

The History of Group Art Therapy with Adult Psychiatric Patients

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The History of Group Art Therapy with Adult Psychiatric Patients

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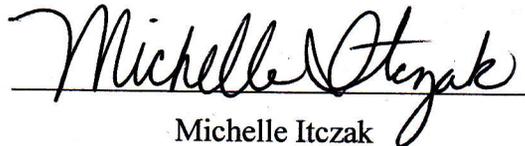
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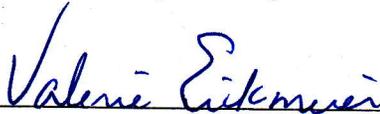
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## Abstract

History is a cyclical phenomenon; by reviewing the past, we can gain knowledge to improve the future. Since art therapy was first conducted in psychiatric hospitals, it is important to reflect on the history and commemorate where art therapy initiated. Art therapists have been facilitating group art therapy with adult psychiatric patients since the 1940s (Walker, 2012). Through reviewing the history of group art therapy that has been conducted with adult psychiatric patients, current art therapists can learn from art therapists' experience to inform current treatment. This thesis will examine the history of group art therapy with adult psychiatric patients from the 1960s to the present and explore the changes that have occurred in both the hospital setting and group art therapy structure. This thesis will also inspect the findings documented in articles about group art therapy with adult psychiatric patients as well as how the authors reported the findings.

Keywords: group art therapy, history, adult psychiatric patient, mental illness

### **Dedication**

This thesis is dedicated to my husband, Ben. You stood by my side through this whole process. I could not have done this without you. Thank you. We made it.

### **Acknowledgements**

I would like to acknowledge Juliet King MA, ATR-BC, LPC; Eileen Misluk ATR-BC, LPC, LMHC; and Michelle Itczak ATR-BC, LMHC. Each of you encouraged me and gave me valuable insight that guided me through this process. Thank you for all of your hard work and dedication.

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## Chapter 1: Introduction

Treatment in psychiatric hospitals has been evolving since the first hospital was constructed in America in 1752 (Foerschner, 2010; National Institute of Health, 2006), and until the 1950s the hospital system was constantly searching for a treatment that would cure mental illness and permit patients to return to society (Dain, 1975; Deutsch, 1946). Over the years, numerous different methods have been used in psychiatric hospitals to treat patients. Art therapy originated in psychiatric hospitals in the 1940s and 1950s, when artists and art educators facilitated open studio classes for the patients (Walker, 2012). Group art therapy allowed for a unique form of treatment that was different from the traditional treatments in psychiatric hospitals by providing the participants a non-threatening method to express themselves. Art therapy promotes a distinctive process that aids in eliciting expression in ways that verbal therapy cannot and assists with accessing the unconscious, providing participants a mode to bridge their inner and outer world (Shechtman & Perl-Dekel, 2000). The artwork also supports communication among patients that frequently have difficulty articulating themselves verbally (Landgarten, 1975).

As the hospital system continued to advance in the 1960s and 1970s, there was a decrease in long-term hospitalization of patients and an increase in acute treatment (Geller, 2006). During this time, art therapists learned to adapt to the changing system. Their groups were modified to meet the needs of the new hospital structure, and there was an increase in the publications about group art therapy in psychiatric hospitals as well as texts documenting the art therapists' struggles to meet the patients' needs within the new system (Allen, 1983).

A search of the literature shows that while art therapists have been researching how patients benefit from group art therapy, they have not assembled any single document that

reports the complete history of group art therapy with psychiatric patients. This research will attempt to fill this gap by compiling research on group art therapy with adult psychiatric patients and outlining the history of group art therapy treatment with this population. This thesis will also analyze the types of studies the authors conducted, the outcomes documented by the art therapists, the directives used in the group sessions, and how the groups were structured. While group art therapy with adult psychiatric patients began in the 1940s and 1950s, no articles were found during this period (Hogan, 2001; Walker, 2012). Therefore, this thesis will only examine research that has been conducted on group art therapy with psychiatric patients from the 1960s to the present day.

Accumulating the history of group art therapy treatment with adult psychiatric patients could uncover approaches that would benefit the art therapy community. Learning from the preceding research will guide art therapists on how to structure their groups by obtaining information from what other art therapists have discovered to be beneficial. Additionally, this study seeks to support the importance of conducting research in the art therapy field by demonstrating how therapy has evolved over time. Research questions in this literature review are as follows: What is the history of group art therapy with adult psychiatric patients? What kinds of studies did art therapists conduct and how did they structure the groups with this population? How did art therapists communicate the outcomes?

This study is a significant resource for art therapists since there is no evidence that a compilation of literature that focuses on group art therapy with adult psychiatric patients has ever been completed. Therefore, this literature review will serve as the first comprehensive document on this topic. Since art therapy was first conducted in psychiatric hospitals, it is important to reflect on the history and commemorate where art therapy initiated in order to improve future

treatment for patients. By examining the whole history of group art therapy with adult psychiatric patients, we can begin to see patterns that emerged and discover best practice methods to inform future treatment.

### **Operational Definitions**

Adult Psychiatric Patient: An individual, 18 years old or older, that receives psychiatric inpatient treatment for a severe and persistent mental illness (Reaume, 2002).

Art Therapist Educational Training: “A master’s degree is required for entry level practice in art therapy. Educational requirements include, but are not limited to, theories of art therapy, counseling, and psychotherapy; ethics and standards of practice; assessment and evaluation; individual, group, and family art therapy techniques; human and creative development; multicultural issues; research methods; and internship experiences in clinical, community, and/or other settings” (The American Art Therapy Association, 2014).

Chronic Mental Illness: A mental illness that causes the patient to be unable to provide basic needs such as medication regime, food, hygiene, and money management for a significant period of time (Shadish, 1989).

Closed Group: A group closed to outside participants with a limited number of sessions (Sprayregen, 1989).

Forensic Mental Health Services: Mental health services that are provided by the court through the criminal system. “Forensic services range from evaluations of competency to stand trial to providing mental health services to persons found by courts to be not competent to stand trial, not guilty by reason of insanity, and/or guilty but mentally ill” (Lutterman, Berhane, Phelan, Shaw, & Rana, 2009, p. 19).

Group Art Psychotherapy: A type of group art therapy in which the therapist is an active leader and plans interventions to create a supportive environment. The group has a focus or goals that the members are working on in the group setting. Problems are explored through the art in the group (Sinrod, 1964).

Group Art Therapy: A therapy group that utilizes art making as a method for people to express themselves or as a technique to support group cohesion. The art therapy group is a therapist-guided space in which individuals can make art in a supportive atmosphere with other individuals (Malchiodi, 2012).

Group Therapy: A setting that allows patients the chance to learn from each other in a controlled social environment that is lead by a therapist (Svavarsdóttir, Ólafsdóttir, Sturludóttir, & Júlíusdóttir, 2012).

Hospital Psychiatric Unit: “A section of a general, regional, or community hospital devoted to the provision of twenty-four hour inpatient psychiatric treatment” (Farley, 1998, p. 8).

Open Group: A continuous group that allows individuals to attend group when they desire and leave the group as they desire (Nassar, Kremberg, & Corso, 1981).

Open Studio: A type of group art therapy in which individuals create self-initiative artwork in a group environment. Each person works at their own pace and the act of creating art is healing for the participants (Allen, 1983).

Short-Term or Acute Treatment: Time limited treatment with the goal to stabilize the patient and provide a safe environment while the patient receives a prescribed medication regime and therapy (Dick, 2001).

## **Chapter 2: Methodology**

This study is a literature review of research conducted on group art therapy with adult psychiatric patients. This review used a predetermined guideline to search for articles on group art therapy. This guideline encompassed the following two components: a population of adult psychiatric patients and the type of group used was group art therapy. Group art therapy, in this context, encompasses various treatment methods and techniques. Subsequently, all of the related articles were collected, evaluated, and entered into a literature matrix that was organized by decade.

Electronic search engines, such as EBSCOhost, ProQuest, Google Scholar, IUCAT, and Web of Science were used to research articles for the subject of this research. The EBSCOhost search engine is comprised of seventy-three databases, ProQuest has thirty-six different databases that it searches, the Web of Science search engine includes four databases and Google Scholar is a search engine that utilizes scholarly resources from a broad number of databases. IUCAT searches books, journals, films, and other resources within the Indiana University network. An assortment of search terms were used in an attempt to encompass all research conducted on the topic of group art therapy with adult psychiatric patients. Research that encompassed various countries was collected that included dissertations, books, and journals on the topic. Sources included psychiatry, medical, mental health, and art therapy articles, all of which were related to group art therapy with adult psychiatric patients. A list of search terms and electronic databases was constructed and displayed in Table 1.



literature was examined to evaluate the types of studies conducted, the types of structure that the art therapists used during the group sessions, the directive given during group, materials used, and the outcomes of the art therapy group.

Analysis of data examined the findings of the articles in order to identify the type of study that was conducted, which were group case studies and experimental designs. The data was analyzed to determine the type of structure that was utilized. The articles were categorized by type of structure that included open studio, semi-structured, and structured. Open studio groups were defined as a group that granted the patients with the greatest amount of freedom in the group setting. Semi-structured groups were defined as a group that still allowed the patients to have some freedom in the group while having a framework of how the session was organized. Structured art therapy groups were defined as a group that provided the highest level of structure during the group art therapy sessions.

The data was examined for the directive given during group and the materials used, as well as the outcomes discussed by the art therapists; these components were tracked in the literature matrix. These outcomes were noted through various methods including observations, surveys, pre-post art therapy interventions, changes in artwork, and self-report from patients.

The limitations of this study include focusing solely on adult patients and not considering articles that encompass children or adolescents patients. Another limitation is concentrating on psychiatric patients and excluding other populations that group art therapy has been conducted with. By only focusing on adult psychiatric patients, this study will reject group art therapy articles that have been conducted with other adult populations, such as in nursing homes and group homes.

The first delimitation is that this researcher chose not to utilize articles that identified family art therapy as the intervention during the group sessions. While family art therapy is a form of group art therapy, this study only incorporated group art therapy with non-related individuals. The next delimitation was not using articles that only discuss a single person case study within the group art therapy sessions. This study chose to focus on all group members' experiences within the art therapy group. The final delimitation of this study was not including any articles that were conducted in nursing homes or group homes. This helped narrow the focus of this study to include patients in psychiatric hospitals.

### Chapter 3: Literature Review

#### Psychiatric Hospitals

Psychiatric hospitals have been treating patients in America for the past 260 years. When the first mental hospitals were introduced in 1752, they were viewed as a revolutionary system to treat individuals with mental illness (Foerschner, 2010; National Institute of Health, 2006). Individuals with mental illness were no longer locked in jails or cared for by their families, but treated by physicians that attempted to cure the individual's mental illness (Dain, 1975). By the 1950s, the population of America had grown to 152 million people (National Institute of Health, 2006; U.S. Census Bureau, 2000), and the growth of patients in the psychiatric hospitals increased to 512,501 patients (Lutterman, Berhane, Phelan, Shaw, & Rana, 2009). There was an increasing fear among the public that mental illness was a disease that could be contracted to other people by proximity (Geller, 2006). This fear, coupled with the credence that mental illness could be cured, contributed to the greatest increase of psychiatric hospitals. The state psychiatric hospitals in the 1950s and 1960s were mainly focused on long-term care, with many patients remaining in the hospital for years. The growth of the patient population in psychiatric hospitals continued to increase in the following years, as seen in Table 2, and institutions struggled to keep up with the growing number of patients.

Currently in every state, there are state operated psychiatric hospitals available for individuals that require an intensive level of mental health treatment. As of 2007, 13 states had one psychiatric hospital, 26 states had three or fewer psychiatric hospitals, and 11 states had six or more psychiatric hospitals (Lutterman, et al., 2009). These psychiatric hospitals treat approximately 50,000 patients each year, and patients stay for shorter amount of days than they prior to the 1980s (Lutterman, et al., 2009; National Institute of Health, 2006; U.S. Census Bureau, 2000).

While there was a decrease in psychiatric hospitals, there was an increase in community centers, forensic mental health facilities, and outpatients treatment facilities. Some of hospitals were repurposed into community mental health centers and forensic mental health facilities; others were closed completely.

Table 2

*Number of Resident Patients in State and County Psychiatric Hospitals: 1950-2005*

Year	Number of Hospitals	Residents at the End of Year
1950	322	512,501
1955	275	558,922
1960	280	535,540
1965	290	475,202
1970	315	337,619
1975	313	193,436
1980	276	132,164
1985	279	116,136
1990	281	92,059
1995	258	69,177
2000	230	54,836
2005	204	49,947

Note. Adapted from “Funding and Characteristics of State Mental Health Agencies,” by T. Lutterman, A. Berhane, B. Phelan, R. Shaw, and V. Rana, 2009, *Center for Mental Health Services: Substance Abuse and Mental Health Services Administration*, 2007, p.43.

### **Treatment of Mental Illness**

In the late 1700s the rise of *moral treatment*, which was based on treating the patients with kindness and sympathy, began with Philippe Pinel in France (Deutsch, 1946). Pinel refused to use restraints or chains to subdue patients; instead they were given access to music, books, and fresh air (Deutsch, 1946; Gardner, 1975). Pinel also began talking to patients and taking background information about them (Gardner, 1975). This allowed many patients for the first time to tell their story and a great number of patients began to exhibit improvements that were previously unseen. However, moral treatment did not come to America until 1828 when Dr. Galt introduced the new program in Virginia hospitals (Kety, 1975). Dr. Galt was also the first person to separate the chronically ill patients from the acutely ill patients within the hospital structure (Dain, 1975; Gardner, 1975). This form of treatment claimed to improve 60% of patients in the hospital, the greatest improvement seen thus far by any treatment (Dowdall, 1996; Dain, 1975). Unfortunately, moral treatment was shorted lived and by the Civil War it was no longer utilized; the prior methods of restraining and locking up patients returned as the common technique to control undesirable behaviors (Kety, 1975).

Throughout the years clinicians believed that mental illnesses could be “cured” and they tried many techniques in an effort to find an treatment that “cured” the patients. This belief often led to changes in the psychiatric treatment. The greatest transformation and growth of psychiatric hospitals occurred over the past one hundred years. In the early 1900s the rise of scientific and biological medicine to lead chemically restraining patients; these included drugs chloroform, bromides, and ether (Kety, 1975). Neurologists contributed to the field with the rest cure. Patients prescribed the rest cure were left alone to lie in bed both day and night; the idea was that rest would heal the patient’s nervous system (Foerschner, 2010). Also during the 1900s,

psychiatric hospitals began to use psychoanalysis, and hypnosis began as a mode of treatment (Geller, 2006). For the first time since before the Civil War, patients were being listened to and asked about their history, and once again, patients' symptoms were being reduced at a high rate (Dain, 1975; Foerschner, 2010; Sabshin, 1975). Important discoveries about the brain function in neuroscience and behavioral research lead to the development of electroshock therapy, psychosurgery, and psychopharmacology in the treatment of chemical imbalances in the brain (Foerschner, 2010; Geller, 2006; Kety, 1975). Huge leaps in psychiatric understanding and treatment continued in the following years. The first lobotomy was performed in 1935, with the intent to tranquilize uncontrollably violent or emotional patients (Foerschner, 2010). In the 1950s, there was a major breakthrough and the first antipsychotic medications were being used in psychiatric hospitals to treat severe mental illnesses such as schizophrenia and other types of psychosis (Foerschner, 2010). Additionally, there were significant discoveries about brain function in neuroscience and behavioral research that informed the treatment of chemical imbalances in the brain (Foerschner, 2010; Geller, 2006; Kety, 1975). Monumental advancements in psychiatric understanding and treatment continued in the following years. Although medications did not cure mental illness like clinicians believed at that time, it was able to manage the symptoms (Foerschner, 2010; Gardner, 1975). New forms of therapeutic treatments were also being introduced such as client-centered approach, behaviorism, group therapy, and family therapy (Junge, 2010). The 1950s proved to be an innovative time for managing mental illness.

Currently psychiatric hospitals have moved away from using the milieu model that was popular in 1930s and use a psychodynamic focus in therapy. The treatment that is presently being used is the medical model where the majority of the decisions are made by staff (Geller,

2009). The role of the psychiatric hospital is to stabilize the patient with medication and extensive programming with the goal of returning the patient to a less restrictive setting (Dick, 2001; Lipsitt, 2003). Many authors stated that this new method of treatment has led the psychiatric hospital to become a 'revolving door' with most patients having recurring acute stays in the hospital (Dick, 2001; Foerschner, 2010; Geller, 2009; Lipsitt, 2003). Current reports state that one in four Americans experiences a mental health or substance abuse disorder each year and more than two million Americans will be discharged from a hospital with a diagnosis of mental illness or substance abuse disorder (American Hospital Association, 2014). This is a large number of individuals that continually cycle through the mental health system, which could be due to the deinstitutionalization movement.

### **The Deinstitutionalization Movement**

The psychiatric hospitals has gone through several changes since the first hospital was built in 1752, but the deinstitutionalization movement and development of medication to treat mental illness introduced the largest reform in mental health care to date. It began in 1954 when the continuation of pharmacological treatment stimulated the deinstitutionalization movement (Foerschner, 2010). Deinstitutionalization initiated when anti-psychotic drugs were introduced that helped to control symptoms of psychosis (Foerschner, 2010; Junge, 2010). Medication worked best for acutely ill patients, and they were quickly released into the community (Junge, 2010; Shadish, 1989). Most of these patients were never violent or never had very severe symptoms. The advancement of pharmacological treatment allowed these patients to return to their homes, to their jobs, and families. Over time, acute patients were primarily treated in community settings and did not need to be placed in psychiatric hospitals (Shadish et al., 1989). This led to an increase in outpatient mental health clinics and treatment outside of the hospital

setting. The use of pharmacological treatment facilitated a new form of treatment and understanding of mental illness, and the theory of having a chemical imbalance in the brain seemed to be substantiated. This was the first wave of deinstitutionalization and it continued in this manner for the next 10 years.

While new forms of medical treatment initiated the first wave of the deinstitutionalization movement in the mid 1950s, it was changes in the social and political culture that started the second wave of deinstitutionalization. In the 1960s, there were multiple revolutions in social and political policy, such as counterculture, the anti-war movement, the African-American civil rights movement, second-wave feminism, and the gay rights movement. These movements placed an increased value on individual human rights and changed many aspects of American life (Kliwer, McNally, & Trippany, 2009). Also during this time, America began to enter another war and financial support was needed. Due to the increase cost to fund the treatment in state psychiatric hospitals and the decreased level of quality care, President John F. Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which called for a 50% decrease in state psychiatric hospitals (U.S.C. 101, 1963). The act was intended to increase community mental health centers before the hospitals began to close. However, 90% of the hospitals closed at a rapid rate leaving many patients without adequate care once they were released (Davis, Fulginiti, Kriegel, & Brekke, 2012; Kliwer et al., 2009).

There was a rising cost of running multiple state hospitals; it proved to be more cost effective to treat patients in outpatient clinics. In addition, there was a shift to more privately funded psychiatric hospitals, which left many of the patients with chronic mental illnesses unable to receive adequate treatment due to not being able to afford the care (Warner, 1989). Chronic

and long-term patients were released from hospitals in large numbers in order to live in less restrictive settings (Foerschner, 2010; Warner, 1989). For some of the chronic and long-term patients this was the first time in many years that they had been living outside of the hospital. Due to the changes in the psychiatric hospitals and social policy, there was an increased sense of hope and optimism. However, most of the patients did not have the necessary life skills to function in the community and consequently would have to return the hospital as a result.

A steady decline in state psychiatric hospital funding took place between 1965 and 1975. By 1975, nationwide there were 13 mental hospitals that had closed, while others closed parts of the hospitals or were transformed to community mental health centers (Warner, 1989). Deinstitutionalization did lead to various advances in therapeutic treatment such as group homes, community centers, day-care facilities, outpatient care, and acute hospital stays (Foerschner, 2010). Many patients were incapable of living independently and became homeless due to lack of housing and aftercare follow up (Foerschner, 2010). Currently, psychiatric hospitals are still closing or converting into other mental health facilities. Presently, there are three levels of stays at psychiatric hospitals: acute, intermediate, and long term. The average length of acute care is less than 30 days, intermediate is between 30 and 90 days, and long term is greater than 90 days. According to Lutterman et al. (2009), the majority of hospital stays for adult patients is evenly ranged from acute, intermediate, and long term. Table 3 displays information on the different types of inpatient facilities that provide treatment for adult psychiatric patients and the percentage of how often that form of treatment is utilized.

Table 3

*Number of States Using State Psychiatric Hospitals by Age and Service*

Population	Acute Inpatient (Less than 30 days)		Intermediate Inpatient (30 –90days)		Long-Term Inpatient (More Than90 days)	
	Number of States	Percent	Number of States	Percent	Number of States	Percent
Adults	41	84%	43	88%	43	88%
Elderly	37	76%	40	82%	40	82%
Forensic	36	73%	41	84%	43	88%

Note. Adapted from “Funding and Characteristics of State Mental Health Agencies,” by T. Lutterman, A. Berhane, B. Phelan, R. Shaw, and V. Rana, 2009, *Center for Mental Health Services: Substance Abuse and Mental Health Services Administration*, 2007, p.46.

The prevalent failure of deinstitutionalization is the lack of successful, long-term care for the nearly two million chronic mentally ill patients (Warner, 1989). The decrease in inpatient hospital care resulted in an increase in homelessness and incarceration among the mentally ill (Davis, et al., 2012; Foerschner, 2010; Kliwer et al., 2009; Warner, 1989). In the 1980s, one third of individuals with mental illness were homeless and 100,000 individuals with mental illness were in jail (Foerschner, 2010). Currently, it appears that the treatment of individuals with mental illness has come full circle and once again, if family members do not care for individuals with mental illness, they are forsaken to wander or are placed in jail (Davis, et al., 2012; Warner, 1989). Patients cycle in and out of psychiatric hospital due to the acute nature of the current treatment. Patients are often medicated, stabilized, and released in a period of months versus being treated for years, as was the norm before the 1970s. Although the deinstitutionalization movement began over 30 years ago, and has had many successes, it also has left many gaps in treatment that need to be filled (Shadish et al., 1989). One type of treatment that has been consistently used in psychiatric hospitals for over the 100 years is group therapy.

## **Group Therapy**

The early 1900s was the first time group therapy was used with patients. The first group therapy sessions were facilitated by doctors with the goal to educate their patients about their physical illness. Barlow, Fuhriman, and Burlingame (2004) and Committee on History (1971) both credited the first group therapy session to Dr. John Pratt, who used “thought control classes” to treat his tuberculosis patient in 1905. Dr. Pratt had the idea to educate a large number of his patients at the hospital and allow them to talk about their efforts of dealing with their illness (Barlow et al., 2004; Committee on History, 1971). Dr. Pratt’s method enabled the patients to share with one another the effective techniques they had found to help cope with their illness. These group therapy sessions also attempted to provide emotional support for patients in a hospital setting through peer support. The group therapy sessions were viewed as a useful method to treat the patients because more than one patient could be treated at one time and the patients benefited from the social interaction.

The first group therapy conducted with patients that had a mental illness occurred in 1921 when Lazell (1921) began modeling his lectures for people with chronic schizophrenia from Dr. Pratt’s groups (Committee on History, 1971). Lazell continued to use the educational model to inform the patients in the hospital about their mental illness. Lazell (1921) reported that the groups increased socialization and decreased fear of the psychiatrist (Gabrovšek, 2009). It took another ten years for other hospitals to add group therapy to their programs. Group therapy expanded from the educational group model in 1936 when Paul Schilder (1938) developed group psychotherapy at Bellevue Hospital in New York City (Committee on History, 1971). Schilder (1938) was the first individual to interpret resistance, transferences, and dreams during group psychotherapy sessions (Pinney, 1978). Schilder’s (1938) techniques provided the patients with

insight and normalized some behaviors that in previous years would not have been discussed by therapists. Schilder's (1938) use of psychodynamic theory within the group therapy sessions would continue to influence the direction of group therapy treatment for the next 20 years.

In the 1950s, there was a surge in the use of group therapy as a treatment due to trauma people experienced during World War II (Scheidlinger, 1995). At that time, there was a large return of soldiers and an influx of war refugees that came to America, and many of these individuals had survived severe trauma during the war. Group therapy used in military hospitals during World War II illuminated a necessity for an improved system. This need for better treatment led to the innovation of modern group theory, which highlights the here and now, belongingness, and universality of the therapy group (Farley, 1998). In the 1960s, there was growth in the use of group therapy in other settings (Scheidlinger, 1995). There was continuation in the 1960s of the different theories that were being introduced into the psychology community and by the late 1960s there were over 60 different types of psychotherapies.

In the mid to late 1970s, Yalom (1977) emerged as a prominent figure in group therapy and his work prompted the development of interpersonal group therapy. This method was structured, focused on the 'here-and-now,' and avoided environmental factors, life stresses, or analytic issues. For the past 15 years, research and application of group therapy has been based on practical needs of the patient and relatively non-psychodynamic. A variety of techniques including cognitive, affective, and behavioral methods had been used in group therapy in psychiatric hospitals. The focus of the sessions encompasses achieving treatment goals, strengthening social skills, changing maladaptive behaviors, and increasing reality testing (Kibel, 1992).

Currently group therapy is a popular method of treatment in psychiatric hospitals because it is cost effective and beneficial for patients (Zamacona, 2012). Groups can be offered to a wide range of participants with various degrees of mental illness (Zamacona, 2012). Groups are commonly used in inpatient hospitals because of the nature of the problems the populations deal with (Malchiodi, 2012; Zamacona, 2012). Group therapy typically begins from a shared problem or concern and individuals come together to discuss their mutual issues and problems (Sprayregen, 1989). One reason that group therapy is a cost effective treatment is due to the number of patients that can be in a group with a single leader. Group therapy can encompass a large range of topics to address the needs of the patients. Weiner (1992) discussed that group therapy can focus on a number of different topics including education, socialization, problem solving, and peer support. Nurses or other trained staff may lead the groups depending on the topic. The group creates a place for members to learn from each other, support one another, and promote self-growth. Current inpatient groups tend to focus on daily living skills, socialization, coping skills, education, problem solving, medication, and peer support (Barlow, Fuhriman, & Burlingame, 2004; Long, Fulton, & Dolley, 2012; Weiner, 1992). As the psychiatric hospital and knowledge of mental illness transformed over time, there were often changes in attitudes about different treatments. How art was used within the hospital system was one idea that altered over the years.

### **History of Art in the Psychiatric Hospital**

Pinel was one of the first individuals to introduce art in psychiatric hospitals in the late 1700s (Deutsch, 1946). However, the first actual interest in psychiatric art did not happen until the late 19<sup>th</sup> century when psychiatrists noticed spontaneous works of art that were made by patients in psychiatric hospitals (Rubin, 1999). The creation of art was seen as a way to cope

with the chaos and confusion of the patients' psychotic breaks. Yet the clinicians at the time were uncertain about what the artwork meant and only viewed it out of curiosity. At first, art making in psychiatric hospitals was seen primarily for its aesthetic value and for its ability to provide patients with a soothing activity. However, some professionals believed that the patients' artwork could possibly divulge diagnostic insights to the patients' symptoms and contribute information for treatment (Vick, 2012).

Hans Prinzhorn (1972) was a psychiatrist and art historian who began to collect over 5,000 works of art from 400 psychiatric patients (Frazzetto, 2011). Prinzhorn thought the artwork of the patients represented the individual's internal state and was a symbolic expression of the psyche. Other psychiatrists began to note how the artwork reflected the patients' symptoms. In his article about Prinzhorn's work, Arnheim (1986) discusses how the artwork reflects symptoms of the patients. One example is the manic-depressive symptoms that are mirrored in the art making. A fluctuation between unrestrained scribbles and energetic lines can be seen during manic phases and delicate faint lines during depressive phases. Arnheim (1986) discusses that with symptoms of schizophrenia the individual detaches from reality and this can be seen in the artwork. In addition, symptoms of delusions and hallucinations can be seen as well. Psychiatrists began to believe that art served as the medium to connect the internal state to external world and gives insight to the individual's inner being. Art therapists continued to build on the beliefs that the artwork holds symbolic meaning of the symptoms and unconscious projections of the patients.

### **History of Art Therapy**

In the late 19<sup>th</sup> century, the theory of the unconscious based on the work of Freud and Jung became the prominent psychological model. The proximate development of the artistic

movements Expressionism and Surrealism allowed for the right climate for the beginning of art therapy. The original art therapists believed in the intrinsic healing nature of art making, that the art is the medicine and agent of change (Hogan, 2001; Junge, 2010). The formation of art therapy groups originated in the 1940s and 1950s when Hill and Kramer led the first open studio groups in psychiatric hospitals and used a teaching art approach that permitted a form of self-expression (Malchiodi, 2012; Ulman, 1953; Vick, 2012). When art therapy was first introduced in psychiatric hospitals, the *moral treatment* was most commonly used to treat patients. Art therapy was a natural fit within the framework of the *moral treatment*; patients were allowed to paint, draw, and create art without restraint. Art therapy was a type of treatment that was different from the methods that were being used at that time.

The first art therapists were artists and art teachers; most of them had not intended to work in hospitals or schools with people with mental or physical illnesses (Junge, 2010; Wix, 2000). Individuals such as Viktor Lowenfeld, Maria Petrie, and Florence Cane all used art as a therapeutic tool when working with children and adults (Rubin, 1999). They were not called art therapists in the beginning, yet after discovering how art could help heal individuals that were suffering from a range of psychological and physical illnesses, the term art therapy began to be used to describe the new treatment method. Initially, the art therapists taught the patients what they knew, how to make art. As they educated the patients on how to create art, they began to notice changes in behavior and verbal expression. Often the art therapists would create in conjunction with the patients; both art therapist and patient learned from one another (Hogan, 2001; Junge, 2010; Wix, 2000). Patients were treated as students, which tended to focus on their capabilities versus their limitations. Creating art and reflecting on the art process allowed the patients to express themselves in a new way. Art was recognized as a tool to be used within

treatment to facilitate growth and change; the importance was placed on the process of art making versus the art product (Ulman, 1953; Vick, 2012).

### **Art Therapy Psychotherapy and Art as Therapy**

Margaret Naumburg and Edith Kramer were the primary pioneers of art therapy in the early 1940s (Rubin, 1999). Kramer and Naumburg both relied on psychoanalytic theory to develop the foundation of art therapy, yet their views differed on the principal healing factor. Naumburg emphasized the importance of therapy and symbolism, while Kramer viewed the art making process as significant (Naumburg, 1987; Vick, 2012).

Naumburg was one of the first art therapists to use psychoanalysis and the theory of the unconscious with art to examine the symbols of the patients that were seen in the artwork (Wix, 2000). Naumburg emphasized the importance of art as a construct of “symbolic speech” and connected art to the unconscious, comparable to dreams (as cited in Rubin, 1999, p. 98). This symbolic speech could be extracted through spontaneous art making and free association. Through art making, individuals are able to release conflict from their unconscious and are more adept to dialogue about their artwork. The individuals creating the artwork provide their own associations, which deepen the unconscious process. Through this method, the individuals are able to examine their own problems with objectivity, which consequently empowers them to solve their own problems.

Edith Kramer placed emphases on the creation of art making in of itself as the principal instrument for the healing process (Moon, 2010). Kramer used the application of psychoanalytic principles by concentrating on sublimation through the creative process and the art product (Junge, 2010). Kramer’s theory of art as therapy focused on the creative process as the positive release of negative emotions this helps increase the mental and emotional health of the

individual. There was little importance attributed to the interpretation of the artwork. This created a distinct difference from Naumburg theories. These two different perspectives of art in psychiatric hospitals would create a framework of how art therapy would be used in the progressing years.

### **Group Art Therapy**

During World War II, the development of group art therapy advanced alongside the development of group therapy (Malchiodi, 2012). Many new forms of therapeutic treatment were being introduced in psychiatric hospitals such as behaviorism, family therapy, and client-center therapy. The influx of these new revolutionary methods provided the right climate for the growth of art therapy and other forms therapeutic treatment. Along with the increase of new treatments, there was a sense of hope and optimism in the mental health community, as well as the growth of art imagery as a psychology tool; this propelled the use of art therapy (Junge, 2010). However, there are no texts discussing a primary art therapist that established a framework for conducting group art therapy (Hogan, 2001). Art therapy groups can be based on different theoretical frameworks. Malchiodi (2007) states, “While many types of art therapy groups exist, there are basically two kinds: art psychotherapy groups or open studio” (p. 195). This is based on the two different theories of art psychotherapy and art as therapy.

The intent of group art therapy is to assist individuals in expressing emotions, problems, and conflicts (Malchiodi, 2007). Art therapy groups can support patients by encouraging optimism, facilitating positive social interaction, and enhancing problem solving (Liebmann, 2004; Malchiodi, 2007; Wilks & Byers, 1992). Group cohesion may be improved with art making because cohesiveness is linked to self-disclosure, and frequently individuals discover that it is easier to self-disclose with artwork (Shechtman & Perl-Dekel, 2000). The artwork

provides a connection that is unique to the group art therapy process. The art materials allow the individual unconscious to be placed on the paper for the rest of group members and leader to witness. The artwork is then a tangible record of the group session.

By the late 1950s and early 1960s, many other individuals started to build on the foundation of Kramer and Naumburg's work. By 1961, the first art therapy classes were taught at five schools, and by 1971, master's degrees in art therapy were offered by four schools in America (Agell, 1980). The first art psychotherapy groups commenced in both Britain and America in the mid 1970s (Malchiodi, 2012). Art therapists began to change how they structured group art therapy sessions, from open studio sessions to structured groups that included art psychotherapy (Agell, 1980; Saotome, 1998). During art psychotherapy, the individuals worked on their own art and then convened collectively to discuss what had been uncovered through the art making process (Sobol & Williams, 2001). Also established at this time was the use of goal oriented art therapy groups (Saotome, 1998). Goal oriented art therapy groups focused on the cohesion of group members and provided stable group boundaries (Saotome, 1998). The goals of these groups were to enhance group cohesiveness, peer support, and interpersonal relationships.

Despite the fact that group art therapy was growing during the 1960s and 1970s, there were few articles being published about the topic (Rubin, 1999). The first American Art Therapy Journal started in 1961, but it was not until the early 1980s that information about group art therapy began to be published (Agell, 1980; Junge, 2010). The first book on group art therapy called *Art Therapy and Group Work* was published in 1982 and discussed a range of group types from open studio to theme-based (Rubin, 1999). There was much debate among art therapists at that time about which form of group art therapy should be used: open studio or art psychotherapy. Also during this time, deinstitutionalization was taking place in the psychiatric

hospitals. Patients in hospitals were often released after a few months versus being treated for years, and art therapists had to learn to adjust to constant influx of patients being admitted and released while still providing quality care. Art therapists adapted to the new hospital system through various methods, such as returning to the open studio format (Allen, 1983; Rosman, Assael, & Gabbay, 1975), using specific art tasks (Cains, 1989; MacRae & Smith, 1973; Williams, Tamura, & Rosen, 1977; Young, 1975), or returning to art education techniques (Miller, 1993, 1998; Nathan & Hesse, 1978; Patch & Refsnes, 1968). Many art therapists also integrated the use of art making with different therapeutic theories, including Gestalt therapy theory (Potocky, 1993) Jungian theory (Polt, 2005), and client-centered theory (Luzzatto, 1997; Martin, 1997; McGarry & Prince, 1998).

The structure of group art therapy varies in these settings and is based on the needs of the patients, the training of the art therapists, and the desired outcomes (Saotome, 1998; Malchiodi, 2012). Open studio groups allow the patients to create freely within the group setting. During the open studio, the art therapists would be present to monitor the group and offer support if needed. In this thesis, semi-structured and structured is used in art psychotherapy groups. The type of structure used depends on the needs of the patients and the hospital setting. Most of the time in semi-structured groups, patients had the liberty to choose the art media they wished to use or the topic that would be discussed during the art psychotherapy group session. Structured groups often included a directive and art media chosen by the art therapist based on the desired outcome of the session. Structured groups provided the highest level of structure during the art psychotherapy group sessions. The structured groups served as a container and a safe space for the patients to explore themselves and the artwork. Art media and the creative process are used to facilitate self-expression, cultivate self-awareness, and to increase coping skills. Throughout

the years, the principle goal of art therapy has always remained the same: “to improve or restore a client’s functioning and his or her sense of personal well-being” (American Art Therapy Association, 2014).

**Open studio groups.** Open studio groups are based on the framework of art as therapy and focuses on the creative process as the positive release of negative emotions (Junge, 2010; Vick, 2012). Art as therapy places an emphasis on the application of psychoanalytic principles by concentrating on sublimation and use of art making itself as the principle healing instrument. An individual is able to reach sublimation by creating a good product. In addition, art as therapy is ego supportive and aids the client creatively when the client needs assistance (Malchiodi 2012; Rubin, 1999).

Studio groups are based on the belief of the intrinsic healing nature of art (Moon, 2010; Saotome, 1998; Wix, 2000). Some art therapists believe that open studio sessions are designed to enable the participants to resolve their own problems through creating art (Junge, 2010). The art room is a shared space and a holding place for the patients to express themselves; it allows them to foster a social connection in a relaxed environment (Saotome, 1998). The space creates a sense of community and belonging. Some patients may begin to see the art room as an “oasis” within the hospital, a place where they are can express themselves freely through the art media (Saotome, 1998 p.158).

The leadership role of the art therapist involves facilitating the art materials and co-creating with the patients (Allen, 1995). The art therapist acts as a mentor and role model, as well as resource for the patients. Art therapists may use a range of methods to facilitate open studio groups, from completely unstructured to having an art technique or goal for the patients to focus on during the session (Malchiodi 2012). Group members can assemble in the art room,

they can create art freely, and each of the patients can work at their own pace (Liebmann, 2004; Wix, 2000). The space is relaxed and informal. If any sharing takes place it is typically one-on-one with the therapist, and rarely does the group come together to discuss artwork in this setting (Liebmann, 2004). Studio groups are more flexible to meet the needs of the patients (Liebmann, 2004; Moon, 2010).

**Art psychotherapy groups.** Art psychotherapy groups evolved from Margaret Naumburg's "spontaneous art" group (as cited in Rubin, 1999, p.172). Naumburg (1987) constructed her dynamical oriented art therapy from Freud's free association principal and Jung's theory that artwork is connected to the unconscious. The patients would create spontaneous art, and then interpret their own symbols with Naumburg (1987). Through this process, patients are able to release any conflict from their unconscious and achieve autonomy. Art Psychotherapy encourages patients to discover parts of themselves in the unconscious when they are ready, which enables patients to objectively examine their own problems.

Currently, group art psychotherapy tends to concentrate on building interpersonal relationships through the group process and interactions (Rubin, 1999). Art therapists take on a strong leadership role as a facilitator and offer guidance to the group members. As with open studio groups, art psychotherapy groups can utilize a range of methods to facilitate the goals of the group (Malchiodi 2012). The art therapist tends to implement structure through art directives that are connect to a specific desired outcome. The art therapist could use the art directives as a technique to assist in promoting the group member's interaction. These art directives could include group murals, storytelling, goal-oriented, or art tasks. Often art psychotherapy groups have an overarching objective that the group members attempt to accomplish (Malchiodi, 2007). This objective provides structure for the group members and aids in establishing group cohesion

(Liebmann, 2004; Malchiodi, 2007). Art psychotherapy groups typically have some form of structure and have a stable core group of members that attend. The sessions tend to focus on the group's needs as a whole versus the individual's needs within the group. (Liebmann, 2004).

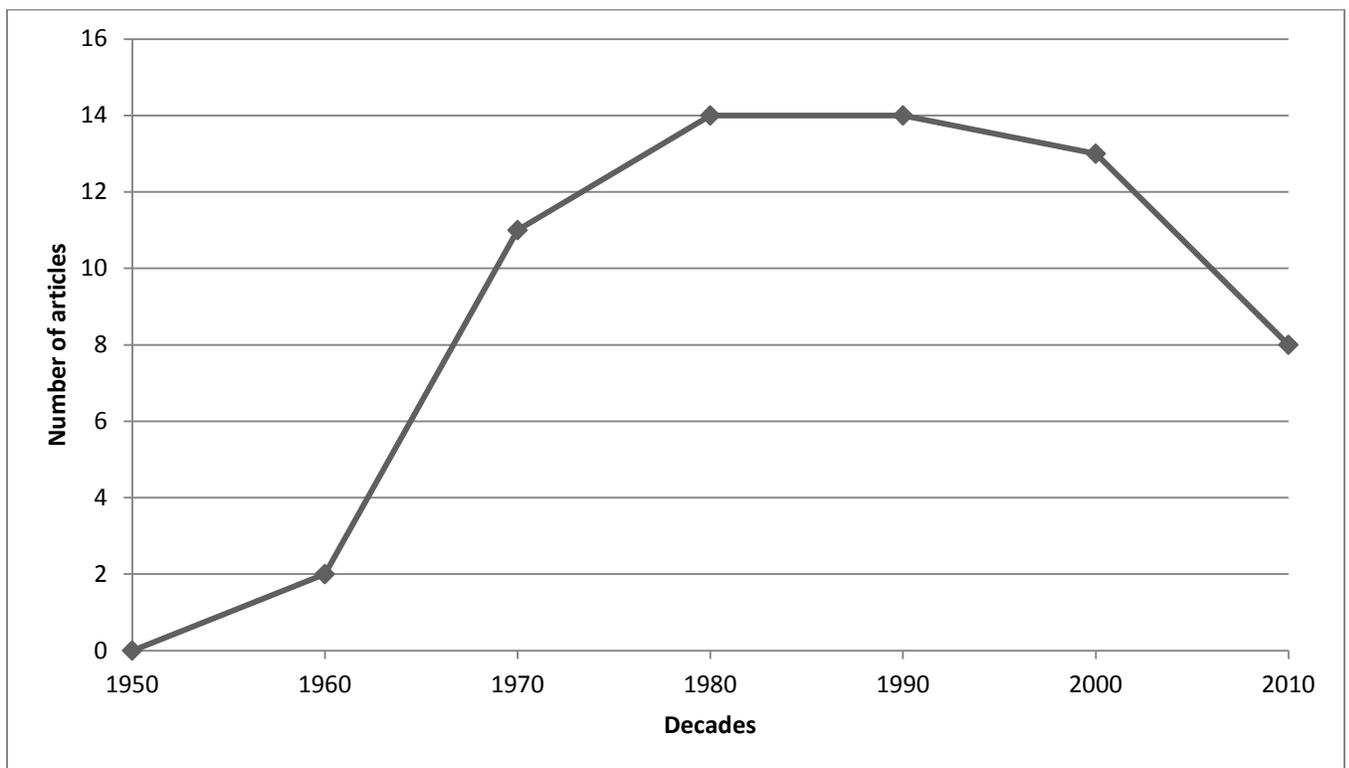
After the artwork is made, the group members discuss the process of the art making and the images created (Hogan, 2001). The group members can begin to uncover the meaning behind the artwork and begin to integrate changes discovered during the group (Junge, 2010).

### Chapter 4: Results

Sixty-two articles were found on the topic of group art therapy with adult psychiatric patients. The articles attained on this subject span six decades. There were two articles from the 1960s, 11 from the 1970s, 14 from the 1980s, 14 from 1990s, 13 from the 2000s, and eight from the 2010s. Figure 1 illustrates a timeline of the articles gathered for this study.

Figure 1

*Number of Articles on Group Art Therapy with Adult Psychiatric Patients per Decade*

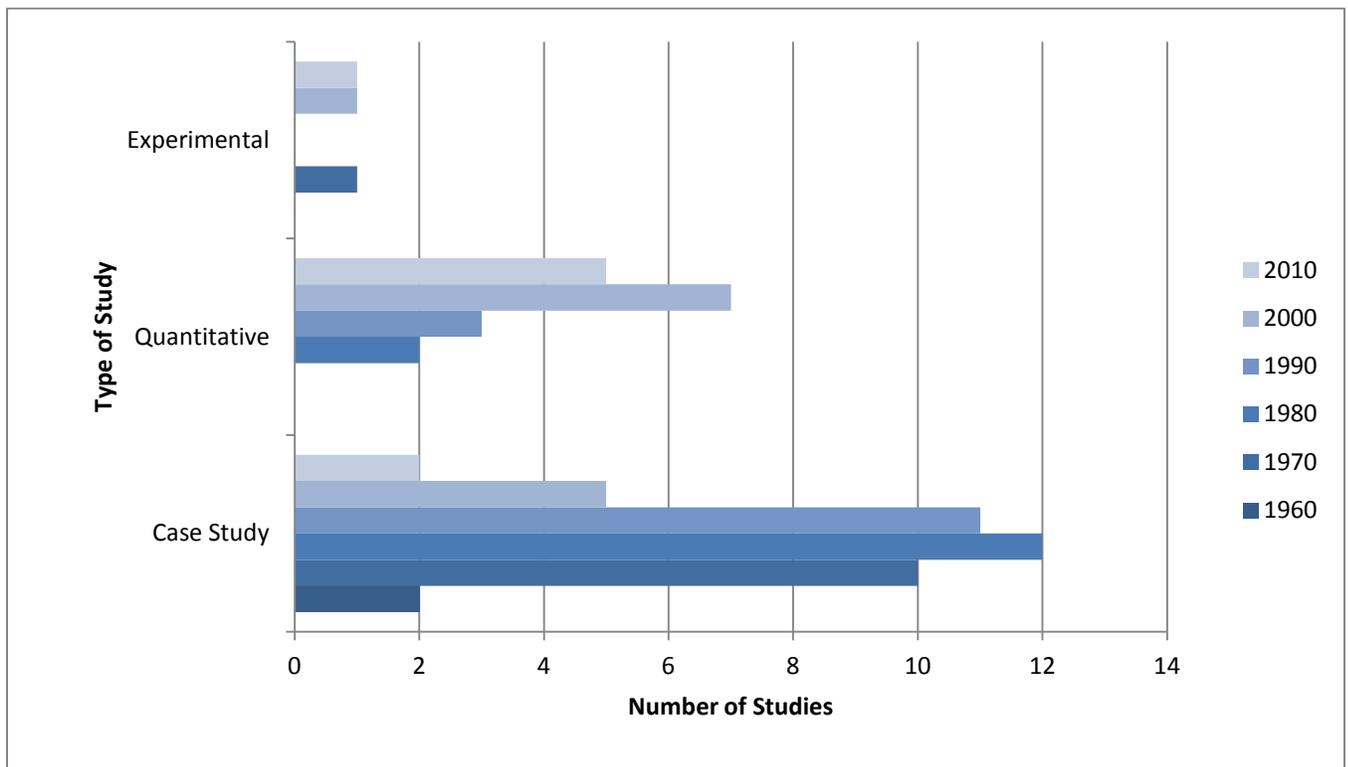


The results revealed that there are three types of studies conducted on the topic of group art therapy with adult psychiatric patients. These studies were experimental, quantitative, and group case studies. Experimental studies included two or more groups that receive the same pre-post intervention. Experimental studies compared at least one art therapy group to a control group that used verbal therapy. Quantitative methods of collecting data used a variety of techniques including surveys, interviews, and gathering information from patient charts. Case

studies included observations of both patients’ artwork and behavior before, during, or after group. Case studies also incorporated verbalizations and feedback from the patients. Figure 2 reports the different types of studies that were found on group art therapy with adult psychiatric patients separated by decade.

Figure 2

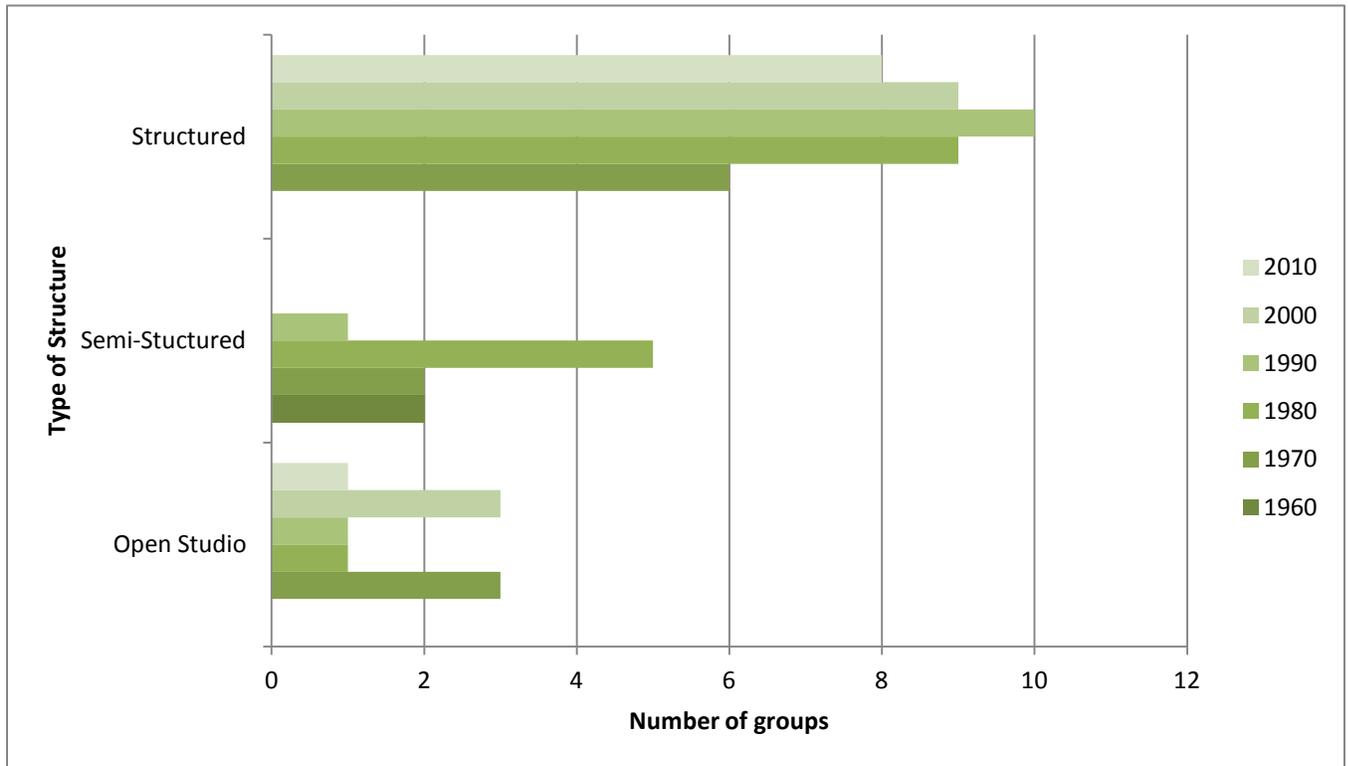
*Type of Studies Conducted on Group Art Therapy with Adult Psychiatric Patients by Decade*



The results revealed that there were three types of group structure used by the art therapists conducting the group art therapy sessions: open studio, semi-structured, and structured. Open studio groups typically included spontaneous or free choice art making. The semi-structured groups varied in each article. Semi-structure allowed the patients with the liberty to choose some element within the group. This may have included a choice of the art media they wished to use or the topic of the session. Structured groups provided a framework and a guide for the patients as they created artwork. Structured groups often allowed for little choice by the

patients as the art therapists during these groups generally selected the media and the directive based on the desired outcome of the group. Figure 3 displays the number of groups that used a specific type of structure separated by decade.

Figure 3  
*Structure of Art Therapy Groups with Adult Psychiatric Patients*

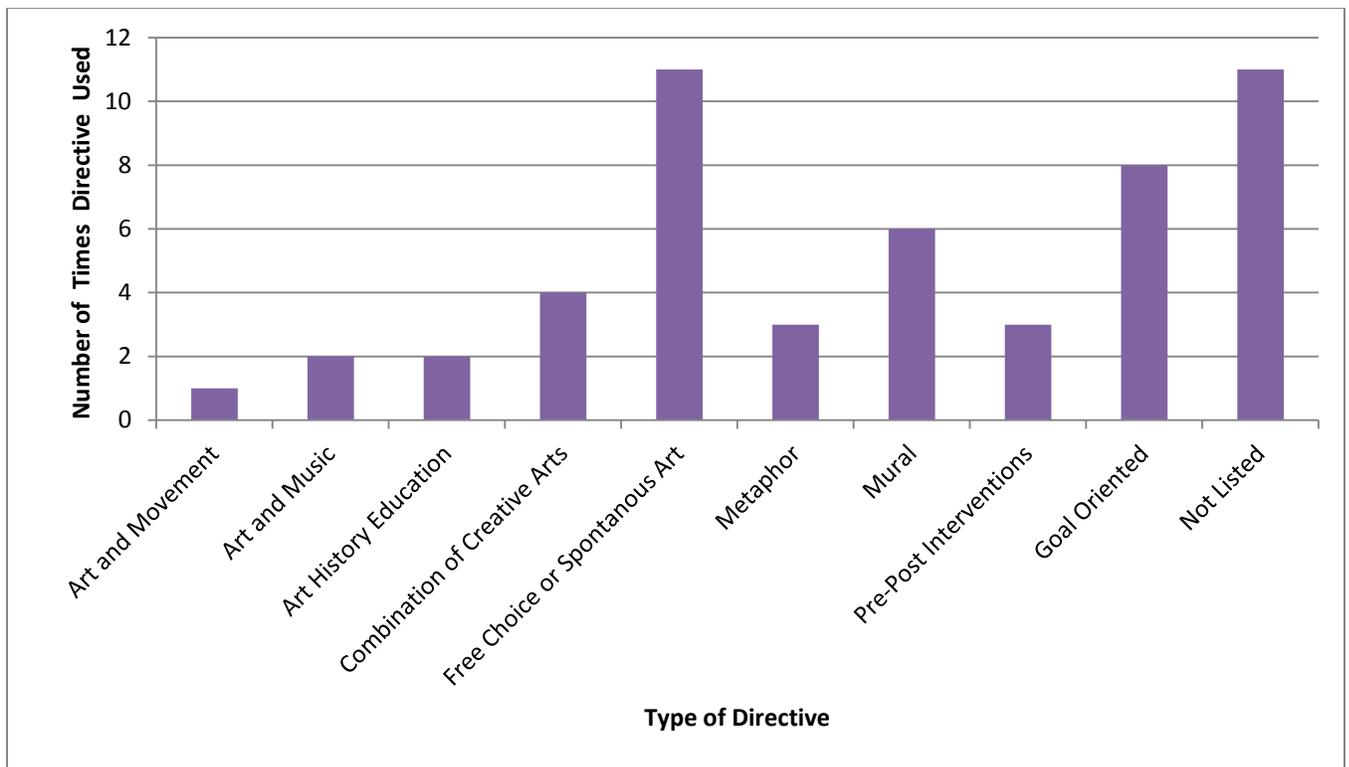


The results showed a variety of directives were used in the group art therapy sessions with adult psychiatric patients. Free choice or spontaneous art making was the most frequently used directive. Some art therapists choose not to discuss what type of directive they used during the art therapy groups. These authors focused on discussing the statistical measures they used to collect data and the outcomes of the art therapy group. Not listing the type of directive that was used during the art therapy group was found in the same number of articles as the most frequently used directive. The least used directive was art with movement. The term metaphor was used in this figure to categorize three directives that the authors used as a metaphorical

representation of the patients situation. These directives included drawing a road, an island, and an amusement park. In the articles, the authors discussed by using these directives the patients were able to connect their situation to the image that they were asked to create. All of the directives by all the decades and the number of times they are used are listed in Figure 4. The remaining results section will summarize the findings of each decade by type of study, structure of the group, and directive used, and outcomes discussed by the authors of the text.

Figure 4

*Type of Directives 1960s to Present*



**Group Art Therapy in the 1960s**

There were two articles found on the topic of group art therapy with adult psychiatric patients from this decade. Patch and Refsnes (1968) and Sinrod (1964) wrote articles that used observations of patient interactions, artwork, and behavior to inform their case studies. Both

articles also employed free choice or spontaneous art as the directive used during the group sessions.

Patch and Refsnes (1968) called their group “art class” and its foundation was based on the Freudian theory that unconscious material would manifest in the images produced by the patients. Patch and Refsnes (1968) additionally discussed that this method allowed the patients to express feelings that are not easily accessed verbally. Findings reported by Patch and Refsnes (1968) were that the patients increased self-control, developed a new method of coping with unacceptable thoughts through the artwork, and achieved catharsis.

Sinrod (1964) believed that spontaneous art was a way to foster communication and communicate emotions. Sinrod (1964) observed that the group members began to respond to one another through the artwork. The group members were able to work through anxiety, anger, and frustration when creating art. Despite the fact that some members began to isolate themselves from the other members, they still created artwork that communicated with the group, which was found to be valuable for patients who have difficulty verbally expressing emotions. While discussing with a group may be overwhelming for less articulate patients, this group uncovered a technique to convey emotions in a comprehensible manner without using language.

### **Group Art Therapy in the 1970s**

The search for articles resulted in twelve articles on the theme of group art therapy with adult psychiatric patients from the 1970s. Eleven out of the 12 articles used observations and case study methods to report their discoveries. Young (1975) was the only author in the 1970s that used experimental methods to observe and collect data from an art therapy group. Out of the 12 articles, two used a semi-structured group format, three used an open studio group format, and seven used a structured group format. Directives used during this decade included a combination

of art and music, murals, pre-post draw-a-person, free choice or spontaneous art, and goal oriented. Figures 2.1 and 3.1 displays the data collected from this decade.

Figure 2.1  
*Type of Study in the 1970s*

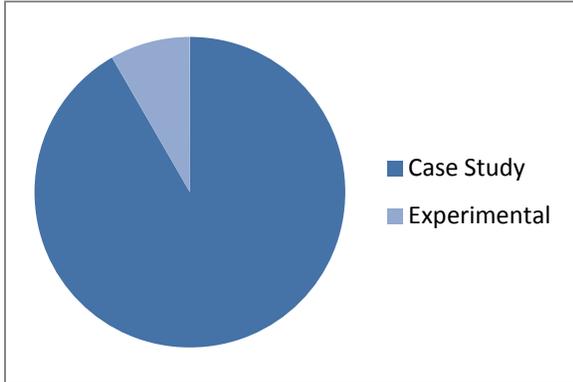
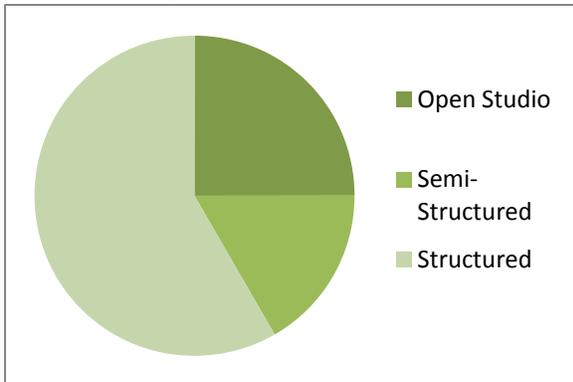


Figure 3.1  
*Type of Group Structure in the 1970s*



Serban (1972) utilized psychoanalytic techniques and some art education instruction in his groups. Serban (1972) taught his group about the Surrealist and Expressionist art movements. After the patients had received some art instruction, they were given the independence to paint in a manner that allowed them to express an idea or emotion. This method enabled patients a new way to communicate and connect with reality. This method also allowed the art therapist to observe various stages of psychosis through the art and notice subtle changes in patients. In addition, it also evaluated if the art was congruent with the verbal associations the patients gave.

This method could provide the art therapist with a greater insight than creating art without verbal associations.

Bellomo (1974) also implemented a semi-structured group. The members would create a mural every session and were allowed to create what they desired. After the mural was finished, they would discuss the images and the group process. Brown (1976) discussed that she typically used an open studio approach with her art therapy group. However, when the patients and the staff were told that the unit where she was working was going to close, she changed the structure and the directive of the group to fit the new need of the patients. When Brown (1976) shifted the focus of group, she began to have the patients create larger group murals. The use of murals provided the patients with a boundary to express their emotions and a way to connect to each other. Through changing, the structure of the group provided the patients with a better outlet and container to express their anger. Both Bellomo (1974) and Brown (1976) believed the mural intervention increased the patients' autonomy and communication.

Like Brown (1976), Rosman, Assael, and Gabbay (1975) also reported an increase in communication after patients participated in an open studio group in the hospital. All patients would begin to paint on the same paper. Through this method, the patients began to communicate with one another through symbols and brush strokes. Rosman et al. (1975) concluded that the patients learned to react to others through the mural painting. After the painting was finished, the patients were able to communicate to one another about what they made and gained insight from the art making process.

Gibson's (1979) open studio was different from the group structure in articles thus far. Gibson (1979) discussed how the unit she was working with was extremely regressed and unwilling to participate in treatment. Gibson (1979) began to teach art and patients were called

“students” (p. 10). This is the way many of the first art therapists began conducting their groups in the 1940s and 1950s. Gibson (1979) used the art to engage the patients and achieve the goals of the group. Something as simple as signing and dating the artwork would assist in facilitating communication among group members. This was significant because most of the patients in the group had trouble expressing themselves verbally. The patients were provided a space to create freely and given a choice for the first time in their treatment. This gave the patients a new identity as artists and tools to solve their own problems. Gibson (1979) discussed that the patients were allowed to be independent in the creation of the artwork and learned how to handle their own problems. During the art therapy group, Gibson (1979) observed an increase in problem solving, insight, coping skills, and social interaction. Most of the patients in the group were not considered able to make any improvements by the staff, yet art uncovered a new treatment method that worked for this population (Gibson, 1979).

Both MacRae and Smith (1973) and Edelstein and Kneller (1977) used art and music during their groups. In their article, Edelstein and Kneller (1977) suggested that music would help “loosen up” emotions that could be expressed through painting (p. 322). The group met once a week for two hours. During the first part of the sessions, the patients listened to music while painting on paper, and the second part of the sessions included the patients discussing artwork. The main goal of this study was to view the interpersonal reactions of the patients. The music in this case helped the patients express emotions and connect with the other group members.

MacRae and Smith (1973) used music differently than Edelstein and Kneller (1977) in their group. While MacRae and Smith (1973) used music in combination with art to help the patients express emotions, music was also used as a method to help patients identify emotions.

MacRae and Smith (1973) would play music while the patients painted; the patients were able to translate emotions expressed in the music into an image. MacRae and Smith (1973) began to bring in other sensory items, such as food, that corresponded with countries that the music came from. The patients were able to explore different aspects of themselves through the expressive materials. Both MacRae and Smith (1973) and Edelstein and Kneller (1977) found that music and art increased expression of emotions.

Moriarty (1973) discussed using collage making with a group of female patients with schizophrenia. The goal of the group was to orient the patients to the here-and-now (Moriarty, 1973). The art therapist wanted to provide the patients with freedom to choose their own pictures while still having some structure within the group process. This was achieved by using collage materials for each group session (Moriarty, 1973). Similar to Moriarty (1973), Williams, Tamura, and Rosen's (1977) group directive helped facilitate group cohesion and ensured that the patients would be successful in the art making. Simple art tasks decreased anxiety related to art making and increased the patients' self-esteem. The art task also allowed for verbal expression because it did not have the added pressure of having to create from imagination.

Young (1975) was the only author in the 1970s that used experimental methods to observe and collect data from her art therapy group. Young's (1975) experiment had three groups that participated. Two of the groups utilized art therapy directives and the control group did not receive any art therapy during the three weeks they were at the hospital. All three groups completed a draw-a-person assessment before and after the group interventions. The first group used interventions that focused on building self-esteem, the second group's focus was on increasing insight, and the third group did not receive any specific directive.

The results of Young's (1975) experiment concluded that the first group and second group showed a difference in figure drawings after the group was terminated. The figures made by the first group were less bizarre and had less omitted body parts. However, only one patient in the second group illustrated signs of developing insight in their posttest. Young (1975) speculated that this could be due to the severe nature of patients' illnesses. The control group showed no significant changes in their pre and post draw-a-person. Young (1975) discussed the need for flexible patient focused treatment instead of pre-planned directives that may not be applicable for the needs of the patients.

### **Group Art Therapy in the 1980s**

In this decade, there were 14 articles from the 1980s, two articles out of 14 collected quantitative data in the form of pre-post surveys. Fryrear and Stephens (1988) also conducted interviews and videotaped the responses. Green, Wehling, and Talsky (1987) used two pre-post surveys to examine any shifts in psychosocial functioning and self-esteem. The remainder of the articles in this decade used observation of patients' behaviors or artwork to evaluate the growth of the patients. Three articles use an open studio method, two use a semi-structure format, and nine articles use a structured group format. Directives used during this decade included art in combination with movement, free choice or spontaneous art, metaphors, murals, themes, and goal-oriented. Some Directives were not listed in the articles from this decade. Figures 2.2 and 3.2 present the information collected from this decade.

Figure 2.2  
*Type of Study in the 1980s*

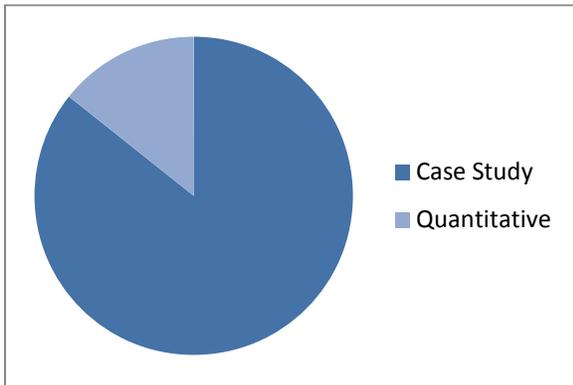
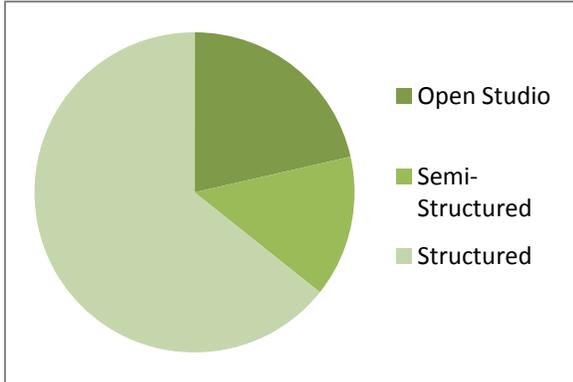


Figure 3.2  
*Type of Group Structure in the 1980s*



Allen (1983) discussed that the ever-changing group dynamics made it difficult for both the patients and the art therapist. Allen (1983) stated that the patients were often hesitant to share their art with the other patients and would choose to process with the art therapist after group. The author decided to return to an older style of running art therapy groups and began using an open studio method. To have some form of interaction among the group members, the author asked patients to write down one or more goals to work on during group. Patients were able to work on their goals independently and report to the group when the goal was completed. The whole group was encouraged to help one another work on their goals during the sessions.

Sprayregen (1989), like Allen (1981), struggled with the short-term nature of treatment at the hospital. The average stay for the patients was 52 days, which led to ever-changing group dynamics. Sprayregen (1989) suggested, to counter this, the art therapy groups needed to have clear expectations, directives that focused on problems, and group support. With group art therapy sessions that clearly stated objectives and had structure, the patients were able to gain peer support and problem solving skills, and were able to express themselves.

The change with the hospital system led Borchers (1985) to question the lasting effects of short-term group art therapy. Borchers (1985) recreated a past study completed in 1979, which suggested that group art therapy increased patients' self-esteem and social interaction. Borchers's (1985) study examined if the effects of group art therapy lasted after nine months had passed. Patients that attended ten sessions were asked to complete a survey on self-esteem, getting along, and attitude toward self. While the results suggested that the improvement lasted nine months after the group was over, Borchers (1985) still suggested that an ongoing art therapy group might provide the maximum benefit for the patients.

Buchalter-Katz (1985) and Goodwin (1983) allowed their patients a choice in creating artwork. Goodwin (1983) reported that allowing women to make choices in the group art therapy sessions also enabled them to voice changes they wished to make on the unit. Many women invested in taking part in treatment for the first time during the group art therapy sessions. Social workers and staff began to note a positive change in the behavior. Buchalter-Katz's (1985) art therapy group was primarily composed of patients with depressive symptoms. Buchalter-Katz (1985) observed that most of the patients used color and superficial symbols of suns, flowers, and trees in the artwork, which the art therapist was not expecting. Buchalter-Katz (1985)

questioned the level of depressive symptoms and if the positive images were an attempt to sublimate unacceptable feelings or a defense mechanism.

Cains' (1989) article discussed that her art therapy group was comprised of mothers with mental illness, and the group focused on how their mental illness affected their relationship with their children. Cains (1989) used topics related to motherhood to address feelings of pain, loss, and frustration that were caused from being separated from their children. The group members were able to gain support and strength, while realizing that they were not alone. Like Cains (1989), Levinson (1986) also ran a goal-oriented art therapy group. The goal was often based off the group discussion, and artwork was created about that topic. Levinson (1986) discussed that many of the patients struggled with poor language skills and impaired thought processes. The creation of art was a way to communicate the patients' feelings that they might not have been able to express verbally. Group art therapy in this case allowed the patients to gain a greater freedom and provided a method to express their unconscious (Levinson, 1986).

In their article, Nassar, Kremberg, and Corso (1981) discussed that they used a mural as the directive when working on a short-term ward of a general hospital. The average stay of the patients on the ward was 24 days. All of the patients were invited to join this voluntary group. The purpose of the group was to enhance the interpersonal skills of the patients. The patients had to learn to work together to come up with a theme each week for their mural. The process encouraged each patient to problem solve on his or her own rather than to rely on the therapist.

Like Nassar, Kremberg, and Corso (1981), Siegel (1988) also used a group mural to foster a sense of group cohesion. Siegel (1988) is the first author out of the research explored thus far that uses metaphor as the directive in the group process. In Siegel's (1988) article, she discusses using the metaphor of moving to an island to help the patients deal with the trauma of

being moved from their normal unit. By allowing the patients to create their own environment through the metaphor, they could possibly gain a form of control over their situation. Siegel (1988) discussed that the directive of a metaphor aided in increasing the patients' autonomy and communication.

Similar to the art and music combination by MacRae and Smith (1973) and Edelstein and Kneller (1977) in the 1970s, Lubart (1985) used art and movement in her art therapy group to reduce resistance and help focus the art making. The patients created a piece of art; then they would stretch and create a second piece of art. Lubart (1985) observed that movement often led to the patients somewhat regressing while creating the first artwork. However, the second piece of artwork assisted in containing the regression. Lubart (1985) reported that this process increased defenses in a healthy manner and increased ego strength of the patients as evident by changes in the artwork.

Both Fryrear and Stephens (1988) and Koppelman (1984) made use of non-traditional art materials in their art therapy groups. Fryrear and Stephens (1988) used masks and videos with the goal to facilitate an increase in interpersonal communication among the group members. Fryrear and Stephens (1988) had the patients create a mask, then videotaped themselves answering questions, and afterwards the patients reviewed the video tape. The patients were able to incorporate parts of other people onto the mask and role play parts of their lives that they were struggling with. This method allowed the patients to increase self-acceptance and gain insight through using the mask to examine the unacceptable pieces of themselves.

Koppelman (1984) used puppetry to facilitate interpersonal communication and enhance creative thinking. Koppelman (1984) believed that art and drama could be useful in aiding self-expression and integrating positive traits of the character. Creating a puppet and performing in

front of peers enabled the patients to play out social interactions in a safe space. In both Fryrear and Stephens's (1988) and Koppelman's (1984) studies, there was an further distance created with the addition of drama and play. Patients were able to express their feelings through the puppets or the masks that might have been difficult to express verbally.

### **Group Art Therapy in the 1990s**

In the 1990s, there was a slight increase of quantitative studies. Out of the 14 articles collected from this decade, four of the articles used quantitative methods. McGarry and Prince (1998), Miller (1993), Sherman (1996), and Zaidi (1994) used a variety of different ways to collect the quantitative data to evaluate their art therapy groups including pre-post surveys, questionnaires, and written exercises between sessions. The other 10 articles from this decade used group case studies to report the findings from their art therapy groups. These methods included observations of patients' behaviors, artwork, and verbalizations during the sessions. Some authors noted a change in behavior while the patients were on the unit as well. In the 1990s, most articles discussed using a structured style format for running art therapy groups. One article used a semi-structured format, and one article from this period used an open studio format for the art therapy group. Directives used during this decade included art history education, combination of creative arts, free choice or spontaneous art, metaphors, murals, pre-post bridge drawings, and themes. During this decade, some articles did not list the directives that they used during the group art therapy sessions. Figures 2.3 and 3.3 display the data collected from this decade.

Figure 2.3

*Type of Study in the 1990s*

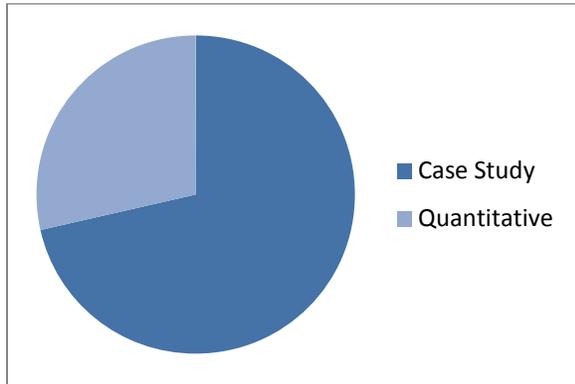
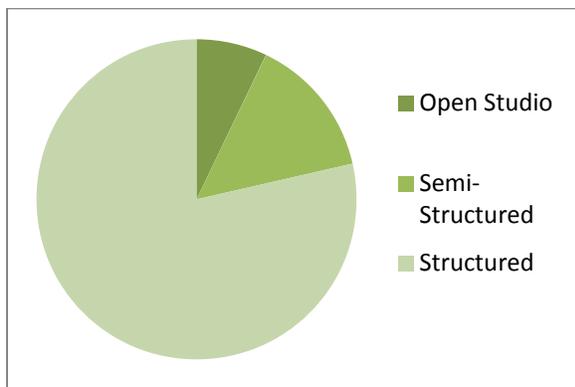


Figure 3.3

*Type of Group Structure in the 1990s*



Two of the research articles used creative arts therapy groups (Klose & Tinius, 1992; McGarry & Prince, 1998). The creative arts groups incorporated more than one form of expressive arts in the hospital program. The focus of Klose and Tinius’s (1992) group sessions was to increase the self-esteem of the patients. Klose and Tinius (1992) use art making, poetry, storytelling, and music to facilitate an increase in self-expression and peer support. The patients were able to use the structured exercises as a conduit to discuss their personal problems (Klose & Tinius, 1992). The authors discussed that the structured art tasks allowed the patients to lower their defenses and facilitate deeper conversations about themselves. McGarry and Prince (1998), like Klose and Tinius (1992), used creative arts groups to increase self-expression and fun.

McGarry and Prince (1998) had five different groups that took place on Saturdays. These groups included individual and group poetry, music, stories, and drawing. McGarry and Prince (1998) used two methods of data collection; they collected pre-post surveys that measured perceptions of changes in self and documented group observations. McGarry and Prince (1998) concluded that the creative arts groups not only increased self-expression but also increased acceptance of each other and self.

Two of the articles used a therapeutic framework to structure the group sessions (Potocky, 1993; Zaidi, 1994). A therapeutic framework was used to structure group sessions and helped guide art therapists. Potocky (1993) discussed using Gestalt techniques in her group art therapy session which included, “asking the client to be the drawing and to describe what it was like, asking the client to be one part of the drawing, and asking the client to describe what he/she was experiencing while viewing another group member’s artwork” (p. 75). This approach was used to help patients be aware of the “here-and-now” and facilitate interaction among group members (Potocky, 1993, p. 75). Zaidi (1994) also used a type of therapeutic framework to guide the directives used during group sessions. Zaidi’s (1994) therapeutic framework was an eclectic approach that included “psychoeducational, cognitive, behavioral, and art therapy techniques” (p. 720). The additional use of art therapy allowed the patients to engage easily in self-exploration and group discussions. In both of the articles, the therapeutic framework not only helped the patients enhance their social functioning but also helped the art therapist formulate directives that would facilitate change in the patients’ behaviors.

Luzzatto’s (1997) group structure differed from the other articles found from the 1990s. Luzzatto (1997) used what he describes as an open session “where both the image-making process and attention to group dynamics remain essential factors” (p. 2). Luzzatto (1997) found

this structure to be beneficial due to the acute nature of treatment at the hospital. Flexibility appeared to be a key term for the art therapist as patients would often come and go during the sessions. Luzzatto (1997) observed that the patients in the open studio sessions were able to use art media as a way to communicate with the other members of the group. In addition, the patients were able to use the artwork as a method for self-expression.

During this period, art therapists began to write about one specific art therapy directive that they would use during group art therapy sessions and what the results were from that directive. Hanes (1995) discussed using the metaphor of the road with patients that had a dual diagnosis with substance abuse. Hanes (1995) discussed how the directive allowed the patients to develop insight and examine symbolically what the path ahead would look like if they continued on the same path. Hrenko & Willis (1996) also discussed a similar directive that they used with dual diagnosis patients. Hrenko & Willis (1996) used an amusement park metaphor during the group. Patients often connected their substance abuse with rides at the amusement park and patients were able to relate to other members' feelings about the symbol of the rides.

The directive used during Martin's (1997) art therapy group was a lifeline. Martin (1997) noted five different line qualities that the patients used in the artwork. They included ascending, descending, jagged edge, spiral, straight, and wavy lines. Through this technique, patients were able to see both the positive and negative points in their lives. The patients were also able to connect with the universality of highs and lows of life and visually see that other group members had comparable experiences (Martin, 1997). Mango-Hurdman and Richman (1994) also employed a form of universality by means of humor. The patients would create and tell jokes during the group art therapy session. Humor was used to help the patients increase their interpersonal skills and release some of the negative feelings associated with mental illness.

Miller (1993, 1998) discussed using art instruction and art history during art therapy groups to decrease anxiety surrounding art making. Miller (1993, 1998) brought in artwork of famous artists to show the patients and then they created artwork similar to the work of the artist during the group. Miller (1993, 1998) discussed that patients often find difficulty in creating spontaneous art and this is one way to help ease some of the difficulty. This also helped the patients increase reality testing and concentration through focusing on the technique versus internal stimulus.

### **Group Art Therapy from 2000 to Present**

There are 21 articles from 2000 to present, two used experimental research methods with two or more groups and a control group, five used case studies, and 14 used surveys or other quantitative methods to collect data. Lamont, Sutton, and Brunero (2009) were the first art therapists thus far to survey the patients that attended the open studio sessions. Three articles from this decade used an open studio structure for their art therapy group sessions. The remaining articles from this period used a high level of structure during the group art therapy sessions. In this decade, there was a reduced amount of discussion about the art therapy directives in the articles. Eight articles discussed the types of interventions used in the sessions. The directives included combination of creative arts, murals, free choice or spontaneous art, themes, and goal-oriented. The remaining articles did not list the type of directive that was used. Figures 2.4 and 3.4 display the data collected from this decade.

Figure 2.4

*Type of Study from 2000s to Present*

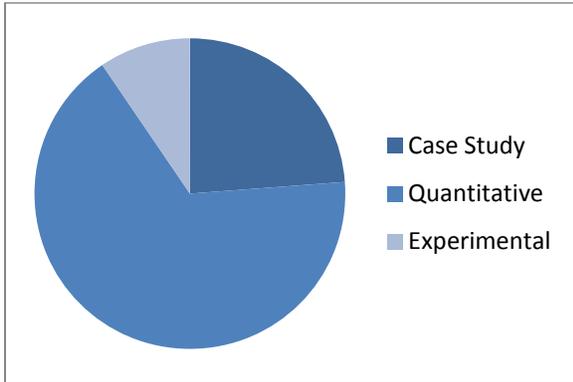
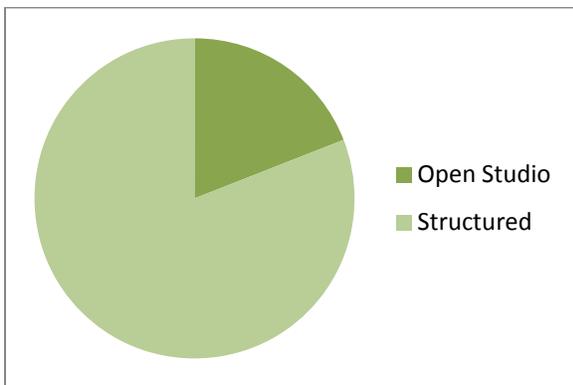


Figure 3.4

*Type of Group Structure from 2000s to Present*



Four articles from this period used open studio art therapy groups. Dick (2001) examines the usefulness of brief art therapy on a hospital unit. Dick (2001) focused on the goals of increasing reality orientation and social interaction. To achieve this, she used structure and flexibility in the form of a group mural (Dick, 2001). This directive allowed the art therapist to observe the change in the patients' behaviors and artwork over the course of their hospitalization. As the patients started to come out of their state of psychosis, the art therapist noted the patients began communicating with the other patients. The art therapist also observed a change from bizarre artwork into more realistic images. The patients were also able create more detailed images. Over time, the patients were able to problem solve, complete more complicated art

forms, and have positive social interaction. Dick (2001) found that group art therapy improves social interaction as well as reality testing.

Hanes (2003) discussed that the open studio sessions allowed the patients freedom and ability to play with the art media. Hanes (2003) observed a change in social interaction during the open studio sessions at the hospital. This was not only noted by an increase in communication among the patients but also by trying to connect through the artwork. Dudley (2012) used spontaneous art making in her open studio to aid in decision making. Similar to Dick (2001), Dudley (2012) also used an open studio to study if group art therapy improves the patients' communication and autonomy. Dudley (2012) discovered that group art therapy enhances self-esteem through the individual contributing to the group as well as social inclusion. The patients were able to foster a new identity of being an artist and connect to other group members through this shared identity. In their article, Lamont, Sutton, and Brunero (2009) were the first art therapists to survey the patients that attended the open studio sessions. The results demonstrated a decrease in the patients' anxiety as well as an increase in relaxation. The patients also stated that they enjoyed expressing themselves through the creative process.

The remaining articles from this period used a high level of structure during the group art therapy sessions. Like Dick (2001), Plante (2006) also used the directive of a group mural to promote connection and facilitate communication. The sessions focused on reality testing and group cohesion. During the group art therapy sessions, the patients learned to listen to one another and to compromise through the process of making the mural. The author discussed that the patients' artwork displayed themes of identity and self-expression. In Fuller's (2008) dissertation, she discussed using deep breathing relaxation exercise and the creation of spontaneous artwork. Fuller (2008) noted that patients showed an increase in coping skills,

communication, relaxing, self-awareness, self-acceptance, and social skills. This change was noted in the artwork as well as the patients' behaviors during the sessions.

Drapeau and Kronish (2007), Chandreaiah et al., (2012), Liebmann (2006), and Teglbjaerg (2011) all conducted group art therapy sessions that used goal-oriented directives. Chandreaiah, Anand, and Avent (2012) focused on decreasing depressive symptoms among the group members. Drapeau and Kronish (2007) focused on improving the patients' psychological well-being through art making. Liebmann's (2006) goals focused on decreasing anger and anger management. Teglbjaerg's (2011) group used goals to provide inspiration during the art making process, yet patients still had the freedom to create what they desired. Chandreaiah et al. (2012) reported a reduction in depressive symptoms. The authors also noticed an increase in interpersonal skills and assertiveness. These observations were noted through changes in the patients' artwork and improvement in post survey results. Drapeau and Kronish (2007) also observed changes in artwork and verbal associations that were connected to insight. Liebmann (2006) found that the art therapy group allowed the patients to express themselves in a positive manner and discover new methods for anger management. Both the artwork and the relaxation components were significant factors in building relationships between the group members and developing group support. Teglbjaerg (2011) reported that group art therapy benefited the patients in many different ways. The main findings included an increase in self-esteem and social competences.

Most studies in this decade discussed using surveys or other quantitative methods to collect data. Both Karterurd and Pedersen (2004) and Korlin, Nyback, and Goldberg (2000) use a combination of expressive arts therapies in their hospital programs. In their research, Karterurd and Pedersen (2004) examined the benefits of group-based treatment in a short-term intense

hospital program for patients with personality disorders. Over six years, 319 patients completed the day treatment program. The study reviewed ten different therapy groups that took place for ten hours a week. Groups included psychodynamic group psychotherapy, larger group psychotherapy, art therapy group, cognitive group therapy, problem solving group, body awareness group therapy, medication group, cognitive-behavioral group for anxiety disorders, group for eating disorder, and “day closing” group (Karterurd & Pedersen, 2004). The patients rated which groups they thought benefited them the most as well as how much they enjoyed the group. The comparison between the groups suggested that the benefit of the art therapy group rated higher than all the other groups. The smaller psychotherapy group was the next most highly rated group out of the ten groups. The art therapy group was highly structured and allowed the patients to explore the visual symbols of the mind. Karterurd and Pedersen (2004) discussed that all of patients could search for meaning of the visual symbols within the art therapy group. The authors suggest that the art therapy group should be added to the core of treatment programs due to its benefit to the patients.

In their research Korlin, Nyback, and Goldberg (2000), suggest that creative arts groups can be helpful to patients when other forms of therapy have failed. Korlin et al. (2000) discussed that the creative arts can “help access, give form to, and integrate experiences, memories, and emotions that cannot be directly verbalized” (p. 333). Korlin et al. (2000) used music, art, movement, occupational, and verbal therapy over the course of a week. Korlin et al. (2000) reviewed the effectiveness of the program after four weeks of treatment. In the study, the results of the mood scale showed that the patients in the art therapy group had an improvement in their mood. Korlin et al. (2000) also reported improvement in cognitive and emotional functions.

Because of this study the hospital chose to increase the use of creative arts therapies in the other units.

Research by Richardson, Jones, Evans, Stevens, and Rowe (2007) evaluated a twelve-week group for patients with schizophrenia using a pre-post survey to investigate whether group art therapy would aid in decreasing symptoms of schizophrenia. Richardson et al.'s (2007) study found that group art therapy helped improve the negative symptoms of schizophrenia. However, there was no change in the positive symptoms of schizophrenia. Richardson et al. (2007) discussed that twelve weeks may have not been enough time to show a lasting change. Crawford et al.'s (2012) study examined group art therapy with patients with schizophrenia. Crawford et al. (2012) stated that their study was the first comprehensive art therapy research conducted with patients with schizophrenia in England. Their study was conducted over several years and included over four hundred participants. Fifteen different sites offered group art therapy on a weekly basis. Like Richardson et al. (2007), Crawford et al. (2012) had difficulty confirming that group art therapy helped improved functioning in patients with schizophrenia. Crawford et al. (2012) discussed that the results could be due to the lack of consistent participation of the patients. Most patients did not attend more than one or two group sessions making it difficult to receive the full benefits of group art therapy sessions.

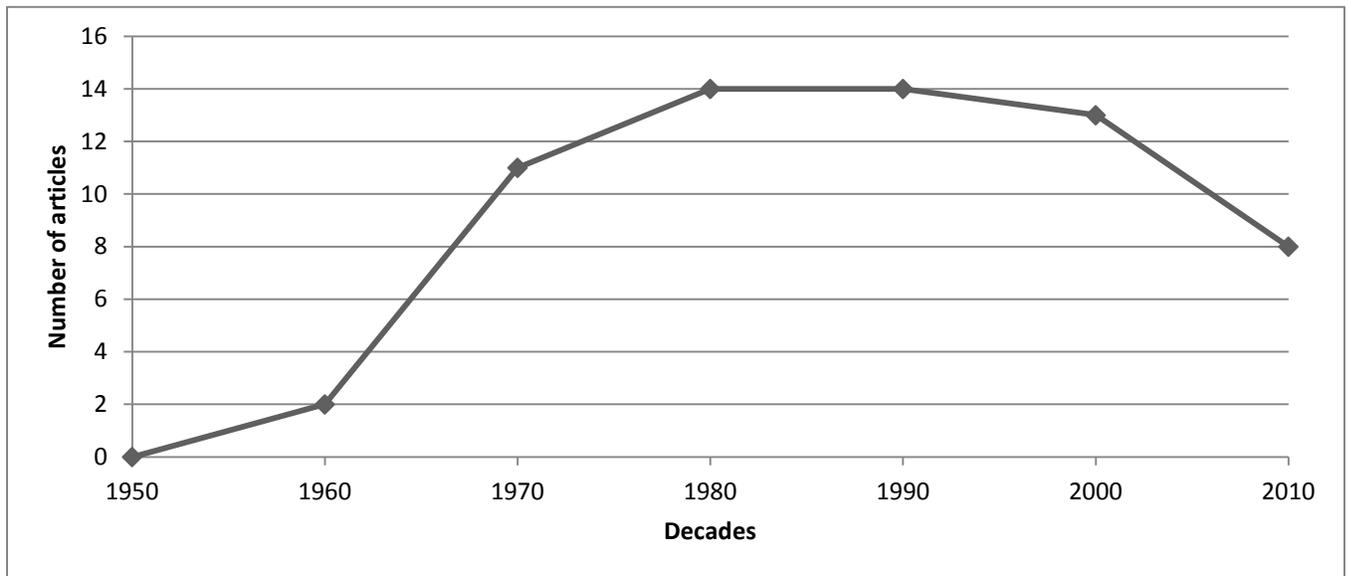
Research completed by Purvinaite and Bruzaite (2009) examined group art therapy over a one year period. The purpose of the study was to evaluate if group art therapy improved quality of life of the patients. The results showed a general improvement of health which lead to higher quality of life. However, Purvinaite and Bruzaite (2009) questioned if the number of group art therapy sessions were increased whether the patients' symptoms would decrease even more than shown in this study. Comparable to other studies of the time, Shechtman and Perl-Dekel (2000)

conducted a quantitative study to discover if there was a difference between an art therapy group and a verbal group therapy. The art therapy group was structured to promote interaction and self-understanding through creative expression, while the verbal therapy focused on here-and-now and personal problems. Shechtman and Perl-Dekel (2000) noted that there was greater sense of group cohesiveness and communication in the art therapy group versus the verbal therapy group.

## Chapter 5: Discussion

As the hospital system has changed so have how art therapists have conducted their groups. There are many variables for why art therapists used the methods that they do when running art therapy groups. The results show there have been numerous different methods used to facilitate group art therapy with adult psychiatric patients, yet there is not one technique that stood out as the standard method. As the hospital system, types of therapy treatment, and length of stay changed over time, art therapists had to learn how to adjust with these changes. There were three concepts that are repeatedly discussed in the articles that include meeting the needs of the patients, conforming to the structure of the hospital systems, and proving the effectiveness of group art therapy in psychiatric hospitals. These concepts often shaped how the art therapist facilitated and conducted the group art therapy sessions.

Over the six decades, many different methods have been used to conduct group art therapy with adult psychiatric patients. Figure 1 displays a timeline of research that was collected on group art therapy with adult psychiatric patients. Despite the fact that the largest number of psychiatric hospitals existed from 1950 to 1975, the largest number of articles for this thesis came from the 1980s and 1990s. This could be due to the fact that the first art therapy journal did not begin until the late 1960s (Rubin, 1999). Most of the articles found for this thesis during the 1960s and 1970s were either from the art therapy journal or from the arts in psychotherapy journal. This could indicate that art therapists did not begin to write an extensive amount of articles about this topic until after these journals were established or that it was harder for art therapy articles to be published in other therapy journals at that time.

*Figure 1**Number of Articles on Group Art Therapy with Adult Psychiatric Patients per Decade*

Treatment in psychiatric hospitals has changed significantly in the past six decades. When art therapy was first introduced in the psychiatric hospital psychoanalytic therapy was the population treatment method and the length of stay for a patient could last for years. Art therapists used techniques such as spontaneous art making in the group to elicit the unconscious. The art therapists would encourage the patients to uncover their own symbols through art making. Psychoanalytic therapy lasted as the popular method in the hospital until the mid 1970s. However, with time other forms of therapy became prominent within the psychiatric hospital including group therapy, humanistic therapy, and cognitive behavioral therapy. Changes in the structure of psychiatric hospitals' system in the 1980s left art therapists scrambling to change their group structure. The new short-term treatment left some art therapists struggling to find the right methods to help patients. The length of stay was shortened due to several reasons' including budget cuts and deinstitutionalization. These changes may account for some of the new ways art therapists structured their groups. In the 1980s to mid 1990s, the art therapists used humanistic

theory and client-centered methods to shape how they conduct their groups. These methods can be seen in the art therapy groups through patient-led topics and free choice of art media. Groups were flexible and allowed for adjustment when needed. These groups also allowed for a consistent rotation with patients being added and leaving the group due to the reduction in length of stay at the psychiatric hospital.

By the late 1990s, cognitive behavioral therapy was the primary form of therapy used, which led to the biggest modification to art therapy groups in psychiatric hospitals. This could be due to the fact that cognitive behavioral therapy has had the greatest success in research results as a proven form of treatment. Due to short psychiatric hospital stays that now may last only a few weeks or months and pressure to use proven treatment methods from insurance companies, art therapists have moved toward researching group art therapy with quantitative methods. In the past 15 years, art therapists have increasingly used quantitative methods. This may be an attempt to prove that group art therapy is a successful treatment for psychiatric patients. Art therapists used more highly structured groups that had clearly defined objectives and followed a systematic group process every session. The authors used surveys more often to collect feedback from the patients that attended the group sessions. This empirical data could be helpful in conveying the validity of group art therapy to professionals outside of the art therapy field. However, this allowed for few opportunities for flexibility during the sessions. Before the 1990s, there was an overwhelming amount of articles that used a case study format to report group art therapy research that implied what methods of data collection art therapists are comfortable using. However, with case studies there is a greater room for error and subjective biases by the researcher. For the art therapy field, the quantitative research lacks the rich narratives of the case studies and observations that were done in past decades. These quantitative studies tend to have

less discussion about the art directive and the art making process. This seems unusual due to the fact that the art intervention and the art making hold such an important role in the art therapy group. These articles seem to focus more on the outcome of the art therapy group instead of what happened during the group process.

Out of the articles found for this thesis there was no research conducted with this population where the hypotheses were completely satisfied by the results. In fact, most of the art therapists discuss that the use of quantitative methods tends to leave the researchers with more questions than answers (Borchers, 1985; Crawford et al., 2012; Purvinaite & Bruzaite, 2009; Richardson et al., 2007; Shechtman & Perl-Dekel, 2000; Sprayregen, 1989). For this thesis, there were not any articles that used a mixed methods design to collect data from the art therapy groups. If the art therapists had collected a combination of both quantitative and qualitative methods, they may have been able to create a clearer depiction of the benefits of group art therapy with adult psychiatric patients.

## Chapter 6: Conclusion

The objective of this thesis was to document the history of group art therapy with adult psychiatric patients. This research examined articles on group art therapy with psychiatric patients from the 1960s to the present. The research questions in this thesis were: What is the history of group art therapy with adult psychiatric patients? What kinds of studies did art therapists conduct and how did they structure the groups with this population? How did art therapists communicate the outcomes? Currently in every state, there are state-operated psychiatric hospitals available for individuals that require an intensive level of mental health treatment. Art therapists have an obligation to ensure that they are providing their patients with the most effective and appropriate form of therapy. There continues to be a great need for research into models of care, best practices, professional roles, and treatment outcomes for group art therapy.

The results of this research included 62 articles on the topic of group art therapy with adult psychiatric patients. Forty-two of the articles used a case study research method, 17 articles used quantitative research methods, and three articles used experimental research methods. Forty-two articles had structured groups, 10 had semi-structured groups, and 10 had open studio groups. Numerous interventions were used in the articles but spontaneous art or free choice was the most commonly used. In addition, eleven articles did not list the interventions that they used. In the past 15 years, there has been a shift in research to use quantitative methods; however, many art therapists found results to be inconclusive from those studies (Crawford et al., 2012; Purvinaite & Bruzaite, 2009; Richardson et al, 2007; Sprayregen, 1989; Young, 1975). Since the beginning of art therapy in the 1940s and 1950s, there has not been one individual that has emerged as the founder of group art therapy. Malchiodi (2007) discussed group art therapy as the

most common form of treatment in psychiatric hospitals. As the hospital system has changed, so have the art therapy groups that are conducted with adult psychiatric patients. By examining the history of group art therapy with adult psychiatric patients, art therapists can progress and move forward in providing quality treatment for patients. In times when government budgets are continually stretched, the fate of general hospital psychiatric services is often uncertain. Art therapists may feel the need to 'prove' themselves by justifying their costs and validity, yet valuable information may be getting lost in the process.

### **Recommendations**

Due to the findings in this thesis, it is recommended that future research with adult psychiatric patients include using a mixed method design. This could include collecting surveys, interviews with patients and staff, and observations of behavior and artwork. By accumulating this data, the art therapist is provided with more information to portray accurate representation of the benefits of group art therapy. Current art therapists are missing important information such as the art directive used and behavior of the patients during the sessions. Art therapists need to examine why they are leaving out the art making from the research, which is considered the core of the discipline.

The current psychiatric hospital system seems to be focused on short-term crisis stabilization treatment. This would require the art therapist working within the psychiatric hospital to be able to meet the short-term goals of stabilization when conducting groups. It is recommended that the art therapist receive some form of crisis intervention training during their course work in graduate school. This would help make them ready for the job market in psychiatric hospitals or acute hospital centers based on the finding of this thesis. In addition, it is recommended that graduate schools examine the curriculum used within the art therapy program.

The movement towards evidence-based treatment is necessary to receive payment from insurance and to be a justified form of treatment in the psychiatric hospital system.

These evidence-based therapies currently include cognitive behavioral therapy and dialectical behavior therapy. It may be essential for art therapy programs to incorporate proven therapy techniques into the curriculum to meet the demand of the psychiatric hospital system.

It is also recommended that a future study be conducted that would survey art therapists to gather information on how many art therapists currently conduct group art therapy with adult psychiatric patients. Questions on the survey may include how many art therapists are currently working with adult psychiatric patients, the type of structure that art therapists use when facilitating group therapy sessions, and the number of groups the art therapist facilitates. Other information that could be gathered by the survey includes information on art therapists' research practices during group sessions and benefits or improvements made from group treatment.

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