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Defining animation therapy: the good hearts model

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http://doi.org/10.1386/ap3.6.1.17_1

PUBLISHER

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VERSION

AM (Accepted Manuscript)

PUBLISHER STATEMENT

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REPOSITORY RECORD

Hani, Melanie. 2019. "Defining Animation Therapy: The Good Hearts Model". figshare.
<https://hdl.handle.net/2134/33809>.

**DEFINING ANIMATION THERAPY: THE GOOD HEARTS
MODEL**

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Defining Animation Therapy: The Good Hearts Model

Melanie Hani

Abstract

This article discusses ‘the Good Hearts Model’ (GHM) (Hani, M 2011), a programme of therapeutic practice that employs the process of producing animated films and allied materials. Though ‘Art Therapy’ in all its guises and diversity has a long pedigree, I argue that the use of animation, (the GHM) offers an additional approach to traditional therapeutic strategies and that moreover it can be used as a diagnostic, educational, crime prevention and dissemination tool. Crucially, this discussion argues and proposes that like art, drama and music therapy, there is a need for a professional body for Animation therapists, and inclusion in the Health and Care Professions Council (HCPC). For this to transpire I will propose a definition of ‘Animation Therapy’, and example the contexts for its use.

The article will begin with a brief overview of the current context for Art Therapy and its conduct followed by an introduction of the current situation regarding Animation Therapy in the UK identifying how Animation Therapy is distinct, before engaging with the GHM, and its potential within the field as an alternative approach to traditional therapy.

There are many other creative therapies but for the purposes of this article, I will only discuss Animation in relation to Art Therapy and within the wider paradigms of therapeutic practice. It will be specifically focused upon the UK and the development of animation as a regulated therapy with attention specifically to the GHM. It is also impossible to discuss all the research projects that have been undertaken over the years evolving this model of animation therapy so a selection has been made to relate to the most appropriate arguments.

Key words: animation, therapy, education, criminology, art, creativity

This article discusses ‘the Good Hearts Model’ (GHM) (Hani, M 2011)¹, a programme of therapeutic practice that employs the process of producing animated films and allied materials. Though ‘Art Therapy’ in all its guises and diversity has a long pedigree, I argue that the use of animation, (the GHM) offers an additional approach to traditional therapeutic strategies and that furthermore it can be used as a diagnostic, educational, crime prevention, dissemination tool and a first animated therapeutic model in Animation Therapy. Crucially, this discussion argues and proposes that like art, drama and music therapy, there is a need for a professional body for Animation therapists, and

¹ The research organisation ‘HEART’ (Healing Education Animation Research Therapy) was established in 2009. For further information please see www.animationtherapy.info. The term ‘The Good Hearts Model’ was first used in 2011. The name was influenced by the work of Tony Ward, the developer of the Good Lives Model (2002).

inclusion in the Health and Care Professions Council (HCPC). For this to transpire I will propose a definition of 'Animation Therapy', and example the contexts for its use.

I will begin with a brief overview of the current context for Art Therapy and its conduct. I have chosen initially to address Animation Therapy in relation to Art Therapy as it is the only umbrella creative therapy that is identified as a profession by the HCPC. I will then introduce the current situation regarding Animation Therapy in the UK identifying how Animation Therapy is distinct, before engaging with the GHM, and its potential within the field as an alternative approach to traditional therapy.

There are many other creative therapies but for the purposes of this article I will only be discussing Animation in relation to Art Therapy and within the wider paradigms of therapeutic practice. It will be specifically focused upon the UK and the development of animation as a regulated therapy with attention specifically to the GHM. It is also impossible to discuss all the research projects that have been undertaken over the years evolving this model of animation therapy so a selection has been made to relate to the most appropriate arguments. The multiplicity of techniques and applications in the GHM process is complex and cannot fully be taken into account in a piece of this length, so only particular aspects of the procedural model will be addressed. The discussion of the model as a diagnostic/educational tool will be also only introduced but expanded on in further planned publications.

Key Definitions

I define 'Animation Therapy' as a profession and the GHM as an approach outlining a technological procedure and ethical process, correspondent to the definitions stated by the HCPC. The HCPC register health and care professionals, legally regulating the professions and identifying professional titles and responsibilities protected by law. The output of the work undertaken as part of, and as a result of the GHM process will be referred to as 'the data' or 'production process outcomes'. This will constitute items such as scripts, background designs, character designs, storyboards, artwork etc. I will be using the following terms:

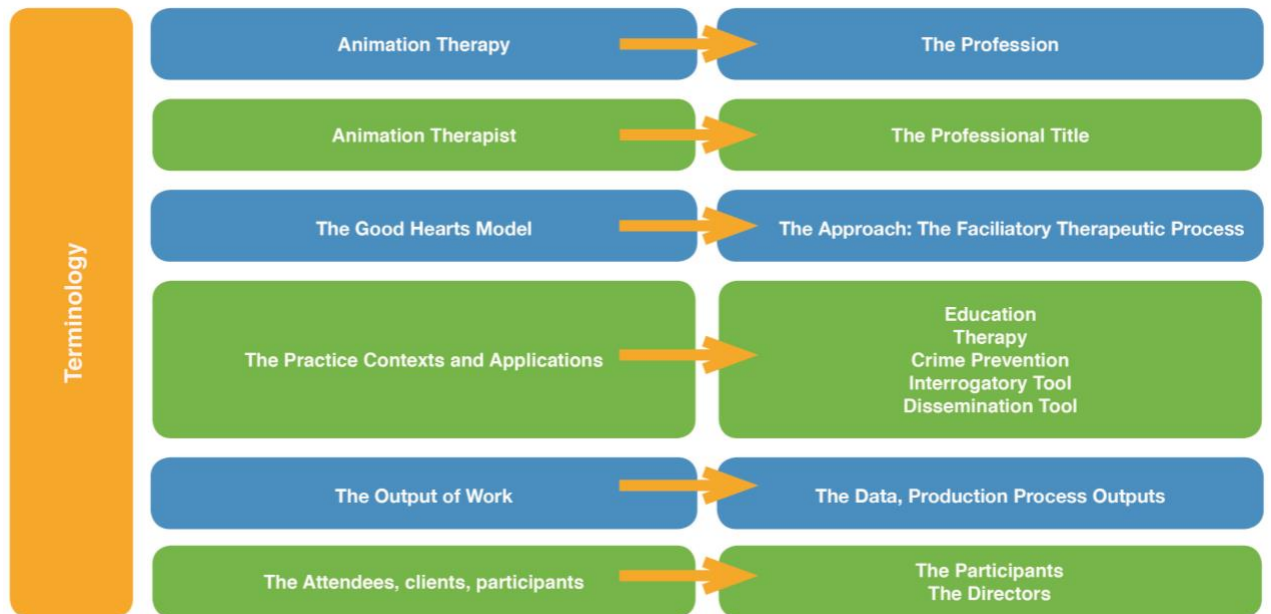


Figure 1: Terminology.

Art Therapy: Contextual Apparatus

The definition of ‘Art Therapy’ has changed and diversified since the 1940s when it was first named and pioneered in the UK in 1942 by the artist Adrian Hill (Hogan, 2001, p.25). Hill identified art making as therapeutic when he personally experienced the process when recovering from tuberculosis in 1938 (Bitonte and De Santo, 2014, p.18). He documented his ideas in 1945 in *Art versus Illness* and was employed as the first art therapist in 1946 (Bitonte and De Santo, 2014, p.18). Margaret Naumberg pioneered the term in the USA and developed what became known as a ‘psychodynamic’ approach, ‘recognising the fundamental importance of the unconscious ... graphic art becomes a form of symbolic speech which may serve as a substitute for words or as a stimulus which leads to an increase of verbalisation in the course of therapy’ (Case and Dalley, 2006, p.2). Edward Adamson, another key figure in the development of art therapy in the UK, positioned his view of Art Therapy in a role between the medical practitioner and the patient (Edwards, 2014, p.26). Using this technique, the patient presents their artwork to the psychiatrist as the basis of, and catalyst for, a discussion, rather than it being interpreted by the art therapist.

Presently there are ‘numerous and ... conflicting definitions of art therapy – or art psychotherapy’ (Edwards, 2014, p.1) – however, we can summarise that there are three core Art Therapy approaches that originated from the 1940’s; firstly, seeing the process that the participant engages with as being therapeutic, secondly, using the artwork as a way to explore the unconscious and thirdly, an opportunity to use the outcomes as an opportunity for discussion.

An endeavor is made to draw down a more current definition, therefore it is important to identify how art therapy/the art therapist is outlined by key organisations: The HCPC (Health and care professions council) and BAAT (The British Association of Art therapists). The HCPC regulates the profession of Art Therapy which currently includes

the creative therapies, Music Therapy and Drama Therapy (HCPC, 2018). The HCPC describe the art therapist as ‘a psychological therapist who has arts-based experience plus training in psychological interventions ... helping the individual to experience themselves and others in different ways through an arts-based activity within a therapeutic framework’ (HCPC, 2018).

BAAT, the regulatory professional body for Art Therapy define Art Therapy as ‘a form of psychotherapy that uses art media as its primary mode of expression and communication’ (BAAT, 2018). It goes on to say ‘Within this context, art is not used as a diagnostic tool but as a medium to address emotional issues which may be confusing and distressing’ (BAAT, 2018). The BAMT (British Association for Music Therapy) states that Music Therapy ‘concentrates on the use of music as a means of communication, self-expression and interaction’ (BAMT, 2018) BADth (The British Association of Dramatherapists) identifies that ‘Dramatherapy has as its main focus the intentional use of healing aspects of drama and theatre as the therapeutic process. It is a method of working and playing that uses action methods to facilitate creativity, imagination, learning, insight and growth’ (BADth, 2018). I wish to argue here that though these approaches to therapy in the arts are established, and relate in some degree to Animation Therapy, ‘Animation Therapy’ is ultimately a separate model of creative therapy that draws specifically upon its essential procedural elements to inform its distinctive therapeutic practice.

Art Therapy is a tool, a medium to express and communicate. It is established, even though characterized by a myriad of approaches, and provides a useful framing analysis in regard to my later engagement with animation. ‘Art Therapy is an intervention method that traditionally has drawn from psychoanalytic theory for its framework and procedures’ (Eaton, Doherty and Widrick, 2007, pp.256-262) and is influenced by diverse paradigms that use ‘art media’ to improve mental health. In the contemporary era the definition of Art Therapy is clearly defined by a therapist’s choice of an artistic and therapeutic approach in relation to the type of client, personality traits, and the problem in hand (Case and Dalley, 2006, pp.5-18) approach is therefore custom designed accordingly to befit the psycho-social characteristics and psychological needs of the clients (Eaton, Doherty and Widrick, 2007, pp.256-262). This approach resists the previous schism in the understanding of what art therapy might achieve. ‘Art therapy was and remains committed to the socio-cultural model of mental illness in contrast to the so-called ‘medical model’, rejecting, for example, the use of images as diagnostic tools or as evidence of psychopathology’ (Waller & Guthrie, 2013, pp.4-13.).

This focus on the primacy and importance of ‘the image’, and the ways in which image-making is used in the therapeutic process has always proved to be contentious. ‘Although the practice of Art Therapy has been in existence for many years, until very recently, the efficacy of Art Therapy has not been empirically addressed’ ((Eaton, Doherty and Widrick, 2007, pp.256-262). This is yet more problematic when using moving images, especially when they have been produced as procedural art work in the service of the film-making process. Arguably, then, in animation, particularly, the combination of constructed ‘still’ imagery and its application as a ‘moving image’ enables the client / patient to both interpret *and* analyse their own process in collaboration with the therapeutic facilitator and analyst as the image is created,

developed, and made to move. The process in both making animation and engaging with the production materials as the subject and object of therapeutic practice, works within the parameters of self-reflexive choices and reflective motives that characterize approaches in person centred therapy. This allies readily with the work of Carl Rogers when he discusses the reflection of feelings, the ‘testing understandings, or checking perceptions’ (Wilkinson, 1992, p.193). He notes, ‘I am *not* trying to reflect feelings. I am trying to determine whether my understanding of the client's inner world is correct whether I am seeing it as he or she is experiencing it at this moment’ (West and Cox, 2014, p.40). Each stage of the animation preproduction process acts as a repeated empathetic response to the participant. The participant observes their inner world unfolding through script writing, storyboarding to completion of the film. However, each stage provides an amendment opportunity (an edit) to what is being conveyed a ‘testing of understanding’ and a ‘checking of perception’. I want to further argue, here, then, that the GHM has the capacity to apprehend and evoke an inner world that can be visually expressed and discussed. Crucially, then, the GHM empowers the inner voice that Rogers seeks out, and provides a secondary level of insight beyond the continuous reflective questioning in the construction of the film, leading to another model of expression and response in the film itself.

So to summarise, Art Therapy is variable in its approaches; the identification of therapeutic practice is wide ranging and sometimes questionable, yet still operates as a regulated form. This differs from a more developed and defined view of ‘Animation Therapy’, the conduct of which is not protected by law, has no professional title, is not regulated, nor is classed as a profession with any standards of proficiency to answer too. Consequently, anyone can call themselves an ‘animation therapist’, and if not practising purely using animation, practice within the broader framework of ‘Art Therapy’ along with other techniques and approaches. In addition, there is no requirement for anyone to have completed previous study in animation, nor that is intrinsically allied to therapy, nor that the practice of such could be distinctive, and definable on its own terms and conditions.

Defining Therapy in the context of Animation

As yet, there has been limited discussion on ‘talking therapy’ and how this may relate to Animation Therapy and its development. The talking therapies of counselling and psychotherapy are currently not regulated in the UK by the HCPC. They are however regulated by the two leading registering bodies in the UK: The British Association for Counselling & Psychotherapy (BACP) and the UK council for Psychotherapy (UKCP). The most recent response in consideration of regulating these approaches was from the MP Anne Milton (Secretary of State for Public Health 2011) to Marc Seale (Chief Executive and Registrar HCPC 2011) stating ‘...it is not currently our intention to proceed with statutory regulation of psychotherapists and counsellors’ (Milton, 2011). However Milton then advises that ‘the assumption will be that assured voluntary registration would be the preferred option’ (Milton, 2011).

The Mental Health Foundation describe how confusing it can be for the public to understand the difference in the various forms of therapy in this particular case: psychotherapy and counselling (Mental Health Foundation, 2018). ‘The terms

'counselling' and 'psychotherapy' are often employed in a loosely interchangeable way' (Crago, 2000, p.73) 'Historically, psychotherapy was differentiated as a form of helping that focused on serious problems of an intra-psychic nature with treatment delivered by a trained professional' (Sangganjanavanich, 2014, p.2). Generally, professionals identified a difference between the two terms, the key disparities being: length, location, focus of treatment, clients presented issues and the overall aims of the two types. However these differences in practice are no longer stressed or accepted (Sangganjanavanich, 2014, p.3). This is emphasized by the statement from the BACP indicating that as an Association, the BACP does not distinguish between counselling and psychotherapy and states there is 'no agreed difference between counsellors and psychotherapists, although there is much debate about it' (Dale, 2018, p.3). It goes on to state that 'Counselling and psychotherapy are services sought by clients to help them resolve emotional, psychological and relationship issues within a context of confidentiality and clear ethical boundaries using evidence-based interventions to foster long-term recovery, increased resilience and wellbeing' (Weitz, 2015, p.107). This does not reduce the process to a single term, however, nor does it clarify the central importance of 'evidence-based interventions'.

The BACP was the first registrar for psychological therapists, who are accredited under a scheme developed by the Department of Health; they define counselling and psychotherapy as 'umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing' (Dale, 2018). Dalley notes, however, that 'Therapy involves the aim or desire to bring about change in human disorder' (Dalley, 1984, p.11) citing Ulman who adds 'A therapeutic procedure is one designed to assist favourable changes in personality or in living that will outlast the session itself' (Dalley, 1984, p.11). The BACP goes on to say

'Therapy is time set aside by you and the therapist to look at what has brought you to therapy. This might include talking about life events, (past and present), feelings, emotions, relationships, ways of thinking and patterns of behaviour. The therapist will do their best to help you to look at your issues, and to identify the right course of action for you, either to help you resolve your difficulties or help you find ways of coping. Talking about these things may take time, and will not necessarily all be included in one session. The number of sessions offered may be limited, and so it is best to ask about this in advance, for example, brief therapy or short term therapy might provide a maximum of 6, 8, 10 or 12 sessions' (O'Driscoll, 2018, p.1).

It is important to note here that animation therapy in particular the GHM, also mirrors this approach but allows a realisation of such events in a moving, physical form. It allows the visualisation and exploration of past and present events, emotions, relationships, thinking and pattern behaviours over a set period of time (15 sessions); a plan (a storyboard, script) allows the participant to identify a therapeutic course of action.

UKCP also define Psychotherapy as a 'talking therapy' that 'helps people with emotional, social or mental health problems.' (UK Council for Psychotherapy, 2018). It goes on to state that 'psychotherapy' covers a range of approaches and methods' that provides a confidential setting where feelings can be expressed allowing for a greater

understanding of difficulties; where ‘the objective is to find coping methods, ‘bring about changes’ in thinking and behaviour that will improve mental and emotional well-being (UK Council for Psychotherapy, 2018). It discusses how the therapy may take a minimum of 6 sessions and up to two years or more (UK Council for Psychotherapy, 2018).

However, it is not my intention to consider the debate around counseling and psychotherapy as separate and distinctive, or similar approaches here, but rather to cite these approaches, however termed and defined, as ‘therapy’, and define its relationship to Animation. I will draw upon certain models of ‘counselling’ and ‘psycho-therapy’ then as resources in identifying some of the particularities in animation therapy.

Crucially at this point it is also important to look at the client’s perspective and how they understand ‘therapy’. This, as in any course of therapy, will impact upon how the psychological, emotional and physical benefit of Animation Therapy is identified and proven. ‘Clients want to be treated with respect, to be understood and helped to resolve problems. Counselling provides another person who is willing to help the client do that. Clients want a counselling relationship that treats them as individuals with acceptance and hope’ (Aldridge, 2014, p.4). Therapy in this context is a talking therapy that has diverse approaches and techniques. Animation Therapy is also a ‘talking therapy’ of extremely considered sentence build up. The talking takes place visually and verbally and within the process of recording and editing. The final film, the ‘animated talk’ is one that has been well thought through, worked through and finalised over a period of therapeutic process. Traditional therapists are trained practitioners who work with clients on a short or long term basis in a confidential, understanding, individual, respectful, accepting and ethical setting in order to bring about effective change, enhance well-being, increase resilience, help with emotional, social, relationship or psychological issues. Therapy allows for a greater understanding of one-self and provides coping methods that aims to promote long term recovery. Therapy permits discourse about life, thoughts, emotions, relationships and repetitive behaviours, in a way that is non-judgmental, and provides the substance of an interactive and pro-active engagement with less enabling, inhibiting or challenging aspects of personal experience. The Animation Therapy undertaken to date has considered and incorporated all of the above areas.

The Definition of Animation

Part of the path to developing a definition for Animation Therapy is to identify a core definition of Animation. However as Brian Wells noted in 2011 ‘After over ten years of teaching in higher education, I was not surprised to learn that animation theorists and scholars cannot, or will not, formally define animation’ (Wells, 2011, pp.11-32).

This is partly, of course, because in the digital era, applications and perceptions of ‘animation’ have changed, and with the myriad of techniques used and the various approaches to making animation, it has proved difficult to identify a core definition that does not reduce animation merely to a ‘frame-by-frame’ practice and not take into account the overall manipulation of the image as a deliberate and conscious illusionist act, nor indeed, the distinctiveness of its pre-filmic process in constructing pro-filmic materials.

There are two prominent societies that support Animation in the UK: The Society of Animation Studies (SAS) and the Association Internationale du Film d'Animation (International Animated Film Association) (ASIFA). They are distinctive because both support Animation specifically and only, recognising animation as a particular practice, with changing and developmental parameters. In 1973, Alexander Alexeieff noted 'Animation which has found numerous production techniques, presents itself as a 'frame by frame' method of creation of movement, no matter what technique has been used...but the high number of the possible applications of animation is precisely what makes its classification so difficult' ((Bendazzi, 1994, p.Preface xxi). Wells cites Holloway who suggests animation as a giving of 'life and soul to a design, not through the copying but through the transformation of reality' (Wells, 1998, p p.10). This emphasis of giving life and soul to an inanimate object seems prominent and yet dismissed easily by its reoccurrence, which is manifested in so many publications. However, it is this 'giving', this 'breathing' of life which is so very important to Animation Therapy as it reflects the opportunity of giving new life, restoring old life, presenting current life and past life - lives which include humans and experiences and occurrences and lives that have not had the experiences that animation can provide. Animation Therapy then affords the opportunity 'to give life' afresh, not merely through a technical application, but through psychological, emotional, and physical re-configuration. One participant from the 'Made With Love: Mediating the use of Animation when tackling Bereavement' project. (Hani, 2006) states 'Since I was 16 I have been wanting to get married...at least I got married on my animation. I don't feel guilty...I have got to the church and I did get married' (Hani, 2006, p.43). The participant had been with her partner for many years and they had three children together. The participant remained with him whilst he was at the hospice and only left on the day of the planned wedding to collect the paperwork from the registry office. Whilst she was absent, he passed away and the wedding never took place. Her film was based on creating, preparing and re-enacting their wedding day whilst being chased by the grim reaper. In her film, she defeated the grim reaper by having her wedding. She states 'I really had it on my brain why why why why did I walk away. I was really mad with myself leaving but this is my way of getting my emotions out and my dream come true out on a picture' (Payne, 2006).



Figure 2: Film frame from *Made With Love: Mediating the use of Animation when tackling Bereavement*.

Another participant from the same project was consumed by thoughts regarding her husband's illness and the development of that illness leading to his passing. She would discuss issues about the hospital care, unavailable support from the council and expressed she had forgotten the life she had previously lived with him prior to the illness. The designed Animation process at this point was influenced by cognitive behaviour techniques (CBT). The participant created a film based on their life together rather than her husband's death from motor neurones disease. When watching her film she stated 'I feel as if I have got Dick back the way he was and I can look back now and think yes we did have happy memories and the illness is to the back of my mind now and I can think positively about moving forward' (Payne, 2006) The participant watches the film regularly.



Figure 3: Film frame from Made With Love: Mediating the use of Animation when tackling Bereavement.

To summarise, animation with its numerous techniques and possible applications, is normally understood as a 'frame by frame' method of creation, that provides an illusion of movement made by photographing successive positions of inanimate objects or drawings. I wish to propose though that it is actually a 'stage by stage' method of production which 'gives life' by paralleling and integrating the making of animation with the *re-making* of individual lives arrested and deadened by personal issues and problems.

Animation 'Gives Life' to Therapy

The GHM is a mode of therapy that is intrinsically related and entwined closely and specifically to the process and deployment of animation, and its numerous techniques and possible applications. Animation Therapy has as its main focus the intentional use of aspects of animation production as parallel and integrated stages of the therapeutic process.

Aldridge argues, 'Engaging research respondents in participatory research (PR) methods that promote the autonomy and 'voices' defined as vulnerable has gained prominence over recent years' (Aldridge, 2016, p.7). Animation Therapy promotes autonomy and the voice of the individual through the execution of the participant created and directed animated film. Animation Therapy is a talking therapy that engages with the traditional therapeutic approach but also allows the facility for a voice to appear through the use of static visual materials and moving-image visual materials. Crucially it allows for the silent, hidden voice to be heard, seemingly promoting security, trust, and confidence in a participant, to express themselves openly without judgment or persecution. This is vital when the GHM is used in its 'diagnostic' form – though this is essentially facilitatory rather than medically identificatory - and

evidenced in the project, 'A Friend to Circles: protecting and safeguarding children through the use of the Good Heart Model', in the treatment of high risk sex offenders when the participant clearly outlines the emotional stages that are experienced when going through the judicial system and for the identified reasons and rationalisation of why offences took place. The participant's identity was made anonymous through the use of animation, and this allowed him to express, reason, and emote, without fear and without having to disclose his identity, increasing the validity of the research outcomes and moving towards a more persuasive version of the 'truth'. Wells 'recognises the possibility in 'animation' of expressing feelings and thoughts about taboo subjects without inhibition' (Wells, 1998, p.11). In the GHM, the animation studio environment is made confidential and an added level of confidentiality is assured by using a soundproofed recording studio.

The function of this facility was clearly evidenced when working on the research project: 'Made With Love Too: Analysing the effectiveness of animation' (Good Hearts Model 2011), in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs. One particular participant chose not to discuss her deceased mother, the relationship with her, and any feelings she was experiencing, until she entered the sound proofed studio. It was here that she used the microphone as a tool to tell her mother what she felt and expressed this in a heightened emotional state of anger with most of the sound track remaining in the red cut off point of the volume control, and the levels expanded past what the computer could manage.

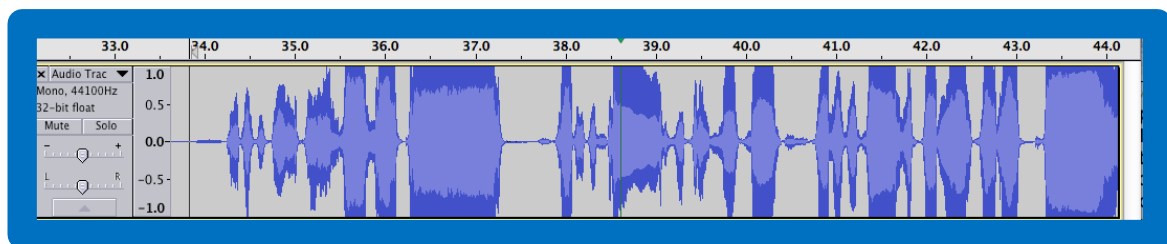


Figure 4: Example of sound levels and their elevated state plus the script.

SCRIPT

This is a song for you Mum-Muppet
When did you say you didn't like my cat...
Oh when did she die to night
Oh she didn't die to night, to night, to night
Why did I miss her
Why do I miss her
When did I save my life to night with my pussy cat called
Muppet, pussy cat Muppet – My pet
Why did you say you didn't like my cat, that's when I said 'you
like my cat'
Why did you go quiet on my Dad
When did you say you didn't like me
Why did you say you didn't like Dad
Why did you say that to you and me...
When did you say bye
When did my mum die too to night
Why why why why why why did you say
Why did you say that
Why did you say that
Why did you do that
What did you do the music for
Done

Figure 5: Script from 'Made With Love Too: Analysing the effectiveness of animation' (Good Hearts Model 2011), in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs.

The participant accidentally starts: 'this is a song for you Mum' but corrects herself initially by saying 'Muppet' who was her cat. At the end, the participant calmly states 'done'. The completed film edited to the soundtrack was compiled from a portrait of the participant's deceased mother, an animated 'splice' of that character - the body and legs going one way and the head and torso going another - the participant's cat and then a more abstract exploratory, non-figurative use of materials: paint, clay, objects, etc, ending with the depiction of a circle into an outer space scene. Wells strongly states 'Animation is the most dynamic form of expression' (Wells, 2006, p.6) and in this case that was evidenced; 'the animated film enables the film-maker(s) to be more expressive and thus more subversive' (Wells, 1998, p.6).

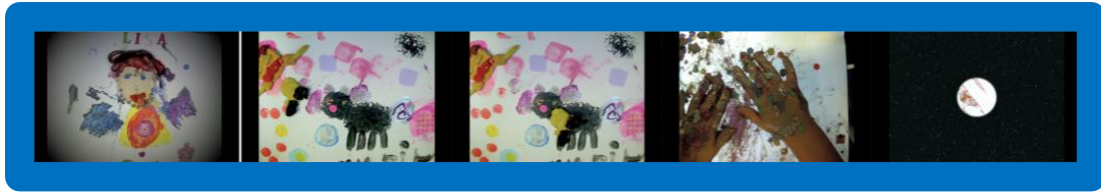


Figure 6: Film frames from ‘Made With Love Too: Analysing the effectiveness of animation’ (Good Hearts Model 2011), in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs.

Autonomy, personal direction and control, all significant attractions in using animation, are important factors when applying the GHM, but crucially, they are concerned primarily with *personal* control before *artistic* control. This person-centred, self directed, animated therapeutic process ensures a ‘truth’ in the outcome, which is not first about aesthetic or conceptual achievement, but evidence in the process of allowing ‘for a greater understanding of oneself’. The GHM allows the participant total control and the hand of the participant is the only hand in the work; this makes it even more effective therapeutically and as research evidence. This is especially important in that only by proving that the process in making the animation itself is also a model of stage-by-stage therapeutic development will there be full acceptance of the GHM as a significant and particular practice model, just as specific as music or drama (both of which animation practice can employ, too).

At a recent conference, ‘Victims: Journeys through the Criminal Justice System’ 25 March 2015 collected feedback from police representatives stated that ‘Qualitative research methods as opposed to quantitative data gathering approaches are needed to understand victims’ stories and that this needs to transpire within data gathering in the police force also’ (Hani et al., 2015). A Police inspector identified that his fellow colleagues and victims were more effective in giving narrative accounts than ticking boxes for data with no meaning. Animation was identified at this conference as one area that can support the transference of such narratives and has been successful in doing so in the ‘A Friends to Circles’ project where the film spoke to a number of audiences including the National Offender Management Service (NOMS) and the police force. The GHM then, is recognized as a ‘qualitative’ research method in itself, and an applied model of accumulative evidence in proving therapeutic success.

In 2000 NACRO employed Animation as part of a scheme - ‘the Venture’ - to reduce juvenile crime on the Caia Park Estate, Wrexham, North Wales. NACRO are a crime reduction charity who ‘are dedicated to reducing crime and reoffending in communities across England and Wales.’ They work with ‘the most disadvantaged people, offenders and those at risk of offending, to help them find positive alternatives to crime and to achieve their full potential’ (Nacro.org.uk, 2015)(NACRO, 2000).

Animation was embedded into the programme of activities and ‘The Social Exclusion Unit’s report on ‘Arts and Sport’ noted that ‘The Venture project on the Caia Park Estate in Wrexham cut juvenile crime on the estate by 54% within four years’ (NACRO, 2000). Though animation – using aspects of the GHM model - was embedded in the programme of work, it was allied with an assortment of other activities, so it was difficult to define the effectiveness of animation had as a single discipline. Therefore, the following projects define how the singular use of animation

has enabled research outcomes to develop a clear methodology underpinning the working model of the GHM.

The GHM

As I have noted elsewhere,

‘The GHM is an applied and adaptable theoretical and practical strategic approach to tackle negative issues experienced by people in marginalised groups. It was developed to provide a safe and effective way of using animation in ‘participatory practice’. In addition, the GHM uses animation and the preproduction process to directly and indirectly impact socially and economically. It aims to bring about positive change within people, communities and governments nationally and internationally and is used to educate, inform, resolve, and challenge communities, individuals, attitudes and behaviors working towards respect and equality. It aims to continue to generate a growth of creative solutions and accomplishments’ (Hani, 2014, p.2).

Using the person centred approach, pioneered by Carl Rogers, the GHM uses animation to directly engage with the participant and their perceived problem, embracing marginal groups often characterized by ‘difference’ and ‘otherness’, and using unconditional and empathetic approaches to encourage emotional, action-led investment and outcomes. By using the animation process itself as a conduit for the stage by stage visualization of the therapeutic journey, there is considerable evidence of the structures and strategies to enhance well-being and productive processes of healing. Each project refines the approach, and among other things has provided evidence for analytical research; achieved impact on public policy and public services; improved the lives and well-being of individuals and communities.

By working through the linear preproduction process with evidential outputs (data) at each stage; character designs, sound recordings, animations, to mention a few, the participant has ownership of what outcomes are produced and can evaluate, reflect upon their personal healing process during and after the therapeutic sessions have ended. All the created parts are then owned in one form; the animated film. Want by the participant of ownership has been evidenced throughout the testing of the GHM. This is most prominently seen in such projects like ‘the Venture’ - to reduce juvenile crime (Hani, 2001) when participants at the end vocalize ‘Who made this?’ and they reply confidently through self portrait animated characters stating their full names.

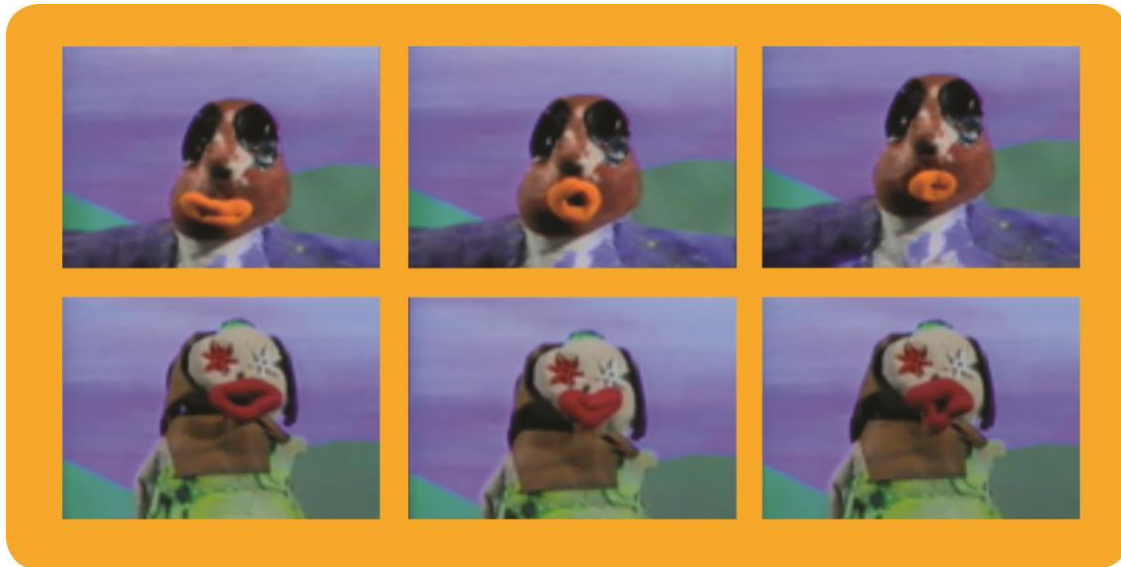


Figure 7: Film frames from 'the Venture' to reduce juvenile crime (Hani, 2001).

Most recently the title design inclusion has been used in a new area where secrets were placed by the participants. When observing still images, any text can be easily read at leisure. However, the text that moves at a speed faster than the eye can read is more difficult. Ofcom detail that any text must be held for a certain time e.g. 10 words must be held for 8 seconds, 3 seconds to allow for recognition time, or an 8 second roll (OFCOM, 2015). One participant from 'Made With Love Too: Analysing the effectiveness of animation (Good Hearts Model 2011) in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs (Hani, 2013), chose to disclose that he liked his father's new girlfriend and he loved his Dad. This was particularly difficult to say outside of the animation because this participant had a diagnosis of Autism Spectrum Disorder but most prominently because he had lost his mum and was experiencing his father in a new relationship. The GHM allows freedom of creation and in this particular film, the participant wanted the text to be moving and only clearly visible if paused on each frame. It ran for 60 frames per second. However, this title did move, was five seconds in length in total from distorted image to distorted image and the participant stated that 'there was a secret message on it'.

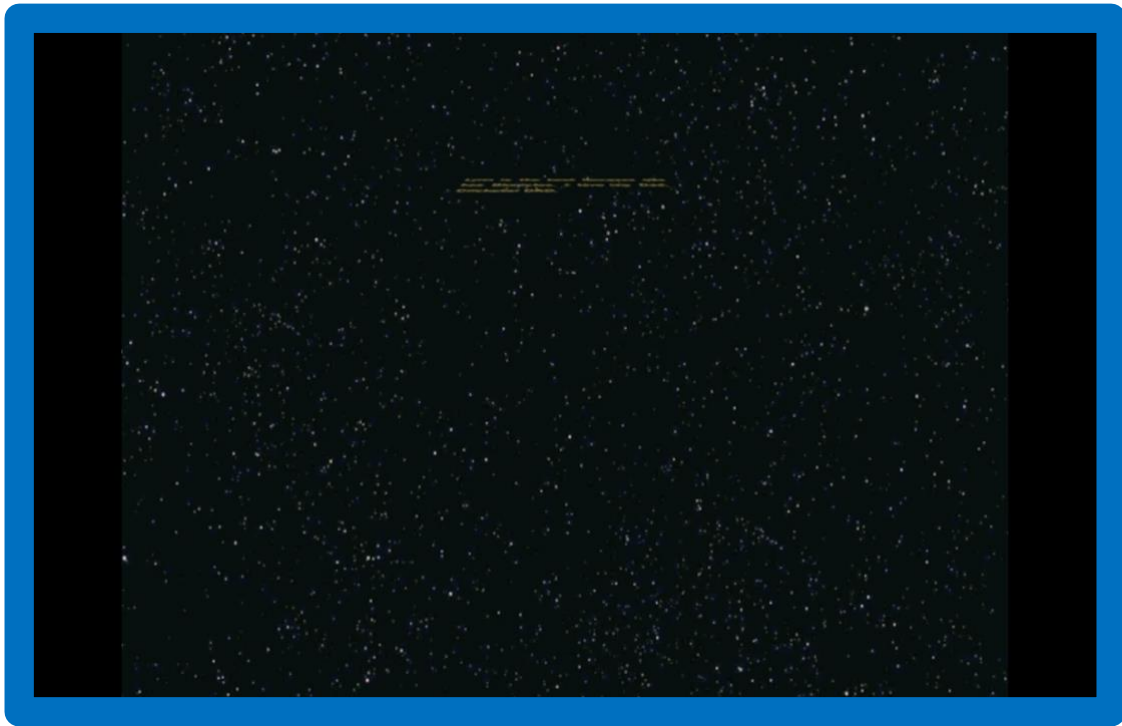


Figure 8: Film frame from the end sequence.

‘The GHM acts as a co-created continuous dialogue between the film process and the participant. The model is designed as a therapeutic continuum, from the beginning of the preproduction process through the making of an animated film, and its viewing.’ (Hani, M 2014) Due to digital storage, easily accessible on a variety of platforms, the animation can be viewed effortlessly, repeatedly but also by others if required (Ware, 2014, pp238-239). The nature of animation as a form allows easy, quick digestion of a context, emotion or a narrative. ‘The Broadcasters Audience Research Board (BARB) show that around 96% of UK homes have a television set, or watch live TV on other devices (TV Licensing, 2016). Film, TV and animation are in our lives and from an early age we are exposed and learn how to read film. You do not have to be privileged to access it.

At this juncture, the GHM has been utilized with individuals who are living with poor emotional wellness, have experienced loss, disengagement with others, endured prejudice and impeachment ‘and ones who have experienced violence or abuse (physical, emotional, sexual, neglect). It has also been used within rehabilitation and with individuals who deem education is exclusive, are in substitute care and have been or are involved with criminal justice activities (Hani *et al.*, 2004, pp.32-33).

The GHM obligates the participant to take total command of the pre-production process and thereby constantly innovates in the relationship between the typical process and the emotional and behavioral response to it, and employing it. ‘Norman McLaren (1914-1987) a pioneering animator states that what takes place between each frame is as vital as what occurs on the frame (a frame being a single still image in an animated sequence) (Wells, 2011, p.13) McLaren’s concept is essentially

focused on the artistic animated practice and its process,' suggesting that the decisions made and the work taking place between the frames is actually an embodiment of the distinctive imperatives in animation. Conversely, I utilise this concept of the space between the frames as a chance to not only apply the GHM's diagnostic tools but also as a facilitatory and therapeutic space in the ensuing creative discussion as an expression of psychological and emotional needs. I argue that this fresh approach allows a different therapeutic opportunity that presents between the frames, on the frames, and at the end of the film making process when the frames form the tertiary therapeutic moment in the form of the animation. The frames and the space between presents the therapeutic boundary.

The GHM is sustained by a framework that highlights four vital levels of consideration when designing the process specific to the participant/s and issues to be addressed. This frame work also acts as an aid in research design, prepare, collect, analyze and share (Yin, 2003, p25).



Figure 9: GHM Framework (Hani, 2014).

So, for example prior to embarking on the Made with Love project an understanding of the subject, the participants and the 'problem' was required. (see Level 1, Figure 9). Interviews with relevant staff and participants were carried out, participant observations, training provided by St Benedicts Hospice, the NHS and Cruse Bereavement Care. The problem; poor healthy personal and family functioning after a loss. Proceeding through the GHM process (Figure 9, Level 2), ethics committee approval was sought from the University of Sunderland and the National Health Service (NHS), and contracts and risk assessments were all put in place. Funding was obtained from the community fellowship fund and two palliative nurses, the hospice Chaplain and a doctor specializing in bereavement and palliative care were recruited and also interviewed.

The research was designed to mirror the 'continuing bonds' perspective; supporting the contemporary theory that ongoing relationships with the deceased are normal and often beneficial aspects of bereavement (Steffen and Coyle, 2011, pp. 579-609). One common continuing bond expression, the experience of 'sensing the presence of the deceased', constitutes an interesting phenomenon in this context. Sense of presence experiences can involve clearly sensory impressions such as the visual, auditory, tactile, and olfactory perception of the deceased or the quasi-sensory subjective but (experienced as) veridical 'feeling of presence' of the deceased (Steffen and Coyle, 2011, pp. 579-609). It was clear that the participants reflected the traditional western theory of being unable to 'move on' but unable to move on from the experience of the dying and the death. It was necessary therefore to design a structure that allowed a

visual, auditory, tactile perception of the deceased that allowed a presence of the deceased and a celebration of their life and experiences with the deceased prior to the illness. Animation with its visual, auditory, tactile complexities enabled and complimented this approach.

Feedback from a participant from the project 'Made With Love'

'Alan's illness was short he seemed to be whipped away from me so suddenly. After the all consuming caring and comforting of Frank then death and nothing but a hurtful void. The project has helped us all to recognise and remember the happy times and the life we shared for 26 years with a real gentlemen and focus on the life before cancer cruelly ended it. Being able to express our feelings through this animation workshop has been a truly healing process.' (Hani, 2006, p.63)

Figure 11 demonstrates in further detail how applied animation corresponds and expands the strategic existing therapeutic practices that occur at Level 3. The GHM gives distinct emphasis to specific elements of the preproduction procedure in each situation. For this certain group, stages were completed for example encompassing the following initiatives: Utilisation of photographs and objects, backgrounds, experimental animation, pixilation, scripts, poems, letters, sound recording and creation, model creation, animation. Part of the process resulted in an increased use of expressive language leading to a group illustration of physical and emotional feelings.

Emotional Feelings

Sad
Cry a lot
Everyone asked me, if I was fine-I
wasn't fine
Scared
I felt normal, which made me feel
odd
Absence/Miss
I felt fine
Happy and sad - confusion
Up and Down
Lonely
Try to hide my emotions
Worried
Numbness
Shock
Guilt
Anxiousness
Desolation
Hysterical
Robbed
Strange
Weird
Emptiness
Washed out feeling
Laughing and feeling guilty
Sluggish
Regret
Relief

Physical Feelings

Sick
Physical emptiness in the home
Tired
Stressed
Felt pain
Feel ill but don't feel sick
Want to have a decent nights
sleep
Go red in the face
Headaches
Can't go out on my own
Restricted to where I can go in
the dark winter days
Loss of appetite
Palpitations
Lack of motivation

Figure 10: Emotional and Physical feelings expressed from the group (Hani, 2006 pp78-79).

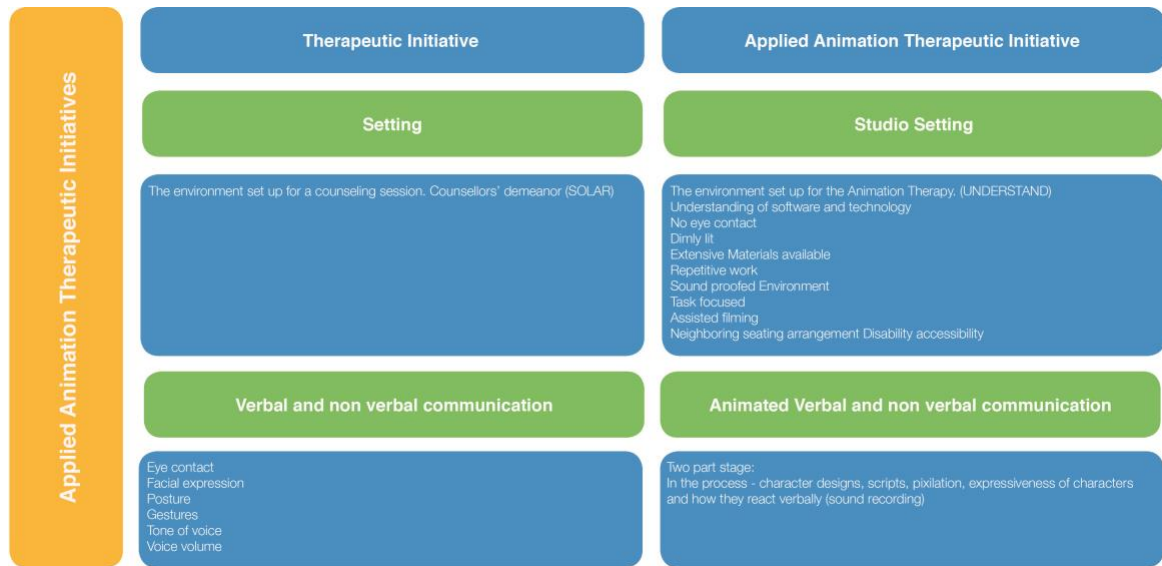


Figure 11: The traditional forms of therapeutic Initiatives, aligned to the Applied Animation Therapeutic Initiatives (Hani, 2014).

‘The idea that people possess multiple senses of self or personas, is not a new one in psychology and sociology ... Rogers’ (1951) notion of the true self was informed by Jung’s (1953) distinction between the unconscious self and its public mask, the persona ... For Rogers, an important feature of the process of therapy was the work towards discovery of the true self’ (Bargh, McKenna and Fitzsimons, 2002, p.34).

The GHM launches by using techniques to engage with the individual and the assumption of the ‘false self’ currently maintained by the participant. The aim is that by the end of the process, the participant will reveal the ‘true self and ‘self actualize’ or move towards ‘self actualisation’, by employing animated autobiographical, communicative methods even if investigational, philosophical or depictive of that instantaneous chosen moment of time or feeling (Maslow, 1948, pp.433-436). The participant is requested to construct a self-portrait that will be animated. Self-portraits are utilized as they offer an opportunity for the participants to convey their internal self and to externalise this internal self physically and psychologically with no difficult confrontations (Smith, 2008, p.8). The essential ‘cutting up’ phase of the image for animation is the critical point in the process. It is necessary that the participant, if physically capable, cuts up their individual image and then independently films the character in movement. The image is recreated and reborn as a consequence of this process and animation allowing for an additional tier of expressive communication. (Image 1)

A dialectical relationship is instigated adopting the ‘Applied Animation Therapeutic Initiatives’ (Figure 11). The method acquaints us to the participant’s physical and psychological needs and their specific interests. The process demonstrates to the participant that they have command permitting and encouraging an instant response of transformation and alteration. This process of opportune self-rule, control and transformation then impacts on the content of the script, stories, expressions, and characters later on. Participants can deliberate how they describe their thoughts, feelings and emotions relative to practice in the third person. The participants are free to visualise individuals or themselves in any style of illustration. The drawing provides an opportunity to express or highlight feelings or issues for example when working

with children of parents in prison, one participant placed her portrait in a bed, it was only till later on from developing the script that it was clear this particular participant missed her father the most when putting her to bed.



Figure 12: Frame exemplifying the reconstructed self-portrait in a scene.

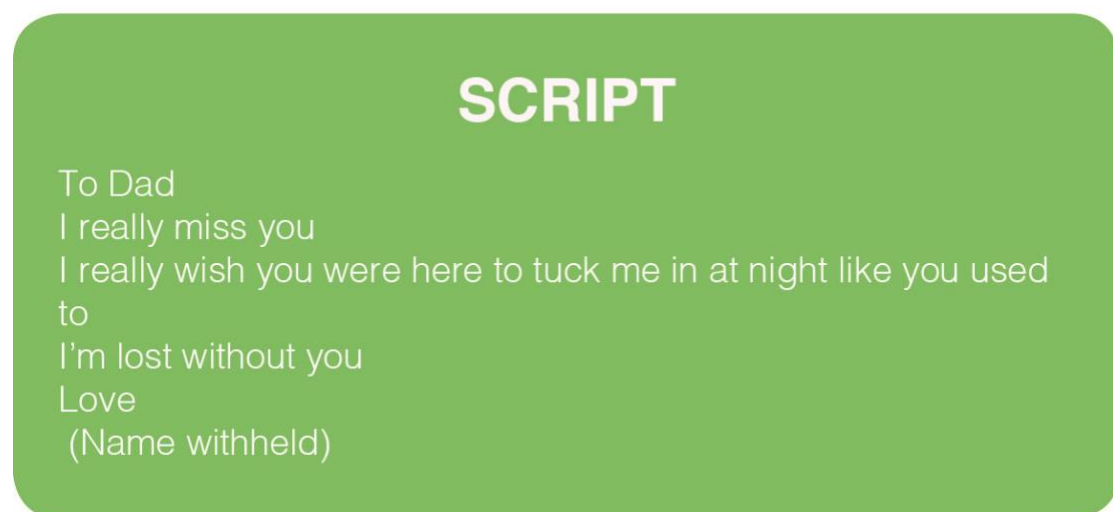


Figure 13: : The script that followed sessions later on in the process.

Not only was this a new disclosure to supporting services but this was the first time that her mother had realized that additional to her losing her partner, her daughter had lost her father and the mothers anger to her partner was not mirrored in her daughter. Her

daughter was struggling with her own differing emotions. At this crucial moment a paradigm shift commences as the reflection interchanges from the first-person experience to the third-person narrative and then back to the first-person reflection or paraphrase stage whilst also allowing another third party to observe.

Though there is sometimes skepticism about ‘participatory’ practice as supposedly more about creative amusement, and the practice of animation still tainted with the idea that it is merely children’s entertainment, these perceptions are changing with the recognition that the very practice of animation has an embedded procedural focus that can be used to engage with psychological and emotional expression dedicated to personal rather than aesthetic or conceptual exposition. Crucially, though, the perception of animation as an ‘innocent’ or ‘naïve’ medium, both familiar and seemingly non-intrusive, enables many to use it without the ‘withholds’ that sometimes come with ‘making a film’ or using a complex piece of ‘technology’. The organized and controlled use of animation offers a method of communication that does not require an intelligible use of meaningful textual and verbal linguistics to demonstrate emotional intelligence. It offers a way for debate and disclosure of issues that may under other conditions have remained unexpressed. The Animation process does not terminate at the close of a therapeutic session or at the end of the creation of a still image. The diverse stages of the process connect affording opportunities for the participant to reflect, heal and improve over an extended time period.

The linear production process promotes an elevation in well-being together with a permanent record that can be replayed and disseminated at any time. Carl Rogers explains that his model facilitates a therapeutic relationship rather than treats, cures or changes. Animation facilitates a therapeutic relationship with the facilitator, their inner self and external audiences. In addition, animation provides the opportunity to have autonomous control of a story, to relive a life, to construct a message and express something whilst hiding one’s identity.

When comparing Animation Therapy to traditional forms of therapy, it is clear that when applying the GHM, the therapeutic benefits occur during and within the pre-production process additional to the presentation of the final film. The pre-production process is a linear, semi-structured approach that helps to make an animated film. It is the ‘preparation of the essential resources and materials to make and complete a project’ (Wells, 2006, p.12). Wells states that the pre-production stages are ‘often undervalued’ however within the GHM, they are equally if not more important to the therapeutic process. The stages make up the therapeutic journey. The preproduction stage is ‘one of the most creative phases in an animation production. It is during the design of the characters that the personalities of the characters are identified, their appearance/look is specified, and their emotions and behaviors are identified.’ (Wurtzel, Wurtzel and Wurtzel, 2005). Similarly in the GHM, it is here that also the participants express their personalities, emotions and behaviors. Of course, within the industry this may not be consistent nor a compulsory approach, but when applying the GHM it is essential that various stages are structured in and presented. However ‘aspects of any production are constantly reviewed and revised as they go along’ (Wells, 2006, p.11). This allows for a staged therapeutic approach to take place, supports the creation of an animated film and keeps a consistency for research purposes.

The key stages included in the GHM are identified in Figure 14

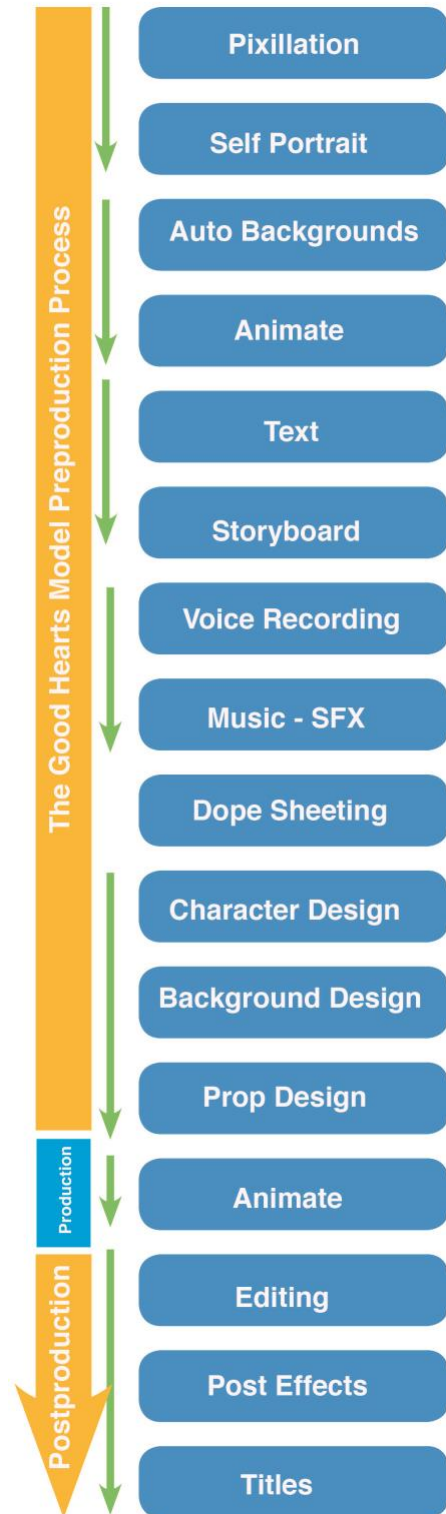


Figure 14: The key preproduction stages undertaken in the GHM.



Figure 15: The key exhibition stages undertaken in the GHM.

Conclusion

I wish to suggest that there are notable and evidencable therapeutic outcomes from using the animation process as identified here. The participants who have undergone the process are afforded a self-conscious recognition of their own therapy because of the self-reflexive modes and ‘animated active listening’ techniques that are embedded in animation practice. It is a multi-faceted tool that does not limit itself to the final animation, but extends further into such areas as sound, writing, music, scriptwriting, storyboarding etc, which separately and together make up the animation process and facilitate therapeutic interventions in different forms. The key principle here is that the animation therapist can use the process effectively to encourage personal self-interrogation through the safety of the creative process, freed from the idea that creativity is about aesthetics and artistic concepts, and fundamentally about problem solving and self-identification through moving mark making (2D and 3D) and the pre-filmic and pro-filmic nature of its negotiation and expression.

Current Regulatory Practice of Art Therapy in England

HCPC Regulation

To date, ‘Animation Therapy’ is not regulated by the Health and Care Professions Council (HCPC). In June 1999 art therapists, the only creative profession in England, were invited to register with the HCPC. Since July 2005, the HCPC has protected four professional titles under this profession; Art psychotherapists, Art therapists, Drama therapists, Music therapists. In 2015, there were 3,574 registered art therapists in England. ‘All these professions are linked by the delivery of psychotherapy through an art form and new entrants are required to have completed previous study in art, music or drama prior to undertaking psychotherapy training’ (Waller and Guthrie, 2013, p.6). Anyone using these titles are ‘protected in law and only someone who has completed an approved training and who is registered with the HCPC can lawfully use one or more of these titles’ (Waller and Guthrie, 2013, p.7). They must be also registered with the HCPC and comply to the HCPC standards of proficiency. ‘The responsibility of the HCPC is to ‘protect the health and wellbeing of those using or needing the services of registrants’ (HCPC, 2018). It accomplishes this responsibility by evolving and monitoring ‘strategy and policy’ in accordance to the Health and Social Work Professions Order 2001. On the occasion that a registrant does not comply with the standards, the HCPC can prevent a registrant from practicing, guaranteeing a high standard of service for all participants and practitioners (HCPC, 2018).

This discussion proposes, then, that the GHM model should be considered as the benchmark process by which ‘Animation Therapy’ should be validated by the HCPC, or ultimately, find its own validation through the recognition of relevant external agencies. As there is no regulatory body or inclusion in the HCPC, the current quality and variety of practice is little understood and unknown in England. The GHM begins to test the effectiveness of Animation Therapy, and to provide a procedure that can be monitored and regulated.

Recent communication from the HCPC detailed that ‘arts therapists became regulated as a result of lobbying from the professional bodies for art, music and

drama' (Guthrie, 2015). Additionally, 'the experience of arts therapies is perhaps notable in that three professional bodies were compelled to join forces to achieve a common goal and have coalesced under an umbrella title closely related to that of just one of them (Art Therapy)' (Waller and Guthrie, 2013, p.11). The consequence of Animation Therapy having no professional body suggests that Animation Therapy needs one to be empowered enough to commence a move to become regulated, labelled as a profession and have a protected title identified by the HCPC. A body for Animation Therapy would help promote the role of Animation Therapy in a variety of social contexts drawing nearer to professional inclusion in the NHS and like Art Therapy to 'succeed in recognition as a profession within itself, provide clarity about the activities, set a fee structure and to provide 'clear standards and training'. The GHM is a proven process and is presented here within the parameters of a field journal in order to substantiate its claims and to encourage further discourse both as a theory of practice, and a practice of theory (Wells, 2013). This validates its presence as a model which will be transferable and subject to specific training for professional and academic purposes. There is already substantial formative evidence of its proven success as a practice, for it to represent a significant summative model of theoretical engagement which articulates the processes, tools, application and outcomes of both animation and therapy.

Biography of Author

Melanie Hani is a member of The Animation Academy, Loughborough University 'a Centre for animation research, scholarship, practice and exhibition dedicated to excellence at a national and international level in all its activities'. Melanie is also founder member of HEART (Healing Education Animation Research Therapy); a research organization that comprises of practitioners, researchers, filmmakers, educationalists and student practitioners who use the process and outcome of animation practice and film in a therapeutic, educational and informative way locally, nationally and internationally. Melanie has now developed a new branch of HEART in the East Midlands at Loughborough University (HEART EM).

Melanie's research examines the effectiveness of the animation practice within therapy, criminology, education, as a methodology and translational device. Service users are from statutory (health, education, social care, research and probationary services) and voluntary sector organisations. Melanie's work has received recognition by the Queen and Duke of Edinburgh and was invited to an award event at Buckingham Palace "marking those who have made a significant contribution to local or national life"; similarly, her inclusive strategies for children excluded from mainstream education and her work with the severely bereaved have been commended by Baroness Morris of Yardley and the Duke of Gloucester. Melanie has also won an NHS Innovation Award, the enterprise Award for social and cultural impact and been awarded a Community Fellowship. Melanie has worked nationally and internationally with diverse groups such as children who were first generation child immigrants in the UK; have transgendered parents; suffering with attachment disorder in Slovakia; bereaved; from the travelling community; bereaved and also have a diagnosis of ASD; high risk sex offenders.

Additionally, Melanie has developed a model; the Good Hearts Model (GHM 2011), a programme of therapeutic practice that employs the process of producing animated films and allied materials. Melanie continues to test the facility of animation and creative practices when working with people who are marginalised and/or have

physical, social, emotional, educational and cognitive issues whilst combining the process with person centered approaches and psychotherapeutic theories.

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Figures

Figure 1: Terminology.	4
Figure 2: Film frame from <i>Made With Love: Mediating the use of Animation when tackling Bereavement</i>	10
Figure 3: Film frame from <i>Made With Love: Mediating the use of Animation when tackling Bereavement</i>	11
Figure 4: Example of sound levels and their elevated state plus the script.	12
Figure 5: Script from ‘ <i>Made With Love Too: Analysing the effectiveness of animation</i> ’ (Good Hearts Model 2011), in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs.	13
Figure 6: Film frames from ‘ <i>Made With Love Too: Analysing the effectiveness of animation</i> ’ (Good Hearts Model 2011), in tackling issues surrounding and relating to loss and bereavement in mainstream children and children with special needs.	14
Figure 7: Film frames from ‘ <i>the Venture</i> ’ to reduce juvenile crime (Hani, 2001).	16
Figure 8: Film frame from the end sequence.	17
Figure 9: GHM Framework (Hani, 2014).	18
Figure 10: Emotional and Physical feelings expressed from the group (Hani, 2006 pp78-79).	20
Figure 11: The traditional forms of therapeutic Initiatives, aligned to the Applied Animation Therapeutic Initiatives (Hani, 2014).	21
Figure 12: Frame exemplifying the reconstructed self-portrait in a scene.	22
Figure 13: : The script that followed sessions later on in the process.	22
Figure 14: The key preproduction stages undertaken in the GHM.	24
Figure 15: The key exhibition stages undertaken in the GHM.	25