Policy Insight / Commentary

Art Psychotherapy for Complex PTSD: A Case for Urgent Research Investment

Kelly Jayne[1], Jane Bourne[2], Eleanor Keiller[3], Eleanor Melvin[4] and Simon Hackett[2]

[1] Independent Researcher, UK
[2] Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, UK; Newcastle University, Population Health Sciences Institute, UK
[3] Youth Resilience Unit, Centre for Psychiatry and Mental Health, Wolfson Institute of Population Health, Queen Mary University of London, UK
[4] Warwick Medical School, University of Warwick, UK
Corresponding author: Kelly Jayne, Kellyajayne@gmail.com

Abstract

Complex post-traumatic stress disorder (CPTSD), formally recognised in the ICD-11 (2019), remains underserved by existing treatment guidelines in the United Kingdom and internationally, and is largely absent from the Art Psychotherapy evidence base. Within the NHS, current NICE-recommended treatments for PTSD — trauma-focused cognitive behavioural therapy and eye movement desensitisation and reprocessing — were not developed for CPTSD, and no equivalent guidelines exist for this population. This commentary draws on the authors' recently completed unpublished integrative review of Art Psychotherapy for adults with complex psychological trauma, which identified only two studies (n = 16) meeting inclusion criteria from a six-year international search, and examines three structural constraints on evidence development: the DSM-5's exclusion of CPTSD and its effects on research infrastructure; the limitations of randomised controlled trial methodology as applied to complex, relational interventions; and the gap between the theoretical and clinical rationale for Art Psychotherapy in complex trauma and the absence of an empirical evidence base. Recommendations are directed at NHS commissioners, UK research funding bodies, the HCPC-regulated arts therapy profession, NICE, and the international research community.

Keywords: CPTSD; art psychotherapy; trauma treatment; evidence base; NHS; NICE

Open Access: Licensed under CC BY-NC-ND 4.0
© 2026 The Author(s). Published by the Complex Trauma Institute under the Creative Commons Attribution–NonCommercial–NoDerivatives 4.0 International Licence (CC BY-NC-ND 4.0)
Licence text: https://creativecommons.org/licenses/by-nc-nd/4.0/
ISSN 2635-0807 | Perspectives on Complex Trauma, Volume 7, Issue 1 (2026)
Published: August 2026

Introduction

Complex post-traumatic stress disorder (CPTSD) is a diagnostically distinct condition characterised by the three core ICD-11 PTSD symptom clusters—re-experiencing, avoidance and a sense of current threat—together with three disturbances in self-organisation: affect dysregulation, negative self-concept and disturbances in relationships (World Health Organization [WHO], 2019; Maercker, 2021). It arises from prolonged or repeated traumatisation from which escape is difficult or impossible, and its clinical presentation frequently renders standard trauma protocols insufficient or contraindicated at early treatment stages. Despite this, the therapeutic evidence base for adults living with CPTSD remains limited, and Art Psychotherapy, despite a theoretically coherent rationale for its application with this population, is notably underrepresented within it.

This commentary is based on a recently completed integrative review of Art Psychotherapy for adults with complex psychological trauma. That review identified only two eligible peer-reviewed quantitative studies (n = 16) across a six-year international search (Coles & Harrison, 2018; Schouten et al., 2019). The argument developed here is therefore not that effectiveness has been established, but that the extreme thinness of the evidence base reflects wider structural barriers to evidence development in this area, both within the UK and internationally.

Three inter-related arguments are developed below. First, the DSM-5's continued exclusion of CPTSD functions as a structural barrier to evidence generation with particular consequences for the UK's position within international research networks. Second, the dominance of randomised controlled trial (RCT) methodology as the primary evaluative framework presents particular challenges for this population and intervention type. Third, the asymmetry between a well-developed theoretical rationale and a limited empirical evidence base warrants critical examination and suggests that methodological and infrastructural factors may be contributing to the apparent research gap.

Current Landscape: Policy Context and Structural Evidence Gaps

This commentary draws on a completed integrative review which found only two peer-reviewed quantitative studies meeting inclusion criteria, together involving sixteen participants (Coles & Harrison, 2018; Schouten et al., 2019). While both studies reported encouraging outcomes, the evidence base remains preliminary and insufficient to support conclusions about efficacy. For the purposes of this commentary, the importance of that finding lies less in the studies themselves than in what their scarcity reveals about the structural conditions under which evidence in this field is, or is not, produced.

Policy and Clinical Context

The ICD-11 formally recognises CPTSD as a distinct diagnostic category; however, ICD-11 has not yet fully replaced ICD-10 across NHS morbidity coding systems in England, creating a gap between diagnostic recognition and routine service coding/data infrastructure (NHS England, 2026). Despite this, the DSM-5, which does not include a

CPTSD diagnosis, continues to dominate the design of international research trials, validated outcome measures, and grant funding criteria. This divergence between the diagnostic system used in UK clinical practice and the framework that governs most international research infrastructure creates a structural misalignment with direct consequences for the utility of international evidence to UK practitioners.

Within England, current NICE guidelines (NICE, 2018) recommend trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) as first-line treatments for PTSD. These recommendations reflect a robust evidence base. However, as Mind UK (2021) has noted, they were not developed for CPTSD, and the clinical presentation of CPTSD — particularly its affect dysregulation, pervasive shame, and relational disruption — frequently requires more extended stabilisation and a different therapeutic approach than standard PTSD protocols provide. The NHS Long Term Plan (NHS, 2019) committed to expanding access to evidence-based psychological therapies, yet CPTSD remains without a dedicated treatment pathway within NHS commissioning frameworks.

The theoretical case for Art Psychotherapy in complex trauma is clinically and neurobiologically plausible, and is supported by a substantial international literature on traumatic memory, sensory-perceptual processing, and non-verbal modes of expression. However, this theoretical coherence should not be confused with an established evidence base for efficacy in adults with CPTSD. Traumatic memory is characteristically non-verbal, fragmented, and encoded in sensory-perceptual systems that language-based therapies are poorly positioned to address (Gantt & Tinnin, 2009; van der Kolk, 2014). Art Psychotherapy engages precisely these systems through the visual, tactile, and kinaesthetic dimensions of artmaking, enabling the externalisation and gradual integration of memories that resist verbal articulation (Collie et al., 2006; Talwar, 2007). The art object, positioned between client and therapist, also offers a mediating third presence that supports the development of therapeutic alliance in individuals for whom relational trust has been significantly disrupted by their trauma history. In the UK, Art Psychotherapy is delivered by practitioners regulated by the Health and Care Professions Council (HCPC, 2023) and represented professionally by the British Association of Art Therapists (BAAT, 2024), placing it within a well-established regulatory and professional framework that distinguishes it from unregulated creative arts activities.

Argument I: Diagnostic Divergence as a Structural Barrier to UK Research Participation

The DSM-5's exclusion of CPTSD carries consequences that extend beyond clinical nosology into the structure of international research funding. The majority of large-scale psychotherapy research funding flows through US federal agencies, including the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH), whose grant frameworks are organised around DSM diagnostic categories. UK researchers seeking to conduct or participate in internationally co-funded CPTSD trials face a structural

misalignment between the diagnostic category they are working with clinically and the categories that govern funding eligibility. Whilst UK funders including the National Institute for Health and Care Research (NIHR) and the Medical Research Council (MRC) are not DSM-bound, the absence of DSM recognition also affects the availability of validated, internationally standardised outcome measures, which are typically normed on DSM-defined populations.

This fragmentation is compounded within UK clinical practice by a historical diagnostic overlap between CPTSD and Emotionally Unstable Personality Disorder (EUPD) and Borderline Personality Disorder (BPD) — presentations now widely recognised as frequently reflecting the effects of complex developmental trauma rather than personality pathology per se (Mind UK, 2021; Karatzias et al., 2019). In NHS services, individuals who have received EUPD or BPD diagnoses have historically been routed into Dialectical Behaviour Therapy (DBT) or Mentalisation-Based Treatment (MBT) pathways, which, whilst clinically valuable, were not developed with complex trauma as their primary theoretical framework. This diagnostic displacement means that the true prevalence of CPTSD within NHS mental health services is likely underestimated, and that a proportion of the CPTSD population has been excluded from relevant research samples.

Formal recognition of CPTSD in DSM-6 would carry practical implications for the UK's ability to participate in and benefit from international research. It would align the two dominant diagnostic frameworks, facilitate the development of standardised outcome measures applicable across research contexts, and enable UK NHS data to be incorporated into international comparative studies. In the interim, NIHR and MRC funding calls should explicitly accommodate ICD-11-based population definitions to ensure that the UK's clinical reality is not excluded from its own research infrastructure.

Argument II: Methodological Frameworks and Their Limitations for This Field

The integrative review's inclusion criteria—experimental, RCT, cohort and quantitative studies only—reflect its effectiveness-focused research question. They are also, this commentary argues, a contributing factor to the finding of n = 2. The application of these criteria resulted in the exclusion of qualitative and descriptive papers, including a clinically relevant UK-based study (Jayne, 2022) that was excluded solely for absence of outcome measures. The research question, not the absence of therapeutic effect, shaped the evidence yield.

RCT design presents well-documented challenges when applied to relational, process-oriented therapies with complex, heterogeneous populations. Blinding is not feasible in psychotherapy research. Protocol fidelity requirements can conflict with the therapeutic flexibility that trauma-informed practice requires, particularly where treatment responsiveness to emerging clinical material is a defining feature of good practice. Recruitment and retention of adults with CPTSD are constrained by clinical and ethical considerations, the population presents with high rates of dissociation, affect dysregulation, and relational wariness that create both ethical obligations and practical

research barriers. These limitations are not unique to the UK context: international reviews of arts therapies research (Van Lith, 2016) have consistently identified them as field-wide challenges that require methodological adaptation rather than methodological deferral.

Adapted methodologies, pragmatic and stepped-wedge RCTs, mixed-methods designs, single-case experimental designs (SCEDs), and realist evaluation frameworks are available, increasingly legitimised within UK health research, and epistemologically appropriate for complex interventions. The updated UK framework for developing and evaluating complex interventions supports selecting methods appropriate to the research question and intervention context (Skivington et al., 2021). Reframing the evidence question, from whether the intervention produces measurable change under controlled conditions, to what the active components are, for whom, and in what contexts, would be more appropriate to the complexity of Art Psychotherapy as a therapeutic modality and would open a substantially wider range of viable research designs.

Argument III: Theory, Evidence Asymmetry and UK Research Capacity

The mismatch between the theoretical coherence of Art Psychotherapy for CPTSD and the limited empirical evidence base warrants examination. An established theoretical rationale, preliminary positive outcomes in the two available studies (noting their small samples and methodological limitations), a developing evidence base in adjacent populations (Sarid & Huss, 2010; Schouten et al., 2015; Hass-Cohen et al., 2018), a substantial international body of practitioner-based clinical experience (Jayne et al., 2021), and a well-regulated professional workforce in the UK have not yet translated into a substantive research programme. This pattern suggests that structural and infrastructural factors, rather than absence of clinical rationale, are the primary constraints on evidence development.

The UK is particularly well-positioned to lead in this area. The HCPC regulatory framework, the professional infrastructure of BAAT, the presence of NHS specialist trauma services, and existing academic centres with expertise in arts therapies research collectively represent a research capacity base that few other countries can match. Relevant international work includes Schouten and colleagues in the Netherlands and the broader trauma-focused expressive arts literature synthesised by Malchiodi (2020). The museum-based intervention by Coles and Harrison (2018), conducted within a UK context and reporting encouraging preliminary outcomes, illustrates the distinctive contribution UK-based practice can make to international knowledge. That no subsequent study has built on these environmental therapeutic findings represents a missed opportunity within UK arts therapy research specifically.

Arts therapies occupy a relatively marginal position within NHS research commissioning and within the NIHR's funding portfolio. The relational and emergent dimensions of Art Psychotherapy present operationalisation challenges, and the profession has not yet established the multi-site collaborative infrastructure needed to generate adequate sample sizes for definitive trials. These are addressable research capacity issues. The development of a BAAT-led or NIHR-hosted practitioner research network, analogous to

those developed within other allied health professions, would provide the infrastructure needed to systematically capture practice-based evidence and build toward larger funded studies.

Implications for Research and Practice

The arguments above generate specific recommendations for distinct UK and international audiences.

For NHS commissioners and NHS England, the absence of a dedicated CPTSD treatment pathway represents a gap in the implementation of the NHS Long Term Plan's mental health commitments. Art Psychotherapy, delivered by HCPC regulated practitioners within NHS and third sector settings, should be identified within NHS England's mental health service specifications as an intervention meriting investment and evaluation, particularly for populations for whom existing PTSD pathways have been clinically insufficient.

For UK research funding bodies, NIHR, MRC, and Wellcome, dedicated funding calls for CPTSD psychotherapy research should explicitly accommodate ICD-11-based population definitions and non-RCT methodological designs. The NIHR's Programme Grants for Applied Research and Health Technology Assessment programmes are well-suited to funding pragmatic trials and mixed-methods evaluations of this kind. Collaboration with international funders, including the European Research Council and national research bodies in the Netherlands, Australia, and Canada, would support the multi-site sample sizes that this field requires.

For the HCPC regulated arts therapy profession and BAAT, building systematic practice-based evidence infrastructure, including standardised outcome measure collection, a clinical case study repository, and a national practitioner research network, is a collective professional responsibility. International professional bodies, including the American Art Therapy Association (AATA) and the European Consortium for Arts Therapies Education (ECArTE), provide relevant models for coordinated evidence development across national contexts.

For NICE, the current absence of Art Psychotherapy from CPTSD guidance should be addressed not by omission but by explicit acknowledgement of the evidence gap and a commissioning signal for its investigation. The precedent set by NICE's treatment of emerging interventions in other areas, including its recommendations for further research into trauma-focused therapies for children, provides a template for how to manage a promising but under evidenced intervention responsibly.

Conclusion

The completed integrative review on which this commentary is based identified only two relevant studies, comprising sixteen participants in total, across a six-year international search. That finding does not establish effectiveness; rather, it highlights the extent to which evidence development in this field has been constrained by diagnostic divergence, methodological conventions, and limited research infrastructure. The purpose of this

commentary is therefore not to claim that Art Psychotherapy has already been proven effective for CPTSD, but to argue that the current evidence gap is itself a policy and research problem. The UK has the professional, clinical, and academic infrastructure to play a leading role in addressing this gap, and the next step should be deliberate investment in the conditions required to generate better evidence.

Declarations

Ethics statement

Ethical approval was not required for this article because it does not report new empirical data involving human participants.

AI-use statement

The authors used generative AI tools to assist with the consolidation and structural organisation of content derived from a completed integrative review. All theoretical arguments, interpretations, and recommendations were developed and written by the authors. The authors reviewed all AI-assisted drafts and take full responsibility for the authenticity, originality, and accuracy of all content, including references, which were independently verified by the authors against original sources.

Conflict of interest

The authors declare no conflict of interest.

Funding

This work received no external funding.

Data availability

No new datasets were generated for this article. Data underlying the integrative review are available from the corresponding author on reasonable request.

References

British Association of Art Therapists (BAAT). (2024). What is art therapy? https://www.baat.org/About-Art-Therapy

Coles, A., & Harrison, F. (2018). Tapping into museums for art psychotherapy: An evaluation of a pilot group for young adults. *International Journal of Art Therapy, 23(3)*, 115–124. https://doi.org/10.1080/17454832.2017.1380056

Collie, K., Bottorff, J., & Long, B. (2006). A narrative view of art therapy and art making by women with breast cancer. *Journal of Health Psychology, 11(5)*, 761–775. https://doi.org/10.1177/1359105306066632

Gantt, L., & Tinnin, L. W. (2009). Support for a neurobiological view of trauma with implications for art therapy. *The Arts in Psychotherapy, 36(3)*, 148–153. https://doi.org/10.1016/j.aip.2008.12.005

Hass-Cohen, N., Bokoch, R., Findlay, J. C., & Banford Witting, A. (2018). A four-drawing art therapy trauma and resiliency protocol study. *The Arts in Psychotherapy, 61*, 44–56. https://doi.org/10.1016/j.aip.2018.02.003

Health and Care Professions Council (HCPC). (2023). Standards of proficiency: Arts therapists. HCPC. https://www.hcpc-uk.org/standards/standards-of-proficiency/arts-therapists/

Jayne, K., Hackett, S., & Hill, M. (2021). Art psychotherapy for adults who have experienced complex trauma: An international survey. *Perspectives on Complex Trauma, 1(2)*, 33–43.

Jayne, K. A. (2022). Identification of the contexts and mechanisms of art psychotherapy treatment that supports healing and recovery for adults who have experienced complex trauma: The development of a treatment manual—Unification Neuro-Informed Trauma Reconsolidation Art Psychotherapy (UNTRAP) [Doctoral dissertation, University of Northumbria at Newcastle]. ProQuest Dissertations & Theses Global. https://www.proquest.com/docview/2778642824?fromopenview=true&pq-origsite=gscholar&sourcetype=Dissertations%20%26%20Theses

Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Ezra, M., Coventry, P., Mason-Roberts, S., Bradley, A., & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. *Psychological Medicine, 49(11)*, 1761–1775. https://doi.org/10.1017/S0033291719000436

Maercker, A. (2021). Development of the new CPTSD diagnosis for ICD-11. *Borderline Personality Disorder and Emotion Dysregulation, 8*, Article 7. https://doi.org/10.1186/s40479-021-00148-8

Malchiodi, C. A. (2020). Trauma and expressive arts therapy: Brain, body, and imagination in the healing process. Guilford Press.

Mind UK. (2021). Complex PTSD. https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/complex-ptsd

National Health Service. (2019). The NHS long term plan. NHS England. https://www.longtermplan.nhs.uk/.

National Institute for Health and Care Excellence. (2018). Post-traumatic stress disorder (NG116). NICE. https://www.nice.org.uk/guidance/ng116

NHS England. (2026). *Terminology and classifications*. https://digital.nhs.uk/services/terminology-and-classifications

Sarid, O., & Huss, E. (2010). Trauma and acute stress disorder: A comparison between cognitive behavioural intervention and art therapy. *The Arts in Psychotherapy, 37(1)*, 8–12. https://doi.org/10.1016/j.aip.2009.11.004

Schouten, K. A., De Niet, G. J., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. M. (2015). The effectiveness of art therapy in the treatment of traumatized adults: A

systematic review on art therapy and trauma. *Trauma, Violence and Abuse, 16(2)*, 220–228. https://doi.org/10.1177/1524838014555032

Schouten, K. A., Van Hooren, S., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. M. (2019). Trauma-focused art therapy in the treatment of posttraumatic stress disorder: A pilot study. *Journal of Trauma & Dissociation, 20(1)*, 114–130. https://doi.org/10.1080/15299732.2018.1502712

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *BMJ, 374*, n2061. https://doi.org/10.1136/bmj.n2061

Talwar, S. (2007). Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *The Arts in Psychotherapy, 34(1)*, 22–35. https://doi.org/10.1016/j.aip.2006.09.001

van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. Viking.

Van Lith, T. (2016). Art therapy in mental health: A systematic review of approaches and practices. *The Arts in Psychotherapy, 47*, 9–22. https://doi.org/10.1016/j.aip.2015.09.003

World Health Organization. (2019). International classification of diseases (11th rev.). WHO. https://icd.who.int