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Creating Order Out of Chaos: A Method of Cognitive Behavioral Art Therapy for

Psychosis (CBATp)

Capstone Thesis

Lesley University

May 5th 2022

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Art Therapy

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Abstract

Psychosis is a mental health condition in which an individual loses touch with reality. Therefore, it is often considered difficult to study and treat and highly stigmatized. Left untreated, psychosis can have devastating and debilitating effects on the individual and their loved ones. The integration of cognitive behavioral therapy (CBT) and art therapy (AT) as cognitive behavioral art therapy (CBAT) may yield greater benefits to individuals with psychosis than either treatment method administered alone. Using a combined approach of AT and CBT may aid delivery of therapy, reinforce skill retention and feelings of mastery, and facilitate social interactions. This capstone thesis aims to address the preliminary question of whether CBAT can be an effective adjunctive treatment for psychosis (CBATp). A method of CBATp with two directives was developed and implemented at a Boston-area psychotic-specific inpatient unit. Thematic analysis of the author's process notes and art-based reflections resulted in themes which explored the content and process from the perspective of group participants and facilitator. Results indicated for participants that making sense of their chaotic inner world through art generally appeared to allow for learning, affect regulation, comprehension of psychoeducational concepts by creating and exploring imagery and metaphor, and resulted in rich discussions. Underscoring this CBATp approach was therapist flexibility and ability to validate the thought and creative processes of individuals with psychosis. Clinicians are encouraged to consider the potential use of integrative psychotherapeutic and expressive treatments for psychosis. Implications for future research and recommendations are indicated.

Keywords: art therapy, cognitive behavioral therapy, cbt, psychosis, psychotic disorders

Author Identity Statement: This author identifies as a white woman from New England with mixed European ancestry

Creating Order Out of Chaos: A Method of Cognitive Behavioral Art Therapy for Psychosis

(CBATp)

Introduction

Control over chaos through art-making is a step towards behavioral self-control.

—Marcia Rosal, 2018, p. 12

On the first day of my clinical internship, I walked onto the locked adult inpatient unit under the psychotic disorders division expecting to see a scene out of a movie with people screaming, muttering to themselves, and utter chaos. What I saw and have come to know is a very different place— one with caring staff and with patients who are just human beings struggling with severe mental illnesses. Individuals experiencing psychosis are often viewed as dangerous and difficult to work with, although the fifth edition of the American Psychiatric Association's [APA] *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5] (2013) notes that "the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population (p. 101), yet still the stigma remains, even within the mental health profession itself.

Psychosis affects upwards of 1% of the population, with approximately three in 100 people in the United States experiencing an episode at some point of their lives (Kingdon & Turkington, 2019). Psychotic disorders and schizophrenia spectrum disorders include schizophrenia, schizoaffective disorder, and other psychotic disorders, such as brief psychotic disorder. "Individuals with a diagnosis of depression or bipolar affective disorder may also experience psychotic states" (Lynch, 2017, p. 12). For my thesis and to this end, I will include those with diagnoses of schizophrenia spectrum disorders, schizoaffective disorder, and other

disorders with psychotic features, such as bipolar affective disorder (BPAD) and major depressive disorder (MDD) with psychotic features. It is important to note that there are very varied presentations within this population and that each individual presents with their own unique symptomology and history.

Left untreated, psychosis can have devastating and debilitating effects on the individual and their loved ones. These effects can impact all domains of functioning. The current frontline treatments for psychotic disorders often rely primarily on psychiatric medications and other medical interventions, such as electroconvulsive therapy (ECT). While medication can be extremely helpful in treating psychotic disorders, there are some individuals for whom medications and medical treatments have limited effect. Additionally, these treatments do not fully address the underlying and re-enforcing factors, such as perpetuating beliefs and maladaptive behavioral coping mechanisms, and negative symptoms may not be treated by medication. Also, because medication adherence is often an issue (Lecomte et al., 2008), this neglect and disregard for other aspects of the illness perpetuates the high rate of relapse.

There are other psychological therapies, such as cognitive behavioral therapy (CBT) and art therapy (AT) that can serve to support these medication-resistant cases and other individuals with psychotic disorders to recognize their symptoms, problematic thought and behavior patterns, to understand how they interact with the world and reality, build self-awareness and self-esteem, and to creatively navigate through the world. The literature review will examine the practice of CBT and AT as they relate to the treatment of psychosis and, ultimately, how these therapies, administered in a combined form, can potentially better serve individuals experiencing psychosis than either method administered alone.

A method was developed to explore how the combined approach of CBT for psychosis (CBTp) and AT for psychosis (ATp) can be adapted and implemented for psychotic populations. It is my hope that the fusion of CBTp and ATp into cognitive behavioral art therapy for psychosis (CBATp) will allow the therapeutic process to become more engaging and successful in reducing distress associated with psychotic symptoms in primary psychotic and related disorders, as well as provide avenues for self-awareness, meaning-making, problem-solving, and social engagement— a way to create order out of the chaos. Ideally, this arts-based research process will allow me to determine the preliminary effectiveness of the interventions proposed and suggest valuable information for future research regarding this nascent hybrid approach.

It is my fervent hope that this capstone thesis project will contribute to the field knowledge of the treatment of psychosis as a holistic, dynamic, and integrative approach in response to the nature of psychosis and the shift towards mindful and expressive approaches to treatment, in addition to evidenced-based approaches, as a way for clients to reflect on and create meaning out of their lived experiences of psychosis, as well as to organize and break down patterns of behaviors, thoughts, and responses to psychotic stimuli. Lastly, it is also my aspiration that this capstone thesis will humanize the individuals behind psychotic disorders and decreases the stigma associated with psychosis.

Literature Review

Defining Psychosis

Psychosis is a mental health condition in which an individual loses touch with reality. It is a term used to describe a state in which a person perceives and interprets the world differently than other people. According to the DSM-5, key features that define psychotic disorders are delusions, hallucinations, disorganized thinking, speech, and motor behaviors, and negative

symptoms (APA, 2017, p. 87). Delusions are "fixed beliefs" and hallucinations are "perception-like experiences that occur without an external stimulus" (p. 87). Delusions may be persecutory, grandiose, somatic, etc. in nature. Auditory hallucinations (usually experienced as hearing voices) and visual hallucinations are the most common forms. These are described as positive symptoms because they are identified by their addition or presence, while negative symptoms, such as social withdrawal, low motivation and energy, and blunted or flat affect, in effect take away from the individual and their quality of life.

Typically, these symptoms can manifest as disorganized speech that can be tangential, circumstantial and/or expansive, with loose associations and flights of ideas. This disorganization can also manifest by affecting activities of daily living, including hygiene and sleep. It may also appear that the person is preoccupied with internal stimuli and distracted, anxious and/or paranoid. It is this combination of negative and positive symptoms, coupled with chronicity and the complexity of clinical and neurological presentations, that make psychotic disorders oftentimes difficult to study and treat. Furthermore, ambivalence to treatment, poor insight, and medication and treatment non-adherence are often sizeable concerns for those with psychosis, especially in early psychosis (Lecomte et al., 2008). Because of these factors, often compounded by substance misuse (Jablensky et al., 2000, p. 226) and stigmatization, psychosis is under-researched, and these individuals can be underserved and forgotten. Psychosis can have sizeable devastating and debilitating effects for the individual and their loved ones. However, we must not equate a disconnect with reality with a disconnect from humanity.

Treatments for Psychosis

Focusing on treating the distress experienced in response to symptoms and recognizing small improvements in mental status and activities of daily living can help clinicians to humanize

psychosis and prevent compassion fatigue. There are many psychological treatments that can be used together with medical interventions and medications for the treatment of psychosis. For the purposes of this thesis, this author will focus on cognitive behavioral therapy (CBT) and art therapy (AT) as they relate to the treatment of psychosis.

Cognitive Behavioral Therapy for Psychosis

Beck, an American psychiatrist, developed CBT for psychosis (CBTp) and this approach was first implemented in the 1950s. CBTp is an evidence-based treatment approach shown to improve symptoms and functioning and reduce length of hospital stay in patients with psychotic disorders (Landa, 2017, p. 4; Turkington et al., 2004; Moritz et al., 2014; Wykes et al., 2008). CBTp allows individuals to break down and reframe or challenge their psychotic experiences and develop coping strategies to manage symptoms and associated anxiety (Health Quality Ontario, 2018). This treatment approach is viewed as an effective adjunctive treatment by both the APA and the National Institute for Health and Care Excellence (NICE) in the United Kingdom. Regarding the efficacy of CBTp, studies have indicated a reduction in distress related to psychotic symptoms when CBTp is employed as a complement to medications, and numerous meta-analyses and studies have confirmed that group CBT is effective for psychosis (Wykes et al., 2008, Lecomte et al., 2012).

This form of CBT emphasizes the collaboration of client and therapist as a foundational component of treatment. "The importance of a trusting therapeutic relationship" (Messari & Hallum, 2003, p.183) was highlighted as a central factor affecting the individual's perception of CBTp as helpful and related to treatment outcomes. According to Jung et al. (2014), "perceived therapist genuineness is the most relevant predictor of patient-related therapeutic alliance in CBTp (p. 34). When there is a tenuous therapeutic alliance, clients are much more likely to

passively comply with treatment, especially at the inpatient level of care in order to facilitate discharge (Messari & Hallum, 2003, p. 176). Once rapport has been established, "clients who receive CBT-P consistently report high levels of satisfaction with this approach" (Sivec & Montesano, 2012, p. 267).

One of the foundational tenets of CBT (and CBTp) is that thoughts, feelings, and behaviors are linked. This is often referred to as the CBT triangle. Hinging upon this concept is the notion that unhelpful thinking styles, or cognitive distortions, can directly affect how we think, feel, and ultimately behave. Becoming aware of these biased perceptions and ways of thinking is the first step in changing unhelpful thinking patterns, which can ultimately lead to "changes in feelings and behavior" (Psychology Tools, 2022, p. 2). Some examples of common cognitive distortions are all-or-nothing thinking, disqualifying the positive, and magnification and minimization. While everyone experiences cognitive distortions to some degree, if they occur frequently, as often in the case of psychosis, it can cause great stress and impact functioning. This initial normalization when educating a client with a psychotic spectrum disorder about cognitive distortions can build the therapeutic relationship and decrease internalized stigma and shame.

Many interventions under the CBT umbrella aim to identify distress associated with symptoms and then address how to cope with this resultant distress. "CBTp interventions have been developed that aim at reducing distress associated with psychotic symptoms" (Lincoln et al., 2012, p. 674) According to Sivec and Montesano (2012), the shared goals of CBTp are "establishing a strong therapeutic alliance, education about the illness, cognitive and behavioral strategies for reducing stress directly related to hallucinations and delusions, suggesting reality testing experiments, and reducing relapse" (p. 263). Because of these shared goals and the

strategies suggested to accomplish these, such as normalizing and teaching coping skills, the CBTp therapist must be creative and able to cope with uncertainty, as well as validate the client's concerns and utilize Socratic questioning in order to "understand their world as they experience it" (Sivec & Montesano, 2012, p. 264, 265). Lastly, since CBTp is collaborative and "CBTp emphasizes the importance of the client arriving at their own conclusions about beliefs and perceptions" (Sivec & Montesano, 2012, p. 265), this therapeutic approach can empower clients and foster self-esteem.

Critiques of CBTp

There are many studies which present heterogenous and mixed findings regarding the efficacy of CBTp as compared to treatment as usual (TAU). In a practice review examining seven meta-analyses that used CBTp for individuals with schizophrenia, CBTp "demonstrated a modest, but significant positive impact (average effect around .35-.40) in controlled studies" on positive symptoms, but when compared with "an active therapy control, the benefits of CBTp are limited" (Sivec & Montesano, 2012, p. 266). However, other studies assert that CBTp incurs mixed results and has been "oversold" (McKenna & Kingdon, 2014). A systematic review by Jauhar et al. (2014) suggested that CBTp has a small therapeutic effect on symptoms, but Jones et al. (2012) posited there was no evidence that CBT was superior to other psychological treatments for schizophrenia and psychosis.

In addition to quantitative mixed findings, there are qualitative indications that some aspects of CBTp need to be critically appraised moving forward as a field. A critique of CBTp in a qualitative study by Messari and Hallum (2003) cited that most inpatients viewed CBT as "compliance with the powerful medical establishment" (p. 176). Therefore, it may be that

patients passively attend CBT groups in order to facilitate a quicker discharge and are not actually engaged with the material and concepts.

Art Therapy

Art therapy (AT) is a unique expressive therapy modality that utilizes art and creative expression to give voice to matters that may be difficult to articulate. Art therapy was developed in the 1940s by Naumberg, who is largely considered the "mother of art therapy," and several other foundational figures, such as Kramer, but the healing and expressive power of art can be observed throughout history. "The arts have played a crucial role in human history and in consciousness" (Junge & Levick, 2010, p. 5). According to the American Art Therapy Association, "Art therapy is used to improve cognitive and sensorimotor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change" (American Art Therapy Association, 2022, paragraph 2).

While CBT is a talking treatment, AT allows individuals to utilize art-making to foster creative expression and communication. "People think in words *and* in images" (Rosal, 2016, p. 72). As a means of nonverbal expression, exploration, and problem-solving, AT allows people to find different ways of making sense of themselves, other people, and their reality. This is especially important with psychosis when reality may seem like chaos. Furthermore, "using art therapy to uncover coping strategies might be as simple as engaging a client in art-making itself" (p. 73). Art in itself can be therapeutic and soothing and a less threatening way to engage socially with a therapist and/or peers.

A tenet of AT conceptualizes the art therapist as artist, teacher, and therapist. Kramer, a foundational figure in art therapy, coined and conceptualized the art therapist's 'third hand' as

utilizing this tri-part combination together with empathy to more directly assist clients in realizing and communicating their experiences through art (1986). Speaking to Kramer's concept of the 'third hand', Consoli (1992) posited that "the art therapist's involvement weaves together the artist, the teacher, and the empathetic clinician into a healing fabric that is subtle but potentially potent therapeutically" (p. 163). Using this more hands-on and involved approach for AT is especially imperative with those who may struggle to communicate with art, such as elderly adults with memory impairments, those with severe mental illnesses, children, and developmentally disabled individuals.

Art Therapy for Psychosis

Art therapy (AT) is recommended as an effective treatment for psychosis by the National Institute for Health and Care Excellence (NICE) in the United Kingdom. However, it has not been widely implemented in the United States as a commonly employed treatment modality. NICE guidelines endorse group art therapy for psychosis with goals of "enabling people with psychosis or schizophrenia to experience themselves differently and to develop new ways of relating to others, [helping] people to express themselves and organize their experience, and [helping] people to accept and understand feelings" (2014, section 1.4.4.3-1.4.4.4), which are all crucial elements of recovery.

Critiques of ATp

Art therapy is not currently widely implemented as a treatment for psychosis in the US due in part to the lack of quantitative substantiating data. The MATISSE study (Multi-centre study of Art Therapy In Schizophrenia – Systematic Evaluation) (Crawford et al., 2010; Crawford et al., 2012) was the first large scale pragmatic randomized controlled trial of AT for schizophrenia in the UK. Using a three-arm, parallel group design, participants were referred to

either AT plus standard care, an activity group plus standard care, or standard care alone. The results of the MATISSE trial indicated that there were no statistically significant improvements in global functioning or reduction of symptoms for the AT plus standard care group as compared to the other groups (Crawford et al. 2012).

Efficacy of ATp Through Qualitative Data

Although the quantitative results of the seminal MATISSE study suggest that their program of art therapy did not improve global functioning, mental health, or other outcomes (Crawford et al., 2010; Crawford et al., 2012), Holttum and Huet (2012) argue otherwise in their critique, stating that the trial "appeared to have weak conceptualization of the mechanisms for change, lack of piloting, incomplete process and subgroup analyses, and inappropriate assumptions about the generalizability of findings" (from abstract). Since clinical presentations of psychosis are so varied and art is inherently difficult to quantify, the results of ATp are often best captured in qualitative studies. Art therapy, while effective, is not often implemented currently in the field in the US due to the lack of empirical data indicating its efficacy for the treatment of psychosis, although many "high quality qualitative articles indicated that therapists and clients considered art therapy to be a beneficial, meaningful, and acceptable intervention" (Attard & Larkin, 2016, from abstract).

In a recent study in which Lynch et al. (2018) explored the effects of AT after a first psychotic episode, AT provided an "unpressured atmosphere" (Lynch et al., 2018, p. 9) that "enabled participants to engage in and express themselves…, connect with others, experience absorption, a sense of freedom, and reflect on their experiences and themselves differently" (p. 9). Art therapy and art-making seemed to "open up a plurality of perspectives and contribute to therapeutic change" (p. 8). In this study, AT was seen to be more helpful to clients who were not

in active psychosis and were medicated. Thus, it may be hypothesized that integrating AT with CBT may make it a more effective, accessible, and engaging adjunctive treatment for clients with psychotic disorders, but willingness, timing, and appropriate medication are important factors (Lynch et al., 2018; Messari & Hallum, 2003).

Resistance to Integration – Third-Wave CBT

Many art therapists have expressed resistance to incorporating CBT into their practice, possibly viewing it as too structured, abstract, or a cookie-cutter approach. In response to this, an understanding of third wave CBT can encourage a flexibility within CBT and challenge these notions. According to Rosal (2018), "the integration of Buddhist psychology, mindfulness, and meditative practices into CBT practice is referred to as the third wave" of CBT. A fundamental aspect of CBT is that it is adaptable owing to its evidenced-based nature (p. 162). Thus, the third wave of CBT was born in the 1990s in response to relapses observed over time after the cessation of traditional CBT. Meditative and mindfulness practices were incorporated to address relapses in populations that are difficult to treat or prone to relapse, both of which pertain to psychosis. Dialectical Behavioral Therapy (DBT), developed by Linehan, is an example of a CBT variant which is under the third-wave CBT umbrella. The evolution of CBT allows it to be more flexible and adjust to what the research shows to be effective (p. 144). Montesano et al. (2014) determined that the use of a "framework that is grounded in the literature, yet flexible, eases the process of implementation" (p. 11) for CBTp. Consequently, this evolution makes the theoretical integration of CBT and AT more compatible.

Furthermore, Morris (2014) examined if art should be integrated into CBT for anxiety disorders, positing that because CBT may "be difficult for some clients cognitively and verbally" (Morris, 2014, p. 1) since it requires abstract thinking, "integrating art into CBT could provide a

concrete foundation to the more abstract tasks of CBT and offer visual and tactile routes to learning and expression" (p. 1). Since "CBTp interventions have been developed that aim at reducing distress associated with psychotic symptoms" (Lincoln et al., 2012, p. 674) and the combined approach of AT and CBT appears to be effective with populations experiencing panic and anxiety (Morris, 2014), it can be posited that a combined approach of CBTp and ATp (CBATp) is worth investigating.

Theoretical Foundations and Processes of CBT and AT

Before moving forward to examine how cognitive behavioral art therapy (CBAT) can be adapted to psychotic populations, it is helpful to look at the theoretical foundations and therapeutic processes of CBT and AT. The theoretical foundations of CBT and AT have some overlap in recent decades, but they arose from different schools of thought. CBT first arose from behaviorism and stoicism, in that interventions were developed "to help clients find a less reactive and more adaptive and rational course of action when dysfunctional behaviors manifested" (Rosal, 2018, p. 2). It was thought that maladaptive behaviors were "learned and maintained by the environment" (p. 2). With the advent of social learning theory, CBT incorporated the idea that one's cognitions or thoughts determine behavior rather than the environment, lending to more autonomy and personal responsibility. Thus, CBT can be considered a top-down approach, with focus on the behaviors first and then towards deeper understanding of the mechanisms behind those behaviors through awareness and introspection. Top-down approaches hinge on thinking, logic, and reasoning to create cognitive distance and the ability to identify behavioral patterns and the thoughts and feelings behind them in order to break habitual maladaptive behaviors and beliefs.

On the other hand, art therapy arose from the psychodynamic tradition. With Freud's fascination with dreams and the unconscious, and Jung's emphasis on symbols and archetypes, it is understandable that AT followed suit as a means to delve into the unconscious through projective imagery. "Through visual imagery which can sidetrack defenses and "reality" by tapping directly into the unconscious, the art therapist effectively gains a visual portrait of the client's thoughts, feelings, and memories in the here-and-now and so does the client" (Junge & Levick, 2010, p. 10). AT also emerged as a means of expression and utilization of the creative experience of art as therapeutic in itself. AT has since evolved to embrace various other theoretical orientations, such as humanistic, Rogerian, and Gestalt.

Art therapy is often considered a bottom-up approach to therapy. Bottom-up approaches engage reptilian and mammalian areas of the brain (such as the brainstem and limbic system) in order to address deeper implicit memories and stress-related arousal as it relates to the body (Elbrecht, 2020). Since CBT relies on the functioning of the neo-cortex and logical reasoning as a foundation, it can be more difficult for those experiencing psychosis to benefit from top-down approaches. "The incorporation of art-making into CBT increases the probability that finding the significance of life events will be possible" (Rosal, 2018, p. 6) Therefore, it may be hypothesized CBT and AT working simultaneously can provide deeper ways of personal meaning, understanding, and change by allowing those in psychosis a means to access the valuable information of CBT through a tactile and visual bottom-up approach.

Theoretical Considerations in the Treatment of Psychosis

While there are many theoretical perspectives and considerations in the treatment of psychosis, one versatile model that humanizes psychosis and psychotic symptoms is the stress-vulnerability model. "The difference between non-distressing and distressing experiences lies not

in the occurrence or even the uncontrollability of these experiences but rather in the interpretation by the person of the experience" (Dudley & Turkington, 2010, p. 78). Dudley and Turkington (2010) also noted that, "drawing on the cognitive model we regard the distress arising from the experience as normal and understandable" (p. 77). Thus, through normalization processes and by acknowledging the distress as valid in response to internal stimuli, the clinician can better validate the humanity of the individual and combat their own compassion fatigue.

Cognitive Behavioral Art Therapy for Psychosis

Cognitive behavioral art therapy (CBAT) integrates CBT and AT. It has only been practiced for a little more than 25 years, so the field is still in its infancy, but holds great promise. "Reducing stress and helping clients identify and employ new coping strategies is a major goal of CBAT" (Rosal, 2016, p. 73). Rosal also asserted in her book *Cognitive Behavioral Art Therapy* (2018) that "often clients have a fixed perspective on an issue or concern. Altering an ingrained point of view can be the impetus for increasing flexibility in their thinking" (p. 9). This therapeutic work is especially important for clients experiencing psychosis because rigid or fixed thinking is a hallmark of delusions and also can appear when people have auditory and visual hallucinations.

Since "meaning-making is a key component of CBAT" (Rosal, 2018, p. 6), this author believes it can be especially effective for the treatment of psychosis because it directly addresses increasing cognitive flexibility and problem-solving, understanding thoughts and perceived reality as precursors to behavior, and relieving stress and distress associated with internal stimuli. In essence, meaning-making through creating art with CBT underpinnings may effectively create order from the chaos for those experiencing psychosis.

Method

This method was developed to address how CBT and AT can be integrated as an approach for the treatment of psychosis. Because of the special considerations explored in the literature review above, psychosis is often difficult to treat with current available treatments and practices. CBTp and ATp are approaches currently utilized in the field, yet there are barriers which make each approach less effective and/or difficult to implement. The goals of this developed method of CBATp were to examine if this new approach can better serve those experiencing psychosis by allowing for exploration of CBT material in a creative, visual way that engages the client more effectively to create awareness and meaning-making through art.

For the method, this author developed two group CBATp directives, delivering each directive four different times. Since "the cognitive components of CBT for psychosis aim to teach people … to identify and monitor their thoughts and assumptions in specific situations and to evaluate and correct these thoughts and assumptions against objective external evidence and actual circumstances" (Health Quality Ontario, 2018, paragraph 24) and "the behavioural components of the therapy aim to increase coping skills and reduce problematic behaviours" (paragraph 24), one of the directives focused on cognitive distortions (the former) and the other directive focused on the behavioral side (the latter).

In a Group Setting

Studies show that utilizing the arts in a group format can create meaningful personal change for group participants by providing a means of combatting negative symptoms, isolation through group bonding, and stigma (Colbert et al., 2013; Williams et al., 2018). If the world is viewed as a scary, confusing, dangerous, and/or chaotic place, having the outlet of art-making in the context of group art therapy is even more imperative and can be used to strengthen social connections. It is recommended for CBTp to be administered in a group also because "the group

format also allows us to work on one of the most prevalence consequences of psychosis: social isolation" (Lecomte & Leclerc in Hagen et al. 2011, p. 152). Therefore, the directives were administered in a group therapy format to ease implementation, gather as much information as possible in a limited times frame, and foster social interactions and connections.

Directive 1 – The Gray Area

The first directive was entitled "The Gray Area" and focused on the common cognitive distortion All-or-Nothing thinking or Black and White thinking. After introducing the topic, this facilitator gave out a worksheet (derived from Tyrell & Elliot, 2015), found below in Appendix B, and discussed the concepts with the group while reading through the worksheet together. This author normalized black and white thinking and called on a different person to read each section of the worksheet, then breaking down the meaning of that section further.

After reading through the worksheet, I asked the group to name any thoughts or feelings they had related to the gray area and if they had any questions. Next, I invited the group to create art with the prompt "Draw the Gray Area. How does the Gray Area look or how does the Gray Area feel to you?" I provided white (8.5 x 11 in.) paper and various art materials, such as markers, colored pencils, and oil pastels. The clients created art for about 15 minutes with soft acoustic background music. Afterwards, the group was given time to share their art and discuss. The focus of this directive was to normalize cognitive distortions, open up different ways of perceiving reality, and build awareness of patterns of thinking.

Directive 2 – Calm Space Collage

In addition to art practice, meditation helps to mollify the ever-shifting tides of the thinking mind and the resulting affect that is often in need of regulation.

—Michael Franklin, 2010, p. 162

The second directive was entitled the "Calm Space Collage." This group directive began with a five minute guided safe space meditation (with script developed by this author provided in Appendix C). During two of these four groups, this author used a guided meditation played from a YouTube video (FamilyGuiding1, 2012) instead of reading the script, due to nasal congestion. This can be a viable option when reading from a script is unfeasible, or to ease facilitation. When the meditation concluded, this writer asked the group to share about their calm place and to name one or two of the colors in the calm place they had just imagined. I then provided the materials: assorted magazines, glue sticks, white paper (8 x 11.5 in.), and scissors.

If anyone looked confused or hesitated to begin, I prompted them to look through the magazines and try to find things that were the color(s) they had mentioned, colors that were calming, or anything that stood out to them. Soft acoustic music played in the background during the art-making. The group was given 15-20 minutes to create their collage and then around 15-20 minutes to share their art pieces and/or a description of it and the process of creating the art. The focus of this directive was to practice meditation and art-making as coping skills, to encourage social interactions, reduce anxiety and/or stress, and to create a visual reminder of a safe and calm place to help in breaking the cycle of maladaptive behavioral responses by providing affective regulation.

Tracking – Arts-Based Research

In order to track my progress and examine the information gathered, this author created art response pieces during and/or after the method to reflect on the process, group participants, and their responses to the method. In art-based research, the researcher is usually an artist who personally participates in the research process (Rolling, 2013). Kapitan (2010) explains in Chapter 7 of *Introduction to Art Therapy Research* that visual forms have the potential to

condense complex information, allowing for more effective communication to various audiences (p.161-181). Kapitan (2010) goes on to endorse reflective art-making by the researcher as a valuable means of information-gathering, analysis, and presentation of findings (p.161-181). Using a sketchbook as an art journal, I created art-based responses in images, collages, and poetry.

To track the content of the discussions following the art making, this author wrote brief notes during the group and reflected on the topics after the group ended, writing down quick notes about each piece created, the discussions related to each individual art piece, and any quotes that stood out. Reflection art pieces from the Gray Area directive were made at a later time but replicated the content created and concepts discussed during the group. For the Calm Space Collage directive, this author created collages during and after the groups in response to the content and the process as facilitator. This arts-based process allowed this author to develop the main themes of the interventions from both the point of view of the facilitator and reflect upon the content created by the group members and the follow-up discussions. For the Calm Space Collage directive, I also tracked the emotional states of the participants before and after the directive by asking "What is one word to describe your mood right now?" The mood tracking component was used to determine affect regulation subjective to the patient. For all directives, the group members' formal diagnoses were retrieved from their medical records to confirm they fit the diagnostic criteria for inclusion.

The Clinical Setting

The method was implemented at a locked inpatient unit under the psychotic disorders division at a psychiatric hospital in the Boston Area (Massachusetts, United States). The locked unit has 22 beds and the patient population is very diverse and dynamic. The author's role as a

graduate intern at the site was to facilitate psychoeducational, general psychotherapy, and art therapy groups. The directives were implemented during the usual time of the art therapy group. Attendance varied between groups and those who attended did so voluntarily, with most groups' attendance ranging from three to six patients.

Limitations, Biases, Ethics

This author recognizes several limitations, including that the group participants came to the art therapy group willingly and so already had a bias towards participation and enjoying the art-making process. Thus, it is important to recognize that the relative success of the interventions may be correlated with the timing of intervention and the readiness of the individual to engage in treatment. Additionally, this author has biases as a white, cis-gendered, privileged woman working within a powerful medical establishment. My goal was to include all who wished to be included in the interventions and make room for the empowerment of individuals while acknowledging the inherent power dynamics. Lastly, this writer conducted the interventions with ethical considerations, disclosing that the groups would be part of a masters thesis, only utilizing art created by this author, preserving anonymity, and respectfully considering the needs of individuals with psychosis when developing the group directives.

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Results

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Using a combined approach of AT and CBT in the treatment of psychosis may aid delivery of therapy, reinforce skill retention and feelings of mastery, and facilitate social interactions. The integration of CBT and AT may yield greater benefits to individuals with psychosis than either method administered alone. For both directives, the group discussion consisted of asking the group members to share anything about their art that they felt comfortable doing. Metaphors were expanded and explored relating to the either the Gray Area

or the Calm Space Collage by probing for more information about the image, asking about the

process of creating, and if any thoughts arose during that process. If patients became tangential

or expansive during their explanations, this author would listen intently and intervene at some

point in order to redirect the conversation back to the topic at hand. Therefore, due to the nature

of psychosis, it is important that the therapist implementing the directives be familiar with

facilitating group therapy and/or be trained in appropriate therapeutic responses to psychotic

symptoms.

In order to derive results from the interventions detailed in the methods section, this

author used art-based reflections to aid in the process of collecting and recalling important

information regarding the facilitation and reception of the two group directives. This process

allowed this author to derive themes from each intervention, which explore both the perspective

of the therapist regarding the facilitation of the directives and of the artwork created by the group

members and resultant discussion. The Gray Area themes focus on the content created and

discussed by the group members and the Calm Space Collage themes mainly focus on the

process of group facilitation. Patient-reported mood tracking for the Calm Space Collage will

also be included in the results. All artistic reflections herein were created by this author and

many contain very similar elements to the art created by the patients.

The Gray Area Themes

Polarity and the In-Between, Movement

Figure 1. *Crayon & Sharpie on paper*   Figure 2. *Colored pencil, Sharpie, & oil pastel on paper*
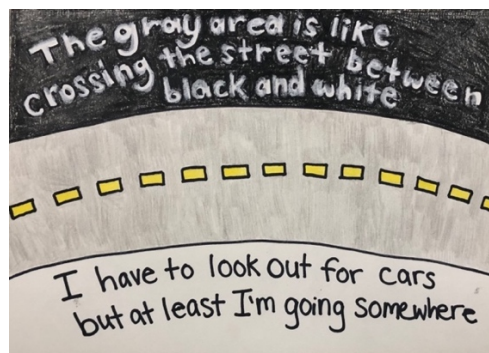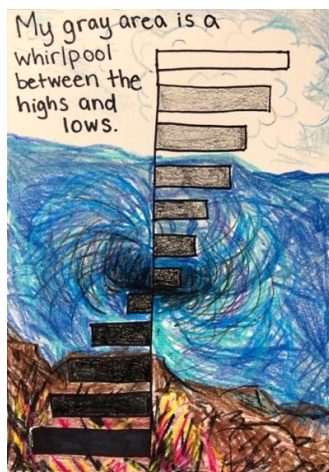
A theme which emerged in many of the patients' artistic representations of the Gray Area

highlighted the polarity between this or that, all or nothing, highs and lows. One patient

explained her idea of the Gray Area as being the 'between' part on a Venn Diagram (see

Appendix A). Another patient drew a series of colored horizontal bars ranging from black to

white, with short, sharp marks at the bottom, cloud-like shapes at the top, and a swirling mass in

the middle that he described as a whirlpool (Figure 1). We explored how the high highs can feel

like floating off into the clouds or off into space, and how intense and sharp the low lows can

feel. As a group, we also discussed the whirlpool in between as the Gray Area. Consequently, the

area between or the movement of going-between was another common theme that arose in both

the artwork and discussion. For example, one patient drew and spoke of his Gray Area as a

pendulum swinging between black and white thinking.

Another group participant, who initially stated he did not want to participate because he

was "really bad at art," drew a street between the black and white sides and spoke about the Gray

Area as crossing the street. With some further discussion, we established that the movement in

crossing the street was important because, although it may feel scary, we cannot get anywhere if

we are stuck on the sidewalk (the black and white thinking patterns). As a group, we further

explored the metaphor of the street, coming to the notion that when we cross the street, we need to look out for cars, but at least we are going somewhere (Figure 2).

Drowning or Spinning, The Uncomfortable, Feeling Trapped
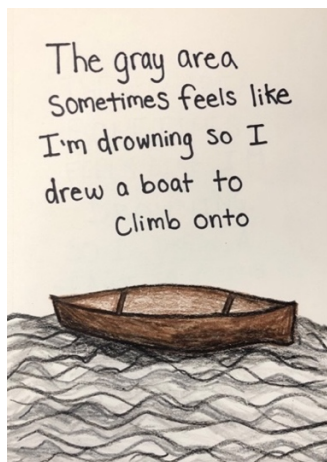
Figure 3. *Crayon & Sharpie on paper*   Figure 4. *Oil pastel on paper*

The gray area
Sometimes feels like
I'm drowning so I
drew a boat to
climb onto

Another major theme that came up was that the Gray Area can feel like drowning or spinning, being trapped, or very uncomfortable. One group member described her Gray Area as a deep dark hole and the group brainstormed how we could rescue her from the hole by letting down a rope to her or throwing down a flashlight, so she could find her footing to climb out. In another group, a patient drew wavy lines to depict waves and a boat shape, saying that the Gray Area felt like drowning to him, so he drew a boat to climb onto (Figure 3). The other group members really resonated with his description of the Gray Area feeling like drowning, so the group continued to speak about how that felt and how to survive the drowning or cope with the feelings of drowning. In the same group, another patient also had drawn the whirlpool image (Figure 1), so the group discussed the feeling of being in that whirlpool as similar to the feeling of drowning. In another group, one patient drew a drain to represent his Gray Area and described the feeling of spinning, but also a "coming together" (Figure 4). I encouraged him to think about how it might be to step back and observe the drain instead of spinning around it.

Shades and Complexities

Figure 5. *Crayon on paper*
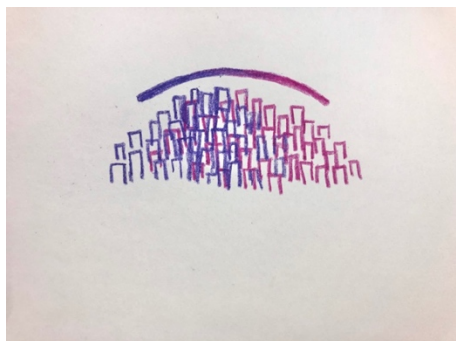
Another important theme that emerged was that the Gray Area has many different shades of gray. This notion can open up opportunities to see things differently or as more complex, but can induce ambiguity and anxiety. Two patients created grids or columns with many different overlapping shades of colors or a gradient between columns of colors. One patient created a city of upside-down square U-shapes in a shade of purple on one side and a shade of dark pink on the other side. The different colored buildings merged together in the middle of the cityscape and a line overheard mirrored the two different colors from each side coming together and blending in the middle (Figure 5). The group explored this city as a place of complexity, but also of opportunities with many different streets to turn down and explore, and with so many different people with different stories. The patient considered the blended middle in his cityscape and what that might mean with regard to concrete thoughts.

Normalization, Fight or Flight

A recurring theme during the Gray Area directive was the normalization of thought and behavior processes, beginning with the worksheet, and that everyone experiences all-or-nothing thinking at some point and other cognitive distortions. To normalize this thought distortion, I used the concept of fight or flight to explain that all-or-nothing thinking is adaptive in some

cases, such as when one needs to make a quick decision, such as fighting a bear. However, when it happens all the time, it can be very stressful for the body and mind because most people are not actually fighting a bear all the time. Many of the patients connected to these concepts and two patients illustrated this concept in their Gray Area artwork. For example, one patient drew a picture of himself cross-legged and meditating, with a yellow line "connecting [him] with God" while a bear approached him on the side. Another patient created a chart of how she reacts and copes with feeling like fighting or fleeing.

Flexibility and Shifting Perspectives

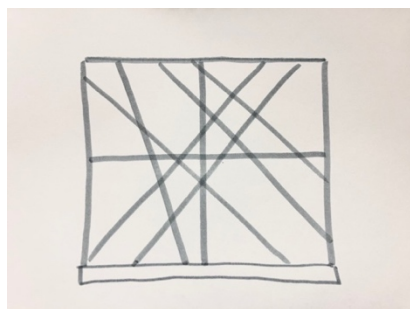Figure 6. *Marker on paper*   Figure 7. *Sharpie, marker & colored pencil on paper*
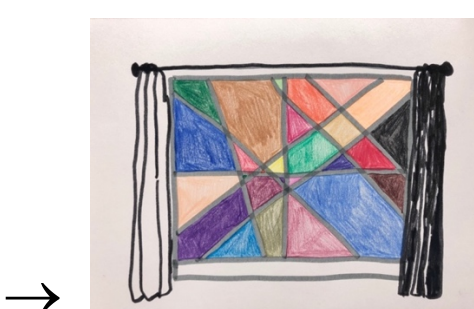

Figure 8. *Crayon on paper*

Another theme of import from the Gray Area directive was developing flexibility and shifting perspectives. For example, one client entered the group near the end. After I gave him the worksheet and briefly explained the concept to him, he began to draw. He drew clouds, with some morphing into sheep, which were raining and a ground line near the bottom of the page

with some flowers. In his explanation of his art, he said he came into the group wanting to draw sheep in the clouds, so he incorporated that into his art piece. He explained that, for him, the Gray Area is like the earth— it can be very messy but can make beautiful things like the flowers. I reflected that he had been very flexible to incorporate what he had wanted to draw within the concept of the Gray Area, and that flexibility within the Gray Area is also very important.

Shifting perspectives was an important theme that underscored many of the concepts we discussed in the Gray Area directive. In one group with three patients, one patient drew an oceanic deserted island with two stick figures on it with water around it and a giant shark that she described as herself. Another drew a nature scene near the water where she walks her leash-reactive dog sometimes. The third patient drew a ghost, who she described as scary but also scared and lonely. She spoke about the ghost wanting to be her friend. All three patients in that group explored how their Gray Area contained fearful or threatening elements and ambiguity, but also of promise, excitement, peace, and hope (related art piece and poem in Appendix A).

In another group, a woman diagnosed with schizophrenia drew many crisscrossing lines in a square with a gray marker as her Gray Area. She finished quickly, and I asked her what her gray area was. She replied "lines." I asked her where the lines were going. She said, "They're going to a different place." I mentioned that the image looked a bit like a window and she agreed. We explored the metaphor of the window as maybe containing stained glass and what she might see out of the window. She said she could see out of the window to a better place with opportunities. We explored how the curtains might be like the black and white thoughts that, when closed, can take away the view of those opportunities. After the group, this patient was beaming with pride at having been part of creating such a powerful metaphor. In my reflection, I

created one art piece that shows a replica of her initial rendering (Figure 6) and another piece that illustrates the Gray Area window that we had metaphorically explored together (Figure 7).

Another example of shifting perspectives came from a man diagnosed with MDD with psychotic features. He drew binoculars with a wooded landscaped through the lenses and explained that black and white thinking "doesn't let him see the forest though the trees" (Figure 8). The group explored how we might use the dial to change the focus of the binoculars and shift the perspective. I asked him how he could do this, and he said, "maybe sometimes I need to let other people look through my binoculars to they can help me shift my focus."

Calm Space Collage Themes

Initial Resistance

Figure 9. *Collage on paper*   Figure 10. *Collage and pen on paper*

In three of the four Calm Space Collage groups, there was some initial resistance to engaging in a guided meditation. This took the form of some people leaving the group or becoming restless and distractible during the meditation. This initial distraction, jitteriness and movement, and people going in and out of the group room was represented by the left side of several reflective collages (Figure 9; Figure 10).

In a smaller group with many distractions during the meditation part, I asked the patients how the guided meditation was for them and validated those who felt that it was difficult to remain focused. I stressed that it was ok and normal to have thoughts wander when learning to meditate. I reminded the group that acknowledging and letting go of judgments when they come up and then refocusing on the meditation is a way to combat this tendency. I asked one patient, who was unable to envision a calm space during the meditation to imagine a place during the discussion before engaging in the collaging and he was able to describe an open field with long grass blowing in the wind.

Nature and Travel

A common theme that emerged in many of the Calm Space Collages was nature and exploring. Many people chose a beach or sunset or hiking as a place where they felt safe and calm. Many group participants described a place they had been, and they were able to connect with the art directive because of a fond memory. By accessing the sensorial aspects of nature, this author aimed to ground the meditation in the physical and elicit the notion that the body and mind are connected. And, in line with CBT, our thoughts, feelings, and behaviors are very inter-connected. Some patients also mentioned travelling in their discussions of their collages.

Safety, Comfort, Home

In addition to nature and exploring, some people decided to imagine the comfort of their room or home for the guided meditation. Two patients created collages related to their home and described pleasurable aspects there, like cooking and gardening with fruits and vegetables.

Memories and Connection

Many group participants described a physical place they had been when asked to share anything they wanted to about their calm place instead of imagining a place they had never been

to. The sharing of these memories and places allowed the group members to make connections. For example, one patient described her love of the beach and another patient agreed that the beach was a special place for her also. Memories allowed this Calm Space Collage to come alive with color and special meaning, a visual reminder of memories and calm. One patient remembered the "beaches of the Caribbean" that she has visited on vacation as her inspiration for her collage. She described feeling "like a queen" and being able to really relax there.

One patient created a collage with a "scene from Faneuil Hall" with images of foods and people gathering. When I asked her why she chose that place, she said that she liked being around all the people and "Boston is my favorite place of all the places I've travelled, and I've been all over the place." She appeared to value the connection and memories at that marketplace as very important to her.

Practicing Meditation and Art as Coping Skills

A major objective of the Calm Space Collage directive was to practice using meditation and art-making as coping skills. Patients usually engaged in the subsequent art activity readily and consistently for at least 10 minutes. Most were focused on the collage-making process and eagerly shared their finished collage.

Below is a table (Table 1) of the self-reported moods for the patients before and after the calm space collage, as well as the content created and discussed. In the wrap-up of the group, this author reminded the group members that envisioning this safe and calm space was something that they can take with them as a coping skill, and they could also use collage and art-making as a coping skill if they had enjoyed it. The patients seemed receptive to employing these coping skills in the future, with many saying they wanted to try using collage and meditation again.

Table 1.

Self-reported patient moods and content created for the Calm Space Collage

Group #	Mood before	Mood after	Content created/discussed
1	overwhelmed/anxious	peaceful	White wintery scene with hints of deep oranges and a picture of a tent. Spoke about camping in the snow with a campfire blazing
1	happy	tranquil	Beaches of the Caribbean, tranquil waters where "I feel like a queen and can relax"
1	depressed, tired	content, elevated	A scene from Faneuil Hall, food-chowder &strawberry shortcake, people gathering. "Boston is my favorite place of all the places I've travelled". "I think I'm becoming more like myself again." "How is that?" "Creative"
2	good	content	A scene that reminded patient of home with colorful fruits and vegetables, Spoke about cooking and gardening
2	anxious	relaxed	Spoke of initially picturing bed as a safe space and then creating a collage about travelling and nature – green mountains and nature imagery
2	positive	peaceful	A collage with food and animal imagery, such as a tiger and tomatoes and oranges
2	calm	calm	A collage with greenery and mountains and spoke about hiking with family
2	sad	sad	A collage with mostly words and quotes cut out from the magazines. hesitant to share at first, saying that it "wasn't good", but eventually shared with the group and spoke about the beach as a special place. Affect was calmer at the end of the group as witnessed by this author - thanked me for the group afterwards
3	tired	"ok"	A collage with sunset colors and spoke about a memory of looking out over a lake at a sleep-away camp in the summer
3	nervous	calm	A collage with vegetables and animals and spoke about missing home
3	tired	good	A collage of a beach scene and shared a memory of sailing
4	unsure	calm	A collage of a field with tall grass and spoke about how during the meditation, it was difficult to remain focused because of internal and external distractions, but was able to come up with a calming scene afterwards
4	satisfied	calm	A beach scene with some legs. When this author asked about the legs, patient said it was "someone walking along the beach"

| 4 | relaxed | relaxed | A collage of a hot air balloon and other geometric shapes in sunset colors with a beach underneath. Patient spoke about being an engineer and intentionally gravitating towards shapes and movement for the collage |
| 4 | anxious | calmer | Patient made collage by ripping strips of magazine and then gluing them irregularly but all vertically. Patient then found a calming quote from the internet and spoke about focusing on the process of the ripping and creating something beautiful from the pieces |

Discussion

Psychosis is often viewed as a chronic mental health condition that is very difficult to treat and holds copious stigma, even within mental health practitioners. Addressing the individuals behind the diagnoses through new integrative therapeutic approaches that incorporate art and expressive therapies may better serve this population to develop meaning and make sense of psychoeducational concepts, allowing for a more easily digested form of cognitive behavioral therapy. The integration of cognitive behavioral therapy (CBT) and art therapy (AT) may yield greater benefits to individuals with psychosis than either method administered alone. Few studies have addressed how CBAT can be adapted for psychotic populations. A method of CBATp was developed and implemented that allowed patients to develop insight and learn through imagery and metaphor, regulate distress associated with symptoms, and incite connection and conversations.

When considering how to improve the current psychotherapy treatments for psychosis, the main question that arose for this author was how to create an approach that would effectively engage individuals with psychosis, allow them to learn and practice skills, and reduce stress. In light of the above results, there is no doubt that the CBATp directives implemented allowed the group participants a means to make sense of and explore relevant psychoeducational topics and their own experiences in a creative way. It is clear that many of the group participants

understood the concepts and were able to expand upon metaphors and imagery during the sessions. By participating, it also appeared that most patients were engaged and completed the directives and therefore were able attend to the content of the group and to cope with any distress resulting from psychotic symptoms, such as intrusive thoughts and internal stimuli. (Figure 12) displays some of the things this author "found" as important aspects and outcomes of these CBATp directives. The following discussion further delves into the themes which emerged from both directives, examines and interprets the results indicated, and explores further steps.

Figure 12. *Look what we found, Collage on paper*

Initial Nervousness/Anxiety & Regulation Through Art-Making

In many of the groups, this facilitator noticed some initial nervousness and anxiety, both in the group and in myself. It was important to acknowledge this anxiety and use grounding and coping skills to calm down and re-focus on the group**.** This initial anticipation is also represented in Figures 9 as orange and red colors and in Figure 10 as the black scribble pen marks on the left-hand side. It was also important to note that much of this anxiety corresponded to some group disorganization, such as people coming and going, and the CBT-focused aspect of the directives.

This initial nervousness appeared to be mirrored in the patients and the art-making therefore served as grounding and coping skills in the moment, further reinforcing the goals of the directives and allowing the therapist and group to co-regulate.

During the groups, I would often create my own art pieces in response to model how to participate in the group. I did so by clipping magazines, making my own collages, or my own interpretations of the Gray Area. During the discussion part of the group, I often shared my art and some of my thought processes behind my art, which appeared to cultivate trust in the therapeutic relationship as not being only one-sided. This modelling also regulated my own trepidations of leading the group CBATp directives and mirrored the affectual regulation garnered through art-making that many of the group participants also appeared to experience.

Art-based reflections created by this author contributed meaningfully to the development of themes relating to the group content and observations. Although my reflective renderings shown in the results section are somewhat more "jazzed up" than many of the original art pieces created by myself and by the patients during the groups, I strove to capture the essence and meanings behind the pieces created by the patients and the resultant group discussions. For example, the street created by the patient (represented by Figure 2), who said he was "not good at art," was very simplistic but permitted the group to explore his understanding of the Gray Area. Art therapy is not about being "good" at art, but rather the meanings and thoughts behind the art and what arises during the process and discussion. I often expressed this notion to patients who felt initial resistance to creating art and they sometimes stayed and pushed past their initial resistance.

Mood regulation was largely reported in the Calm Space collage. In Table 1, out of a total of 15 group members ($N = 15$), 13 individuals reported mood improvement (or regulation) and

two participants' moods remained the same. No group participants reported mood worsening or dysregulation after participating in the Calm Space Collage directive, however those who might have left the group might have experienced mood dysregulation as a result of the directive and/or internal stimuli.

Building Rapport and Connection, Validation, Stigma Reduction

The patient who drew the street left the group smiling and beaming that he had contributed in such a meaningful way and was recognized in the group. He approached me later to thank me for the group. Another patient, who initially didn't want to share her Calm Space Collage, was encouraged to share by this author and came to thank me afterwards, seeking me out for additional art therapy groups during the rest of her inpatient stay. In addition to contributing to patients' understanding, awareness, self-esteem, and sense of mastery, these group directives fostered connection, rapport, and relationship building by not devaluing the patients' thinking (as many people probably did during their lives), as well as reducing internalized stigma.

For the Gray Area directive specifically, a way of building therapeutic rapport was normalizing and validating psychotic experiences and associated distress. "The therapist helps the clients see that they are not alone in experiencing certain feelings and thoughts, and this can enhance feelings of self-esteem, facilitate improved coping and reduce stigmatization" (Dudley & Turkington, 2010, p. 77). Normalization also encouraged trust between group participants, who saw that other people experiencing similar issues and that they were not alone (Dudley & Turkington, 2010, p. 78). When group members shared something of substance, I would ask the group if anyone related to what they said and people almost always affirmed by nodding.

These directives provoked thoughtful and insightful discussions, as well as validated the creative individuals behind the psychotic disorders. Some more acutely psychotic patients approached the directives in ways that did not fully grasp the concepts and/or it appeared that their thoughts and interpretations became mixed with psychotic content. Art cannot be right or wrong. Here, it was important as the facilitator to validate some of the underlying emotions and meanings in their art, as well as direct the conversation back to the topic and to the group. Therefore, it may be posited that the timing after an episode of acute psychosis, appropriate medication (as well as adherence), and patient readiness can affect the reception of the interventions. The ability to validate the thought and creative processes of individuals with psychosis was extremely important to the group dynamic and humanization of the individuals. This therapeutic approach can contribute to a "holding space" for the clients' psychotic experiences, allowing patients to be supported in their recovery and growth by witnessing and validating their thought processes and emotional states.

Both of these directives appeared to hinge on normalization and connection in order to reduce self-stigmatization and disconnection, which can be associated with psychotic disorders. In comparing black and white thinking to having to fight a bear, group members related to the intense stress of thinking in that way, and also that this cognitive distortion can developed as a protective or survival mechanism. This normalization allowed patients to connect to the concept more, as evidenced by nodding at me and attending to the reading. Some incorporated the concept of fight or flight from the initial worksheet in the Gray Area directive into their artwork, appearing to resonate with the concept.

This normalization of some thought processes as faulty can shed light on delusions and hallucinations as part of that faulty processing system and thought processes. It also helped to

combat stigma and social isolation people experiencing psychosis may feel due to experiencing delusions and hallucinations. This was specifically prevalent in the Calm Space Collage, which allowed patients to connect with each other about nature and beautiful places they cherished. Nine of the 15 total Calm Space Collages contained nature imagery.

The social connections in the groups also allowed for the challenging of the negative symptoms of psychosis. This, in turn, fostered the group cohesion and therapeutic alliance, affirming the humanity of the patients as more than just their struggles with severe mental illness. This humanization and normalization, coupled with acceptance and respect from the perspective of the therapist, allowed the CBATp directives to touch the group participants on a deeper level, in addition to building rapport and trust.

Fostering Creativity, Sense of Mastery, Self-Esteem

The CBATp group directives administered fostered creativity, sense of mastery, and contributed to self-esteem, and confidence. In the Calm Space Collage, creating a visual representation of a safe and calm place by focusing on calming colors correlated with regulating affective shifts. Collage is a relatively easy art-making activity, in that it requires little skill to create aesthetically pleasing pieces since it relies on pictures and text from magazines. Therefore, collaging was chosen as a means to explore a less intimidating art practice in order to explore this viable coping skill. Completing a collage can contribute to a sense a mastery and confidence. Since this collage-making often hinged upon connection and memories, the creative process also allowed for self-esteem building. During the discussion after art-making, one women said, "I think I'm becoming more like myself again." I replied, "How is that?" and she said "Creative."

For the Gray Area directive, making art when believing one is not "good at art" and receiving support from the group and clinician, seemingly let people feel heard and understood.

Simplistic drawings were able to be explored and were expanded upon in the group setting. In this way, the developed directives worked to decrease internalized stigma and reward socialization by engaging the patient in discussion of their artwork as related to the topic.

The Need for Flexibility – Holding Space for Chaos

A common thread that was present during all of the CBATp group directives was the need for therapist flexibility. This showed up in being able to provide further explanations of the prompts when people were confused, such as simplifications of the directives. For example, explaining the concept of the Gray Area in various ways, such as thinking in extremes, and asking people to find colors that were calming to them for the Calm Space Collage when they were confused what to search for in the magazines. This also manifested as the ability to follow the trains of thought, or lack thereof, and redirection back to the topic when needed if individuals became tangential, expansive, or had flights of ideas. When thoughts became oddly-related, tangential, or when patients missed some key aspect of the directive, this author validated their art and ideas as very creative or "an interesting way to think about it" and tried to find a connection back to the topic or confirmed their intentions behind what they had created as a means of validating their process.

Flexibility also meant coping with chaos and disorganization, such as people coming in and out of the group room. Because disorganization is characteristic of psychosis, some people left halfway through, came in and out of the room, or became distracted by internal stimuli during the group. As a facilitator, I felt it was important to balance holding space for the group, keeping the momentum going, and addressing the distractions. This balancing was coupled with refocusing myself as a clinician in order to better attend to the group's needs. Being grounded, flexible, and able to "roll with the punches" allowed me to hold space for chaos and distractions,

while attending to the group as a whole. As far as from a facilitation perspective, the therapist's experience in working with patients with psychosis, flexibility, and ability to regulate with distractions and disorganization present will be key to future implementations of CBATp. Letting go of some of my unrealistic expectations for the group and for myself allowed this process to be easier.

Flexibility was also practiced on the part of the patients, who were able to attend to the group content, cope with internal and external distractions, and problem-solve how to translate the prompts into artwork. The individuals also practiced flexibility in being able to explore the artwork in the context of the group, such as expanding upon metaphors like how one might climb onto a slippery boat after drowning, or sharing the details of their calm space, such as a memory of a lake during the sunset at a sleepaway summer camp or walking along a favorite beach.

Meaning-Making Through Making Art — Exploring Imagery and Metaphor

The above mentioned flexibility contributed to another major theme of these CBATp interventions, which centered around creativity and meaning-making. Patients used metaphor as a means to develop meaning related to psychoeducational concepts, such as looking at things through different lenses, climbing out of holes, exploring the feeling of drowning, and befriending our ghosts. Patients also used imagery and art-making to explore and remember a calm place, such as a favorite beach in the sunset or hiking with family. In this way, imagery, metaphor, and art were used to make, explore, and display meaning— a way to order and organize thoughts and experiences and channel them into the art.

Fundamental to this explorative process was the ability to of the therapist to validate the thought and creative processes of individuals with psychosis. Metaphors which emerged from the art were expanded upon and thought about in different ways by gently probing for more

information, which validated the creative process and the art of the individual as something that deserved focus and respect. Central to this process was utilizing the art therapist's third hand (Kramer, 1986) in order to "carry on a visual dialogue with the client as well as offer assistance when the art process derails" (Franklin, 2010, p. 163). This playful, collaborative, and flexible meaning-making process and group discussion created some order, as well as recognized some beauty, hope, and calmness from the chaos often present in the minds of those experiencing psychotic symptoms.

The Gray Area directive allowed beautiful and powerful metaphors to emerge which spoke to discomfort, shifting perspectives, fear, opportunities and other themes in ways that might not have been otherwise explored as deeply in talk therapy alone. These metaphors incited cognitive flexibility by introducing different ways of thinking about the cognitive distortion black and white thinking. The Calm Space Collage seemingly fostered mood shifting through participation in the guided meditation and by creating a collage invoking the colors and imagery from the calm space the participants envisioned. In Table 1, a large majority of the patients reported increased mood regulation and feelings of calmness following the directive as compared to their initial reported mood. Thus, practicing the coping skills in the context of the group appeared to induce regulatory affective shifts. Additionally, there were a few participants who arrived to the Calm Space Collage groups late and missed the meditation, but still appeared to garner affect regulation from the collage aspect of the intervention.

The visual, tactile, and creative components of this method of CBATp appeared to engage the group members in deep and meaningful ways. Because AT adds visual and tactile components to the learning, this approach appeared to tap into sensorial activation and memory to distract and combat internal stimuli and intrusive thoughts. The physical outcomes from the

art-making can also be taken with the patient as a reminder of the concepts learned and discussed.

Moving Forward – Future Implications and Research Recommendations

Moving forward, it may be of more value to focus more on the Gray Area directive due to the robust apparent comprehensive response indicated by the metaphoric applications. However, it is still important to recognize the value of the Calm Space Collage for more acutely psychotic clients. Therefore, it may be more beneficial to assess the client's functioning and current state before choosing which CBATp directive to implement. For example, it may be more advantageous to implement the Calm Space Collage directive with clients who have cognitive or developmental impairments or are in a more acute psychotic state. For clients that have re-compensated enough or are able to employ higher levels of thinking and reasoning, it may be more advantageous to utilize the Gray Area experiential. Furthermore, it may be interesting going forward to first implement the Calm Space Collage and then the Gray Area directive in a sequence as part of a larger CBATp protocol that could be developed in time.

Further steps in the research and practice of CBATp could more thoroughly investigate the mechanisms of the approach through quantitative and qualitative research to prove that this method is effective in treating psychosis and if positive and negative symptom reduction remains upon cessation of the treatment. Other research could compare CBATp to CBTp and ATp administered alone to see if the combined approach is more effective than either approach alone. This will allow the expressive therapies a place in enhancing evidenced-based CBT umbrella methods and continue to improve and evolve care for those experiencing psychosis.

These CBATp interventions required limited and inexpensive materials and were brief, time-limited directives. Therefore, they could be appropriate for both inpatient and outpatient

settings. The flexibility of this model allows for many different directives to be developed going forward. AT can continue to evolve within the evidenced-based therapies as a complement to CBT umbrella therapies, and demonstrated herein, can be administered together as an effective treatment for individuals with psychosis. CBT can add structure, foundation, and evidence-based gravitas to AT, which can be used to add flexibility and social connection to the practice, serve as a visual, tactile, and creative augmentation, and foster non-verbal expression; in essence, the combined approach can be a therapeutic multiplier for the treatment of psychotic disorders.

Conclusion

This method of CBATp with two directives was developed and implemented on a psychotic-specific inpatient unit to discern if this method indicated preliminary effectiveness as a treatment for psychosis. With regard to the above literature review and results of the method developed and implemented, this method of CBATp was observed in a majority of group participants to be a viable treatment model for psychosis in addition to medication and medical treatments. This author observed that this method allowed patients to learn and apply CBT concepts through engaging in AT experientials to reinforce the learning through expression, increased socialization, and allowed patients to create meaning from their lived experiences, effectively creating order from the chaos. Underscoring this approach was therapist flexibility and ability to validate the thought and creative processes of the individuals. This method also provided a means for distress reduction through practicing coping skills. A significant majority of the Calm Space Collage participants reported mood regulation. Further research is needed to explore the mechanisms and efficacy of CBATp and to develop more techniques and directives if proved effective. Overall, this paper explored the theoretical and practical preliminary indications for the use of CBATp.

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Author Acknowledgements

I wish to acknowledge a number of people who contributed to this thesis journey.

Firstly, thank you to my thesis advisor, Denise Malis, for tirelessly supporting me in all drafts and iterations of this thesis, and encouraging my passion and enthusiasm for the work. I would not have been able to do this without you.

Thank you also to Dana Roth, my consultant and internship site supervisor. You have helped tremendously throughout this process by modelling how to facilitate art therapy groups with individuals with psychosis, being a sounding board for ideas, providing supervision and support, and encouraging my growth as a clinician.

Thanks goes out to the incredible group participants, who taught me much more than I was able to teach them.

Thank you also to the amazing staff on the inpatient unit, who supported my therapeutic work with the patients, and accepted and valued my contributions to the treatment team.

Lastly, thank you with all my heart to my family and friends for their unwavering support. It was truly invaluable and sustained me through this time.
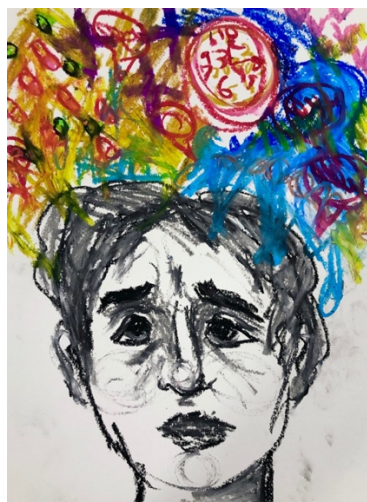
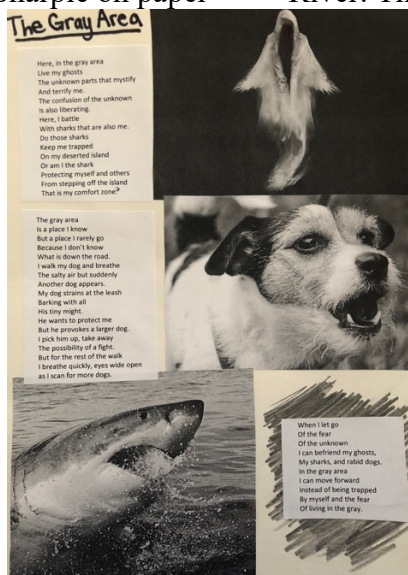**Appendix A: Additional Art-based Reflections by this Author**
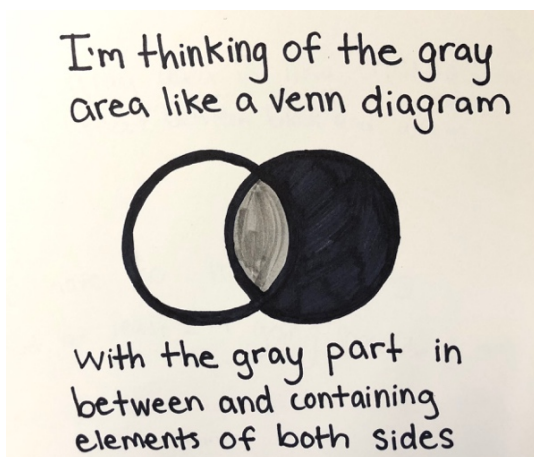
Venn Diagram: Marker and Sharpie on paper
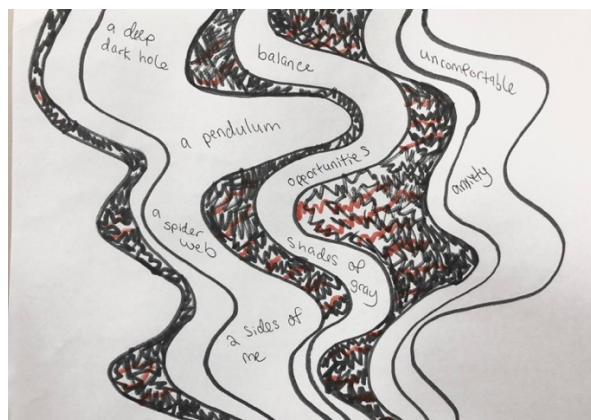
River: Themes from a Gray Area group

Psychotic Thoughts: Oil pastel on paper

Letting Go of Fear: The gray area poem

Lean on Me: Reflection from the Calm Space Collage

Appendix B: The Gray Area Worksheet

(Link to the website by Mark Tyrrell and Roger Elliot from which the following double-sided
worksheet was derived)
https://www.clinical-depression.co.uk/dlp/understanding-depression/all-or-nothing-or-
black-and-white-thinking-and-depression/

All or Nothing', or 'Black and White' Thinking and Depression

MOST life events are not 'completely disastrous' or 'absolutely wonderful' but contain elements of both good and bad. Depression makes people think in absolutes.

All or Nothing, or 'Black and White' thinking is the thought pattern that allows us to generate a "flight or fight" response to danger. It is still needed in the world today, but not many times a day in relation to non-life-threatening stress, as so often happens with depression.

All or Nothing thinking and depression

All or Nothing thinking is found in depressed people all over the World. This is because it is part of the most primitive of human responses: **The Fight or Flight Response**.

When faced with a life-threatening situation, we must make a snap decision and act on it. There is no time for 'maybe this', or 'maybe that'.

Seeing shades of gray

Since All or Nothing thinking is another thinking style strongly linked with depression, learning not to always think in 'all or nothing' terms but to see shades of gray is immensely helpful in tackling depression. It greatly reduces, or stops the emotionally-arousing thoughts that are necessary to maintain the depressed state.

The more we polarize our thinking the more likely we are to become depressed because extreme either/or thinking stimulates the emotions much more. Statements like "I'm a terrible person!" or "She's perfect; she's a saint!" or "I'm just a failure!" oversimplify life and cause massive emotional swings. Few marriages, holidays or jobs were 'complete disasters' but had different elements within them.

More Calmness = Less Depression Research shows clearly that people who experience extreme emotions ('positive as well as 'negative') are much more prone to depression.(1)

Spotting warning words

As an ongoing way of perceiving reality, All or Nothing thinking is emotionally and physically damaging. If you spot yourself using this style, challenge yourself to think differently. There are particular words that people often use when thinking in this way. You can learn to spot them.

Always	Never	Perfect
Impossible	Awful	Terrible
Ruined	Disastrous	Furious

We can all make inner statements about ourselves but that doesn't make them true. Consider the following questions:

Can I be basically an intelligent person and still do something stupid?
Can I love my children and still get angry with them sometimes?
Can my partner love me but sometimes be insensitive?
Can one part of my life be difficult and other parts be easier and more enjoyable?
Can a part of my life be difficult now but in the future get easier?
Can some parts of an experience (such as a social engagement or vacation) be awful and other parts of it be OK?

Becoming less rigid in our thinking allows us to avoid using All or Nothing statements to depress ourselves without examining their validity. Using this 'cognitive' technique will literally allow you to spot what you are doing and therefore challenge its accuracy.

Remember: A major reason people depress is because of the way they perceive reality. Once this begins to broaden, depression has little to cling on to and will start to lift. Depression often centers around one recurring belief, such as "I'm just not the sort of person other people like."

Deliberately challenging this and coming up with alternative evidence starts to break down the depression. This can often be easier with the help of a friend or properly-trained therapist.

Appendix C: Calm Space Collage Guided Meditation Script

Calm Space Collage guided meditation script (developed by this author)

I invite you to close your eyes if you feel comfortable or to lower your gaze. Place your feet fully
onto the floor, connecting to the ground underneath you. Let the weight of your body be
supported by the chair. Let yourself relax into the space around you. We will now take
three breaths together, allowing our exhales to be longer than our inhales. Breathe in,
pausing at the top, and release the breath, sighing it out, Breathe in, hold, and let it out,
breathe in, filling up, and release anything you need to in this moment. I now invite you to
imagine a safe and calm place. This place can be imaginary or a place you know. It can be
a beach or forest, a mountain, or anywhere you wish. Here you can feel at peace. Take in
your surroundings in this place. What do you see? Are there crashing waves or maybe tall
trees? What colors do you notice- the pastels of a sunset? The soft browns and greens of
the forest? Bright greens and tans in a field, maybe bright pops of colors of wildflowers, or
the greens, blues, and browns of the ocean. What do you feel? Do you feel the sun on your
skin or the sand beneath your toes? Do you feel the soft underbrush of the forest under
your feet or rough bark? Do you feel the soft grass or maybe even the crisp cool of snow?
Do you feel cool water? Notice the sensations in this safe and calm place. What do you
smell? Do you smell pine, or a campfire, or the salty ocean mist, maybe something familiar
is baking? What sounds do you hear? Maybe you hear seagulls, or crunching leaves,
laughter, or a crackling fire. Maybe you hear the crickets chirping or a river trickling?
Continue to look around you and let yourself feel all the sensations in this place. When you
feel ready, I invite you to slowly return to the present, taking the time you need to come
back into your body and reorient to the room. When you feel ready, you may open your
eyes.

OR

Safe Place Visualization – 2012 – FamilyGuiding1

https://www.youtube.com/watch?v=pPBxNLpOLNU