ATOL: Art Therapy OnLine

Responsive Art Psychotherapy as a component of intervention for severe adolescent mental illness: a case study

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Abstract

In this paper the author aims to describe the development of Responsive Art Psychotherapy, an innovative multidirectional psychodynamic art therapy intervention. This was developed in the context of working alongside non-art therapists within a multi disciplinary team. Using clinical material from a detailed case study, the paper explores how the use of language can be bypassed through the contact made in and with the images. This is supported by recent research into neurobiological theory of trauma and patients' incapacity to verbalise in the context of severe mental illness and distress.

Keywords: Response art making; art psychotherapy; countertransference; trauma & role of images; innovative practice.

Introduction

This paper describes the development of Responsive Art Psychotherapy within a high severity extended adolescent inpatient setting. This came about in response to the complexity of the mental health issues experienced by the adolescents at the Unit. Most patients who come to the Unit have a two to

three year history of mental illness, often with multiple comorbidities. Typically they have had many admissions to acute units and have received various standard psychological and medical treatments.

A multidisciplinary approach is used to deliver a range of psychotherapeutic treatments. Families of the adolescents who are treated on the Unit are expected to participate in therapy, including Family Art Psychotherapy (Wadeson, 1987, 2010; Malchiodi, 2006) if indicated. The goal of the admission is to promote change within the individual as well as within the family system, in order to avoid relapse and re-admission after discharge.

Art therapy and trauma

It is often not possible for sufferers of trauma to verbalise their emotional distress or traumatic experiences. This is supported by research which has shown that patients with PTSD, (Post Traumatic Stress Disorder) suffer neurobiological consequences of trauma and poor attachment experiences. The potential for loss of verbal or language-based expressive abilities due to trauma poses significant obstacles for the talking therapies. (Van der Kolk 1996, 2005, 2015, Hass-Cohen, 2008, Chapman, 2014)

> ‘When presented with vivid accounts of their traumatic experiences, these individuals showed autonomic arousal; there was a concomitant heightened activity in their right amygdala and associated areas of the visual cortex. At the same time, the area concerned with language in the left hemisphere was ‘turned off’.’ (Klorer, 2005, p.216)

When the thinking brain shuts down and the non-thinking instinct and defences are activated dissociation occurs which can be a survival mechanism to either a single traumatic event or longer-term intergenerational distress. (Cozolino, 2002; Van der Kolk, 1996, 2005). ‘It is characterised by disorientation and disconnection among thoughts, behaviours, sensations, and emotions. Dissociation demonstrates to us that the neural networks organising these functions are, in fact separate.’ (Cosolino, 2002, p.24).

Within an art therapy relationship, images made in the dissociative experience, can be thought about by therapist and patient until the patient is able to find words to describe their image and/or emotional experience.

As Chong (2015) describes, in institutions where language is the only form of communication which is valued, the experience of intense emotions, which often can't be expressed verbally because they have to do with 'the non-verbal nature of instinctual response and implicit encodings of emotional memory,' and are therefore '...inaccessible to the language and logic based left brain', cause enormous amounts of frustration and can make the therapy counter-productive. This means that 'The dissociative tendency of survivors of early relational trauma can lead the therapeutic situation to a challenging scenario, where less ideal emotions are difficult to acknowledge or address and the capacity to reflect is limited.' This leads to a gap where emotions and feelings are not matched with words. Chong goes on to say that the '...art dimension plays a crucial role in this gap to get under the wire of dissociation, by allowing dissociated, unconscious emotions to emerge as vitality affects expressed and articulated in a concrete, external manner which is visible and tangible.' (Chong, 2015, p.121-133). These can be thought about by the therapist and patient until the patient is able to find the words to describe their image and/or experience. In this way, images made in art psychotherapy, offer a bridge for the patient to access and process previously inaccessible thoughts and emotions. It is through the guided and repeated production of the pictorial representations of emotional experiences, that emotional awareness, interpersonal attunement and neural integration can occur. (Medina, 2008; Ginot, 2015).

The role of art therapy within the multidisciplinary team.

Mental Health Services in Australia have a commitment to trauma informed care and developing innovative strategies to improve inpatient consumer experiences of care. Complex trauma results in a loss of core capacities for self-regulation and interpersonal relatedness. These problems extend from childhood through to adolescence and into adulthood (Van der Kolk et.al, 2005). A recent local Mental Health consumer survey for improved services

suggested: ‘Increased clinician strategies for encouraging expression of distress and for responding appropriately.’ (Isobel et al, 2016).

Fortunately, due to their commitment to Child, Adolescent, and Family Mental Health Services, this Unit was allocated a five day a week Art Therapist. This provided the opportunity for art psychotherapy to be included in the development of all aspects of the program, including groups, individual, co therapy dyads, systemic family therapy and responsive art psychotherapy. In addition, using art and making images has proved to be effective as a de-escalation strategy or preventative alternative to restraint and seclusion for patients struggling with aggression. Medical colleagues are interested in the art works of patients and how it links with their internal disturbance. The art works can provide evidence of the patient’s experience and the changing relationship between patient, family members, group members and the art psychotherapist. The images thus help inform treatment planning, both for inpatient and outpatient care and support identification of improvements made in the patient’s recovery.

Art psychotherapy on the Unit

Adolescents on the Unit commonly have difficulty talking about their emotions and are often observed to have particular difficulties in verbalising their emotions about their family interactions. In addition, they may unconsciously or consciously try to protect their family from scrutiny or blame. There are therefore inherent challenges in trying to engage young people in a verbally based therapy.

The art psychotherapist meets with individual adolescents and their families (separately or together) approximately once or twice a week for a period of three to six months. Sessions usually begin by inviting the young person and then later their families into the session. Generally there will be non-verbal art making for more than half the session. Priority is placed on offering the young person a session that they feel is manageable and in providing a containing environment to support the process of emotional expression, Over a period of

time the art psychotherapist and young person work towards thinking together and eventually talking about the artwork and ultimately their thoughts and feelings.

Responsive Art Psychotherapy

This new approach has been pioneered over the seven years of working as an art therapist in this context of highly complex mental health difficulties and some very challenging and volatile behavior. The adolescent who is struggling to regulate emotional states often communicates distress and disturbance with hostility or aggression, which makes capturing thoughtful and reflective moments complex in the face of these strong projections. The need to maintain some capacity for thinking and be creatively receptive to the distress gave rise to the idea of making art in the sessions alongside the patient to manage many of the more uncontained projective processes.

Projective identification, whereby intense emotional states evacuated under distress can knowingly or unknowingly be introjected into an unwilling or willing other (Blake, 2008; Rosenfeld, 1987; Bion 1962) is one of the processes that occurs particularly within families. Family members can unconsciously identify parts of themselves in other family members and use each other to embody these lost parts of themselves, This can then create an enmeshed and unhelpful family system in which all are caught, contributing to the adolescent's illness.

In the family sessions, the art psychotherapist makes use of her embodied experiences by responding non-verbally through the making of art images. This response facilitates a process of containment in that thought can occur and the projections gathered into some meaningful form both in the therapist's mind but also in the image. The containing function of images, projections, transference and counter transference phenomenon in the art therapy relationship has been well documented in the literature (Dalley 2000, 2007; Case 2007, 2010; Schaverien 2014; Killick 2007). Transference and counter transference are part of the thinking process in the art making (Schaverien

1992). 'The tensions which exist and enliven the work bounded by the therapeutic frame and within the frame is animated by multiple transference and countertransferences' (Schaverien, 1992, p.128). The use of the making of art images in the sessions is a novel and innovative way of working in the context of trauma and internal disturbance. In this way family members can free themselves and each other from being caught up in an unhelpful projective system and thereby support the adolescent's recovery.

The therapist's image provides visual representation of a shared experience and, by looking and seeing, the aesthetic response facilitates opportunity to clarify these processes (Case and Dalley, 1992). In extreme cases the image may be a protective factor from unwanted or hostile projections by enabling an experience of a separate self in response to 'other'. This forms a kind of linking communication or interpretive dialogue, which provides an opportunity to be with the young person and their family and to engage with them non-verbally in their emotional experience.

There are three important aspects to consider with Responsive Art Psychotherapy:

1. The role of the art making process for the patients and their families

In the context of responsive art making, the art psychotherapist responds non-verbally in the moment to the individual patient's or families' communication by using art materials. As Meyerowitz-Katz and Reddick (2017, p.190) write, something unique to art psychotherapy is the 'life in and of the art making'. By this they mean that in the safe and contained environment of an art psychotherapy setting and through the experiences of art making, patients are offered opportunities to express and communicate intense emotions that they struggle to speak about. Engagement with the art materials provides an alive and responsive experience in the moment. In making an artwork in response to a patient's image, the art psychotherapist aims not to copy images, composition or colours but offers a different perspective that resonates with the patient's use of materials (Havsteen-Franklin, 2014). This way of working

can offer support to making initial contact with the art materials as the therapist can model use of the materials in order to reduce the patient's anxiety or distress.

In this way, a unique communication evolves; the patient has repeated experiences of expressing his/her feelings and feeling understood and being responded to in a safe and non-threatening manner. 'The skilful art therapist uses response art in order to query, interpret, solidify, consolidate, and express connectivity. This is a visual paraphrase and dialogue that embodies attunement.' (Hass-Cohen and Findlay, 2015, p.117). Over time, the patient begins to talk and think with them about the experiences that the images express. Non-verbal expression becomes verbal and the patient is more able to engage with other people.

2. The importance of the psychotherapeutic relationship that develops between therapist and patient/families within art psychotherapy

The closed art room provides the patient a safe and supportive environment in which repressed, internal experiences may be re-lived. Understanding the subtleties of the projective processes, including transference and counter transference helps to deepen the understanding of the relationship between therapist and patient. Schaverien (1992) suggests that images are part of the transference, countertransference relationship:

> '…These affects are circular; the picture animates the relationship but the relationship also animates the picture. Thus the picture is incorporated and integrated in the therapeutic relationship; it is valued in a way which is consonant with the affect which it embodies." (Schaverien, 1992, p.137)

Therapeutic engagement with mutual curiosity can be central to finding meaning (Weiner, 2009).

How the layers are revealed in the making of an artwork will determine the pace and response of the art therapist by noticing shifts in the patient's pace, gesture's and content in making the artwork. It is helpful to facilitate the

patient to dictate the speed of the work as they may engage with the process and resist at the same time.

> 'Resistance represents aspects of implicit memory that the client presents for the therapist to decipher…emotion and cognition is a primary contribution [in therapy] and reflects fundamental underlying neurobiological processes of growth and change…The therapist attempts to bring the processing of the hidden layers to the client's attention' (Cozolino, 2002, p50).

Progression and understanding of the relationship between therapist and patient is given deeper meaning and significance through the mutual sharing and consideration of the image made in the sessions.

3. The role and value of the art works for the patients

Unique to art psychotherapy is the role of the artworks made in therapy. The final piece is a record of the interaction of that session or sessions over time and much of the process of communication and thinking together is held in the image. Unlike words, the art works can be viewed retrospectively and show change and progress. (Case and Dalley, 1992; Schaverien, 1992; Killick, 1993, 2000; Rubin, 2001). This does not involve interpretation of the image but to converse with the patient via its production and to reflect upon the meaning together when they feel ready to do so. The capacity to engage in verbal communication around the art works takes time to develop; it may only emerge after several art psychotherapy sessions and when the patient has developed enough confidence in themselves and their art psychotherapist to be able to risk trying to verbally articulate what was pre-verbal and not available to consciousness before. It may take some time in this clinical setting before a patient is able to be fully conscious of the layers in their experience with the art making. Premature verbal interpretations can have a negative effect on the patient's progress.

The emotional contact a patient has with their work enables mastery over their feelings and embodies the discussion. This may take a number of sessions sitting with containment and managing the feeling safely before a discussion on their thoughts can be entered in to. At this time, the art psychotherapist could be working with implicit, unconscious processes for some time in their response image making before the patient is more able to make cognitive links to their work in a conscious and motivated way. Transforming the non-verbal (unconscious) process of art making to the verbal (conscious) discussion of the work is central to the patient's therapeutic experience and any possible integration of insight or change.

Cozolino (2002) supports the therapeutic value of this communication technique when he writes,

> 'Across psychodynamic forms of therapy, emotional expression is encouraged, thoughts are explored, and awareness expanded. Feelings, thoughts and behaviours are repeatedly juxtaposed, combined, and recombined in the process of working through…The overall goal is combining emotion with conscious understanding…these factors enhance the growth and integration of neural networks' (Cozolino, 2002, p.50 – 51).

A case study

Permission to write about the work has been granted and pseudonyms have been used to protect the patient's identity. The case study describes the process of responsive art psychotherapy and the complexity of working overtime with a young person and their family with different therapeutic constellations in the sessions. This requires flexibility and understanding of the complex projective processes at work in every session. The images clearly illustrate the non-verbal aspects of communication of, at times, highly charged feelings and previously unknown thoughts, which are spoken about for the first time.

Emma was a 15 year old girl living with her mother and step-father, older brother and younger half-brother. She was enrolled in year 10 at a

mainstream school. Emma was referred to the medium to long stay adolescent mental health unit by a regional acute short stay adolescent inpatient unit where she was admitted following severe self-harm and repeated suicide attempts. Emma had been previously diagnosed with pseudo-seizures, Bipolar Disorder and Eating Disorders. Emma had displayed a clear deterioration in functioning since starting high school and had been referred following no improvement despite the trial of multiple medications including anti-psychotics, anti-depressants and mood-stabilisers.

Prior to the transfer to the medium long stay unit, Emma had disclosed a history of sexual abuse occurring in the school setting. On admission Emma displayed low mood, suicidal ideation, flashbacks, nightmares, auditory and visual hallucinations of two men and a woman. The initial working diagnosis was PTSD with depressive and psychotic symptomatology in the context of past history of sexual abuse. On the unit, Emma engaged in individual therapy sessions with the psychologist, participated in Dialectical Behavioral Therapy with the nurses and systemic family therapy. Often art psychotherapy was used to process individual sessions and family sessions where difficult material was discussed. It was also used as a de-escalation strategy when Emma would get distressed and at times aggressive and would otherwise have been needing restraint.

Over a ten month admission, sixteen sessions of art therapy were conducted with various members of the family including Emma's Mum Audrey, Stepfather John and Emma's older and younger brothers (19 year old Tyrone and Joshua, 8yrs old).

Emma's first two sessions in art therapy

Initially, Emma was unable to speak about her emotions yet her artworks were objectively highly emotive. An invitation to explore the materials and experiment with art making was offered in a group art psychotherapy setting where Emma sat quietly and made her artwork. The following two art works are examples of Emma's early presentation in group art psychotherapy (see figs. 1 & 2).

Emma was not able to talk about the first picture. She used her art making as a nonverbal way of communicating her inner experience of internal suffering, which could not be expressed verbally. After making the second artwork she managed to say that she was feeling trapped and overwhelmed. These artworks contributed to the diagnostic formulation by the treating team. These internalised images of attack were formulated as possible hallucinations, which later in the admission Emma was able to disclose auditory content also.

Figure 1. Auditory and visual hallucination, in charcoal.

Figure 2. Auditory and visual hallucination, in pastels.

Emma's mother, Audrey was invited to join Emma in her art therapy session due to a difficult mother daughter relationship. Unlike her daughter she was articulate and presented as a sophisticated professional. She attended art therapy following stressful family therapy sessions and this was usually the case. In the first art therapy session with her mother, Emma refused to enter the room due to her overwhelming anxiety. Audrey was asked to think of her daughter while making the artwork.

Figure 3. Emma's mother's artwork: Horizontal stripes, in acrylic paint.

In the second session with her mother Emma did attend and, in contrast to Emma's artworks, Audrey's were less visually emotional. They were slow to be produced and restricted in content. These paintings both took fifty minutes of art making time to be completed. Each produced their own works simultaneously while the therapist responded non-verbally through her work (see figs. 4, 5 & 6).

Figure 4. Emma: Show your real colours, in pastels & acrylics.

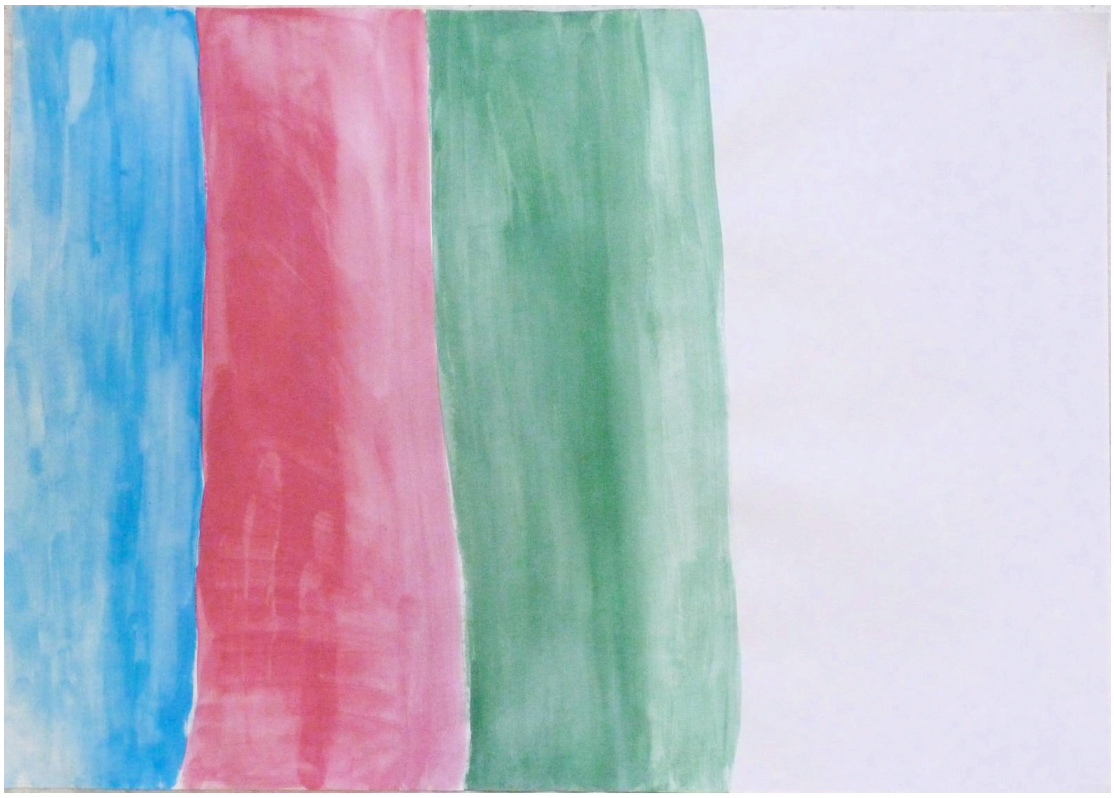

Figure 5. Emma's mother: Show your real colours, mother's response, in acrylic paint.

Figure 6. Art psychotherapist: Show your real colours, therapist's response, in collage & acrylic paint.

The therapist's responding image reflects the slow gestures of watery paint made by the mother while thinking about her daughter in her non-verbal world of no communication. However Emma's artwork clearly communicated her thoughts and feelings (possibly towards her mother) with a comment written in her work, 'Show your real colours.' The therapist has placed Emma as the silhouette, a shadow in the experience of the art making with her mother. Her silhouette was placed inside an ornate border by the therapist to identify the important role of the frame in the thinking of Emma within the process. Audrey's mood as reflected in her artwork was overpowering in its passivity. Her strokes were slow and meticulous in stark contrast to the intense effort and loudness of Emma's work in oil pastel.

One month into the admission

Emma's two brothers attend a family session

When families attend a session, space is made for all members like places at a dinner table. Paper takes the plate's position, paintbrushes as the forks and paint, chalk and oil pastels are placed at the center much the same one would offer food. As the young person becomes more relaxed with the structure of

the art therapy space, the goal of the family therapy is to support the young person in communicating their difficulties with her family and for the family to have the opportunity to respond, either in the looking or in the discussion after their own art making.

Emma described feeling supported by her brothers and less anxious than she was in the dyad with her mother to make art.

Figure 7. Emma during this session: Little girl trapped, in pastels.

Interestingly this image seems to be a diagrammatic version of an image made at the beginning of the admission in a group with her peers (see fig. 2).

Joshua described that he was frightened that his sister was in hospital and the doors were all locked. He generated discussion around Emma's artwork by asking her to explain 'trapped.' Emma was unable to explain the word but their older brother Tyrone, assisted by reminding Joshua of an incident just before the session where Joshua had been locked in the toilet on the ward and was banging on the door to get out. "You felt trapped" he said. The

artworks enabled issues to be brought to the surface that were difficult to say between them.

Figure 8. Younger Brother (Joshua): The screaming at home, in acrylic paint, pencils, chalk and oil pastel.

This was very helpful in supporting the staff's thinking about the family. Prior to this session the treating team had been unaware of the tensions at home as the family always presented as getting along very well without any conflict. Joshua described his picture, "This is my home and the screaming and shouting" (as he pointed to the black outline). The similarity in their marks with Tyrone's and his sister's image could represent an unconscious communication of their shared experience in feeling trapped. This graphic representation of their experience was also represented in the art psychotherapist's response image (see fig. 11).

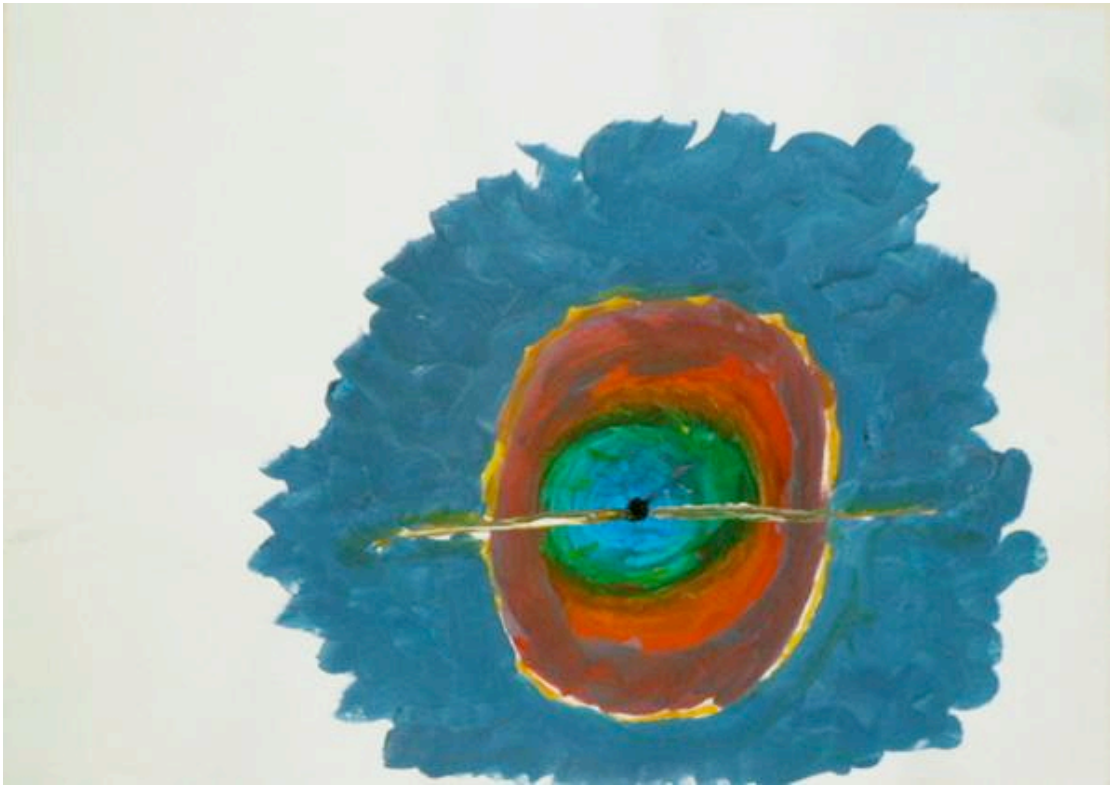

Figure 9. Older brother (Tyrone): Exploding star, in acrylic paint.

In describing his work, Tyrone referred to ‘tension in the universe’ and it’s necessity for life to exist.

Figure10. Mother (Audrey): A little black, in acrylic paint.

In the presence of her other children, Audrey appeared more relaxed and this was reflected in her work. Her verbal description was limited to describing the black in her work as the 'little black dress' she planned to buy on the way home.

Figure11. Art psychotherapist: The nest, in acrylic paint and collage.

The therapists' image demonstrated the multi – directional quality of this experience. The eggs were placed in at the end of the art making as the incubator & container of the experience for the family and as a visual communication to Audrey as the adult, that it is a mother's responsibility to protect their young. Interestingly this was something she verbalised for her self later in the admission, as identified in the verbal response to her image made the session of figures 21 and 22.

Two months into the admission

Written in Emma's artwork were the words, "These scars do not define me. They show that I'm in a battle and once that battle is over they show how strong I was and are."

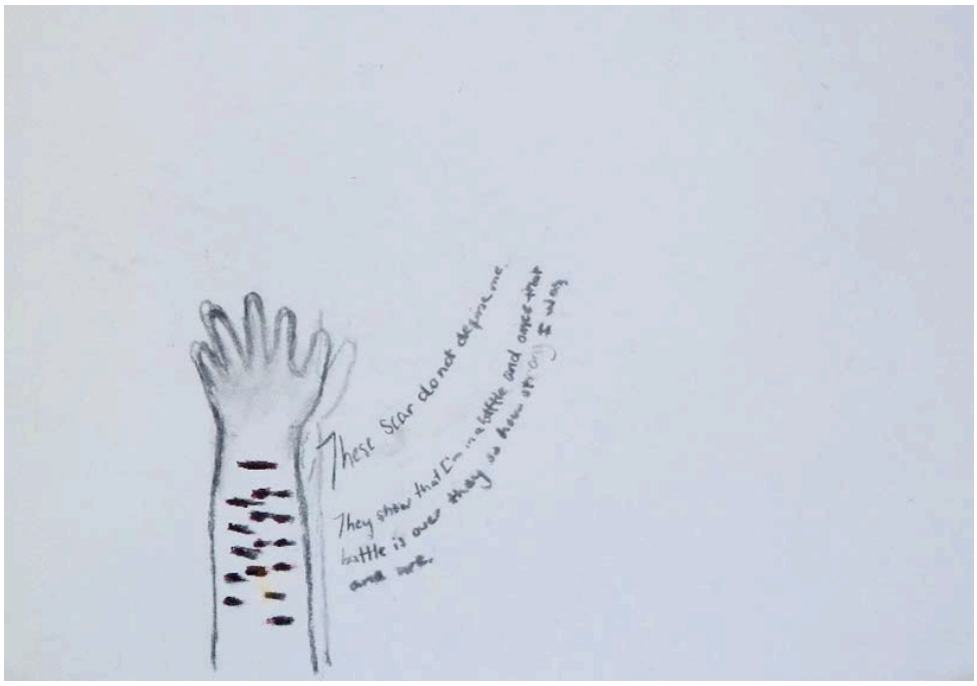

Figure 12. Emma: These scars do not define me, in charcoal and acrylic paint.

Figure 13. Audrey: These scars mothers response, in charcoal and acrylic paint.

Audrey presented as more attuned to her daughter, similar colours and gestures were mirrored and reflected upon as indicated by the red heart and the short grey and black watery marks made with a cutting gesture. Audrey appeared more vulnerable in her husband's presence.

Figure 14. Emma's step-father, John: These scars step-father's response, in acrylic paint and oil pastel.

John took control of his work in a deliberate and planned manner. He described his step daughter's experience factually and simplified things by drawing a diagram of her journey. He made comments like, "She needs to make more effort".

Figure 15. Art psychotherapist: These scars therapist's response, in paint and charcoal.

The art psychotherapist response appears to be offering a 'helping hand', a sign that the therapist can bear her pain. There was a direct visual response in the therapist's communication to Emma, remembering one of her favourite phrases 'H.O.P.E' (Hold On Pain Ends) demonstrated by the hook leaning across in the image. Complex family dynamics are extremely hard to trace in verbal therapy, the images provide a record over time and are invaluable for promoting further thought. For example, in hindsight the therapist was able to consider she had lost her capacity to contain John with his comments. Emma said the session went better than she had expected, however Emma refused to come into the art therapy for some time after. This may have been due to the therapists' countertransference and incapacity to think through the impact of colluding with her superficially charming step-father's need to 'pop in' to the session.

Taken together, these art making processes and the resulting images make visible the complexity of the dynamics.

Three months into the admission

Despite trials with several medications Emma had displayed no change in mental state and Audrey was becoming frustrated with Emma's deterioration and felt hopeless about Emma's current state.

In the next three sessions Audrey entered the room alone. A rationale was provided to Audrey that while Emma was refusing to join her in the work, the therapist would continue to take this time to think about her and offer Emma the option to enter the room at any time. In response to her frustrated feelings about Emma, Audrey made the artwork below.

Figure 16. Audrey: Raw rage, in acrylic paint.

Figure 17. Art psychotherapist: Raw rage therapist's response, in acrylic paint.

Audrey's work was delivered in an agitated and deliberate way, at times stabbing her work with the brush the art psychotherapist wondered if she was wanting to hurt herself, her child or the therapist. Strong feelings of violent agitation were experienced in the countertransference but not beyond the therapist's capacity to think about them, or reflect on the artworks in progress. The emotional tone of the therapeutic relationship can be seen in the therapist's art-based response, one of empathy and support in the hope that Audrey will stay with the process and integrate this experience. This was demonstrated by the therapist's slow soothing response gestures, literally watering down the reds and blacks softening the exchange and providing spaces in-between for potential change to occur. This was a big change in Audrey's work to date and important feelings for her to feel contained in.

Learning how to be with these feelings is commonly misplaced in parents who have children struggling with mental health issues. Audrey could not talk about the work and struggled to find a word, she eventually described her work with the word, 'Disgust.' Due to Emma's escalating distress she was commenced on a different medication following a number of incidents and increase with command hallucinations. She did not attend following sessions.

Figure 18. Audrey: Lost Mother, in acrylic paint)

Audrey made this artwork over a forty-minute period and in the discussion time described that she was feeling lost and numb.

Figure 19. Art psychotherapist: Mother's lost therapist's response, in acrylic paint and collage.

Audrey's numbness was experienced as a heavy and tired sensation. The therapist was clear, this was not her tiredness and this was made possible to be thought about by the therapist through the art making response. Working in and with the tiredness in the countertransference is explicitly revealed in the early grey phases of the art making. The found collage image of a foreign place symbolized potential new unexplored territory that was offered with the therapeutic plan to reframe 'lost' feelings in the discussion. At the end of the session, in the discussion Audrey was able to talk about her feeling of being lost and could see the benefits of exploring new approaches. She also requested the art therapist show her daughter her 'disgust' image. This could be an indication Audrey was beginning to integrate an understanding of the process.

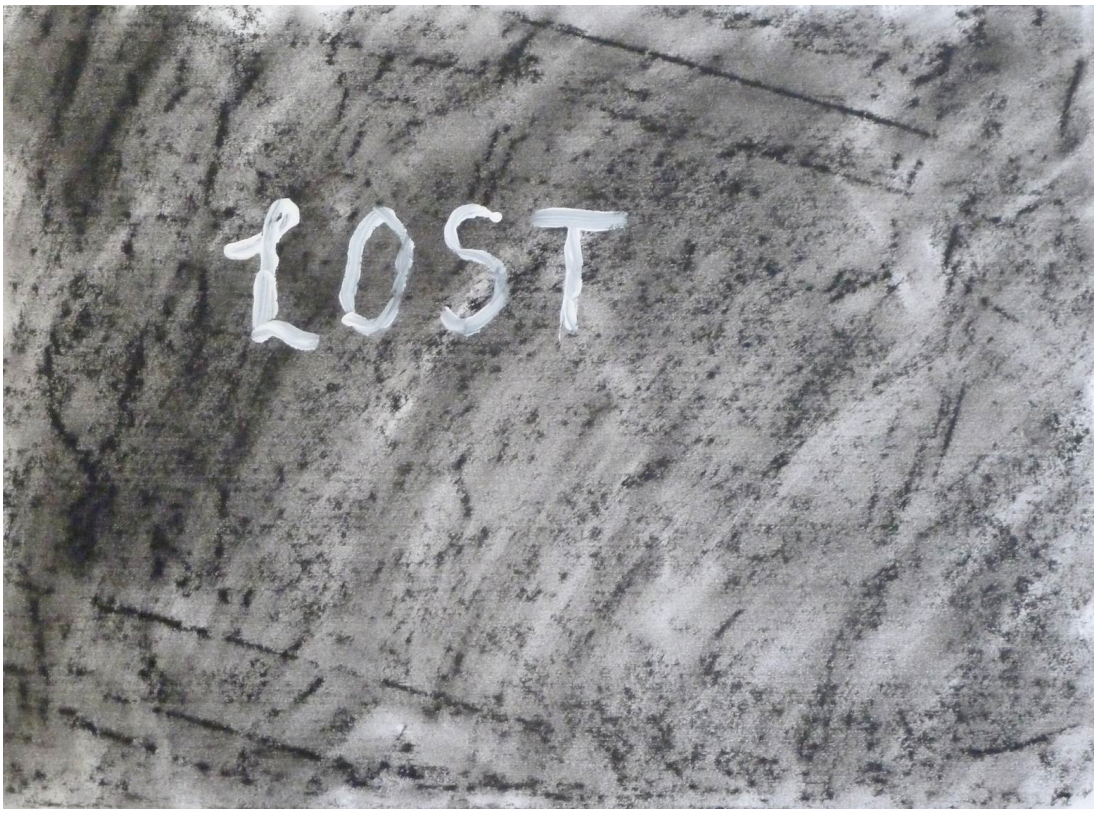

Figure 20. Emma: Child lost not in session, in chalk pastel and acrylic paint.

Emma had returned to the art psychotherapy group on the ward, she made this image not having seen her mother's expression of feeling lost. As Emma had unconsciously delivered an attuned image to her mother's work, the therapist chose this time to show Emma her mother's red 'disgust' painting as Audrey had requested. Emma was interested to see it and pleasantly surprised to see how emotionally expressive it was. She verbally acknowledged how her mother must be changing.

Three and a half months into the admission

Audrey entered the room on the phone, her tone was flat and she sounded small. She stood with her back to the therapist, the therapist wondered if Audrey was trying to protect herself from the sounds of her screaming daughter at the other end the corridor and to avoid the painful attachment. An attack was being conveyed in the countertransference experience, the room felt thick with what seemed like heavy nerve gas. The therapist browsed

through some of the collage material available and by free association found the large flooded water picture along with the woman on her phone. She placed them next to her blank sheet of paper. These images were kept to the side through the session and represented a gathering of fragmented communications. There was a flood of overwhelming emotion in the room, which had been contained by the pictures found to recycle the feelings into symbolic form.

When Audrey finished with the phone she sat down and without speaking began with slow swirls of light green chalk pastel. A benign high tone of green nothingness rang out in contrast to the extreme critical nature of recent events on the ward.

With the found pictures to the side, the therapist was experiencing feelings of dissociative deadness in the work, finding it difficult to think she slowly mixed a watery murky brown and painted a few repetitive strokes of what felt like secreted preverbal diarrhea onto paper, as identified in the bottom right hand of the page. The images provide evidence of a separate self in response to ‘other’. There had been an intrusion of an extreme nature experienced by the therapist in this moment. Unintegrated powerful sensations that could only been dealt with by evacuating them, projecting them out into a containing other. In this case by Audrey onto the therapist and from the therapist into the image.

Audrey then reached for the magazines and found a picture of a mother holding a small child, which she glued into the centre of her image. She continued to slowly circle in chalk pastel around the glued cut out part of her artwork. The mother/baby found picture was surrounded by the dissociative chalk pastel interpretation of the image. As Audrey did this, the therapist cut out wild life mother/child pictures and placed them into the montage of cut outs that still sat to the side of the painting of what now looks like a branch in the finished artwork (see figs. 21 & 22)

Figure 21. Audrey: Attach, in chalk pastel and collage.

Figure 22. Art psychotherapist: Attach, therapist's response in paint and collage.

In the above vignette, it can be seen that:

> ‘The pre-verbal thinking functions involved in the creative use of visual image-making can contain and transform the raw material of experience within the therapeutic relationship, paving the way for symbolization, and the experience of relatedness to the therapist can foster the possibility of a symbolic relation to the images’ (Killick, 1993, p.30).

The art psychotherapist first glued the picture of the woman on the phone, then the flood of water with the two wildlife mother/child pictures. The koala is looking surprisingly in place and supported by the branch, that were the brown streaks of paint from earlier in the session.

During reflection on the artworks and as Audrey looked on her image, which contained the disavowed parts of herself, she burst into floods of tears. She was able to integrate and verbalise the grief associated with the loss in her experience as a child, saying, “Mothers are meant to look after their children.” She explained that this had not been her experience as a child; she had been failed by her mother and she felt she was failing her child. This was an important session as there was a noticeable improvement in Audrey’s relationship with her daughter from this point.

Four months into the admission

Emma displays an improved mental state and was able to go back into the art psychotherapy with her mother.

Audrey’s work was full of expectation for Emma and her planned return to the hospital school.

Figure 23. Emma: Tree, in chalk pastel.

Figure 24. Audrey: Mother's tree response, in paint collage and chalk pastel.

Figure 25. Art psychotherapist: Therapist's tree response, in chalk pastel and paint.

In this therapeutic response it was important to acknowledge the barren nature of Emma's tree and the fullness of her mother's tree. Often parents will leap into health with any small progress their children make which can be concerning pressure for the young person to experience. In scattering the leaves into the surrounding grounds in the therapist's response gave opportunity for further discussion in this area.

After two years the admission ended and Emma was discharged

Emma displayed on-going improvement with some fluctuation, she continued to experience low grade psychotic symptoms. Emma and Audrey's relationship had markedly improved. She was able to use distraction techniques, able to verbalise and ask for help and had plans for the future. Emma had returned to school.

Figure 26. Emma: Good day bad day, in oil pastels and paint.

Figure 27. Audrey: Good day bad day, mother's response in acrylic paint.

Audrey's work shows an ability to tolerate her own distress and be more attuned to Emma's experience. As usual there was little discussion in these sessions. Emma's vocabulary had not significantly increased in verbalising her emotions but in the non-verbal exchange of these two artworks it is perceivable that Audrey had made great improvement with her attunement to Emma's emotions. As the adult, Audrey had more capacity to verbalise what

was happening, more ability to sit with difficult feelings and support her daughter in articulating her needs.

Discussion:

Working as an art therapist within a multi-disciplinary team in an inpatient unit for young people with complex mental health difficulties offers a significant contribution in the containment and understanding in the context of high levels of psychic disturbance, volatile, challenging behaviour and highly charged emotion. The presence of images within the therapeutic relationship provide a visual link to safely process and reflect on intense projections and unconscious communications that develops in the relationship between patient and therapist and also between family members. Awareness is gained and explored as much of the unsayable or unknown thought becomes conscious and worked through.

In the case study, the images illustrate how Emma, struggling with trauma and complex mental health issues, was able to express and communicate her predicament through the use of art materials. There is a flexible approach to involvement of the family in the work by offering some time and space for each member of the family system to work through the concerns and difficulties that can develop due to misunderstandings and poor communication. Complex family dynamics are extremely hard to trace in verbal therapy, and the images provide a record over time and are invaluable for promoting further thought.

The family struggled at first to engage with the art psychotherapy and there were some complicated dynamics contained in the artworks that were not fully explored consciously or verbally but were acted upon by the attendance or absence in the sessions. For example, in and after the session with Emma's step-father as identified in image figures 12 – 15 and figures 18 – 20. Emma's absence from her sessions with her mother gave Audrey the space to work through some of her own repressed experiences related to her sadness that may not have emerged with Emma in the room as evidenced in image figures 16 - 20. Subsequently Emma was able to re-enter as her mother had worked

through some of her own pain. Revealing and working through the repressed pain experienced by Audrey promoted progress in their relationship. In seeing the aesthetic response many of the existing defences were bypassed which created meaning and understanding through these unconscious responses previously unavailable to thought.

This family had a similar experience to the one described by Chong: 'Art offered this client a non-verbal option for communicating her experience authentically helping her to bypass the dissociative use of language' (2015, p.124). The art psychotherapist works with links and linking functions attacked by unconscious projective processes that language and conscious thoughts can evoke. This is demonstrated in the images figures 21 and 22 made after the family meeting. Figure 22 demonstrates how the therapist was able to continue communication in the image making while projective phenomenon flooded the room. Interestingly Audrey's comment from this session, "Mothers are meant to look after their children" had been made non-verbally in the therapist's image earlier in the admission (see fig.11). Transforming the non-verbal (unconscious) process of art making to the verbal (conscious) discussion of the work was central to Emma's and her family's experience with possible integration of insight and change.

Conclusion

Responsive Art Making, as it evolved in the Unit is unique to this setting. It has developed over time as a way of responding to the particular needs of the adolescents and their families. This practice of multi-directional responsive art making, enables reflection on embodied counter-transferences and strong projections. The making of art helps to illustrate the internal emotional work and reflection of each individual including the therapist. The images are the concrete product of this, which bypasses verbal connections, and the presence of the response image adds an extra dimension to the work in terms of developing meaning and understanding. The aesthetic and psychological elements of image making in art psychotherapy can fill a void and provide a metaphorical voice for patients who are otherwise overwhelmed by mental distress and who are unable to sustain a meaningful verbal conversation. In

this adolescent inpatient environment, art psychotherapy provides a significant role in the care and treatment of the young people that impacts on lasting progress and change.

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Biography

Fran has thirty-five years experience in various arts and health projects in the community, private and public health sector. She has worked five days a week as an art psychotherapist at the Walker High Severity Adolescent Unit in Sydney Australia since it opened in 2009. She introduced the art and music therapy program, which has developed into supervising students across a few campuses including Adult facilities.

The work has been presented at national and international conferences. She has recently presented a paper on an evaluation of the art therapy to the National Allied Health Conference, the International Arts and Health Conference Art Gallery NSW, and has an abstract accepted to present at an International Childhood Trauma Conference on Dissociation and Images. She is also in the process of getting the evaluation paper published in a Psychiatry Journal.

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