

THE HEALING BENEFITS OF CLAY IN ART THERAPY WITH EARLY  
PSYCHOSIS AND SCHIZOPHRENIA SPECTRUM POPULATIONS

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## **ABSTRACT**

### **THE HEALING BENEFITS OF CLAY-WORK IN ART THERAPY WITH EARLY PSYCHOSIS AND SCHIZOPHRENIA POPULATIONS**

**JULIE CORRIVEAU**

This research paper focuses on how clay-work in art therapy can benefit healing in adolescents and young adults who have experienced early psychosis, as well as individuals situated on the schizophrenia spectrum. Moreover, the theory included in this inquiry focuses on both the reality of the illness in addition to the origins of its complex unravelling. Most importantly, clay-work within art therapy is introduced as a supportive treatment for this population. Therefore, the particular healing properties of clay-work are detailed in relation to this clientele's needs. Furthermore, this theoretical research means to recognize the various existing ways clay-work can engage repair with this population and the value of promoting such data.

*Keywords:* clay-work, psychosis, art-therapy, healing, supportive

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## Chapter 1. Introduction

Engaging with clay is straightforward and the organic materiality of the medium provides a particular tactile appeal. The use of clay has traditionally also played a therapeutic role in the release of emotional expression and the communication of thoughts with the schizophrenia spectrum population. Furthermore, Patterson et al. (2011) explained that:

[...] the potential of art therapy, described by therapists, are consistent with those proposed by the National Institute of Health and Clinical Excellence (NICE): viz., people with schizophrenia may be enabled to experience themselves differently and to develop new ways of relating to others, they may be helped to express themselves and to organise their experience into a satisfying aesthetic form and helped to understand feelings that may have emerged during the creative process (including, in some cases, how they came to have these feelings) at a pace suited to the person (NICE, 2009, p. 257) (as cited in Patterson et al., 2011, p. 79).

This literature review focuses on the healing benefits of clay-work as an art therapy treatment for the early psychosis and schizophrenia populations. The scope of this review includes an examination of the material properties of clay, as well as the specific therapeutic benefits of clay-work observed within multidisciplinary contexts. Research involving the centring of the unique qualities of the individual (e.g., work pace) within the clay-work context is given particular attention in the following literature review, as this focus appears particularly salient to real-life therapeutic contexts.

This research project was defined in relation to the available literature on clay-work as a therapeutic approach in art therapy with the general population as well as with the early psychosis and schizophrenia populations. The methodology concentrated on the subjects of early psychosis and the schizophrenia spectrum, on the medium of clay and its therapeutic properties as well as on the different theoretical frameworks that informed the practice of clay-work. The delimitations as well as interrelations that were created between these topics enriched this study. To a certain extent, looking at the age of the usual first onset in the early psychosis population seemed helpful in shaping an understanding of psychosis and determined the choice of this topic. As described by Trotman et al. (2013), the development of a first onset of psychosis often occurs in adolescence and young adulthood (i.e., 13 to 35 years old) (p. 413). As a consequence, the

young age factor increases the chances of the occurrence of additional episodes. Then, with possible repetitive psychoses the potential for a more permanent disorder might also escalate. Still, depending on factors including the person's overall health, genetic history and type of psychosis experienced, the time required for recovery can increase or decrease. Trotman et al. (2013) enumerate factors that fuel early psychosis and demonstrate that in predisposed cases of schizophrenia, triggers such as stress, trauma, drug abuse as well as ongoing psychological issues are salient (p. 412). Last but not least, biological, neurological or hereditary weaknesses and predispositions with adolescents and young adults make this population significantly more vulnerable to experience early psychosis (Trotman et al., 2013, p. 414).

In these cases, the experience of psychosis has affected pre-existing psychological and emotional vulnerabilities carried in adolescence life. The experience of psychosis alone has a major impact on the person's psychological and emotional understanding of life. Most importantly, adolescence and young adulthood periods are known for being difficult phases in relation to identity, self-acceptance, relationships, attachment and much more. Having considered these facts, clay-work in art therapy represented a therapeutic approach that could reach this population in their different processes of change, transformations and daily struggles. For instance, a major effect of engaging with clay is described by Nan (2015):

[...] the adoption of clay as the only art medium with the use of the Expressive Therapies Continuum framework organized the intervention on the body and mind from a bottom-up hierarchy. And so, the treatment effects were “activated” rights from the moment an individual touched clay, when kinesthetic-sensory rich activities have produced impacts on the artist (p. 44).

The materiality of clay offers several potential therapeutic benefits. For example, Kimport and Robbins (2012) demonstrate that a five-minute period spent manipulating clay produces more mood enhancement than the same amount of time spent manipulating a soft stress ball (p. 77). Among these unique strengths is the capacity for clay work to offer clients the ability to express themselves without speaking, which is of particular use to a population who often faces difficulty in verbal expression, such as individuals diagnosed with schizophrenia or early psychosis.



## **Bias**

Clay and my personal discovery of its therapeutic potential have truly inspired this research. This strong interest for the medium of clay and its therapeutic advantages prompted a further exploration of the clay, which resulted in my decision to review the literature on this topic. My first experience working with clay was highly positive and I realized that, while working with clay, I was able to reconnect to a sense of purpose, strength and confidence. Through actively manipulating the clay as described in Hinz (2009), I was able to release tension and find inner-rhythm (p. 57).

Clay-work targets the Kinesthetic/Sensory level of the Expressive Arts Therapies Continuum (Hinz, 2009), which suggests that it should be useful for a variety of vulnerable populations. My specific interest was in how this form of art therapy could be applied to early psychosis and schizophrenia, since I had personally witnessed how these could strain a person's mental health. However, clay-work seemed to be a good fit in acting as an intermediate between the client and their thoughts, feelings and ideas. With this principle in mind, the current research is based on the assumption that clay-work in art therapy can benefit the early psychosis and schizophrenic spectrum populations.

## **Statement of Purpose**

As an artist and researcher, my objective was to explore the existing literature on clay in order to find the benefits for this clientele. More precisely, the question was how does clay in art therapy benefit healing in clients with early psychosis and on the schizophrenia spectrum? The impact of an early psychosis has been known to deeply affect the person's mental and emotional health. In that sense, the current research was geared towards finding data which respected the needs of this population and took into consideration preventive and supportive clay-work interventions for these clients. Organizing the findings that facilitated a variety of interventions with clay was a priority as well as keeping the well-being and safety of the client in mind. Pénczes et al. (2015) stated that the literature described the use of art within the context of the ongoing therapy to enhance clients' psychological well-being (Hill, 1948; McNiff, 1992; Schaverien, 2000; Smeijsters, 2008a, 2008b, 2008c, 2011, 2012). Non-threatening interventions were consulted, but inquiring about the possible limits of this material was necessary. An emphasis on supporting and on strengthening the ego of the client has prevailed as a model for this research.

Literature on the existing clay-work interventions which fostered the notion of repair of the early psychotic and schizophrenic spectrum's ego has been assembled. In this vein, one goal of this study was to gain more understanding of the power of clay and its adaptable qualities and to become more equipped with existing clay-work interventions in order to offer tailored quality treatments to clients.

Overall, a concentration of knowledge has been found around this topic and tools have been laid down in order to further a greater understanding of this clientele and of this material. Examining and taking into consideration the theoretical perspectives connected to clay-work in art therapy was fundamental to this research. Likewise, comparing the different theories that have worked alongside clay-work has been a priority during this inquiry. Furthermore, the chosen data concerning available clay properties, techniques, strengths and the challenges of clay-work was brought together. The many treatment variations of this medium have been underlined and triggered some insight. The purpose of this research is to generate further interest in investigating the effectiveness of clay-work when working with vulnerable populations and to contribute to the practice of other art therapists interested in this media.

### **Methodology**

This project followed the theoretical research structure noted in Randolph (2009), which calls for a study to be shaped by the examination, analysis and synthesis of the presented data (p. 2). As explained in Cooper (1988), the goal of this methodology is to provide a cohesive narrative, emergent from the gathered data that may eventually lead to more knowledge on the topic. Similarities and distinctions between theory, research and practice serve as the outline and organized the development of the inquiry. The investigation and data of this study focused on the healing benefits of clay with individuals diagnosed with early psychosis and on the schizophrenia spectrum. In addition, a variety of documents with different approaches concerning the healing properties of clay-work in art therapy were integrated. The process of synthesizing a quantity of data coming from clay-work in art therapy, viewing documented clay interventions and revising experiences and theories about clay in art therapy has facilitated a greater understanding of the potential treatments for this clientele. Finally, having established and investigated connections and exchanges between fields may generate more knowledge to advance existing treatments.

Resources specifically regarding clay-work in art therapy in relation to early psychosis are scarce. The information that was found about the use of clay in art therapy referred mostly to the chronic and acute schizophrenic populations. Limited longitudinal research has been done on this subject and some studies have been based on very small-scale engagement with participants. In addition, most studies simply describe the benefits of clay rather than examine its impact. Patterson et al. (2011) claim that findings are equivocal; according to Ruddy and Milnes (2005) who reviewed the RCT's appraised by NICE, the benefits and harms of employing art therapy in the treatment of schizophrenia are unclear (p. 71). Still, the necessary studies that would strongly advance that clay-work functioned as a valuable tool for the early psychosis and schizophrenia clientele have not yet been fully substantiated.

Research on the function of art materials in art therapy assessment also remains scarce. One of the main goals of art therapy assessment is deciding whether to offer further treatment and choosing appropriate art interventions (Betts, 2006; Gilroy, Tipple, & Brown, 2012 as cited in Péntzes et al., 2015, p. 2). Nevertheless, this existing information structured this research, suggested that it could be applied to the early psychosis population and could also be adapted to the needs of the client. Thus, the methods, interventions and theories utilized with those diagnosed with chronic as well as acute schizophrenia were collected for this topic. Furthermore, in gathering the information for this theoretical research a variety of clay techniques were consulted (e.g., clay manipulations, pottery, the use of the spinning wheel, ceramic clays, etc.) in order to provide useful information on the healing properties of clay. Available data which included international clay techniques were considered when needed during research. However, due to the short length of this paper such sources were not discussed. Additionally, the literature in studio art practice and art education was not considered for this study in order to focus on what was available in art therapy. Additionally, the short length of this paper was insufficient to give a proper rendering of studio art's and art education's contributions to this topic.

Throughout this research different types of therapeutic approaches were encountered and it has been explained how they have been incorporated in the treatment of early psychosis and also acute psychosis. This research on clay-work with this population has unravelled a number of connections with important themes that were not investigated or were only briefly examined. For instance, within psychoanalytic theory, notions of individuation, integration and identity have not

been researched in depth in relation to clay-work and psychosis. The documentation for this research concentrated on the precise topic in order to maintain a simple and clear structure focused on clay-work's healing benefits. As other complex themes arose in connection to the main topic, they were put aside in order to keep going in the right direction. As another example, the multidimensional notion of touch in clay-work has had an impact in many different ways on clients but components were left out in order to prevent scattering. For instance, Elbrecht (2012) goes into depth about the importance of the language of the hands while working at the clay field and has described more interesting concepts such as: the skin sense, the sense of balance, depth sensibility, and a therapeutic dialog with the hands but these notions were left out (p. 1).

The main search tools utilized for this research were Concordia's university library catalogue: CLUES as well as Psych-Info, which were the main sources through which peer-reviewed journals were accessed. In addition, this research incorporated national and international academic journals that specialized in the disciplines of art therapy, psychotherapy of art, psychiatry, psychoanalytic psychotherapy and psychoanalysis. Next, reference lists from significant articles were consulted in order to retrieve additional and more precise data. These searches yielded a variety of articles about this topic, including: literature reviews, mix methods qualitative researches, grounded theory, case studies and mix methods approaches. Overall, the experience of the individual with clay-work has been prioritized in this research, while recognizing that individual and group clay-work in art therapy are both considered beneficial. All relevant data regarding groups has been integrated within appropriate sections.

### **Key Terms**

*Art Therapy:* Kramer (1979) ...it is meant to function as a way of supporting ego functioning by enhancing a sense of identity and self-esteem and in the process, fostering maturation in the patient (Crespo, 2003, p. 183).

*Art therapy* is a modality that uses the nonverbal language of art for personal growth, insight, and transformation and is a means of connecting what is inside us-our thoughts, feelings, and perceptions-with outer realities and life experiences. It is based on the belief that images can help us understand who we are and enhance life through self-expression (Malchiodi, 2007, p. ix).

*Art therapy* is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. A goal in art therapy is to improve or restore a client's functioning and his or her sense of personal well-being.

Today art therapy is widely practiced in a wide variety of settings including hospitals, psychiatric and rehabilitation facilities, wellness centers, forensic institutions, schools, crisis centers, senior communities, private practice, and other clinical and community settings. During individual and/or group sessions art therapists elicit their clients' inherent capacity for art making to enhance their physical, mental, and emotional well-being. Research supports the use of art therapy within a professional relationship for the therapeutic benefits gained through artistic self-expression and reflection or individuals who experience illness, trauma, and mental health problems and those seeking personal growth.

*Art therapy* is an effective treatment for people experiencing developmental, medical, educational, and social or psychological impairment. Individuals who benefit from art therapy include those who have survived trauma resulting from combat, abuse, and natural disaster; persons with adverse physical health conditions such as cancer, traumatic brain injury, and other health disability; and persons with autism, dementia, depression, and other disorders. Art therapy helps people resolve conflicts, improve interpersonal skills, manage problematic behaviors, reduce negative stress, and achieve personal insight. Art therapy also provides an opportunity to enjoy the life-affirming pleasures of art making (AATA, 2013, p. 1).

*Clay*: A compound of decomposed rock containing silica, alumina and traces of organic matter which becomes a plastic modeling compound when hydrated: used for making bricks, pottery (Henley, 2007, p. 21).

*Clay-work*: The process of handling, manipulating, and sculpting clay, and the products of these activities (Sholt & Gavron, 2006, p. 66).

*Expressive Therapies Continuum*: The Expressive Therapies Continuum represents a means to classify interactions with art media or other experiential activities in order to process information and form images (Kagin & Lusebrink, 1978b; Lusebrink, 1990). (Hinz, 2009, p. 4)

*Healing*: To transform, to replenish, solidify, activate.

*Psychosis*: Psychosis is a disturbance of the patient's perception of the normal everyday world which is often viewed from a distorted perspective; the ego is thin, and may be fragmented (Killick, 1993, p. 203).

*Psychosis* is a temporary loss or impaired contact with reality and is a sign of an underlying mental illness such as schizophrenia. Psychosis is not a specific disease but rather a collection of symptoms (e.g., delusions, hallucinations) associated with different mental issues.

*Procedural representations or "internal working models" of self and others*: the recurrent nature of the infant's experiences leads to the development of procedural representations or internal working models of self and others. These working models are generalized representations of events experienced that influence the infant's emotional experiences and expectations throughout development (Bowlby, 1973; Bretherton & Munholland, 1999). For instance, as suggested by Beebe and Lachmann (2002) and Beebe et al. (2010) infants will store models of how interactions unfold, in the dimensions of time, space, affect and arousal.

*Schizophrenia spectrum*: schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia) and negative symptoms (APA, 2013).

## **Chapter 2.**

[...] the path to psychosis is a complex and interactive one which is likely to be uniquely and subtly different for each individual (Hingley, 1997, p. 309).

In this section, symptoms of psychosis are discussed along with the multilayered impacts of the illness and the many life transformations that have taken place. Most importantly, art therapy was introduced as a valid and supportive treatment offering a safe space for clients to explore personal issues. In addition, Nan (2015) discusses how (Hinz, 2009a; Kronholm et al., 2007 & Miljkovitch de Heredia, 1998) how certain features of clay-work stimulate clients' awareness of repressed memories, thoughts and emotions (p. 47):

[...] the kinesthetic component and the rhythmic movement of the body throughout clay work process can also stir up a sense of inner rhythm that produces positive feelings, insight, and enhances the ability to express oneself.

In addition, what has been found in art therapy is that through clay-work, there is an opportunity for the client to freely express emotions in a non-verbal fashion. The inclusion and acceptance of the non-verbal factor in the clay-work in art therapy treatment has facilitated the participation of this population. For example, Wittels (1975) describes that in cases of acute schizophrenia, clay-work has embodied feelings for clients more directly than words (p. 217). Interestingly, Wittels (1975) also states that having enabled the experience of clay with someone in a regressed nonverbal and acute state of psychosis has lessened hindering symptoms (p. 218). In addition, Nan & Ho (2014) focus on the non-verbal benefits of art therapy techniques like clay

[...] it can be challenging to treat depression or anxiety with verbal forms of psychotherapy, because depressed and anxious patients are sometimes overwhelmed with feelings or thoughts. It is common that depressed patients have alexithymia, the inability to find appropriate words to describe emotions, which occurs when depression hampers cognitive and verbal communication functioning [6, 32] (p. 3).

This notion relates to Wittels (1975) caution about how symptoms in the case of the acutely psychotic, have often been dealt with before any so-called underlying fears can be allayed (p. 217). When the client engages with the material and symptoms such as anxiety lessen, deeper work is then possible. To a certain extent, Wittels' (1975) treatment experience with this population focused on following alternative types of expression in art therapy. In that sense, the different therapeutic features as well as the particular sustaining functions found in clay-work are presented to illustrate how they have evolved and worked as art therapy treatments.

### **What Is Psychosis?**

Psychosis can be defined in a number of ways, which account for the many different theories on the subject and the widely varied experiences of individuals diagnosed with psychosis. Robbins (2011) recalls that, in his clinical experience “persons who are recovering or recovered from a psychotic episode often characterize the experience (of psychosis) as having been like a dream, a nightmare from which they were unable to awaken” (p. 131). Likewise, Kolberg (2009) interviewed nine persons who had recovered from psychotic episodes and seven

out of them described the experience as like a waking dream (as cited in Robbins, 2011, p. 131). This section addresses such client experiences of psychosis, as well as evaluations provided by psychiatric professionals.

*Psychosis* has been described as an impairment of reality testing, inability to distinguish the objective external world from one's inner experience. From a phenomenological perspective, the onset of schizophrenia is characterized by a disturbed perception of the self (Estroff, 1989 as cited in Hanevik et al., 2013, p. 313). The relationships to the word psychosis and to the disorder are varied, for instance, psychosis is referred to as both a symptom of schizophrenia and as isolated episodes. When recalling their experience of psychosis, individuals have often reported a sense of being external to the rest of the world, feeling profoundly different from others; unreal, dead, separated, changed and with a lack of emotions. Patients with schizophrenia describe their experience of psychosis as an alienation from themselves and the world, a wordless experience, which in psychiatric terms is described as a "seriously disturbed perception of the self" (Sass, 1992, p. 313). With this clientele, the art therapy framework recognises each personal definition of the experience of psychosis as a basis for the client to freely engage in the therapeutic path.

Symptoms of psychosis are important to understand as they characterize the disorder, but also reveal the debilitating effects of psychosis on one's life. Multiple risk factors trigger psychosis, and the examination of clients' physiological as well as psychological vital signs is crucial in identifying the nature of the behavior related to psychosis. As stated in the DSM-V, psychotic disorders are heterogeneous, and the severity of symptoms can predict important aspects of the illness, such as the degree of cognitive or neurobiological deficits (as cited in Barch et al. 2003). Parker (2014) has reviewed the list of psychotic disorders and changes made in that revised section of the Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As seen in the DSM-V psychotic disorders have been categorised as: delusional disorder, brief psychotic disorder; schizophreniform disorder and schizophrenia, schizoaffective disorder, catatonia, attenuated psychosis syndrome and shared psychotic disorder.

The recognizable symptoms of psychosis are broken down into two separate categories as stated in the DSM-V (2013); they are referred to as *negative* and *positive* symptoms. Negative symptoms are behaviors that were lost to a certain degree and that would normally be seen in healthy people (e.g., loss or lack of emotional expression). Examples of negative symptoms



include mood fluctuations, sleep and appetite changes; loss of energy or motivation, isolation, difficulty in concentrating or remembering, problems at school or work.

Positive symptoms are normally absent in healthy people and are added as a result of the disorder. Positive symptoms include demonstrated disturbances in perception such as: visual and auditory hallucinations (e.g., hearing voices), bizarre or clearly unjustified beliefs and judgments, delusions (e.g., beliefs of being persecuted with no external evidence), suicidal ideation and disorganized thinking and speech (e.g., speaking in ways that are unclear).

### **Psychotic Perception and Art Therapy**

Moon (2009) mentions that becoming a good therapist is not about putting yourself apart from the people you work with; it is about coming to know intimately their pain, their humiliation and their ability to rise above it (p. 31). According to Malchiodi (2007), psychiatrist Hans Prinzhorn did not try to study the psychopathology of his patient's art, but he investigated the signs, symbols and images they created, which became an ongoing influence in art therapy. Prinzhorn (1922/1972) underlined that:

[...] starting with the thesis that pictorial creative power is present in every person, we have to look on tradition and training as external cultural embellishments of the primary configurative process, with under the right conditions can break forth in every person (p. 274).

Such ideas shape approaches in art therapy with this population and help in connecting therapists with the humanity of patients.

Arieti (1974) explains how acute schizophrenics undergo a loss of perceptual stability which allows anxiety provoking perceptual distortions to take hold on clients' daily life experiences (as cited in Wittels, p. 218) which makes this connection particularly important to this population. Additionally, Wittels (1975) articulates how art therapy has been spontaneously used by clients to re-establish more normal perception and thought (p. 217). In the case of clay-work within an art therapy setting, it seems to be a sensible therapeutic option which can enable clients' relationship to their environment. For example, clay-work stimulates motor activity and helps clients get in touch with reality through the tactile experience of modeling. Furthermore, Wald (2003) shows how the client's experience of perception, as categorized by the perceptual component of the ETC has given clients living with psychosis a visual focus for re-entering the

reality of their external environment (as cited in Hinz, 2009, p. 90). Hinz (2009) presented Lusebrink (1990)'s notion that the use of themes from clients' lives in art therapy may enhance and preserve contact with the external reality of their environment (p. 91). Moreover, by increasing perceptual awareness, and focusing outside themselves, the patients may gain greater autonomy in everyday life.

In order to further acknowledge and understand clients' perception of their interior and exterior worlds, Lowenfeld (1957)'s modes of perception have served as guides. Lowenfeld (1957) developed the concept of haptic-and-visual-minded perceptions as they related to figurative sculptures in clay (as cited in Henley, 2002, p. 117). Lowenfeld (1957) has shown that the haptic-minded perception engaged the inward senses of the person's experience when working on a head of clay but was not concerned with portraying the face. In comparison, the visually-minded piece presented by Lowenfeld (1957) revealed that the person was less concerned over tactile contrasts and more concerned with accurate proportion (p. 119). In addition, the clients' awareness of these two types of involvement has also contributed in divulging strengths in coping with this impaired perception. Still, Henley (2002) states that haptic sensation had assumed pathological proportions when individuals were not able to reality test or to make sense of their surroundings because of disconnected or distorted perceptions (p. 116). And so, these concepts serve as parameters to better respond to the clients' needs and direct them to safe and adapted art therapy interventions.

### **Early Psychosis: Adolescents and Young Adults**

This section focuses on the origins, changes and outcomes associated to early psychosis symptoms. Furthermore, the possible onsets of early psychosis in adolescence are at the center of this discussion. For the purpose of the current study, this knowledge was essential to acquire in order to get a sense of the complexity of this mental illness.

Kashavan et al.'s (2005) study explained how adolescents as well as younger adults are susceptible to psychosis when genetic factors or fetal brain development abnormalities are present (p. 412). In genetically predisposed cases, the first onset of psychosis is more likely to appear in adolescence for schizophrenia as well as for psychotic disorders. More precisely, early psychosis affects age groups between 13 and 30 years old. Trotman, Holtzman, Ryan, Shapiro, MacDonald, Goulding, and Walker (2013) also affirm that this age demarcation to be the peak

period at which psychosis is usually first diagnosed (p. 412). Early to late adolescence and young adulthood periods are vulnerable grounds for psychosis to hit. Trotman et al. (2013) explain that psychotic disorders arise from the interaction of pre-existing genetic vulnerability (known as *diathesis*) with exposure to various psychosocial and biological stressors that have the potential to trigger its expression (p. 412). What was also important to note was that these onsets may have been neurologically programmed to function in a certain way but outside tensions (i.e. environmental, psychosocial factors) have the capacity to attack and alter the outcomes.

In the general adolescent population, these particular types of genetic vulnerabilities are not seen. However, adolescents are more susceptible to early psychosis than another age group. Adolescents' rapidly changing brains and bodies are the primary components that determine the root of this prevalence. In the adolescent period brain maturation peaks and hormonal activity intensifies substantially. As a result, the adolescent brain is exerted and may be exhausted due to the level of pressure demanded. For this reason, it is possible that adolescent brain development may be compromised, affected or damaged.

When specifically considering adolescents, Walker et al. (2013)'s state that psychotic disorders almost always unfold between the onset of puberty and the early 20's (p. 142). It has been known that adolescence is a decisive period where an impressive amount of significant biological, neurological, psychological, emotional and physiological transformations occur. Lombardi (2010) observes that adolescents must for example: work through mourning for the end of infancy and must discover linear time as a temporality characterized by irreversibility and limits (Lombardi, 2003c); they must also learn to tolerate the new and the unknown as an essential condition that opens the way to the future development of adulthood (p. 1422).

Therefore, dealing with these internal and external changes makes reaching the threshold of adulthood demanding as well as destabilizing. For instance, having to face such transformations can trigger a lot of anxiety. Interestingly, Lombardi's (2010) professional practice and knowledge of adolescents and individuals living with psychosis shed light on one common thread (p. 1421). The central problem according to Lombardi (2010) relates to the person's representation and symbolic organization of an internal world, which is felt to be alien, chaotic and dangerous (p. 1421). This issue may in some cases leave the adolescent emotionally, physically and mentally vulnerable to early psychosis. In relation to this theory, Lombardi (2010)

submits that, as demonstrated by a number of authors (Baran, 1991; Cahn, 1991; Laufer, 1996; Laufer, 1986):

Psychotic disorders are so common in adolescence that they may be deemed to constitute one of the possible manifestations of the adolescent crisis, in which problems connected with changes in the body and the difficulties of the transition from infancy to adulthood play a prominent part (p. 1421).

For this reason, it is necessary to consider the multifactorial origins which may trigger the onset of psychosis. The onset is not limited to hormonal or developmental factors, and such situations need to be carefully addressed on a case by case basis.

### **Psychosocial Transformations**

Addressing the numerous potential risk factors that may contribute to the prevalence of psychosis is essential since its origins are not clearly defined. Robbins (2011) argues that psychosis occurs when social-cultural expectations are that the adolescent or young adult establishes a separate identity including work and a family of his or her own (p. 210). For instance, in their study Hirschfeld, Smith, Trower and Griffin (2005) interviewed six young men between the ages of twenty and thirty about their personal experience. In these interviews, the participants looked back to past events after their experience of psychosis. Within that process, the participants became aware that they had been through moments of strain which were connected to the expectations they faced from family members and established conventions. Overall, before their first onset the participants felt uneasiness when experiencing typical life situations among other issues.

These life changes and expectations are identified by Hirschfeld et al. (2005) as adjusting to age-related milestones such as going onto higher education, finding work, increasing a sense of independence and personal responsibility, developing sexual relationships and changing relationships with friends and parents. Hirschfeld et al. (2005) confirm that these young men often cited difficulties with these processes as explanations for their psychosis (p. 260). On that note, Robbins (2011) explains that young adulthood allows the maladaptive nature of the mental activity learned and fostered within the family to become apparent (p. 210). For example, a young adult with attachment issues or low self-esteem might not be mentally and emotionally sound to engage with the natural progression of typical life stages. Consequently, in adolescence

and early adulthood such difficulties become salient and might impede the person's personal growth. In addition, these changes and expectations might turn into incapacitating sources of anxiety. The weight of social pressure to succeed as an adult, the failure of not being able to embrace an identity, to get a job or a long-term relationship might relate to the development of psychosis. It is important to clarify that any number of factors can influence psychosis, and that its impetus is often multifactorial in nature.

Hirschfeld et al. (2005) suggest that the symptoms and events lived by these participants demonstrate how psychosis has significantly altered these lives. The young men's immediate responses to their own psychotic experiences, their feelings expressed towards such an issue and the interpersonal changes that took place afterwards were documented. Without a doubt living with the trauma and long-term impact of psychosis had transformed the participants' life paths. Early psychosis meant major set-backs for the participants since its effects disrupted the course of their everyday functioning. Moreover, what was included in the research was the question of recovery and how the struggles regarding that difficult phase have been alike among participants. For instance, Hirschfeld et al. (2005) stated that while in the process of recovery the young men experienced loss, loneliness and alienation in relation to age-related goals such as: becoming more independent financially and from their parents, belonging to a peer group, forming partnerships, achieving at work, or educational goals (p. 260). For example, the burden and fear of dealing with this illness have been shown to make close connections break. More specifically, participants speak about losing friendships, peers and sometimes their family. While being treated before or after the psychosis, support coming from the community, family or friends was essential for the clients to thrive.

The lives of these young adults have been thwarted and recovery unveiled both strengths and vulnerabilities. After the experience of psychosis, the negative symptoms come such as depression and the length of the healing process differs from one person to another depending on each one's personal situation. In fact, Hirschfeld et al. (2005) explains that most of the participants in their research talked about becoming depressed sometime during or after their psychotic experiences and at that time were not seeing an alternative to their situation. Some of the participants spontaneously mentioned that depression was worse than the experience of psychosis (p. 256). The duration of the experience of psychosis has been considered shorter

(e.g., couple of days or a week) when compared to depression which has taken much longer to treat and to come out of (e.g., 6 months to a year). After the psychosis, a lot of the person's energy is needed to engage in a life routine, to focus on taking action and recovering. However, depression depletes a lot of the person's available energy and so moving forward is in itself another struggle. In reality, at the beginning of treatment and depending on the person's mental and psychological state, finding or generating energy becomes a daily challenge.

### **Treatment of Early Psychosis**

In relation to the treatment of early psychosis, each person's response to treatment is unique and care must be taken to determine each client's specific needs. Such settings are composed of interdisciplinary teams which study, research, choose and experiment with treatments to benefit the early psychosis clientele. The team focused on symptom relief for this particular population. Such programs have often been connected to and functioned within a psychiatric hospital structure. In addition, programs are designed to improve outcomes in schizophrenia and other psychoses through earlier detection of untreated psychosis and developed effective treatments tailored to the specific phases of the disorder.

Psychoeducation for families is provided by psychiatric hospitals and overall, focus on the recovery and the resilience of the person has been valued. Support from a therapeutic package is provided to the patient and family: prevention and treatment programs that supply inpatient and outpatient case management, cognitive behavioral therapy, psychotherapy either individual and/or group therapy, family interventions, stress management and relapse prevention, support from interdisciplinary interns and volunteers. Art therapy has been part of these collaborative efforts to engage clients in action. For instance, participating willingly in an activity or group art therapy has had positive impact on clients' social life and recovery. In that sense, social activities are provided at centers to encourage mingling, new friendships and self-esteem. A variety of services are also offered in order to promote healthy lifestyles for clients such as free memberships in gyms. The help and support given by case management and the multifaceted therapeutic support is necessary in order to consistently assist the person in the return to independent functioning.

After a first episode, Dominguez Martinez, Blanqué, Codina, Montoro, Mauri and Barrantes-Vidal (2011) have stated that in order to counter further deterioration (i.e., global

functioning, structural brain abnormalities), treatment must be applied rapidly. As a general rule, the person in crisis will first be hospitalized and psychiatric care and medication will be provided (p. 342). If necessary, antipsychotic treatment will be introduced at low dosage. Before engaging in art therapy, the psychological and physiological state of the individual has to be well enough to benefit from a session of clay-work. As indicated in McMurray, Swartz-Mirman & Maizel (2000) with the example of the psychotic personality organization, they state that in order to assess whether a patient is suitable for referral to art therapy, the diagnostic tool (e.g. DSM-V) must describe the emotional state of the patient as a whole, including strengths, defenses, and behaviors patterns (p. 191). When the person has been stabilized and has the will and capacity to engage in art marking, clay-work in art therapy has the possibility to support.

Kimport & Nan (2012) call attention to the simplicity of using the material of clay in art therapy. This quality facilitates the individual's first contact with the media and further art making. For the schizophrenia spectrum population, there is a value in the ease and pleasurable manipulation of clay. As described by Nan (2015), clay properties as shown in the Expressive Therapies Continuum and in Clay art therapy (CAT) contain nonverbal and verbal; kinesthetic, sensory, and psychological components. All of these mechanisms can be activated through clay-work and may benefit the person's wellbeing at an organic pace. Looking at the use of clay and its effects demonstrated its ability to tap into one's tactile and emotional experiences at different levels. In order to further understand this notion, Hinz (2009) explains how "the adoption of clay as the only art medium with the use of the Expressive Therapies Continuum framework organized the intervention on the body and mind from a bottom-up hierarchy" (p. 64). Fostering the utilization of the body is at the core of clay-work and recognising each individual's rhythm helps in generating expression otherwise untapped. This approach stimulates shifts in the body in a non-threatening way which may unearth issues that need to be addressed. In that sense, Nan & Ho (2014) explain how clay interventions can lessen anxiety and depression, which are common symptoms of psychosis and schizophrenia spectrum issues:

When working clay, the kinesthetic movements of pounding and kneading the clay help depressed or anxious individuals relieve strain on their shoulders, neck, and back, regulate heartbeat and respiration, and can function as a way of expressing emotions in a physical

manner, which can assist in changing their perception of themselves and in producing insight (p. 4).

Furthermore, the advantage of working with the ETC (Hinz, 2009) and the CAT (Nan, 2015) informed the potential and weight of the material of clay with different populations. Nan (2015) explains how “the community-based and strength-based intervention of CAT can supplement mainstream treatment and can be applied to other populations with other forms of affective disorders” (p. 63). The versatility of clay is appealing and may instill energy and hope through its therapeutic properties.

Yet, caution must be applied in the use of clay-work in art therapy. Kagin & Lusebrink (1978) note that “the potential intensity of clay-work in bringing up unconscious material, and amplifying the personal meaning of a symbol has indicated the hazards that lie in premature disclosure, especially in treatment of traumatic issues” (as cited in Sholt & Gavron, 2006, p. 71). Awareness of the client’s personal background, medical history, and so on and so forth must be taken into account when engaging with clay-work. In that sense, it is important to highlight that within this research clay-work in itself cannot and has not replaced already existing treatments such as medication. The supporting value of clay-work in art therapy has its place and contributes to other treatments. These psychiatric treatments have worked on many levels, however, as explained in Patterson et al. (2011):

whilst medication is the mainstay of treatment, many people are poorly adherent of treatment, many people are poorly adherent to regimes and a substantial proportion of those who are experience residual symptoms, relapse and reduced social functioning (as cited in Corrigan, Lieberman & Engel, 1990, p. 76).

When art therapy plays a role in multidisciplinary teams, clay may serve as a positive stimulus in relation to clients’ participation to treatments. According to Czamanski-Cohen (2012) art making can support the medical decision-making process for patients as well as reflection on past decisions (as cited in Morris & Willis-Rauch, 2014, p. 29). A growing impetus to make art may increase the client’s interest in understanding, living and eventually maybe accepting treatments.

### **Art Therapy, Clay-Work and the Schizophrenia Spectrum**

Over time, some establishments considered art therapy as valuable support for patients living with schizophrenia spectrum related illnesses (Killick & Shaverien, 1997). The multiple



therapeutic inner-workings already existing in clay-work in art therapy have had important roles to play in the treatment of clients. Combining these qualities to appropriate theoretical approaches has provided more adaptation with various settings and structures. For this reason, this knowledge has been shared within multidisciplinary teams in psychiatric hospitals or other establishments in order to benefit this population broaden the understanding of the illness as well as the diversity of its supportive treatments. The global functioning of clients has been influenced by interventions that combined the different treatment modalities (i.e., antipsychotics, family intervention, cognitive behavioural therapy, and arts therapies), each of which was thought to be effective for different aspects of the illness, offered greater overall benefits than giving any one treatment alone (Kendall, 2012 as cited in Wood, 2012, p. 89).

As seen in the previous section, medical treatment has been of primary importance for symptom management. However, more often than not symptom management has rarely gone to the root or the cause of the problem. In many ways, art therapy has created bridges between the initial onset of psychosis and the symptoms. Art therapy has been known to facilitate access and retrieval of past traumatic memories, which may not be possible to have articulated in words. Hinz (2009) has shown that patients with schizophrenia may rely on concrete sensory experiences to be anchored in the present (p. 161). For instance, clay and music from the direct surrounding may enhance reality orientation, might lead to the emergence of a state of calm, and recall personal memories. In addition, Hinz (2009) has explained that when a patient is caught in cognition and unable to feel sensations, using the ETC's sensory exploration for example, clay, is indicated.

The clients' position on the schizophrenic spectrum and level of sensitivity to symptoms has shaped the art therapy methods as well as the required interventions. Also, when working with any population, the art therapist has had to get a detailed account of his or her client's present situation and past history. A thorough understanding of the clients' experience of psychosis has been a key factor in facilitating the orientation and organization of the first art therapy sessions.

Crespo (2003) explains that a person with schizophrenia has created another reality to cope with or escape from a world that is perceived as chaotic, fragmented and terrifying (p. 185). Essentially, understanding what is at stake in the here and now for such a client has served

as a guide to respond efficiently to ongoing issues. The therapist has to acknowledge that living with anxiety is a daily struggle for this population. Therefore, a predictable routine in sessions has allowed clients to feel safe and has also facilitated emotional regulation. That is why, according to Crespo (2003) art therapy sessions have been oriented towards reality, human figures, real objects in the environment, or landscapes in order to deviate from disorganization and to some level process order.

In art therapy with clay-work, structure, stability and routines are necessary in order to establish a safe environment for any client and for the therapist. A solid frame needs to be established and a sound therapeutic alliance has to develop in order for the client to feel secure. The effectiveness of the therapy has been dependent on these significant foundations. The therapeutic relationship can evolve when the client has been willing to participate and has gained sufficient trust in the art therapist. The client in art therapy always remains the agent of his or her own growth. With this particular population, Salonen (2002) describes how the therapeutic relationship facilitated the gradual internalisation of the patients' object directional needs and wishes into a more solid psychic structure (p. 143). Therefore, the relationship between therapist and client has been central to the outcome of the therapy. In that sense, the supportive therapy approach became an art therapy approach.

### **The Supportive Therapy Approach**

The supportive therapy approach, developed by Kramer (1975) attempted to engage and respond to the needs of clients through strengthening their psychic structure. This approach was highly relevant for individuals on the schizophrenia spectrum in relation to recovering a sense of self. Crespo (2003) has described the concept of seeing the artwork itself as a means of mending the schizophrenic's shattered ego (p. 187). Furthermore, Kramer's (1975) ego supportive therapy has been described by Crespo (2003) as the most helpful therapeutic approach with this population. The goal of strengthening the person's ego has also been observed in the function of the clay-work process. For example, being physically involved in the clay-work process gave the client a chance to gain new motor skills abilities as well as securing a sense of control over something real, the lump of clay. Kramer (1973) demonstrated that the tangible earthiness of clay and its malleable, cohesive quality conveyed a sense of reality and substance (as cited in Henley, 2002, p. 56). While working with clay, the client could focus on the piece, experience being

present, being in the here and now. Alone, the act of doing has helped the client release anxiety or move away from other prevailing symptoms. Consequently, it became possible for the person to relate to reality through the sensory experience of clay-work.

Another important element of the supportive therapy approach was highlighted by Crespo (2003) and it concentrated on the completion of the artwork itself with the focus on constantly improving technique with continual growth in the mastery of the art skills (p. 183). The opportunity to make, remake, produce and reproduce allowed one to cultivate feelings of accomplishment, productivity and empowerment. Henley (2002) states that as an art therapy intervention, working with clay has typically involved shaping and manipulating the material with the goal of producing a product where both the process of creating and the product are considered to hold significance for the interior world of the creator (p. 57). Both the roles of process and product have been considered valid and have been necessary in order for repair and reconstruction of parts of the self to occur. In that sense, Henley's thoughts have followed Kramer's theory (1975) through supporting the encouragement of ego development, self-esteem and identity through learning the mastery of art techniques were. For example, Henley (2002) argues that in the clay-work process, it is possible to explore senses and to balance technique along with a means of understanding oneself (p. 56).

### **Supportive Therapy and Self-Esteem**

Langarten (1981) declares that the goal of Kramer's (1971) supportive therapy was to pull the client out of a nightmarish, disintegrated, psychotic existence by providing symbolic containment structure and reality (as cited in Crespo, 2003, p. 188). Moreover, what was also significant was that chronic and acute schizophrenics were receptive to the supportive approach because the focus was not to feed on the person's fantasies, hallucinations or delusions. In fact, it has been found that working with reality-based issues or material was essential for the clients to grow beyond the symptoms. For instance, Brown (1975) was only able to connect with her client Sam, a regressed schizophrenic, using non-verbal cues. Brown (1975)'s use of verbal and interpretive techniques only fed the client's confusion and whole defensive framework. Instead, the art therapist decided to work with the non-verbal, tactile, uncontrollable, primitive material of clay (p. 2). In this case, structure with the clay was necessary and the involvement of the art therapist substantial. In a way, the guiding presence offered by the art therapist activated the

healing process. The clay-work supported the client while touching on subjects such as anger, separation, incorporation, individuation and growth among many others.

Crespo (2003) stressed how prevalent self-esteem issues have been with chronic and acute schizophrenic populations (p. 188). For instance, what had been witnessed with individuals living with such an illness was that they had had very few constructive learning experiences in their lives and feelings of failure were quite familiar. Fortunately, the supportive and structured learning approach included techniques geared towards greater ego-enhancement, self-esteem and realistic self-image (p. 188). At this point it has become essential for the art therapist to understand just how living with symptoms of psychosis has negatively affected the client's self-esteem and generated anxiety. Of course, such damaging effects on self-esteem have also been identified in the early psychosis population. Using such supporting techniques with this clientele has been known to be more than appropriate and has also been adapted to the person's needs. Finding trust and security in the therapeutic relationship has always been vital for this population in order to nourish a sense of value and engage in art making.

In addition, Crespo's (2003) states that art therapy has both helped to modify psychotic projections and also provided a constructive rehabilitative approach (p. 189). Such principles have also been found in Patterson et al. (2011)'s article which paid attention to the value of art therapy and the benefits it has brought to people diagnosed with schizophrenia. To start, what was essential to take into consideration in this review was how the process of art making has had a significant impact on the growth of these individuals. Patterson et al. (2011) detailed how multiple developments have occurred with the art-making process:

First, the participants were described as developing a sense of being visible in the world as they made their mark; feeling alive as they experienced complex emotions understood as necessarily entailed in the process of art making; being enabled to adopt an identity as an artist, perceived as preferable to that of a person with mental illness; developing an understanding of internal 'reality' as feelings were externalised and made visible; developing a sense of acceptance and belonging as the therapist tolerated whatever was on paper; developing a sense of autonomy and control as they selected materials, applied them and subsequently chose to allow or disallow others access to the process of creation or image (p. 77).

### Clay-Work Therapeutic Features

Sholt and Gavron (2006) in: *The therapeutic qualities of clay-work in art therapy: A review*, established a framework which conveys an understanding of the use of clay-work in art therapy. This review demonstrates how the therapeutic potential of clay-work in art therapy can reach populations such as the early psychosis clientele, as well as other clients on the schizophrenia spectrum. Fundamentally, Sholt and Gavron (2006) emphasize the meaningfulness of tactile contact to general and more specific populations because it has been recognised as the first mode of communication learned in infancy and experienced throughout life (p. 67). According to Sholt and Gavron (2006) this type of communication has stayed embedded in the body and can be retrieved later through clay-work. Thus, this mode of connection through clay-work has been a relevant experience with this clientele.

Correspondingly, when the art therapist has witnessed how a client has been settling in the room, the therapeutic relationship, has engaged in the process of art making or the completion of an art work, these have been clues hinting at the client's state, struggles and concerns. The experiences of touch, movement, and the three-dimensionality of clay-work, as described by Sholt and Gavron (2006) have made possible an entire non-verbal language or communication for the creator, through which one's mental realm, emotional life, and primary object relations can be expressed (p. 67). Introducing applicable theoretical structures has revealed the potential of clay-work with this clientele. For instance, Bowlby's (1980)' attachment theory as well as the object relations model has been the main direction that Sholt and Gavron (2006) used to emphasize the relevant inner-processes of clay-work (p. 67). Accordingly, Sholt and Gavron (2006) made use of Bowlby's (1980) attachment theory which centered on how humans form close emotional bonds with significant others (p. 67).

The development of mental representations of self or others, also known as *internal working models* has been facilitated with this activity (p. 67). Mental representations contain unconscious non-verbal primary modes of communications which have been called procedural representations. What Sholt and Gavron (2006) have stated was that it is possible to retrieve these procedural representations through clay-work. Such primary activity has conveyed information about the client in the clay-work within the art therapy context. Therefore, non-

verbal modes of expression such as clay-work in art therapy have assisted clients with experiencing and communicating what has been encoded in the pre-verbal phase.

Sholt and Gavron (2006) described how contact with clay has connected on the level of procedural representations:

[...] clay-work taps into primary modes of communication and expression (e.g. through touch), and is thereby linked to actual past memories and feelings that were encoded through touch and movement. In this respect, clay-work could function as a central window to these unconscious, nonverbal representations (i.e. procedural expressions) and may be especially helpful with people who find it hard to express themselves verbally or who are very defensive. The physical-sensual-mental experience that clay facilitates can be understood by procedural expressions (p. 67).

### **Clay and Three-Dimensionality**

Three-dimensionality has been introduced by Sholt & Gavron (2006) as the first therapeutic feature of clay-work. The exploration of the therapeutic roles of clay-work's three-dimensionality and connection to movement has been helpful in understanding the relationship between the client and the material. More precisely, these elements found in clay-work were discussed in order to demonstrate how they have impacted this clientele. Buchalter (2004) gave examples on how working with clay activated movements and touch in multifaceted ways. For example, when in contact with the clay for the first time clients may begin to pound, knead and exert excess energy. Then, as the participants start to feel and integrate different movements, the interaction with the material may begin to change into something else. For instance, switching to actions of molding, stroking and smoothing of the clay has brought for the client a decrease in stress and anxiety. Gradually using clay in art therapy sessions has permitted the person to release emotions as well as tensions through the physical movements as a result of the substance manipulations. As a reminder, these examples of clay-work described above have been conceivable only when a trusting, safe and secure relationship between the art therapist and the client has been established. Still, such art therapy scenarios are not always possible with people diagnosed on the schizophrenia spectrum.

As discussed earlier, it has been found that clay invites touch and physical interaction. It has been interesting to look into why the possibility of close contact with three-dimensional

material generated avoidance in individuals living with schizophrenia. Foster (1997) examined the factors that may have prevented her patients to fully engage and explore with clay. To a certain degree, it has been observed by Foster (1997) that the three-dimensionality of clay was able to activate fears and anxieties related to one's relationship with the self and others. Foster (1997) focused on how the three-dimensionality of clay had the potential to challenge and work on the existing fears of her patients. Additionally, Foster (1997) proposed that the "life-likeness" and affective aspects of object relations with three-dimensional bodies were of major importance for an understanding of many psychotic patients' avoidance of working with three-dimensional substances (p. 55). Initially, Foster (1997) stated that engaging in clay-work in art therapy with the schizophrenic population could provoke "extremely frightening psychotic fantasies" (p. 58). In particular, when faced with the three-dimensionality of clay, reactions and behaviors were clearly stirred in patients. For instance, there were different responses generated with the contact of clay such as avoidance, sudden disinterest, physical distancing, distress or the necessity for urgent removal of the substance (i.e. rushing to clean ones' hands). Interestingly, Foster (1997) explained how patients who actually got to work with this three-dimensional substance seemed to progress more in their self-development (p. 53). The trust between the client and the art therapist had served as a new platform from which to create and preserve meaningful interpersonal relationships.

The quality of three-dimensionality found in clay-work has made it possible for clients to shape the substance into something specific and tangible. Especially with this clientele, focusing on something palpable such as clay has been known to facilitate contact with reality. On this matter Jorstad (1965) explains how the three-dimensional aspect of clay has given the person an opportunity to see things from more than one perspective, which may influence and transform one's personal views (p. 493). For example, to take pauses while working with clay in order to look at the artwork from a distance, to rotate it, to observe it from different angles and find shapes helped modify outlooks.

As a comparison, these positive effects of clay have also been found to be helpful with other populations. For instance, while working with clay cancer survivors have been able to acquire a distance from themselves to reflect upon their cancer experience similar to that of a person recovering from psychosis. According to Šicková-Fabrici (2007) rethinking their cancer

trajectory in the process of working with clay can guide cancer survivors to reconstruct their identity by re-evaluating their own previous and present identities; this is because clay provides metaphorical simulated experiences of shaping, modeling, re-modeling, correcting, sculpting, and casting all within one's own control.

Furthermore, utilizing clay allowed clients to mold behaviors, attitudes, and self-image over time. Clients have been able to explore their feelings of frustration, impatience and as the clay transformed, inner-shifts appeared. Through observation, clay-work clients have gained insight and developed new methods of coping and problem solving (p. 116). Additionally, Buchalter (2009) advances that the individual can become the master of the clay and gain control of it. That experience is empowering for the client, who has a direct impact on the matter and this visible effect on the substance, promotes a sense of mastery. Jorstad (1965) adds that clay forming gives possibilities of a most personal and illustrating form of expression which can be validating (p. 493). Subsequently, created figures can become non-verbal means of communication and at times the only way to express inner feelings. Sholt and Gavron (2006) emphasize the importance of aspects created unconsciously in the sculptures modelled in therapy and how that can be explored later with the therapist (p. 68). Both verbal and non-verbal approaches are valuable and illustrate how the material will serve the needs of the clients.

### **Constructive and Destructive Practices**

The second therapeutic feature of clay-work (Sholt & Gavron, 2006) has involved a reflection on constructive and deconstructive processes. Winnicott (1971) stated that object constancy may be achieved through creative destruction (as cited in Elbrecht & Antcliff, 2014, p. 26). For instance, toddlers may have piled simple building blocks on top of each other and then enjoyed knocking them down over and over again, thus learning creative destruction as a way to achieve "object constancy" (Winnicott, 1971 as cited in Elbrecht & Antcliff, 2014, p. 16). Such play has prepared children to cope with the real world as a continuum of constant change, of encounter and separation, of comings and goings of loved ones and events, of endings and beginnings. Trust has been gained from the ability to survive such changes intact. In a way, such developmental experiences might not have had the chance to be lived and integrated with a number of individuals on the schizophrenia spectrum. More precisely, what have been the



outcomes of going through constructive and destructive processes has been described by Wilson (1979):

Wet clay coheres. Whatever comes apart can be joined again without trace of preceding rift.

Clay can be shaped and reshaped indefinitely. The ultimate outcome must be confronted, but

failures and vain attempts along the road are not so painful (as cited in Kramer 1979, p. 252).

With clay-work the action of doing and undoing, building and destroying has given clients opportunities to stimulate internal repairs. According to Sholt and Gavron (2006)'s review clay-work has also enabled participants to enter in the constructive and destructive aspects of the self, in processes of psychic change, identity formation and becoming themselves (p. 68). Inner-conflicts have been uncovered, acknowledged, played out and processed through clay-work. Sholt and Gavron (2006) add that the chance to make a concrete thing out of the piece of clay, which is a symbol and a metaphor of one's inner world, is crucial to the therapeutic process (p. 68).

An important focus with this population in art therapy is to foster the strengthening of the ego, of the self, of one's identity. When looking at this clientele's transformation from the manifestation of the illness to the recovery, it is interesting to observe how this transformational work is informed by clay-work. Sholt and Gavron (2006) insist that change occurs with the making of one sculpture or a series (p. 68). This is an alchemy-like process: transforming the pain into meaningful expression (p. 68). Furthermore, Elbrecht (2013) showed what the clay field as an art therapy technique has been able to address in that sense:

Every movement of the hands leaves an implant on the clay. Every impulse destroys and creates simultaneously. To create requires the courage to destroy. Individuals who have been overwhelmed by destruction lose their ability to create. They freeze in terror; they dissociate, sometimes for decades to come (p. 16).

Still, the emergence of the inner dialogue between the constructive and deconstructive aspects of self has been witnessed through clay-work. Depending on the clients' level of interaction with the clay as object; emotions, memories and thoughts might become part of the person's development and change. Emotions such as loss, agony and anger are acted out on and absorbed by the clay. Sholt and Gavron (2006)'s review has not considered cases of psychosis. However,

the fundamental properties that have been described surely correspond to the needs of this population.

### **Significance of Regression**

In art therapy, using clay work with a person on the schizophrenia spectrum has been known to activate positive as well as negative emotions. Thus, regression has been part of working with clay and has been identified as the third therapeutic feature of clay-work (Sholt & Gavron, 2006). For instance, manipulating clay has had for some the potential to trigger pleasant as well as upsetting memories. Various reactions have emerged directly or indirectly from the client's sensory experience of clay. Brown (1975)'s case study of a regressed schizophrenic gave many examples of the possible use of clay with this population and the important reactions and products that came from the client. After complex developments with this client, Brown (1975) explained how he entered a "shit phase" and how this difficult regression invited change (p. 7). At this point, pursuing this process could have been considered negative, dangerous and inappropriate. However, the client was able to continue and slowly integrate overwhelming changes in his clay-work. The art therapist and the team were able to contain sessions in order to benefit the client and focus on his strengths.

In that sense, art therapists have had to remain aware of the strong emotional effects that may grow from making clay-work and overseeing the psychological and emotional safety of the client has become an integral part of the therapy. In relation to possible regression, the art therapist has to pay attention to the client's response to the use of clay. Overall, dealing with regression in the context of art therapy and clay-work seems beneficial. It serves as a tool in order to manage clients' issues and support their growth. In this review, Sholt and Gavron (2006) have introduced Knafo's (2002) definitions of three main types of regressions that the art therapist may come across. Mainly, these descriptions help to clarify the role of clay in different regression processes and also to see what information these types of regressions may have generated.

The first definition is known as *temporal regression* and is basically a return to earlier stages of psychosexual development as seen in the clay-work. For instance, Kramer (1973) observed in sessions how children and adults perceive clay as a toy and how they playfully re-enact their oral, anal, phallic or genital fantasies through clay (p. 251). What was observed was

that this type of regression might have enabled the person to revisit unresolved issues and gain insight on the matter. The second definition is known as *regression as risking decompensation* such as “playing with boundaries of self, identity and reality” (p. 25). For example, through clay-work clients are able to represent symbolic, unconscious as well as different or unknown parts of their selves. Consequently, the safety of the therapeutic space allows for the distorted, ugly and scary images of the client to be received and contained. With this experience, the client could acknowledge the existence of other aspects of his personality that otherwise may not have been accessible. Knafo’s (2002) third definition concentrates on *topographical and structural regression* which means freer access to visual and primary modes of thoughts (p. 25). This regression is dominated by sensations, mainly touch and rhythmic experiences, hence the term procedural expressions.

Regression processes are considered therapeutic features in Sholt and Gavron (2006)’s work. Sholt and Gavron state that because of the sensual and primary qualities of clay, which involve the client in procedural communication, clay-work allows and even invites regression processes that are crucial in therapy. Henley (2002) confirms that clay stimulates all of the body senses and holds regressive qualities (p. 55). Thus, a structured intervention and understanding of both progressive and regressive potentials of clay-work is essential in order to protect the client’s safety. When referring to children in art therapy, Kramer (1979) feels that the propensity for clay to induce regression is outweighed by its power to stimulate integration and self-control. To a certain extent, Kramer’s (1979) position on regression in children in art therapy has demonstrated the potential and benefits of experiencing regression for clients on the schizophrenia spectrum through art therapy. Clients in acute or chronic states of schizophrenia could work with clay if they are deemed capable of sustaining the art-making experience and the possible occurrence of benign or malignant regressions.

Killick (1993) explains how an acute schizophrenic might move within the process of regression. First of all, Killick (1993) expresses that the structure of the art therapy setting fosters the patient’s encounter with art materials. For Killick (1993), this encounter, although initially serving the purpose of the attack on reality, seems over time, by virtue of its concreteness, to grow into an area of meaning for the patient (p. 32). And so, the act of making an image, if it is creative, offers an experience of ‘benign’ regression in the service of the ego (p. 32). Most

importantly, Killick (1993) declares that the very objects and materials used initially in the service of malignant regression can foster a shift in the quality of the regression itself (p. 32). And so, the client's experience of regressive processes may allow for healing to take place. Regressive and progressive processes are activated by clay-work and might, in time, allow for transformations to occur within the patient. This *area of meaning* introduced by Killick (1993) is described as available space for the patient to have claimed matter as his own when engaging in art making. Clearly, in order to serve the client appropriately it is necessary to recognize that regression processes play an essential therapeutic role. For instance, issues that have interrupted one's growth on different levels may be looked at by the client when experiencing regression through clay-work. And so, through clay-work and a controlled regression the client may have the opportunity to acknowledge more emotions.

### **Clay-work as a Treatment of Choice**

McMurray, Swartz-Mirman and Maizel (2000) explain how art therapy has been known as a treatment of choice for people specifically living with psychotic personality organizations. This study focused on the psychotic personality organization; however, this data could be consulted to address other types of psychoses. An understanding and precise knowledge of this clientele was necessary in order to give appropriate and adapted art therapy treatments. Moreover, such material has also been utilized to guide interventions with clients located at different positions on the schizophrenic spectrum. As previously mentioned, when introducing clay-work to this population many precautions were taken and maintained to protect the person's global safety. For the client to participate and truly benefit from art therapy, an understanding of the person's health, capacities and ego functions is crucial.

Murray et al. (2000) articulate that art therapy is an appropriate choice of treatment for clients that find it hard to organize their emotions verbally (p. 196). For instance, Hinz (2009) explains how clients can easily be absorbed in the immediate experience of art making such as clay-work and that stroking wet clay might trigger emotion in individuals (p. 77). Hinz (2009) adds that the release of energy through clay is healing and the creation of form engages development (p. 77). However, the choice of art therapy as a preferred treatment for this population, as demonstrated by Murray et al. (2000), depends primarily on the client's level of

ego functioning (e.g., how well the client relates, perceives and adapts to reality, deals with impulsivity, etc.).

A client with significant disruption to ego function can still be indicated to do clay-work, provided the creative activity is not chaotic (Murray et al., 2000). The key to success in such a case is to lower the threshold of frustration vs tolerance, as described by Hinz (2009). However, such treatment is not recommended if the client shows extreme signs of ego disturbance or weakness (Murray et al., 2000). The type of disturbances that would cause clay-work to be contraindicated would be: incapacity for sublimation, incapacity to restrain impulses, incapacity to sustain object relations, and incapacity for reality testing (p. 194). In these cases, Murray et al. (2000) argue that a spontaneous encounter with art materials can lead to excessive emotional stimulation and cause uncontrolled regression (p. 194). Crespo (2003) suggests that all fluid materials including clay may prove to be too challenging, threatening or stimulating for the regressed, less integrated schizophrenic client and the same may apply to this population (p. 191). On the other hand, as described in Hinz (2009) clay can vary from soft to hard depending on the amount of water (p. 77). This variability of the properties of clay might potentially allow the art therapist to monitor a safe interaction between the client and the clay, if there is a particularly strong desire on the part of the client to use it.

### **Clay-Work in Art Therapy: Therapeutic Facilitators and Approaches**

In this section, therapeutic facilitators are introduced and could lead the art therapy intern and art therapist in managing future interventions. As expressed by Henley (2002), clay-work promotes, enhances and motivates the senses (p. 55). More precisely, it has been observed by Sholt and Gavron (2006) that in both art therapy and psychotherapy contexts, expressions of emotions as well as catharsis are released through clay-work. In addition, in past observations Jorstad (1965) witnessed strong liberations of emotions with clients forming clay and wondered if working with so primitive and original a material as clay satisfied previously frustrated needs (p. 494). Brock (1991), Henley (2002), Keyes (1984), Mattes and Robbins (1981), Mciver (2001) and Mitchell (1984) sustain that many descriptions in the literature refer to clay figures as representing powerful emotions that previously were inaccessible to the client (p. 70). In supporting these ideas Bratton, Ferebee (1999) and Wadeson (1987) affirm that clay-work has enabled the expression of feelings fairly quickly, due to the tactile quality of the clay, which

allows haptic involvement (Kagin & Lusebrink, 1971) and rhythmical movements that accompany clay-work (as cited in Sholt & Gavron, 2006, p. 70). The movements and manipulations with clay allow emotions to flow. The haptic involvement and movements permits the client to unconsciously reach repressed emotions. For example, the many opportunities of modeling in clay provide countless ways in which anger can be expressed or ventilated, such as scratching, claspings, stabbing, throwing, smashing, and so on. Clay-work has served as a tool and as a support for communicating emotions.

What was observed when practicing art therapy with this people living with an illness on the schizophrenia spectrum was that the contact as well as the expression of emotions was enabled through creative expression of clay-work. According to Sholt and Gavron (2006), the expression of emotions and the catharsis are also facilitated by clay. What is necessary to keep in mind is that when someone has done clay-work that also allows the person to encounter and experience a variety of movements and emotions and not automatically generate catharsis. Predominantly, the body has remained the vehicle allowing internal tensions to materialize, to be communicated outside and received by the client and art therapist. To clarify, Sholt and Gavron (2006) have explained that through the experience of catharsis which has been facilitated by clay-work, unconscious repressed ideas, feelings, wishes, and memories have been brought back to consciousness (p. 70). What was recognized by Sholt and Gavron (2006) was that clay-work, through employing tactile contact and invoking somatic impressions, was the most primal and procedural mode of communication and as a consequence emotional impressions often emerged (p. 70).

Through clay-work, the client's body has become the vehicle which permits another communication and the possibility of catharsis. On the other hand, what is important to explore is that clay-work has also been found to reveal unconscious materials without catharsis due to the impact of procedural expressions. For example, physical movement memory and other data residing in the body are still transferred as an unconscious substance. Anderson (1995) claims that clay-work evokes direct expression that has not been filtered through the client's mind (p. 70). Henley (2002) suggests that focusing on the physical manipulations of the client would help in detecting this particular process (p. 70). In such a case, discussing the art work after completion may have enabled the person to uncover unconscious material in connection with the

art product. Moreover, by witnessing the physical work of the client the therapist is able to access more expressions and more depth in subjective meaning. Here, the presence of the art object in therapy triggers more verbal communication between client and therapist. Nevertheless, the exchange and relationship between client, artwork and art therapist contributes to the emergence of impending topics. Clay-work has the potential to activate different processes depending on the multidimensional state of the person and that connection has been seen with the Clay-Field approach.

### **The Clay-Field (Deuser)**

The clay field intervention developed by German art therapist Heinz Deuser has not been researched in relation to psychosis for this paper. However, it could be considered as another treatment possibility for the schizophrenia spectrum population. Even though the potential use of the clay field with the early psychosis population has not been verified in this research paper; some key points have been introduced in this section. Elbrecht (2012) brought forward the idea of trauma healing at the clay field and describes the clay field as a psycho-physiological art therapy that engages the hands with the material of clay within the safe setting of a rectangular box (36 cm by 43 cm and 3 cm deep) (p. 1, p. 15). In addition, what was of particular interest with this approach is the cohesiveness between the clay field and trauma healing. Elbrecht and Antcliff (2014) describe how traumatic experiences are processed within the clay field and how they became interconnected with trauma therapy and trauma healing. According to these authors, the clay field may potentially become an appropriate and safe space to engage with for early psychosis and schizophrenia spectrum populations. At the clay field, a delimited space with safe boundaries is established. The box is cleanly filled with clay and to a certain extent contained the client's movements as well as framed acts of creation. This concept focuses on trauma healing and this subject matter has been taken into account with this population. The different use of space at the clay-field and with clay-work has an impact on the experience of any artist: some may prefer boundaries, others not.

### **Forms of Expressions in Clay (Jorstad)**

Clay-work stimulates the manifestation of emotions and expressions when other means to do so have failed. Horowitz-Darby (1992) suggest that there may even be greater likelihood that clay-work will produce a more authentic affect than other forms of art therapy (as cited in Sholt

& Gavron, 2006). This possibility may be due to the tendency that Hinz (2009) observes, for clay-work to allow for sensory exploration, which increases the depth and dimension of the art experience. More generally speaking, the art-making process allows both client and therapist to gain a certain awareness of matters during the creation of art and when dealing with the final product. Reflecting on the emotions that emerge from the sensory aspect of clay might lead to the correspondence of internal sensations and internal rhythms (Hinz, 2009). Additionally, Hahnemann (2006) explains how clay can be introduced when clients suffer from sensory deprivation; exciting the senses may stir emotional responding, therefore igniting cognitive processes.

Having been in accordance with the force of expression that has emerged with clay-work, Jorstad (1965) suggested that there were forms of expressions in the clay products which revealed different types of problems. Five types of these problems have been isolated by Jorstad (1965) and may be used as reference or diagnostic help when needed in art therapy with clay-work and relevant fields.

The most common problem or form of expression that is found with clay products is the feeling of guilt, which usually manifests as downcast, oppressed human clay figures. Secondly, contact problems with the central object from childhood stand out in the clay. As an example, mother and father figures appear, displaying the transference situation (e.g., overprotective or avoidant behavior). Next, the expression of identity problems in relation to one's sexual role (i.e., as children or adolescents) may appear as well as a questioning about identity in a more sexual sense. According to Jorstad (1965), in clay sexual problems were projected in an abstract way, either symbolically or more naturalistically. In addition, regressive and infantile tendencies were identified in the clay (p. 493).

The repetition of these themes and many others can help in identifying unresolved issues. However, any meaning found in the clay products remains only relevant to each individual client. Such guidelines help to identify patterns and problems, but applying these elements requires the art therapist to remain critical in order to avoid prejudice and serve the client's well-being. Jorstad (1965)'s five problems do not refer specifically to experiences of individuals struggling with psychosis. Still, some of the discussed examples may arise in clay-work with this population, depending on their level of reality testing. Therefore, as explained by Ault (1987), the



product in a therapeutic setting is used to create metaphors, express a vision, increase a sense of self, build skills helping the client develop inner images and challenge physical limits. All of these elements need to be taken into consideration in order to serve the client's well-being.

### **Clay Modelling Alone or in a Group**

Psychoanalytic psychotherapists Rey and Chouvier (2011) and two other therapists introduced clay modeling to five non-verbal adult participants, one portion living with autism and the other with psychosis (p. 57). These particular participants' capacity to differentiate what is internal and external was greatly compromised as well as their individual psychological and physical limits. This particular research was also particularly significant in that the clay-work element was as valuable as the group element. What is more, the clay experience was meant to serve the structure of the psychic boundary of the group. Furthermore, Rey and Chouvier (2011)'s intent was for the participants to engage with clay in order to demonstrate

[...] que cette expérience permet de (re) saisir les étapes de la constitution de l'enveloppe psychique groupale et mobilise les processus de symbolisation à partir de la sensorialité. Les patients présentant une véritable faillite de la constitution de l'enveloppe psychique (Anzieu, 1985) et de l'image du corps (Pankow, 1969), nous leur proposons une rencontre à partir d'une matière brute et malléable (l'argile), gageant que celle-ci pourrait avoir un écho sur le plan de la matière psychique (p. 57).

This clay-work experience was meant, within the group framework, to offer the subject the possibility of working on self-identification through sensory, bodily, and psychic stimulation. In addition, groups were categorised in relation to the four different types of textures or forms of clay that were produced. Therefore the four groups were described as: "unintegrated," "pasty," "crumb-like" and finally "conglomerate". Through these different complex experiences with the group, Rey and Chouvier (2011) were able to identify elements of progression connected in the evolution of the two-dimensionality to the three-dimensionality factors in the participants work. According to the authors, clay modeling served as a device that enabled repair. Therefore, introducing clay-work to this particular group somehow demonstrated possibilities of activating and assisting group connections and developing psychic boundaries.

Hanevik et al.'s (2013) observations have shown how the clay-work group session helped these five participants from different backgrounds (i.e., bipolar disorder, acute schizophrenia,

schizoaffective disorder and paranoid psychosis) to cope with their psychosis and other issues (p. 318). For instance, when their session was completed, some participants expressed how they were able to gain awareness of some of their symptoms while doing clay-work. Also, to a certain extent the art therapy session helps the participants in the understanding of their psychotic experiences. While continuing clay-work in art therapy, clients make connections to emotions that helped develop a sense of empathy and care for their own life. For these participants, focusing on the task and the substance facilitates reaching a grip on what is real. Accordingly, coping abilities relate to lifestyle management to control symptoms and improvement of reality testing skills emerge through clay-work in art therapy. In addition, later in their experiences of art therapy and clay-work, some artists are able to perceive and identify symptoms as warning signs for the expression of psychosis. To a certain degree, the understanding of these signals appeared to have facilitated the participants' management of their symptoms. Arieti (1974) argued that the use of art was a method of mastering the extreme anxiety-provoking perceptual distortions in acute schizophrenia. For that reason, it is important to remember that for an acute schizophrenic being engaged in the gradual process of grasping, exercising and eventually mastering an art technique such as clay-work can affect the management of different symptoms (e.g., focusing on the task of clay-work relieved anxiety). Consequently, the same dynamic has also had positive effects with the early psychosis population. Overall, in Hanevik et al. (2013)'s research it seems clear that the artistic explorations of the psychotic experience contributed to the patient's cognitive understanding of the disorder and that these interventions have benefited this population.

### **Discussion**

This research aimed to fill the void of knowledge in relation to the benefits of clay-work as an art therapy treatment with the early psychosis and schizophrenia population.

Through the literature, clay-work as an art therapy approach was found to provide a variety of benefits to the schizophrenia spectrum clientele. Actually, touching and engaging with the fundamentally real, concrete, earthly-based substance of clay has had the potential to ground clients in the moment, in the here and now. In clay-work sessions, some clients have a chance to distance themselves from their everyday life with this overwhelming illness and experience a connection with creation. Clients also have the opportunity to perceive themselves as able to

make, they are in action like artists and they have the possibility to achieve. In addition, other populations such as cancer, dementia and mental health illness survivors have been able to reconnect with their ability to play through clay-work. Getting accustomed to this material as well as working through the processes of transformation that arise from manipulating the clay has permitted clients to work with other senses and gain access to emotion in a non-verbal manner. The experience of disconnection from the self, the body and the outside world maybe worked through in what has been created as well as destroyed with clay. To a certain extent, reaching the space expression through regress allows reparation to set in. Clay-work allows for what is at stake in the regression to be expressed as well as addressed in therapy. Sholt & Gavron (2006) observed that different types of regressive expressions by clients enabled them to enlarge their understanding of the clients' inner world and needs. Even if perceived as potentially harmful in certain situations, in clay-work regression has served as a guide in order to treat these key periods as opportunities for growth while keeping the person safe.

The validation of the benefits of clay-work in art therapy and in other therapeutic spheres as well as demonstrating how treatment has been tailored to individuals' specific needs have been noted in this research. The unique qualities of clay-work in art therapy have engaged clients to recognize and acknowledge their own rhythms and capacities in the present moment and on the road to recovery. Therefore, helping to gain awareness of one's needs was consistent with the role of clay-work in art therapy (Patterson et al., 2012, p. 78). The relationship between the client, the art therapist and the material truly has become the core of the therapy. For instance, the solid construction of the relationship between the client and the art therapist plays a vital role in the interpersonal development of the individual living with schizophrenia and the spectrum. The rapport that is generated and established in the therapeutic relationship facilitates by clay-work which serves as an organizing, reality-centered material used to further solidify the person self-esteem and ego strength. Engaging with clay-work is meant to connect with another being, with the art therapist and maybe with other participants in the context of a group. Safe spaces such as open studios, individual and group therapies have given individuals a rest from their isolation.

The generalized perceptions of this illness have to be filtered through each person's individual's personality when beginning treatment. Additionally, an awareness of the fact that

each client has had a different experience of psychosis is necessary to give appropriate care. Moreover, it is necessary to take into account each client's level of awareness of the experience of psychosis and its traumatic impact. The causes of psychosis are multifactorial and they are as numerous as they are complex. Clinical data on the origins, symptoms, existing treatments as well as the different conditions of early psychosis and the schizophrenia spectrum have over the years informed the practice of clay-work in art therapy. Clay-work in art therapy treatments has been shaped by these resources as well as existent theoretical lenses. The scope of the strengths and weaknesses of clay-work in art therapy with this population have yet to be defined. Research has shown that clay-work in art therapy has mostly positive results with this population. Patterson et al. (2011) explained that the benefits and harms of employing art therapy in the treatment of schizophrenia are unclear and also mention that with theory alongside practice there is no consensus about the process of therapy and mechanisms of action or for whom it is most effective (p. 71). In general, clay-work interventions in art therapy have been applied only when the safety of the client is secured. Comparable with existent types of therapy and its impact on the client's progression, the beneficial effects of clay-work might be triggered during sessions prolonged in between visits and continued well after termination. Furthermore, significant benefits have been observed in both short and long term art therapy treatment such as clay-work (Wood, 2012, Patterson et al., 2011). The NICE has evaluated the impact of some methods of treatment with clay-work in art therapy and recognized the general as well as more particular responses of individuals. Overall, positive results have emerged from this art therapy treatment however the scope of its benefits have yet to be determined.

Throughout this research the presence of family, friends and community are vital factors in helping individuals recover from a first episode psychosis and schizophrenia spectrum illness. In the same way, a safe space where one is able to connect with an art therapist and with members of a clay-work group play an important part in trying to make sense of one's identity and reality. Knowing how numerous the changes after the trauma of psychosis have been and how arduous recovery was both psychologically and emotionally, art therapy is often welcomed as a relief from these struggles. The evidence gained from the literature has shown that art therapy has been a means of survival, growth, and hope for this clientele. Unfortunately, the loss of support systems and the setbacks in treatment have been part of the reality of early psychosis

and schizophrenia spectrum populations. For some clients family assistance may have been maintained during treatments and recovery, however, in other cases that support strained due to the many difficult challenges that come with coping with a close one living with such an illness. In that sense, survival, growth and hope have to be maintained through interventions from clay-work in art therapy. The existence of art therapy spaces such as open studios that function inside and outside mental health facilities plays a significant role in gathering individuals otherwise isolated. Maintaining this source of sustenance for persons struggling with and working through recovery of early psychosis as well as on the schizophrenia spectrum is crucial.

The positive results discussed within the context of this literature review suggest how clay-work has the possibility to reach the healing potential of clients through touch. Emotions and thoughts are not only been fixed in words but can also be found in the body, through the use of the body. In the near future, more research in relation to the impact of the use of touch and of the material of clay should be considered. The applicable use of clay-work by more art therapists in diverse contexts and with various populations is fundamental.

## Conclusion

This paper centered on providing an account of the therapeutic potential and benefits of clay-work with the early psychosis and schizophrenia spectrum populations, with specific regard to how it can enable a process of transformation and healing. The evidence gained from the literature suggests that clay-work in art therapy can indeed be a means for this population to begin a process of transformation and healing around the experience of psychosis. In the same way as other forms of nonverbal psychotherapies, Lusebrink (1990) states that art therapy utilizes media that require the participation of different sensory modalities, stirring up responses from the sensory, kinesthetic, affective, perceptual, symbolic, and cognitive levels (as cited in Nan & Ho, 2014, p. 5). The medium of clay encompasses all these sensory modalities and allows this clientele to safely express themselves with the help of the material. This in turn allows verbalisation to potentially become easier since other tensions have to a certain extent been worked through the substance.

Clay is flexible and can be transformed, put together and destroyed, liquefied and solidified, cooked and broken to pieces. In other words, clay is a highly versatile substance that can be used with a wide variety of clients who have varied therapeutic challenges. It pairs particularly well with the supportive therapy approach, which allows clients to focus on making objects in clay to move away from overwhelming symptoms and direct their attention to the present reality. This approach allows therapists to respect the rhythm of each individual client, regarding their capacity for art-making and connecting with clay-work.

With specific regard to the schizophrenia spectrum population, clay-work in art therapy has been suggested to be a useful tool in helping clients safely express their emotions and develop new ways of connecting with others. Patterson et al. (2011) note that “clinical accounts and anecdotal evidence point up improvements in wellbeing extending to recovery and improvements in ability to enter and maintain relationships” (as cited in Wood, 1997, 1999; Killick, 2000, Karkou & Sanderson, 2006, p. 70-71). Being in contact with the different therapeutic properties of clay also facilitates facing identity and self-esteem issues as well as perception of self and others. Most importantly, such healing properties have an impact throughout the course of treatments starting from the first manipulation of the material to the completion of a piece and beyond therapy.

This research also indicated that utilizing clay in art therapy may be harmful for some clients. However, in general results suggest that when it comes to employing clay-work with clients who experience benign regressions the positive effects outweigh negative effects. Regressive and progressive fluctuations function together and clients benefit from safely working sensitive areas with the support of the art therapist and exploring the therapeutic properties of clay. McMurray et al. (2000) state that clay-work in art therapy may be harmful in more specific cases on the schizophrenia spectrum such as with the psychotic personality disorders (p. 192). A set of common directives would be helpful in order to safely evaluate and exercise clay-work with this population. In that sense, more research needs to be made in order to increase the credibility and the significance of the material of clay as a supportive therapy, as a treatment of choice and as a true contributor to multidisciplinary teams.

Having examined at the approaches and interventions reviewed in the current study, I conclude that a more comprehensive gathering of existent short-term and long-term data about the benefits of clay-work with this population is needed. With further knowledge, the expansion and further integration of clay-work with this population can be applied more confidently. In order to illustrate the multilayered benefits that arise from clay-work in art therapy, longitudinal research would be particularly useful in verifying the validity and reliability for this approach for this population. At the same time, the existing documentation on the subject also needs to be further explored, on a larger scale that would have been outside the scope of the current study. Future avenues for research also include implementing more detailed clay-work interventions for this clientele. Moreover, clay-work and phenomenological research studies would be useful to further investigate notions such as attachment, trauma, separation, loss as well as progression, resilience, support and personal growth within the schizophrenia spectrum population.

The nature of using clay-work should be carefully considered and investigated in relation to the family unity. The continued support given by family, friends and community has a positively significant impact on the recovery of the early psychosis and schizophrenia spectrum population. In that process, caregivers undergo many straining challenges and witness the weighty repercussions the illness has on their loved one. As an art therapist I would like to offer clay-work to inpatients as well as outpatients of psychiatric facilities. Both individual and group

art therapy would be available in order to foster intimate and communal environments. Moreover, such spaces would provide the person the possibility to explore, within safe limits, clay-work alone and with others. The combination of the therapeutic benefits of clay with the safe, respectful, structured art therapy space sets the stage for a nurturing, challenging and to transformative experience.

The influence of the open studio would also tint art therapy sessions. This approach benefits this population and focuses on the growing needs unmet with the present treatments. For instance, the development of an open studio within a psychiatric unit belonging only to the inpatients and outpatients could serve as source of empowerment. This idea would be following in the steps of Arts In-Reach, a program in the United Kingdom, evaluated by Stickleby and Hui (2012) that served people in psychiatric settings by encouraging creativity and enhancing the hospital environment (as cited in Morris & Willis-Rauch, 2014, p. 29). This program addressed common problems found in inpatient facilities such as the need for engagement and socialization. Participants in the program showed increased socialization and self-confidence; art making provided a form of escapism, a sense of achievement, and a means of expression. The art therapy space would serve as nourishment where belonging, community and accomplishment would be possible.



## References

- Ault, R. (1987). *The healing vision [DVD]*. The Menninger Foundation. Available from <http://www.expressivemedia.org/resourcesr.html>
- American Art Therapy Association. (2013). <http://www.arttherapy.org/upload/whatisarttherapy.pdf>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*.
- Buchalter, S. I. (2009). *Art therapy techniques and applications*. London & Philadelphia, PA: Jessica Kingsley.
- Buchalter, S. I. (2004). *A practical art therapy*. London & Philadelphia, PA: Jessica Kingsley.
- Brown, J. J. (1975). Therapeutic developments in clay and imagery with a regressed schizophrenic. *Art Psychotherapy, 2*, 1–14.
- Cooper, H. M. (1988). Organizing knowledge syntheses: A taxonomy of literature reviews. *Knowledge in Society, 1*, 104–126.
- Crespo, V. R. (2003). Art therapy as an approach for working with schizophrenic patients. *International Journal of Psychotherapy, 8*(3), 183–193.
- Elbrecht, C., & Antcliff, L. R. (2014). Being touched through touch. Trauma treatment through haptic perception at the clay field: A sensorimotor art therapy. *International Journal of Art Therapy, 19*(1), 19–30.

- Elbrecht, C. (2013). *Trauma healing at the clay field: A sensorimotor art therapy approach*. London and Philadelphia, PA: Jessica Kingsley.
- Foster, F. (1997). Fear of three-dimensionality: Clay and plasticine as experimental bodies. In Killick, K., & Schaverien, J. (Eds.), *Art, psychotherapy and psychosis*. London, England & New York, NY: Routledge.
- Hinz, L. (2009). *The expressive therapies continuum*. New York, NY: Routledge.
- Hanevik, H., Hestad, K. A., Lien, L., Telglbjaerg, H. S., & Danbolt, J. D. (2013). Expressive art therapy for psychosis: A multiple case study. *The Arts in Psychotherapy, 40*, 312–321.
- Henley, D. (2002). *Clayworks in art therapy: Plying the sacred circle*. Philadelphia, PA: Jessica Kingsley.
- Hingley, S. M. (1997). Psychodynamic perspectives on psychosis and psychotherapy I: Theory. *British Journal of Medical Psychology, 70*, 301–312.
- Hirschfeld, R., Smith, J., Trower, P., & Griffin C. (2005). What do psychotic experiences mean for young men? A qualitative investigation *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 249–270.
- Killick, K. (1993). Working with psychotic processes in art therapy. *Psychoanalytic Psychotherapy, 7*(1), 25–38.
- Killick, K., & Schaverien, J. (Eds.). (1997). *Art, psychotherapy and psychosis*. London, England & New York, NY: Routledge.

- Kimport, E. R., & Hartzell, E. (2015). Clay and anxiety reduction: A one-group, pretest/posttest design with patients on a psychiatric unit. *Art Therapy, 32*(4), 184–189. doi: 10.1080/07421656.2015.1092802
- Kimport, E. R., & Robbins, S. J. (2012). Efficacy of creative clay work for reducing negative mood: A randomized controlled trial. *Art Therapy, 29*(2), 74–79. doi: 10.1080/07421656.2012.680048
- Knafo, D. (2002). Revisiting Ernst Kris's concept of *Regression in the Service of the Ego*. *Art Psychoanalytic Psychology, 19*(1), 24–49.
- Lusebrink, V.B. (2004). Art therapy and the brain: An attempt to understand the underlying processes of art expression in therapy. *Art Therapy: Journal of the American Art Therapy Association, 21*(3), 125-135.
- Lombardi, R., & Pola, M. (2010). The body, adolescence, and psychosis. *The International Journal of Psychoanalysis, 91*, 1419–1444.
- Malchiodi, C. (2007). *The art therapy sourcebook*. New York, NY: McGraw Hill.
- Morris, F. J., & Willis-Rauch, M. (2014). Join the art club: Exploring social empowerment in art therapy. *Art Therapy: Journal of the American Art Therapy Association, 31*(1), 28–36.
- Nan, J. K. M. (2015) Therapeutic effects of clay art therapy for patients with depression.
- Nan, J. K. M., & Ho, R.T. H. (2014). Affect regulation and treatment for depression and anxiety through art: Theoretical ground and clinical issues. *Annals of Depression & Anxiety, 1*(2), 1–6.
- McMurray, M., Schwartz, O. M., & Maizel, S. (2000). Art therapy: Indications for treatment of choice. *The Arts in Psychotherapy, 27*(3), 191–196.

- Patterson, S., Crawford, M. J., Ainsworth, E., & Waller, D. (2011). Art therapy for people diagnosed with schizophrenia: therapists' views about what changes, how and for whom. *International Journal of Art Therapy, 16*(2): 70–80.
- Pénzes, I., van Hooren, S., Dokter, D., Smeijsters, H., & Hutschemaekers, G. (2015). Material interaction and art product in art therapy assessment in adult mental health. *Arts & Health, 1*–17. <http://dx.doi.org/10.1080/17533015.2015.1088557>
- Pestalozzi, J. (2003). The symbolic and concrete: Psychotic adolescents in psychoanalytic psychotherapy. *The International Journal of Psychoanalysis, 84*(3), 733–753.
- Randolph, J. (2009). A guide to writing the dissertation literature review. *Practical Assessment, Research & Evaluation, 14* (13).
- Rey, B., & Chouvier, B. (2011). Modelage et psychose: une clinique de la groupalité dans ses fondements archaïques et sensoriels. *Revue de Psychothérapie Psychanalytique de groupe, 57*, 65-77.
- Robbins, M. (2011). *The primordial mind in health and illness: A cross-cultural perspective*. New York, NY: Routledge.
- Salonen, S. (2002). Understanding psychotic disorder. *The Scandinavian Psychoanalytic Review, 25*(2), 143–146.
- Šicková-Fabrice, J. (2007). *Basic art therapy*. Bratislava: Terra terapeutica.
- Sholt, M., & Gavron, T. (2006). Therapeutic qualities of clay-work in art therapy and psychotherapy: a review. *Art Therapy: Journal of the American Art Therapy Association, 23*(2), 66–72.
- Teneycke, T., Hoshino, J., & Sharpe, D. (2009). The bridge drawing: An exploration of psychosis. *The Arts in Psychotherapy, 36*, 297–303.

- Trotman, H. D., Holtzman, C.W., Ryan, A.T. Shapiro, D.I., MacDonald, A.N., Goulding, S.M., Walker, E.F. (2013). The development of psychotic disorders in adolescence: A potential role for hormones. *Hormones and Behavior*, 64, 411–419.
- Wittels, B. (1975). The use of art to master symptoms as demonstrated in the art work of acutely psychotic patients. *Art Psychotherapy*, 2, 217–224.
- Wilson, L. The art materials in art therapy. In Kramer, E. (1979). *Childhood art therapy*, (220–266). New York, NY: Schoken Books. Wittels, B. (1978).