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ORIGINAL ARTICLE

The key to being in the right mind

JOSEPHINE CANTY

Abstract

This paper is about the structure and value of art therapy within a drug rehabilitation therapeutic community. It looks at the group culture and how, within this client group, rigid structures were created and resolved. A case study of a ‘key’ session offers a ‘key’ image and looks at group dynamics, exploring how—by the group owning feelings belonging to the group as a whole—the need to use a scapegoat was avoided. The paper discusses some of my own findings looking at this group from a group analytic perspective and from interpretations in neuroscience.

Keywords: Drug abuse, therapeutic community, group, art therapy, image, neuroscience

Introduction

My experience is drawn from my work spanning eight years working as an art therapist within three different drug rehabilitation therapeutic communities. Two of the communities were with Cranstoun Project, and one at the Richmond Fellowship. I initially had to sell the idea of art therapy to the staff teams in all three places, after which I set up and ran art therapy groups, working on a sessional basis in each project. Each group ran for two hours with staff handover both before and after the sessions.

One of the Cranstoun Projects was an ‘open house’ with people able to move freely in and out of the outside world. The ‘open house’ work was quite frustrating and less fulfilling, as often members of the group were under the influence of drugs.

... a successful detoxification experience must involve ego development. I must stress that I am not implying that the deep work does not ever happen. Sometimes the timing is right and these sessions precipitate the patient’s own ego development. Under these circumstances the group and special environment it offers can confirm these insights. (Springham, 1992, p. 8)

The intensive Cranstoun project

The intensive Cranstoun project was a residential therapeutic community of 14 residents, mainly in their 20s and 30s, with an equal number of men and woman, though the women had often given up more to participate in the programme, for instance the custody of their children. The project was very contained, with a format of two separate parts. The first, running for a year, consisted of a slow open programme with new members chaperoned by senior members when they were able to venture outside of the house. The first programme had a multi-disciplinary format with small groups, individual key worker sessions and large groups, both therapeutic and organisational.

The community was drug free and the detoxification began quickly. New members had to be drug free 24 hours before arrival. They would be searched for drugs on entering the project and would be chaperoned by other more senior members for the first three months.

The project had an additional year-long programme. After completing the initial year, clients moved onto a sister house where members did voluntary work and came together each evening for small group therapy. At the end of this second year members would be re-housed and supported into employment with a weekly small group meeting held in their home. This meant that each member’s home environment was seen by their peers at least once every eight weeks.

This project, although requiring an enormous commitment both financially from the charity and in time from the clients, had a huge success rate, with people remaining ‘clean’ and functioning well in the world many years after completing the programme. It is from my work in the first year of the two-year project that I am presenting this piece of work.
The group culture and the dynamics of the community

I was the only member of staff working sessionally, which consisted of a two-hour session slotted into the programme held on the community’s premises. All other members of staff worked on a residential rota basis, sleeping, cooking and eating with the residents as well as running groups and acting as individual key workers, so my role was on one hand a privilege, as I could keep a clear therapeutic frame, but on the other hand I was also therefore a perfect target to carry all the negative transference, i.e. splitting (a method of emotional survival allowing the good to be separated from the bad, pleasure from displeasure and love from hate, so as to preserve a sense of a positive experience as described by Klein). This potential splitting was always acknowledged within the staff team and was therefore not often a problem but this position gave me the advantage of allowing me to work creatively with the negative transference within the group. Drugs create the defence against ‘feeling the pain’, so it was no surprise that vulnerability was very close to the surface.

My role. The group and its boundaries

All community members attended the group. I arrived half an hour before the group started which enabled me to attend the staff handover and I was often only told of a new member in the community at this point, immediately before the group began. This meant that on entering the group there would sometimes be one or two new faces that I had never seen before, much less selected or assessed as appropriate for the group.

Contrary to all the usual rules for setting up an analytic group, this worked surprisingly well. I attribute this to the ‘holding’ that a therapeutic community creates. Initially I had asked for a circle of chairs but in the first session the group asked to sit on cushions on the floor, which we continued to do for the life of the group.

I saw my role as dynamic administrator, firstly to hold an environment, a safe space in which to enable the group to structure and use the therapeutic space. In this respect I set firm boundaries of time, i.e. no-one must speak, even in response. This in effect was like each member giving a monologue. This was all before any artwork was attempted. I would constantly question why we needed such a rigid format. Strangely, it was generally supposed that I had imposed it. I wondered about this need to control, looking at the nature of drug use and addiction and at the chaos of the culture. It is as if the need to control and structure the sessions was much more pronounced within this client group than with any other group that I have worked with. The groups also implemented a rule of no swearing or sexist remarks, rules that were constantly broken.

Respecting and accepting the clients

To make a generalisation, most new clients were well defended, often with a hard ‘street image’. I believe it is important that the therapist accepts and respects his or her clients, however unlovable they may seem. Indeed the more unlovable the more necessary it is to try to see beyond the image to find something to love; often it is possible to detect the sad neglected child. These outward defences would take many forms. For example, Nick (I have given pseudonyms to all group members) stood six feet tall, completely covered in tattoos, with a colweb across his face, a dotted line around his neck, and the words ‘cut here’. Inside his lip were the words ‘fuck you’, and ‘hate’ was written on his knuckles. Lips, nose and eyebrows bore multiple piercings. His demeanour was angry, derisive, sneering.

Nick was an obvious symbol of the unlovable, but perhaps so was Mike, small, grubby, pale, bad skin, looking sly yet vicious; all ‘a street pose’; or Anna who has been working the streets, looking gorgeous, arrogant, derisive of me and the lifestyle she assumed to be mine.

Because most of these patients had such poor maternal relationships it will be hard for them to see the therapist as helpful. (Springham, 1992, p. 147)
As a therapist, it is my duty and my job to look beyond, to find perhaps the unloved child, and I do not think it is too strong a phrase to use: ‘I need to try to love the client’. Often I surprise myself for after a while I find I don’t have to try.

Bowlby (1997) has likened the therapist’s role to that of a mother who provides her child with a secure base from which to explore. This is a role very similar to that described by Winnicott (1982) as ‘holding’ and by Bion (1961) as ‘containing’. This means first and foremost that he/she accepts and respects his/her patient, ‘warts and all’, as a fellow human being in trouble.

Anger in the group

In the vignette below I look at anger in the group, and focus on how potentially destructive it could have been, yet how ultimately valuable it was. I look at the key art therapy image and discuss lack of attachment and how universal that experience was within the group (Skaife & Huet, 1998). I describe one image from the group production as the key image, for, although all the other images represented some aspect of loss and abandonment which represented the theme of the group, this image alone resonated on many levels with all the other images and the dynamics within the group.


Vignette: a key image

During breakfast on the morning of this session, John had been aggressive, threatening physical violence; there was a strong likelihood that he would be asked to leave the programme (as physical violence was a dischargeable offence).

Substance abusers also may exhibit intense rage. It functions to ward off pain. In treatment it often emerges from the feeling of loss. (Milliken, 1990, p. 311)

The session began with accusations thrown backwards and forwards about his behaviour. John and the group seemed unable to let go of the anger with each other, like dogs with a bone. I commented on the energy in the group, I wondered where this anger originated and how it felt very raw, like very early feelings.

My comment seemed to have some effect as the arguing stopped and the group went off to their various tables or spaces on the floor to draw. When the group regathered it was noted that, strangely, many of their images were of emptiness, empty bottles, and empty lonely spaces. One image, however, stood alone as encapsulating the essence of the group’s theme that morning—the key image. This image was acknowledged as a powerful one, which the group instinctively chose to work with.

John drew a picture (Figure 1) of a baby cut off, separated from his parents, who have their backs to him, their attention taken up by their own self-soothing with nicotine and alcohol. They are drinking and smoking and his mother has four cigarettes in one hand. One wonders whether they were trying to alleviate their own pain. The unacknowledged child is reaching out to parents who are oblivious of it. There is a broken line separating each parent and the parents from the child. I wondered whether this represented the child’s shattered attachment. Symbolically, the child is surrounded by bottles, but as opposed to baby feeding bottles, these are empty beer bottles. The baby is left with nothing. The connectedness of the images encouraged the group to explore their own feelings of abandonment and lack of good attachment. As each member of the group shared their stories, it became increasingly clear that John also was suffering from this shared pain. The group was able to identify with John’s image despite the animosity they held for the anger he had displayed in the morning. The image was a vehicle for the group as a whole to share their experience of having parents that were too drunk or uninterested to care for them when they were children.

I said, ‘I wonder if you feel that I, as a member of the staff team, seem uninterested in you?’ The hostility that I frequently experienced in the group was often uncomfortable for me. Equally, however, I felt confident that the group felt safe enough with me to be able to express their fury, knowing I was not going to leave them because they showed their anger. They were able trust that I would retain the boundaries; I in turn felt safe in the knowledge that with very good supervision I could allow the group to explore their anger towards me as representing authority and the parents who have let them down, without my getting upset and making the group deal with my issues. As the pain expressed within the group community was of such an early and raw nature, I wondered to myself whether they were projecting the rage originating from the pain within themselves onto to John, creating a convenient container for all their shared feelings. I therefore mused to the group, saying, ‘I wonder, as there are so many shared feelings in the group if John is the one expressing the rage for the hurt experienced within the whole community?’ The group nodded and acknowledged this to be true.

The group looked at the initial incident earlier that morning that had triggered old feelings of rejection for
John—feelings which he expressed by reacting in anger, the anger veiling deep early pain which was represented in the subsequent image that John produced, a picture of a child (himself) not having its needs met.

A susceptibility to illness and addiction is rooted in this estrangement from one’s own body—in particular, the attempt to escape from feelings has its origin in a babyhood in which the baby’s feelings have not been identified and responded to in a contingent way. (Gerhardt, 2004, p. 110)

The anger that initially threatened the entire community was gone; there was a lot of sharing of feelings, tears, and ultimately calmness within the group.

At the staff handover I shared the unfolding of the group, the ultimate connectedness the group expressed, and the group’s forgiveness of John.

‘Key session’ formed around a ‘key image’

In reflection on this session, it seemed to me that the ‘key image’ resonated powerfully for the whole group and, I believe, unlocked deep unconscious shared pain. For this reason I, in the context of the year programme, viewed this session as a fulcrum, a significant point of change in the progress and understanding of this group.

In this picture we see a child ignored by its parents; they have their backs to the child. From the image and from subsequent use of the therapeutic space, we learnt that John and most of the group experienced feelings of abandonment and lack of interest from their parents.

**Interpretations in neuroscience from an art therapy and group analytic perspective**

The power of this image led me to explore the current thinking on how early experiences impact on our subsequent behaviour. I found the field of neuroscience fascinating in attempting to explain the effect nurture has on our developing brains. Current research in the fields of psychiatry, neuroscience and medical practice looks at the effect of the mind and body connection and the effect that one has on the other. There is now a deeper understanding of how the impact of nurture and care on the early developing mind is acquired and stored.

In the first part of this key session, early patterns of behaviour were repeated and re-enacted as if there were a drive to repeat and add to old known experiences. In this group each person seemed to be responding from their original narcissistic wound. This group shared early experiences, both physical and mental, which they expressed in their drug abuse and their responses to life.
We see from current neuroscientific understanding (de Zulueta, 2006; Schore, 2005) that the right brain is able to respond to more visual stimuli and has also been found to be central to the development of a sense of self.

The first part of this session was filled with anger and rage, which had the effect of blocking empathy. By contrast, the image in the art therapy session was able to be recognised, and through that the group was able to work with more right brain thinking in creating an ability to empathise with each other in the pain rather than the anger. I think that it was important in this session that this channel through the art work could be accessed so the group were able to stop repeating old patterns of aggression when confronted with the pain. The early lack of connectivity with mother (or major carer) sets the scene for early damage to the emerging emotional structure of the brain.

Early care actually shapes the developing nervous system and determines how stress is interpreted and responded to in the future. (Gerhardt, 2004, p. 64)

De Zulueta (2006) describes how childhood neglect appears to produce fewer endogenous opiate receptors and hence less inbuilt capacity to experience emotional pleasure, which may be a possible link to addiction. Schore (2003) describes how the right hemisphere in the early developing brain, which is the centre for self-regulation and the implicit sense of self, is shaped by early attachment, and without loving attunement from its parents an infant fails to develop these capacities.

In our ‘key image’ we see a child ignored by its parents to the extent that they have turned their backs on him. Schore explains how the initial conditions that set the early forming self are found in the bonding experiences between mother and infant. This interaction with mother (or major care giver) is the infant’s first attachment to another human being and it is through this interaction that the empathy provided by their gaze influences development of the early maturing right hemisphere of the brain.

The right hemisphere, which is centrally involved in both the capacity to perceive the emotional states of other human beings and the control of functions supporting survival and enabling the individual to cope actively and passively with stress, is in a growth spurt in the first 18 months of life and is dominant for the first three years. Its maturation is experience-dependent and this experience is embedded in the attachment relationship between caregiver and infant. (Schore, 2003, p. 232)

This right hemisphere is responsible for visual and acoustic communication for the pre-verbal child and enables the formation of its early sense of self. So self-awareness and empathy are indelibly imprinted into the brain structures that are maturing in the first years and, more specifically, in the first few months of the child’s life.

Interference with the organisation of these right hemispheric neuronal circuits limits the child’s capacity to empathise, form attachments and regulate emotions. Felicity de Zulueta, in a lecture on attachment and trauma (2006), stated that, according to Winnicott, the mother’s gaze and response to her child is important for a child’s development, because this early attachment impacts on the maturing circuits of the developing right hemisphere, the highest level of affect regulation of the brain. When this developmental process is less than ‘good enough’, the infant experiences either trauma or neglect, and the brain does not develop as fully as a child whose needs are responded to, who is encouraged and played with. In particular, when the child is faced by a frightening or rejecting attachment figure, he or she resorts to an unconscious form of escape by dissociating emotionally from the terrifying parent.

The origin of an environmentally impaired right brain system for regulating aggressive states thus all too frequently lies in early relational trauma and the intergenerational transmission of an insecure disorganized/disoriented attachment pattern. (Schore, 2003, p. 295)

Art therapy: finding the ‘right’ mind together in group

Schore believes that this damage, described above, can be healed, and to some extent reversed by psychotherapy. Through Professor Schore’s and Felicity de Zulueta’s work, it is becoming increasingly clear that art, and I believe more specifically art therapy, is one of the most effective ways of reaching the damaged right brain functions and providing an integrating healing process which is necessary for change. I outlined the catalytic role played in this session by John’s image. I now attempt to expand a little on the role of the group dynamics. The group was in full swing to escalate the anger, which was located in John. My initial intervention was aimed at the group, not the individual. When I said, ‘I wonder where this anger originated. It feels to me as if these are very raw, very early feelings’, the group united.

By using John’s image of abandonment and by becoming aware of his terrible feelings of rejection, group members were able to own their own dissociated memories of painful and fearful rejection and thereby come together.

As Sue Gerhardt writes:
The missing experience of having feelings recognised and acknowledged by another person, particularly of having strong feelings tolerated by another person... through these types of experience with a psychotherapist, a new muscle develops... Psychotherapy offers the chance to rework the emotional strategies. (Gerhardt, 2004, p. 205)

John would almost certainly have been the group’s scapegoat, bearing the community’s anger and underlying pain. Although this may have solved the situation temporarily, this would have been at the cost of facing the underlying issues. By using the group’s dynamics and deflecting the anger to the pain, the pain was able to be claimed by the group as a whole, the situation was contained and emotional learning took place.

John and the group were enabled to access their ‘right’ reflective minds. John was now not needed to carry the angry violent role alone and was subsequently able to continue successfully with his programme.

I have described this as a key session because it was as if this session freed the group, releasing it from the rigid pattern of structure, which they as a group had imposed on themselves. This is not to say that the group did not slowly return to using negative patterns, but there was a spiral of growth. Even if the group at times regressed, the strengths they had gained were woven into the group’s history and became part of its matrix. I also believe that having one sessional group with an outside convener within the programme gave this group the frame in which to be potent. As all of the staff were involved in every aspect of the programme, from being key worker staff members in both therapy and community groups and also sleeping, cooking and eating with the residents, I was able to be the ‘blank screen’ or unknown person for the group members to project their own fantasy of who I was or what my position in the community was.

I acknowledge that it was with the expertise of the staff and commitment to good handovers that this group was not just used as a way of splitting.

In conclusion, recent advances in neuroscience allow the recording and the viewing of brain activity. Areas of the brain that before were inactive, due in some cases to childhood trauma, have been seen to have undergone a process of change and repair. In this paper I highlight a session where outward change was illustrated within a therapeutic setting. In this experience of art therapy in a group setting, the initial issue (of anger) was expressed verbally and physically by one group member (who carried the issue). Subsequently this group member produced an image—the key image—that linked and represented on many levels the images produced by most of the other members in the room.

The key to facilitating the group was to empathise with the pain that was being expressed by the anger that John had been acting out in the group, and to encourage the ‘group as a whole’ to own this shared feeling of pain to anger, the feeling that could not be expressed until the group reunited with the ‘key image’, which connected and enabled the group to be in their ‘right mind’.

References


Biographical details

After training as an art therapist at Goldsmiths College, University of London in 1988, Josephine Canty practiced as an art therapist for 12 years. She established and ran groups, three within drug rehabilitation therapeutic communities. She also created and ran a group for people with learning difficulties, some having little or no speech. She also worked with the long-term mentally ill in the NHS. In 1997 she trained at the Institute of Group Analysis and became a member of the IGA. She currently works as a group analyst both in private practice and in Oxleas NHS Trust at Bexley Psychotherapy Service.