How can art therapy contribute to mentalization in borderline personality disorder?

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Neil Springham, Diane Findlay, Ami Woods & Jane Harris

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NEIL SPRINGHAM, DIANE FINDLAY, AMI WOODS & JANE HARRIS

Abstract
This article evaluates a pilot mentalization-based treatment programme for borderline personality disorder (BPD), which had an art therapy group as one of its three components. Evaluation involved a range of standardised measures and showed the programme had positive results with increases in distress tolerance, lowered service use and at least two participants no longer meeting criteria for the BPD diagnosis. The question was asked about what art therapy might contribute to mentalization in this context. A qualitative research strategy was undertaken to explore one of the author's experience of art therapy as one of the programme's service users. Repeated rounds of audio-recorded interviews resulted in eight themes which describe what helped and what should be avoided in art therapy treatment of BPD. The service user view was that art therapy was an essential ingredient in helping to develop greater mentalization. The study suggests that in anchoring mental content in an externalised form, art therapy offers the flexibility to slow down the process of explicit mentalization to a manageable pace. These findings were linked with similar service user research in Norway and the USA.

Keywords: mentalization, borderline personality disorder, outcome, service user experience

The Oxford English Dictionary (2010) cites the first recorded use of the term 'mentalize' in 1807 and currently gives it two senses: first 'to construct or picture in the mind, to imagine, or to give a mental quality to'; and second 'to develop or cultivate mentally or to stimulate the mind of'. The clinical use of the term 'mentalization' does not define a school of psychotherapy. Instead, mentalizing is identified as a basic human process that can be supported by particular human interactions. By this definition mentalization is a mechanism of change common to all forms of psychotherapy because it '... addresses a fundamental human capacity to apprehend our own and other's minds as mind' by '... a calibration of [the patient's] own self perception through the understanding of other's view of them' (Fonagy, Bateman, & Bateman, 2011, p. 102).

Mentalization-based treatment (MBT) is one of a number of evidence-based treatment approaches specifically designed for borderline personality disorder (BPD). BPD is characterised by unstable moods, identity diffusion and difficulties in interpersonal functioning. It is proposed that these difficulties are primarily mediated through an ability to mentalize because mentalization is the central method of self-cohesion for the individual. Formulating treatment to specific conditions in this way is part of an intellectual framework for psychotherapy in which '[t]he mechanism of (therapeutic) action can only be understood only when applied to an explanatory model of the condition treated' (Kazdin, 2004, p. 923).

Evidence exists that the need for therapy to have condition-specific features is particularly pressing in BPD. Stone's (1990) 30-year study of the fate of BPD patients indicated that generic forms of counselling and psychotherapy were ineffective or even iatrogenic. The National Institute for Clinical Excellence now stresses that specific features need to be in place in psychological therapy to be safe and effective for BPD. Recommendations include longer treatments with a number of inputs from therapists working together within a coherent treatment model which is shared with staff and service users.

MBT is usually delivered in a concurrent mode which involves both individual and group interventions. Individual work aims to explore intra-psychic issues and the group focuses on interpersonal functioning. The model is clearly defined and aims to address the particular barriers to therapy posed by the BPD condition (Allen & Fonagy, 2006). Summarising a large body of neuro-scientific research, Fonagy and Luyten (2009) point out that adult BPD patients appear to have a lower threshold for the activation of the fight or flight system and an associated readiness to deactivate mentalizing. The understanding of this has a direct bearing on the potential to maintain therapeutic alliance and therefore the effectiveness of therapy. The lasting efficacy of MBT was demonstrated in an
eight-year follow-up of MBT versus treatment as usual (Bateman & Fonagy, 2001a, 2001b, 2008). While there remained difficulties in interpersonal functioning, significant gains made in MBT in terms of vocational status, global functioning, medication and service use persisted. Similar results were found in an 18-month follow-up study (Bateman & Fonagy, 2009). The outcomes were encouraging because positive effects of treatment usually tend to diminish over time.

The proposition of mentalization as a common mechanism of change is helpful for clinicians of different professions who aim to work together within a shared model. For example, an art therapist in an MBT programme service aims to increase mentalization where it is compromised by BPD. But such an aim poses interesting questions for art therapists: can we define the unique features the practice of art therapy contributes to mentalization in BPD? Answering this question is important and will no doubt require a number of different research strategies, of which this article represents but one.

Art therapy in BPD treatment programmes

The use of art has a long tradition within BPD treatment and most successful day treatment programmes for BPD contain expressive therapies (Conway et al., 2003; Dolan et al., 1992; Karterud & Pederson, 2004; Kravitz, 1997; Piper et al., 1996; Wilberg et al., 1998). The use of art therapy in treatment programmes has been particularly advanced in Norway where it formed an integral part of most personality disorder treatment units (Karterud et al., 1998). A number of MBT services have included arts-based therapy (Allen, Fonagy, & Bateman, 2008; Franks & Whitaker 2007; Vermote, Lowyck, Vandeneede, Bateman, & Luyten, 2012). However, studies of effective treatment programmes reveal less about the contribution of particular components of treatment, such as art therapy, and so a different research strategy is required.

The contribution of a particular component of treatment can be examined through the lived experience of people who use that service. Such an approach acknowledges that art therapists are not the only contributors to the phenomena of art therapy. Those who have used art therapy services have a high investment in the practice. Their capacity to look back and review the art therapy they engaged in, from the inside of the experience, can help us to understand more about both the troubling psychological conditions they entered therapy with and how the interaction between people and art objects worked with the effects of those conditions. By comparison with other countries, UK art therapists, heavily influenced by psychoanalysis, have neglected this approach, favouring research by therapist-reported case study. Latterly the situation has begun to change in recognition that such an approach has limitations due to the power of professional bias in observation and recall, which can result in mere induction of practice into existing theory. Service users are of course also subject to bias, but their differentiated observations have a balancing value precisely because they are untrammeled by the professional constructs which have dominated art therapy theory. This article therefore aims to explore what art therapists might learn about how art therapy might enhance mentalization in BDP from those who have received it.

Studies which seek to understand the contribution art therapy makes to day treatment programmes for BPD include that by Kasuistik (2006), who used a case study approach of a female service user with BPD who underwent an inpatient psychosomatic rehabilitation programme in Germany. Of these components the service user found art therapy particularly helpful in externalising her concerns into visual form so that she could then re-integrate the issues. The single case study approach is useful because it explores in depth and is context specific, but its limitations are that it may be describing idiosyncratic phenomena.

In Norway, Sigmund Karterud and colleagues embarked on a series of evaluations of their personality disorder services, which resulted in a number of related papers in 2004. Karterud and Umres (2004) asked what the optimal composition of day treatment programmes should be for short-term day treatment programmes for personality disorder. Using data from the Norwegian personality disorder treatment network, they were able to gain the outcomes of 1244 treatments in day programmes between 1993 and 2000. The data reviewed included: scientific evidence; theoretical rational evidence; evidence from user satisfaction surveys; clinical experience of staff; descriptions of comprehensiveness and consistency of programmes and available clinical experience of staff. One category of components for day treatment was entitled ‘creative therapies’, which included art therapy, psychodrama, role play and body awareness. All categories of personality disorder gave the art therapy group the highest significant rating. Moreover, the authors found art therapy ratings correlated significantly (p = 0.005) with overall benefits of the treatment programmes they undertook.
They concluded: 'In other words, it seems like art group therapy favours development of mentalization and reflective functioning' (Karterud & Urnes, 2004 p. 246).

Karterud and Pederson (2004) likewise looked at the rating of individual components of treatment in relation to overall gains from the whole programme in a single site day hospital for personality disorder. The sample was 319 patients who completed treatment between 1994 and 2000. Individual components were rated by semi-structured interviews and on a seven-point Likert scale in response to the question: how much benefit have you gained from the following groups during treatment? These were compared to overall outcomes using the self-report symptoms checklist (SCL-90R), circumplex of personal problems (CIP) and psychological levels of function (GAF). These were analysed with a paired t-test. The art therapy group was rated by patients significantly higher (p < 0.001) than all other groups.

Our findings suggest that there is a positive relationship between the subjective experience of benefit and outcome measures in day hospital treatment. Ratings of overall benefit correlate moderately (range 0.23 – 0.32) with the outcome measures. (Karterud & Pederson, 2004, p. 50)

Service user views of the effectiveness of art therapy were as follows:

- Non-competitive calmness of the group
- Being able to concentrate on their own mental images
- Being encouraged to find a personal expression of these images
- The response from fellow patients and the art therapist to their production
- Being witness to other’s mental images
- Helping them to understand and reflect upon their own mind in comparison and contrast with the minds of others. (Karterud & Pederson, 2004)

The authors reflect that it may be possible that the high rating was because the art therapy group put emphasis on meaning and mentalization rather than on more frustrating issues such as were dealt with by components of the programme such as the problem-solving group (i.e. paying bills and taking responsibility), which were still likely to be beneficial but not liked.

A strength of the overall Norwegian project was that in making efforts to identify the contribution of art therapy, there was an attempt to define it in the form of guidelines for one of the art therapy groups featured as part of the study, which include service user views of valued aspects of art therapy (Johns & Karterud, 2004). The guidelines share many common features with the group structure developed for the present study. Johns and Katerud (2004) published their guidelines in the journal of the Institute for Group Analysis alongside invited responses from four peers (Bhurruth, 2004; McNeilly, 2004; Tanna, 2004; Waller, 2004). Such an approach has the potential to explore in greater depth how the use of art in therapy might interact with the condition of BPD. However, the discussion missed the opportunity to question how art therapy might be structured to best meet the needs of those with BPD as per Kazdin’s (2004) framework. Only one author made any declaration of the clinical populations they themselves worked with, describing a mixture which included some ‘moderate personality disorder with enduring neurotic conditions’ (Bhurruth, 2004, p. 143). This has a limited comparison to BPD.

The debate centred more on the guidelines’ lack of fidelity to group analytic principles, particularly in the steps outlined to explore each picture in turn. This was referred to as individual therapy in a group and was seen to lack meta-level group-as-a-whole interpretation. Waller (2004) questioned the lack of art therapy group literature involved in compiling the guidelines, suggesting that issues of directive and non-directive group approaches had been debated. Bhurruth (2004) also criticised both the project to identify components as having particular effects and utilising service user feedback to do so. Basing his argument in group analytic philosophy, he rejects any attempt to appraise therapeutic day programme components as a pathological splitting defence mechanism. Bhurruth (2004, p. 146) interpreted the researchers as being in a shared state of idealisation because they were ‘...uncritically enmeshed with the patient’s perception of the art therapy group’. Such an interpretation does not seem to take any account of Karterud and Pederson’s (2004) own questions about patients simply liking the art group or Karterud and Urnes’ (2004) extensive efforts to correlate service user views and overall outcomes for treatment.

In the US, Persons (2008) explored service user valued outcomes and opinions on mechanisms in art therapy in a population of 46 incarcerated males aged 16–20 years who had a diagnosis of BPD. Using service user selected artworks at the end of mixed group therapy and individual art therapy treatment, he conducted interviews asking what was most therapeutically
helpful about art therapy. Employing a content analysis approach with three experienced raters (with high inter-rater reliability of .94) he identified eight items:

1. Stress relief and relaxation; took my mind off upsetting things; an emotional outlet
2. Reduction of boredom
3. Pride and self-confidence
4. Positive recognition from others
5. Helped me not quit when I was frustrated
6. Enjoyment and fun
7. Improved ability to concentrate
8. The way I was treated, encouraged and not put down

The study’s strength is also that it gives a practice description of a directive form of art therapy, i.e., a service user who has abused women is directed to paint images of women with feelings of their own. The service user view of mechanisms in art therapy is a strength of this article, as was the use of artwork to gain data. The images themselves were research analysed through expert opinion of the art therapist although the expert status is not qualified and those judgements on the mental state of the patient were not triangulated with any other form of measure. Although the sample size is quite large, the context is very specific and the population narrow in age range and gender, so the outcomes of art therapy described, such as the reduction of boredom in an incarcerated setting, might not generalise to other settings.

Significantly, art seems to be important to service users who graduate from BPD treatment services which include art therapy. They have wished to continue with their involvement in art-based activities (Mellier & Brukha, 2010; Turner, Lovell, & Brooker, 2011) and their reasoning can tell us much about what is helpful:

Participating in creative and arts based social activities offers a level of stimulation that distracts from the pain of ‘being together’. Meaningful connections are nurtured in what is described as ‘attachment to art’ and ‘attachment through art’. These processes provide an experiential focus for conversation that helped people to stay engaged whilst lessening the impact of their social isolation. (Turner et al., 2011, p. 342)

These studies offer evidence that the use of art in therapy is valued by service users with BPD and that this has a relationship to effectiveness of treatment. Perhaps because of the newness of the treatment, MBT day treatments appear to have been a small minority of the samples used so less is known about how art contributes to mentalization. However, the Norwegian studies and the work of Franks and Whitaker (2007) offer clues that art therapy might offer a mechanism in which making artworks has a relationship to stronger and more benign self-awareness under certain conditions. This appears to be when there is a movement between making artworks with reduced social contact and then moving to social contact through jointly viewing artworks, a process explored by Isserow (2008, 2011). Repetition of this appears to help service users make sense of their minds at an intrapsychic and interpersonal level. The present study aimed to ask more explicitly how mentalization might be supported by this mechanism by using data from evaluation of the whole service and going in depth into one participant’s experience of art therapy to view what may be occurring in terms of the MBT model. To this end, the results of the evaluation of the whole service are now presented followed by an evaluation of DF’s lived experience of the art therapy component.

Research approach

While there are likely to be numerous areas of how art might interact helpfully with the condition of BPD that need to be explored, this article has a much more modest aim of narrowly focusing on art and mentalization within an MBT programme. To this end, a combined quantitative and qualitative methodology has been adopted. Outcome data from the programme as a whole are presented alongside an in-depth exploration of one of the author’s experience of art therapy to view what may be occurring in terms of the MBT model. To this end, the results of the evaluation of the whole service are now presented followed by an evaluation of DF’s lived experience of the art therapy component.

Diane Findlay (DF) and Ami Woods (AW) were co-investigators in the qualitative approach. Both were members of ResearchNet, a service user and provider research network (Springham, Wraight, Prendergast, Kaur, & Hughes, 2011). The ResearchNet structure brought together the co-investigators and supported the research process throughout. DF co-investigated her experience of using the MBT service with AW, an art therapist who was not involved in delivering any treatment on the MBT programme. Jane Harris and Neil Springham both underwent advanced training in MBT to deliver and evaluate the MBT service described in a team of five professionals, but were not involved in the heuristic research interviews by DF and AW because it was felt it would be stronger if it was
undertaken independently from the providers of the service.

The qualitative methodology chosen was heuristic, which required a process of structured introspection. The present study adopted an approach of co-investigation based on methodology of repeated interview cycles to explore lived experience developed in Woods and Springham (2011). Repeated in-depth interviews were conducted involving co-investigator DF describing to AW what an art therapist does that is effective and what they should avoid doing that is harmful when working with BPD. Each interview was audio recorded and this recording was reviewed by each co-investigator independently between meetings in order to identify and group their findings into key themes. The comparison of themes formed the basis of the subsequent interview.

Exploring lived experience of mental health service use is not without risk and the choice of this method was an ethical consideration. The interviewing roles were divided because, as AW had found in her own heuristic research in Woods and Springham (2011), the demand characteristics of simultaneously recalling difficult lived experience and addressing a research question were not easily compatible. AW had found that gaining distance on painful life events through the repeated use of recorded interviews enabled her to step back and put her experience outside of the immediate personal domain and this reduced the level of distress involved. This division of labour between DF and AW allowed AW to attend to the research question and probe for practice descriptions suitable for an art therapist and DF to speak about her experiences spontaneously without constraint by the research question. While it is argued that the distancing function of the methodology aided the co-investigators in addressing the research question with more clarity, the authors do not wish to misrepresent this as a claim for objectivity. As Kvale (1996) suggests, all qualitative research is based in personal perspectives and this is its value. Rather than try to ameliorate this factor, validity is strengthened by explicit transparency about those perspectives the researchers operate from. To this end, both co-investigators produced the following declaration of their perspectives.

**Notes about co-investigator perspectives**

AW is an art therapist but one who does not work in personality disorder services. AW has spoken about her own service use in relation to anxiety and depression and in 2012 she was elected onto the British Association of Art Therapists council to help build and develop stronger service user involvement in art therapy research. She was therefore working from the position of not knowing and attempting to find out about what can be learnt about how art therapy can contribute to mentalization in a condition she had not experienced personally or professionally from DF.

All authors felt it was important to present a fuller description of DF’s life story in her own words as it has a direct bearing on the research:

*I am 43 years old and Mum to three boys. I’d like to share with you my life history so that you can build a clear picture of the journey I have travelled and what led me to suffer with BPD.*

**My childhood was a continuous ordeal of trauma and violence. I had a mother who was an alcoholic and a father that was a violent sex offender.** At two weeks old I was rushed to hospital with a twisted windpipe caused by my father trying to strangle me. As I grew up I witnessed my father beating my mother on a daily basis and that violence extended to me and my older brother. Although I had been on the ‘At Risk’ register from birth, I was left in a world of serious beatings and fearing for my life.

I remember attending school and being unable to sit down or walk properly because I’d been punched, kicked and thrown against the outside wall of the house. My school called in the doctor and the police but the only thing that came out of it was a phone call to my mother who was unable to protect me. At the age of 13 my father started sexually abusing me. He told me if I ever told anyone that he would kill me and I truly believed he would. For over a year the sexual abuse continued and while that was happening, the violence to me, my brother and my mum calmed down.

Eventually I found the courage to speak out but the police made me feel dirty and as though they didn’t believe me. I was put into care and the staff told me I should forgive him as you only ever have one Dad in your life. To me I have never had a Dad, only a biological father as a Dad would never behave in that way. While in the children’s home a male member of staff dragged me up the stairs by my hair, removed all my footwear and clothes from my bedroom, and then locked the door. I climbed out of a window and ran away in the middle of the night in bare feet with no coat. Days later after eluding the police I was found and returned to the Children’s Home.

I met my first ever boyfriend at the age of 16 and immediately fell pregnant, was forced to marry and found myself in a violent, controlling relationship. I fell pregnant again and within
three months I escaped the relationship and immediately struck up a relationship that lasted seven years with a man, who unbeknown to me at that time was a sex offender. He was also violent and controlling. I eventually gave birth to a third son with this man. I found the strength to tell him to leave but he came back and beat me up and smashed up my home. I took my first overdose; it was a serious attempt on my life and resulted in my first experience of inpatient care. Nobody talked to me or asked me why I had made the attempt on my life. I was put on antidepressants and six weeks later discharged home. I lasted less than 48 hours at home before I made another serious attempt on my life. This time I ended up unconscious and fighting for life and once again was transferred from the general hospital to the psychiatric unit. While at the unit my support didn’t come from staff but from other clients.

During this second inpatient experience I was diagnosed as a Manic Depressive. I was introduced to my community psychiatric nurse (CPN) but because he was a male I found I couldn’t talk to him. I didn’t trust him and every time I knew he was about to visit I would become so distressed that I made myself physically sick. I was so withdrawn and frightened of everyone and everything that I couldn’t speak out and say a female CPN would be better for me to talk to. I also became totally agoraphobic at this time. Eventually I started therapy. I was nervous but so desperate for help that I didn’t care what I had to endure so long as I felt better at the end of it. Sadly my experience of therapy was a disaster. My therapist always sat and said ‘Talk about whatever you want to, I will sit and listen. Begin when you’re ready’. I would talk, pour my heart out and become so distressed that I would be sick while she sat not saying a word, no eye contact, no empathy … in fact like there was no interest at all. The therapist told me to imagine a box inside of me and to put all the bad things into it. After my hour weekly slot I would leave to walk home with tears still streaming down my face and feeling more in distress than when I first arrived so I stopped attending.

I continued to muddle through life without support, without medication and without any friends or family until I was 29 years old. I had violent relationships and had no understanding of why I was always treated this way by men. At this time I found a good GP who I could talk to and trusted. For the first time in my life I realised someone wanted to help me, he met with me for 20 minute appointments every week. He would offer advice and alternative ways to view my thoughts. I became a little stronger and happier than I’d previously been. I attended college, worked voluntarily in a primary school and had a dream for my future. I gained worked as a special teaching assistant for children with serious learning and behavioural difficulties. Sadly my GP retired and I once again struggled.

I eventually experienced more therapy but once again it wasn’t right for me. Maybe my mind was closed and I wasn’t in the right place to be helped or maybe the past experience of therapy had put me off forever! The cycle of medication, being an inpatient and strong urges to end my life took over once again. Finally I was taken to a ward which was different. Staff spent time talking to me and listening. I was treated like a human being and told about my treatment, the plans for future support. There was also a breakthrough in my diagnosis: I wasn’t suffering from Manic Depressive Illness, I was acutely clinically depressed and also suffered from Borderline Personality Disorder. I felt like for the first time in my life I wasn’t alone. It was here that I was offered the opportunity to attend MBT.

DF completed the full MBT programme and has since been told by her psychiatrist that she no longer meets the criteria for a diagnosis of BPD. She formed a relationship with a supportive man and they planned to get married but he died from an undiagnosed heart condition shortly after they became engaged. This resulted in her being admitted to hospital once. However, she has found that gains made in MBT have persisted and she has now started and maintained voluntary work in an inpatient setting within Oxleas NHS Foundation Trust and is working towards psychiatric nurse training. The validity of the results below should be considered within the context of this lived experience.

The context of the art therapy described

The MBT service involved an initial six-week period of group psycho-education which then became a three-times-weekly programme comprising one session of verbal individual, one session of verbal group, and one session of group art therapy over an 18-month period. The team met weekly to discuss the programme and had clinical supervision from an experienced MBT supervisor. The aim of the pilot was to examine the case for establishing such a service more permanently within the borough.

The MBT art therapy group’s structure was based on clinical work developed in addiction services (Springham, 1992, 1998) with modifications to fit the MBT model as follows.

The group lasted two hours. The group painting time and discussion time were pre-set. Participants painted and drew on any subject they chose for 30 minutes. The discussion of artworks...
followed a particular structure in that each image was discussed one at a time and structured in the following sequence:

- The artist was invited to describe their intention for their image, often with an invitation such as: ‘Tell us about what you think of your picture now it’s finished, perhaps as if it were someone else’s’.
- The art therapist then invited other group members to comment or explore. This was done by asking ‘What do you think the artist was intending? If you don’t know what to say just say what is obvious to you’.
- The art therapist then invited the artist to focus on the feedback the group had given, asking them what sense they had made of it.
- The art therapist tended to comment only after this sequence and framed their comments not as an expert but as just another perspective.
- At the end of this sequence, the artist was thanked and the group moved onto the next artist.

This approach was designed to focus attention on the images that service users had had the courage to make. However, the structure needed to be flexible to respond to phenomena in the group. For example, if there was low attendance the art therapist made an image, focusing on their view of their own artwork and the attending members were invited to mentalize the art therapist’s artwork. This would involve the art therapist going through the same sequence as above as a process of exploring their view of the group through the image. Equally, if there was an episode of high emotion (affect storm) or another major event in the group, this became the focus of mentalization. However, the group tended to favour a return to the turn-taking structure after such events.

The art therapist’s stance followed generic MBT principles as outlined in Allen and Fonagy (2006). This primarily involved the art therapist monitoring the levels of reflective functioning in the group utilising the implicit/explicit, internal/external, self/other and cognitive/affective dimensions of mentalizing. Complex or abstract interpretations were avoided and the art therapist took a stance of genuinely not knowing and attempting to find out, being highly active in supporting curiosity and encouraging contingent responding at every opportunity.

**Evaluation of the MBT service**

Approximately 30 per cent of referrals to the MBT pilot were accepted for treatment. In general, this was a young, female white group with very high levels of BPD symptomatology, general psychopathology distress and service use. This is consistent with the type of presentation of BPD often seen in secondary mental health services. Six people were recruited as the cohort for the pilot. All participants were assessed on a range of standardised measures at intake and immediately post-treatment, including:

- Borderline Personality Disorder Severity Index (a diagnostic semi-structured interview assessing severity and frequency symptoms of BPD).
- Distress Tolerance Scale (a self-report questionnaire assessing ability to tolerate distressing affect).
- Client and Carer Service Receipt Inventory (a questionnaire assessing service use in the last three months).
- Employment status.

Of the six people accepted to the MBT programme, four completed the programme (although for one of these people this included a period of several months’ non-attendance mid-programme due to conflict with another patient). One person left treatment within the first few months of the programme and one person dropped out of the groups approximately half-way through while continuing to attend individual sessions, but failed to complete the full course of any of the modalities of treatment. Rates of non-attendance during treatment were high, despite pro-active attempts to follow people up, which is characteristic of the diagnosis. All six service users (regardless of whether or not they completed the treatment programme) were approached to complete follow-up assessments. Within this data set DF’s scores are represented as patient no. 3 (see Table 1).

For patients who were able to engage with the treatment programme, substantial gains were possible. At least two service users’ presentation changed to the extent that a BPD diagnosis was no longer warranted. Scores indicated marked improvement in distress tolerance even where intense and difficult emotions continued to be experienced.

**Evaluation of the art therapy component of the MBT service pilot**

There was high agreement between co-investigators on themes analysed at all stages of the process and then by additional rating by Springham. After two rounds of recorded in-depth
interviews, the co-investigators achieved saturation with no new data being identified. In answer to the question ‘How can art therapy contribute to mentalization in BPD?’, the following eight themes were agreed:

1. Art replaces the words the service user can’t find.
2. Joint attention in art therapy is enhanced by homogenous group composition.
3. Therapist models the application of inquiry, rather than pre-determined knowledge to exploration of artworks.
4. Service user to service user comments on artworks support capacity to accept multiple perspectives.
5. Continuous movement between art making and sharing artworks develops emotional regulation.
6. The unresponsive therapist is iatrogenic in BPD treatment.
7. Art therapist’s ‘watchful, not watching’ stance during art making supports immersion in art making.
8. Art therapy can be used as self-help.

These themes will now be expanded using extracts of the recorded conversation to clarify what was meant.

Art replaces the words the service user can’t find

This theme is concerned with an elliptical process of using the art materials to externalise feelings and perceptions and then discussing them in a safe way to experience mental content. First making art created some kind of order to mental content. Then art making is followed by art viewing and discussion from others, which is explicitly directed at naming the image’s content in relation to feelings and thoughts. This can create a language for mental content which supports mentalization.

DF: When you’re traumatised about something it’s finding that starting point, how to share that with anyone…I wouldn’t have had the words to actually start off and say ‘this is what happened’ and ‘this is how I really felt about it’, ‘this is how I feel about it now’… anytime I tried to do anything I was all over the place. It was just all jumbled up with everything.

When I first started (MBT) I thought how on earth is art going to help me and I was very cynical I suppose about the whole thing but when it came to the art it turned out to be, probably out of the three parts of the MBT, the art turned out to be the most powerful because that was always the starting point for anything traumatic that I wanted to share and couldn’t find the words so that opened the door to the other sessions if you like…you just start doodling, it’s like the hand starts doing whatever it’s doing and that’s how the work is produced. It’s not ‘focus, ok I’m going to do this because I can think about that and that’s how it makes me feel’, art gave me the confidence to share things I couldn’t bring myself to say to someone.

Joint attention in art therapy is enhanced by homogenous group composition

It was particularly helpful that in viewing the artworks, emphasis was put on sharing group members’, rather than therapist’s, observations first. For the service user the knowledge that others in the group had similar experiences and struggles with mentalization provided credit to observations offered.

DF: If you get a professional trying to help or telling you something, you think ‘well how can you possibly understand? You don’t know what I’ve been through, you haven’t been there’ but you get somebody who’s going through the same thing saying ‘well look this helped me, this is how I see it’ or ‘yeah I do exactly the same’ and that’s quite comforting and reassuring and you take to heart more their suggestions. That really makes a difference…you’re with people with the same diagnosis who understand and who you can trust. You trust their opinion. You can see your reflection in them and they can see their reflection in you and there is this very solid connection between BPD sufferers…it’s quite unbreakable really and I don’t know if that comes from because you can

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<td>(0-90 = 10-20)</td>
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<td>Pt 3: 28.4</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Pt 4: 30.92</td>
<td>25.42</td>
</tr>
<tr>
<td>Distress Tolerance Scale</td>
<td>Pt 1: 1.25</td>
<td>1.6</td>
</tr>
<tr>
<td>(higher scores =</td>
<td>Pt 2: 2.29</td>
<td>3.49</td>
</tr>
<tr>
<td>higher DT)</td>
<td>Pt 3: 3.179</td>
<td>3.95</td>
</tr>
<tr>
<td></td>
<td>Pt 4: 2.04</td>
<td>2.83</td>
</tr>
<tr>
<td>Employment status</td>
<td>Pt 1: Unemployed</td>
<td>Nurse training</td>
</tr>
<tr>
<td>Pt 2: Unemployed</td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td>Pt 3: Unemployed</td>
<td>Volunteering</td>
<td></td>
</tr>
<tr>
<td>Pt 4: Unemployed</td>
<td>Unemployed</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions</td>
<td>Pt 1: 1 admission</td>
<td>None</td>
</tr>
<tr>
<td>(previous 18 months)</td>
<td>Pt 2: none (A&amp;E</td>
<td>Admission (post</td>
</tr>
<tr>
<td>contact)</td>
<td>Pt 3: 3 admissions</td>
<td>bereavement)</td>
</tr>
<tr>
<td></td>
<td>Pt 4: 1 admission</td>
<td>None</td>
</tr>
</tbody>
</table>

Table 1. Summary of pre- and post-treatment scores with follow-up.
see the mirroring in each other and the understanding.

Therapist models the application of inquiry, rather than pre-determined knowledge to exploration of artworks

Mentalization was supported by the therapist explicitly declaring their own need to make efforts to find out what the maker of the image was intending or feeling and thinking.

DF: The therapist is always going to be a little on the outside of that group because we were all the experts, we understood each other… If the therapist said ‘Yes I’m a qualified therapist but right now I’m not the expert, the group’s the expert and every time we meet I’m learning more about you, the illness, how it makes you feel’… I think doing something like that would be a breakthrough. I think for a therapist to say that to a group suffering from BPD that’s the most powerful thing they could ever say.

Service user to service user comments on artworks support capacity to accept multiple perspectives

When mentalizing was compromised, other people’s viewpoints on most matters were too painful or confusing to listen to. However, comments on artworks, rather than issues such as what was said or behaviour, were more acceptable on the condition that they came from other services users rather than the art therapist first. Once this began to happen more regularly, the fear of other viewpoints became more manageable.

DF: When you’re really unwell there’s no reasoning with that because everything is either black or white, there’s no in between, so for someone else with that diagnosis to say ‘actually can you not see that, that looks like that to me’… It was quite amazing to hear from people who were suffering the same and to trust them because I did trust their views because I thought they know where I’m coming from. They know what it feels like. And to hear different people saying different things about one of my pictures was probably the first time that I’d been accepting of somebody else’s view. I don’t ever remember trusting anyone, trusting anyone’s view. I just thought that everybody wanted to hurt me.

Continuous movement between art making and sharing artworks develops emotional regulation

This theme describes how the dynamic between making and sharing art can both intensify emotion by allowing feelings to flow in art making and then build structure to thinking by discussion and viewing of each other’s artworks, thereby down-regulating emotional intensity. Continuous practice of this interplay allows feelings to be perceived as safer and corresponds with the cognitive and affective mentalizing dimension in the MBT model (Allen & Fonagy, 2006).

DF: You produce that bit of art. You let the inner you, if you like, come out but as soon as you pick that piece of art up and put it on the floor that is where the change comes. That action of… it’s no longer yours if you like, it’s the action of putting it down in that circle and it is now shared. It’s now not personal, it’s not connected; it’s not just yours. It’s not something you’ve got to hide anymore. So that transition comes by putting it down and it’s out of you. It’s out… it’s like the brain suddenly switches back on, kicks in and then you’re back to the world of words.

AN: And that, correct me if I’m wrong, but I always understood that BPD sufferers have difficulty regulating their emotions, it’s all very overwhelming, and that sounds like it’s (the art making) allowed you to be in touch with your emotions, allowed you to sort of lose control. Then you come back to being more in control and putting it out there. Which is sort of like regulation… it’s like teaching you, you can take the risk to be in touch with emotion…

DF: Yeah you can take that step, you can experience those really intense… that are so scary, it’s so frightening to be able to let go if you like because you’re so frightened of losing control… The only way that a BPD sufferer can be in control of anything is, all they’ve ever been in control of is, that trauma that they’re hiding inside, or trying to hide… they haven’t been able to stop it, so they haven’t been able to control what’s going to happen to them… It’s like inside that’s the only control they’ve ever had or whether to share that or not share that. There’s no power in it anymore because you’ve shared that in the group. It’s like it’s lost its power, it’s like its lost its control.

The unresponsive therapist is iatrogenic in BPD treatment

In response to the question about what art therapists should avoid with BPD in their practice because it causes harm (iatrogenic), DF stressed that, generically, she has experienced how unresponsive, passive therapists are very damaging. For art therapists this includes not engaging with the artwork verbally, leaving long silences and muting their own reactions to artworks. She described how the service user’s
core self is in constant jeopardy through the perceived judgement by others, particularly those in authority.

DF: As a BPD sufferer you’re never had interest, you’ve never had support. You’ve probably never had anyone interested in you as a person so for a therapist to sit there and not say a word and just be so blank and blunt and cold is just making you relive anything you’ve ever been through. It’s that feeling that you’re doing something wrong, that you’re not a nice person. It just brings in so many negative emotions and feelings and you walk away with anything that you have tried to share, basically it’s like opening up a can of worms, and you walk away and again you have to deal with it by yourself and you can only do that so many times before things explode. And the risk, the risk from that coldness, of self-harm and everything else. Suicide.

AW: So sounds like a real risk issue.

DF: I get goose bumps… because I’ve been there because of my experience of that blank screen therapy, that coldness. I get quite emotional about it because of what I walked away with… That’s got to be the worst kind of therapy you could give to someone with BPD because you’re just doing to them what they’ve had all their lives. You’re not giving them any warmth or interest or making them feel like a valued member of the human race.

Art therapist’s ‘watchful, not watching’ stance during art making supports immersion in art making

This theme is closely linked to the previous concern about the need to manage the relationship between perceived unresponsive authority as a jeopardy to the core self in BPD. Art therapists need to manage a great many things while the service users are making art, such as time keeping, seeing how everyone is in the room. Perhaps because of this, or perhaps because of psychodynamic ideas, it is unusual for art therapists to make art. But when the art therapist did make art DF experienced an enhancement in her own art making. She attributed this to a lowered hierarchy which reduced the persecutory feeling of critical watching of service users as they painted.

DF: Even to just sit at the end of the room and just be staring… it’s like you can feel that, you can feel those eyes staring at you and then that just affects because you’re more busy concentrating and getting yourself in a panic.

AW: And what’s the fear?

DF: I think because you’ve always been criticised, you’ve always been told that’s not right, you’re useless. To be watched it is intrusive, it makes you nervous. You feel like you’re doing something wrong… It’s like they’re trying to read your work. It’s like they’re judging before you’ve had a chance to put down the full story, it’s too close.

AW: So how does the therapist keep the right distance but also make you feel that they are interested and that they care?

DF: I think, there was one particular art session I recall and that was fantastic and that was the one where the art therapist said ‘I’m going to sit and do some doodling, I’ll keep an eye on the time just so you know when it’s getting close to stopping’ and every time I looked round and I thought are they, because you check and I could see they’re sat doodling away and I’m quite aware that there was like the head up and glimpse around the room but there wasn’t this eyes burning into you. So there was this glimpse around the room probably quite a few times but because the therapist is doodling away concentrating, you don’t realise how many times they glimpse around the room.

AW: I wanted to ask you why is that important for BPD sufferers?

DF: You know why it’s so important, I mean on so many levels, is that there isn’t that divide. There isn’t that therapist client divide. It totally cuts that out. It’s like ‘wow they’re joining in’. There isn’t that feeling of intimidation, the feeling of doing something right or wrong, or the worry. It takes that pressure off… You’re not focusing on what the therapist is doing. You’re focusing on being relaxed to be able to produce that piece of work. If you’re too busy thinking about whether the therapist is watching you or not, that distraction just wipes out anything deep that you might produce.

Art therapy can be used as self-help

DF transferred gains and mentalization skills from art therapy to her life through deliberate art practice at home. This helped to structure her mind and to name feelings which helped her cope in stressful times.

DF: The artwork was the base, the confidence if you like to then be able to work together as a group to verbalise from that piece of artwork. In the art therapy when something was said about one of my pictures I said ‘actually that isn’t what it
means and your comment has actually really upset me and offended me’. I could never have said anything like that to anyone. The first time I displayed anger and then learning to control that. That anger is quite a normal feeling and I’m allowed to feel like that. I never knew all that, I just used to just hurt myself rather than tell somebody or display that I’m angry. So to not only display anger but control it… as a BPD sufferer you don’t have those skills, to be able to interact with others and for me all those skills the baseline was my art even to the point of my interpersonal relationships, partners and so on I used my art to work on that. I used to at home, I used to sit and if I was really stressed out about something and I couldn’t find the words I’d sit and doodle. I actually took the skill I learnt in art therapy home with me. I actually bought paint and all sorts… sometimes it would just be little diagrams and then I’d put it together what I was trying to say. I didn’t have the words so it would be little diagrams and I’d put it together what I was trying to say.

Discussion

In terms of supporting mentalization, DF’s experience elucidates some key points. DF describes the alexithymia that results from trauma and neglect yet she always came across to the treatment team as an articulate person so the strength of these difficulties can easily be missed. Art therapy seems to have particularly helped this issue in allowing a slow, manageable pace to the organisation of thoughts and feelings through art making and a stepwise process of converting these into words and then communication with others in a group discussion. The repeating oscillation between art making and art sharing as explicit mentalization appears to have increased implicit mentalization over time.

Being able to hold on to thoughts and feelings, without getting lost in other people’s issues (corresponding to the self–other dimension of mentalization) seems to be supported through a differentiated role system between other group members and the art therapist. Other group members seem to have offered more memorable and even accurate contingent mirroring capabilities and the art therapist is less able to use experience to offer comments like ‘I see what you mean’. Bateman and Fonagy (2008) often refer to the value in the therapist being explicit in their own mentalization by stating when they do not understand something the service user has said and DF’s testimony supports this. However, the therapist has a unique role to play in terms of keeping the group safe and to task. Attention needs to be paid to not holding authority in an ambiguous way. In verbal interactions this requires something which the MBT stance offers good guidance for, but it appears we need to understand more about the ambiguity involved in the therapist’s presence when art making is taking place. In this the interactive MBT stance would interfere with art making but the silence or blankness of the therapist can easily create the kind of ambiguity which feeds into a sense of persecution. Involvement in art making, or ordinary studio pottering activity seems to be helpful in lowering ambiguity in this process where the therapist needs to be available but neither intrusive nor a blank screen.

How might the results of the present study contribute to growing knowledge about art therapy and BPD day treatment? Research on service user experience of art therapy is now approaching a point where there are increasing consistencies about what is helpful. The work of Karterud and colleagues in Norway, Persons (2008) in the US and the present study share questions at a comparable level in this respect. Persons’ (2008) study requires controlling for the specific issues that may come from incarceration (reduction in boredom and enjoyment and fun) and noting the narrowness of the sample in terms of gender, age, context and art therapy approach. Also taking out service user values that might be described as outcomes (art therapy as self-help; improved ability to concentrate; pride and confidence), combining all summaries reveals an emerging picture of service user valued mechanisms in art therapy with BPD. This is formulated in Figure 1.

In Figure 1 the therapeutic stance of the art therapist and the mechanism in art therapy have been differentiated. The therapist stance appears to require two different approaches. The first approach is to be available but not intrusive on the art-making space in order not to arouse self-protective vigilance in service users. This can include generating a feeling of non-judgement and encouraging emphasis on art making while giving the sense that the group is safe because the art therapist can intervene with authority if anything anxiety-producing should arise in the group. Secondly, when the group is discussing images the therapist is more active in continuously emphasising the value of group members offering differentiated perspectives of artworks to support mentalization. The art therapist as the expert is not valued. However, their constant respect for the power and valuing of the artistic expression as it relates to the core self of the maker is essential. Clearly a passive or unresponsive therapist can have a highly negative impact. On this point, while many art therapists may not describe themselves as a blank screen,
the challenge is to assess one’s practice through having it recorded, as per MBT training, because in the clinical authors’ experience it is not possible to judge this factor subjectively. Art therapy in the current service is now routinely recorded for this purpose.

In terms of mechanisms, the uniqueness of the oscillation between self-reflection through art making and interpersonal reflection through art sharing appears to offer a graded means of supporting mentalization in art therapy. Participants seem to find helpful clarification of ownership through the anchoring of mental content in art objects which addresses self–other confusion common in BPD. At points this may reduce the emotional power in favour of thinking, corresponding to the cognitive affective dimension of mentalization. Descriptions of the way that DF structured her mind through art closely resemble those described by Huckvale and Learmonth (2009). However, it is equally important in the MBT model for service users to mentalize in the midst of high affects, described as feeling while thinking about feeling. Michaelides (2012) notes concern regarding Norwegian studies that art therapy may favour a pretend mode of mentalization, a pre-mentaliztic mode where affects are dissociated from cognition. However, it is clear from DF that art making and art sharing can involve high levels of feeling while explicitly focusing on maintaining mentalization.

It is possible that it is the stepwise process of art making and art sharing in art therapy that particularly supports mentalization in BPD. The use of the group as a resource is vital, but again because of identity diffusion, the negotiations of the relationships need to be broken down into identifiable structures that define self and other mental contents.

It is not yet possible to know if the structured art therapy group approach described in this study is more effective than others, and more work needs to be done to evaluate this. One issue may arise from the possibility shown by DF’s description that art therapy is particularly strong at exploring intra-psychic issues. This raises the question of concordant therapy where the division of labour between group as interpersonal and individual and intra-psychic may be altered by having art therapy as the group component. In other words, does art therapy reduce the balance of interpersonal interaction to intra-psychic exploration in a programme if it is the sole group? Viewing and discussing other people’s artworks is highly interactive and this is described well by DF. However, the flexible structure of the art therapy group described does seem to be important so that when interpersonal issues become so pressing they are prioritised over the exploration of artworks. Springham’s experience is that service users will then return to art-focused work in subsequent weeks and integrate the two. The question may be whether there are yet more ways that art therapists can use art to the service of mentalizing interpersonal interaction that we have not yet explored.

It seems unlikely that group analytic models of art therapy which use highly abstract group-as-a-whole meta-interpretations would support the particular stepwise approach DF valued so greatly. Continuous focus on group culture assumes that the self–other and cognitive affective dimensions of mentalization are functioning highly, which they tend not to do in BPD. As Karterud (a group analyst) and Bateman (2012) suggest, therapist interventions only at
this level add to confusion where BPD identity diffusion exists and this is borne out by research into BPD drop-out experience in group analysis (Hummelen, Wilberg, & Karterud, 2007). In describing MBT groups, in comparison, Karterud and Bateman (2012) state that profound group-as-a-whole interpretations are rare as MBT does not seek to achieve psychotherapy through group process. ‘Relative to group analysis the MBT approach involves frequent and longer sequences of exploration of individual patients’ perception of interaction with others’ (Karterud & Bateman, 2012, p. 90). In art therapy these sequences become similarly elongated through the focus on art making and art sharing. DF summarises how a stepwise art therapy approach contributed to her treatment:

I’d use the art sessions to begin a sentence or the first paragraph of what I wanted to say. If art therapy hadn’t been included in that programme I probably wouldn’t have gone so deeply into anything and probably a lot of it I would never have shared with anyone because it would have meant sitting face to face with the therapist, or with the group, and having to find those words to start off. But, because the art opened the door, I could then continue to discuss that in the group work, in my one to ones. It was the first step. To be honest with you it was probably the first ten steps.

The MBT therapist needs to be highly active in supporting these steps and in so doing the MBT group model departs radically from the Foulkesian doctrine of ‘leave it to the group’. Critics, such as Bhurruth (2004) suggest that such a high level of therapist activity leads to service user dependency in the group. Karterud and Bateman (2012, p. 90) counter that dependency is not determined by ‘…therapist activity or passivity but the therapist signalling implicitly or explicitly a sense that the therapist has some sort of privileged access to the unconscious of the individual’. In this, the not knowing but trying to find out stance of the therapist, showing that mentalization is hard but common to everyone, takes precedence.

In exploring group interaction it is important that art therapists avoid doctrinaire adherence to drawing on the available models of art therapy groups. Group analytic models have been highly prevalent in the professional literature and in training models. But for all that influence, Patterson, Crawford, Ainsworth and Waller (2011) show that art therapists have few descriptions to draw on for what they do in practice. Terms such as directive or non-directive lack specificity of therapist approach to be useful. Clearer descriptions of art therapy, linking therapeutic action to a rationale for addressing condition-specific factors, are needed.

Summary

In the present study, art therapy contributed to an effective programme for BPD sufferers. The outcomes resemble MBT outcome studies (Bateman & Fonagy, 2001a, 2001b, 2008, 2009; Franks & Whitaker, 2007; Karterud & Pederson, 2004; Karterud & Urnes, 2004) in day treatment, adding to evidence that art therapy should be a part of any effective treatment for BPD. The evaluations of the pilot MBT service presented here have been used to design the more permanent MBT services comprising weekly individual verbal sessions and an art therapy group, mirroring the programme outlines by Franks and Whitaker (2007).

How art therapy contributes has been less understood but service user research in the present study and those by Johns and Karterud (2004) and Persons (2008) has played an important role in elucidating how the process of oscillation between art making and art sharing helps to make mentalization manageable without loss of affect.

A strength of the present study is that it combines a range of both quantitative and qualitative methods within a naturalistic practice setting. The authors feel the service user research methodology employed here was safe and effective for in-depth exploration of lived experience by repeating a clearly defined research methodology developed in Woods and Springham (2011). The case study is explored in depth within a co-production of knowledge framework from the start from service user and provider perspectives. The process resulted in a description of mechanism in art therapy that supports mentalization. A limitation of the outcome data for the programme as a whole is that it represents a small data set and evaluation was without a control group. Also the qualitative element is represented by a single case. This research would be greatly strengthened by replication from other art therapists in comparable settings. In so doing, the fuller practice descriptions needed for evaluation of effectiveness of art therapy might be constructed with increased validity.

The lived experience of art therapy has clear value when it is explored in a research rather than clinical context alone. Service user testimony, as DF shows us, is powerful in reminding professionals, particularly when the interpersonal
difficulties entailed in BPD can seem like deliberate challenges to therapy, that the relationship choices are drawn from the limited templates resulting from childhoods full of very real trauma and neglect. Hearing lived experience of progress in MBT can inform art therapists so that they can legitimately approach therapy with a respect for what BPD sufferers have already survived and an optimism about what can be achieved with therapy that addresses condition-specific factors.

References


Biographical details

Neil Springham trained in art therapy in 1988 and has worked in adult mental health, addictions and now specialises in personality disorder treatment. He was a course leader at the Unit of Psychotherapeutic Studies, Goldsmiths College, co-founded the Art Therapy Practice Research Network and was chair of BAAT from 2005–2010. He is currently a consultant art therapist at Oxleas NHS Foundation Trust where he founded ResearchNet, a service user and provider collaboration which develops co-produced research in mental health. He has published and lectured internationally on a wide range of issues in art therapy.

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Diane Findlay left school early with no qualifications, to raise her younger siblings. At 17 years old she started her own family and went on to have three boys. Later in life she wanted a career and attended college to achieve qualifications which enabled her to gain employment in a mainstream primary school teaching special needs children with severe behavioural difficulties. She eventually had to take years out of employment to devote time to her own special needs son. Now that he is at residential college she has focused on her career, working as a health care assistant on an inpatient ward at Oxleas NHS Foundation Trust. Her goal is to become a qualified psychiatric nurse in the future.

Ami Woods trained in Creative Arts and has worked full time as an art therapist with adults with learning disabilities and autistic spectrum disorder since 2005. She is a founder member of ResearchNet and her interests are in service user-led research as an evidence base for practice innovations in art therapy. She co-facilitates a ResearchNet group for adults with learning disabilities and autistic spectrum disorder. She co-ran a gallery-based art group for staff and service users with the artist Kim Noble who has dissociative identity disorder. She is an elected BAAT Council Member and currently works in Adult Learning Disability Services in the London Borough of Merton.

Jane Harris is a consultant clinical psychologist who is currently head of complex needs and recovery psychology at Oxleas NHS Foundation Trust. She completed her training in 1988 and for six years chaired the South East Thames Adult Mental Health Special Interest Group. For the last 10 years she has worked within complex needs services and has taken a lead in developing specialist mentalization-based therapy services for individuals diagnosed with personality disorder.