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Sensory Approaches with Serious Mental Illness: Capturing 'Sanism' in Mental Health Treatment

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Abstract

This thesis examines the relevance of sensory approaches in adults with serious mental illness. Furthermore, it approaches mental illness from a critical psychology perspective, inquiring who is considered mentally ill and why, the stigma attached to this label, and the oppression of mentally ill individuals as a minoritized group, known as sanism (LeBlanc & Kinsella, 2016). This topic was studied by facilitating therapy groups using sensory-based artmaking and sensory psychoeducation. Three group sessions with three different groups of 5-12 individuals at a partial hospitalization program (PHP) were conducted. Artmaking and thought processes of the group participants and myself as a facilitator were examined through arts-based research and reflective notetaking. Using qualitative data analysis, three themes were identified arising from the group process: sensory experiences and preferences, narratives of success or failure, and interpretations of the therapeutic benefit. Sensory approaches were indeed relevant in this population, corroborating existing research on this topic (Kandlur, 2023; Hitch et al., 2020). Furthermore, it was theorized that the artmaking process elicited subconscious material in the participants about the theme of success or failure in their lives in general, and connected to societal expectations around compulsory able-mindedness in mental health treatment (Egner, 2019; Rimke, 2016; Hess, 2022). The thesis concludes by overviewing relevant frameworks with the potential to empower individuals in their mental health treatment, as well as suggestions for further research.

Keywords: serious mental illness, sensory approaches, neurodiversity, art therapy, sanism

Author Identity Statement: The author identifies as a straight, cisgendered, white woman from New England of Ashkenazi Jewish descent.

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Introduction

A client in group therapy is talking, talking, talking… He is not aware of how much he is monopolizing the space. The other clients show subtle signs of becoming disinterested: a sigh, a glance at the clock, an expression of annoyance. The therapist interrupts the client to gently redirect him, "Thank you for sharing with us, let's pause to let others speak." The client becomes red-faced and huffs, "You don't want me to talk…?" He gets up and makes a run for the door. A few minutes later, he can be heard in the hallway, screaming profanities. Several other clients notice the disturbance and become distracted and anxious.

What went wrong here? A relational therapist might say there was a rupture between the first client and the therapist. A trauma therapist might say that the first client was triggered by the therapist, who reminded him of his father who yells at him to shut up. The director of the program might say that nothing was wrong, and the clients were just experiencing their triggers in real time: a great opportunity to practice coping skills. In any case, the first client became dysregulated, and this threw off the equilibrium of the group.

After experiencing multiple scenarios like this one throughout my internship, I decided to research the topic of sensory approaches in mental illness, as well as client narratives in their experience of partial hospitalization program (PHP). I noticed that clients, like in the example above, develop a disenfranchised narrative that the staff at PHP are not helping them, and experience dysregulation when confronted with a perceived lack of support in their treatment. I theorized that sensory approaches could help clients in acute distress to increase awareness of their heightened emotional state and learn coping techniques to help regulate and process their

emotions. To investigate this hypothesis, I developed a sensory-based artmaking group therapy approach and conducted research on three sessions of this group with PHP clients. I investigated the clients' impressions of the group and my impressions as the facilitator.

Clients such as the one in this example come to PHP with a history of serious mental illness and experiencing current acute distress. Serious mental illness (SMI) is defined as a "diagnosable mental, behavioral, or emotional disorder" that results in "substantial impairment in carrying out major life activities" (ADAMHA Reorganization Act, 1992). An estimated 6% of adults in the US were found to have SMI in 2022, about 15.4 million people (SAMHSA, 2022). Typical treatments for SMI include psychotherapy to teach coping skills and increase understanding of one's condition, medication to reduce symptoms, and community supports to facilitate supportive housing and employment (SMIAdvisor, n.d.).

While psychiatry addresses mental illness from a medicalized framework of diagnosis and symptom management, organizers in the field of mental health such as SAMHSA (Substance Addiction Mental Health Service Administration) have advocated for a more holistic recovery-oriented approach. SAMHSA (2012) defines mental health recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3).

PHP can play a significant role in an individual's mental health recovery, helping them to stay grounded in their homes and communities while receiving intensive care. Individuals who attend PHP are those debilitated by their condition since treatment takes up most of the daytime on weekdays and most individuals are unable to work while attending program. As a clinical intern at PHP, I have participated in facilitating therapy groups, providing individual support, risk assessment, safety planning, and case management for this population.

In my observation of the clients at PHP, I came to identify themes where clients have shown a need that is not addressed in their mental health treatment. One theme I noticed among my clients was dysregulated sensory processing and a potential need for sensory approaches. Another theme I noticed was clients struggling with the stigma of mental illness and the ideal of being cured of their conditions. And I also noticed a desire to attain empowerment and autonomy that was not always met within the program.

Before I examine the specific topic of sensory approaches in mental illness, I would first like to outline my positionality within the institutional framework of mental health care. At my internship site, the method I have developed is termed an "intervention" as part of the "treatment" of "mental illness." This terminology implies a pathology located within the individual that needs to be corrected. However, just because an individual experiences distress does not mean that they are inherently ill. In fact, many individuals diagnosed with mental illness experience justifiable distress in reaction to oppression and trauma, which is pathologized by a medicalized model. Other types of mental illness may fall under the umbrella of neurodiversity but remain pathologized due to a notion that differing behaviors or nervous systems are abnormal and therefore pathological (Lyons, 2023). Regardless, I needed to work within the system of my internship site, in which clients can only receive treatment if they are diagnosed with an illness. Furthermore, I needed to access research that was produced within the current model of psychiatry to create this thesis. Therefore, I continue to use this language, though it does not necessarily align with my perspective.

Literature Review

In the following literature review, I will introduce the concepts of sensory processing and the Neurodiversity paradigm. I will provide an overview of sensory profiles in adults with mental

illness and the use of sensory interventions in this population. Lastly, I will summarize two case studies utilizing sensory approaches in psychotherapy and creative arts therapy.

Sensory Processing

Researchers have defined sensory processing as "a person's ability to receive and organize sensory information for use in everyday life" (Blanche et al., 2014, p. 531). Sensory processing patterns are thought to influence an individual's behavior (Hattori et al., 2023). For example, a person with sensory over responsiveness, also called sensory defensiveness, may have lowered quality of life, as well as associated depression and anxiety due to their need to avoid overstimulation. While sensory processing differences are often associated with neurodevelopmental disorders, researchers have found that mental illnesses also tend to present with atypical sensory processing. There is a large body of evidence in the literature supporting this association (Bailliard & Wigham, 2017).

The Neurodiversity Paradigm

While conventional psychiatry identifies these differences in processing as "deficits" and clinical signs of psychopathology (Bailliard & Wigham, 2017), Neurodiversity advocates argue that these differences "represent valuable and valid forms of human diversity" (Bridget et al., 2023, p. 73). Neurodiversity takes a "difference not deficit" perspective and advocates "for neurological variations to be accepted and valued alongside other forms of difference, such as race, gender, or sexuality" (p. 81). Following the Neurodiversity paradigm, neurological differences need not be cured nor fixed, but rather, are inherently valuable forms of neurodiversity, and need only be "ameliorated" if doing so would "improve quality of life and support self-determination for neurodivergent people" (p. 83).

Though Neurodiversity has been primarily associated with autism, advocates and

scholars have utilized the term to describe other conditions such as ADHD, dyslexia, and bipolar disorder (Bridget et al., 2023). Mental illness in general is not typically included under the umbrella of Neurodiversity, but some scholars such as Lyons (2023) have begun to think differently. Lyons rejects the "dominant conception" of mental illness as one that falsely presumes an "incompetence-inducing pathology" hindering "normal" functioning. She posits that the so-called symptoms of mental illness are actually a form of neurodivergence that is "integral to and indistinguishable from the self" (p. 1993).

Egner (2019) takes a similar position describing that the pathology paradigm of mental illness has created normative expectations of neurotypical bodies and minds parallel to the hetero/cisnormativity identified by the LGBTQ community. In response to the neurotypically normative paradigm of mental illness, Egner suggests "neuroqueering" disability justice to be more "mind-based" and to challenge forms of "able-mindedness" (p. 129). Egner describes that no matter how inclusive our communities and practices may be, they can and do devalue disabled experiences with "compulsory able-bodiedness" and "able-mindedness" (p. 128); i.e., even though you can be accommodated for your disability it would be better not to be disabled in the first place. Egner describes the root of this problem as being "located within dominant discourses that devalue bodily and mental diversity" (p. 134).

Lyons (2023) proposes the social model of disability as a counterpoint to the pathology paradigm of mental illness. The social model of disability rejects the idea that an individual is inherently disabled, rather, focusing on the way that society fails to accommodate the individual as the source of disablement (Davis, 2016). Lyons (2023) further proposes a Neurodiversity-informed model as a solution to mental health treatment: that mentally ill people are the experts of their own experience, and therefore also experts in determining what support is most needed

in times of distress. In this thesis, I focus on the relevance of sensory interventions as a Neurodiversity-informed approach to improve quality of life with mental illness, as well as the Neurodiversity Paradigm as a framework with the potential to empower individuals with mental health diagnoses in the face of stigma and oppression.

Sensory Theories

Sensory theory was first introduced by Ayres (1972), who proposed the theoretical framework of Sensory Integration, describing how the nervous system integrates sensory input into behavioral action. Sensory Integration refers to the process of discriminating and distinguishing between stimuli, then conceptualizing and carrying out an action in response to them (Lynch & Simpson, 2004).

Researchers such as Dunn (1999) have continued to expand upon Ayres' framework. Dunn developed a system for categorizing the relationship between an individual's behavior and their level of sensitivity to sensation. Dunn conceived of the following four categories: sensation seeking, sensation avoidant, heightened sensitivity, and poor registration of sensation. Dunn theorized that individuals could be accommodated based on their unique sensory needs, which tended to fall into a pattern following these categories.

More recently, researchers such as McGreevy & Boland (2020), Kandlur et al. (2023), and Hitch et al. (2020) have come to focus on sensory modulation as a central principle of sensory intervention. Sensory modulation is a component of sensory integration, involving the neurological ability to interpret sensory input and self-regulate in response to it. Therefore, the concept of neuroplasticity is applied to assist individuals in obtaining an ideal level of arousal by either decreasing or increasing their overall sensitivity to sensation by adapting to sensory interventions. Sensory interventions have been found to reduce nervous system arousal in mental

health inpatient units, emergency departments, and forensic psychology (Hitch et al., 2020). Sensory interventions have been specifically recommended as an alternative to seclusion and restraints in mental healthcare settings (Huckshorn, 2006).

Sensory interventions can be classified based on the senses involved. The auditory sense involves hearing, the gustatory sense with tasting, olfactory with smelling, visual with seeing, tactile with touching, proprioceptive with movement and positioning of the body, and vestibular with motion and balancing of the body. Tasks can involve multiple senses, such as chewing gum, which involves the olfactory sense in smelling the scent of the gum, the gustatory sense in tasting it, and the proprioceptive sense in chewing it (Hitch et al., 2020). The arts can also serve as sensory interventions, such as clay with stimulation of the tactile and proprioceptive senses, music with the auditory sense, images with the visual sense, and so on (Howard & Prendiville, 2017).

Arts-based sensory interventions can be classified following the expressive therapies continuum (ETC) model (Hinz, 2019). The ETC divides arts approaches into levels of different experiences: kinesthetic/sensory, perceptual/affective, cognitive/symbolic, and creative. Implications around sensory experience arise from the first two levels. The first level, kinesthetic/sensory, pertains to the engagement of the kinesthetic and vestibular senses with action through movement on the kinesthetic side of the spectrum, and the felt sense of the art materials and other sensory experiences of the artmaking on the sensory side. The second level, perceptual/affective, pertains to the external sensory perception of the art and its relationship to the outside world on the perceptual side, and the internal perception of the affective response to this sensory information on the affective side.

Sensory Profiles in Mental Illness

Bailliard and Wigham (2017) conducted a scoping review of the existing literature on the relationship between mental illness and sensory processing. They found a significant body of 73 studies identifying sensory processing differences as traits of mental health diagnosis, especially schizophrenia. Individuals with schizophrenia had differences in their capacity to distinguish auditory information from background noise, a "dimmer" (p. 8) perception of visual contrast, and lowered visual movement tracking capacity. Audio processing differences were also found in individuals with bipolar disorder and OCD, and visual processing differences in individuals with depression, PTSD, and bipolar disorder.

However, despite the growing evidence that these sensory differences exist, Bailliard and Wigham (2017) found limited research about the functional implications or clinical relevance of these findings. Their review presented a breadth of studies and was successful at identifying some sensory differences in mental illness populations, but more information is needed about clinical interventions and their effectiveness. This was the landscape of literature at the time of publishing this review in 2017, however, since then research has continued to evolve, with another review of the literature published in 2022 by Van den Boogert et al.

Van den Boogert et al. (2022) conducted a meta-analysis of sensory processing differences in psychiatric disorders, expanding on the existing research on this topic. To do this, the researchers chose four self-report questionnaires evaluating sensory processing for adults and sought out peer-reviewed articles that utilized these to assess sensory processing preferences in individuals with psychiatric conditions. A search of seven databases yielded 33 studies, which were then categorized by mental health diagnosis and age group.

Analysis of the studies (Van den Boogert et al., 2022) found that individuals with a

mental health diagnosis were more likely to have increased patterns of low registration of sensation, heightened sensitivity, and sensory avoiding behavior, as well as a lowered incidence of sensory-seeking behavior. This pattern held across all diagnostic categories and age groups, except for adults with ASD and elderly people with neurocognitive disorders. Researchers suggested that future research focus on integrating the neuroscience of sensory processing with psychopathology from a transdiagnostic perspective. They also suggested that sensory sensitivity may be elevated across categories of mental illness due to heightened stress sensitivity in general.

The studies in this review (Van den Boogert et al., 2022) were limited in the use of self-report questionnaires as opposed to other diagnostic methods, samples in which Caucasian individuals were overrepresented, and the lack of a control group without psychopathology for comparison. More research will be needed to verify these findings; however, this preliminary analysis suggests a specific pattern of sensory processing in individuals with mental illness that transcends diagnostic categorization.

Hattori et al. (2023) investigated the relationship between sensory processing, autonomic nervous system function, and social participation in people with mental illnesses receiving occupational therapy in Kyoto, Japan. To achieve this, researchers recruited 27 individuals with a modified global assessment of functioning scoring at 67 or lower who were receiving therapy for a mental illness at a local hospital and collected data related to their sensory processing, social participation, and respiratory sinus arrhythmia (RSA). RSA is known to reflect parasympathetic nervous system effectiveness and was used to measure the stress response.

Hattori et al. (2023) used the Adult Adolescent Sensory Profile (AASP), World Health Organization Disability Assessment Schedule (WHODAS 2.0), and pulse wave measurement

and analysis to collect the data and used statistical analysis to identify correlations. They found that for individuals with low registration of sensations or sensory sensitivity, lowered stress response was associated with increased social participation. Meanwhile, individuals with sensory avoiding patterns experienced lowered social participation regardless of stress response, so sensory interventions were advised as a primary intervention in this group. Only sensory seeking behavior had no correlation with social participation.

Hattori et al. (2023) concluded that "mentally ill individuals have atypical sensory processing patterns, and these characteristics influence their subsequent behavior" (p. 44) and underscored the need in mental health treatment to understand each individual's sensory processing style, its impact on daily life situations, and the individual's behavior in response. The study was innovative in its exploration of the functional outcomes of sensory processing deficits, but was limited in its small scope, with a broad array of mental illnesses across only 27 participants who were majority women. Nevertheless, it poses as a starting point in suggesting that sensory processing differences have a complex relationship with stress, and this can impact functional outcomes in individuals with mental illness.

Bailliard et al. (2023) examined the lived sensory experiences of six adults with psychotic disorders. Researchers met with the participants three times over a one-month period. They also provided the participants with a digital camera and instructed them to take photos of "situations when their lived sensory experiences impacted their engagement in meaningful activities" (p. 105). Lastly, participants were asked to choose an activity they enjoy doing in daily life for researchers to videotape.

Bailliard et al. (2023) conducted a thematic analysis of the interview and video transcripts, including discussions with participants about the video and photos they had created.

Themes identified included polysensoriality (interrelatedness of the senses), embodied aesthetics (aesthetic or sensory preferences derived from meaningful memories), sensorial guideposts (long-standing habits that are part of a familiar routine), and self-management (sensory experiences that enhance well-being).

While much of the above research has focused on so-called deficits in sensory processing, this study (Bailliard et al., 2023) identified positive aspects of the individuals' sensory experiences "outside of the clinical context" (p. 109). The study challenges the "prevailing assumptions" (p. 110) about individuals with psychosis that their sensory perception is inadequate or not grounded in reality. The researchers suggest that these experiences could be harnessed to support individuals to participate in more activities that contribute to their quality of life.

Though the findings are not generalizable, the study (Bailliard et al., 2023) provides insight into the positive narratives and sensory experiences that support these individuals. For example, one individual, Lucas, "associated enjoying the sensation of smoking to include the sensation of listening to music on his back deck while having a cigarette" (p. 106). Although researchers had only asked about one sensation Lucas enjoyed, Lucas reported utilizing multiple senses to create a specific experience that stimulated him in a positive way. It would be interesting to know more about the types of narratives or experiences that different individuals with other diagnoses might have, and whether any aspects of the narrative or the way of using senses might correlate with any diagnostic category.

Sensory Approaches with Mental Illness

While there is much research about the association between mental illness and sensory processing differences, the research has yet to identify a standardized sensory approach to

working with mental illnesses. Some interventions found in the literature include the use of sensory rooms and sensory kits, the use of sensory profile assessments to individualize treatment, and specific approaches such as sensory modulation or sensory pressure therapy (McGreevy & Boland, 2020).

Kandlur et al. (2023) conducted a scoping review of sensory modulation interventions (SMI) for adults with mental illness. They searched eight databases for articles related to sensory modulation and mental illness, then screened these for those published 2010 or later, and excluded studies on children, individuals without a mental illness diagnosis, and individuals with neurodevelopmental or neurocognitive disorders, resulting in a final total of 17 studies.

Kandlur et al. (2023) identified trends of increasing clinical interest in sensory modulation, most studies being pilot studies, and a lack of higher-level research. Earlier studies focused on distress tolerance, whereas one more recent study from 2018 focused on improving functional outcomes, such as using sensory strategies to facilitate use of public transportation. The researchers identified benefits of SMI, including its potential to replace seclusions and restraints in acute settings, its alignment with a "recovery model" (p. 66) focusing on participation in daily activities rather than solely reduction of symptoms, and its potential to empower the individual by allowing them to choose their preferred sensory activities. The researchers suggested that future research focus on "developing guidelines" (p. 66) regarding suitable interventions for different mental illnesses based on sensory profiles.

Hitch et al. (2020) conducted a comprehensive literature review overviewing sensory modulation in mental health practice. They also conducted a qualitative study interviewing focus groups and practitioners about their experience with these interventions. They utilized the literature to rate the evidence for various interventions from one to four stars, one being lowest

quality evidence and four being highest. Out of the interventions reviewed, none were rated four stars. Researchers noted that while the literature describes a broad range of interventions, "the ways in which they are used, including duration and the sensory systems targeted, are not well described" (p. 14).

Hitch et al. (2020) identified benefits of sensory interventions, including the low cost of materials, potential for shared decision-making by choosing the client's preferred activities, and reports that both staff and clients perceive sensory interventions as "nurturing," "enjoyable," and "supportive" (p. 15). The researchers identified challenges of sensory interventions, including the need for an individualized approach based on each person's sensory preferences, and the perception of these activities as "simple" or "toys" (p. 15) rather than therapeutic interventions. The researchers suggested that future research identify strategies to utilize sensory interventions in the community rather than only clinical settings. They concluded that "sensory modulation is an effective intervention that supports [...] recovery, but further research is required to consolidate knowledge on optimal practice" (p. 15).

McGreevy and Boland (2020) conducted an integrative literature review on sensory-based interventions with adult and adolescent trauma survivors. They noted a paucity of research on this topic, leading them to choose the integrative review approach. They searched six databases for relevant articles and excluded those pertaining to children, autism, traumatic brain injury, dementia, or trauma as an emergency room admission. The final review identified 18 studies that utilized sensory-based approaches with adolescents and adults who had a history of trauma or PTSD diagnosis.

McGreevy and Boland (2020) found that "sensory interventions target intense physical manifestations of traumatic sequelae and offer a different therapeutic experience to that of

conventional psychopharmacological treatment" (p. 36). They described that the need for interventions that help to regulate emotions and affect, as well as a reported reduction of seclusion and restraints with sensory interventions, have driven the growing interest in this approach for individuals with mental illness.

McGreevy and Boland (2020) described the use of sensory interventions in the literature as "preparatory," (p. 45) in that they provide stabilization of trauma symptoms so that clients can participate in daily life activities. They also identified sensory interventions as part of trauma programs, like the post-traumatic stress recovery program. They suggested that future research focus on identifying the mechanism of change in these interventions, and again noted a lack of high-quality empirical evidence for sensory approaches.

Case Studies

In lieu of an established protocol for the clinical use of sensory approaches with mental illness, the following case studies provide insight into potential applications of these tools. The first case study utilizes sensory approaches in psychotherapy, and the second, creative arts as a sensory approach to process trauma.

Case Study 1. Van Nest (2019) presented a case study of psychotherapy integrating sensory approaches. She created a composite of three clients, named "John," whose case she used to demonstrate the applications of sensory integration theory. She describes John as initially "belligerent" and "dysregulated" with a "'fight' response" (p. 170). One of John's favorite activities is running, and Van Nest frames this from a sensory theoretical perspective as "an activity that gives major proprioceptive input to the body and brain" (p. 171). Through psychotherapy, John notices that he feels more able to tolerate stressful situations after having gone for a run, which Van Nest frames as "a connection between the sensations of his body and

the emotional intensity of a situation" (p. 171)

In therapy, John also reflects about his experience of anger that it affects his vestibular system, stating, "I swear, when I am angry, I mean really angry, I cannot walk straight" (p. 172). Van Nest frames John's loss of balance as his body's way of seeking "vestibular input to help regulate the brain" (p. 172). She describes that through therapy, John "has come to understand that this is a physical cue that his sensory system is dysregulated" (p. 172). Van Nest draws a parallel between John's lack of security in his interpersonal relationships and his experience of "gravitational security" with his vestibular system function that provides "the trust that we are grounded and secure" (p. 172). When he loses his ground in his personal relationships, John also loses his literal ground with his loss of balance.

Van Nest summarizes her work with John, describing that she "engaged a client who was resistant to intervention because of sensory dysregulation" (p. 174). She elaborates, "While psychotherapy can interact with the brain when affect and sensory systems are dysregulated, it will not reach consciousness, as awareness is unavailable when the nervous system is so activated" (p. 174). On a cognitive level, John knew already before therapy that his anger was exacerbating his situation, but he was unable to regulate himself using cognitive approaches. Therefore, sensory approaches allowed John to develop a capacity for self-regulation of his emotions and "united the brain and body and emotions in a non-judgmental way" (p. 174).

Case Study 2. Perryman et al. (2019) examined creative arts in trauma therapy as a "nonthreatening way for clients to access and express their trauma, creating a corrective experience in the brain" (p. 80). They used the case study of Janet, who had lost her husband in a car crash, to examine the use of expressive therapy techniques with sensory modulation to help Janet process this trauma.

The counselor worked with Janet on mindfulness and grounding techniques for three months before moving on to directly process the trauma. This first period of therapy was helpful to develop the therapeutic relationship and reduce some of the trauma symptoms Janet was initially experiencing, such as depression and isolation. However, Janet's story of the traumatic incident "remained fragmented," which the counselor took as an indication that "further integration" (p. 87) was needed.

Before prompting Janet to recall the trauma, the counselor first put her in a state of relaxation by playing classical music, along with using breathing techniques and mindfulness that she had already been practicing. The therapist then prompted Janet to remember the car accident and use fingerpaints to express her feelings about it. Janet painted using broad movements that incorporated her body. In this way, Janet self-initiated movements that could "serve as bodywork" (p. 90).

The counselor advised Janet to note any memories that resurfaced after the session. Indeed, during a later session, after Janet had used a sand tray, she "verbalized the slideshow of traumatic memories in a continuous narrative with a beginning, middle, and end," which the authors identified as evidence of the integration of her trauma narrative. The authors describe that the music served to stimulate "non-verbal memories" through "sensory pathways" (p. 89), and the bodywork was "used to help make deeply entrenched memories in the lower portions of the brain more accessible" (p. 90). The use of relaxation techniques and creative arts offered "a safe zone for the client to reexperience the trauma, providing a corrective experience" (p. 89). In sum, the counselor used sensory approaches through artmaking and music to elicit a relaxation response, as well as to recall and integrate trauma.

Method

The goal of this research was to investigate the relevance of sensory approaches in adults with serious mental illness at PHP. Following my observation that sensory-based interventions are relevant but lacking in this population, I implemented a sensory-based expressive therapy group using various art materials. Individuals typically attend PHP as a step down from inpatient psychiatric hospitalization, or a step up from outpatient therapy. They attend the program daily 9:30-3:00 on weekdays, typically for two weeks. Over the week, they attend therapy groups with psychotherapy, psychoeducation, and expressive therapies interventions, and the groups conducted for this research were one such group. Individuals also engage with case managers and psychiatric prescribers for additional support with medication, referrals, and discharge planning.

To investigate the relevance of sensory approaches with this population, I developed a sensory-based arts group to facilitate with the clients and collect their impressions through reflective notetaking. I conducted this group repeatedly in two-week intervals as the clientele cycled through the program, with a total of three sessions over a six-week period. Each session was one hour long and included three totally different groups of individuals, the first with a group of twelve, the second with five, and the third with eight. The groups took place in a group room with a large rectangular center table surrounded by chairs.

I began each group with a discussion of the senses and their potential impact on mental health. First, I listed the seven senses on the board. Since it is commonly understood that there are five senses, I prefaced this discussion with an explanation of the two lesser-known sixth and seventh senses, proprioceptive and vestibular. I invited the group members to think of examples of pleasant experiences they have had with each sense. For example, a pleasant visual experience

included “seeing a forest” and a pleasant auditory experience included “hearing the sound of rain.”

As the group members contributed their ideas, I encouraged reflection that some experiences pleasant for one person could be unpleasant to another. For example, one person might enjoy running as a proprioceptive/vestibular experience, but another person might greatly dislike it. Then, I provided psychoeducation about stimulating versus relaxing sensations, and I encouraged further reflection on how these sensory experiences might impact mental health by stimulating a person in pleasant or unpleasant ways.

Following the discussion, I facilitated an artmaking activity. In the first iteration, I provided watercolors, then in the second, I provided paint markers and brush pens, and for the third, I provided beads and objects to glue onto cardstock in a mosaic. I prefaced the activity by inviting the participants to notice that artmaking involves more than just the visual sense, although painting, drawing, and mosaics are commonly understood as visual art. This concept is known as “polyaesthetics” (Knill et al., 2005, p. 128) and informs the expressive arts therapy multi-modal approach of utilizing multiple modalities. The imagination encompasses all the senses, so various art forms can serve to express different aspects of the imagination.

In the painting group and the drawing group, I asked the participants to try painting with no paint on the brush, and I demonstrated what some different movements could look like: fast or slow, flowing or staggered, repetitive or erratic. This directive took inspiration from Natalie Rogers’ (1993) “The Big Doodle” directive, which asks the client to start a drawing by “doodling in the air” (p. 28) before moving to the page. Once the group members began to engage with movement, I invited them to explore the touch of the paper and the water, as well as the sound of the paintbrush or marker. I guided them to notice the feeling of each sensation and whether it

was pleasant or unpleasant, stimulating or relaxing. Then, I invited them to add paint to their brushes and to notice that some colors are more stimulating or relaxing as well, and to make a painting inspired by these sensations.

With the mosaic group, I encouraged them to notice the different sensory experiences of the objects, such as their textures, weight, appearance, and the sounds they make. I encouraged them to choose objects that they enjoy based on their sensory preferences to create a mosaic. In the painting and drawing groups as well, I encouraged the clients to make art based on the feeling of the sensations, rather than what the image looks like. This again mirrored Rogers' (1993) directive in "The Big Doodle" to "let anything happen" (p. 28) without worrying about its appearance.

The transition from movement to visual art-making happened naturally as the individuals felt inspired to create images through their movements. This process is known in expressive arts therapy as intermodal transfer, the idea that art may evolve from one modality to another as the artist works to fully express themselves (Knill et al., 2005). Since different modalities correlate to different aspects of the imagination, from an expressive arts perspective, the use of movement helped to elicit different imaginal material than visual artmaking alone.

As the group members began working on their paintings, drawings, and mosaics, I again invited them to notice their sensory experiences of how varying pressure creates differing strokes on the page, or how coordinated movements are required to place objects in a mosaic. I provided psychoeducation about the proprioceptive sense, informing them that proprioception allows them to notice where the art implement is on the page, how firmly they are pressing it, and how much it weighs (Taylor & Squire, 2009). I again invited them to notice how these sensations felt potentially stimulating or relaxing, pleasant or unpleasant.

I took 20 minutes to complete this initial set-up, and then I allowed the group members to make art freely for 20 minutes after that. Then, I asked everyone to find a stopping point with their art, and we arranged them on the table so that we could look at them all together during the remaining time. I invited group members to reflect on what they felt about their piece and to comment on someone else's piece as well, and I briefly documented these responses in my notes. Lastly, we closed by cleaning up, and participants filled out group notes documenting their takeaways from the group. These group notes are a requirement of the program, and group members hand these back to the facilitator to be documented in the client charts.

In addition to the group notes, I documented my experience as a facilitator with my own notes and reflective artmaking. After each group, I noted my feelings and thoughts about how it went and any comments on the efforts of each client to engage. I also later made my own watercolor paintings at home in reflection of the group activity. Lastly, I discussed these groups with my supervisor in supervision to gain insight into my capacities as a facilitator and the group therapeutic process and made note of this, as well.

To organize this information, I reviewed my notes, as well as the group notes, and pared down what seemed salient. I focused on the themes in client artwork, themes arising in discussion and group notes, and themes of my process and growth as a facilitator for each respective group session. To analyze these data, I highlighted words and phrases that stood out as salient and organized these by sub-category. Then, I wrote down new insights in reflection and repeated the above process until a few core themes crystallized, which I present below.

Results

I conducted the three group sessions with three totally different groups of individuals over 6 weeks, in two-week intervals. Though each session contained the same format and

directive to make art based on sensory experiences, each group utilized a different artmaking medium. The first group utilized watercolor, the second group, brush pens and paint markers, and the third group, mosaic making with beads and small objects glued to cardstock. For each session, I collected personal notes, and I created an art piece in parallel process to the directive I gave to the group. My notes address my developing clinical skills, as well as difficulties as a developing professional living with a chronic pain disorder and my own sensory sensitivity.

Group 1: Watercolor

The first group consisted of 12 adults aged 19-58. This was a larger group and the members engaged well in a discussion about sensory experiences. A few group members identified pleasant sensations: "petting a dog," "the smell of baking," "the sound of rain," "the sight of a beach," the movements of "dancing," "swinging," or "running," and the taste of "cheesecake." Knowing that one of the group members had a fear of dogs, I used this discussion as an opportunity to introduce the idea that different people have different preferences: one person can feel relaxed by the sensation of petting a dog, and another person could feel triggered by it. The clients were familiar with the language of "identifying your triggers," and the group made a connection between gaining awareness of sensory input and identifying the triggering sensation.

The group engaged well with the directive of painting without using pigment. Sometimes in an artmaking group at PHP, clients will observe or leave the group because they do not prefer to make art, but everyone in this group produced an image using watercolors. While everyone started off with abstract imagery due to the nature of the prompt, five out of twelve participants chose to add representational imagery to their paintings. Representational images included: a pot of flowers, a dolphin, a cartooned face, a sunset, and the word "love." Amongst participants who

painted abstract imagery, there was much discussion of the appearance being "chaotic" versus having "flow" or "pattern." Some clients reflected on their intended meaning, for example one client said that her painting represented "my version of the American flag" and then reflected that it could be her own personal flag. There was much commentary about the painting of a pot of flowers, which was a group favorite. The artist said that she usually spends hours on painting without enjoying it, "but this reminded me it's okay to do silly little paintings and it was quite therapeutic."

Group 1: Personal Process

In my personal notes, I reflected on general feelings about my progress and growth as a group facilitator and a clinician at this site, as well as my challenges with managing my own stress and wellbeing. I wrote, "I am in transition. I am growing and changing. I am noticing my edges, and pushing them. I am awake to the possibilities and potential of life." Next to this I drew wavering lines in a pattern that resembles ripples in water. I also wrote, "I feel in flow. I feel warm, sweaty. I was dizzy. My head hurts in my temples." Lastly, I reflected on the stressful nature of this internship: "When I'm up, I dream of rest. When I'm at rest, I think of being awake. What is the balance? How can I find peace? Contentment right where I am?"

For my artmaking, I did my own abstract sensory watercolor painting in my sketchbook and drew small shapes of leaves and florals in pen over the paint (Figure A1). The movement of my brush is apparent in the visible strokes across the painting. I gravitated toward warm colors in yellow-green, red-brown, and ochre, a palette reminiscent of autumn.

Group 2: Paint Markers and Brush Pens

The second group consisted of 5 adults aged 18-29. This was a smaller, less talkative group, so I took a different approach starting with a warmup and then moving into artmaking. To

warm up, I brought a collection of postcards and asked each group member to choose one and share its image with the group. Images chosen had metaphorical meanings such as a tree growing in a “difficult place” on a rock, as well as cultural meanings such as a “Zen temple” and a “New England fall” scene. Images were also shared with emotional impressions such as “calming,” “humorous,” or “peaceful.” While not an exclusively sensory approach, the postcards still provoked an emerging connection between aesthetics and emotions.

This group was receptive to psychoeducation about the senses but appeared more eager to engage hands-on with the materials rather than discuss these concepts. One participant was pulled for a meeting with a case manager during the directive portion of the group. However, the other group members followed the prompt, first painting without pigment, then creating abstract images based on their movements. The paint markers and brush pens were new to everyone in the group, so part of the artmaking was an exploration of how to work with these materials. Group members explored their preferences between the brush pens, which provided little resistance and higher precision, or the paint markers, which provided high resistance and lower precision. Some group members explored how these materials interact with water, as well.

Only one person in this group created representational images, coincidentally the same person who had been pulled during the sensory psychoeducation portion. He made an image of a train moving through space, and fruits on a path. Other participants incorporated symbolic imagery into an abstract image, adding numbers in a spiral shape like a clock, or another Image that had red and blue dripping edges on each side of the paper. Multiple sensory experiences were discussed, such as a participant who used “colors and movement that I liked” in a “calming, repetitive” way. Another participant discussed the experience of comparing the different output and textures of each material. However, the visual remained the focus across the group, with

commentary about the impact of various colors, forms, and approaches to composing the page.

Group Two: Personal Process

In my own notes, I reflected again on my embodied sensory experience. I wrote: "How am I doing? OK. Frazzled. Tired. Nervous. Tense." I also wrote," I'm struggling. I want to do better, but better isn't always better. I'm tired of being strong. I am always doing & not letting myself 'be.'" Following my own directive, I doodled a movement with my pen, loosely looping and waving across the page. I wrote again about my frustrations with my health and well-being: "When can I feel energetic & strong instead of just pretending it?"

For my own parallel process of artmaking, I drew a movement-based abstract drawing with colored brush pens in my sketchbook (Figure A2). Since these pens were new to me as well, I explored a variety of strokes and movements, creating patterns in multiple colors across the page. The patterns take on a nature-based theme with oblong leaf-like shapes in green, blue, and brown starting at the bottom of the page. Moving up the page, other colors and shapes are incorporated, with fiery red magenta dots as accents, and golden yellow undertones.

Group 3: Mosaic Making

The third group consisted of 8 adults aged 29-69. Based on the talkativeness of this group, I decided to start with the discussion of sensory experiences and not the warmup. This group had an interest in the polysensoriality, or the integration of multiple senses in their experiences, as termed by Bailliard et al. (2017). One group member became interested in the idea of a "road trip" to the beach and immersed herself in imagining the sound of waves, the feeling of the sand, the smell of the ocean, and the sight of the beach landscape.

Since this group utilized mosaics, I did not include the activity of painting without pigment. Rather, we started by examining the different sensations provoked by the mosaic

objects, which consisted mostly of beads, pompoms, and tiles. There was a focus on the shape, color, and texture of the objects. I also brought to the group's attention the sounds made by digging through beads and the smell of the glue. In the process of creating the mosaics, the participants worked together to share materials and approaches to their work. Later, participants noticed a certain amount of dexterity was needed to arrange and glue the small objects. Participants expressed difficulty with using glue, but also a certain amount of nostalgia with crafts from childhood.

One participant was pulled from the group for a meeting halfway through and did not return until after the end, so she could not finish her artwork. 4 out of 8 participants Included words, symbols, or representational images in their mosaics. One participant made mosaics with her name and her daughter's name. Others chose beads with smiley faces. The person who had been interested in the beach wrote "road trip" with lettered beads and drew a palm tree beach scene. Another person wanted to write something but could not find the letters needed, then pivoted to try to make a "nonsensical" piece of art.

Even participants who did not utilize words or symbols were concerned with the artwork's appearance, describing an interest in "symmetry" or "cohesion" of the "various elements." Other participants became interested in the sensory experience of materials. One participant used only tiles and enjoyed exploring their smooth glaze, muted colors, and weightiness. Another participant made a mosaic using only pompoms in a variety of bright colors. Yet another participant chose to make beaded bracelets instead of the mosaic suggested in the directive.

Group Three: Personal Process

In my personal notes, I once again reflected on my feelings and capacities as a facilitator.

I wrote, “I’m feeling calm but also flustered. In my element with art, but also anxious—anyone could need my help at any time—how can I help everyone? ... I’m scared I won’t do a good job.” I also reflected again on my somatic sensations and concerns of stress: “My low back hurts. I’m tired. My eyes are heavy. My mouth is dry. I feel overwhelmed. ... Why is it like this? I just want to be OK right now.” I drew a “mosaic” of sorts in my notebook; various patterns arranged in sections around the words on the page with stars, music notes, carets, squiggles, and commas.

For my own parallel process of artmaking, I did not have access to the same mosaic materials at home, so I opted for a collage made of gift-wrapping materials instead (Figure A3). I felt that this mirrored the mosaic directive in the use of various materials collaged into one piece. Following the nature of the materials, the color palette is reminiscent of winter and Christmas. Aqua and silver florals and wintergreen branches decorate the page. Aqua and magenta ribbons float in coils on top of the collage work. A few doodles of hearts are sprinkled throughout the background. The crumpled paper and ribbons puff up from the page, resisting the glue that holds them down.

Discussion

Analysis of the resulting data yielded three main themes: sensory experiences and preferences, interpretations of the therapeutic benefit, and narratives of success or failure. As sensory psychoeducation was provided during the intervention, the theme of sensory experiences and preferences was expected to arise in the data. Interpretations of the therapeutic benefit was also an expected theme as this is a frequent reflection in the treatment of PHP. Narratives of success or failure was not an anticipated theme, since the goal of the group was to explore and not achieve or reach any specific outcome. However, this theme arose prominently in the expectations that participants placed on themselves in their artmaking process, as well as my

expectations on myself as a facilitator.

Sensory Experiences and Preferences

Sensory experiences and preferences were common responses across both the group participants and my own experiences as a facilitator. Sensory experiences consisted of identification of a memory of a past sensation, or a present experience of sensation occurring within the activity. Sensory preferences consisted of identifying that a sensory experience was either liked or disliked.

In discussion, participants readily recalled pleasant sensory experiences involving single or multiple senses (polysensoriality.) Building on this pre-existing awareness, participants described positive and negative sensory experiences that occurred in the artmaking process. Senses described included the tactile feel of the materials, visual aesthetics of the image, movement of the brush (or in the case of the mosaic, the movement of placing and gluing the objects), background sounds of music played during the session, and embodied aesthetics of memories (such as the beach scene). One participant described, “The feeling of running a utensil across a blank page and creating color is like no other.”

In a parallel process, I noticed again that I am a sensory-sensitive person by nature and highly aware of the aesthetics in my own creative work. I am especially drawn to using color and shape to express myself. I also prefer to use expressive movements in my art, which I incorporated even in the margins of my notetaking. I was surprised, however, to notice my own usage of embodied aesthetics in my parallel artmaking process with nature themes that stimulated my pleasant memories of the outdoors, as well as with giftwrapping materials and memories of the holidays.

I found that the participants and I both reflected on our respective sensory preferences

through engaging in artmaking, psychoeducation, and discussion. Therefore, I concluded that sensory approaches were relevant in this group of participants and led to therapeutic insights for both the clients and myself as a clinician. This finding is supported by the work of Kandlur et al. (2023) and Hitch et. al (2020) whose research has shown emerging evidence of sensory modulation interventions applicable to populations with mental illness. Mcgreevy & Boland (2020) have also identified the usefulness of sensory interventions in working with trauma survivors, which is relevant to this group because most individuals participating had a trauma history, and some individuals also had a PTSD diagnosis.

Interpretations of the Therapeutic Benefit

In the process of PHP, participants are continuously made aware of what they might have learned from each group, and they are asked to report on this regularly. As such, they are highly aware of whether they perceive a group to be beneficial and their underlying reasons for deciding such. While this directive emphasized the sensory aspect of psychoeducation, participants found their own ways to independently integrate various benefits of the activity.

Therapeutic takeaways that participants identified included mindfulness (being in the moment while creating art), relaxation (a perception that creating art relieved stress), identifying preferences (ways that the activity was enjoyable or likable), distraction (taking one's mind off difficult emotions or thoughts), expressing oneself (conveying a unique expression through art), creating gifts (artwork made to give to a family member or friend), tackling challenges (working through a problem that arose in the process of artmaking), cooperation with the group (giving and receiving help, advice, or shared art materials), and trying a new activity (using a new medium to create art). Some participants described with specificity how the activity benefited them in their group notes. One participant wrote that the activity was, "very nice to relax and let

my worries slip away temporarily." Another described that art "can make you think of different emotions that are put on paper." Yet another described taking away from the activity that there is "art within us all."

The benefits observed by the group participants are corroborated by expressive arts therapy theorists. Knill et al. (2004) describe the therapeutic benefits of arts activities, including that "they are rich exercises with repetitive experiences of accomplishment; they are psycho-physical, concrete experiences that allow emotional and cognitive reasoning; they are sensory experiences that touch or nourish the soul […]; beauty [of the artwork] can be motivating and convincing, bypassing the barriers built by cognitive reasoning and the logic of resistance and fear; with the repetitive experience of coping, belief in one's lack of competence and ability are challenged" (p. 92). Rogers (1993), describes that the arts help clients to "identify and be in touch with feelings; explore unconscious material; release energy; gain insight; solve problems; and discover intuitive, mythological, and spiritual dimensions of the self" (p. 96).

The therapeutic outcomes that clients named were not necessarily aligned with what they had discussed initially as the potential benefits of sensory awareness, as they had resulted from the totality of an artmaking experience, rather than a purely sensory one. In a parallel process, I found again that I had my own goals for what I wanted to achieve for the group with this activity, but I was surprised by the diversity of takeaways that arose from artmaking. I reflected that my effectiveness as a facilitator arises from multiple capacities outside of psychoeducation alone: facilitation of group reflection and discussion, therapeutic artmaking, and processing the issues that arise within the group.

As a further benefit to myself as the facilitator, the group process elicited sensory reflections of my embodied experiences, which I journaled in detail. These included bodily

sensations of tiredness, physical pain, and stress responses such as sweating or having a dry mouth. I also reflected on my emotions of sadness, anger, and fear, which came to the surface as I tuned into my sensations. Through this reflection, I identified repressed emotions that had pent up while working as a clinical intern, and I have since sought supervision to manage this countertransference.

This release of repressed emotions could be an effect of the artmaking process by externalizing inner, unspoken feelings into a physical product through art (Rogers, 1993). Malchiodi (2003) suggests that the act of artmaking helps the individual to connect to unconscious thoughts not readily accessible in talk therapy. This can further help the client to "reconnect implicit (sensory) and explicit (declarative) memories of trauma" (Perryman, 2019, p. 83) through artmaking as a less threatening means of self-expression.

Narratives of Success or Failure

In the process of artmaking, participants showed a tendency to assign value judgments to their work. These judgments related to skillfulness with materials, craftsmanship, realism, cohesiveness of visual elements, and aesthetic effectiveness. Though no such standards were assigned in the directive, participants brought their own judgment criteria presumably from cultural norms or experience. Judgments were both positive and negative, indicating perceived success or failure in the creative process. Narratives of success correlated with liking, loving, or enjoying the group, while narratives of failure correlated with difficulty in execution and upsetting emotions. Narratives of success were backed by compliments received from peers that an artwork was well-executed or beautiful.

Several participants conveyed these narratives in their group notes. Examples of success narratives included one participant who conveyed the idea that he could "see things through to

the end" by completing the artwork and participating in the group. Another participant described that he enjoyed the process of "trying to make a cohesive piece of the various elements." Narratives of failure included comments such as the activity was difficult and reflections of anxiety or frustration in the artmaking process, corroborating a view that the intervention was unhelpful overall. One participant described feeling that "even when the precision doesn't matter and the outcome is irrelevant, painting still gives me anxiety." Another participant wrote, "I am not into arts + crafts that much. I find it hard to do."

In the group discussion process, I countered these narratives with the idea that all artwork produced in this activity is valuable in its inherent achievement of self-expression. As I noticed the emerging theme in the earlier group sessions, in the third session, I offered to help a participant who struggled with gluing objects onto her mosaic. Therefore, a narrative of challenge and difficulty was transformed to one of success in receiving the support needed to achieve the desired creative outcome.

In a parallel process, I found in my notes that I had made critical judgments on my own skill as a facilitator. I wrote, "I'm scared that I won't do a good job." and "I need to be on guard, always doing better." I found that I could counter these judgments as I processed the group's therapeutic outcomes, in opposition to my own narrative of my lacking skills or limited professional experience. In a final affirmation to myself, I wrote, "What's a good job? I'm good. ... I got this."

From these narratives of success and failure, I concluded that these participants have evaluated the success of their treatment based on their perceptions of these groups, and further, that I have evaluated my effectiveness as a clinician based on my perception of these client narratives. Although these narratives of success or failure pertained to artmaking, I theorized that

they may represent a greater metaphorical collective experience.

Expressive arts therapy theorists such as Halprin (2002) have demonstrated the idea of the creative process as a metaphor. Halprin conceives of "blocks in the creative process as metaphor" standing in for "a larger life experience" (pp. 88-9). She describes that "how we work creatively and how we get blocked reflect our personality and life scenarios" (p. 89). Examples include patterns of fear of collapse, black and white thinking, silencing of the self, or hypercriticism. Therefore, I theorized that black and white narratives of success or failure in these groups may correlate to an experience of striving toward perfectionistic goals of remission, functioning, or achieving otherwise sound mental health resulting from mental health treatment. My own narrative of my facilitation also correlated to this view.

The hyper-idealized treatment outcomes expected by some clients may result from the societal expectation of compulsory able-mindedness, which compels everyone to strive toward norms of a 'healthy' mind. Meanwhile, "unpleasant feelings such as sadness are misunderstood as symptoms of impairment rather than effects of discrimination" and "can easily be dismissed as hysterical" (Wechuli, 2023, p. 2). By nature of being categorized as mentally ill, these individuals become minoritized, and therefore will "experience heightened stress resulting in poorer mental health outcomes simply by virtue of the microaggressions and daily barriers associated with minoritized status" (Thomas, 2024, p. 4).

Compulsory able-mindedness demands for the reduction or elimination of symptoms or pathology, which may be impossible to achieve with solely clinical interventions. Furthermore, the medicalized model of mental healthcare impedes clients from identifying certain origins of their distress, since this is diagnosed as a pathology located within the individual, without systemic or trauma-informed context. Symptom management is applied to mitigate the identified

pathology, but cannot necessarily cure it, and the individual is assumed by their diagnosis to live a life of dysfunction and distress (Lyons, 2023).

Due to the pathologizing of distressing emotions, the epistemology of mentally ill individuals is subjugated beneath medicalized and scientific understandings of psychiatric disease (Wechuli, 2023). This subjugation of knowledge is one manifestation of the oppression of mentally distressed individuals as a minoritized group, also known as sanism (LeBlanc & Kinsella, 2016). These individuals are prevented from implementing their learnings of their own lived experiences within mental healthcare institutions that demand compliance with established rules and policies, or else go without care (Lyons, 2023). However, "what presents as a 'bold claim'" through the "mainstream lens" of psychology and psychiatry "may be a matter-of-fact observation from the lived experience of a minoritized perspective" (Thomas, 2024, p. 2).

Therein, narratives of perceived failure amongst mentally distressed individuals may result from their experiences of compulsory able-mindedness, whereby 'recovery' signifies the complete eradication of abnormal behavior in favor of normed expectations of behavioral health. Such unreachable societal expectations could lead the individual in distress to feel an inevitable failure, as social distress itself has been deemed abnormal psychology in the hyper-individualistic society, which commodifies mental health and well-being for mass consumption (Rimke, 2016). Therefore, psychiatry, psychology, and the so-called "psy complex" (p. 4) serve to habituate individuals in distress to a systemically unjust society, thereby blaming "the marginalized and underprivileged for their socially produced suffering" (p. 9). Rimke (2016) terms this societal tendency as "psychocentrism" (p. 4).

As mental health professionals operating within this established system of care, we are likely to be influenced by the tendency toward medicalization, which causes the framing of

problems to shift “towards medical and technical solutions, neglecting necessary social, community, or political action” (Clark, 2014, p. 2). However, clients and clinicians can benefit from recovery-oriented practice in mental healthcare, wherein the goal of treatment becomes “self-determination, empowerment, and self-esteem" (Chisholm & Petrakis, 2022, p. 1382) as well as “delivering hope” (p. 1392). Furthermore, the Neurodiversity Paradigm acknowledges natural biological variation in neurotypes without assigning a value judgment to them, and thereby allows *difference* to be distinguished from *distress.* Lyons (2023) proposes that within a Neurodiversity-informed paradigm, mentally ill people are the experts of their own experience, and therefore experts in determining what support is most needed in times of distress.

To reclaim the politicized identity of mentally ill individuals, scholars have begun using the term “Mad” to self-identify as members of this group (Russo, 2001). Hess (2022) describes that so-called “Mad stories” (meaning, narratives of mental distress) are subjugated due to their tendency toward narratives that do not conform to conventional structures of “temporality, sociality, and place” (p. 7) and therein defy expectations of coherence and congruity. Therefore, Hess suggests a model of critical storytelling to empower the epistemology of madness as a way of knowing.

Artists like Hess (2022), a music educator, have been at the forefront of reframing narratives of distress toward collective liberation and empowerment. Artist, social scientist, and psychiatrist J.L. Moreno (1953) described the creative process of challenging extant cultural products and ideas as “The Creative Canon” (p. 46) in which spontaneity functions as the means for creativity to be released, thereby challenging existing norms. Drama therapist Sayre (2022) builds on Moreno’s (1953) framework to argue that marginalized individuals are most strongly invested in their creative impulses because of their desire to shift the status quo and envision a

better world without marginalization.

Sayre (2022) proposes that a decolonized 'therapy' could "include a perpetual process of discovery, un-internalizing oppression, and learning to celebrate and value the very traits the mental health field pathologizes" (p. 5). Applied to a Mad Studies and Neurodiversity informed perspective, Sayre's (2022) decolonization of therapy suggests a new way of mental healthcare where lived experiences are valued as knowledge, distress is met with community and compassion rather than medicalization, and stigma and oppression are met with resistance, empowerment, and acceptance of difference.

Limitations

This study was limited in its small scope and subjectivity. Though I theorized about broad narratives of success and failure within the experience of mental health treatment, the findings of this study were not generalizable to clinicians or clients in the field of mental health, and only represented the experiences of myself as a facilitator and the clients in these three sessions. The client base was diverse in mental health diagnosis and age range but limited in diversity in terms of race/ethnicity and LGBTQ identity, with most clients identifying as straight, cisgendered, and white, as well as myself. The discussion of recovery-based mental health practice was also limited within the scope of PHP, which is a higher-level of care and a medicalized setting. Future research could expand on narratives of sanism and experiences of mental health treatment with larger studies of more diverse populations, quantitative data collection, and a broader examination of the literature pertaining to this topic.

These themes are complex, and I struggled throughout the research process to reconcile my desire to pursue empowerment and autonomy on behalf of the clients with the reality of what I was able to accomplish as an expressive arts therapy intern. There is much more that could be

said about recovery-oriented practice in mental health, the eradication of compulsory able-mindedness as a form of social justice liberation, the empowerment and acceptance of folks debilitated by mental distress, and sensory approaches in mental health. However, I offer this method, a sensory-based group activity at PHP, to explore and address the potential for change in the way we think about mental health systems of care.

Implications

This study adds to a large base of research showing the relevance of sensory approaches in individuals with mental illness, however, the research is lacking in specific methods to utilize in therapy (Bailliard & Wigham, 2017). Arts-based sensory approaches are one potential method highlighted in this thesis. Research shows that art therapy is effective in the treatment of trauma and that trauma symptoms contribute to sensory dysregulation (Perryman et al., 2019). Future research might explore whether the sensory focus of this method of art therapy provides an alternate therapeutic benefit as compared to more cognitively based art therapy directives.

In the setting of PHP specifically, this method also suggests the helpfulness of sensory psychoeducation, which can be integrated into existing group therapy approaches. This method provided the opportunity to collect extensive data on the perceived helpfulness of art therapy in the PHP setting. Clients provided specific, relevant, and thoughtful reflections on the ways that they experienced art therapy as helpful to their treatment. Therefore, this method contributes significant evidence that art therapy can be experienced as helpful in the PHP setting and provides initial evidence of the same for sensory psychoeducation.

This study provides a perspective of some clients who viewed their mental health treatment in black-and-white terms as either a success or a failure based on how positive or negative they felt about their experience in a therapy group. Further research could inquire about

the perceptions of individuals in mental health treatment about their care in general, and how these narratives may promote or inhibit successful outcomes in treatment. Furthermore, research could inquire as to how recovery-based mental health practice might impact client perceptions about their mental health treatment, as compared to the medicalized model of psychiatry.

Conclusion

In this thesis, I presented a method in which I conducted three sensory-based art therapy groups at PHP with adults with mental illness. I theorized that sensory approaches could benefit clients who struggle with hyperarousal during therapy groups, and I found evidence that some clients did benefit from self-reflection and identified their capacities for self-regulation during these sessions. I found that the therapy groups elicited client reflections on their sensory preferences and experiences, their interpretations of the therapeutic benefit of the group, and narratives of success and failure. I used these findings as a starting point to theorize about the benefits of recovery-oriented mental health practice and the need to decolonize the able-minded ideals of what "successful" mental health treatment looks like.

This research was impactful to me as a clinician in reframing my definition of "success" with clients in my practice, and even the definition of what success might mean in the greater scope of my career. I am confronting an ongoing realization that the idea of cure is based on the medicalization of disability, and poses a patriarchal, ableist, normative ideal of what health and wellness should be (Clare, 2017). I am coming to terms with my own mental health and chronic pain and the understanding that my life experience with recovery and self-empowerment will set the stage for my future clinical work. I am gaining the understanding that the empowerment of individuals with mental and physical disability functions as a resistance against ableist norms, and that resistance can be a form of therapeutic success in the face of oppressive ableist

standards in society (Piepzna-Samarasinha, 2018). I am looking forward in my career to becoming a practitioner who embodies empowerment and self-acceptance with disability and fostering this in my clients as well. I hope that this thesis provides insight into the relevance of disability justice, recovery-oriented practice, and expressive arts therapy so that others might also inform their clinical work with this approach.

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Appendix A

Parallel Artmaking Results

Figure A1. Watercolor Painting.

Figure A2. Brush Pen Drawing.

Figure A3. Mixed Media Collage.

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA

Student's Name: _____ Margo Seidan_____

Type of Project: Thesis

Title: Sensory Approaches with Serious Mental Illness: Capturing 'Sanism' in Mental Health Treatment

Date of Graduation: _____ May 18, 2024_____
In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor:_____ Raquel C. Stephenson_____ **_____**