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Making Room: Addressing the Counter-Therapeutic Nature of Psychiatric Hospitalization Through Containment- Based Group Expressive Therapy

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Making Room: Addressing the Counter-Therapeutic Nature of Psychiatric Hospitalization
Through Containment- Based Group Expressive Therapy

Capstone Thesis
Lesley University

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Expressive Arts Therapy

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Abstract

The process of hospitalization and the environment of a typical psychiatric hospital is often counter-therapeutic. To challenge this problem, clinicians may introduce the concept of psychological containment. To elaborate, being hospitalized anywhere can be disorienting, frightening and even traumatic. This problem is only further exacerbated in psychiatric hospitals where patients may be disorganized, manic, or struggling with psychosis. Furthermore, psychological containment is essentially the ability for psychiatric patients to prevent their intense emotions from effecting others negatively, and to act with resiliency when other patients are unable to contain their own disruptive behaviors. This paper utilizes both an initial literature review to understand the problem at large, as well as the creation and an application of a therapeutic method on a hundred-bed psychiatric hospital. This method aims to address and explore containment and is further examined through personal artistic inquiry on the part of the writer. This work leads us to a main conclusion: introducing the concept of containment to a psychiatric unit is one step in creating an environment that is less traumatizing, and more therapeutic.

Making Room: Addressing the Counter-Therapeutic Nature of Psychiatric Hospitalization
Through Containment- Based Group Expressive Therapy

Introduction

For the last several months, this writer has worked as a masters-level intern at a psychiatric hospital in Massachusetts providing group expressive therapy to dozens of patients at any given time spread over six inpatient units (three acute care units, one detox unit, one standard unit and an adolescent unit). This writer is part of the “rehab department” a group of clinicians whose work is not exclusive to substance use recovery but is meant to serve patients across the diagnostic spectrum by providing mental health rehabilitation through group work on every unit.

Having faced countless patients, I believe that one particular memory of mine is the most fitting way to introduce the forthcoming topic. Once, in my teams’ office, I overheard a patient screaming on a unit above: “I don’t want to be here, I’m not supposed to be here, I don’t belong here”. The person’s voice seemed terrified, drained of agency and replaced with fear, desperation, and confusion. She was in a bedroom that wasn’t hers, answering strange questions, wearing foreign scrubs, and was surrounded by peers who may likely have been experiencing non-consensus realities.

For many like this patient, hospitalization can in itself be traumatizing. This concept stands even in medical hospitals, not just facilities that serve patients with psychiatric conditions exclusively. Hospitals and institutions that are supposed to be sanative often appear as just the opposite: frightening, foreign and chaotic. Part of this is due simply to the nature of hospitalization (having to stay in a foreign place, being looked after by strangers etc.), and part of this is due to the specific nature of psychiatric hospitalization, where the patients’ community

may include peers who are disorganized, manic, struggling with psychosis or at risk for violence. However, to say the challenges present at a psychiatric hospital are completely unavoidable would be irresponsible, and it is this reality that leads to the topic of this thesis : the provision of “containment” on acute care psychiatric units for the prevention and treatment of medical trauma and the complex environment it creates.

Containment is a broad therapeutic concept. Countless clinicians may offer countless definitions, but there is common ground across theoretical orientations. Böhmer et al. (2019), for example, describes it briefly as “a feeling of being held together and of being safe – needed by patients in distress or at risk” (p. 5). Shore and Rush (2019) concur, claiming that “containment of psychosis includes a –‘restriction on stimulation levels’ for patients ‘whose boundaries are already too fluid’” (p. 4). Worth noting here is that containment is not exclusive to psychosis treatment, but in any that requires boundaries (or, all forms of treatment).

In other words, containment is a feeling of group safety or calm that specifically regards the boundaries between members, and their relationship to their environment(s). Containment is an environmental factor, constructed in the group therapeutic process, that allows members to contain certain emotions and behaviors while protecting them from the emotions and behaviors of others. In a group where containment is present, patients don’t just have resiliency in the face of distress and disorientation but prevent themselves from acting as sources of these problems for others. This is the overarching theme of the following paper and leads to several questions:

1). What does psychological theory say about containment? 2). Can its presence on psychiatric units prevent distressing behavior from occurring and build resiliency in the face of said behavior? And, 3). can the expressive therapies be a tool for building containment in the aforementioned setting?

Forthcoming, is an inquiry into these questions. First through the building of a greater understanding of the nature of a psychiatric unit as one that can be at times distressing and traumatizing; and worse, violent. Next, the literature surrounding the concept of containment will be explored; this includes research that defines containment and helps us to build a further working definition, explores the environmental factors that necessitate it and displays working models for its achievement currently in use across different settings and through different modalities.

Dispatching from this formal literature-based research, this paper will display an expressive therapy-based group directive called “Making Room” which intends to focus patients specifically on the concept of containment. This directive has been performed five times at the afore mentioned internship site of the writer and has served thirty six patients over three different units. Furthermore, personal artistic inquiry on the part of the writer will be used to reflect on the experience of participating in the method. This combination of academic research, real-world application, and analysis of the concepts it expels, will help to affirm our central hypothesis; that the challenging, chaotic and at times traumatic environment of psychiatric units can be improved on an individual and community level through containment-focused group expressive therapy.

Literature Review

Understanding the Environment of The Psychiatric Unit

There is no singular image of a psychiatric hospital, and it would not be accurate to paint all forms of treatment with a broad brush. However, to properly understand the topic at hand, it is necessary to build an understanding of the commonalities that exist within the average facility. To do this, one must begin with an overview of the general history and subtypes of psychiatric institutions. Furthermore, one must reflect on the plethora of research which describes the

environment of psychiatric units from the perspective of care providers and patients alike. Finally, with this understood, one can begin to understand the issues (such as risk of violence) that arise at psychiatric hospitals, their causes, their current solutions (such as physical and chemical restraints) and their potential solutions (like containment focused therapy).

An Overview of Psychiatric Institutionalization

Inpatient psychiatric care (as far as recorded history tells us) began around 2,500 years ago (Hodak et al., 2011, p. 979) in the form of Christian officials taking care of the sick (including the mentally ill) in Jerusalem. This practice would spread across Europe throughout the middle ages culminating in the establishment of one of the most famous, or perhaps infamous institutions, Bethlem Hospital (better known as “Bedlam”) in 1330 (p. 979). As psychiatric care across Europe became more commonplace, it’s necessary to understand that this care was a far cry from what is practiced today. In fact, Hodak et al. (2011) tell us that “until the eighteenth century, care and accommodation for the mentally ill was often identical to that provided for beggars, traitors, criminals and the politically unsuitable” (p.980). This establishes a theme to be repeated throughout history: the use of inpatient psychiatric settings as carceral institutions to control those with mental health problems, not to help them.

A century later in the United States, psychiatric institutions began construction and by the mid-nineteenth century “awareness of inhumane and inappropriate treatment of the mentally ill was growing” (Hodak et al., 2011, p. 980), and this (combined with development in psychopharmacology in the 1960s and 1970s), would lead clinicians closer to their modern, client-focused model of psychiatric hospitalization (p. 980). Even in this more modern treatment however, the ill history of psychiatric treatment is still present. Though restraints and seclusion are less present, and dangerous experimental therapies (i.e., hydrotherapy and lobotomies) have

been eliminated; one could argue that these cruel efforts have only been replaced by constant, and sometimes forced, medication.

Ethical Notes and Hospital Subtypes

Here, it is crucial to note the ethical issues inherent to the process of psychiatric hospitalization to properly understand its history and modern standing. Committing a person to a hospital against their will for example, clearly goes against their wishes and agency, however, would it not be just as unethical to release a patient who is either incapable of taking care of themselves or at risk for hurting themselves and others? It is these ethical discussions that one must keep in mind to create therapeutic models that can balance the humanity, dignity, and agency of a patient, with the need to keep them and others safe.

Furthermore, it must also be made clear that there are several different forms of psychiatric hospitalization. The general population may be quick to imagine the state-hospital, where chronically acute patients stay for long periods of time. However, many modern inpatient hospitals serve patients for much shorter stays, with the intention of reducing the acute nature of their illnesses to a point where they are able to better live in the world and accept outpatient care. It is on these types of hospitals on which the present research focuses.

Medical Trauma and the Nature of Psychiatric Hospitals

Modern psychiatric hospitalization looks very different from the asylums of past generations: however, hospitalization can still be a traumatic experience for anyone, let alone somebody with a psychiatric diagnosis. It is this concept of medical trauma (trauma developed as a result of negative medical experiences) that greatly forms the troubling and challenging environment that patients experience on psychiatric units, and it is on this that the next several paragraphs focus.

Hall (2013) tells us that “For many people the hospital or other clinical setting is an environment that is very different from their own; indeed physical surroundings, reduced personal agency and volition, and personal symbolism and history... contribute to a stress response” (p. 8). Furthermore, the process of hospitalization can create a sense of powerlessness and disorientation in patients. For example, regardless of movements towards person-centered care “many adults have been socialized to yield to those with more training and education. Perceived or actual powerlessness can incite strong psychological responses, including PTSD, depression, and anxiety” (p. 8). Furthermore, Hall (2013) tells us

Most people who have stayed in the hospital could attest to the disorienting nature of the environment. For most adults... the experience of being without their calendars, clocks, and other items linking them to daily tasks and goals can be disconcerting. When we add sedation, medications, and sleep deprivation to the general absence of a temporal context, it is not surprising to find that some patients can become disoriented. (p. 8)

Though Hall’s work focuses on intensive care units, the concept of medical trauma is applicable to acute psychiatric care. Patients are still without their own possessions and personal spaces and are following a schedule and orders that are foreign to their way of life. This, Hall argues, causes notable mental stress for anyone, including patients struggling with severe mental health problems.

Psychiatric Hospitals: Patient and Staff Perspectives

With this understanding of medical trauma as a potential product of hospitalization, one can move on to understand how this effects psychiatric-unit specific situations. Largely, this becomes clear in the disorganization of units, and the potential for physical and emotional violence.

Survey based research performed at a psychiatric hospital in Copenhagen by Shjodt et al. (2003) found that “regarding the ‘real’ ward atmosphere, patients and staff unanimously perceived it to be less supportive, less characterized by order and organization, and more spontaneous than recommended” (p. 218). In other words, though not described as necessarily positive or negative, this anecdotal evidence tells us that the people receiving and providing care in psychiatric hospitals see it as being less organized and contained than it is spontaneous. This understanding of inpatient settings as disorganized was echoed in Hannah’s (2018) research of psychiatric settings in Boston. Intending to focus on the role of race in hospital culture, Hannah soon found that

The episodic violence and chaos, and the routine low staffing and degraded physical plant gives one the impression that a form of “brute life” has developed on the unit, where focusing on cultural issues seemed almost ridiculously beside the point and not relevant to the “real” work that needed to be done just to keep the place calm and safe. (p. 590)

This is a troubling reality in many inpatient settings. Sometimes providing actual treatment to patients ends up coming in second to simply keeping psychiatric units organized and safe. In fact, violence on psychiatric units is a serious, and not uncommon, problem. To elaborate, Tishler et al. (2000), tells us

a survey of 300 independent practitioners revealed that 81% experienced at least one incident of patient physical attack, verbal abuse, or other harassment... Armed police in acute psychiatric facilities and pharmacies, panic buttons, and metal detector searches of patients have become the norm” (p. 34).

Tishler (2000) continues, noting how the stressful nature of a hospital can be part of what creates this violence, claiming “a violent or potentially violent patient who has been prescribed

involuntary hospitalization or medication is likely to be angry and frightened, which may increase aggressive tendencies” (p. 35). In the stressful, disorienting or frightening setting of a hospital, patients may become prone to violent behavior and this becomes a major factor in how clinicians conduct therapy and how patients relate to one another. Obviously, a patient expressing violent or aggressive behavior requires immediate care and attention for the sake of their mental wellbeing and their physical safety. This is how therapy sometimes takes a back seat to simply maintaining order and safety. This becomes much more complicated in group or congregate care settings. Here, patients are likely to feel threatened by their own peers when this violent behavior begins and the clinician must now provide care to patient struggling with aggression, and the patients who are frightened by this. This predicament may lead to the use of physical or chemical restraints. These “restrictive interventions, such as mechanical restraint and seclusion, have long been used in inpatient psychiatric settings” and though “historically, many providers viewed restrictive interventions as safe and effective means for managing aggressive behavior” (Godfrey et al, 2014, p. 1277) modern scholarship tells us that restraint can create even more issues for individual patients, the unit at large, and the clinicians providing care.

Restraints as a Response

Physical and chemical restraint is not an uncommon response to the aforementioned environment and situations of violence in American psychiatric hospitals. Before understanding the preventative and therapeutic alternative to restraints (containment-focused group work), it’s necessary to build an awareness of how restraints are currently used on psychiatric units, and how this effects patients on an individual and community level.

Mahmoud (2017) informs us of the fact that “patients, as a result of being restrained reported that they felt angry, helpless, sad, and powerless, punished, embarrassed, and that their

right to autonomy and privacy has been violated” (p. 2). Furthermore, “these experiences were summarized in two themes: restriction and discomfort” (Mahmoud, 2017, p. 2-3). In many ways, the process of restraint as a reaction to violence and aggression, though it may physically protect those on a unit, can cause severe distress and trauma to patients who are already deeply struggling. Here, one sees a cycle in which the traumatic environment of a hospital begets violence begets trauma etc.

Also, worth noting here, is that restraints are not only upsetting for those forced into them, but for those who must perform this action. According to Mahmoud (2017) nurse responsible for restraining patients experienced “anxiety, anger, feeling bored or distressed, crying, inadequacy, hopelessness, frustration, fear, guilt, dissatisfaction, isolation, being overwhelmed, feeling drained, vengeance and repugnance” (p. 3).

With this understanding the tension that exists on psychiatric units, clinicians must consider how they work to address, prevent, and acknowledge aggression and violence. The research performed on a 398 bed psychiatric unit by Godfrey et al. (2014) provides promising results on this subject. This study involved the implementation of a de-escalation training program to attempt the elimination of restraints.

reduction and even elimination of mechanical restraint can be accomplished in a state psychiatric hospital on both acute and rehabilitation units without increasing assaults and injuries to consumers or staff. In addition, our efforts resulted in reduced use of seclusion on the acute unit... (p. 1280)

Though this study is not representative of all acute care treatment facilities, it provides the promise of hope that the cycle of trauma and violence existing in psychiatric hospitals is not a necessity and that it can be broken through de-escalation training among staff. With this in mind,

it must be noted that even when violent behavior is less present on psychiatric units, this does not mean that healthcare professionals can completely eliminate the safety measures that it necessitates. No matter how therapeutic an environment is, when working with a patient struggling with psychosis there is the chance that they may become a risk for hurting themselves or others. Here, one finds oneself in an ethical quandary: as horrible as it sounds to restrain a patient, Clinicians must ask themselves if it is worse than allowing them to hurt themselves or others. To circumvent this situation, however, clinicians can work to create an environment where the necessity of restraint is less commonplace. One way to do this is through the concept of containment. Containment is the social skill involving containing one's negative emotions that may have an ill effect on others, while building distress tolerance to the actions of peers. The following paragraphs aim to explore this idea in depth.

Containment

The psychotherapeutic concept of containment is not a simple idea to pin down, and an understanding of its use on psychiatric units takes notable scaffolding. The following paragraphs aim to do just this. To start, one must understand what psychological theory says about containment and build a working definition. From here, one can begin to see how this theory can be applied to psychiatric units to improve the overall environment and make it more therapeutic. Finally, we can examine the practical application of containment to the therapeutic space through traditional therapy, and expressive therapies alike.

Containment in Theory

Brown et al. (2008), provides an excellent introduction to the concept of containment, claiming that a therapeutic environment requires a "sense of containment" because "when powerful emotions are being addressed, or are as yet in the background, a secure container for

those feelings is important, if not essential” (p. 3). To elaborate, this writer claims that “almost all psychotherapeutic approaches utilize processes” (p.3) that provide a safe boundary within the therapeutic space. These boundaries exist to make it possible to explore upsetting, challenging psychic content in a way that is safe and productive. To elaborate on this point, Brown et al. (2008) tells us that , “boundaries and containment encourage trust, which in turn provides a better situation for the exploration of these difficult shadow areas” (p. 7). Essentially, containment and boundaries encourage a sense of trust where the exploration of trauma is more possible and more responsible. Furthermore, Brown et al., (2008) continues, arguing that “this is particularly so because much of what we encounter in the shadow is itself related either to a previous breakdown of trust or to trust not having been established in the first place” (p.7). As containment breeds safety, it also acknowledges that many of the client’s problems may stem from lack of containment, which becomes a major opportunity for personal learning and constructive change.

In this conceptualization of containment, Brown et al. (2008) tells us that safe and productive psychotherapy requires specific care. Clinicians need to work to provide a sense of boundary, holding or containment for our patients to establish a space where the challenging work of therapy is possible. It is this sense of containment that informs “participants that, although highly intimate and personal, the therapeutic encounter must not include violence, social contact, or sexual behavior” (p. 11). It could be said that it is on this sense of containment that therapeutic space and the relationships developed within it are built.

Worth further consideration is the fact that psychiatric patients are not the only ones who benefit from containment, “in order to explore the unknown, the practitioner also needs the containment of a bounded space that is not interrupted.... the boundaries around the space help

the therapist to feel contained, so that he in turn becomes part of the containing space around the client” (Brown, et al., 2008, p. 10). In other words, a sense of containment does not just help to create a therapeutic space for the patient, but a space where the therapist is more capable of working effectively.

It is this work which informs the working definition of containment as it appears in this thesis. Containment, as mentioned earlier, is effectively an environmental factor, constructed in the therapeutic process (be it individual or group based) that establishes safety focused boundaries and allows participants to contain (or effectively, productively and safely communicate) certain emotions and behaviors while protecting them from the emotions and behaviors of others. With this in mind, the importance of containment in group and milieu settings cannot be understated. If it requires so much work to establish a sense of trust between a client and therapist, then establishing it within a group or community setting is quite the undertaking. Furthermore, if containment is meant to protect the participants of therapy from each other, then it can only become more necessary (and complicated) as the number of participants increases. Within milieu and community settings specifically (i.e. psychiatric hospitals) the feeling of containment is not limited to the therapy room but should be extended throughout the community. How then, can clinicians make this happen? How does psychotherapeutic theory claim we can establish a sense of containment?

Providing Containment

Providing containment is no simple feat and there are countless ways to introduce it in therapy. However, two general tenets stand out in current literature and provide a strong basis for the use of containment. These are: a strong therapeutic relationship among participants and the establishment of boundaries between members. Furthermore, there are specific aspects of the

expressive therapies that can help to establish containment.

Böhmer et al. (2019) argues that the best starting place for the establishment of containment is with the immediate therapeutic relationship. Regarding their qualitative study of inpatient psychiatric units in South Africa, it was found that “from the patients’ perceptions and experiences, the main theme that emerged was how important the doctor-patient interaction and therapeutic relationship are in the treatment planning and in helping patients cope with their distress and anguish” (p.3). In other words, the establishment of containment requires a strong therapeutic relationship that is born through positive and thoughtful interactions between clinician and patient. In order to explore a patient’s problems, there must be a trusting relationship between the therapist and patient. Brown et al. (2008) offers a similar theory of trust in containment, claiming that clinicians should “encourage trust, which in turn provides a better situation for the exploration of these difficult” discussions that can arise in therapy (p.7)

Furthermore, Böhmer et al. (2019) introduces another side of containment. “To help create a safe space that provides containment and understanding of the patient, keeping to a frame linked to boundaries is essential” (p.5). As much as the connection between therapist and patient is important, so are the established boundaries that make this connection safe and productive.

Containment and The Expressive Therapies

Moving forward, it is essential to understand that these tenets of containment are understood in several different theories, however, specific theoretical orientations also provide a lot of insight, one of these, being the expressive therapies. The following paragraphs review literature focusing on music and art therapy, helping one to understand where these treatment orientations fit into the work of creating containment.

Silverman's 2020 study involved 58 patients on an acute care psychiatric that received 45 minutes of songwriting-based group music therapy for 20 sessions. "The goal of the songwriting sessions", Silverman (2020) claims "involved identifying potential sources and causes of distress as well as how to be psychologically flexible to tolerate that distress while in the community" (p. 3). This, sense of distress tolerance is a key aspect of containment. After the course of therapeutic intervention, the patients' responses were analyzed through the distress tolerance scale which found that, over the control group, those receiving the specialized treatment "tended to have slightly higher mean distress tolerance scores than the control condition in all measures: tolerance, absorption, appraisal, regulation, and total distress tolerance" (p. 4). In other words, the implementation of containment-based music therapy helped, at least marginally, to improve distress tolerance among psychiatric patients, an important skill on the challenging environment of an inpatient unit.

With this being said, despite the positive outcomes with the Silverman study, the information must be taken with a grain of salt. Though patients receiving music therapy did tend to experience slightly improved distress tolerance over the control group, this difference did not achieve statistical significance (Silverman, 2020, p. 4). Furthermore, this study involved a very small research pool ($N=58$) that lacked diversity with only ten participants who identified as people of color out of the total. With this being said, this research still offers a positive perspective supporting the notion that the expressive therapies can, at least minimally, act as a tool for providing containment on psychiatric units. The research performed by Shore and Rush (2019) has similar findings in art therapy practice.

In their article exploring the provision of art therapy on psychiatric units, Shore and Rush (2019) present six guiding principles for creating group containment. These are: 1). a "focus on

under-stimulation” (p. 3) , 2). building “individual strengths through accessing creativity” (p. 4), 3). “re-examin[ing] definitions of group cohesion” (p. 4), 4). understanding “the continuum of relational tolerance” (p. 7), 5). “help[ing] patients to gain a sense of control” (p. 9). And finally, 6)., “encourage[ing]reality orientation through art-based form” (p. 9)

Essentially, these writers present ways to extend the initial tenets of containment even further through the use of expressive therapies (specifically visual art based therapy). Largely, they argue that practice helps to add to general containment a sense of control, strength, reality orientation and calm. This is important because these seemingly simple themes that can be brought to the group through art strengthen containment on an individual and group level, continuing the cycle of containment in the group and the unit at large. Together, the research done by Silverman (2020) and Shore and Rush (2019) introduce the theory of containment focused expressive therapies and how this can be effectively achieved.

Conclusions

It is not fair to paint with broad brush strokes when trying to understand the nature of psychiatric hospitals or the means of the care that is provided inside of them. However, research and theory are able to point out a common thread that is simpler than one would imagine: Hospitalization is scary. This sense of fear creates a cycle of medical trauma: fear of the environment makes the environment feel less safe, the less safe the environment is, the more fearful it becomes. As the preceding paragraphs have established, medical trauma begets medical trauma, and the challenging environment of a psychiatric hospital can, in some ways, contribute to the mental health problems of those being served there. There is no one solution to solve this problem, but one theoretical concept provides a helpful and hopeful future: containment. If clinicians work to build an environment where patients can contain and work with their sense of

fear or trauma, clinicians could stop that fear or trauma from effecting the environment at large. This can be achieved through several methods, like the establishment of boundaries and trust, and the utilization of the expressive therapies. However, making the environment safer, more comfortable, and more contained, is not the work of the psychiatric hospital. It is simply the first step. It's part of what creates the environment where the actual work of therapy can be done and is accessible to all. With this understood, this review of literature moves into the forthcoming method section, exploring how we can bring this idea to reality.

Method

To bring a sense of containment to a psychiatric unit is not easy, however, this writer has developed an expressive therapy method for groups, intended not only to start a dialogue on containment, personal space, and boundaries; but to begin providing these as well. This method has been performed five times on three different intensive treatment units from December 2020 to February 2021 and has served thirty six different patients. Each group included five to nine patients and was of mixed racial and gender identities. The following section briefly outlines this method.

General Group Method Curriculum

The proposed intervention is entitled "Making Room" and is described as follows: The intended length is 45 minutes. The intended population is adults with mental health conditions receiving inpatient treatment. Each group includes two to 15 members within an inpatient psychiatric unit. The materials used were watercolor paper (8-by-11 and 8-by-5.5 inches), watercolor paints and colored pencils. The goal is to address the topic of containment in life and during hospitalization through expressive arts based group therapy that is itself containing.

The intervention begins with a five to ten minute check in. Group participants introduce themselves to the group by name and answer the question: what is something that you need in your personal space? From here, participants are instructed to create an image of their ideal space or something attributed to it. This can be representational, abstract, or even words-based. Patients who need more concrete instruction may be asked to paint “a place they feel safe”. Patients work with watercolor paints and watercolor pencils. This medium was chosen because it gives patients agency over how they want to work (in a more, or less structured way). Patients are also given the option of using large or small paper to work with (8-by-11 and 8-by-5.5 inches), Quiet, instrumental music is played in the background, as this often helps patients to feel safe, contained and audibly quiet while working.

After 25 to 30 minutes, the concluding portion of the method begins with processing, as participants are encouraged to share and discuss their work as well as the importance of personal space, of being able to hold intense emotions inside and have agency over what they allow in from the outside. Moving forward, patients are prompted to discuss how they can make their current space (the hospital) more comfortable and containing.

Essentially, this intervention aims to test the work of Shore and Rush (2019) through the lens of containment. The use of watercolor and calming music (with the option of using colored pencils) helps to make the intervention less stimulating and more calming. The creation of an image that reflects something belonging solely to the participant and reflecting their personal space helps to encourage individual agency and gain a sense of control. The topic of containment and discussion focused on boundaries helps to explore group cohesion and the continuum of the group relationship. And finally, the format of discussion, art-making, discussion (check in

question, directive, and processing) helps to establish reality orientation and containment in itself.

Results

As mentioned previously, this method has been used five times on three different intensive treatment units and has reached thirty six different patients. The following paragraphs aims to display some of the general information gathered from these groups and discuss the content of patients work, their overall affect, and how this relates to the topic of containment. This group can be separated into three parts: the check in, the directive, and the processing. The following paragraphs will walk through the group as it occurs in these stages, noting what occurred throughout the separate groups.

Ethical Notes

Before exploring the application of this method, it is important to note that all information regarding patient identity and work must be kept specifically vague, and for this reason, certain specifics (such as names, specific cultural identities and notable direct quotes) have been avoided.

Check In: What Do Patients Need in Their Space?

To begin understanding patient reactions to the group, its interesting to examine their answers to the check in question “what is something you need in your space”. Among the most common answers were, organization/structure/cleanliness (six patients), quiet (four patients), pets/animals (four patients) privacy/alone time (three patients), family and friends (three patients) and the outdoors (two patients). Other answers included “healthy stress”, “sense of humor”, “no chaotic or manic people” , and “safety”.

Perhaps the most glaring piece of information that emerged from these answers is the

contradiction to the nature of a psychiatric unit. The spaces patients need to feel comfortable are organized, quiet and private, but the hospitals where they seek care (as we've previously established) are often quite the opposite.

Another important aspect of this check in is acknowledging that space is going to be different for different people. In the same group that someone mentioned needed quiet, another patient mentioned needing loud music. One patient may stress the need to be alone, others to be around friends or family. This leads to discussion during check in around how different people need different spaces and different coping skills.

Directive

After the check in, the group is moved into the art-making directive. Patients are told that the following art making exercise is to explore their personal space. I often tell them that this can be done in way that is concrete (creating an image of a real or imagined place), or abstract (using color, shape, and texture to convey an emotion of the imagined environment). I offer patients watercolor paints, watercolor pencils and watercolor paper of different sizes. The reasoning behind this choice of medium is that it gives patients personal agency into how to explore their inner space. Furthermore, the flowing nature of watercolor paint can be seen as a practice for tolerating disorganization, within the confines of a piece of paper.

Across the five different groups, the directive portion of the method generally creates a quiet, focused environment. Even on units with more disorganized patients, once the group is settled into the directive, what generally follows is ten to fifteen minutes of silence while patients work. Often, I will create work alongside patients to perpetuate the communal nature of the group (this work is explored in the personal artistic inquiry section).

With this being said, there were some cases when patients may not be so focused during

the directive stage. In one group, a patient who had been dysregulated for several days asked to leave the group to take a scheduled phone call. Given that this was time sensitive, it was necessary that I break the containment of the group to allow her to do so. After this patient left, several other group members made it clear that they did not want me to let her back in. They said she had been disruptive on the unit and would disrupt the calm of the group. I was clear with these patients, saying “I will let her in when she comes back, but if she is at all disruptive, I will do what is needed to keep our group together”. When the patient came back, she was immediately disruptive. As soon as I opened the door she said, angrily “I want to talk to you about something”, to which I replied, “I’d love to talk after group, however, if you want to be here, I have to ask you to be silent like the rest of the members while they’re working”. Almost to my surprise, this patient obliged. Though she needed some slight redirection throughout the rest of the group, by the time we moved into processing, the group members who had been frustrated with her were now supporting her. I bring this lengthy anecdote in because it illustrates something important about directive portion of this method. Even when challenged with disruption, with the exact type of dysregulation this group is meant to prevent, the group sense of containment stayed strong. The boundaries I placed on this specific patient not only maintained containment but helped it to grow in the form of peer support. This leads into the processing portion of this method.

Processing and Group Conclusion

When patients begin finishing their work, the group is opened up for sharing. Patients are offered to share their work, or just any thoughts that came up for them. Generally, patients are comfortable sharing and discussing their work and there are several themes that reoccur at this point across the different groups.

Regarding the content of the patient's art-work it was not possible to record this for all patients, as some were not comfortable sharing their work, or shared it very briefly. However, there are some general points that can be made about the content of the work created in group. Patients often created images of the outdoors, with several patients' painting images of beaches, mountains, and trees. Some patients mentioned that this created a sense of calm and freedom that they felt unable to achieve while hospitalized. Several patients also created images of their own homes or bedrooms (comfortable, familiar places). Interestingly, some patients created images representing activities that they enjoy doing (mainly, sports or creative endeavors). What is interesting about this reoccurring content is that it stands directly opposing the patient's current reality of being hospitalized. Instead, patients wanted to be free open spaces, familiar spaces or doing calming, leisurely activities. When this contrast was noticed, I would often ask patients, "is there a way to bring that sense of personal space here? How can we achieve that?". Here patients typically said that, though they may not be able to change the overall environment of the unit, they can change the things they do there. By coming to groups, partaking in familiar leisure activities (i.e., watching television or reading) patients could create a temporary personal space while being hospitalized.

Another reoccurring theme in patients work was the idea of healthy distance, this was most clearly represented by images that were created of an island, and a distant mountain and the group discussion that arose from them. One patient, a young white man, created an image of an island, but in the far corner was the mainland. He explained that he wanted to be able to get away from his struggles and stressors but acknowledged that he didn't want to cut them off, he wanted to be able to return and find grounding in them. Other patients in this group amplified this metaphor, saying that privacy can be like being on a boat, its relaxing to get away, but when you

look around and realize you surrounded by water without land to center you, its frightening. A patient in another group (a young Latina woman) brought up a similar theme, she created an image of her and her cats living in a distant mountain, away from society. The patient joked however, “there would still be a convenience store and a hospital around or something though”. Though simple, these anecdotes provide telling information when understood as a metaphor for mental health treatment or hospitalization. When patients get help, they may feel like a boat surrounded by ocean, an island that’s too far from shore or a valley that’s miles from civilization. They are literally entering a foreign environment. This distance from their everyday lives cannot be sanative unless they are able to see the shore, unless they are able to provide a sense of safety, reference, and containment for themselves.

Issues with Gathered Information

It must be noted that the observations gathered here is far from exhaustive, however, these anecdotes are telling. The results of this method show us what individuals need in their personal space and how this effects their mental health progress. Furthermore, these stories tell us what it’s like to create a personal space with patients and then work within it. The specific cases explored show that, when patients work in a contained environment where their needs are brought to the forefront, they can be resilient in the face of trouble on the unit. Furthermore, the structure and boundaries of these groups, one could argue, are part of what keeps patients from becoming a source of distraction for their peers and creating a hostile or even dangerous environment.

Personal Artistic Inquiry

For confidentiality purposes, the artwork created by patients cannot be shared, however, work that the writer created in process with patients can be. The following images are ones I

created while facilitating this group during our engaged work period, and they can provide examples as to what comes out of this exercise for those participating. The first image (Figure 1.) depicts yellow bike locked to a fence outside of a brown home on a sunny day. This image references the outside of my own living space. Looking back on the image, it brings back memories of repairing my bike in the back yard on warm summer days.

Figure 1.

Personal Artistic Inquiry: That Summer Feeling



Furthermore, the lock (located on the top bar of the bike) is an interesting detail that I included. It seems to me, to represent agency over one's safety. Symbolically, the lock has the ability to protect oneself, to keep oneself held tightly to ones' home.

Personally, I felt as though creating this image helped to put me in a calm, centered space in myself that I would carry throughout the day. I felt as though I had a little bit of home with me

wherever I went throughout my day at the hospital. I hope that this group created similar thoughts and feelings for the patients who participated

Figure 2.

Personal Artistic Inquiry: Natural Borders



The second piece (Figure 2) was also created during group and is a pen and paper sketch of the worktable I was sitting at with patients. This image displays an organized work-space, where patients have created their own sections to work in with the boundaries of their papers and palettes. To me, this image is like a snapshot of a story. It shows a moment of pause within a time of movement. It shows a calm, open space that has room to breathe. In many ways, it feels like the contained, yet free space, that patients seem to want in the therapeutic setting. This image portrays a communal space that is subtly divided through the placement of materials. Patients have the ability to find their own space or be part of the community at large. This is, in many ways, the goal of this group. To give patients the opportunity to create their own space within that of the community, where they can engage or disengaged with others at their comfort

level. Creating this work did not have such a lasting effect as Figure 1, but it's an interesting document of this group to be reflected on and a good example of what leading this group looks like from the perspective of the facilitator.

Discussion

The use of this method onsite with patients has yielded several interesting pieces of information. Mainly, it shows that what patients want in a space is largely consistent with the theory of containment. Patients want organization, quiet, and room to work. However, not all patients feel the same way. To create a therapeutic group space requires communication and compromise, skills that are already important to learn during psychiatric hospitalization ahead of discharge.

Furthermore, this method can serve as a tool for providing containment (not just presenting it as an idea) and this has also yielded several interesting outcomes. These are best understood through the provided anecdotes. Essentially, what was observed was that when patients were provided with a contained, structured directive tailored to their wants and needs, they were better able to self-regulate and follow group protocol. Within these boundaries however, patients had the opportunity to make their own choices and practice distress tolerance (through their ability to pick materials, watercolor paints or pencils, and the size of their paper).

Even when this group space was broken (which is an inevitable situation on psychiatric units) the group was able to reform and work together to create a space that worked for everyone. Bringing containment focused work into psychiatric hospitals creates a communal discussion on how patients relate to one another and affect one another. Patients learn what they need in an environment to feel contained, and what they can do to bring this to life on the unit.

Future research could take these ideas much further. If researchers were able to record

what a psychiatric unit was like before and after containment focused group work, they may be able to see differences in the community climate. On this small scale however, one can see the work of self-regulation and containment in real time.

Conclusion

Psychiatric patients are already facing substantial stress and trauma, they would not be hospitalized if they were not. The process of hospitalization can itself be distressing and traumatizing for anyone, causing disorientation, discomfort, and anxiety. It does not require much imagining to understand that a building filled with people who may be in crisis, experiencing psychosis, or simply struggling with chronic mental health problems, can quickly become an extremely uncomfortable environment.

The work of inpatient clinicians then is not only to provide therapy, but to ensure safety in a way that respects the dignity, humanity, and agency of patients. There is not a simple way to achieve this. However, one promising concept is that of therapeutic containment. Containment gives patients the opportunity to understand how they are affected by the behavior of others and how their behavior affects others. Containment offers patients a better understanding of what it is that they need to get better, what they as individuals require for fruitful care. Problems that could lead to violence on a unit are inevitable, but the process of building containment in a group helps patients to build resiliency in the face of these situations. In many ways, containment can even transform the fear and discomfort of the psychiatric unit into a learning experience and an opportunity for growth. It shows patients that, even when threatened with deep rooted problems of others, they have the agency to establish their own boundaries, stay safe and make room for themselves wherever they go.

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***THESIS APPROVAL
FORM***

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

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