Art Therapy Online: ATOL

Think Group: The Median Art Psychotherapy Group

Jane Dudley

Abstract: The group analytic theories referring to large and median groups can offer the understanding of the benefits of large group membership; something desired but often absent from the studio /open art psychotherapy group. The suggestion to keep the focus on the group and not necessarily the individual provides the opportunity for societal, cultural, class and political concerns to be considered and actioned.

Keywords: Median Group, Art Psychotherapy Studios, Adult Psychiatry, Studio Groups, Large Groups, Social Inclusion.

Introduction

As early as the forties large groups were employed as part of therapeutic programmes (Foulkes (1975), Bion (1961), Main (1946), Jones (1966) and through my experience of working within various psychiatric settings since the early seventies I am aware of the ways that the environment of the institution affects the people within it. I discovered as early as 1975, when I was a student psychiatric nurse on a psychiatric rehabilitation ward for those who had been in hospital many years that as part of a ward programme the large group had a significant effect on empowering self awareness across the membership including staff.

> "Such a group can either be part of an institution or may encompass the whole of a smaller institution. They may be less organised groups devoted to some movement or pursuit wishing to improve their efficiency, their spirit of common concern and co-operation, to reduce conflicts and friction and to liberate creativity." (Foulkes 1975:.40).

The studio art psychotherapy group offers the possibility to harness such a potential.

Over some time I provided clinical supervision to a colleague who facilitated a weekly ninety minute semi open art psychotherapy group to patients within adult psychiatry. On occasions a trainee art psychotherapist would join for eight months and co therapy supervision would take place at these times. The membership was formed of both in- and outpatients, some making the transition from the inpatient ward to outpatients and vice versa. All patients were offered the possibility of a formal assessment to determine whether this was the right mode of art psychotherapy, as opposed to group analytic art psychotherapy or individual art psychotherapy.

In a service review this group was called into question and furthermore we were asked why we needed such a large space for the group to take place and on what grounds did we assert that a group with such a large membership, usually 15 to 18, was indicated. For instance, we were asked how we could keep all these people in mind, particularly with respect to case management and clinical risk.

In order to think about the concern as to how we could undertake psychotherapy with so many people and to give the group the gravitas I felt it deserved a return in my reading to De Mare (1991) and theories relating to the median and large group proved helpful. Jones and Skaife (2009) also made use of his theories and I, in turn, valued their contribution on thinking about the large art psychotherapy group and the group space. Such theories also helped me to think about and contain the political challenges we faced in the form of our specialism being called into question in terms of lack of quantitative evidence. These challenges threatened to detract from thinking about the therapy itself and, most painfully, the challenges made me doubt my own belief that the group had value.

The Median Group

For a long time we rather fudged what the group title was. At the same time as the group was being called into question the AHP DH lead for *New Ways of Working* (DH, 2003) asked for examples of good art psychotherapy practice. I wanted to include the group, in particular its capacity to hold those making the transition from in- to outpatients and still holding people when readmission was necessary. I needed to find a theoretical frame to give the group a context and meaning for the reader.

It was not quite an open studio group with ever changing membership nor could it be described as an analytic art psychotherapy group. I realised, in writing up for the document, that I wanted to emphasise 'think group' rather than about each individual person, including the therapist. By holding this apparently obvious position, we witnessed that over time that the group became an entity with a life of its own and with a securely boundaried identity. Through this we achieved a median group with the steady numbers of members, sometimes as many as twenty. De Mare's (1991) median group was a sitting circle of members facing each other and was considered a transition between a small and large group. Our group could also be considered thus but was a moving median group in that the members never sat in a full circle. Even so, like De Mare, we desired that dialogue would be possible and achieved between the members and within the groups in which they also moved.

> "Dialogue in the median group is of a special nature. As one member remarked, it is unlike social dialogue; it has to be learnt. One reason is that social dialogue is usually dyadic, bivalent; the median group dialogue is polyvalent. One must learn to listen, to contribute, and to be content to pass on....." (Chazan, 2001:170).

She further explains;

> "De Mare writes of this aspect of the group dialogue. The Platonic dialogue, he points out, was a process of reasoning between two or more people, at most eight; it was different from group dialogue. Arguments are

> binary oppositions, and basically hierarchical. They are bivalent and digital. Dialogue in the larger group, on the other hand, is polyvalent and analogic. It is equalitarian, 'lateral, tangential, and multipersonal'." (Chazan, 2001:171).

Jones and Skaife (2008) have written about the value of a large art psychotherapy group of sixty plus members: a group which I have been within since its inception that is a key and valued, if challenging, component of the art psychotherapy training at Goldsmiths College. Although much larger than the group I am describing, for me Jones and Skaife remind us of the importance that by thinking large we can hold the larger group in mind. This might include the organisation, the country, the world and so on.

Our median group, as the Goldsmiths group, had the added bonus of the possibility of making images. In the larger group, to make such art in the presence of many others without the need necessarily to speak is an act that demands attention and to be seen. To allow this in the presence of so many who are rich with large group journeys seems to me, just by the act of this witnessing, a potentially powerfully political and emotive act.

> "Unlike in structured forums for political debate and institutional decision making, all voices are given equal weight which levels out hierarchy resulting in strong group cohesion, inclusiveness and true democracy." (Skaife & Jones 2008:202).

My experience of working during the mid eighties in the Henderson Hospital, a Therapeutic Community for those given a diagnosis of personality disorder, added this dimension in the experience of the large community meeting (a key part of Therapeutic Community working). I came to realise that the group was a mix of a median and therapeutic community group; a group where a community meets together to discuss business and community concerns.

Many members of the median art psychotherapy group knew each other from other times in hospital or through patient led groups. 'Community' issues often arose and

were discussed. For example, service or staff changes on the wards and announcing of leavings and joining could be seen as announcements to the group community. News would sometimes enter to the group in the form of someone a member had met whom the group knew. There was a sense of in and out, of linking, of connection came to, through and out of the group and an ever strengthening of the group existence as part of other groups inside and outside of the hospital. By such thinking I believe we lessened the idea of us the staff and they the patients; rather we all exist as part of these larger groups and of our various communities, some of which overlap. The introduction of members from across the world, including those with refugee status, gave potential to think globally. For example when a person had few words of English, or another's language seemed hard to understand due to its apparently psychotic nature; we were able to find and value all our different ways of communicating, including in ways that at first hearing may seem to make no sense.

The group could be said to be a mixture of sociotherapy, drawing on group analytic therapies (McNeilly, 2006), art psychotherapy studio groups, & interactive art therapy (Waller 1993, Deco 1998, Luzatto 1997) and all of which were highlighted by Skaife in her concern to understand the balance and priorities of verbal expression and art making within art therapy groups. (Skaife, 1995). She was particularly concerned to understand the "interface between verbal psychotherapy as a system with its own set of norms, values traditions etc and art making as a separate system". (Skaife 1995, p.4) and she continues that the notion of interpersonal learning "involves direct patient to patient interaction, whereas art work is an individual activity in which the patients attention is focussed away from the others" (ibid, p. 4). However, Sociotherapy (Rapoport 1960) and large group theories seemed to me to be an added, more explicit, body of theories that summed up that what we wanted was to enable within the group a sense of equality and democracy. Instead of having a collection of individual meetings within a group; in addition, we wanted a group where art was an accepted part the group's life and existence.

The Balance of Sociotherapy & Psychotherapy.

Whiteley (1979), in describing how to maintain the balance of sociotherapy and psychotherapy within community groups, argues that psychotherapy within the large group can be a facilitative process if most of the group are considering here and now concerns and incidents and making links to their feelings. However, if attention is given to the individual this can be obstructive and a distraction from the member's own and others' considerations. His concern is that too much emphasis on psychotherapeutic individual interventions leads to a position where members, staff and patients, can begin to feel less capable of competing with the individual (patient) and the expert (staff) speaking to them. His concern is "the expert becomes even more powerful in the eyes of the group and it is difficult not to take on this power in a *prima donna* way". (Whiteley ibid:139.)

The patient coming to art psychotherapy groups may have high hopes of change and of cure or, worse, few hopes at all that anything can ever be different. Some will have been told their 'illness' cannot be cured, only their symptoms alleviated by medication with hopes for periods of remission. If the therapist holds or takes the wise position given by and within the group (not that 'one' isn't wise sometimes) then "the patients simply wait dependently for the next wise statement and group progress is halted. The patients assume a passive role waiting to be cured. The psychotherapy has become *obstructive.*" (Whiteley, 1979:139.) Such passivity could be said to be caused by the art psychotherapists predominantly taking the lead in interest shown in member's images.

This in my view is something to try and avoid. The images people make are of great interest, often exciting and seductive in their power to draw the therapist in. It is not that this should be discouraged, but that the emphasis should be for all or one to show an interest if desirable and wanted by the person. And thus the individual will find their place and way to share something or relate should they wish and it becomes known that they are *relating* by their very presence within the group.

Irregular Membership

The familiar trend of studio groups in my experience is of a membership of irregular attendance and absences, often with low numbers. In aiming for a larger membership and setting this as primary it changed our approach and thinking. At first there was a fairly high turnover of people. However, encouraging the group to be held in mind enabled a core identity and responsibility for itself; once established, the turnover of members reduced. It was necessary to think and think again ‘group’; the actual group and the internalised group experiences which come into this forum, as by this the group starts to live and exist .

A person’s identity within larger groups becomes thought about and known (e.g. community and race.) All, including the therapist, are considered to be part of the community and the large group of the institution. As the images made can show an existence, so too the group identity of which each person affirms their existence and membership of the group: ‘I am part of the group, this means I exist, belong and have status and am part of a shared responsibility to keep this group existing. I can put something into this group which will have influence. I am seen, I can be seen, and it can be seen. The group will be there in my absence and there when I return to it.’ The space in which the group takes place is a place to move around in and relate to directly or indirectly just by being allowed to be there. When the therapist talks to the group as whole this includes ‘me’. This, in my experience, is different in its explicit expression to the studio ward group which tends to predominantly consider what each person is bringing that day.

> “The larger group is a micro culture of society, with the distinction that we can address it and be answered by it. It is the watershed between the world and the personal individual, experiential mind. it has features of the unconscious mind, with the unique distinction of being like a dream in dialogue; it offers us the opportunity to humanize both individual and society concurrently.” (De Mare, Piper &Thompson 1991:.21)

The Open Group

When I started in my post in 1988 open groups were the key part of the service. They were available to anyone from all areas of the hospital in the form of morning and afternoon sessions. (Dudley, 1993). Sometimes the group could be as many as twenty five or as few as three or four. People would come and go; this included visits from staff. I was concerned, at the time about serious cuts in the health service; a government white paper (Kenneth Clarke, DH, April 1991) was proposing radical reforms to the health service. This included making the service provision for art psychotherapy very clear. As a consequence, these open groups were stopped because of our concerns that such groups would not be taken as seriously and, concurring with Woddis (1992) that they may have been seen as mere diversionary activity and hence difficult to justify.

I was concerned that without clear boundaries of attendance and time that some might feel threatened within this large group environment. At the time such redefining of the service and clear provision to the various specialisms previously absent was welcomed and a clear assessment and referral pathway was set up. In 2004 I wrote about the gradual defining in boundary terms of what I described as the semi open group in that when it started there were opportunities to have tea and to have a break half way though for a cigarette. However, I came to feel such breaks allowed unhelpful sub-grouping resulting in opportunities to hold the group and it's potential to think together about things being lost. It was even perhaps a little patronising "implying that some patients have impulses that cannot be controlled, let alone discussed." (Dudley, 2004: 22)

In deciding to define what this group was to achieve, I planned for the membership to be large. Looking back, I was still thinking open studio and forgetting all the reasons I had closed down the group in the first place. Taking a practical stance I was concerned that the turnover would be high with people coming and going; so to hold any sense of a group required a large allocation of members. There was also a practical necessity as referrals were high and we needed an alternative group to the analytic art psychotherapy group. However, instinctually and from past positive experience of larger groups as far back as the seventies, I think at some level I still

knew that to have a large membership would be a good thing and that in order to contain such a membership one had to look after the group as a whole.

While not wishing to generalise, my supervisory experience of those working in similar settings to mine tells me that the studio group most written about in the context of acute psychiatric admission wards frequently has very small numbers, although there are always hopes for higher attendance. The therapist seeks out each individual person, hoping they will come and knocking on bedroom doors, putting up posters announcing the group at ward meetings and so on.

The literature on studio groups does not address the meaning and impact of membership numbers, although the value of such groups is highlighted by writers such as Killick (2000). Deco (1998) described the studio group as a life raft or as a mother, a container: consistent, regular, and reliable and that each person has the opportunity to find their own rhythm and level of involvement. (Deco, 1998:102).

Although Deco emphasises the group as a whole it is my experience of supervisees that the studio open group is viewed predominantly as individuals within a room, where there are others around and where the key point is verbal communication, usually via the therapists. It is a setting where the therapist/s will go from person to person to connect with them or speak to the image. In other words the therapist is thinking of 'each' person. Although I would not want to negate the value of this it seems to me an opportunity is lost in not thinking *'group'* from the time of the referral and the time of meeting the patient, however short the meeting is.

A culture emerged in the group whereby at the point of assessment or meeting of the patient, usually the case when someone was an inpatient and not able to come for a longer assessment meeting, I and my colleague would stress the value of the group as a whole, that they would for a time be a member and that their contribution would be of importance to the other members, including the therapist. For example, perhaps with a new person 'recalling the day you started in the group and the challenges of making art in the presence of a new group of people'.

This idea of the 'group as a whole' (Foulkes 1975) introduced to the patient that a space - literal and psychic -could offer both individual freedom and at the same time

connection, if desired, with ‘another’. Around all were the ‘arms’ of a group, arms to which each person, therapist or patient, contributed ensuring they could be held firmly; arms by which you would want to be held; arms which could work for you, with you and for others.

Prior to someone starting we would try to take the person to the room to show the space and its potential and where the art work would be stored. We would always make a point of connecting with each member as close to introduction to the group as possible, on the understanding that when a new member entered the room/group there would be a familiar face who would always be there.

Such simple, perhaps obvious, actions were with the intention of always having in mind that we should make it clear from the beginning that the work/therapy/group starts once ‘you’ are *within* the space. And that the group will work because of what you will bring and contribute. For many to come to believe this was actually true was a huge step in notching up their self esteem. The large room, when first viewed, was often seen negatively with bad memories of school or of the care home sitting room. As the group and the space became as if intertwined the individual gaze could shift to the place being one each could influence and create something within

The Large Room

Within the art psychotherapy room looking out onto gardens, where there was a wide range of art materials textiles and clay with kilns to fire, all sorts of things could happen at the same time: talking, making, painting, emotional expression, physical expression and so on. As with any larger group there was an ambiance of energy, action, aliveness, of movement, of potential through multi opportunities for relating and feeling that all sorts could occur. One person for a long time could never shift from their seat but then one day began to move about and, as it were, allow themselves to meet others and find new things.

Jones and Skaife (2009) observe

> “The larger physical space necessary for the Art Therapy Large Group poses the room as an interactive stage, and the art materials and peoples bodies, as performers or spectators, become art works. The relationships

> between the student (*patient)* and their art work, the art and the group all become mixed, inviting new ways to consider the art in art therapy. If we understand all activity in the group as interrelated performances and apply this to the small group, it helps confront the issues of art and the perceptual being thought of only as a bridge to the more important verbal interaction." (Jones and Skaife 2009: 207).

The closure of hospitals' large art rooms, in which there was such potential of connecting and moving freely and a sense of group could be discovered, has removed these opportunities. Within small rooms, often someone else's office or a multi use room such as the ward dining room, many forms of art are not possible, such as larger sculptures; paint is banned for fear of ruining the office carpet or concerns are voiced about not having certain materials where food is to be prepared. However, at the same time the smaller space seemed to denote seriousness in the therapy, and as we see increasingly a move away from groups to individual short term treatments or very small groups then how can the larger group survive? And indeed, if treatments are short term are such groups even necessary or viable?

As Wood observes, the art therapy studio is seen by some as the polar opposite to art psychotherapy. "The suggestion that it is time to reassert the significance of studios for art therapy caused some disquiet when I first introduced it ... and the fear that asserting the need for studio space could detract from the psychotherapeutic nature of art therapy relationships" (Wood, 2000:.40). Many others have mourned the loss of the art therapy studio (Deco 1998, Saotome, 1998, Maclagan, 1997).In 2010 Edwards asked for art psychotherapists to submit digital images of their designated art therapy studio spaces. He notes, however, that the image cannot ever record the atmosphere. "What you never get from a photograph is how the space smelled, or what it sounded like." (Edwards, 2010: 4.) His "studio smelled of art making, and more specifically of instant coffee, tobacco, fixative, damp clay, white spirit and paper. While the smell of the room was more or less a constant, it sounded different every day. Sometimes we played music, sometimes we talked or argued or shared a joke and sometimes we just got on with whatever we were busy doing. It felt comfortable and informal, but at the same time safe and containing." (Edwards ibid: 4.)

The Members.

The room, even in the absence of studio groups, somehow survived over the years, although it was seen as having potential for many things, including offices and an ECT suite, and many emotional, often fierce, battles needed to be fought to keep the space. The room, 5.5 by 6 metres, was arranged so that a person could work privately 'enough' should they wish, but also could be seen by the group.

We realised that the sense of space, of body space, of potential to almost hide away was vital. To move directly to the intimacy of one to one therapy or a smaller group was a lot to ask of many. Members often led very isolated lives, rarely leaving their houses and in some cases rarely speaking to anyone. Some felt extremely paranoid in the presence of others, feeling they might be attacked or hurt in some way, or they described leading very limited lives due to trauma such as sexual abuse, domestic violence or serious emotional deprivation.

Others observed when we first met them that they found they were always looking outwards and wished for much more. People spoke of not being able to imagine that anyone would want to be in their presence within a group and others, through their anger and rejecting persona, regularly pushed others away even whilst wishing they did not. A good majority were preoccupied within a world which was one of hearing unexplained voices or seeing things which others said were not there. Some found themselves within an unfamiliar culture and race, having been displaced because of political reasons, sometimes having experienced torture, and were trying to find their way to belong. With limited English language, they needed to find a way to get along, learn the language and communicate with others in group settings. All members I think would agree they wished to communicate with others or another but something preventing this was a familiar, often existentially stirring but also uniting resonance.

I have come to believe such a phenomenon was the strengthening force of the group matrix despite all the members' wide ranging differences of class, race, background, psychological, psychiatric presentation etc. Importantly the art making, the image, seemed the uniting force which all equally could do as and when they wished within the frame of the group and whoever or from wherever they came. Talking was necessary and valued. Sometimes, however, the group members who

had trod a path through the psychiatric services where words seemed to be the most demanded and valued way of expression came to know that this was not always so and sometimes just not necessary; it might even, perhaps, be of lesser value and the silence which many brought with them as a usual way of 'being' was as acceptable as any other way of being.

In collaboration with a clinician and ex service user of the Henderson the art room was available to the residents any time day or night and offered opportunity for, as Melliar describes it, a "gestation of selfhood". Residents could make art seen or unseen and sometimes she allowed them to make art on the actual walls. That the " art room offered a rich field for a particular type of action that didn't appear to be socially constructive in the manner of gardening, cooking or cleaning but was interactive and social in nature" (Melliar & Bruhka 2010: 8).

I had created a hierarchy of diagnosis when thinking about who went into the group I came to know and wrote about in 2004 (Dudley, p.23). I had viewed the analytic group as being suitable for the apparently more psychologically insightful such as those given a personality disorder diagnoses. I had considered what I was now calling the median group was for everyone else and certainly for those who would be deemed to have a serious psychiatric diagnosis. It is familiar within the art psychotherapy field for patients to graduate from the studio group to formal individual therapy or to the more analytic group and for some the studio group is a place to try out how the patient gets on with art making within a therapeutic frame before being introduced to more formal forms of art psychotherapy.

Since 2004 the NICE guidelines have increasingly shaped services and so despite my desire in 2004 for art psychotherapists to avoid deferring to diagnosis this is hard to achieve when within the NHS one needs to offer NICE recommended treatments and funding is increasingly directed to these recommendations. Hence for services to survive we need to be explicit that for example NICE recommends the arts therapies for those given a diagnosis of Schizophrenia. Even so although accepting the reality of this, it is important we remain confident that what we are offering is of use to the person seeking therapy whatever their diagnosis.

I feel I can now argue more confidently that the median group is a formal therapy. When I came to be able to conceptualise this I had confidence to not think diagnoses but to think about which sort of group was appropriate if individual therapy was not indicated. I was able to think about which, would be most helpful to each person rather than depending on their 'given' diagnosis. In the early days I placed a person in the group if I felt they would be better in the analytic group because they had been given a diagnosis of personality disorder, were articulate and so on. If there were no places within the analytic group they entered the median group to wait. However, they gained so much from the median group that they often asked that they stay and complete their treatment within that group.

A person given a diagnosis of schizophrenia was automatically deemed to be for the median group. She asked though if she could though go into a smaller group where she could sit with others and talk in a defined time about the images she had made. She attended such a group for three years and did very well, gained work and started a relationship after a long time of being alone. An important contribution was the sharing experiences of hearing voices with the discovery that such experiences were familiar to many in the group but too difficult to say out aloud.

I was to realise too that referrers were referring to certain groups based on class. Those considered middle class and educated more likely to be referred for the analytic group and those who would be considered working class, less articulate or less educated more likely to be referred for the median group. Once I began to not take on board such assumptions and think 'individual' rather than 'diagnosis' at the assessment then such professional education and class divides were much less evident within the group membership.

There is a debate within art therapy about whether to interpret the transference or *whether* even to acknowledge it (Schaverien 1994). I agree with Skaife (1995) that to single out diagnoses in terms of some being able to cope with transferential interventions and others not is an unnecessary restriction. However, I think when running a group it is worth holding in mind the possibility and potential of transferential enactment. Thus knowing a person's history can sometimes help the therapists think what 'might be' being enacted from the person's early life when

words are not possible to be used to tease this out. Such thinking and ongoing awareness can enable the person to be and remain in the group.

As I had created a hierarchy many group members at the point of assessment already had in mind a hierarchy of verbal therapies over arts therapies and questioned how making pictures could help. The value of art or not, perhaps dependent on class, cultural or educational influence became worth voicing and thinking about together.

> "The relationship between the art and verbal language or between perceptual and the cognitive is historically hierarchical and mirrors divisions in race, class, and gender which is reflected in the low status given to the perceptual and imaginative in treatments for psychiatric conditions." (Skaife 2008 cited in Jones and Skaife 2009:207).

It remained an explicit part of the therapy that the group as a whole identity was acknowledged and spoken to by for example speaking *to the group* about any changes, announcements such as group breaks or in the need for a group decision about (for example) a trainee joining and was this okay? Frequently themes would emerge in discussion between group members and we were often surprised at the synchronicity of what emerged. The joining of a co therapist trainee art psychotherapist each year evoked a theme related to the trainee's background such as their previous professional training without any information being made explicit.

Such discussions seemed to us to identify the existence of a group unity and sense of belonging. Which, although a life experience that had seemed previously profoundly lacking was even so something that could be discovered within the group and/or perhaps emerge from a place that was pre conscious; and hidden. In this apparently non-connecting group membership there was a group which was connecting to each other. As the group matured and a group culture passed, as it were, from generation to generation of members they took on the responsibility of such group awareness and so when the group was to close members decided, without any therapist input, to protest at its closure. This indicated to us that the aim had been achieved. A voice found which from within the group translated to a voice outside of the group. Over the group's time admissions reduced, people found work,

made friends, joined adult education courses and many continued to make art. The images stayed in the room throughout the members time in the group. The group's shelf and cupboard acted as if temples a central point of ritual to which all would go at one time or another to put something, to revisit to take away and replace and so on. The symbolic representation of why we were all there.

As Jones and Skaife highlight "Through 'their making a mark' and 'finding a voice', students (group members) in the Art Therapy Large Group struggle with feelings of alienation and fragmentation and with how to find a place for themselves in the group. Their actions in art or talk, recognised by others in the group, allow them a sense of belonging in the community. The boundary of the arena, which creates a space like an empty page, allows for a response to an action or visual statement to be observed, noted and reflected upon" (Jones & Skaife, 2009, p.206).

The Gate Keeper & The Witness

A gate keeper, we realised, was necessary in managing to secure the boundaried walls in which this group of sometimes 20 people could thrive.

The service administrator was the first point of contact with the members and in introducing the sense of group. She would plan their assessment and joining with them. Many needed her support and kindness just to get to the department at all. Some would take some weeks before they eventually got to the assessment and then the group. Coming into the department she would greet them and she would acknowledge if they were very late or finding it hard to get through the actual group door or left after only a short time, further reinforcing their connection to the group. It was always she who spoke to them on the phone if they couldn't make it. She would sometimes phone if we were concerned about them not coming but increasingly such phone calls became rare. These apparently inconsequential acts were actually very important for people to know that they were part of a group and their membership was important to make this group work. Crucially she protected the 'walls' of the group and all within it through the therapists or other group members not being pulled into 'out of', 'outer' group work.

Should and did the therapist make art too? No, I think not. I feel that it is important to even within a median group within a democracy to know who you are and your position within it. I am not sure we need to spell out our belief in art by actually making as this seems to me to fall into the trap of art equals production and action. I think to work alongside denies your position of power as a staff member and so any opportunities to think about status and power may be lost. Thus I viewed the therapist as a leader keeping a watchful eye on the group as a whole and ready to respond as openly and honestly as they could.

Even without specific information the group gets to know you, your views and interests and so I am certain the group knew that the therapist had respect and regard for art making. I don't see a tension between the amount of art and the amount of talking (Skaife, 1995). I think too they knew that we would listen to their concerns on psychiatric diagnosis and their concerns on medication and on occasions the group enabled a person to talk with their team psychiatrist and changes were made.

I learnt through the therapeutic community approach that for a group to believe it can be a group it needs to know the therapist is genuine in their views and opinions can get it right and wrong and can really take it on board and do something if need be. And this is not just the therapist but all group members. In art psychotherapy studio groups, as well as doing art or doing art with a patient on one piece of work it is common practice for the therapist or therapists to move around the room from member to member. I prefer that the therapists as much as possible remain still and seated. I am concerned that the therapist moving around the group person to person re-enforces the sense 'I the therapist' have all the knowledge and the power to bestow the word of support of encouragement and so on or equally perhaps felt as the opposite by the person being 'visited'.

It reminds me of the many trainees I have supervised and people I have seen for therapy who are artists and their profound memories of the critique by their tutors. One described the ambivalence of the wish for the visitor and the opposite the terror of what they might say or do. One said 'suddenly they were behind you or beside you and you thought what will happen now? 'Sometimes the intrusion evoked terrible

anxiety. I have often wondered what similar transferential enactments are evoked for the group member/s and which probably are left unthought about or discussed but nevertheless likely to occur.

The experience of good and bad in the group is an important clue to the dynamics of the group. Yet so often the therapist will seek simply to have a good experience with his group members and to minimize the bad ones. “This is a way of surviving but makes for a group where nothing happens, where there is superficial harmony which may be beneficial for some, but others will feel some issues cannot be raised and some feelings cannot be expressed such as anger. These will be driven underground and so the purposes of the group, to facilitate expression and openness of communication, will be defeated.” (Hinshelwood 1987:.28.) Might our visiting the patient in the group or working alongside prevent such free and open expression within the art making?

The Once Only Group

I have a great deal of sympathy with Yalom’s (1986) ideas of the value of the once only group within the acute setting where the assumption is one of high patient turn over. Therefore it is perhaps helpful to consider each session as a group in its own right. However, it seems to me this can cause thinking that the group is simply a matter of people coming together. It concerns me that Yalom’s position, adopted by many art psychotherapists and spoken to in common parlance, “does not take into account the developing matrix of the group which despite the changing population is communicated to new staff and patients not only at a conscious level but also subliminally” (Sarra, 1998: 82). Thus, as Sarra puts it, through thinking within a longitudinal time frame although indeed there may be people who only come once there are many who stay longer. If from the outset of the group you are thinking of a group continuing for a long time then, as in all groups in society, we have people who stay a fair time, but within our societal, cultural, racial, peer, friends and family groups etc. we have those who come and go and perhaps return again and may, in some way, be considered part of our life groups, possibly an important part.

Given that the NICE treatment guidelines for those given a diagnosis of Schizophrenia (NICE 2009) stresses the desirability of the continuity of therapy from

in to outpatients we became more legitimately able to say that patients were advised to stay within the group for up to two years and indicate to the other professionals who questioned what it was we were doing that we had made a clear group treatment plan. The members were told in advance of holidays and people were asked whenever possible to give notice of leaving and the group was given notice of someone joining.

Within these boundaries flexibility was allowed. Specific group analytic observations were not made in the group although they would form a key part of supervision and pre and after group discussions. To an extent I agree with Main who thought that such discussions were too formalised and there is the danger that all the anxieties are taken from the group to these smaller forums with the result the patients are used for new and continued projections. Even so such discussions are vital, in my view, if one is to hold the group as a whole in mind and to discuss process rather than the content of the group. I would, though, keep Main's concerns in mind, that it becomes very easy to talk about 'them' rather than 'us'. (Main 1974, cited in Goering and Littman 1981: 54). Ideally these discussions are with your co-therapist (Dudley, 2001), if not finding a space to process with another colleague if not supervisor.

An example for such reflection would be the person only able to come for a very short time sometimes as little as five minutes or only able to get to the group half way through. Where we might, in analytic art psychotherapy, consider such boundary challenges, within the median group the therapist would quietly and gently observe the person's arrival or departure just enough to acknowledge that it was important to observe the member's presence or absence. An important progression for many members was to come on time and stay for the duration of the group and most, even the most socially withdrawn or those deemed the most psychiatrically unwell, eventually achieved this. Importantly other members would in time take on the therapist's role and make similar observations.

Group Empowerment

Despite extremely positive patient and staff feedback the group was closed and the art psychotherapist made redundant and now the room will be lost too with a move to new premises. A management consultant asked what sort of space would be

needed. At first I was apologetic that of course to ask for such large room was out of the question and defensive that I felt he was not going to give me anything I asked for anyway. He asked to see the room and was immediately struck by the space and it's potential. He began to speak of his own experiences and of making art and how such a space and opportunity for expression seemed to him should be recreated. 'I expect,' he said, 'you could not do your job and your professional bodies would be very concerned if the premises were not as they should be.'

At the time of writing I have no idea what space will be offered and I am cleaning out the large room ready for the move. It has been a terribly moving experience and people have said how dreadful it must be. I have not felt this and instead think the group and experience of the space stays with you and carries you on to the next space to be discovered and dialogue continues in some shape or form in some place or another . And for me most importantly such an event can evoke political awareness and action.

'What is the best thing about the median art psychotherapy group?' a colleague asked me. I said keeping the group in mind and that to not talk is no matter and sometimes in larger groups words are not what is needed. Sometimes things cannot and should not be spoken about and words not sought. It is better to live the experience as if in a land where you cannot speak the language. It can be as much about simply being present with others. To move with others. To feel the sense of the body of another and to smell and see them and to know they are experiencing you too. Skaife writes of "our bodiliness in our attitudes attitude to materials, by attention to visual and tactile experience, then a real interaction between the physical material of the world and the clients body is brought into focus, with the result that the client comes to inhabit their body more, through finding it in the interaction. The result of this is to begin to feel alive and connected to the world again". (Skaife, 2001:48).

To make art does not require words and as art psychotherapists we know this. However, sometimes I think we forget and somehow words are once again sought, but many times it is worth resisting this urge.

What could we have done differently to save posts and the group? Should we have rebranded the groups within the frame of mentalisation (Fonagy & Bateman, 2006) or within UK Department of Health proposals undertaken arts in health projects? I think not although this may be very controversial (people have lost and are losing jobs). I am not saying any of these things may not have value; however it is not necessary to take things on wholesale or at all and I am glad we did not. What we did worked. NICE is clear in its guidelines that they recommend treatments and approaches and do not dictate what local services should do.

It is perhaps better to look outwards to the social political context and not necessarily to be integrated into the current societal drives in terms of the *Social Inclusion Agenda* (2006) and to take action via intervention, word or image. Social Inclusion rather assumes that some are not included and these should be aided by those who are. Perhaps it not about being included within the society but questioning what is this society to which we are supposed to want to belong and maybe I am advised not to be part of it but to try and bring societal changes.

Pines has pointed out that the "clinical large group runs counter to the forces and pressures in society, that for so long has regarded the mentally disturbed patient both as irresponsible and lacking in the normal skills required for socialisation". The use of the large group runs counter to this, the well staff and sick patient are not clearly defined and "threatens the fundamental process of the wider society which has resulted in the creation of the hospital as a system for isolating and containing mental illness. Both staff and patients in their "social unconscious" contain and are to some extent controlled by their powerful unconscious image of the proper relationship of patient and staff" (Pines, 1974: 302 cited in Kreeger 1974).

I have needed to work hard since joining the NHS in 1973 not to be drawn into the seductive position of power my professional status affords me. I have written about my concerns that art psychotherapists, in their wish to be accepted and included within the world of psychiatry, are drawn to diagnostic categories and the desire to feel connected to the dominant influential group and the subsequent power and connection this affords. It is preferable that they should try not to lose sight of our specialism and artistic background, which can bring a much needed non-

categorising and refreshing voice (Dudley, 2004). While owning my position it should be remembered that a group has the potential to enact the collective of the organisation, where professionals generally have more status and power than the patients and this is felt implicitly even if not stated explicitly. Thus in order not to bow to my omnipotence it is important within 'my' groups to keep this in mind and by protecting the group status then the group is then perhaps empowered to make changes and influence much more forcibly than one individual can, be it staff or patient.

I was worried we used the language of sickness and were colluding with the essentialism of psychiatry (Dudley, 2004: 24). I have since seen this get worse. We see in art therapy journals articles using medical terminology referring to users, carers and professionals, diagnosis etc. The person is a subject not an object "Non diagnostic approaches demand a very different set of assumptions which in turn demand a different set of social and therapeutic responses." (Boyle, 1999: 88)

Maybe not today, but perhaps the 'large' group voice will be strong enough to be heard another day in the future. The collective memory, after all, remains. This is better than allowing a process of colonisation whereby we accept the colonial voice of scientific and government rhetoric which tells 'us' how we should be treated and what 'we need' to be well. And to not necessarily believe that the profession of art psychotherapy will only survive if it takes this rhetoric to heart and allow this apparent science and reason to rule over the views and qualitative experience of the art psychotherapists concerned with the unconscious and relationships and who *apparently* have no reason or evidence, so should be culled in favour of those who can provide 'proper' evidence for what they do.

Conclusion.

I have wanted to demonstrate the value of making use of and understanding large group theories and practice. By such attention particularly through thinking 'group' not about each individual, the therapists saw the group settle into having a regular

and committed membership who could also welcome and be alongside the one-off attendee or person who could not stay for the whole group.

In the wider context of the larger group, members including the staff were empowered politically to value the group they had created. There is a desire for 'users' integration into 'our' society sought 'outside' and artificially in my view through such as the arts in health, recovery or social inclusion agendas and frequently very expensive initiatives. My concern is this further separates/defines us from them instead of discovering such opportunities within the large group itself. There is already expertise and wisdom to be found from every group member. By separating staff and users as somehow different to each other then the assumption emerges that such expertise and wisdom comes firstly from professional and managerial leads. By acknowledging knowledge can emerge from the group we can then think together about those many societal, political large group issues which at one time or another concern us all.

Acknowledgements.

All patient and organisational details are changed to protect confidentiality. Therefore I cannot acknowledge the names of the colleague who was the therapist who facilitated the group for whom I have the highest regard and respect; the service administrator who fiercely and lovingly protected the service or all the group members who made this group special.

I can name Sally Skaife & Kevin Jones who lead the large art psychotherapy group at Goldsmiths and acknowledge all the staff and trainees at Goldsmiths who over the years have made this group the exceptional learning & rich forum that it is**.**

Biography.

Jane Dudley was a Consultant Art Psychotherapist within the NHS where she worked for over thirty years. Trained as an RMN she is also a Psychoanalytic Psychotherapist and Group Analytic Psychotherapist. She is registered as a Psychoanalytic Psychotherapy supervisor with The British Association of Psychoanalytic Psychotherapy Supervisors. She is in private practice and working within the voluntary sector as an art psychotherapy and psychotherapy supervisor and therapist. She is an Associate Lecturer on the MA in Art Psychotherapy training at Goldsmiths College, London University where she has worked since 1990. She has previous publications in books and journals.

References

Bateman, A, & Fonagy P, (2006). *Mentalization-Based Treatment for Borderline Personality Disorder: A Practical Guide.* Oxford: Oxford University Press.

Bion, W, R, (1961). Experiences in Groups, Tavistock, London.

Boyle, M 1999. 'Diagnosis', in *Newness, Holmes, Dunn,. C. (eds) This is Madness: A Critical Look at Psychiatry and the Future of the Mental Health Services, pp75-90. Ross on Wye: PCCS Books.*

Chazan, R. (2001). The Group as Therapist. London, JKP Press.

Deco, S. (1998). Return to the open studio group: art psychotherapy groups in adult psychiatry in *Art Psychotherapy Groups Between Pictures and Words.* (ed) Skaife, S and Huet V. London, Routledge

De Mare, P, Piper, R & Thompson, S, (1991). Koinonia: From Hate Through Dialogue to Culture in the Large Group. London and New York: Karnac.

Department of Health, (2006). National Social Inclusion Programme: Second Annual Report. December.

Dudley, J, (2001). The Co Therapy Relationship: A Married Couple in *Inscape 6(1), 12-22*

Dudley J & Tyler J, (1991). In the Wilderness, Art Therapy in an NHS Trust. *Inscape, Winter.*

Dudley, J. (2004). Art Psychotherapy and the Use of Psychiatric Diagnosis in *Inscape, Vol 9, No 1 14-25*

Edwards, D. (2010). Art Therapy Studios Project. *ATOL: Art Therapy on Line. 1(1).*

Foulkes, S, H. (1975). Group Analytic Psychotherapy. Method and Principles. Gordon & Breach, London.

Hillman, J. (1979). Peaks and Vales *(In Puer Papers).* Dallas. Spring Publications.

Jones K, Skaife S, (2009). The Art Therapy Large Group as a teaching Method for

the Institutional and Political Aspects of Professional Training in *Learning in Heath Care & Social Care., 8, 200-209.*

Jones, M (1966). *Group work in mental hospitals. British Journal of Psychiatry, 112, 1007-11(101)*

Killick, K. (1997). Unintegration and Containment in Acute Psychosis in Killick K and Schaverien J (eds) *Art Psychotherapy and Psychosis.* London and New York. Routledge.

Lanham, R. (2002). Inscape Revisited. *Inscape, Vol 7, No 2.*

Luzzato P. (1997). Short term art therapy on the acute psychiatric ward: the open session as a psychodynamic development of the studio based approach*. Inscape 2, 1, 2-10.*

Main, T, F. (1946). The hospital as a therapeutic institution in *Bulletin of the Meninger Clinic, 10 (3), 66-75*

Main, T, F. (1974). Some psychodynamics of large groups. In Kreeger L, (ed), The Large Group, Constable, London.

Maclagan, D. (1997). Has “Psychotic” Art become Extinct in Killick K and Schaverien J (eds) *Art, Psychotherapy and Psychosis,* pp131-143. London & New York, Routledge.

Melliar P & Bruhka A, (2010). Round the Clock: A therapists and users perspective on the image outside art therapy. *International Journal of Art Therapy, Inscape. Vol 15, Issue No 1, June.*

McNeilly, G. (1983). Directive and Non Directive Approaches to Art Therapy in *The Arts in Psychotherapy, vol 10: 211-219.*

McNeilly, G. (2006). Group Analytic Art Therapy. Jessica Kingsley Publishers, London and Philadelphia.

NICE, (2009). Treatment Guidelines for Schizophrenia. NICE Recommendations.

Pines, M (1974). Overview. In Kreeger, L. (ed). *The Large Group. Constable. London.*

Rapoport, R (1960). Community as Doctor. Tavistock, London.

Saotome, J. (1998). Long Stay Art Therapy Groups in *Art Psychotherapy Groups Between Pictures and Words.* (ed) Skaife, S and Huet, V. London, Routledge.

Sarra, N, (1998). Connection and Disconnection in the Art Therapy Group: Working with forensic patients in acute states in a locked ward in *Art Psychotherapy Groups Between Pictures and Words.* (ed) Skaife, S and Huet V. London, Routledge.

Schaverien J, (1994). Analytical Art Psychotherapy: Further Reflections on Theory and Practice. *Inscape, Vol 2.*

Secker J, Hacking, S, Spandler, H, Kent, L, Shenton, J (2007) Mental Health Social Inclusion and Arts: Developing the Evidence Base. Anglia Rusking University/UCLan Research Team funded by the DH.

Skaife, S & Huet, V. (1998). Introduction in *Art Psychotherapy Groups Between Pictures and Words.* (ed) Skaife, S and Huet, V. London, Routledge

Skaife S, (2001). Making Visible: Art Therapy and Intersubjectivity in *Inscape Vol 6, No 2.*

Skaife, S. (1995). The Dialectics of Art Therapy in *Inscape, Vol 1.*

Waller, D (1993). Group Interactive Art Therapy. Routledge, London.

Whiteley J, S & Gordon, J. (1979). Group Approaches in Psychiatry: Social and psychological aspects of medical practice. RKP, London.

Woddis, J (1992). Art Therapy: new problems, new solutions? In *Waller, D &Gilroy, A (Eds) Art Therapy A handbook.* Open University Press, Buckingham.

Wood, C. (2000). The Significance of the Studio. *Inscape Vol, 5, No1.*