

# Art Therapy Online: ATOL

## **What aspects of an art therapy group aid recovery for people diagnosed with psychosis?**

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### **Abstract**

In the light of current UK national guidelines, this paper considers how outpatient art therapy groups can reverse the development of the pervasive effect of negative symptoms of schizophrenia. Five therapeutic aspects are identified that lead to improvement in the mental health and quality of life for group members. Theoretical understanding based on clinical experience from the 1980s and 1990s is revisited and presented again to reflect current research, understanding and scientific evidence from the neurosciences, in particular through the concept of mentalization.

**Key words:** Schizophrenia, outpatient, mentalization, neuroscience, attachment theory

### **Introduction**

A version of this paper was first presented on 29<sup>th</sup> October 2011 at the Art Therapy Northern Programme in Sheffield, England as part of a conference exploring the implementation of the National Institute of Clinical Excellence guidelines for schizophrenia (NICE 2009). In the NICE recommendations, arts therapy groups are advocated with specific relevance to reduce negative

symptoms of schizophrenia. Whilst UK art therapists have been delighted by the recognition of the value of their work, it remains difficult to provide the necessary evidence base. NICE gathers research evidence, giving greatest weight to randomised controlled trials (RCTs), and makes treatment recommendations on the basis of estimates of clinical and cost effectiveness. The latest RCT, called the MATISSE project (Crawford et al.2010), has failed to show that art therapy groups are more clinically and cost effective than the control treatments of activity groups and treatment as usual.

In a separate research process aimed to supplement the MATISSE project, Patterson et al (2011) used a constructive grounded theory approach to examine art therapists' understanding of schizophrenia and art therapy. 'Demonstrating faith-like commitment to their practice, therapists described the protean nature of art therapy as the key strength of the approach, enabling therapy to meet diverse needs of different psychotic patients over time. "Capturing" art therapy by articulating its process was somehow antithetical to its ephemeral nature' (Patterson 2011). Whilst I do not share this criticism, I aim to make a contribution in the direction of articulating how art therapy might be helpful, what it looks like and what might be achieved for people with psychotic illness. This is not a piece of research but, in line with evidence based practice, I hope to provide material useful for the development of clinical guidelines to, 'make implicit processes explicit' to quote Andrea Gilroy (2006:46).

My experience and interest in this client group spans three decades. I aim to re-visit my thinking from the 1980s onwards in the light of current ideas influenced by advances in linking neuroscience and attachment theory to psychotherapy which began in the 1990s. I feel these new developments offer greater potential for the theories and practice of art therapy to be grounded in science. This thinking has been applied to my individual art therapy with non-psychotic clients, for example to those who might be diagnosed with personality disorder, and I have been interested in the area of early relational trauma (Greenwood 2011). However, more material is emerging in the literature that explores this work in the field of psychosis.

The paper begins with a discussion of most recent ideas and developments in the literature. Then to address the question, "What aspects of an art therapy

group aid recovery for people diagnosed with psychosis?" five factors are identified and described with underlying theoretical concepts: firstly there is reconstruction and strengthening of psychological boundaries, then, side-by-side approach, mediation between concrete and symbolic ways of thinking, use of humour and sublimation, and finally, containment. My focus lies with outpatient groups for clients who are not in acute psychotic states of psychosis. Generally people will attend such groups from a home environment in the context of services directed towards health and well being rather than a hospital environment associated with illness and treatment.

The clinical material I will present here is based on the original experience of setting up an outpatient art therapy group in 1984 for people with a history of psychosis. The group became warm and cohesive and admissions to psychiatric hospital greatly reduced; patients' commitment to the group was impressive. An end to the group was not fixed at the beginning and I acted as art therapy facilitator for the first 4 years; it was brought to an end after a further 4 years. Together with one of my co-therapists Geoff Layton, who was a psychiatrist, we used a descriptive method of process research to generate hypotheses and to consider the meaning of changes within the group. This has been previously published (Greenwood & Layton 1987, 1988/91) and further developed (Greenwood 1994, Killick & Greenwood 1995, Greenwood 1997). Before drawing the paper to a conclusion I provide 3 clinical vignettes to illustrate changes achieved for individual group members as reflected through their art work.

### **Developments since the 1990s**

In her discussion of the history of art therapy, Chris Wood identifies a third period from the early 1980s to the mid 1990s when, '...Greenwood, Layton and Killick have been putting forward the idea that very particular approaches are needed in art therapy with people who experience psychosis. These approaches depend upon whether or not the client is in the midst of psychosis or comes to the therapist with a history of psychosis' (Wood 1997). Kathy Killick is identified with the former and Geoff Layton and me with the latter. Wood identifies these authors with an application of psychoanalytic ideas in the Kleinian tradition especially from Wilfred Bion and Hanna Segal.

In her contemporary period, Wood describes one feature as being the 'increasing concern to produce systematic evidence for practice' (Wood 2011: ix). I would like to raise the significance of developments linking neuroscience, attachment theory and psychotherapy. Since the mid 1990s attempts have been made to bridge the divide between biological models of the brain and psychological models of the mind. It is exciting that evidence based research is becoming available and sophisticated neuro-imaging techniques might one day enable us to demonstrate in what ways psychotherapy changes the brain. Yet, I think it is credit to the early analysts, like Bion and Segal, that their theories remain relevant to the understanding and treatment of psychosis.

My personal introduction to these ideas has been through lectures about mentalization in group therapy given by Anthony Bateman and by art therapist Neil Springham, and the significance of early maternal attunement in individual therapy by Jungian analyst Margaret Wilkinson and by art therapist Frances O'Brien. I have limited knowledge of the subject of neuroscience but the literature that has shaped my thinking includes Bateman and Fonagy (2006), Wilkinson (2006), O'Brien (2008), and a range of articles by Schore, Cosilini, Lapedes, Siegel and Teicher. Whilst Hass-Cohen and Carr's edited book (2008), from USA, on art therapy and clinical neuroscience is invaluable, it is of less interest in the context of a psychodynamic perspective.

Wilkinson developed the ideas of Schore, Siegel and Stern, when she wrote, 'My contention is that in response to the earliest relational experience with the primary care-giver, developing self and mind arises out of the developing brain, and these in turn affect the brain's development as new neural connections are made as a result of interactions with significant others throughout life and not least within the consulting room' (Wilkinson 2006). I now understand how the therapeutic relationship can help create new neural connections in the brain (Greenwood 2011). Research has shown how new neural pathways are forged by emotional connection and attachment to another person, both in early years and throughout life. This has led to an understanding of the attachment system, inherent in the therapeutic

relationship and the process of therapy, as a mechanism of change in therapy where the development of insight is not the primary goal and the stance of the therapist becomes more active.

Frances O'Brien describes the unique benefit of art therapy, 'The art process is a right brain activity, it accesses the right hemisphere's emotional memory of abuse and neglect; at the same time the relationship with the therapist activates the left hemisphere. Words are found by the therapist to make meaning, gradually integrating left and right hemispheres and unifying the explicit construction of narrative that accompanies the implicitly emotional experience of "making" in art psychotherapy' (O'Brien 2008). I believe, art psychotherapy is uniquely placed (together with the other arts therapies) to integrate left and right brain functioning. I think it is this process that brings a person to life: the emergence of a sense of self. This can have an impact on the negative symptoms of schizophrenia. Through neuroscience we understand that the left and right hemispheres of the brain are connected by a bundle of nerves and the size of these connecting nerves is reduced by adverse early experience. What is important here is the facilitation of connectivity between the hemispheres of the brain which can occur through the relational aspects of therapy (Wilkinson 2006).

Art therapists are becoming interested in mentalization based therapy (MBT) which was introduced in early 1990s for the treatment of people diagnosed with borderline personality disorder (BPD) (Bateman, Fonagy 2008). A deficit in mentalizing is seen as one of the key difficulties for such people. MBT is evidence based practise, reliant on extensive research and it comes manualised. The essence of mentalization is the capacity to see ourselves from the outside and others from the inside. It is related to the capacity to put ourselves in the shoes of others, social intelligence, empathy, reflective thinking, and learning to mediate between stimulus and action. 'Mentalizing in psychotherapy is a process of joint attention in which the patient's mental states are the object of scrutiny' (Bateman, Fonagy 2006:93). The focus is on states of mind and not behaviour. In comparison to analytic therapy, MBT places more focus on current mental reality rather than consideration of past

and future; therapists offer more explicit support; there is a modification of interpretive techniques and there is more transparency of the therapist (Bateman, Fonagy 2006). The debt to analysts such as Winnicott, Segal and Bion is acknowledged and explored by Jeremy Holmes in the development of MBT (Holmes 2010).

Following Holmes ( 2010) I believe the concept of mentalizing has a much wider application than the treatment of BPD. The capacity to mentalize emerges in the context of secure attachment with primary care givers. Andrew Gumley (2009) summarises that 'both psychosis and personality disorder share common developmental pathways characterised by the lack of a secure base and/or the presence of relational trauma and loss during childhood and adolescence'. This leads to increased risk of poor mentalization and reflective functioning. In schizophrenia he proposes that the combination of avoidant affect regulation together with poor mentalization leads to the development of negative symptoms. Individuals diagnosed with BPD are likely to have disorganised attachment strategies and without appropriate regulation may respond with intensified symptoms in therapy. The programme of MBT addresses these characteristics. However, the negative symptoms of schizophrenia are more associated with dismissing/avoidant attachment strategies and a closing down of affect so creating engagement and relationship will be more challenging. It is noted that further longitudinal research exploring the role of attachment and mentalization in recovery from schizophrenia is pertinent (MacBeth et al 2011).

I will now examine 5 different aspects of outpatient art therapy groups which I think lead to good outcomes. These will be considered in the light of this contemporary theory.

### **1. Reconstruction and strengthening of psychological boundaries facilitated by the social and physical setting of the group.**

We described how the boundary, space or structure between inner and outer reality, or between conscious and unconscious aspects of the self, are frail or flawed in psychotic states (Greenwood, Layton 1987). This damages the capacity for thought and for relationship and thus promotes the development of negative symptoms.

For therapy to be helpful both staff and group members need to feel secure about the setting. The therapists reserve a time in the timetable and a space in the building which corresponds to a time and space in their minds. They have to take responsibility for this setting and ensure that the session is not interrupted or threatened by others who might want the room for other purposes. Thus, therapists do not leave the group to take phone calls or to deal with other matters, do not arbitrarily change the time of the sessions, and give warnings of absences and holidays (Greenwood, Layton 1987). This is standard practice and the Clinical Practice Guideline for people prone to psychotic states reinforces that, 'It is essential that the art psychotherapy space should be respected and free from interruptions' and that 'Art psychotherapy sessions should take place at a regular time and place' (Brooker et al 2007:40).

The weekly outpatient group, which was the subject of our research, took place in a day centre in an inner city area of Birmingham. This was an ordinary terraced house identifiable only by its house number. Primarily, the building was used for a daily programme of psychotherapy for people with personality disorder and neurotic problems, but it also housed lithium clinics and depot injection clinics for people diagnosed with psychotic illnesses. Patients were referred from these clinics to the art therapy group. The group was predominantly white, predominantly male, mixed age range and mostly single. None were in current employment.



Figure 1. Room used for art therapy.

At the outset, the group was offered the following facilities: a large carpeted room with an area of comfortable chairs and tables that needed to be erected, art materials – paper, crayons, paint, and clay (sink located in next room), time of 1\_ hours, and 2 therapists. There was no separate art room. Sessions began by sitting in a circle, in comfortable arm chairs, acknowledging those present and any messages from others. We then moved swiftly to erect the tables (in an island form) and engage in art, with both therapists joining in this activity. I encouraged group members to begin an exploration of art materials to find what suited them. I sometimes introduced non-threatening themes.

When everyone had finished we shifted to sit in the comfortable chairs with our art work in front of us on the floor. Then something like 50 minutes was spent in verbal discussion giving the opportunity for each person to describe their work and comment on others. A common theme might evolve in



discussion which the group pursued. The group was brought to an end after 1\_ hours and this was followed by a staff after-group for the two therapists. Further containment was provided by group supervision. We described this reticulum of containers on the basis of Bion's psychoanalytic concept of containment (Greenwood, Layton 1987).

Given these facilities it was interesting to look at the changes that began to be observed and how these illustrated the formation of boundaries and the growth of ego control over the environment. After about 3 months, when a core membership had emerged and absenteeism had more or less disappeared, the group members began to arrive early and congregate in the kitchen downstairs which formed part of the queue for the injection clinic. They gradually separated themselves from these other patients by socialising with each other as a group. They then moved upstairs to meet in what became "their room" prior to the session. The previous users of the room were the intensive psychotherapy group, who for a long time had felt themselves to be the most important group in the building. They integrated themselves with this group but then separated themselves off by clearing and tidying the room and erecting the tables ready for their session. We discovered that group members were going off for an early evening drink after the session.

## **2. Side-by-side Approach**

We referred to our stance as "side-by-side therapy" (Greenwood & Layton 1987). By this we meant there was a sense of equality between therapist and patient, addressing something outside themselves. The relationship was felt to be an empathic sharing in openness. The fact of the group acting as therapist and the therapists joining in the art work and being prepared to share something of themselves were forms of the side-by-side approach. We believed that exposure to the therapist's good objects, their ability to think, paint, experience, indeed to their personality in general, was a major therapeutic agent. We understood that the more of yourself you put into therapy the less you can be an object of transference, but we believed the

effectiveness of therapy, with people diagnosed with psychotic illness, was not necessarily related to intensity of transference.

The value of this stance is echoed by Bateman and Fonagy , ‘A detached, aloof, refined, defended therapist is unlikely to form a relationship with a patient which helps the patient find himself in the mind of the therapist in an accessible and meaningful way’ (2006:99). To aid the development of mentalization they advocate therapists to be open minded, safe in their own failures and appropriately doubtful about their viewpoint (Bateman, Fonagy 2006). They state that joint therapists should be able to disagree respectfully and question each other in front of the group. A stance is advocated where therapists demonstrate that they are participants and not observers of the group ‘...the therapist’s stance is inquisitive, active, empathic and at times challenging but most importantly the therapist should refrain from becoming an expert who knows’ (Bateman, Fonagy 2006:101).

The complexities of the joint attention skills employed when looking at pictures together are eloquently explored by art therapist John Isserow (2008). He makes links to early child development when the child is able to shift from looking *at* the primary care giver to looking *with* her. This requires the infant understands that other people have minds separate to their own. Isserow links this to the development of mentalization.

We thought that to achieve engagement of people with psychosis, a shift in emphasis away from “treatment,” and encouraging them to take responsibility for themselves was necessary. The concept of side-by-side therapy describes how sharing the experience of making pictures gives opportunity for servicing boundaries and feeling relationships between individuals. Showing the art work and looking and talking about the pictures together provide additional opportunities for development of self in relation to others and sharing and modifying anxieties. With the benefit of hindsight I now understand this facilitates mentalization and furthermore the therapists’ participation in art work models their continuous reflection on what goes on in their mind.

Back in 1987 we found support for our art participation in the work of Mildred Lachman-Chapin (1979), an American art therapist, who followed the theories of Heinz Kohut (1966) – self psychologist. She described the value of producing art work alongside the patient, stressing the importance of providing an empathic and nurturing experience. This was important in addressing early narcissism, rooted in the pre-verbal period of infancy.

### **3. Mediation between concrete and symbolic ways of thinking**

The absence of symbolic functioning in psychosis has a profound impact in the therapy situation, and necessitates a modification of technique. Hanna Segal (1975) clarified that the psychotic client's experience of the transference is very concrete as is the experience of the analyst's interpretation. She quite strongly states, 'I emphasize this point here, however, in order to make it clear that it is useless to interpret to the psychotic as though he were a neurotic' (Segal 1975). She understood how interpretations could make these clients worse.

In our joint chapter from 1995 "Research in art therapy with people who have psychotic illnesses" Kathy Killick and myself advocate that the therapist responds to formal aspects of the client's relating, suspending references to content and meaning, until symbolising functions enable the client to experience interpretation as interpretation. At times the focus may shift from the search for meaning to be entirely on the concrete aspects of relationship, the art materials and the physical environment. Killick describes how the person in an acute psychotic state tends to react to the therapist's attempts to establish relatedness with intensified symptoms. She proposed an approach that meets them at the level of their concreteness, to reduce persecutory anxiety (Killick, Greenwood 1995). The concreteness and physical nature of the art-making process, Killick believes, '...can form a transitional, or intermediary, area of thinking for the patient in relation to the living presence of a therapist' (Killick 1993). In her work with individual patients in acute states of psychosis Killick would sometimes write down what patients said about

their art work. This was read back to them and edited where necessary thus introducing conversation and negotiation (Killick 1993).

In the outpatient group I found that levels of concrete and symbolic thinking fluctuated. One of the benefits of art therapy is that the therapeutic relationship can be maintained through these fluctuations by shifting focus to concrete aspects of the art activity when symbolising functions are absent. It is a hugely important feature that art work is both concrete in its existence and also potentially meaningful in the symbolism of its images. The meaning can be explored at any future time, as the work is preserved in folders.

When thinking is concrete, mentalization will be poor and the distinction between thoughts or beliefs emanating from the internal world will lose their distinction from physical reality. In art therapy groups the presence of physical activity through making art allows for a retreat into concrete thinking, but dialogue can be maintained and reference to internal states avoided. The movement between symbolic and concrete understanding can be facilitated within the structure of the art therapy sessions.

#### **4. Use of humour and sublimation**

Humour emerged as an adaptive mechanism of defence at both social and mental levels in the outpatient group. This was the focus of my paper written with Geoff Layton called "Taking the Piss" (1988/1991) and then developed in my chapter "Maturation of the Ego" (Greenwood 1997) The psychoanalytic concept of ego mechanisms of defence were introduced and modified by Freud, at the end of his life, and then passed on to his daughter Anna to develop further. Ego mechanisms of defence rearrange sources of conflict (id, superego, interpersonal relationships, reality) so that they become manageable, leaving us feeling OK. The diagnostic and statistical manual of mental disorders (DSM III-R) first included a diagnostic axis of defences in 1987 (American Psychiatric Association 1987). The classification was largely based on George Vaillant's hierarchy of psychotic, immature, neurotic and

mature defences. At one end of this scale, psychotic defences can profoundly alter perception of external reality, for example: delusional projection or denial, whereas, to the other extreme, mature defences are more adaptive than pathological and can look like voluntary coping strategies to an onlooker. With mature defences components of conflict are allowed more consciousness. Taking the example of sublimation, Freud explained how the force of sexual instincts can be directed to new, non-sexual aims, without a diminishing of intensity. Sublimated activities are socially valued and leave you feeling good. I think one of the values of the arts therapies is the opportunity offered for sublimation.

Hanna Segal stated that, 'No-one is completely psychotic. Even in the psychotic there are areas of personality which are neurotic and capable of forming an object relation however flimsy' (1975). She described how analysts treated people diagnosed with psychosis by focusing on the healthier part of the ego, '... mainly in the positive transference with the aim of strengthening it enough to enable the healthier part of the ego to become dominant in relation to the psychotic part, a state of affairs which obtains in remissions'(Segal 1975).

I have been interested how mature defences can occur in the context of psychotic illness and how they can appear alongside psychotic defences (Greenwood 1997). Insight orientated, dynamic psychotherapy is offered to people employing neurotic defences and where interpretation is a useful tool. Where defences are more immature then supportive psychotherapy is more useful with understanding and management rather than interpretation. At the time I felt that Winnicott (1972) and Kohut (1966) were useful in understanding the value of empathy and management instead of confrontation and interpretation when immature defences predominate.

I was inspired by George Vaillant (1993) to understand that in an environment of empathy, understanding and mirroring, defences can become less pathological. The social milieu needs to be predictable and supportive. The therapist alone cannot provide the necessary holding environment for growth

of the ego to resume, and recovered peers can become a valuable source of constancy. Vaillant maintained that we are more likely to feel safe enough to deploy mature defences in an atmosphere of warmth and support. Conversely, he notes that, our ability to attract others to become our friends is very much dependent on the maturity of our defence mechanisms and our psychosocial maturity. Vaillant's ideas go some way to explain the success of the outpatient art therapy group.

There is not a manual that teaches how to make ego mechanisms of defence become more mature – we are speaking of a psychoanalytic concept that occurs unconsciously and not a conscious problem solving strategy. However, in art therapy groups we can provide a setting that might facilitate the maturation of the ego and, for example, the appearance of humour or sublimation. What is important is that these transformations are not confronted as defences in an attempt to knock them down, but they should be noticed and admired. They are particularly remarkable in the context of psychotic illness.

The Clinical Practice Guideline (for people prone to psychotic states), advocates humour as enhancing development of playful, inventive and imaginative processes in art making and social interaction (Brooker et al 2007). Bateman and Fonagy state, 'Humour and playfulness are necessary in our view to enhancing mentalization, partly to demonstrate that mental states are inherently modifiable and malleable. This approach to subjectivity produces a creative stance to the world' (2006:8).

## **5. Containment**

Bion's concept of containment (Bion 1962) and Winnicott's notion of holding (Winnicott 1971) are essential elements in building a secure attachment, ensuring growth of the ego and development of mentalizing functions. These concepts are well established in art therapy literature and provided the theoretical basis for our understanding of what happened in the group (Greenwood, Layton 1987).

Theories of containment can be applied to the process by which themes spontaneously emerged in the initial discussion which were taken up as subjects for exploration in art. In time group members suggested difficult and threatening themes which gave focus for the projection of anxieties. Individuals made their own interpretation of themes in their art work and there was scope to respond with either concrete understanding, complete denial of the theme or personal reflection of meaning. As therapists it was our inclination to avoid themes, preferring an approach which would encourage free association. However, we recognised that this might increase anxiety and lead to further disintegration when there was a potential for psychosis. Whenever it was suggested we had no theme the group were quick to respond with an appropriate idea.

If group members suggested a theme they would still turn to me to be reminded of it or name it for the group to use. It was as if the “intolerable” was projected and put into me in the form of a theme. When I heard the suggested theme I might feel fearful and protective towards group members. I would sit with this uncomfortable feeling dealing with it by my own internal processes of mental digestion until I was able to give a slightly modified theme back to the group, or if the theme was not modified the anxiety associated with it had been. The dynamics of the group then changed from one of dependency to taking back the projected material and using the theme to work on in their art.

I will present clinical material from the group to illustrate different elements of containment. Alan arrived last for a session. He was a 50 year old man diagnosed with psychosis associated with temporal lobe epilepsy who was withdrawn from social relationships except with his wife. The coat stand in the corner of the room was heavily laden and liable to fall over. To hang up his coat he mounted a coffee table that was in the way and then the coat stand toppled over towards him and he became angry, ostensibly with the coat stand. This struck a chord of fear in the group. In the past Alan’s violent outbursts had resulted in repeated admissions to prison. The panic was deflated when one group member commented, ‘Yes, Alan, we know you have

to have a fight with the coat stand before you sit down.’ This was an ironic combination of acceptance and criticism. Alan was thus teased about his behaviour in a sensitive way which resulted in a release of the tension in the room and a sense of shared amusement. When we were looking for a theme to respond to in the art work, Alan joined the discussion and suggested one of *accidents*. This theme, which referred to the coat stand incident, also touched on the loss of 3 fingers in an industrial accident, which was one of his original complaints at his first presentation. More broadly, the theme addressed the psychotic experiences of the group, as accidents are felt to be the surfacing of the unconscious or at least a loss of mastery by the conscious self.

The incident with the coat stand was developed and not put out of consciousness. ‘In this instance the materials in the room, including the coat stand, formed a symbol of a container into which anxiety – fear of loss of control – can be projected. The secure relationship between the people in the room provided a therapeutic space where the projected anxieties could be worked on, first by a feeling of sharing it, secondly by transmutation into humour, and thirdly by art work in relation to a theme’ (Greenwood, Layton 1987). The group itself, rather than the therapists, were able to mobilise affect and control its flow and intensity.

We applied Bion’s concept of containment to the process of art therapy in the group (Greenwood, Layton 1987). A painting or piece of sculpture can be seen as a safe container into which psychic material can be projected and then modified giving the group member, and the therapists, experience of their own abilities to manage their unconscious contents and grapple with affect regulation. Later the images are shared both visually and verbally in the group and some aspects might be brought into consciousness in the discussion. We felt that the interpretation of images and the question “What does it mean?” was not an important issue for this group. When the group and therapists became the container, the projected material, the picture, was acknowledged and explored, and then work was done to relate this to the artist with reference to previous art work, and also to the group. Once the projected material could be seen in the context of a structure, symbolising



internal mechanisms, then it could be re-introjected, acknowledged and accepted as part of one's self. This function was reinforced physically by collecting individual's art work into a folder each week.

I now present 3 vignettes to show how individuals used the group beginning with a description of the use of humour.

### **Vignette 1**

One member of the outpatient group, whom I call Andrew, aged 36, had been detained in secure units and psychiatric hospitals for 13 years on a prison section because of arson and a schizophrenic illness. Before joining the group he had moved to a rehabilitation hostel. He was a large, placid, taciturn man who had a master's degree in mathematics. Andrew presented with negative symptoms of schizophrenia with a lack of interest in the world and other people; he was institutionalised by his hospitalization.



Figure 2. Ultimate Support

One week in response to a theme of “support” he produced an image he designated “ultimate support” with bearers carrying a coffin. The group’s initial response to such pictures was of stunned silence. He presented his work stony-faced, almost daring people to laugh, cry or even comment. He was uncommunicative to the extreme, as though he was robbed by words of his experience as he was robbed of feeling by the bland objectivity of concrete thought. As a relationship with Andrew developed in the group, the humour of his work was enjoyed when his stony face gave way to a sparkling wit and warmth belied by his usual appearance.

Andrew deflated the people and things most precious to the group, ridiculing the importance attached to them. He drew Geoff dancing, and in another picture showed him waiting in an ambulance to take away the injured in a race. He drew me in black leather with a whip, and in other pictures, as an authoritarian school teacher, or blowing daisies.

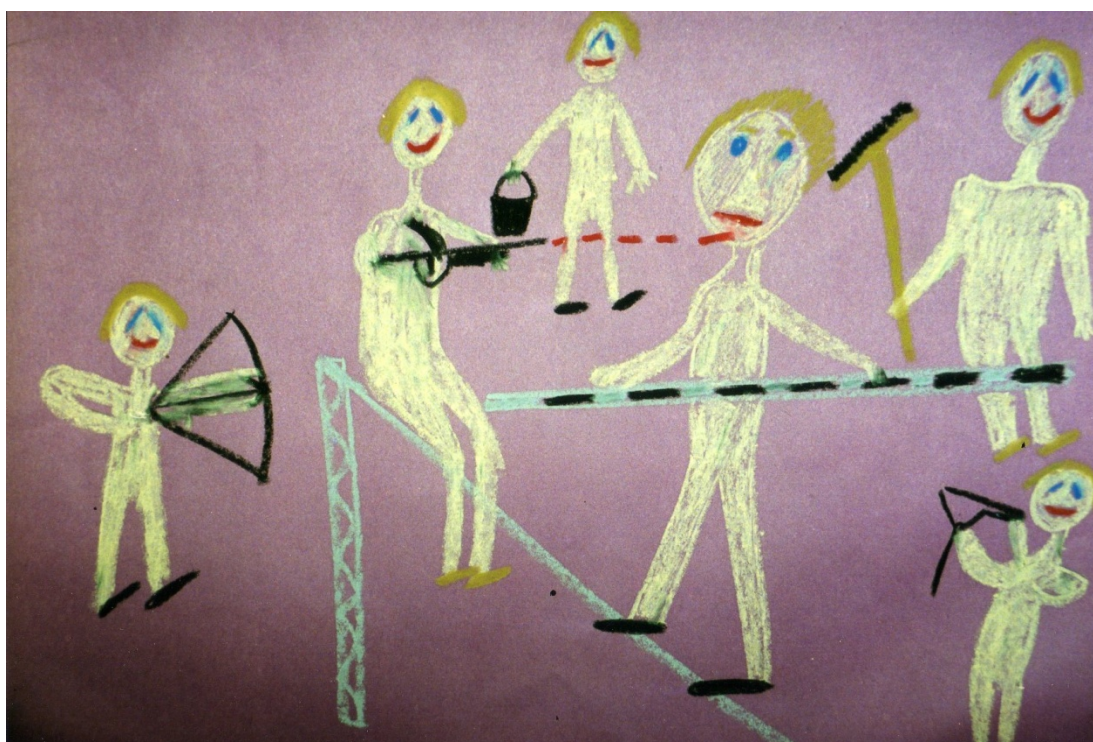


Figure 3. Art Therapy group

He illustrated how he felt under the spotlight when he saw it as his turn to present his art work to the group. He drew himself walking a tight rope with group members trying to knock him down with a broom, bullets, arrows and a bucket of water symbolising penetrating questions about his picture. He aimed to cross the tight-rope without being unbalanced by these attacks.



Figure 4. Planning New Services

He treated with satire the group's cohesiveness and warmth. One week he deflated the group's altruism and its hopes to influence planning of psychiatric services at an important public meeting. A group member had planned to make a presentation at the meeting and only Andrew joined me to support him. He is ridiculed with a big mouth in Andrew's picture.

Andrew's relationship to reality had been coloured by objectivity and a humorous penetrating insight. He was involved and somehow affected by events around him but he was able to separate himself from the conflict and pain. His art work had an absurd and seemingly cruel style. In time we were

able to come to some understanding of Andrew through an exploration of satire and by studying the Dada artists Duchamp and Picabia (Greenwood, Layton 1988/1991). The device of deflation is an important aspect here and if we are able to allow ourselves to be deflated by our patients this is more likely to facilitate the emergence of humour and a playful attitude. 'By Socratic irony the therapist does not trap himself by assuming all the answers, but makes a pretence of ignorance to understand the patient's inner feelings and outer games' (O'Connell 1976). Similarly, in MBT the active therapist stance is described as, 'able to withstand being dismissed, ridiculed or made to feel useless' (Bateman, Fonagy 2006 p156).

### **Vignette 2**

A young man, I call Brian, lived at home with his mother. He was first diagnosed with schizophrenia 6 years previously and had multiple admissions to psychiatric hospital. He had a tendency to lie in bed getting up only for the group, to perform in his rock band and in his pursuit of Buddhism. There was some initial inconsistency in his attendance when he joined the group. His early art work was dominated by decorative sheets of pattern, like mosaic. At the time we interpreted this style as a defence against the flowing away and disintegration of his personality.



Figure 5. Mosaic of pattern

After 4 months in the group he was suddenly admitted to hospital with, what his doctors described as, paranoid ideas, auditory hallucination, and thought broadcasting. We had not been able to understand his picture the week of his admission. There was a complex layering of different marks, colours and images with no apparent focus. Attempts had been made to frame the content suggesting that forms could not be contained on the paper. Similarly, he rambled on verbally expanding his thoughts and telling us he felt great. On return from hospital, 4 weeks later, he described how he had felt small and vulnerable at this time.



Figure 6. Picture before breakdown

Increased medication with depixol helped stabilise his mental health but he had no motivation to do anything except maintain a consistent weekly commitment to the group. Brian was well liked by other group members; he could express his thoughts through his art and was actively interested to understand others. Sometimes he preached Buddhism in the group. His art work became well integrated, embodied and symbolic. When his band re-

formed and he had an interview for a job, he expressed his optimism by drawing the Buddhist story of the one eyed, one legged turtle rising to the surface as a log passes by.



Figure 7. Buddhist story

When he felt quieter, with a desire to rush back to bed, he returned to drawing dense patterns. At times it seemed that he came close to relapsing into psychosis. Two years after joining the group feelings from a time before his first breakdown surfaced again and he produced a painting with an enormous wave towering over a fire on the beach beside a figure playing music. 'If we take this as an illustration of the potential danger of being overwhelmed and as showing something of the boundary between conscious and unconscious aspects of his personality, it seems that his potential for breakdown was *held* in awareness by the group and by himself. Over the following two weeks he was able to resolve the feelings without breakdown' (Greenwood, Layton 1988/1991).



Figure 8. Towering wave

Brian had no further admissions to hospital and hoped to leave the group to develop the success of his band. He took casual work and planned to leave his mother's house for a flat. Later art work showed an exploration of quite powerful and often difficult thoughts and feelings, developing a much looser and expressive painterly style.

### **Vignette 3**

Another group member, whom I call Aidan, was referred from the depot injection clinic. He was aged 37 and presented to psychiatric services via the police when he was brandishing a knife with the idea of protecting his mother from intruders. He had just one previous admission to hospital, but psychotic symptoms re-emerged whenever his anti psychotic medication was withdrawn. There were some persistent hallucinatory voices. From the outset he had no absences in the group; he was always well dressed, punctual and friendly - telling jokes in a rather nervous way. His thinking tended to be rather

concrete. At home he felt left behind by his siblings who were going out to work. He complained of having nothing to get up for except to attend the group and maintain his commitment to playing darts.

Aidan's art work developed considerably. Initially, he was very careful, and rather rigid in his approach, for example by drawing boxes. In time, and when he developed trust in the group, he learned to express emotions by colour symbolism producing non-figurative patterns that filled the page. Aidan described pictures like this as representing headaches which were sometimes noted as pressure behind his eyes or sometimes as his hallucinatory experience.

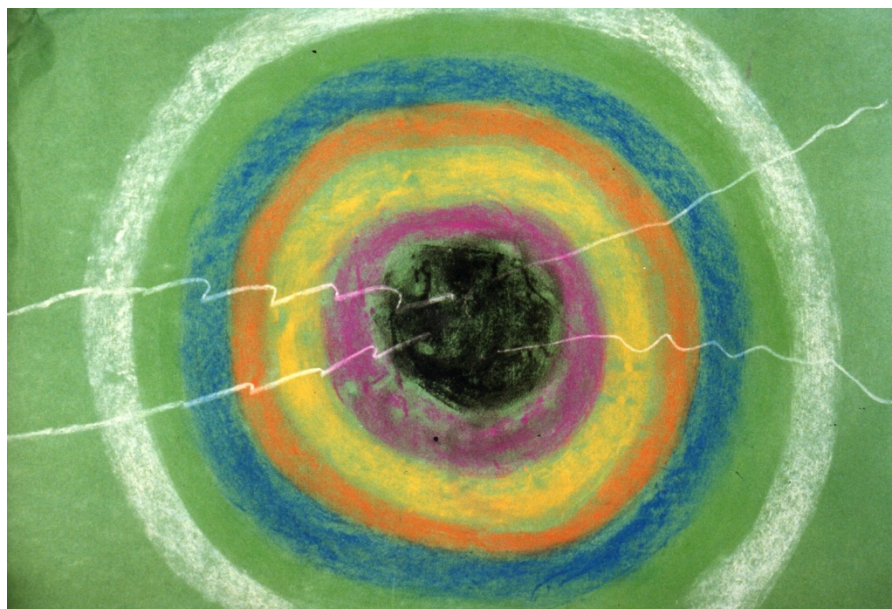


Figure 9. Headache

Occasionally he produced powerful figurative pictures holding difficult thoughts and feelings. At other times he drew gentle image of plants and gardens, here a tree in blossom.



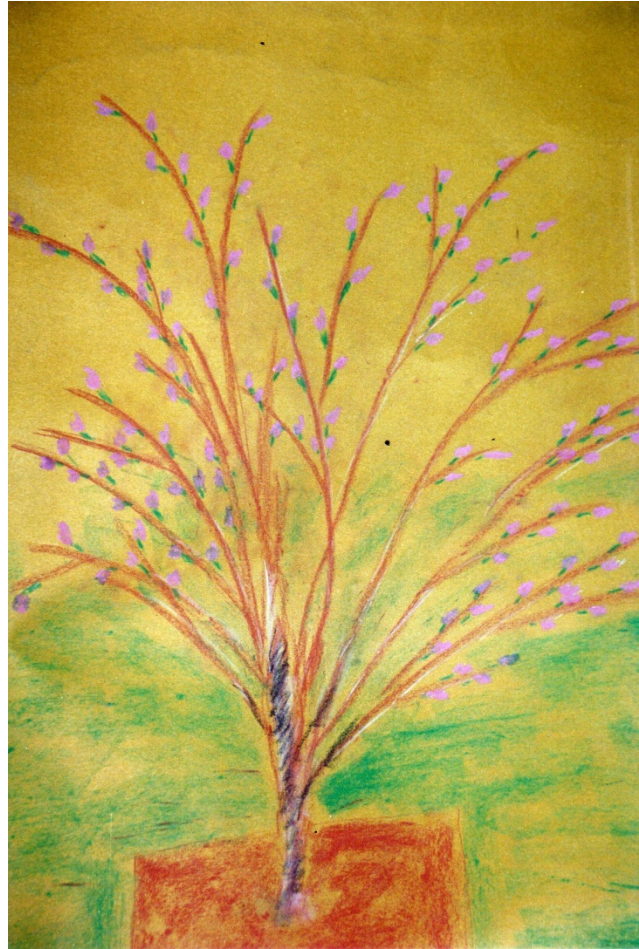


Figure 10. Tree in blossom

Aidan attended the group for two years. Both his confidence and sense of purpose improved. He saw himself as more relaxed and comfortable amongst people. He made plans to marry and was optimistic of getting a job, but tragically he died of a brain haemorrhage just before his wedding. Aidan's last picture before his death shows him feeling "on top of the world". He is climbing a mountain in the sunshine, on a ladder provided by the group. Alongside this he depicts himself struggling to climb in the rain without a ladder.



Figure 11. On top of the world

## Conclusion

I have illustrated specific elements of art therapy groups that are likely to lead to good outcomes and aid recovery for people with psychosis. This is long term therapy of at least 18 months duration, not short term time limited therapy. The five aspects are not discreet and separate. By way of conclusion I will bring these together and provide a summary. The NICE guidelines (NICE 2009) note how the arts therapies are uniquely placed to improve the negative symptoms of schizophrenia. Recent research links the development of negative symptoms in schizophrenia with the combination of a predominance of avoidant affect regulation strategies with weakened mentalization (Gumley 2009).

In art therapy with people diagnosed with psychosis the main shift in technique concerns the value placed on a therapeutic stance that is empathic and supportive rather than confrontational or focused on an interpretative

stance. I have described this in terms of the side-by-side approach. The intensity of the transference is reduced, changing the difficult feelings that arise in treatment of formidable psychotic anxieties into a manageable stream so that the therapeutic relationship is not destroyed by them. The therapeutic relationship can be maintained by a suspension of reference to meaning and a shift to the concrete aspects of art making then returning to symbolic ways of thinking when appropriate. For clients with avoidant relationship patterns they can stay connected by shifting attention from interpersonal issues to the activity of art making.

Playful exploration and the development of symbolic functioning can be stimulated within the context of a secure, attuned attachment. If warmth and cohesiveness can develop in a group then defences are likely to mature, becoming less pathological and resulting in the improvement of mental health. The goal becomes one of strengthening the healthier part of the ego. The containment and holding offered in an art therapy group both through relationship to art images, to other people and to the environment provides opportunity for mentalization – for developing and sharing thoughts and feelings, and beginning to learn an emotional language. I would hypothesise that this both stimulates, and requires, an integration of left and right brain functioning.

Art therapists have taken the concept of mentalization on board. Franks and Whitaker describe how the art psychotherapy process starts with group members making images alone, 'When the group returns for the verbal discussion, the image assumes independence, and is available to the "viewing mind" of the group. The process of art therapy in a group affords a safe method of exploring the mind in the presence of mentalizing self objects. The mentalization process is made visible' (Franks, Whitaker 2007). Within group art therapy, individuals are encouraged to look into the minds of others through their art.

Hass-Cohen describes the mentalizing aspects of art therapy, 'We encourage clients to take action by creating tangible art that expresses their inner state.

The exploration of emotions through the manipulation of art media (simple forms, colours or cut-outs) within a therapeutic relationship results in concrete art that can successfully match the client's internal world' (Hass-Cohen 2008: 285). She usefully stresses how the physical dimensions of art making and the importance of the invitation for purposeful action, contribute to therapeutic value.

Recent advances, linking attachment theory and neuroscience, have offered me greater understanding of the processes that occurred in the outpatient art therapy group. Given art therapists' extensive experience of hard to treat clients, I think the proposed new ways of working will be familiar. Holmes says, 'I believe that an awareness of mentalizing can help clinicians to see more clearly what they are intuitively doing and saying in the consulting room' (Holmes 2010:29).

Essentially, I believe it is the health giving value of relationships with therapists and group members that constitutes a core part of the recovery process for people diagnosed with psychosis. These relationships are facilitated and made manageable by the inclusion of the purposeful activity of art making.

### **Acknowledgements**

The staff and culture of Stratford Road Day Centre provided the necessary containment for the development of the outpatient art therapy group. Geoff Layton, psychiatrist, made most of the referrals to the group at the outset, and as well as becoming a co-therapist he introduced me to the discipline of applying theory to practice and the challenge of putting this into words for publication. Writing this paper motivated me to get in touch with him again, and we both shared warm memories of the group and its members. I valued the experience of working alongside my co-therapists Mervyn Morris and later Greg Davies, both then community psychiatric nurses. I am also indebted to art therapist Kim Thomas to whom I entrusted the group when I left Birmingham.

## **Biography**

Helen Greenwood has 30 years experience as an art therapist in NHS adult mental health services. Currently, she practises privately in clinical supervision and teaching. She is an associate of the Art Therapy Northern Programme. Her areas of interest have been working with people diagnosed with psychotic illness or psychotic thought processes, and also those seen as personality disordered who are hard to engage and likely to have endured abuse, deprivation or early trauma. She has published a number of papers on these issues.

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