Research article

Co-leading for community building: A program description of a dual-modality creative arts therapy group in psychiatric emergency care

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ABSTRACT

This article describes a dual-modality group, created and co-led by an art therapist and a dance/movement therapist, designed to build a sense of community among patients in a child and adolescent comprehensive psychiatric emergency program (CPEP). This program description begins to address the dearth of literature published on the provision of therapy in psychiatric emergency care by describing the goals, methods, interventions, and observations of the therapists, including the benefits of integrating two creative arts modalities by co-leaders. The method of beginning with a dance/movement therapy segment, followed by an art therapy segment to build upon themes developed during the dance/movement, and concluding with verbal processing, was observed to provide an effective structure for building community and mitigating specific challenges of the CPEP: short stays (up to 72 h), ability of patients to feel safe amid constant group population changes, a large age range, diverse diagnoses, varied trauma experiences, and necessary emergency room care interruptions. A description of a Community Building group session is included to illustrate the practices and observations discussed in the article.

Introduction

The joint dance/movement therapy (DMT) and art therapy community building group described in this program description took place on the child and adolescent unit of a comprehensive psychiatric emergency program (CPEP) located in the Bronx, New York, USA. The CPEP is a unique environment, and little is written about providing therapeutic services within one. In this article we describe our observations of the challenges specific to leading therapeutic groups within the CPEP, our attempts to overcome these challenges utilizing a psychodynamic-group therapy framework, the intentional use of two co-therapists and two creative arts modalities, and a description of one of our Community Building group sessions.

Comprehensive psychiatric emergency program (CPEP)

CPEPs are hospital-based, psychiatric emergency centers that function as triage units and serve as access points to mental health care for the community. From the time of initial evaluation, patients are observed for up to 72 h, during which a clinical determination is made for admission to psychiatric units, transfer to another facility, or discharge back to the community with connections to outpatient services (Sullivan & Rivera, 2000). As of July 2016, 23 CPEPs were operating in

New York State, with the highest concentration in New York City. Each CPEP follows a specific organizational structure, is licensed and overseen by the New York State Office of Mental Health (NYSOMH Statewide Comprehensive Plan 2016–2020), and is unique in its approach based on the expertise of staff and the community it serves (Sullivan & Rivera, 2000).

Population

The CPEP model was created in 1989 to relieve pressure on medical emergency rooms that were experiencing a substantial increase in demand for psychiatric emergency services by people who were formerly institutionalized, abusing substances, or homeless (Oldham & DeMasi, 1995). Upon the implementation of the CPEP model, children and adolescents were identified as growing utilizers of these services, with a growing subcategory of children under the age of 12 years (Sullivan & Rivera, 2000). This increase in demand for psychiatric emergency care for children and adolescents reflects the need to identify specific interventions and care models that will meet the diverse needs of this population.

The patients who attended our groups in the CPEP were viewed as representative of the surrounding community. In the New York City Department of Health and Mental Hygiene's community health profile

(2015), the neighborhood in which the hospital is located, and in which the majority of our patients live, is described as predominantly Hispanic and Black, and as one of the poorest neighborhoods in the city. It has low levels of educational achievement and one of the highest incarceration rates in the city. The neighborhood rates of hospitalization for substance abuse rank among the highest in New York City, and are more than double the citywide rates. In our own CPEP, we observed that many of our underage patients had unstable home lives, fragmented family units, involvement with the foster care and/or juvenile justice system, and a history of early traumatic experiences.

Challenges

There is a noticeable lack of published literature specific to conducting therapeutic groups of any kind within a CPEP unit. While the work is closely related to that undertaken on inpatient psychiatric units, the CPEP has additional challenges that inform therapeutic goals: extremely short lengths of stay, vast age and developmental levels, large range of acuity, diverse diagnoses and symptoms, and environmental factors, such as the lack of a group therapy room.

As the CPEP is designed to facilitate rapid triage, a patient's length of stay can span from a few hours to a few days. The constant flow of admissions and discharges in and out of the CPEP during a single day requires the CPEP therapist to assume each group will be a standalone session in which group members may likely be interacting with one another for the first, and possibly the last, time.

Within a single session on the child and adolescent CPEP, patients may be anywhere from 5 to 17 years old, carry a variety of diagnoses, and present with symptoms at varying levels of severity. Such a wide age range can pose challenges to group engagement and cohesion as members may be at vastly different developmental levels. The lack of a private group room exacerbates this challenge as groups cannot be divided by age or developmental level.

Constant negotiations are taking place for the patients' time and attention, as well. Groups can be subject to interruptions from other clinicians who need to interview a patient, staff administering medication and routine procedures, and the presence of visitors. These factors negatively impact the ability of the therapist to hold the frame of the therapeutic group and provide necessary containment for patients. As Yalom and Leszcz (2005) note, the group therapy session is never independent, but rather exists in relation to the unit in which it takes place.

Another complication in our CPEP is the absence of a separate room for conducting therapeutic groups. Therapy groups are conducted in the center of the CPEP unit, directly opposite the nursing station and surrounded by patient beds. There is a single, multi-use table in the middle of the CPEP for therapy groups, eating meals, and socializing during downtime. If there are patients who are disruptive, intrusive, or cannot tolerate being in the therapy group, it is impossible to set a physical boundary or expel them from the group setting. This lack of a therapy group room also limits the therapist's ability to prioritize privacy of patient disclosures and minimize interruption caused by the daily routine of the unit. As a result, our approach to facilitating a therapy group needed to be adaptive and directly responsive to the immediate needs of the CPEP.

Trauma

Based on interactions with group members, examination of patient charts, and research indicating that children living in less safe and more economically depressed neighborhoods are more at risk of adverse childhood experiences (Soleimanpour, Geierstanger, & Brindis, 2017), we found that a majority of the children and adolescents served in the CPEP had histories of traumatic interpersonal experiences related to abuse or neglect by primary caregivers or other family/community members.

Interpersonal trauma has an ongoing impact on one's ability to form and maintain meaningful relationships, and has a direct impact on children's development in key areas of communication and distress tolerance (Cook et al., 2005). Adverse experiences put the child or adolescent at increased risk of problems related to affect regulation, attachment, dissociative responses, poor sense of self, lower educational engagement, and behavioral issues, and can make them more vulnerable to additional trauma exposure in adulthood if left untreated (Cook et al., 2005; Gerge & Pederson, 2017; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; Soleimanpour et al., 2017).

Hospitalization itself can be a traumatic experience, as patients may be held against their will and may have adverse reactions to staff, peers, or the environment (Frueh et al., 2000). Seclusion, restraint, and other clinical procedures have the potential to cause traumatic responses by reinforcing experiences of loss of control, confinement, and/or forced compliance (Frueh et al., 2000).

By focusing the group on building community among the CPEP patients, we hoped to negate potentially traumatizing effects of hospitalization and approach pre-existing trauma experiences sensitively. We strove to create a safe and structured environment through co-leading and the use of two creative modalities to allow for meaningful interactions that could possibly strengthen prosocial behavioral skills. This was seen as a starting point from which patients may eventually be able to question and renegotiate maladaptive interaction styles developed secondary to their trauma (Perry, 2013; van Westrhenen et al., 2017).

In conceptualizing the feasible scope of interventions within the community building group, we had to consider the limitations of a single session group to address possible trauma responses. Considering the ever-changing nature of the CPEP, and the structure of a phase-based approach to trauma treatment, we prioritized the containment of trauma narratives in service of fostering safety and stability within the physical and interpersonal space (Herman, 1992). Such containment was intended to avoid triggering experiences and discussions that might be developmentally inappropriate for some group members. Should a group member need to process something that was not appropriate for the group as a whole, opportunities were provided to speak privately with one of the therapists after the conclusion of the group.

Neuroscience, trauma, and treatment

Neuroscience research has illuminated some of the biological effects of psychological trauma and early experiences of emotional abuse and neglect. Crenshaw (2006) provides a review of some of the field's major findings: psychological trauma can cause acute and chronic disruptions to many organs and body systems (Solomon & Heide, 2005); trauma exposure affects children's information processing and appraisal (van der Kolk, 2003); trauma to early attachment relationships can lead to disorganized or disoriented attachment style, deficiencies in right-brain regulatory functioning, and disruptions to the brain's coping systems (Schore, 2001).

Neuroscience research further indicates adaptive brain development and maturation is experience-dependent, which is particularly relevant to the creative arts therapies as they are experiential by nature (Perry & Pate, 1994; Perry & Pollard, 1998; Schore, 2001; van der Kolk, 2003).

Neuroimaging scans have illustrated the left-frontal cortex, which houses the language and speech center, shuts down and impairs speech processes when people attempt to recall traumatic experiences (van der Kolk, 2003). As such, van der Kolk (2003) recommends combining more action-oriented and experiential therapies, such as DMT and art therapy, with talk therapy when treating clients with trauma histories.

Theoretical framework

Psychodynamic approach

We chose a psychodynamic approach for our Community Building

group for its evidenced ability to facilitate the relief of symptoms, the ability of individuals to experience continued growth, the strengthening of psychological competence, and the improvement of interpersonal skills for more fulfilling relationships even after therapy has ended (Shedler, 2010).

As the psychodynamic approach involves providing new interpersonal experiences to correct or transform maladaptive relational patterns, it can be further supported by the experiential nature of the creative arts therapies (Yerushalmi, 2018). By concentrating on the core components of the psychodynamic approach – affect and expression of emotion (either through verbal processing or creative arts expression); awareness and exploration of avoidance techniques; and interpersonal relations among peers and within the therapeutic relationship (Shedler, 2010) – we found the framework to be appropriate for short-term group therapy.

Group therapy

Yalom argued the group therapist in the inpatient unit must have a vastly different approach than the group therapist in an outpatient setting, and identified six achievable goals for inpatient group therapy: "1. Engaging the patient in the therapeutic process; 2. Demonstrating that talking helps; 3. Problem spotting; 4. Decreasing isolation; 5. Being helpful to others; 6. Alleviating hospital-related anxiety" (Yalom & Leszcz, 2005, p. 485). We contend the approach of the group therapist in the CPEP is similar to that of the therapist in the inpatient unit, but more constricted due to the increased number of limitations and challenges present in the CPEP.

We believe all of Yalom's inpatient goals, except that of problem spotting, are achievable in the CPEP therapy group and fall within the three goals we devised for our Community Building group: develop prosocial behaviors (addresses Yalom's goals 1, 2, 4, 5); foster a sense of belonging (addresses Yalom's goals 2, 4, 5, 6); facilitate a safe and structured environment for self- and group exploration (addresses Yalom's goals 4, 6). We found problem spotting was not a conceivable goal in the CPEP, as it is an emergency setting designed for extremely short patient stays while admission or discharge is decided and during which patients are often too acute for such insight.

Yalom's first goal of engaging the patient in the therapeutic process relates to our belief that providing a good enough experience in the group may prompt patients to seek similar experiences outside the hospital. As the length of hospital stays is becoming shorter owing to insurance and other administrative factors, patients' compliance in aftercare treatment is critical to their wellbeing. We hoped to achieve this goal by facilitating an engaging and valuable therapeutic experience through the use of two creative modalities and the extra support from co-leading.

We extend Yalom's second goal to include self-expression through any creative means (e.g., movement, visual art, and drama), as creative arts therapy theory is based upon the belief that artistic mediums provide more opportunities for communication than sole reliance on traditional talk therapy (Vernon, 2013). With the option to express oneself through dancing, art-making, or talking during the group session, group members might have an increased chance of experiencing the relief that comes from knowing they are not alone in their feelings, worries, or concerns. Such relief paves the way for group cohesion (Yalom & Leszcz, 2005). We observed group members regularly bonded after expressing, through movement or visual art, similar feelings, which often appeared to lead to increased group engagement and exploration of other connections between members.

Simply by participating in the therapy group, patients can achieve Yalom's fourth goal of a decrease in isolation. By interacting more, patients may improve communication skills and decrease isolation in daily life outside the hospital (Yalom & Leszcz, 2005). After community building groups in which participants appeared to increase communication, we often observed an increase in play and engagement in the

milieu following the conclusion of the group, as opposed to the patients returning to their beds.

Admission to a psychiatric hospital can bring feelings of guilt or shame; thus, it is all the more important to provide opportunities for patients to experience themselves as helpful, contributing members of a group. We observed the possible achievement of Yalom's fifth goal in a few ways: group members helping to move the table and chairs to prepare the physical space; sharing of art supplies; and cheering other members in their dancing or complimenting their artwork. When such positive and helpful actions took place, we observed they engendered more of the same from other group members.

As mentioned previously, hospitalization itself can be a traumatic experience. Yalom argued his sixth goal of alleviating hospital-related anxieties can be achieved by providing a safe and structured environment in which "patients can air these issues and often achieve reassurance simply from learning that these concerns are shared by other members" (Yalom & Leszcz, 2005, p. 487). We often witnessed group members express grievances with the hospital, ranging from the quality of the food to the disposition of staff members. After such expressions, group members often appeared less preoccupied with these complaints, and more focused on what they might be able to gain from their hospital stay.

Combining DMT and art therapy

Joint DMT and art therapy groups have been shown to positively impact group members' social interactions and interpersonal skills through observations of participants' progress toward goals and quantitative data reporting enhanced mood (Free & Gould, 1978; Grodner, Braff, Janowskly, & Clopton, 1982). We believed prosocial behaviors, i.e. being respectful, sharing, taking turns, and listening, could be developed inherently through the use of the artistic mediums: members were required to share (dance floor space, art supplies) and to take turns (being the dance leader, using specific art materials).

DMT and art therapy groups facilitate listening to and observing other member's ideas (body movements or visual art) through mirroring, which may lead to better understanding of the other's experience and developing the skill of empathy (Berrol, 2006). From a neurological perspective, the experiential and relational nature of DMT and art therapy groups has the potential to rewire the brain for more habitual prosocial behaviors (Cozolino, 2017).

As preferences toward creative outlets vary, and people tend to learn differently (e.g., some being more adept at visual, kinesthetic, or auditory learning) (Mahdjoubi & Akplotsyi, 2012), we believed we could accommodate more patients by integrating our two therapeutic mediums. Dual-modality groups may also be more inclined to promote exploration of self, and exploration of self in relation to others, by layering different therapeutic mediums within one session (Burrell & Cohen, 2018; Cohen, 1983). Since the group session represents a microcosm of the members' larger worlds, we believed this experience of belonging could make it more likely for our participants to seek ways of being contributing members in their communities outside the hospital (Wittig & Davis, 2012). From a developmental perspective, such a sense of belonging is important to healthy psychological growth, as children with socially avoidant behaviors have been found to struggle most with pervasive socioemotional difficulties (Coplan et al., 2013).

By utilizing dance/movement and art, we hoped to provide a safe enough environment for self-disclosure by working through imagery, metaphor, and symbolism. Group members could explore feeling states, memories, and thoughts from the potentially less threatening distance of symbolic body movement and visual art, rather than direct disclosure of private experiences (Burrell & Cohen, 2018; Cohen, 1983; Free & Gould, 1978). Such use of symbolism also addresses the possible imbalance created by a diverse age and developmental range by allowing members to explore themes without use of inappropriate terms or information (Neushcul & Page, 2018).

Co-leading

We believed the presence of two co-therapists might be able to create a safe and structured environment, or a good enough holding environment (Winnicott, 1986), to allow for self- and group-exploration despite the many challenges presented by the CPEP. By co-leading, we felt we could better address the issues of physical containment, privacy, and interruptions caused by the lack of a separate group therapy room.

We approached each session with transparency and communicated verbally and non-verbally to make clinical decisions in the moment and model cooperation for the group. Dance movement psychotherapist Claire Burrell and art psychotherapist Marika Cohen (2018) highlighted the power of the co-leader taking on the "peer position role" (pg 17) to model engagement and risk-taking within their joint DMT and art therapy group for women coping with long-term mental illnesses. As such, the non-leading co-therapist could act not only as a buffer from the interruptions of the milieu, but also could model the use of group as a place to try out new methods of expression, and possibly new behaviors, without fear of judgement (Byers, 2016; Cohen, 1983).

In addition to modeling and providing more containment, we aimed to broaden our therapeutic skill set through co-leading. When collaborating with a creative arts therapist of a different medium, opportunities for professional growth and development arise that can lead to greater understanding and respect (Best, 2000), as well as an expansion of professional resources that benefits patients (Burrell & Cohen, 2018).

Structure of the community building group

Intention setting

Over time, the structure of our Community Building group was developed, adjusted, and adapted to meet the emergent challenges and needs of the CPEP and the group. One aspect that remained constant was the introduction of the intention of the group before each session. Once members were gathered, we inquired on their understanding of and involvement in communities, and then prompted them to consider how the current group may resemble a community. We encouraged them to reflect on this discussion throughout the group session.

Sequencing modalities

A consideration when developing the group structure was whether to begin with the art therapy or the DMT segment. We facilitated multiple groups using both orientations, and ultimately determined that starting with DMT and following with art therapy provided the most successful structure for our Community Building group in the CPEP. A few distinct challenges were encountered when beginning the groups with art therapy: more resistance to engagement, rougher transitions between modalities, and more difficulties processing at the end.

When first facilitating the DMT segment, we found we could better combat resistance to engagement through a set, structured warm-up verbally instructed by the dance/movement therapist that moved sequentially through the muscles of the body. This warm-up appeared to reduce group members' anxiety as it provided clear movement instruction and allowed members to become present to the sensations and feelings in their bodies. Once this reduction of anxiety occurred, group members appeared more inclined to engage as a group, which we found harder to facilitate when DMT followed art therapy.

The transition from one modality to the next was marked by the moving of the table, chairs, and art supplies, and was a vastly different experience with the different sequencing of modalities. When beginning with art therapy, the transition to DMT often disengaged group members. Many members simply did not assist in cleaning the art supplies and moving the table and chairs, making for a longer transition time. There was also the complication of where to store the art piece while we danced, which contributed to the third challenge of bringing group members back to the art piece for verbal processing after the DMT segment. This challenge made the two modalities seem at odds with one another, which was antithetical to our goal of developing themes from one modality to the next to support group exploration and community building.

DMT segment

When we began the group with the DMT segment, the aforementioned challenges were less apparent, and the goals for building community were more often observed. After the opening verbal discussion on community, we began the group with a structured warm-up, leading into a more spontaneous and communally created dance experience that fostered rhythmic action in synchrony, mirroring, and imagery that allowed for symbolism.

Rhythmic action in synchrony creates a sense of unity between members of a group and is at the core of DMT theory, as it allows group members to relate to one another nonverbally, which can lead to group cohesion (Chace, 1951). As rhythmic action occurred, the dance/movement therapist often encouraged mirroring, or the trying on of others' movements, as it can create interpersonal relationships through movement and build empathy skills (Berrol, 2006; Sandel, 1993a, 1993b). By mirroring others' movements, group members may come to understand others' feeling states and experiences better. This DMT concept has become a researched topic within neuroscience with the discovery of mirror neurons in the brain. Mirror neurons occur when "the same sets of neurons are activated in an observer as in individuals actually engaged in an action or the expression of some emotion or behavior," and relate to such psychosocial concepts as empathy, attunement, and attachment (Berrol, 2006, p. 303).

As group members began making interpersonal relationships through this dance experience, the dance/movement therapist facilitated the use of imagery by asking the group to verbally identify images that corresponded to the movements being performed. Imagery and symbolism are used in DMT to work through emotional issues or concerns from the safe distance of symbolic play (Berrol, 2006; Sandel, 1993a, 1993b), which is important for a trauma-centered approach within a group setting (Crenshaw, 2006; Dieterich-Hartwell, 2017).

For example, when the group identified the image of blasting off in a rocket ship to represent the movement of bending the knees deeply and then jumping, the dance/movement therapist guided the group through the imagery by asking questions about where the spaceship was going, whether the ride was smooth or bumpy, and if others were in the spaceship. Such inquiry and prompting of further movement exploration can "elicit deeper experiences of the feelings and meaning contained in the image" and allow interpersonal issues to surface and possibly be resolved (Sandel, 1993a, 1993b, p.117). Through such symbolic work, group members may feel greater safety in sharing, which may provide more opportunities to experience the relief that comes with knowing others have similar thoughts, feelings, and emotions (Yalom & Leszcz, 2005).

We also used imagery and symbolism to facilitate a smoother transition to the art-making segment by asking group members to consider what emotions they might associate with various movements, and then to identify a corresponding color. The art therapist then referenced these symbolic thoughts when beginning the art therapy segment.

To prepare the group for the transition between modalities, the dance/movement therapist reserved the final song for a structured cool-down that often involved communal sound making to a unified rhythm (e.g., clapping, tapping, or stomping in unison). This use of communally created sounds appeared to ground the group members in the here and now, and aid in maintaining focus during the transition.

Art therapy segment

After the cool down, we asked participants to assist in returning the table and chairs to the center of the room as the art therapist brought over the art supplies: one large piece of mural paper, markers, crayons, and oil pastels. The choice to use a single large piece of mural paper, on which all group members could work simultaneously, was intended to further the goal of improving prosocial behaviors (e.g., sharing, taking turns) necessary for building community. It also provided a shared space that was comparable to the circle we most often used as the frame during the DMT segment. The art therapist provided only markers, crayons, and oil pastels as art materials to promote ease of use and containment.

Depending on the make-up and size of the group, the art therapist made a clinical judgment as to whether the art-making would take place on the table for more containment, or on the floor for more freedom. If more containment was needed, we brought the chairs to the table; however, we often found it was beneficial to remain standing as it helped maintain a connection to the movement experience.

We observed that prompting the group members to correspond colors with feeling states during the DMT segment made a significant impact on their comfort in beginning to make visual art. The art therapist further facilitated the transition by suggesting group members consider both the theme of community and their experience of the DMT segment. Group members were encouraged to express freely what had been initiated in dance, with the art therapist providing a more directive approach if necessary, such as reminding members of specific imagery that had emerged or suggesting the creation of a visual line to represent a movement we had made.

In communally creating the artwork, we sought to strengthen a sense of belonging among group members and allow for greater ease in sharing thoughts and feelings symbolically. When group members were engaged in communal artmaking, they more often asked questions about one another's work, reflected on the dance experience, and at times mimicked images or took inspiration from one another.

From an attachment theory perspective, copying in art relates to the act of mirroring as a way of attuning to develop a more defined sense of self (Stott, 2018). Since many of the group members suffered from a lack of sufficient care in early childhood, we believed the act of copying other group member's artwork may have been an attempt toward engagement and a means of deriving comfort and familiarity (Stott, 2018). As such, art-making can be used as a means of responding to one another and promoting the experience of being seen by others (Franklin, 2010). As the art-making segment drew to a close, we provided a two-minute warning, after which we asked group members to clean up the art supplies before the verbal processing of the work.

Group closure

Both therapists engaged in facilitating the verbal processing for group closure. We prompted discussion by asking about experiences of the group as a whole, or any changes in their perceptions of community. The art therapist often held up the artwork and invited discussion on how their individual contributions fit together to create the whole piece of art. Isserow (2008) highlighted the importance of the triangular relationship that occurs when the therapist and the patient look together at artwork by comparing it to the mother–child dyad's "capacity to look and feel together" (p. 36). Such joint looking can promote empathic skills and contribute to the creation of a safe environment by allowing time to examine what was created within the shared group experience.

Finally, the group was encouraged to decide on a title for the artwork, the physical orientation of the work, and whether or not they wanted to hang it on the wall of the CPEP. By ending with group decision making, we intended to facilitate an opportunity for the group to take ownership of their communal experience, with the artwork being a concrete representation of the process.

Discussion

Prosocial behaviors

In addition to the intended prosocial behaviors of sharing, taking turns, etc., we also witnessed the development of a greater awareness of self in relation to others, improved tolerance of others' needs, and increased altruistic behaviors. Within the DMT segment, these changes were often observed during synchrony in rhythmic action. By stepping, clapping, stretching, swaying, etc. to the same beat, we appeared to create a commonality among us, paving the way for group cohesion. By moving together to the same rhythm, we observed interpersonal connections developed quickly, which may have contributed to our experience of the community building group flowing more effectively when beginning with DMT.

Themes of self-awareness in relation to group awareness frequently arose through pointing movements, which often began with pointing at others, transitioned to pointing at the self, and then at the group as a whole. In a few sessions, this was accompanied by the verbal cues of "you" and "me," and then followed by a circular pointing movement with the verbal cue, "us."

Mirroring of movements, which requires members to subserviate their own movement desires in service of others', exemplified improved tolerance among group members. Mirroring occurred organically, with the dance/movement therapist picking up on group members' movements and incorporating them into the dance, as well as more directively, with the dance/movement therapist suggesting that group members take turns being leaders and followers.

Mirroring of images similarly occurred during the art therapy portion. The visual images we often saw mirrored by group members included eyes, faces, circular shapes, and idiosyncratic elements. Through such mirroring, group members appeared to display acceptance of each other's artwork, which may have indicated acceptance of one another within the group.

In the art therapy segment, changes in prosocial behaviors were also observed through the sharing of materials and the proximity of individuals' mark-making to those of other group members. The art therapist endeavored to foster respectful interactions and validate healthy communication around the navigation of boundaries and intrusions within the artwork by highlighting positive actions between group members. For example, when one group member asked permission before drawing closer to or within another members' image, such permission-asking was identified and encouraged.

Sense of belonging

Imagery and symbolism often aided in creating a sense of belonging. During the DMT segment, the dance/movement therapist facilitated imagery with the intention of uniting the group in a common theme to be worked through symbolically. Imagery emerged from the movement and was then clarified by the group as a whole, which appeared to provide group members with a sense of ownership over the DMT process. Common themes that arose included marching in parades, moving in slow motion, being in outer space or in rocket ships, passing an energy ball, and creating a "heap" of emotions/wishes/dislikes/etc. in the center of the circle.

The dance/movement therapist made clinical judgments when directing the processing of the imagery to facilitate symbolic meaning making. During one session, a movement developed out of repeatedly putting our hands in front of us with palms facing outward. The dance/movement therapist asked questions about this movement, and the group decided we were mimes feeling the walls around us. The group members were encouraged to explore the walls, such as their texture, temperature, etc., and to remark upon any sensations. The dance/movement therapist then prompted questions about emotions associated with this imagery, which ultimately led group members to share

and make connections between their similar experiences of being held within the walls of the hospital.

Images and movements from the DMT segment were often carried through into the art-making and conceptualized in similar forms among group members, such as the abundant use of flowing lines, circles, and spirals. The regular appearance of similar lines and shapes may indicate the presence of a shared experience, or may be a product of copying artwork.

The art therapist made clinical decisions to provide further interventions for a sense of belonging when needed, such as asking participants to rotate places at the table and continue drawing in a new place on the paper. This intervention reinforced the concept of community and that the artwork was being created by the collective. It also allowed participants to experience the responsibility of preserving or adding to another members' artwork, facilitating the opportunity to be a contributing member of a community.

The art therapist also encouraged participants, when deemed appropriate, to visually connect their images to those of other group members to strengthen group connection. These directives often led to constructive communication between group members and revealed varying levels of comfort within the group. Some group members refused to make visual connections, with a few members going so far as to enclose their drawing within a frame or border to prevent contact, while others actively looked for ways to join with or build upon other members' artwork.

Safe and structured environment

Creative arts therapy groups often have an intentional structure of a beginning, middle, and end to alleviate anxiety that can arise from personal expression within a group setting. This progressive structure from introduction to experiential stage to processing provides a reliable order that can instill a sense of safety in group members, which is essential for trauma-informed care (Dieterich-Hartwell, 2017).

The dual-modality nature of our group also aided in the goal of a sense of safety, as it allowed for more opportunities for expression through different creative mediums. Members who were more resistant to dance may have found greater expression during the art segment and vice versa. During many sessions, we observed group members discussing their resistance to the different modalities, which often led to either universality of experience or to the other members encouraging participation despite resistance.

The construction of a safe environment was also intended to alleviate hospital-related anxieties, such as missing home or lack of control over discharge, which might cause isolation or withdrawal among patients. When a safe-enough environment appeared to be attained, the community building group provided a forum for members to discuss these anxieties freely, whether through movement, art, or verbally.

Group session description

The following description of a group session is included to illustrate the aforementioned structure, goals, and observations of our Community Building group. Any identifying information has been omitted.

This group session took place with three group members: A, B, and C. Group members B and C were of the same gender. Group members A and C had histories of trauma and neglect, and had previous stays in the CPEP. All three group members were participating in the group for the first time. The group members' ages, symptoms, and severity of symptoms ranged greatly.

We began the session with the discussion about community, asking questions to glean the group members' understanding of and experiences with communities. Some resistance to sharing was encountered, and the therapists encouraged the group members to keep the questions in mind during the group.

The dance/movement therapist then gave a brief introduction to DMT and turned on the music. Songs were selected prior to the beginning of the group, and arranged to create an arc within the DMT segment: warm-up, middle, and cool-down. The dance/movement therapist chose songs without set, popular dances to steer clear of prescribed movements, and instead encouraged more spontaneous or authentic movements. Songs with clear rhythms were chosen to more naturally facilitate rhythmic action in synchrony. The art therapist participated throughout the DMT segment, modeling engagement and risk-taking for the group members.

The dance/movement therapist asked the group to form a circle and guided a structured warm-up involving a progression of isolations, cuing the participants to move the head, the neck, the shoulders, the torso, and so on, down to the feet. Such a guided, structured warm-up was chosen to alleviate group members' anxiety about how to participate, and to sequentially ready the body for more movement. Group member A began to dance right away, while members B and C displayed more resistance. Member A even performed some variations to the dance/movement therapist's cues, which the dance/movement therapist incorporated into the guided warm-up with the intention of validating member A's efforts.

Following the warm-up, group member A requested taking turns dancing in the center of the circle. When asked why this exercise was desired, member A cited an enjoyment in sharing personal dance moves and seeing others share their own. Anticipating that such an exercise could cause stress on some members, especially so early in the group, while not wanting to dismiss member A's enthusiasm, the dance/movement therapist prompted the exercise for those who wished to partake. Member A readily danced in the center first, and the outside members provided encouragement through clapping to the rhythm. The therapists then modeled risk-taking by taking our own turns to dance inside the circle. Perhaps due to the encouraging atmosphere being built, member B took a turn dancing in the middle of the circle, as well.

The group then resumed moving together as a whole. Upon observing member A performing a snake-like movement through the arms, the dance/movement therapist began to mirror the movement to better understand member A's experience. Other members began to perform the movement, as well, and a pattern arose organically in which one member passed the snake-like movement to the next member, and so on, until the movement made its way around the entire circle. The group identified the movement as passing an "energy ball," and the dance/movement therapist encouraged members to find new ways of passing it. Members A and B engaged creatively and began to move different parts of their bodies to pass the energy ball, including feet, head, hips, and eyes, while member C remained resistant. Noting the group was not yet in a cohesive stage to work through the imagery of the energy ball, such as deciding together how to dispose of it, the dance/movement therapist let go of the imagery once the members appeared ready to move on.

The dance/movement therapist then directed all members to slide to a new spot in the circle with the hope of engaging member C. Such traveling appeared to get the whole group motivated, and we all continued to travel by walking in toward the center of the circle and then out toward the edge of the circle. Member A suggested the group try performing the movement in slow motion. All members agreed and traveled in and out in slow motion. With all group members engaged in the same directive, it appeared a sense of group cohesion was forming.

Once all group members were back on the edge of the circle, the dance/movement therapist observed two members moving their legs in circles. To build off this movement, the dance/movement therapist prompted everyone to use one leg like a paintbrush to paint their names on the floor. The movement naturally progressed to our arms and hands, and the art therapist prompted questions around what colors the group members were painting with and what kind of strokes or marks they were making.

Once the imagery had run its course, the dance/movement therapist

guided a sequential slowing of movement to cool the body down. Clapping was then introduced to bring an audible sound to our synchrony of rhythmic action and to plant us firmly in the present. The group struggled to make a unified clap sound, which may have correlated with the struggle it took to find cohesion overall within this diverse group.

The therapists then reviewed the images and themes that arose throughout the DMT segment with the intention of making the transition to art-making smoother: the snake-like motion with the arms, passing the energy ball, painting with the arms and legs, and the various colors with which the members had been painting. The group members then aided in moving the table as the art therapist laid out the art materials.

The art therapist chose to have members stand around the table to support connection to the preceding segment and maintain a sense of body action. The art therapist placed a large piece of mural paper in the center of the table and provided oil pastels, glitter crayons, and markers. Members were asked to reflect upon community and their experience in the dance segment through artmaking. The group was encouraged to make images spontaneously, and discouraged from writing words or names with the intention of minimizing resistance via stereotypical themes. The art therapist continued to verbally review the experiences of the preceding segment to provide structure and relieve any possible anxieties during the transition between modalities.

Although there was hesitation among all group members at the outset, member B was eventually drawn in by the art materials, which prompted members A and C to follow suit. Member A initially expressed a desire to write their name in graffiti, and was reminded to avoid the use of words. Still wanting to honor member A's desire to engage, the art therapist suggested member A could create an image to symbolize their name. Member A was receptive to this intervention, and began to find creative ways of expressing identity through imagery. As the group members began to draw, the therapists also began to create images to model engagement and risk-taking.

Many of the images created by the group members, while not all explicitly connected to the dance/movement experience, appeared to build upon and further reveal interpersonal dynamics developing within the group. Member A appeared to seek acceptance from the group by taking visual cues from others through the copying and adapting of other members' images. Member B encased their image in a strong black frame, appearing to discourage connection with others' artwork, which may have been representative of feelings of resistance or protectiveness. Member C drew a solar system with planets orbiting around the sun. Throughout the group, member C had been more internally preoccupied and less vocal about experiences of the group, and this image may have been indicative of their view of their role on the periphery, orbiting the other group members.

As members B and C tended to stay in more self-defined areas on the mural paper, the art therapist made the clinical decision to verbally question how making connections within the artwork might reflect community. Acting upon the art therapist's intervention, member A attempted to build connection by urging other members to be more involved in the group's creative process, while members B and C appeared to remain resistant. Such interpersonal dynamics may indicate the level of social functioning these members display when in their home communities, and may provide information on their readiness to strengthen interpersonal skills.

Toward the end of the art making, the art therapist made the group aware of the large, empty space still left in the center of the mural paper. With the intention of promoting more social interaction for community building, the art therapist asked if there was a way the group could join their images in the center. Member A suggested drawing a big thought bubble in which each member could draw a symbol to represent themselves. The other members agreed, and members A and B quickly engaged. Member C continued to show resistance toward creating communal art outside of their self-designated

space, but after encouragement from the group, drew a symbol in the center.

The therapists then facilitated a verbal processing of the group experience. Member A verbalized the fear of exposing oneself and how it can be difficult to take chances when getting to know new people. The therapists asked members B and C their opinions, and both agreed it can be difficult and anxiety-producing to be in a new situation with many unknowns. Member B related such anxieties to the experience of the dance/movement segment, sharing initial feelings of fear of judgement that inhibited engagement in the beginning. Member C reported feeling a sense of relief after learning that other members had similar emotions and experiences. The therapists felt this was a key moment of connection during the group that contributed to an overall sense of cohesion despite diagnostic and developmental differences.

With the goal of giving the group a sense of ownership over their experience and value to the concrete representation of their time together, the art therapist asked the members to title the piece and decide upon an orientation and location for the mural to be hung. All group members gave suggestions for the title, and they were able to combine different aspects of the suggestions to agree upon one: "Community Thoughts." The group members decided they wanted to hang the mural, agreed upon a placement, and assisted the therapists in hanging their art piece.

Conclusions and recommendations

The environment of the CPEP can be challenging for clinicians to facilitate a therapeutic group. With adaptations and adjustments, there is a place for creative arts therapy in psychiatric emergency care. During our experiences co-leading and observations of the Community Building group sessions, it appeared the dual-modality approach provided more opportunities for engagement than a single-modality group and aided in deepening interpersonal connections among group members. Given the limitations of space and the nature of interruptions in the emergency setting, we found having two co-leaders imperative to holding the therapeutic frame and providing a safe enough environment for engagement.

As this article is a program description intended to begin to address the need for literature on providing therapy in psychiatric emergency settings, further quantitative and qualitative research is needed to measure outcomes and determine best practices. The scarcity of related literature underscores the dire need for more program descriptions, evaluations, and research into the provision of therapy in psychiatric emergency care.

References

Berrol, C. F. (2006). Neuroscience meets dance/movement therapy: Mirror neurons, the therapeutic process and empathy, 2019 therapeutic process and empathy. *The Arts in Psychotherapy, 33*(4), 302–315.

Best, P. A. (2000). Theoretical diversity and clinical collaboration: Reflections by a therapist, 2019 dance/movement therapist. *The Arts in Psychotherapy, 27*(3), 197–211.

Burrell, C., & Cohen, M. (2018). Moving colour: Combining dance movement psychotherapy and, 2019 art psychotherapy in a NHS community women's group. In T. Colbert, & C. Bent (Eds.). *Working across modalities in the arts therapies: Creative collaborations* (pp. 15–29). London: Routledge.

Byers, J. G. (2016). Expressive arts in play therapy. In K. J. O'Connor, C. E. Schaefer, & L. D. Braverman (Eds.). *Handbook of play therapy* (pp. 277–288). Hoboken, NJ, US: John Wiley & Sons Inc.

Chace, M. (1951). Rhythm in movement as used in Saint Elizabeths Hospital. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.). *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 193–196). Columbia, MD: Marian Chace Memorial Fund of the American Dance Therapy Association.

Cohen, B. M. (1983). Combined art and movement therapy group: Isomorphic responses. *The Arts in Psychotherapy, 10*, 229–232.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398.

Coplan, R. J., Rose-Krasnor, L., Weeks, M., Kingsbury, A., Kingsbury, M., & Bullock, A. (2013). Alone is a crowd: Social motivations, social withdrawal, and socio-emotional functioning in later childhood. *Developmental Psychology, 49*, 861–875.

Cozolino, L. (2017). *The neuroscience of psychotherapy: Healing the social brain* (3rd ed.). New York, NY: W W Norton & Co.

Crenshaw, D. (2006). Neuroscience and trauma treatment: Implications for creative art therapists. In L. J. Carey (Ed.). *Expressive and creative arts methods for trauma survivors (21–38)*. Philadelphia, PA: Jessica Kingsley Publishers.

Dieterich-Hartwell, R. (2017). Dance/movement therapy in the treatment of post traumatic stress: A reference model. *The Arts in Psychotherapy, 54*, 38–46.

Franklin, M. (2010). Affect regulation, mirror neurons, and the third hand: Formulating mindful empathic interventions. *Journal of the American Art Therapy Association, 27*(4), 160–167.

Free, P. D., & Gould, S. (1978). Bridging the gap between art and dance therapy. *American Journal of Dance Therapy, 2*(2), 33–34.

Frueh, B. C., Dalton, M. E., Johnson, M. R., Hiers, T. G., Gold, P. B., Magruder, K. M., et al. (2000). Trauma within the psychiatric setting: Conceptual framework, research directions, and policy implications. *Administration and Policy in Mental Health, 28*(2), 147–154.

Gerge, A., & Pederson, I. N. (2017). Analyzing pictorial artifacts from psychotherapy and art therapy when overcoming stress and trauma. *The Arts in Psychotherapy*. https://doi.org/10.1016/j.aip.2017.02.001.

Grodner, S., Braff, D., Janowsky, D., & Clopton, P. (1982). Efficacy of art/movement therapy in elevating mood. *The Arts in Psychotherapy, 9*, 217–225.

Herman, J. L. (1992). *Trauma and recovery.* New York, NY, US: Basic Books.

Isserow, J. (2008). Looking together: Joint attention in art therapy. *International Journal of Art Therapy Inscape, 13*(1), 34–42.

Kinniburgh, K. J., Blaustein, M., Johnson, Spinazzola, J., & van der Kolk, B. A. (2005). Attachment, Self-Regulation, and Competency. *Psychiatric Annals, 35*(5), 424–430.

Mahdjoubi, L., & Akplotsyi, R. (2012). The impact of sensory learning modalities on children's sensitivity to sensory cues in the perception of their school environment. *Journal of Environmental Psychology, 32*(3), 208–215.

New York City Department of Health and Mental Hygiene (n.d.). Community health profiles 2015. New York.

New York State Office of Mental Health (n.d.). Statewide Comprehensive Plan 2016–2020. New York.

Neushcul, T., & Page, E. A. (2018). Creating shared worlds: Promoting mutual aid and community-building through expressive intervention. *Social Work with Groups, 41*, 21–33.

Oldham, J. M., & DeMasi, M. E. (1995). An integrated approach to emergency psychiatric care. *New Directions for Mental Health Services, 67*, 33–42.

Perry, B. D. (2013). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood.* Retrieved from https://childtrauma.org/wp-content/uploads/2013/11/Bonding_13.pdf.

Perry, B. D., & Pate, J. E. (1994). Neurodevelopment and the psychological roots of post-traumatic stress disorder. In L. Koziol, & C. Stout (Eds.). *The neuropsychology of mental disorders: A practical guide* (pp. 129–146). Springfield, IL: Charles C. Thomas Publisher.

Perry, B. D., & Pollard, R. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7*, 33–51.

Sandel, S. L. (1993a). The process of empathic reflection in dance therapy. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.). *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 98–111). Columbia, MD: Marian Chace Memorial Fund of the American Dance Therapy Association.

Sandel, S. L. (1993b). Imagery in dance therapy groups: A developmental approach. In S. L. Sandel, S. Chaiklin, & A. Lohn (Eds.). *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 112–119). Columbia, MD: Marian Chace Memorial Fund of the American Dance Therapy Association.

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 201–269.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *The American Psychologist, 65*(2), 98–109.

Soleimanpour, S., Geierstanger, S., & Brindis, C. (2017). Adverse childhood experiences and resilience: Addressing the unique needs of adolescents. *Academic Pediatric Association, 17*(7S), 108–114.

Solomon, E. P., & Heide, K. M. (2005). The biology of trauma: Implications for treatment. *Journal of Interpersonal Violence, 20*, 51–60.

Stott, S. (2018). Copying and attunement: The search for creativity in a secure setting. *International Journal of Art Therapy, 23*(1), 45–51.

Sullivan, A. M., & Rivera, J. (2000). Profile of a comprehensive psychiatric emergency program in a New York City municipal hospital. *The Psychiatric Quarterly, 71*(2), 123–137.

van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America, 12*, 293–317.

van Westrhenen, N., Fritz, E., Oosthuizen, H., Lemont, S., Vermeer, A., & Kleber, R. J. (2017). Creative arts in psychotherapy treatment protocol for children after trauma. *The Arts in Psychotherapy, 54* 238–135.

Vernon, A. (2013). Creative approaches to counseling. In D. Capuzzi, & D. R. Gross (Eds.). *Introduction to the counselling profession* (pp. 256–290). New York, NY, US: Routledge/Taylor & Francis Group.

Winnicott, D. W. (1986). The theory of the parent-infant relationship. In P. Buckley (Ed.). *Essential papers in psychoanalysis. Essential papers on object relations* (pp. 233–253). New York, NY, US: New York University Press ((Reprinted from the "International Journal of Psycho-Analysis," Vol. 50, pp. 711–717) (1986)).

Wittig, J., & Davis, J. (2012). Circles outside the circle: Expanding the group frame through dance/movement therapy and art therapy. *The Arts in Psychotherapy, 39*, 168–172.

Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Yerushalmi, H. (2018). Relational focal therapy: An integrative psychodynamic approach. *Journal of Social Work Practice.* https://doi.org/10.1080/02650533.2018.1460586.