	+0.64	0.07	N/A	N/A	N/A	-2.5	-0.46	0.47	+2.25	+0.56	0.17	**-5.5**	**-0.92**	**0.006***
Total Score															
Baseline v Intervention	-1.5	-0.18	0.49	+12.5	+0.66	0.10	+10.83	+0.59	0.10	-3.83	-0.31	0.35	-3	-0.10	0.81
Intervention v Follow Up	+2	+0.23	0.36	N/A	N/A	N/A	+4.92	+0.30	0.52	+10.83	+0.61	0.09	-23.5	-0.62	0.22
Baseline v Follow Up	+0.5	+0.09	0.81	N/A	N/A	N/A	**+15.75 ****	**+0.84**	**0.02**	+7	+0.55	0.28	**-26.5 ****	**-0.96**	**0.001***

Table 4

Mean difference and SMA analysis of Rosenberg Self Esteem Questionnaire Results

Participant	**1**			**2**			**3**			**4**			**5**		
	Diff	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***
Baseline v Intervention	0	0.00	1.00	-4.6	-0.59	0.047	-2.58	-0.51	0.13	-1.42	-0.31	0.35	+1.33	+0.32	0.40
Intervention v Follow Up	-1	-0.45	0.07	N/A	N/A	N/A	+0.83	+0.21	0.60	-1.08	-0.25	0.47	+3.17	+0.66	0.18
Baseline v Follow Up	-1	-0.35	0.35	N/A	N/A	N/A	-1.75	-0.49	0.17	-2.5	-0.80	0.02	+4.5	+0.89	0.02

Table 5

Mean difference and SMA Analysis of Scale of Body Connection Questionnaire Results

Participant	**1**			**2**			**3**			**4**			**5**		
	Diff	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***	**Diff**	**r**	***p***
Body Awareness															
Baseline v Intervention	-0.14	-0.45	0.11	-0.02	-0.07	0.80	-0.35	-0.64	0.05	-0.32	-0.47	0.15	+0.15	+0.35	0.27
Intervention v Follow Up	0	+0.01	0.97	N/A	N/A	N/A	+0.07	+0.21	0.44	-0.34	-0.48	0.19	+0.15	+0.40	0.18
Baseline v Follow Up	-0.14	-0.44	0.38	N/A	N/A	N/A	-0.28	-0.60	0.30	-0.66	-0.91	0.02	+0.3	+0.75	0.17
Body Dissociation															
Baseline v Intervention	+0.3	+0.5	0.06	+0.5	+0.49	0.09	-0.08	-0.18	0.60	+0.29	+0.53	0.15	+0.07	+0.08	0.83
Intervention v Follow Up	-0.25	-0.45	0.13	N/A	N/A	N/A	+0.24	+0.45	0.16	+0.04	+0.06	0.86	-0.96	-0.75	0.06
Baseline v Follow Up	+0.05	+0.12	0.71	N/A	N/A	N/A	+0.16	+0.39	0.24	+0.33	+0.57	0.32	**-0.89**	**-0.93**	**0.006***

Table 6

Mean difference in CORE-OM scores pre and post intervention

	1			2			3			4			5		
	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change	Pre	Post	Change
Total score	29 *Low level*	62 *Moderate*	+35	86 *Severe*	N/A	N/A	47 *Mild*	62 *Moderate*	+15	87 *Severe*	90 *Severe*	+3	89 *Severe*	68 *Moderate to severe*	-21
Clinical score	**7.9**	**18.2**	**+10.3**	25.3	N/A	N/A	13.8	18.2	+4.4	25.6	26.5	+0.9	**26.2**	**20**	**-6.2**

Qualitative Findings

Three of the five participants (P1, P4 and P5) participated in face-to-face interviews with an independent researcher. One participant (P3) could not participate due to caring commitments and provided written feedback.

Thematic analysis aimed to identify themes evident in both participant interviews and the research diary, as there was considerable variation between participant experiences. Consequently it was not possible to determine saliency of themes based on frequency. Participants' feedback on analysis was not sought due to study constraints and ethical considerations.

Following data coding and theme review (Braun & Clark, 2006), a final thematic map of the data was produced (Figure 5). One overarching theme was identified with three sub-themes; these are presented below with illustrative quotes from participant interviews and the research diary. All participants were assigned pseudonyms to protect their identity, whilst the group facilitator retains her name – Katie.

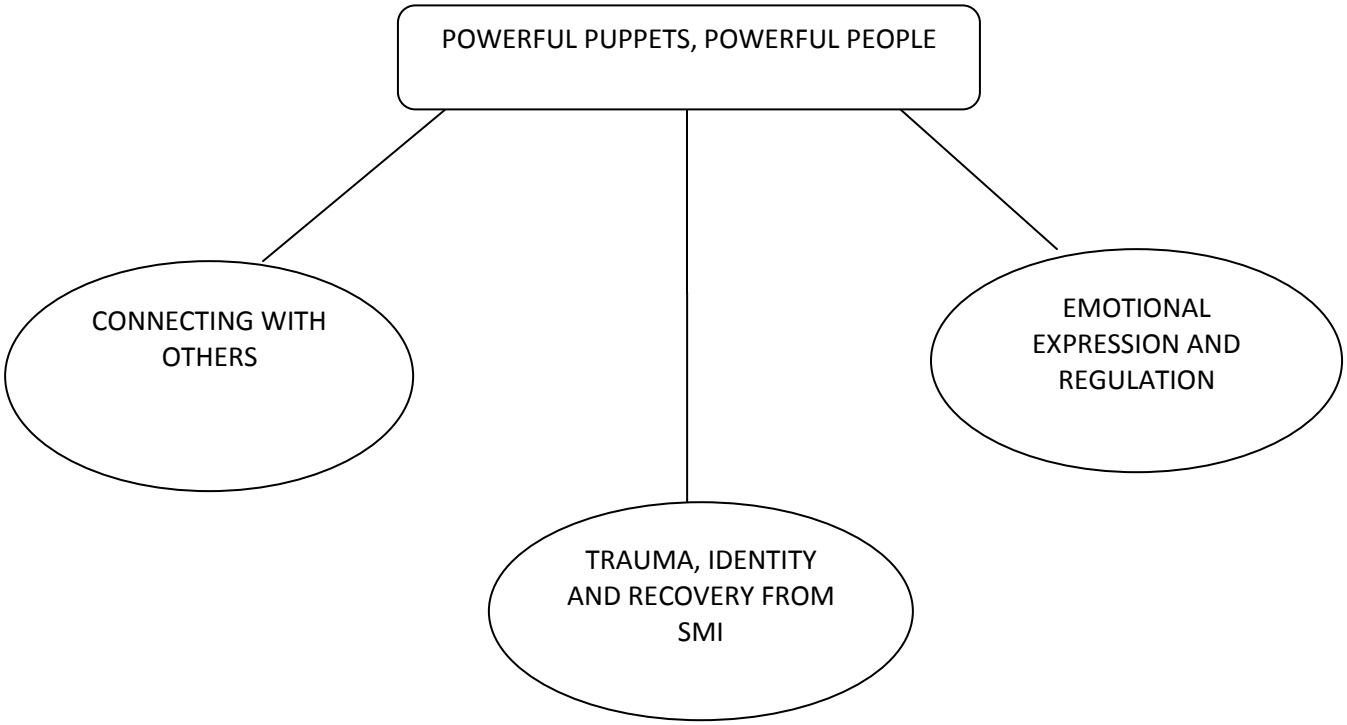

Figure 5: Thematic map of qualitative data. Figure illustrates results of thematic analysis of post-intervention participant interviews and participant-observation research diary.

Powerful puppets, powerful people.

Participants used a range of descriptors for their experiences of group therapeutic puppetry including “powerful”, “traumatic” (P4), “interesting”, weird and bizarre” (P1), “good” (P5), and “positive” (P3). The powerful puppets, powerful people overarching theme highlights how processes of change associated with therapeutic puppetry interact and overlap with generic group therapeutic processes such as installation of hope, development of socialising techniques and imitative behaviour (Yalom and Leszcz, 2005).

***Connecting with others*.**

Participants described the importance of connecting with other people who had experienced similar difficulties, resulting in a sense of normalisation and validation: “Whatever you said you just had people there who totally knew where you was coming from.” (P1); “It’s been good getting to know the other people in the group.” (P2); “...being around other people and hearing their experiences...makes you feel a bit less on your own” (P5). One participant also described the importance of the group being mixed gender: “because I’ve had big problems being around men especially and I think it’s helped coming to the group because it’s a mixed group and it’s sort of helped me to realise that not all men are that bad.” (P5). The research diary also noted how supportive the group was, with a real sense of camaraderie and care and concern for its members: “Julia...described experiencing flashbacks this week and finding it very distressing. This led to a lovely moment where Helen and David both said that she could come to their houses for a cup of tea when she is distressed.” (RD, p.7).

This strong group bond allowed participants to be themselves in a non-judgemental environment, resulting in self-acceptance, increased confidence and a sense of belonging: “It’s unusual to experience it especially with people who are experienced in the same things as you on a day to day basis it’s quite nice to be able to be like that, and them not judge you...I’m feeling a bit more happier I would say. Yeah, within myself yeah.” (P1).

Group formation was partly facilitated by the shared experience of making and using puppets: "Just all doing it [puppetry]...I don't know why but we were just able to talk, and I think it's very hard to do that with people you don't know straight off." (P1). This allowed participants to pursue their individual therapeutic journey with the puppets whilst participating in a beneficial group experience: "It was quite fun doing it. Just sort of being able to make something and seeing other people make theirs." (P5).

***Trauma, identity and recovery from SMI*.**

Participants described consciously and unconsciously using puppets to represent themselves or significant others: "You can make them who you need them to be...You know, the second one I knew it was going to be me. I decided it before I made her... it meant that she could say stuff that I can't say" (P4); "... different ideas came into my head as we were doing it[making puppets]. But right in the beginning I didn't know, I just hadn't got a clue (P5). One participant described how the spontaneous unconscious process of making and using puppets decreased their avoidance of issues and conflicts resulting in more effective therapeutic work:

> I mean I've done quite a lot of 1:1 talking therapy which I'm not very good at because I don't actually talk a lot but I found it a lot different to that and the puppetry stirred up a lot more for me because once it started to come out you couldn't stop it. Whereas in talking you can...You know you can look out the window, "Oh weather's nice" or just change the subject if you don't want to go too deep. Whereas with this you couldn't. So you would work, in my opinion, again you would work through whatever issue it is without trying as such. You wouldn't be able to stop it. (P4)

Puppet representations were used by the group in two ways. Firstly, one participant used the puppets to re-work past conflicts and traumas: "And I just did this little sort of rendition where I put the

nasty puppet on one hand, the nice one on the other. And the nice one just said something along the lines of, 'This stops today. You know you've had your power and I'm not letting you do this anymore'" (P4). Secondly, three participants used the puppets to negotiate identity and develop self knowledge: "... it was something I wanted to be that I was putting into the puppet." (P5). Core to this work was reflection, with the group thinking together about the meaning of the experience for the individual and the group:

> Katie invited the group to reflect on the exercise. Helen said that she thought Tina had been very brave and that she was glad that she had done the exercise because it was clear that that was what she needed to do. She said that she could identify with the feeling of being completely controlled by the abuser. Julia said that Tina was very brave but that it had been difficult for to listen to as it was 'almost too close for comfort'. (RD, p.17)

The opportunity to re-work traumatic experiences seemed especially salient for this group, all of whom had experienced past abuse. Three of the group members described how past disclosures had been dismissed resulting in abuse continuing and little support. In contrast, the group offered validation, empathy and support when disclosures of abuse were made. The group also acted as witnesses to one participant's attempts to gain mastery over past traumatic experiences. Whilst participants appeared to benefit from gaining social recognition for and mastery over, past traumas, it was a difficult experience which left one participant feeling that their mental health had declined. However, this participant also thought that this was part of therapeutic progress: "I think I got worse in a lot of ways... but on the flipside I think it's a very, very good thing to do...to kind of work through it and resolve issues." (P4).

Three of the five participants used puppets as a means of negotiating identities and developing self-knowledge. Identity struggles seemed to result from both past traumas and the ongoing difficulties associated with SMI. Puppetry allowed participants to 'play' with their identities in a safe environment,

discovering new abilities or recovering ones lost due to SMI: "...using the puppet it's made me think a bit more about maybe some of the things that I can do that I didn't think I could do." (P5).

Three participants created puppets that were strong, confident and able to resist the negative judgements of others. One example of this is the puppet created by Julia (P5) called 'Gutsy'. In the following extract from the research diary, Julia uses the 'five questions' exercise to ask Gutsy how she can help her:

> Why have you got purple hair? Because I don't care if people look at me or what people think of me...Would you have been someone to look after Julia when she needed it? Yes. She needed someone gutsy to look after her. Is it possible for Julia to be gutsy? (Considerable delay before Julia responds in a quiet voice) Yes...Following the exercise, Katie reflected to Julia how interesting it was that she had made a puppet that could wear what she liked and didn't care about others. Katie related this to Julia's earlier comment about having to wear long sleeved clothes to hide her scars. (RD, p24-25)

Resisting the judgements of others was a strong theme within the group which seemed to connect with questions about whether, and to what degree, people could recover from SMI. One participant described how they lost a valued social role as a result of SMI: "David said that he felt that he used to be a gentleman and feel passionate about caring for others, but couldn't ever do that again. Katie asked him why not and he seemed shocked by the idea of working in health and social care again." (RD, p.9). Questions about recovery were linked with group discussions about the role of medication and services in assisting recovery: "She [Julia] also described her frustration at frequent missed appointments by her key worker, whom she still had yet to meet. This led to David, Penny and Helen talking about the frustration of reaching out for help only to not get any when you ask." (RD, p.11-12).

Puppets appeared to play a part in the recovery process by helping participants both renegotiate their identities and re-connect with their innate creativity through participation in the

spontaneous creative process of making puppets: “David talked about how participating in the group had encouraged him to continue painting again, and he showed the group a photo of a recent painting. It was of a woman looking distressed and surrounded by black and red swirls. The group were very appreciative of the picture.” (RD, p.8); “Julia said the she had a good couple of weeks, was the best she been in a while and was starting to do her arts and crafts again.” (RD, p.27).

***Emotional expression and regulation*.**

A range of emotions was evident during the intervention, with the group offering participants the opportunity to share their emotions in a safe and supportive environment: “You could sit there and cry your eyes out or you could sit there and scream and shout, or you could just sit there and have a laugh” (P1). Puppetry, specifically, also seemed to provide a means of accessing unacknowledged emotions:

> If you were to do the puppetry for longer you would kind of sub-consciously get into whatever place that puppet takes you and then you could work through it without even trying because it just, for me anyway, you know, it brought up so much emotion from nowhere. You know and I was like “whoa, where’s all this coming from?” (P4)

Expression of these difficult emotions led participants to disclose a fear of being overwhelmed by emotions: “Theme of today was anger: people described being scared of their anger, that they would be overwhelmed by it, or that if they did feel it they would hurt themselves of someone else” (RD, p.17). Puppetry, however, seemed to provide a way of experiencing these difficult emotions without becoming overwhelmed, as participants could regulate their emotional arousal by focusing on the puppets and because the puppets seemed to act as emotional containers for difficult feelings:

> Well, I think I was more anxious about being in a group of people because I’m not good at being around people but I think it made me feel a bit better being able to just sort of focus on what, you know, what I was doing, you know, especially when the conversation got

> difficult at times it was easier to sort of. I think if I didn't have that actually physical doing something with my hands I would have probably been out the door. (P5)

The emotional regulation provided by the puppets helped participants to 'face their fears' and engage in challenging new experiences, thereby increasing tolerance of felt anxiety and building confidence: "And I found that when I did the little performance I spoke very, very quickly without meaning to. It was just like blur, blur, blur, finished, done it. And I felt extremely sick. That was the one thing I do remember, just nauseous actually doing it. So again that was very powerful for me too. The whole experience was." (P4); "I think there's just part of me in having anxiety problems. You sort of get used to having a whole lot of physical sensations that you don't want. But I think they've got easier as I've got more sort of used to coming to group and being a part of it." (P5)

Discussion

This study benefitted from a mixed methodological design which allowed the findings from standardised measures to be placed within a meaningful context developed through the triangulation of qualitative participant experiences and researcher observations.

Three of the five participants in this study experienced statistically and clinically significant changes in either positive or negative directions on standardised measures. One participant improved during the course of the intervention with positive changes in overall wellbeing as measured by the OQ, symptom distress, social role, body dissociation, and CORE-OM score, which indicated a clinically reliable movement from severe to moderate/severe level of difficulties. This participant had a history of PTSD, self-harm, depression, and social isolation, and in the post-intervention interview discussed the importance of connecting with others, especially men, and the opportunity to renegotiate their identity and discover new abilities. The intervention may also have taught new emotion regulation skills and provided normalisation and catharsis via witnessing others work through intense emotional experiences (Yalom and Leszcz, 2005). For example, in the post-intervention interview, this participant talked about

how another participant's working through of a past traumatic event prompted consideration of similarities to her own traumatic experiences. The improvement in body dissociation, specifically, may also be attributable to the theorised role of puppetry in healing the body self (Krueger, 2002).

Whilst participant five improved during the course of the intervention, participant three experienced a decline in interpersonal relationships and overall wellbeing as measured by the OQ, although this was not reflected in changes on the CORE-OM. In the post-intervention interview, this participant was aware of the declines in their wellbeing and attributed this to the previously unacknowledged trauma which puppetry spontaneously brought to the fore, necessitating a painful working through process. The participant described this work as difficult but rewarding, and was keen to take it forward in the post-intervention dramatherapy group. The experiences of this participant demonstrate the power of puppets in revealing unconscious conflicts, and also provide tentative evidence for their theorised role in facilitating mastery of past traumatic events by turning the passive into the active (Ostow, 1987).

One further participant also declined during the course of intervention, moving from low level to moderate difficulties as measured by the CORE-OM. They did not, however, experience any statistically significant or clinically reliable changes on other standardised measures. Furthermore, their pre-intervention CORE-OM score was not congruent with their scores on other standardised measures suggesting that it may not be an accurate representation of wellbeing. In the post-intervention interview, this participant described the intervention as a positive experience and expressed appreciation for the opportunity to connect with others and receive non-judgemental acceptance.

The study's findings provide a mixed picture of the effectiveness of therapeutic puppetry. Quantitative findings suggest that participants could improve or decline during the intervention; in contrast, qualitative findings suggest that all participants found therapeutic puppetry acceptable and more consistently beneficial. This suggests that the intervention may impact individuals differently, thus

necessitating a qualitative understanding of participant change. Indeed, three of the five participants experienced significant life events such as physical illness and bereavement during the intervention, which may have impacted upon their scores on standardised measures.

Regarding specific study hypotheses, there is tentative evidence for therapeutic puppetry being associated with changes in overall wellbeing, symptom distress, social role, and body dissociation, but not interpersonal functioning, self-esteem, and body awareness. Lack of change in interpersonal relating is surprising considering that thematic analysis of qualitative data suggested that connecting with others was an important aspect of the intervention. Similarly, participants made frequent references to increased confidence and self-acceptance in post-intervention interviews, but this was not reflected in changes on the RSE. However, of the measures employed, only the OQ is validated for weekly measurement of psychotherapeutic progress, suggesting that results on other scales must be treated with caution.

Thematic analysis of qualitative data indicated that puppetry as a medium interacted and overlapped with therapeutic factors inherent to group psychotherapies generally (Yalom and Leszcz, 2005). Four key mechanisms of change specific to therapeutic puppetry were identified. Firstly, creating puppets is a shared social activity which facilitates group formation and performance. Secondly, creating puppets as representations of self and others facilitates the spontaneous emergence of conscious and unconscious conflicts via the bypassing of client defences and avoidance. This is concordant with the object relations perspective on therapeutic puppetry (Gerity, 1999). Thirdly, using puppets within dramatic rituals and performances facilitates the mastery of past traumas and allows for the negotiation of personal identities. This is congruent with both adult play theories (Blatner & Blatner, 1997); (Colarusso, 1993); (Ostow, 1987); (Solnit, 1987) and narrative theories (White & Epstein, 1990) of therapeutic puppetry. Participants were using puppets, therefore, to create new ‘thick’ stories that incorporate past losses and traumas and challenge the ‘thin’ stories resulting from societal stigma and

discrimination (Gerity, 1999). Finally, psychotherapeutic work with puppets results in high levels of affective arousal that the puppet modulates by acting as an emotional container and effective distraction-based coping strategy.

Limitations of this study include the use of standardised measures that were not normed for repeated, weekly use and a relatively short time series data stream raising questions of whether these measurements were sufficiently numerous to be considered stable indicators of client wellbeing across time. This latter concern is particularly salient as the majority of statistically significant changes in this study were based on analyses of baseline versus follow-up data, each of which only contained four time points. This may have resulted in random variation producing false positive results. A further limitation is the use of SMA as a technique for analysing data. SMA does not allow for multivariate analysis across standardised measures, which would have allowed for the effects of all variables of interest to be considered simultaneously, possibly decreasing the likelihood of obtaining multiple significant results.

Future research examining the effectiveness of therapeutic puppetry is clearly needed before substantial claims can be made about this intervention. A second pilot study with a larger group of participants and a longer follow-up period of up to six months is required. In particular, it would be helpful to further investigate the hypotheses proposed in this study due to divergence between findings on standardised measures and participants' qualitative feedback. Future qualitative investigations of therapeutic puppetry could include a grounded theory study with the aim of refining underlying theorised conceptual models.

Conclusion

This study presents preliminary evidence from a small scale pilot study that supports further investigation into therapeutic puppetry with adults with SMI. The scale of the study does not yet allow practitioners to be fully confident in solely using puppets as a psychotherapeutic intervention or as a therapeutic medium within other models of psychotherapy. However, it does present encouraging

support for the potential of such interventions. Indeed, service users in this study found therapeutic puppetry to be both acceptable and beneficial. Until further research is undertaken, and due to the potential for puppetry to rapidly reveal difficult traumas and conflicts which clients may have been avoiding, considerable thought needs to be given to the clinical use of therapeutic puppetry; this includes the type of difficulties the client is experiencing and their mental and social wellbeing. Participants in this study felt that twelve weeks was insufficient time to create and use puppets effectively, suggesting that therapeutic puppetry may also only be suitable within longer-term psychotherapies when working with clients with SMI.

From a clinical psychology perspective, therapeutic puppetry may provide a means by which the profession can move away from a reliance on talking therapies and utilise other media that may be equally or more effective. This may be especially true for those clients who have experienced trauma at an early developmental stage and who may be less able to utilise verbal therapies. However, this would require services to have a well-equipped arts space, which unfortunately is not always feasible. Furthermore, arts-based interventions place additional demands on the therapist in terms of preparation of materials and physical space. In this study, these burdens were managed via the partnership of dramatherapy and clinical psychology, providing an effective model for future ways of cross-discipline working, which could harness the potential therapeutic power of puppets.

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Section C: Critical Appraisal
Word Count: 1998

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Completing the major research project (MRP) necessitated my direct involvement in all stages of the research process, from identifying gaps in the evidence base and development of an original study proposal, through to seeking NHS ethical approval, data collection and analysis, and production of final reports for dissemination of study findings to a range of stakeholders. As a result I have developed advanced skills in research project management, especially the ability to complete multiple project tasks within tight time limits. I have also furthered my skills in research design, particularly in developing realistic financial budgets.

In completing this MRP, I have developed skills and knowledge in conducting mixed methodological studies. This required reflection upon the contrasting epistemologies underlying quantitative and qualitative research methods. I adopted a critical realist (Willig, 1999) epistemological position, because this was not only congruent with my own personal epistemology, but also allowed for the realist position inherent to quantitative methods and the constructionist position which can underlie qualitative methods to be included in the same study. This epistemology showed how these different types of data can complement each other to provide a rich picture of psychotherapeutic interventions. However, it also entailed further reflection on possible conflict between a critical realist epistemology and an intervention largely based upon psychodynamic theoretical models. Psychodynamic concepts, such as the unconscious, have been described as unverifiable tautological hypotheses because evidence for their existence is drawn from unconscious processes such as dreams, 'Freudian slips' etc (Roustang, 1984). This is problematic in the current study because epistemology discredits theoretical endeavours which are fundamentally tautological (Roustang, 1984), hence introducing a conflict in the use of psychodynamic theories and a critical realist epistemology within the same study. Although I was not able to resolve this conflict, reflection upon it allowed me to be more thoughtful in the use of psychodynamic concepts as applied to therapeutic puppetry.

Conducting a mixed methodology study also challenged me to combine different types of data into a meaningful narrative about how and why therapeutic puppetry may be effective. As a result, I feel my writing skills and style have developed. However, I would like to pursue further narrative skills training to more effectively communicate findings from mixed methodology studies in the future.

Completing the quantitative aspect of my MRP entailed the acquisition of knowledge relating to small *n* research designs, in particular case study methodologies and time series data. As a result, I have learnt that single case time series are an effective method for monitoring individual therapeutic progress across time, whilst also allowing the mapping of changes to specific events within the course of therapy. I hope that I will be able to use these skills and knowledge both as part of future research projects and as a means of auditing my own clinical practice.

Completing the qualitative aspect of my MRP, I further developed my knowledge of qualitative research methodologies, especially participant-observation research. Acting as a participant-observer to the therapeutic puppetry group allowed me to gain a first-hand appreciation of the power of using puppets as part of therapy. It also resulted in a comprehensive research diary which proved an excellent means of triangulating information obtained from service user interviews. However, acting as a participant-observer also raised ethical questions about my role in relation to the group and how to balance the 'participant' and 'observer' roles. Frequently, I was called upon to use my therapeutic skills and participate as an active member of the group, which may have hindered an unbiased appraisal of study findings. I was able to reflect upon and manage these potential biases through the research diary and regular supervision. In the future, I would like to gain more experience of research methods where the researcher is embedded in the context, such as ethnography, so as to have a conceptual framework in which to reflect and act upon these ethical dilemmas and as a way of considering the advantages and disadvantages of first-person researcher accounts of psychotherapeutic interventions.

One aspect of the participant-observer role was to document the puppetry group using film and photography. I would like to pursue training in multimedia production to produce more professional end products. I would also like to learn more about different methods of analysing film and photographic

data, and how the information gathered can be integrated with other data sources such as participant interviews and standardised measures.

If you were able to do this project again, what would you do differently and why?

Firstly, applying for NHS ethical approval and R&D approval simultaneously would allow more time for recruitment. In the current study, recruitment was rushed due to the need to start and finish data collection within time limits stipulated by the doctoral course. As a result, my participants were limited to five. Seven participants would have allowed for attrition, and added more depth to study findings.

Considering the study design and procedure, I would reconsider the use of standardised measures which were not developed for weekly measurement of psychotherapeutic progress. Collecting time series data is a considerable burden for participants, and this is only justified if the data collected is meaningful and useful. Using the Rosenberg Self-Esteem Scale and Scale of Body Connection may have prevented detection of participant change on these constructs over time. Indeed, no significant change was found on these measures, despite participants reporting increases in self-acceptance and confidence. However, there is a lack of standardised measures validated for the measurement of more uncommon constructs such as body connection on a weekly basis.

Considering the thematic analysis, a key dilemma was whether to report findings for the group of participants as a whole or by individual participant. The former approach was indicated by the research questions which sought to examine the benefits and processes of change associated with therapeutic puppetry. The latter was indicated given that data from the quantitative strand were collected and analysed on an individual basis. In the current study, thematic analysis was reported for the group as a whole despite individual differences in participant accounts. This was only possible due to the existence of the research diary which provided triangulation with participant accounts. However, a future study could report the results on both an individual and group basis, allowing for additional comparisons between individuals.

Finally, I would like to increase the amount of service user involvement. Service user involvement in this study was limited to consultation from the Salomons Advisory Group of Experts on the study design and acceptability of the medium. However, having previously trained service users in research data collection, I would like to have used this experience to train a service user researcher to collect the qualitative data regarding participants' experiences of therapeutic puppetry.

Clinically, as a consequence of doing this study, would you do anything differently and why?

As a result of this study, I have a strong interest in incorporating non-verbal media such as puppets, art, film, photography, and music as a means to enhance my clinical interventions. In the future, I hope to work primarily with clients who have experienced complex trauma, particularly in childhood, and I believe that these non-verbal media will greatly enhance my work through increased client engagement and more flexible ways of working within traditional psychotherapeutic models.

Reviewing the literature on recovery for people with SMI has also re-emphasised the importance of personal recovery-orientated principles within mental health services. In my future clinical work, I would like to utilise these principles both within my psychotherapeutic work with service users and carers, and as a set of key orientating principles underlying my consultation and training work with mental health professionals.

In the future, I would consider using single case design and time series data as a means of auditing my own clinical work and the work of others whom I may supervise. This method is highly appropriate for use in routine clinical practice as a means of both demonstrating service effectiveness to key stakeholders, and in allowing progress to be related to specific events within therapy thereby allowing for efficacious, and non-efficacious, elements to be identified. This method also has the potential to result in greater service user involvement in therapy - time series data could be used as a shared means of reviewing progress, identifying what works, and developing future therapeutic goals.

If you were to undertake further research in this area, what would that research project seek to answer and how would you go about doing it?

Completing a small scale pilot investigation of therapeutic puppetry has demonstrated the feasibility of further effectiveness research in this area. Furthermore, such research is urgently required as this study has shown puppetry to be a potentially powerful medium that can bypass client defences and enhance engagement. However, these powerful effects may also have negative consequences such as possible retraumatisation of the client. I would therefore like to conduct further research into the types of clients who may benefit from this medium, and what safeguards need to be in place to ensure that therapeutic puppetry is a safe and effective intervention. One of these safeguards may be the length of the intervention, as participants in this study acknowledged that the process of recovery was possible but found twelve weeks to be insufficient. I would investigate this in future effectiveness studies of therapeutic puppetry by including groups of longer duration with larger sample sizes and a longer follow-up period. Group duration would be determined by consulting the theoretical literature on group psychotherapy (e.g. Yalom and Leszcz, 2005).

Reviewing the literature regarding therapeutic puppetry has highlighted a lack of conceptual clarity regarding underlying theoretical models. I would like to further investigate these models as a means of beginning to link therapeutic processes associated with puppetry to the theoretical literature. This could be achieved through a qualitative grounded theory study of therapeutic puppetry including interviews with both service users and professionals. It may also be helpful to conduct a Delphi study with experts in therapeutic puppetry to elicit their views and gain consensus on mechanisms of change associated with puppets as a therapeutic medium.

I would also like to further investigate which professionals can effectively deliver puppetry-based interventions. As part of the background research to this project, I attended a conference on applied puppetry for professional puppeteers. At this conference I was encouraged by the interest from non-mental health professionals in using this medium with vulnerable populations, but I was also left with questions about the appropriateness of this, considering that professional puppeteers often have little psychotherapeutic training. These concerns have been further reinforced by the findings of this study regarding the potential therapeutic power of puppets and how this may need to be managed and

contained in a thoughtful way by skilled mental health professionals. One solution to these concerns may be to have interventions co-delivered by professionals from puppetry and psychotherapeutic backgrounds.

Regarding clinical psychology in particular, I would also like to research how as a profession we can use puppetry to either move away from our reliance on verbal therapies, or potentially integrate it with existing psychotherapeutic models to enhance their effectiveness.

Finally, in addition to researching therapeutic puppetry specifically, I would also like to be involved in future research projects regarding the effectiveness of creative arts therapies and arts and health interventions more generally. This is partly due to my own personal interest, but also because there is considerable scope for cross-discipline research partnerships between clinical psychology and creative arts therapists, who often have not received the same level of training in research and audit evaluations. I am currently pursuing this aim by participating in a Masters qualitative research project examining the role of the dramatherapist within the community mental health team, providing input around the use of qualitative research methodologies and coding focus group data alongside the primary researcher.

References

Roustang, F. (1984). On the epistemology of psychoanalysis. *MLN, 99*, 928-940.

Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionism. In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (37-51). Buckingham: Open University Press.

Yalom, I., & Leszcz, M. (2005). The theory and practice of group psychotherapy (5th ed.). New York: Basic Books.

Section D: Appendix of Supporting Material

Appendix One:

Section A literature review search strategies

Both search strategies were utilised across ten bibliographic databases to ensure search comprehensiveness, these comprised: Embase, Medline, British Nursing Index (BNI), PsychINFO, Current Index to Nursing and Allied Health Literature (CINAHL), Applied Social Science Index and Abstracts (ASSIA), the Web of Science, books@OVID and EBM Reviews which includes the Cochrane Database of Systematic Reviews, American College of Physicians (ACP) Journal Club, the Database of Abstracts of Reviews of Effects (DARE), Cochrane Controlled Trials Register (CCTR), *Centre for Medicines Research (CMR),* Health Technology Assessment (HTA), and NHS Economic Evaluation Database (NHSEED). Separate key word web-based searches were also conducted using Google and Google Scholar.

Literature Search One: Arts and Health

All searches were conducted in October 2010 and updated in May 2011. The following search terms was used in combination dependent upon specific database limiters and Boolean operators.

- art therapy
- drama therapy
- psychodrama
- schizophrenia
- bipolar affective disorder
- severe depression
- severe anxiety
- psychosis
- severe eating disorder
- severe panic disorder

Literature was included if it evaluated an art or drama therapy based intervention and excluded if it evaluated music and dance/ movement based therapies. Included literature is also limited to peer-reviewed publications in English language journals published after 1980.

Literature Search Two: Therapeutic Puppetry

All searches were conducted in June 2009 and updated in May 2011. The following search terms was used in combination dependent upon specific database limiters and Boolean operators

- therapeutic puppetry
- puppetry
- puppets
- drama therapy
- schizophrenia
- bipolar affective disorder
- severe depression
- severe anxiety
- psychosis
- severe eating disorder
- severe panic disorder

In addition to the ten bibliographic databases and google searches, the following specific resources were also utilised:

- **Online resources:**

www.intute.ac.uk – Online search engine for identifying web based study and research material

artsintherapy.com – Arts in Therapy Network

www.artslynx.org – Bibliography of drama therapy publications

- **Journals:**

Dramascope

The Arts in Psychotherapy

International Journal of Action Methods – Journal of Group Psychotherapy, Psychodrama & Sociometry

Music & Arts in Action

UNIMA – Puppet Notebook

The Puppetry Journal – www.puppeteers.org

INSCAPE – the Journal of the British Association of Arts Therapists

Arts & Health

- **Reference checking**:

Astell-Burt, C. (2001). *I Am The Story: The Art of Puppetry in Education and Therapy*. London: Souvenir Press.

Gerity, L. (1999). *Creativity and the Dissociative Patient*. London: Jessica Kingsley.

Bernier, M., & O'Hare, J. (2005). *Puppetry in Education and Therapy*. Bloomington, Indiana: AuthorHouse.

All literature relating to therapeutic puppetry was included in the review regardless of whether it had been published in a peer reviewed journal and did therefore include 'grey literature' such as conference proceedings, unpublished doctoral theses and books. This was only possible due to the paucity of conceptual and empirical literature on therapeutic

puppetry. Included literature did, however, have to be in English as it was not feasible to obtain translations of foreign language materials.

Appendix Two:

Copy of NHS Research Ethics Committee approval

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Appendix Three:

Copy of NHS R&D approval

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Appendix Four:

Participant information sheet and consent form

Participant Information Sheet:
What are the benefits of therapeutic puppetry for adults with mental health problems?

I would like to invite you to take part in a research study looking at the benefits of a therapeutic puppetry group for adults with mental health problems. Before you decide to participate you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. If you have any questions or would like further information please do not hesitate to ask me.

1. What is the research study about?

The main part of the project is a group therapy intervention using puppets and puppet play. This means that you will be invited to attend 12 sessions of group therapy on a weekly basis. During the sessions, you will have the opportunity to create puppets and use them in story-telling and performance.

2. What is the purpose of the study?

The purpose of the study is to explore the use of puppetry within therapy. Part of the project will be an investigation of how a therapeutic puppetry group can be helpful to people with mental health problems. I will, therefore, be asking everyone who participates in the group to complete questionnaires before, during and after the intervention.

3. Why have I been invited?

You are being invited to participate in the study because you have been referred for a dramatherapy intervention at the [redacted] Psychological Therapies Service.

4. Do I have to take part?

No. It is up to you decide. I am giving you this information sheet and asking you to consider participating. If you are interested, you will then be invited to attend a screening interview. At the interview, I will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw from the study at any time, without giving a reason. This would not affect your care.

5. What will I happen to me if I decide to take part?

You will be involved in two ways. Firstly, you will take part in a 12 week therapeutic puppetry group, with weekly sessions lasting 90 minutes. Group activities will include puppet making and performance. You may also like to create a 'puppet book' which can include photographs, stories, your thoughts and feelings about puppetry etc. Photographs or film made during the group may also be used as part of the research. If this is the case, I will ask you to sign a separate consent form saying you have allowed us to use this material for research purposes.

Secondly, you will take part in the investigation of the therapeutic puppetry group. This will involve completing three questionnaires before, during and after the therapeutic puppetry intervention. These questionnaires take approximately 20 minutes to complete and look at

your mental health, social functioning and self-esteem. In total, you will be asked to complete the questionnaires on 20 separate occasions:

- Four interviews on a weekly basis before the therapeutic puppetry group starts. This can be done either at the [redacted] or in a location convenient to you.
- Twelve interviews during the weekly therapeutic puppetry group. This will be done prior to group sessions at the [redacted].
- Four interviews on a weekly basis after the group finishes. This can be done either at the [redacted] or in a location convenient to you.

At the end of intervention, you will also be invited to attend an interview looking at your experiences of the therapeutic puppetry group. This interview will take place at the [redacted].

6. Will I receive any expenses or payment for participation?

Unfortunately, I am not able to reimburse any expenses incurred as a result of participation. I am also not able to offer any payment for participation.

7. What will I have to do?

You will be expected to attend a weekly therapeutic puppetry group, and complete questionnaires on a weekly basis, before, during and after the intervention.

8. Are there any risks associated with participation?

As with any form of psychological therapy, there is the potential for people to become distressed as they process difficult thoughts, feelings or experiences. However, you will be supported throughout the therapeutic puppetry group by a trained dramatherapist, who has extensive experience of working with people with mental health problems.

9. What are the possible benefits of participation?

Therapeutic puppetry can be beneficial by helping people to express thoughts and feelings which cannot be easily expressed through words. By expressing these thoughts and feelings it is hoped that participants will see improvements in their mental wellbeing. As therapeutic puppet making and play takes place in groups, they may also help people to improve their social skills. Participants have also reported feeling more confident as a result of therapeutic puppetry interventions.

10. What happens when the research study stops?

When the research is finished, you will be invited to attend a group dramatherapy intervention which does not include therapeutic puppetry.

11. What if there are any problems?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you feel comfortable, you should first approach me or the dramatherapist who will attempt to resolve your concerns. If this is not possible, you can contact the [redacted] Patient Advice & Liaison Service (PALS) via post - [redacted] or telephone [redacted]. The PALS service can also support you if you wish to make a formal complaint.

12. Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the [redacted] Psychological Therapies Service will have your name and address removed so that you cannot be recognised. Only the research team and the group facilitator will have access to information

collected. All anonymous information will be stored within a locked filing cabinet for a period of 10 years after the research has finished.

If at any stage during the research, you disclose information which may lead to harm to yourself or others, me or the dramatherapist will need to discuss this information with your care team. Where possible, we will try to discuss this with you first and gain your consent to do this.

13. What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any stage. If you decide to withdraw, I may still use information about you which has already been collected.

14. Who will know I am participating in the study?

With your consent, I will inform your care team of your participation in this research. Your care team may be a care co-ordinator at the community mental health team or your GP.

15. What will happen to the results of the study?

The results of this study will form part of my doctoral research project. They will also be sent for publication in a scientific journal, and may be presented at conferences. You will not be identifiable in any report or publication resulting from this study. Written feedback of the results will also be made available to participants.

As part of the report or publication resulting from this study, I may want to use direct quotes from group participants. Any quotes used will be anonymised.

16. Who is organising and funding the research?

This research is being organised by me, Adele Greaves, trainee clinical psychologist, as part of my doctoral research project. I will be supervised throughout by a qualified researcher at Canterbury Christ Church University. The study is being funded by Canterbury Christ Church University.

17. Who has reviewed the study?

All research in the NHS is approved by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by [redacted] Research Ethics Committee.

18. Who should I contact for further information or support?

If you have any questions about this project or would like further information, please contact me on [redacted]

If you require further support during the study, you can contact:
In office hours: [redacted].
Outside of office hours: [redacted] **You can also contact your local out of hours GP service or Accident & Emergency centre.**

Thank you very much for reading this information and for considering participating in my project.

Participant Identification No:

CONSENT FORM

What are the benefits of a therapeutic puppetry group for adults with mental health problems?

Name of Researcher: Adele Greaves

Please initial each box:

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my NHS care or legal rights being affected.	☐
3. I understand that relevant sections of my medical notes and data collected during the study will be looked at by the researcher, and group facilitator. I give permission for these individuals to have access to my records.	☐
4. I agree to my care team being informed of my participation in the study.	☐
5. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix Five:

Consent for audio and video recording

Participant Identification No:

CONSENT TO VIDEO AND PHOTOGRAPHY OF PUPPETS AND PUPPET PLAY/ PERFORMANCE

As part of the research study looking at the benefits of a therapeutic puppetry group for adults with mental health problems, we may like to take photographs or short videos of the puppets created and any puppet play or performance.

No individual participants will be included in the video or photographic materials.

These photographs or videos can then be included in our analysis of the benefits of therapeutic puppetry. With your consent, we may also use them as part of the lead researcher's doctoral thesis and research publications resulting from the study.

If you are happy for the puppets you create to be videoed or photographed, please indicate your consent to this below. You will be able to change your mind about your consent at any time during the research study without your care being affected.

1. I agree to photographs being taken of any puppets I create and any puppet play/ performance. I understand that I will not be included in these photographs. I agree to the inclusion of these photographs in the lead researcher's doctoral thesis and in any publications resulting from the research study.

Name_____
Signature_____Date_____

2. I agree to videos being made of any puppets I create and any puppet play/ performance. I understand that I will not be included in these videos. I agree to the inclusion of these videos in the lead researcher's doctoral thesis and in any publications resulting from the research study

Name_____
Signature_____Date_____

STATEMENT OF PERSON OBTAINING CONSENT

- I have explained to the person above the reasons for taking the photographs and videos of puppets created and puppet play/ performance
- I have explained that no individual participants will be included in the photographs and videos

Name_____
Signature_____Date_____

Appendix Six:

Confidentiality agreement with professional transcription service

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Appendix Seven:

Copies of standardised measures

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Appendix Eight:

Participant interview schedule

What is the service user experience of therapeutic puppetry?

Please note this is a semi-structured interview and the following questions are included as a guide for the interviewer only. Please be flexible during the interview and allow the participant to tell the story.

1. Tell me about your experience of the puppet group.

   Supplementary prompt questions (as required):

   - How did you experience making puppets?
   - How did you feel when making puppets?
   - What was your experience of using puppets like?
   - How did you feel when using the puppets for performances?
   - How did you experience the group?
   - Tell me about your feelings during the sessions

2. Has anything changed for you as a result of participating in the puppet group?

   Supplementary prompt questions (as required):

   - What changed for you during the group?
   - Have these changes helped you? If so, how?
   - Did you notice any change in how you felt before the group to how you feel now?
   - Did you notice any changes in how you feel about yourself at the end of the group?
   - Did you notice any changes in your relationships with others at the end of the group?
   - Did you notice any changes in that way your body felt at the end of the group?

3. What do you think are the benefits of using puppets as part of therapy?

4. Would you change anything about the puppet group? If so, what and why?

Supplementary prompt questions (as required):

- What did you like/ dislike about the group?
- What could have been done differently to improve your experience?

5. Is there anything else you would like to comment on?

Appendix Nine:

Research diary including group narrative with initial coding for thematic analysis

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Appendix Ten:

Example participant interview transcript with initial coding for thematic analysis

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Appendix Eleven:

List of initial codes from thematic analysis

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Appendix Twelve:

NHS Research Ethics Committee end of study declaration and report

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Appendix Thirteen:

Journal of Mental Health author instructions

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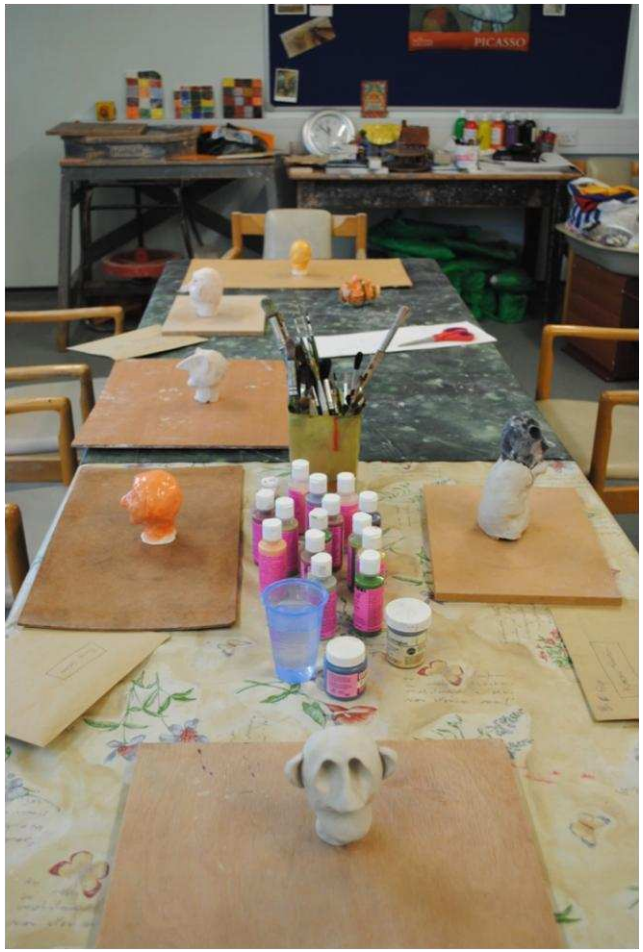
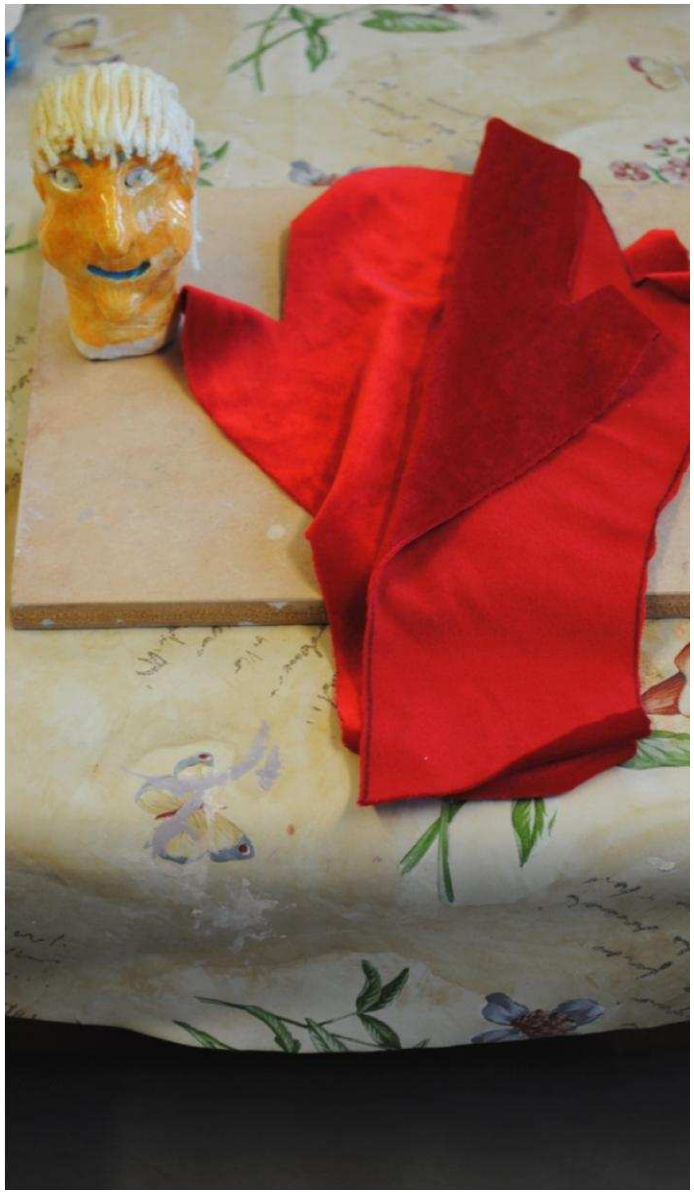
Appendix Fourteen:

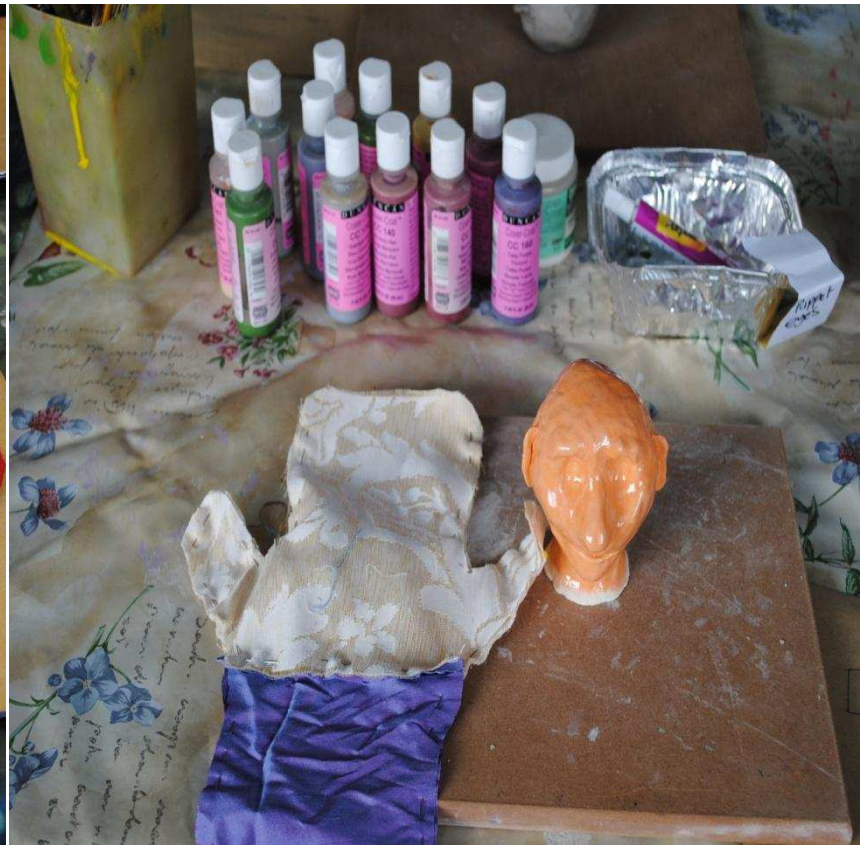
Film and photographic data

1. Setting up the arts space

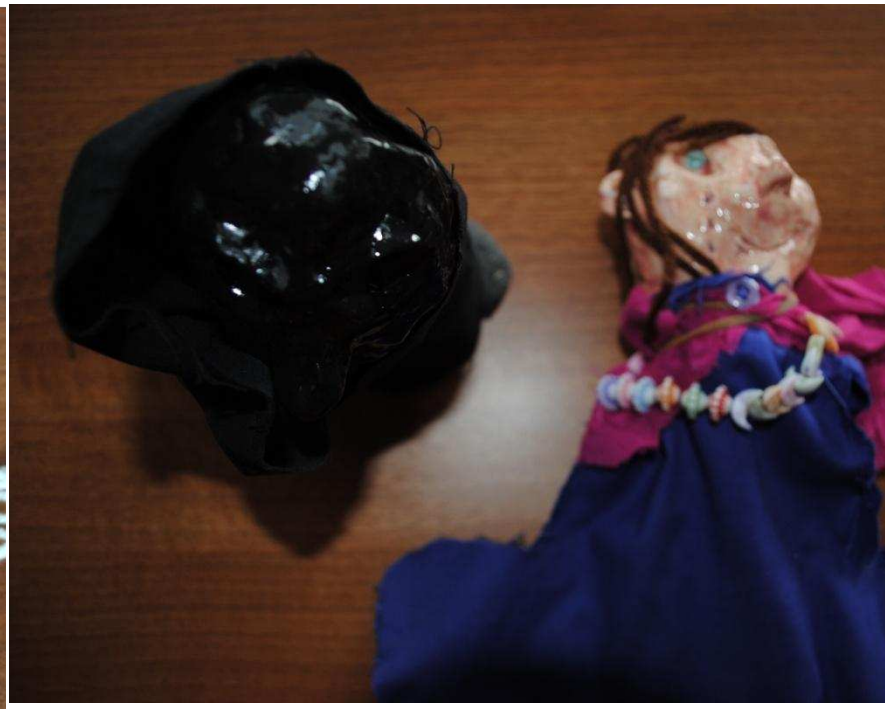


2. Making Puppets





3. The Puppets



4. Using the Puppets