Inpatient Art Therapy: Implications and Applications for Training

by Paul Nassar, M. Roy Kremberg, and Vivian Corso

Abstract

The use of art therapy on an acute short-term inpatient ward of a general hospital is described. Among the topics discussed are the theoretical basis for this form of therapy, some considerations in its application, and implications for training mental health care professionals.

After months of preliminary meetings and discussions among ourselves, as well as with hospital administrators and unit staff, the first art therapy group on our inpatient service was formed. Because of the newness of this modality on this inpatient unit, caution and close scrutiny by its staff were not surprising. In fact, this served to promote a greater commitment to our project.

A brief description of our inpatient unit and its structure may help the reader to understand the environment in which the groups were conducted. The ward consisted of 36 beds with a patient population that was mixed racially, ethnically, and socioeconomically. The average length of stay was 24 days.

At the interdisciplinary staff-team meeting to which the therapists were assigned, potential group members were discussed and chosen on the basis of patient manageability, disregarding diagnosis. Patients were invited to join the group after the weekly patient-staff rounds in which the entire team (patients and staff) met. Patients were told that they were welcome to join an art activity group aimed at developing better communication through a cooperative task. Those invited to participate in the group always had the option to decline.

We planned to focus on the interpersonal relationships in the group. Our aim was to understand, evaluate, and assess those interpersonal skills that reflect individual ego functions. We were eager to employ our interest in art and our training as therapists in treating patients. We felt a particular need for a creative and expressive modality in our residency training program because the first year of this program focused on psychopharmacologically augmented verbal psychotherapy. We proposed that using a nonverbal modality might allow for exploration of feelings and ideas in a less threatening way.

The mural was the medium of expression. Pastels were used by the patients who initially sat in a semicircle facing a large 3' x 5' sheet of paper which was taped to a wall. This format is similar to the long-term inpatient group study in Murals of the Mind (Harris and Joseph 1973). The mural had its origin in an animated discussion and active development; finally, it was frozen upon completion for inspection. The actual session consisted of three distinct phases: selection of theme, actual production, and postmural discussion.

The group met on the unit once weekly for approximately 75 minutes and ranged in size from two to eight patients. In the first phase, the group was introduced to the idea of creating a mural through a cooperative effort. Theme and organization of the mural were dis-
discussed. Instruction to the group was left open ended, allowing for a broad spectrum of creative ideas.

The discussion which began each art therapy session centered around the selection of a theme and a plan for the following production phase. During this production phase, the therapists were the least active, allowing patients free range to interact verbally and nonverbally. It also permitted our observations and encouraged a therapist-independent rather than a therapist-dependent group, thus decreasing the potential for competition between patients and therapists.

The last phase was the postmural discussion. If this phase did not begin spontaneously, the therapists asked exploratory questions based on group and individual psychopathology. The therapists focused attention and underscored the limits and goals listed below. Our goal was “designed to enable the patient to experience fully, to accept what he has experienced, and to share the experience with others” (Cummings and Cummings 1970, p. 16).

The guidelines of the session were:

1. To adhere to the rules of communication by:
   - One person speaking at a time.
   - Each speaker relating to the topic at hand.
   - The majority ruling in decisions (for example, regarding theme).
   - Individuals taking turns in speaking.
   - Encouraging a mutual respect for each member’s ideas.
2. For each patient to stay for the entire session.

The goals of the session were:

1. To foster teamwork on a collaborative activity by:
   - Actively seeking out everyone’s ideas.
   - Taking turns working on a project.
   - Incorporating many variations on a major theme.
2. To gather information about individual patients for:
   - Immediate use in the art therapy group.
   - Use by the individual primary therapist.
   - Use by the therapeutic team.
3. To explore an alternate modality of treatment.

An inherent problem in the group was limited contact because of the short-term nature of the unit. Hence the population was transitory, with patients entering and leaving weekly. What can be accomplished in a group in which every meeting must be considered as an entity rather than as an incomplete part of a process which unfolds over many months? There are many appropriate and realistic goals. Patients may share problems and concerns, thus alleviating their loneliness and sense of unique unworthiness. They may be taught social skills. They may learn simply that there is help to be obtained through talking and thus be better prepared and motivated to pursue psychotherapy after discharge. [Yalom 1975, pp. 62–63]

Further, some patients, especially in the early stages of psychotic episodes, communicate quite readily in graphic rather than in verbal terms. It is possible when working within a nonverbal modality to enhance the therapeutic relationship by encouraging the visual representation of fears and conflicts. Identifying the symbolic content of such representations strengthens the therapeutic alliance because the patients feel understood. It is precisely because many of the most disturbed patients are the least verbal or understandable by others that expression through drawing is so valuable. By augmenting the expression of feelings, fantasies, or perceptions, the corrective emotional experience can progress.

Clinical Vignettes

The following are vignettes demonstrating principles outlined above.

Mural #1 was entitled “Coal Miner by the Sea” (see figure 1). During the session, Mr. CS opposed the seashore theme chosen by the rest of the group. He felt that his coal miner was the only worthwhile idea. While ostensibly a nonparticipant, he managed to maintain the focus of the group on himself. Although supportive of his need for autonomy, his peers were eventually frustrated. The rest of the group was relatively high functioning, more capable of verbally communicating their feelings than was Mr. CS. With minimal therapist intervention, the coal miner was drawn into the seashore theme by the group. The mural of this session holds a great deal of energy, movement, and life. During the final discussion, patients gave each other valuable feedback. Mr. CS, through his pictorial drill and hammer, which his coal miner needed to survive, reflected his own need to be armed in order to relate to the group. His
Figure 1. Mural #1: Coal Miner by the Sea
feeling at the session was one of being abused by the other group members. They, in fact, were responding to his treatment of them by openly ventilating hostility toward him and handling their anxiety via comic relief. The therapists did have a glimmer of insight into Mr. CS's own strong dependency needs and conflicts. Mr. CS's defensiveness had not been so transparent in strictly verbal groups.

Also in group #1, Ms. OG was having difficulty working with the group. She drew a sand castle lacking windows or door. She was asked by another patient, “Why are there no windows in your castle? Like you, it's beautiful and we would like to see inside.” A lively discussion ensued, after which other group members were granted permission by the withdrawn Ms. OG to draw windows on her castle. Ms. OG later demonstrated more security in self-disclosure, an attitudinal shift consistent with the interpretation made by the group. Thus, her resistance was exposed and eliminated through the art therapy modality.

An escape from reality can be seen in Ms. KC's large multicolored bird in mural #1. Her bird in flight pointed out her tendency to flee when stressed. This interpretation was made during a group discussion of how the bird reminded the group members of the way Ms. KC responded. Thus, in art therapy, a characteristic defense can be pictorially represented and successfully interpreted by the group in a manner that fosters acceptance by the patient because it is easier to relate to the impersonal bird.

Group #4 contrasts sharply with group #1. In group #1, the mural was organized in theme, color, and perspective. The symbolism used in mural #1 generally conveys a meaning to others. This is indicative of the relatively high level of functioning of this group. Mural #4 (figure 2) was amorphous and chaotic in spatial organization. When Dr. K was briefly called away, Mr. BN made a sexual advance toward the co-therapist, Ms. C. In response, Ms. KE deflected the attention to herself. Upon Dr. K’s return, Mr. BN drew an eye over his drawing of a phallically steepled cathedral and encircled its cross. The group discussed the mural in a self-effacing way. When Dr. K was requested to contribute to the mural, he drew a purple sun to complement the already drawn yellow one. This addition to the mural was applauded by the group members, who then felt secure enough to encircle the mural with a border.

Group #4 was able to relate the session in a constructive way to their lives and present difficulties. The level of functioning of this group was very poor. It was fraught with unresolved sexual and aggressive conflicts. The therapists felt that Ms. KE maintained the communally held image of her as the good yet seductive mother. Mr. BN’s eye was interpreted by us in supervision as symbolizing his paranoid perception of the moral, ever-watchful eye of male authority figures. The group lamented its obvious psychotic production, perhaps in defense of anticipated therapist reproach. They were unable to relate with any cohesiveness and every individual effort remained autistic and isolated until the last gesture of unity, which followed Dr. K's drawing. His act helped improve communication and increase relatedness. In turn, this created the warmth that the group craved, while it simultaneously accepted the members' individual psychoses. These were responded to by Dr. K's choice of a fantasy color scheme. By adding his own irrational element, the therapist joined the resistance and concretely exposed the difficulty of the patient group.

In group #6 (see figure 3), Mr. KS refused to participate in the group discussion, feigning sleep. He left the group only to re-enter later. This manipulating behavior seemed to undermine the group process as he drew attention away from the project onto himself. Both therapists confronted him, each presenting a different viewpoint as to the reason for his behavior. The therapists then had an open and honest discussion in front of the group about the differences in their point of view. The lack of discomfort in not agreeing served as a model for the group in how to deal with differences of opinion in healthy relationships. Following this discussion, Mr. KS made a grandiose and inappropriate drawing covering almost two-thirds of the space, but this was not challenged (see group #7).

Meanwhile, another patient, Ms. NC, who was extremely psychotic, left the group only to return quite late in the session. This initiated another discussion between the two co-therapists focusing on whether she should be allowed to stay. The group members then engaged in a lively discussion in which Ms. NC was confronted on her use of psychotic behavior to alienate herself from others.
The following week, in group #7, Mr. KS seemed to have benefited from the confrontation of the previous week and the open exchange between the two therapists. In this regard, he took an egalitarian amount of space and drew more reasonable figures. He became more flexible and appropriate in his range of responses. We interpreted these changes as being due to the effects of modeling. The concretization of his behavior in drawing helped Mr. KS to perceive his actions in relation to past and present experiences. He began to modify those aspects of his behavior that were not constructive for the group process.

Mr. KS attended a total of five sessions, more than any other patient. We were therefore able to work closely with him, observing and experiencing his progress.

**Implications for Therapist Training**

In the supervisory situation, having a mural to discuss also introduced a new element into the consideration of dynamics and patient management. Art therapy affords the supervisor another "peek" at the patient and his problems, as well as at the trainees' difficulties. Recognition in turn allows for faster intervention (i.e., medication change) and ultimately affects length of stay. With time at a premium, this beneficial effect cannot be overemphasized. Those involved in training psychiatrists are frequently asked for service versus training needs in a medical setting. More than ever, service justification is required by funding sources, hospital administrations, and other regulatory groups. Art therapy clearly offers therapeutic benefits for the patients and training for the co-therapists. The art therapy group offered the therapists more patient contact with a minimal increase in session time. This is helpful in the face of ever-increasing pressure to treat and discharge psychiatric patients as rapidly as possible. Special equipment is not necessary, thus eliminating any capital expenditures. Supervision conducted jointly keeps supervisory time reasonable as well.

At a time when patient management by teams is widely accepted, teaching must be directed to the several disciplines involved. The pairing of a first year psychiatric resident with an art therapy intern, exemplifies interdisciplinary teamwork in the caregiving process and strengthens the concept of milieu treatment. As Almond (1975, p. 13) points out, "there is no special, abstruse expertise connected with management that gives any one subgroup a special, exclusive role in treatment." Role modeling takes place between therapists and patients, and at the same time, role blurring occurs between the co-therapists. Whether or not this is seen as positive will depend upon theoretical positions. Because psychotherapy is not exclusive to psychiatry, recognition of this fact in a psychiatric residency could be a step toward career preparation. To accomplish this, the resident must be willing to relinquish some of the power and prestige of the traditional doctor role. When a psychiatric resident is paired with an art therapist, each has a chance to experience the other in a work situation. Both of the therapists in this example brought different skills to the art therapy group. The art therapy intern, who was new to the inpatient ward of a general hospital, brought her knowledge of art media, task orientation, and training in psychological concepts. The resident brought authority, analytical medical approach, and knowledge of psychopathology. The art therapist became more assertive. This was reflected in her increasing comments to the team on her general observation of the patients during the group session. Her participation in the team became more active, and she was gradually accepted by the other team members. As the art therapy modality became accepted, so were the art therapist's suggestions given more openly. Surely, this had a positive affect on her experience as well as on the team's education.

Another interesting ancillary effect of having murals from the group to display was that it added a new dimension to the team meeting. The interest, delight, and curiosity generated helped establish a place for both the therapists and the treatment modality.

For the resident, the usual defenses enhanced by medical education—including repression, isolation of affect, denial, and intellectualization—were challenged. As Bruch (1975, p. 87) aptly points out, "In learning psychotherapy, the beginner tends to be preoccupied with terminology and exhibits excessive use of psychiatric cliches." Especially during the first year of training, resident-patient interactions may be stilted and formalized. Art therapy offers the resident a chance to participate with, interact with, and be "real" with patients while in the role of a therapist. It makes the
residents available for nonverbal interactions in a task-oriented setting.

Another task was to explore the interaction between the two therapists. This reflected on their behavior in the group. Both therapists were encouraged to communicate with one another directly in the group, thus exposing some of their uncertainties. They became more flexible and willing to reveal themselves through this kind of participation. It is to be hoped that such initial acts of courage will become incorporated into a therapeutic style. In turn, this will add life to the “work” of psychotherapy in whatever form it is practiced.

The supervision itself was eventually directed along two lines. The first was to suggest ideas and introduced flexibility into problem solving. An example is a discussion of mural #1, “Coal Miner by the Sea.” In the mural, the presence of a coal miner out of context was disruptive and provocative. It was suggested that in a similar situation, the coal miner’s figure could be placed on another piece of paper and taped onto the mural. This would underscore the inappropriateness of such a figure and aid in reality testing for a disturbed patient by permitting him to add or remove it from the mural. Many such suggestions were derived from understanding the underlying psychopathology and psychodynamics involved, as in any treatment supervision.

In this article, we have attempted to relate how an art therapy group met the short-term treatment needs of our inpatient population. Finally, both therapists-in-training gained respect for the other’s discipline. This modeled the blurring of roles in areas of arbitrary differences for the entire therapeutic team.

**References**


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