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Can Collage-Based Art Therapy be a Bridge to Engage Patients Experiencing Social Isolation with a Diagnosis of a Psychotic Disorder?

Option One: Development of a Method

Capstone Thesis

Lesley University

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Art Therapy

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Abstract

Social isolation is not only a common part of the experience of people with psychotic disorders but also often acts as a barrier to their treatment and recovery. Causes of this isolation seem to include not only symptoms of the psychotic illnesses themselves but also the social stigma related to psychotic illnesses, as well as feelings of hopelessness, anxiety, and low self-esteem related to common comorbid disorders. Engaging with patients in acute inpatient units with short lengths of stay can be extremely difficult. This paper reviews the literature and describes a collage-based art intervention with six particularly isolative patients in an acute inpatient unit, with emphasis on a supportive one-to-one approach. The patient's levels of activity were observed before and after the directive. The positive experience of the actual intervention and common themes are described, as well as an encouraging trend towards increased engagement afterward.

Keywords: Art therapy, collage, psychotic disorders, paranoia, isolation

Introduction

I spent my final graduate internship working on a locked inpatient unit for adults ages 18 and older diagnosed with psychotic disorders. I was nervous when I first began; I had no idea what to expect. I will never forget standing in front of the locked door on my first day at the hospital. I thought to myself, "can I do this?" I still rang the bell and entered the unit. From that day, I began realizing that I was holding a stigma I had previously been unaware of towards the world of psychotic disorders. I have been fighting that stigma since, and I wanted to find a way to share the privilege I have been given to learn on the unit. I intended to give the patients I worked with the experience of engaging with a part of their identity that was not solely tied to a psychiatric diagnosis within this research.

During this internship, I was particularly interested in working with clients on the edge of the social and treatment milieu: clients rarely engaging with their treatment teams, with other clients or staff, frequently spending much time in their bedrooms, etc.

Social isolation is a serious and common problem for people with psychotic disorders (Tee, 2020). Not only does it interfere with treatment involvement, which I saw when observing patients on the unit, but it also significantly increases the long-term symptoms for patients, such as increased paranoia, depression, and social anxiety (Fett et al., 2022) and suicidality (Bornheimer, et al. 2020). While isolation was often seen by the patients dealing with paranoia as a way to keep themselves safe while on the unit, my goal was to try and challenge that and safely bring them out into a place to work on battling their isolation.

This paper describes my development of a non-threatening one-to-one approach and art directive with six isolated patients. I began with the question, can collage-based art therapy be a

bridge to engage patients experiencing social isolation with a diagnosis of a psychotic disorder? Collage was used as a medium to promote a safe, non-threatening, and adaptive approach to the patients to support them in creating a piece of art that represents the feeling of safety, comfort, and support. Patients were observed before, during, and after the directive to assess changes in their levels of social isolation and comfort in being with others. I found their level of engagement in the activity to be surprisingly high. Given the rapid turnover in the unit, it was difficult to follow these patients afterward, but there was a trend towards increased engagement, which could be related to various treatment factors.

Literature Review

Psychotic Disorders

Psychotic disorders include various diagnoses, which can present with a wide variety of symptoms. Common psychotic diagnoses include schizophrenia, schizoaffective disorder, bipolar disorder, psychotic depression, and substance-induced psychotic disorders. The fifth edition of the American Psychiatric Association's [APA] Diagnostic and Statistical Manual of Mental Disorders [DSM-5] (2013) states that schizophrenia spectrum and other psychotic disorders are "defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms" (p. 87). All psychotic disorders involve some loss of contact with reality. "Positive" psychotic symptoms include hallucinations, delusions, disorganized thinking (thought disorder), and disorganized behaviors, while "negative" symptoms refer to a decrease in behaviors "related to motivation and interest or verbal/emotional expression" (Correll & Schooler, 2020, p. 1).

There are a wide variety of available treatments for psychotic disorders, including but not limited to antipsychotic and other medications, individual and group talking therapies (frequently Cognitive Behavior Therapy based), family psychoeducation, social skills training, expressive arts therapies, and vocational therapies (Lynch, Holttum, & Huet, 2019). Psychotic disorders are frequently comorbid with several other diagnoses, most commonly depression, substance use disorder, and anxiety disorders, particularly social anxiety disorder, panic disorder, and post-traumatic distress disorder.

While many people with psychotic disorders are driven to seek treatment due to the painful and debilitating effects of their symptoms, several common factors cause them to avoid or resist treatment simultaneously. These factors can include stigma related to major mental illness, paranoia-based fears, or other delusional beliefs regarding mental illness and treatment, as well as the effects of associated disorders, such as depression, substance use disorder, and anxiety disorders, including social anxiety disorder.

Isolation and Psychosis

Psychosis often works hand-in-hand with paranoia, which can then lead to social isolation or isolation as a whole. While isolation does occur as a result of other mental illnesses, psychosis has been stated to be one of the more significant causes of isolation. “People with psychosis experience more social isolation than any other diagnostic group and have smaller social networks than the general population,” stated Tee et al., (2020, p. 1). The smaller the social network often, the more difficult it can be to battle the fear within paranoia, leading to symptoms worsening. While often social isolation can be battled through interactions with others the individual can see as safe to be around, the heaviness of the fear can take over. It can be blinding and feel impossible to battle.

Psychosis often promotes isolation through feelings of hopelessness, depression, paranoia, and social anxiety. People with psychotic disorders often experience high levels of fear. Whether that fear results from paranoia or not, it often promotes isolation. Social isolation often brings feelings of immediate relief and control for people with psychotic disorders. In the short run, the decision to isolate often brings those feelings of immediate relief and control for people with psychotic disorders (Fett et al., 2022). However, this frequently leads to more severe isolation and long-term problems of worsening paranoia, depression, and social anxiety (Fett et al., 2022). Over the long-term social isolation has been shown to significantly increase the chances of suicidal ideation in people with psychotic disorders (Bornheimer et al., 2020).

When a person socially isolates, it becomes more difficult to challenge their paranoid thoughts, feelings of depression, and hopelessness. Fett et al., (2022) conducted a study focusing on the differences between feelings of safety when alone and with others for people who experience paranoia. It was discovered that while these people typically experienced isolation as the safe decision, interactions with familiar people lowered their levels of paranoia (Fett et al., 2022). Tee et al., (2020) described the importance of having one-to-one support for developing more social connections and a social circle. Tee et al. (2020) emphasized the importance of the need for that support person to provide the feeling of safety and patience, understand interpersonal communication, and have the ability to empathize.

One of the comorbid diagnoses which is frequently overlooked that seems to have a powerful effect on social isolation for people with psychotic disorders is social anxiety disorder. Social anxiety disorder seems to be particularly underappreciated, perhaps because it can be hard to distinguish symptoms of psychosis from those of social anxiety (Roy, Demers, & Achin, 2018). However, studies show that people with schizophrenia frequently also have genuine

symptoms of social anxiety. Paying attention to comorbid social anxiety symptoms is particularly important, as people with schizophrenia and social anxiety disorder have been shown to have higher rates of suicidality and substance misuse, as well as worse social adjustment and quality of life. (Pallanti et al., 2004).

The Practice of Art Therapy with Psychotic Disorders

Art therapy used with psychotic disorders, on its own, provides an opportunity and space to express oneself without the need for talk and social engagement. It can be a way to control the form and flow of communication with oneself in a therapy session, whether in a group format or one-to-one (Lynch**,** S., Holttum, S., & Huet, V., 2019, p. 5)**.** Art therapy needs to be seen as safe; it is important to acknowledge that the person you are working with is coming into an environment where at the beginning, they may feel as though they do not have control, especially when it comes to paranoia and overall psychotic disorders (Wood, 2013). Behind the scenes, there are things to do to create a safe environment and process as the art therapist, such as focusing on what the creator will physically be surrounded by (Wood, 2013).

In his article Wood (2013) proposes several principles for using adaptive art therapy to treat people with psychosis. He proposes using an empathic and supportive "side by side" approach instead of a more confrontational or interpretative one. The emphasis here is on establishing a safe psychological space. He also emphasizes establishing a consistent and "safe" physical art environment. Wood (2013) speaks in detail about creating a safe space by paying close attention to the materials that the patient is surrounded by, the art books, the imagery on the walls, and more. In addition, he emphasizes the importance of having a private space where patients will not be interrupted by others. Wood (2013) also speaks of the importance of communicating clearly with other involved clinicians. The inclusion of the treatment team in the

art therapy process provides alternative points of view, as well as provides the art therapist with additional information, such as the patient's familial and other social supports, their housing situation, other aspects of their treatment, including medications, and much more.

Group Art Therapy with Psychosis and Psychotic Disorders

Often group art therapy can provide those dealing with psychosis with an alternative way to speak and express themselves through the support of others who have had or are going through similar experiences (Teglbjaerg, 2011). The wordless aspect of art therapy provides a unique way to express oneself. Teglbjaerg (2009) documented a study that focused on reducing psychopathology in people diagnosed with schizophrenia experiencing group art therapy and discovered the positive outcomes from the alternative therapeutic process (Teglbjaerg, 2011). Art-making can serve as a "buffer" between verbal and artistic communication to provide control to the art maker (Lynch, S., Holttum, S., & Huet, V., 2019).

There have been various versions of therapy for those with psychosis. The socialization needed to fight isolation and gain support can be found and grown through group therapy. Group art therapy with those who deal with similar symptoms can also provide a safe space to express themselves without needing to verbally state what they are processing (Crawford et al., 2012).

Similarly, Teglbjaerg (2011) noted that the participants in their study shared that the fear from their paranoia could be decreased when creating art in a group therapy format, even though their paranoia and related fear was not necessarily the focus of discussion in the group. The lowering of fear can allow a person who often experiences it to have more of an ability to be in social environments (Teglbjaerg, 2011). Art therapy can allow people to have an identity outside of their mental illness and allow the artwork's creator to feel like a creator in control of a part of

themselves (Teglbjaerg, 2011). Lynch et al. (2019) created a study that focused on working with people after they had received their first diagnosis of a psychotic disorder and discovered that the group art therapy format provided a safe space to process an extreme new event in the patient's life. It allowed them to communicate in multiple ways, such as creating and responding to art. As well as finding support from others going through similar experiences after receiving their new diagnosis (2019).

Critique of Art Therapy with Psychosis

There is some controversy regarding the efficacy of art therapy as a treatment for psychotic disorders. Although there is a multitude of articles supporting the value of art therapy for psychosis, and although art therapy is formally recommended for the treatment of schizophrenia in the 2014 and 2017 National Institute for Health and Care Excellence in the U.K. guidelines, a large 2010 study titled MATISSE, found no benefit for art therapy in the treatment of schizophrenia. Many subsequent articles have found fault with the MATISSE study's methodology and its conclusions, particularly in how art therapy was administered in the study and how the outcomes were measured.

Collage-Based Therapy

Within art therapy, collage is a less intimidating material to work with. It is easily accessible, adaptable to many situations, cultures, and environments, provides more structure, and certainly not lastly, it gives control to the creator (Raffaelli & Hartzell, 2016). Raffaelli & Hartzell (2016) conducted a study comparing the uses of collage versus drawing materials. It was noted that collage materials evoked less anxiety, to begin with than drawing materials (Raffaelli & Hartzell, 2016, p. 4). With collage, the materials and imagery are already provided; in a sense,

the materials are meeting the creator halfway. Collage does not require the skills to be able to draw. It gives freedom to the creator while providing enough structure for the process to feel safe and controlled (Gussak, D., & Rosal, M., 2016).

The collage process can be simple as well. There are enough steps for the creator to create something unique to themselves, yet not too many for it to feel overwhelming from the beginning and throughout the process (Raffaelli & Hartzell, 2016). The imagery and words are already there, then all that is often needed is a way to attach the collage materials to a page and, if needed, a pair of scissors to cut things out further or find another source to get images from. From there, if it is wanted, other various materials can be introduced but not required. While collage is structured, it is also adaptable; all sorts of 2D materials can be used. The structure and provided materials allow the creator to gain control in that moment and associate the control and safety with imagery connected to a part of themselves (Gussak, D., & Rosal, M., 2016). It is a straightforward process and, at the same time, has much room for creativity (Raffaelli & Hartzell, 2016).

Collage can also replace the need for verbal communication (Gussak, D., & Rosal, M., 2016). Not everyone feels comfortable communicating verbally (Lynch, S., Holttum, S., & Huet, V., 2019). Combining already created imagery can help the creator develop a unique language, a format for them to connect with a part of themselves and, if possible, share a part of themselves and their language with the viewer (Gussak, D., & Rosal, M., 2016).

Combining different materials, many of which belonged to other larger imagery and stories is a form of communication with oneself. The materials help document the different parts of what the person is communicating and learning about themselves (Chilton & Scotti, 2014).

They help document the artistic decisions that may otherwise have stayed invisible (Chilton & Scotti, 2014).

Method

My research began with the question, can collage-based art therapy be a bridge to engage patients experiencing social isolation with a diagnosis of a psychotic disorder?

With this work, I wanted to provide a safe and enjoyable experience, a directive that encouraged connections and support from myself and the art materials. However, I also wanted to promote independence. I wanted to include three stepping stones for the research, a pre-directive group, the directive, and the post-directive observation. All lead up to providing the patients with safety, an ability to connect to a part of themselves not dominated by their diagnosis, and an enjoyable artistic experience.

Setting

I researched and worked in a crisis stabilization locked short-term psychiatric unit for adults ages 18 and older diagnosed with a psychotic disorder or symptoms of psychosis. The unit was in a large psychiatric hospital in a suburb of a large city. The unit has 22 beds, most often having 21 patients, at one point having a low of eight and at another time a high of twenty-two. Often patients stayed for five days to two weeks but, at times, may stay for more than two months. The unit consisted of four social workers, three doctors, nurses, mental health specialists, the art therapist, who was also the group coordinator, me being the art therapy intern, and other visiting staff. Each patient had a treatment team of one of the social workers and one doctor and switched between mental health specialists and nurses. The art therapist, group coordinator, and myself worked with all patients. Being able to work alongside the art therapist

allowed me to take on a similar role and schedule. Outside of this directive, I ran discussion and skill-based groups at the beginning of the day, an art therapy group later in the day, and at the end and between open times, I met one-to-one with patients. I also participated in team meetings, known as rounds on the unit. I also had access to and wrote notes regarding groups and patients in the electronic program used by the unit.

When working with patients one-to-one, I often met with them in the art room, a medium-sized space that could fit a maximum of ten people with walls covered in present and past patients' artwork. The room had three large cabinets filled with a large variety of art supplies and three other small to medium-sized spaces for storage of art supplies. All were locked if a staff member with keys to the cabinets was not in the room. The room still had painting materials, beads, and coloring materials left out for patients to use independently, and a large speaker to connect their phones to or listen to the radio. If I could not use the art room, I used the conference room; it had a table with phones and two cabinets with other art supplies, books, and extra materials for various parts of the unit. If I could not use either of those spaces, I used a chess table area with a small bench, a chair in an open area, and a small table.

One-to-one

I began interacting with patients more closely when we worked on the directive and met one-to-one. I believed it was important that the first in-depth connection I attempted to create with a patient was one-to-one. I knew one-to-one I could provide more attention and empathy; I knew about the unit and the ways and places that socialization could happen; I knew various ways of communication, especially through art making, and that I could provide patience and empathy (Tee et al., 2020).

Participants

I worked with six patients from the psychiatric unit. We worked in separate one-to-one sessions spread over a month. Each patient gave consent to taking part in the activity and being a part of the research. Two patients met twice with me one-to-one, and the rest met once. Patients ranged from ages twenty-two to sixty-five. I did engage with patients post and pre-directive in groups and informally in the milieu. There was one cis-gendered patient who went by she and her pronouns, one patient whose gender was not disclosed but went by they and them pronouns, and four cis-gender men who went by he and him pronouns. Marital status was disclosed by one patient who was married. Race and ethnicity information was provided through the electronic system used at the hospital for two patients that stated that they were Caucasian; the rest of the patient's race and ethnicity information was not provided.

Diagnoses among the patients were schizoaffective disorder, psychosis, psychotic depression, major depressive disorder, post-traumatic stress disorder, substance use disorder, and unspecified psychotic disorders. On the unit, symptoms presented often were paranoia, becoming hyper-religious, self-isolation, and auditory and visual hallucinations, and while certain patients did not fit the specific diagnosis of social anxiety disorder, they presented symptoms of it.

Self-isolation was a specific symptom and presentation I was focused on when I chose patients to work with. Signs of self-isolation that occurred with the patients worked with were staying in one’s room for 70% of their time each day, low attendance in groups, and lack of interaction with other staff and patients on the unit.

Directive

The activity was meant to last thirty minutes and consisted of one session per patient due to the short-term stay. I was able to meet with two patients twice as a result of their longer stay on the unit and the benefits found from the first session. The activity was introduced to the patients as creating a small collage on a notecard about different people, places, objects, animals, etc., that, in a supportive and healthy way, helped them feel grounded or an overall comforting feeling. Before beginning the activity, patients were given information regarding my research and why I was doing it. Each patient was provided information about what a collage is, stating that collage is a form of visual art in which visual elements are combined to create a new image that conveys a message or idea (American Art Therapy Association, n.d.). The materials could be various designs, often paper materials that were images and words from magazines and books. It was also stated that other materials, such as markers, stickers, or drawing materials, could be used in a collage. It was stated that we would be using pre-cut images and words from magazines and calendars, a decorative materials book, colored pencils, markers, and oil pastels. They were also informed that I would create my notecard alongside them. Examples were provided, and patients were reassured that their artwork did not have to look a specific way and that it was what felt most comfortable for them throughout the session. I also asked them if they had any questions and let them know that if they had any questions throughout the activity, they were welcome to ask me. The art materials were introduced to the patients one by one. The patients were asked if they would like to listen to music, and all patients but one said yes. When the materials and the art process were combined, it helped the patient have many forms of comfortable control to explore a topic, such as their identity outside of their diagnosis. The activity did not depend on verbal conversation; I stated that if they were uncomfortable answering questions and would appreciate a quiet space to create their collage, they were

welcome to it. I ended the introduction of the activity by stating that once they were finished, I could laminate their card.

During the activity, I took a mental note and then wrote notes after the session of how the patient interacted with the materials, which ones they used, where they placed them on the table, and how they responded to the materials being introduced. I also considered questions such as did they press hard on the page with the colored pencils, did they use the scissors to cut out their images, or did they only use one envelope of the images I pre-cut for them. I also paid attention to physical presentations and responses such as body movements, eye contact, speech content, and speed of speech and tone. Throughout the artmaking process, I created one notecard to reflect how I responded to the patient and used the artmaking as a form of note-taking.

Once the patient stated they were done, I moved into the final reflection part of the activity. I asked each patient permission for me to hold their notecard up in front of them. If the patient agreed, I held it up in front of them and gave them 30 seconds of silence to view it from another perspective. I then asked the patient if their perception of the card was different, if they could tell me something about their card, or if they noticed anything new that the images could be connected to. Once done, I asked if they would like their card laminated and thanked them for creating art with me.

Materials

Materials used were red, yellow, white, blue, light green, dark green, light orange, orange, light pink, and light purple colored four-by-six-inch notecards, glue sticks, orange, pink, red, yellow, blue, and green oil pastels, markers, and pre-cut collage images. A book of decorative art materials was also provided. The pre-cut collage images were organized in small

white envelopes in categories such as people, plants, art & design, animals, words, outdoors, food, and miscellaneous. The patients were also given the option to cut out their images and words from one magazine provided. If possible, the lamination process was done in front of them. If not, they were told to hold onto the card and that I would come to them with the laminator and laminate it by the end of the day. A speaker was used to play the music the patients chose, or I already had a playlist that contained wordless calming music.

Often on the unit, when patients join an art group or are just told about the art room, the response is, "I am not an artist." This is part of the reason collage was chosen. Collage helps connect the art to something that most people understand, paper images, images of all different cultures, parts of the world, and more, as well as highly adaptable materials and spaces.

Process Before the Directive

While the directive aspect of the research was the focus of the art-based research, I used my observations and interactions with the patients beforehand as information. I wanted to note where the starting baseline with each patient was regarding socialization, paranoia, and isolation.

The patients were spoken with either earlier in the day and briefly encouraged to come to the group that morning or spoken with the day before, where I encouraged them to go to the first group, which I was running or observing the next day. I decided to work with them by reading their notes, observing them in the group, and learning about them from their social worker, doctor, nurse, and mental health specialist that checked in with them. I always checked in with my supervisor to confirm that working together would be safe and beneficial for the patient and me. I paid attention to the patients that isolate themselves, experience any form of paranoia, are having difficulties attending groups, and if their treatment team believes going to groups would benefit them. This helped me understand the best way I could introduce myself to the patient in a

non-threatening way. I then noted their verbal response and overall reaction to the encouragement to go to the group and my introduction of myself to them.

The patients did not always verbally respond or show acknowledgment of the invitation to the first group, or they may have agreed to come to the group but never arrived. Within the first group, I began by introducing myself and asked the group members to go around and share their names and answer a brief question regarding the group topic. The group members were never required to answer a question or engage in conversation. If group members asked not to share or say anything, they were told they were welcome to observe the group if they would like to, to put less pressure on the group members and more on the importance of presence in the room. That also started with getting the group member involved in a social environment that is within their control and can adjust to the level of safety in the group that feels best for them.

I gathered my information by taking brief notes during groups and then more thorough notes afterward, noting the patient's movement, eye contact, speech content, space they stayed in in the room, overall physical presence, if anything stood out, and if and how the patient interacted with other group members. After the group, I approached the patient, gave brief information regarding my thesis and directive, and asked if they would like to join. Four patients were met with beforehand and given a choice of when we could meet later in the day. Four patients let me choose when we could meet; I told them I would come and find them then. When explained the directive, two patients stated that they could do it at that moment, and we immediately transitioned to the introduction and artmaking process.

Post Directive

Information after the activity was gained through observation of whether the patients attended groups and had changes in isolation, such as spending less time in their room and interacted with others or even their presence in the milieu post-directive. If a patient had already been attending groups, I noted any changes in presentation and interaction in the group. I also noted how they interacted with me either later in the day or the next day if I could see them. If I could meet with a patient twice, I would focus on their comfort level with the art materials, space, and artmaking process and how they began the session the second time we individually met.

After each patient stated they were done with artmaking, I noted how they ended the session. Whether that meant they helped me clean up, walked away silently, or stuck around and continued to talk with me even when they were done with the artmaking. During that period, I also paid attention to whether they made eye contact when leaving, if they kept their head down and stared at the floor, kept their arms close to their body, or had more open movements. That was all input for me to understand if their comfort with me had changed since we first met. I also noted their response to seeing their card laminated and if their appreciation of their artwork changed.

Organization and Collection of Data

After taking notes and observing the patient for at least a day, I sat down with my artwork and notes. I also got written consent from the patients to take pictures of their notecards for my reflection benefit, not to share with future readers. I had my notes, notes from the electronic system on the unit, briefly stating basic information about the patients, their age, gender, pronouns, diagnosis if provided, symptoms, marital status, race, and ethnicity if provided. Through my artmaking reflection and actual notecard, I had my artistic response.

I started by considering the parts of the activity where the patient showed enjoyment and openness or began communicating. I then thought about what helped them get to that place. From there, I took note of the big themes that popped up, the things that stood out to me enough for them to impact my artwork as well. After I worked with three patients on my own, I went back to my notes and looked at any overlaps within the themes of the three patients; then, from there, I did it again with notes and reflections on five patients and, finally, six. I considered if any of those themes showed up in my note cards, if it was in the final product, or if the theme showed up in the artmaking process for myself. I also noted what changed the patient's affect, whether negative or positive.

Results

Pre-Directive Group

Five of the six patients attended a pre-directive group held earlier on the same day as the directive. Three patients who attended the first group did not speak, and two spoke minimally during the introduction part of the group. One patient before the group asked if they could attend without having to talk, and two at the beginning of the group stated that they did not want to speak. One patient who stated he did not want to speak ended up talking throughout the whole group.

It was consistent with all patients that in the first group, they had a limited range of body movement outside of mildly adjusting their seating position in their chair, brushing their hair out of their face, or moving their head upwards to look at group members when group members were speaking. One patient focused their eyes on the floor below them and towards their lap throughout the group.

Before the directive, two patients voiced prior experience and comfort with artmaking, two expressed discomfort with artmaking and art materials, and one did not provide information regarding artistic experience.

After the group, various reasons for not wanting to speak or interact in the group were brought to light. At one point, it was discovered that a patient had felt uncomfortable in the group due to their difficulty speaking English; that patient mainly spoke Spanish and understood and spoke minimal English.

Directive

Six patients came and completed the one-to-one art directive. Six patients demonstrated high-interest levels in the directive, much different than their usual social and treatment engagement levels on the unit. Two patients met for fifteen minutes, two for thirty minutes, one for forty-five, and one for sixty minutes. All became conversational during the directive. At some point within each session, the patients spoke about a positive memory while they worked on their notecards. Each patient at one point verbalized this memory inspired by a chosen image from the collage materials.

As a result of experiencing Electroconvulsive Treatment the morning of the one-to-one session, one patient presented with tiredness, and when looking at their notecard the next day, they remarked on not remembering creating the notecard. That patient still reflected on a connection and appreciation of the two chosen images. During that reflection, the patient expressed interest in creating more notecards over the weekend and was provided with the supplies.

One directive session had to be performed in a semi-public area, so musical accompaniment was not possible. The other five chose to have music during their session. One patient chose their music, while the other four agreed to my choice of calming music. Patients also reflected on the support the music gave the artmaking process. The music helped fill space that may have been quiet and uncomfortable for certain patients. Each patient reflected in different ways on how they enjoyed the music; three stated that it was helpful to listen to it in the background, and two moved to the music and hummed to themselves at different times through the artmaking or between talking.

Five patients' cards were laminated, and four showed more affect when presented with them. Each patient was asked what they would like to do with the card; three stated that they wanted to hang theirs up in their room, and one stated they would like to hold onto it now that it was safer with the lamination. One other patient who did not want the lamination asked to keep it to show to his mother. The final patient said he did not know what to do with it. All patients demonstrated attachment to the art piece they had created. Two of the six patients shared their notecards with family members, others hung it in their rooms, and one attached it to the front of their room’s door.

Post-Directive

After the artmaking, the patient was witnessed in the milieu and in groups if I could attend them later in the day. I was able to see each patient the next day or week after the artmaking, which allowed me to see how they reacted to me as a group leader in the future and as someone who spoke with them and passed by them in the hallway. Four of the six patients attended a group the next day after our one-to-one session, and two patients were witnessed

speaking more openly with staff and other patients in the milieu, living room, and art room. Two patients were observed showing and explaining their notecards to other patients in the milieu.

Post-directive, each patient presented with an increased affect than pre-directive. All but one patient began joining all the art groups and showed more flexibility in working with new materials and being around others within the group setting. Not only did the patients attend art groups post-directive, but they also engaged in artmaking and finished at least one piece of art each. The patients, also post-directive, began speaking with me more openly, laughing, and demonstrating in a way that they began to feel safe with me.

The six patients began verbally engaging more in groups, and two patients began engaging in eye contact and briefly answered questions provided by myself in talk-based and art groups. Given the high turnover rate in the unit, it was hard to follow the patients' course for long after the directive, but all appeared more engaged; they attended more groups, particularly art groups, in the days afterward.

Themes in Artistic Process

Connection to others (family, friends, important people)

Within each session, I discovered the consistency of content about loved ones in the patient's lives, represented verbally and artistically in their notecard. Each patient, with a smile, spoke about a loved one that brought them joy. Whether the patient shared or I was previously aware, three of the six patients did not have a positive relationship with the loved one they spoke of at the time. Nevertheless, the focus in their artwork was always presented as positive. They smiled while sharing them and spoke about the people as if they were just with them yesterday. They spoke of times of stillness within their lives and how the people in their lives helped

provide them with that and be a part of it. It was as if they were being supported throughout the artmaking process by the people they remembered. Those connections seemed to create comfort in the artmaking process and opened the opportunity and space to continue to create and connect to the imagery in front of them. In the moment, they spoke of these important people in their lives not as if they were grieving the loss of that relationship or prior selves but as if they were allowing themselves to feel the joy of that connection with a loved one.

Memories

Within the imagery, the connections helped unearth memories from each patient. Memories were a theme that even influenced the other themes. Before our artmaking session, patients did not talk about themselves often or even engage in conversation with me, yet as the artmaking process went on, the imagery started to connect to parts of the patient's past. After each patient shared their memory, they tended to connect more to the imagery available, and present a part of themselves, their identity in a sense, that I had not previously seen. This was not just memories from a few days ago. Instead, every patient talked about something that happened as a child or at least one year ago. They were memories that brought laughter and openness to the artmaking experience.

Safety in oneself

I noticed each patient begin to open up to myself and themselves throughout the artmaking process. Starting in the beginning of the directive, the patient began working on the environment created by the art supplies around them. One patient opened up all the materials, surrounded themselves with all the pre-cut images, and took out the colored pencils and markers. Other patients kept the materials organized to each side of themselves. The choice of where

materials went was left up to them, I provided the overall space and materials, and they chose where to go. As each session went on, I could see how each patient connected and showed more expressive emotions than at the beginning.

Socialization

The artmaking process with every patient began quiet, and there was no laughter; if anything, three of the sessions began with the patients and the space feeling and presenting as gloomy and quiet; not much was being said, and if there was, it was more myself pushing a conversation and starting the directive. However, as the session moved forward, I became less of the conversation director in 6 out of the eight sessions and more of the listener and responder. I laughed, smiled, and listened as they presented with more energy each time they looked at an image, picked up a colored pencil, or looked through the decorative art supplies. Patients began to speak to me more than usual throughout the artmaking process, and often after our artmaking session, they were seen speaking with others on the unit or myself more.

Communication

With all but one patient, the artmaking began with silence on the patient's end, but over time, as the music continued to play and more and more imagery began to be looked at, combined, and created, more conversation began. The one patient that asked not to engage in the first group verbally often spoke to me during our session, and he showed me materials he enjoyed throughout the session; he laughed and talked about whom he wanted to give the notecard. That continuous conversation then began a deeper and further discussion between that patient and an art therapy group attended a day after the artmaking activity. All other patients verbally communicated with me and, during reflection, were able to pick out various symbols

within their artwork that represented their connection to others and often the ability to communicate.

My Artistic Response

Within each session, the patient and I were learning from each other. This was our first one-to-one interaction, and we were learning to communicate through our artistic responses to each other (Teglbjaerg, 2011), which are documented in the images of the notecards I created in each session below. I worked on the figure one notecard over two sessions, and figures two through seven were each completed during one session each. Figures six and seven were completed over two sessions with the same patient.

I noticed a consistent theme of animals and floral imagery when I reflected on each card. Those both represent safety, joy, and comfort for me. Not just that, but they are also imagery and beings that are a part of my everyday life. I always have animals around me; I greatly appreciate floral designs and flowers. I was creating my own safe space, trying to be my best self for the patient and myself. I not only wanted the patient to enjoy the directive, but I also wanted to. I found myself branching off into different materials. I was not fully aware of this change until my reflection process; I realized that while trying to demonstrate how different materials looked and were used, I was also highly influenced by the patient and my feeling of safety. I was searching for that safe space and person to work with. We were co-creating and co-learning together (Tee et al., 2020). With each session, I became more flexible and felt more comfortable presenting the patient with different examples of how to use materials (Rubin, 2009). Looking back at the materials I used reminded me of the patient's response to materials; figures five and six were reflections of the patient who opened up all the materials on the table.

The lines and shapes created on each notecard also helped me reflect on the form of communication used and how much verbal communication happened. In figure three, throughout the session, the patient slowly became more comfortable verbally communicating and, by the end of the session, spoke more than myself to the point where I was mostly the listener.

Figure one. Cut out paper images, glue, sticker, colored pencil, and pen used.

Figure two. Cut out images and paper and glue.

Figure three. Pen, sticker, cut-out images, paper, stickers, and glue.

Figure four. Cut out images and paper, glue, marker, and sticker used.

Figure five. Stickers and oil pastels.

Figure six. Cut out images, glue, sticker, colored pencil, and marker used.

Figure seven. Ripped up notecard and paper, cut out image, glue, and oil pastel.

Discussion

Looking back, it appears that three aspects of this research helped create a “bridge” to engage these patients during the collage-based intervention. Patients found comfort in materials allowing them to open up more to various personal and unique topics, memories, and conversations about loved ones. The materials did not just provide comfort when they used them. Comfort also came from how they chose to surround themselves with them. Empathy and patience were vital from me towards the patients and the patients towards themselves. Lastly, allowing myself and the patient to focus on who they are outside of their diagnosis opened up an entirely new door for the patients to express and remember themselves. This research was highly detailed, and without the focus on those details, I would not have learned and supported the patients as much as I could, as well as them supporting and learning from themselves. These themes, while all strong individually and woven throughout the research and writing, also significantly strengthen each other.

Comfort from Materials

Rubin (2010) spoke of the importance of materials and the art therapist being aware of and experiencing the art materials provided to clients. I discovered that it was vital for me not just to test the materials that I was offering but demonstrate using them to the patients during each session without outright announcing to them that I was showing them. Often patients expressed being nervous to try something new; as Raffelli and Hartzell (2011) also documented, there was fear of being unable to use the art materials “correctly” or feeling judged by myself or themselves. However, my demonstration of using the materials and creating something that did

not look like any particular image seemed supportive. The patient saw me as “the artist,” the person who should know how to make art and use the materials correctly, yet when I demonstrated being able to play with the alternative materials, that seemed to make the patients feel more comfortable to experiment and connect to. The patient that eventually used all of the materials offered did not say anything when oil pastels were offered, yet once I began using them for about five minutes, I noticed he started to use them as well. Then slowly, he began using more and more of the materials, eventually creating his own safe space and becoming more verbally open with the memories he was sharing and describing his artwork.

Patients often said they did not want to use a new material besides the cut-out images. The cut-out imagery seemed to provide a safe entrance to artmaking, which many patients had not done in many years; even three patients stated not making art since elementary school. Wood (2013) describes how supportive a safe space can be, including how the materials and environment are presented. I discovered how true that was more and more throughout my sessions as I observed the other patients creating their environment using the materials, and the materials always surrounded them; it was as if they were looking at a gallery and the gallery was observing their artmaking.

Raffaelli and Hartzell (2016) documented something similar to what I noticed with patients' interactions with collage materials: their ability to pick images that were best suited for them quickly. As well as providing flexibility and multiple ways to define and represent oneself (Raffaelli & Hartzell, 2016). Not only did the pre-cut materials provide easily accessible materials to connect with, but they also gave the patients flexibility in what they physically surrounded themselves with while experiencing the art-making. The safety and comfort of

collage materials allowed patients to dive deeper into experimenting with various unknown materials safely.

Empathy and Patience

Throughout this research and writing, I discovered the importance of patience and empathy. Without patience from myself and the patients, I would not have been able to pay attention to all the details needed, such as how I approached the patient at the beginning of the day and what tone I used if I had even talked directly to them, as well as focusing on their physical and verbal presence within a group and the session. My connection with the patient did not begin immediately, it took time, and I stuck with the patient the entire time and adapted to what worked best for them. I believe that successful engagement with these patients depended upon how I approached them at the beginning of the day, whether I stood in their doorway and made eye contact or briefly introduced myself and invited them to the group in a hallway, to how I presented the art materials and space to them. Attention to these details could be what opened the gate for these patients and welcomed a part of themselves that they may not have been able to engage with or appreciate for a long time.

It is important to be aware of the time that it takes to go from having difficulty engaging with others and parts of the self to then attending groups, interacting with others, and opening up and expressing a part of oneself that has been hidden as what is believed to be a safety tactic from the body. It does not happen immediately, which I continuously reminded myself of. Although with patience and understanding, as Fett et al., (2022) also stated, being able to have social interactions with those who are already known and seen as safe for a patient can be that successful and supportive push that a patient needs to fight that isolation and paranoia.

Wood (2013) highlighted the importance of meeting with a patient before art making, which I would not have been able to do without patience. More specifically, when I met with the patients, I needed to show them that I was providing them with the amount of patience, kindness, and empathy, as Tee (2020) speaks about being important. This more specifically applies to the patient I worked with who received Electroconvulsive Therapy the morning of our session. First, we had to be patient and adapt to the new and open environment we had to work in because the art and conference room were not available. Second, they rarely verbally communicated with me; their energy level was low, and they had difficulty maintaining their memory throughout the session. They held kindness and empathy towards themselves in moments of confusion or if they needed a reminder of something I had said previously in the session. I held patience for them, always reminding them of what I had said in a kind and calm tone. Their patience and empathy for themselves did not end there. The next day they expressed no memory of creating the notecards but were surprised and proud that they could make them; they even found that they had connected the imagery to an important memory without knowing it while creating the card. Their patience and empathy towards themselves not only allowed them that appreciative experience but also gave them the momentum and excitement to create more cards and interact with others in the art group being held at that time.

Focusing on the Patient apart from their Diagnosis

I also took care to allow patients to talk about and experience themselves apart from their diagnoses. On a short-term unit, clinicians understandably need to focus on symptoms, diagnoses, and treatments. As a result, it often seemed that patients struggled to honestly talk about themselves in groups, about things they enjoyed, family, memories, or other subjects that might have a unique connection to their identities. Instead of trying to lead our interactions

towards illness and treatment-related topics, I instead tried to allow the patients to take the lead themselves. As a result, it was a happy surprise to hear patients in our 1:1 sessions speak about loved ones, favorite movies, hobbies they enjoyed, and memories prior to the onset of their illness or at least prior to the point that the illness caused them to be hospitalized. Not only did they share that information, but they consistently shared it with smiles, laughter, and a positive tone. My observations parallel the findings of Teglbjaerg's 2011 study, where she noted how her patients shared being able to connect with a part of themselves outside of their diagnosis, feeling more self-confident, a stronger sense of self, and a stronger understanding of self.

In our quick meeting before the art-making session, a patient I worked with told me about her experience with art and her love of it. She said this with sadness, though, sharing that she felt like she had lost that part of herself when she got sick and had not been able to make art since she is gotten sick. I told her that she would be supported through the whole process, and there was no pressure to create the notecard in a specific way, and all she had to do was pick images and glue them onto the notecard if she wanted. Once she began artmaking, I noticed her cheeks slowly lifting under her mask, presenting what I believed to be a smile and laughter at jokes she or I made throughout the session. She picked up images relating them to things she loved as a child. She spoke of her family and how they would have felt about her chosen images. Before this session, outside of her speech content, it was extremely hard to notice any affect from this patient. She stated that she was tired and sad, but besides that was consistently mono-tone. The imagery presented in front of her helped bring back her light. The memories from before she was sick were not just memories but made her sound and look much brighter. From that point, I noticed the patient engaging more with others, creating art for herself and other patients and friends outside the hospital. She stayed for multiple weeks after the artmaking and ended up

attending most of the art groups and engaging with more of an affect with me throughout her stay.

Adaptations

I could not always create a closed-off artmaking space for the patient. The art room was unavailable during one session, leading one patient and me to work in an open area. I did my best to position myself where the space felt more closed off, and the materials created a space and barrier around the patient as Wood (2013) stated being important to providing the feeling of safety to the patient. This still led me to have to communicate with passing-by patients with questions they had about the activity that I was doing in the one-to-one session with the patient. I told the passing-by patients that I would happily explain the activity later.

The unit I worked on demanded adaptations. Being on a short-term unit with patients diagnosed with psychotic disorders caused the space often to be quite chaotic, leading to me always being ready to change my plan. Shore and Rush (2019) spoke about the unpredictability that can unfold on short-term inpatient psychiatric units and therefore the importance of being able to adapt. Whether that was how I approached a group, interact with a patient, or did a one-to-one session. I knew I wanted to give the patients the best I could and keep them safe.

Implications

The information gained and documented above stands as a pilot study, hopefully opening the door for further research regarding the creation of communication bridges for people experiencing social isolation with a diagnosis of a psychotic disorder and help them understand themselves outside of their illness identity.

As a result of external factors not allowing me to meet with patients three or more times, I could not discover how the artmaking continuously supported them long-term. To view the connection that the directive sessions created would possibly have been even more of a privilege than this research has already given me. I hope what I have provided above can be the start for someone with the passion and intrigue to move forward with fewer time constraints and more resources.

Given more time and access to more collage imagery materials, I would have enjoyed and been interested to see if there are any further commonalities within the themes stated throughout this paper, especially the ones stated in the above discussion section. If this directive was conducted in a longer-term facility, it could give the patients more of an opportunity to receive longer-term support and growth from the art-making. It could give a form of longer art-based support and connection with an art therapist to help them grow in their ability to interact with others in social environments and spaces that will help them in treatment with others. While that is not something I have access to doing currently, I still am passionate about what I did and the results and experiences I gained.

Limitations

I could not access the art room and conference room each time I met with a patient, at times resulting in the patient and I meeting in an open space. This could have partially taken away the feeling of safety with some patients.

I am a Caucasian English-speaking woman who does not speak other languages, making communication difficult. I must acknowledge my privilege as well as being a staff member who does not live on the unit and can leave the unit. I do not know the experiences of living on the

unit and being a patient in the groups I am asking patients to attend. While I try to break down the hierarchy as best as possible, I am still in a higher power position as the group facilitator and a staff member. This, therefore, sets a barrier between myself and the patients. I continued to remind myself of that barrier and the power level I held in sessions, one-to-ones, and groups. All but one patient spoke and understood English. One patient understood and spoke minimal English, creating a language barrier between them and me.

This study's limited number of patients presents a lack of diversity in race and ethnicity and sexual and gender orientation. I could not work long-term with most of the patients, often only getting to interact with them three-to-four times, including the first introduction. I also experienced time constraints due to the constantly changing schedule and environment of the unit and could not observe the session and patients one-to-one for long periods.

While I would like solid results proving that my art activity and research supported the patient and were why they improved post-artmaking, I cannot come to that conclusion. Patients on the unit are provided with various treatments, medications, Electro Convulsive Treatment, groups run by others on the unit, family supports, and a whole list of possibilities that lead to improvement. What I can share is their experience within the moment of creating art and finding new ways to communicate with themselves, myself, and past supportive memories. It is impossible to conclude that my directive was responsible for any improvements seen in patients after the directive. Exactly what factors were responsible for the patients' isolation is also unclear.

Conclusion

This paper focused on the difficulty of engaging with socially isolated patients with psychotic disorders on a locked inpatient unit. A collage-based art intervention was trialed, using a supportive and non-threatening approach, emphasizing safety and personal choice, as opposed to more typical treatment and illness-based focus.

Although I entered this thesis work with hope and interest, I was particularly surprised and gratified to see the intensity of the impact such a short intervention seemed to have. All the patients were more open and involved in the directive than expected from their other experiences on the unit. They also generally seemed to have positive experiences: enjoying and often taking pride in their artwork, connecting with meaningful and usually positive memories during the directive, and often speaking about important positive connections to others in their lives. It appeared that their feelings of safety and ability to connect and socialize increased during the directive. There was also some suggestion of decreased isolation and better treatment engagement afterward.

This research suggests that even in a fast-paced inpatient unit, where clinicians' time is scarce, there may be a role for 1:1 interactions with no obvious illness or treatment-related purpose. Creating "bridges" to socially isolated patients with psychotic disorders could help their treatment goals, even when their treatment is not the focus of the intervention itself. It appears that a careful initial approach to engaging these patients, the use of a non-threatening activity such as collage, as well as the avoidance of treatment pressure, were important parts of building such "bridges." This, of course, was a small pilot study. Further exploration of such an approach should be made before larger conclusions or recommendations are made.

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Student's Name: Nora Wolff

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Title: Can Collage-Based Art Therapy be a Bridge to Engage Patients Experiencing Social Isolation with a Diagnosis of a Psychotic Disorder?

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Raquel Chapin Stephenson