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Notes in Tune: Arts-based Therapy (ABT) at Schizophrenia Awareness Association in Pune, India

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Abstract

The use of the arts as therapy is a paradox in India. Despite a long tradition of healing rituals and practices, there is barely any arts-based model consistent used for contemporary mental health needs and settings. With the aim of introducing and investigating use of ABT (Arts-based Therapy), regular sessions were conducted at Schizophrenia Awareness Association's day-care centre in Pune, India over a period of eighteen months. The group was heterogeneous, with varied severity of symptoms of schizophrenia. With therapeutic goals of present moment attention and interpersonal engagement, participant responses were recorded through PANSS (Positive and Negative Syndrome Scale), a Rating Scale, a Checklist and qualitative observations. All data sources show definite though variable response to ABT. PANSS scores noted a decline in negative symptoms and general psychopathology, especially the sub-items marked 'severe' show a clear trend of reduction. The correlations between PANSS, Rating Scale and Checklist are notable though not statistically significant. The qualitative data uncovers the nuances of the process. Despite a small sample size, the study points in the direction of use of ABT in mental health settings, especially within the Indian context.

Keywords: ABT, Arts-based Therapy, Schizophrenia in India, arts in mental health, PANSS

Introduction:

Arts-based Therapy (ABT) sessions were conducted at the day-care centre of Schizophrenia Awareness Association (SAA) in Pune between September 2013 and April 2015 for a group of 14 participants. Of that, data was collated for 7 persons in the age range of 23 to 60 years, all diagnosed with Schizophrenia. The aim of these sessions was to reduce symptom severity, with the therapeutic goals of building present moment attention and interpersonal engagement.

ABT is evidence-based use of art forms to accomplish individualized goals within a therapeutic relationship. ABT derives theoretical base from a systematic training in Subtle Energy Guide (Pillai-Balsara 2013) drawn from the Indian Mind Traditions, notably Buddhist Psychology and Ethics further interfaced with information from neuroscience and developmental psychology (Balsara et al 2013). The practice of ABT is based on use of multi-arts modality to address the therapeutic goals. Within this framework interventions are designed as per the specific needs of each client.

Schizophrenia causes a number of fundamental disturbances and distortions in cognition, perception and behavior of a person. There are an estimated four million people diagnosed with schizophrenia in India, with different degrees of impact on some 25 million family members (WHO 2010). Within India, for those who reach out for help, the first line of treatment is mostly psychotropic medication and institutionalization. Even after medication clients experience persisting symptoms, side effects and need for care and capacity building. Additionally, Long term disabling consequences of lost opportunities, stigma, residual symptoms, and medication side effects are also well documented (Spearing 1999, WHO 2001). The SAA day-care centre is thus a host to a growing number of persons seeking relief and care.

Historically within India, like in other native cultures, spirituality, rituals, shamanic rites were used in conjunction with traditional healing and medical systems (Davar and Lohokare 2009, Evers 2008, Simoes 2002). In post-independence in India period 'the need to develop services beyond mental health institutions' (Kumar 2004, p. 174) was recognized, which called for a distinctive approach. However, insights were not followed up with systematic actions and the ground reality thus has been the degeneration of traditional understanding and treatment modalities on the one hand and inadequacy of mental health care institutions and trained personnel in face of high need (Thirunavukarasu and Thirunavukarasu 2010) on the other. A middle way that combines the strengths of traditional healing with contemporary specifics has been mostly unexplored. Interestingly, in what is termed as the 'outcomes paradox', markedly better outcome for schizophrenia patients in India has been reported in WHO's long-term studies (Jablensky and Sartorius 2008, Padma 2014). The better results are attributed to socio-cultural factors, like family, community and local conditions. WHO's recent programmes in India also clearly report that in the Indian context it is important to have 'innovative programmes' that are 'strongly anchored in the community' and are 'family-based and family-oriented' (WHO 2010, p. 3). Approaches that recognize the differences and nuances of social, cultural and economic variations are extremely important.

In this context ABT strives to make way. In ABT, the difference between the person labeled with mental illness and the one without is considered one of degree and intensity of suffering, and its consequent impact on functioning in life. Multiple realities and their coexistence are acknowledged, and the ability of a person to navigate skillfully and meaningfully between different levels of experiences and existence is significant.

The arts are uniquely situated as they experientially create alternative realities, yet the boundaries between them are held in awareness. ABT offers a range of artistic tools — a rich language of music, rhythm, songs, stories, drama, visual art methods — and their numerous combinations. The artistic activities bring the attention onto colours, images, stories, rhythms, musical phrases. Metaphors make things manageable, and possible to understand. Sharing, giving-receiving in a co-creative spirit happens seamlessly in a group. Here, the emphasis is on the process, the artistic outcomes are secondary and playfulness ensures that there is no stress, no pressure. The focus is on the 'capability' of the person no matter how small or insignificant the contribution may seem (Chabukswar and Daniel 2009).

The artistic process also presents a complementary counterpoint to mere verbal engagement in therapy – that experience can transcend conceptual barriers to 'reach' a person. The creative interactions record nuances of the therapeutic process that otherwise cannot be documented. ABT thus navigates towards symptom relief, supplementing the vital institutional agenda in the rehabilitative process.

ABT projects in adult mental health from 2006 to 2013 from WCCL Foundation's archives were reviewed (Chabukswar 2013) to note case studies of 129 participants in the age range of 15 to 79 years, all diagnosed with mental health disturbances (depression, schizophrenia, emotional distress, trauma) all engaged with ABT for a minimum period of 6 months. Client-specific individualized therapeutic goals were worked on and overall positive therapeutic outcomes are noted (Table 1). These projects used varied assessment tools, including standardized assessments tools, checklists and observation formats. However, qualitative data (interviews, structured and unstructured feedback, observations) yield more meaningful data. Many projects note the limitations of time, tools and methods and lack of availability or reliability of standardized assessment tools given the specific conditions of work in India.

Table 1: ABT projects in adult mental health (2006 - 2013):

Therapeutic outcomes
• Better mood and affect than before
• Better comprehension of tasks
• Clients opening up: showing interest and initiative
• Higher confidence and self-efficacy
• Improved communication in the group
• Improved speech through storytelling and singing
• Improvement in perception and cognition
• Increase in attention span
• Increase in expression of emotions
• More effective symptom management
• Overall improvement in somatic memory
• Sensory integration

This paper explores the trajectory of a particular ABT intervention at SAA in Pune, India. How engagement with ABT challenged the symptoms that resulted in a significant decrease in severity, and reflected a decline in negative symptoms and general psychopathology measured on PANSS (Positive and Negative Syndrome Scale). The observations from PANSS further demonstrate a positive correlation with ABT Practitioner's Rating Scale as well as the Checklist on attention and interpersonal engagement. This is further corroborated by qualitative observations made by an independent third person and the ABT Practitioner. The outcomes are significant enough to make a case for ABT as a friendly and accessible therapy that complements the tools for symptom relief and rehabilitation in Schizophrenia.

MATERIALS AND METHODS

The setting and the group

Schizophrenia Awareness Association's (SAA) Swanand Punarvasan Kendra is a day-care centre for people with mental illness. At the centre, such a person comes to an environment that is meant to provide a structure and tools for day-to-day functioning that can support the process of recovery. Activities like yoga, dance, cooking, computer training and vocational activities like making lamps, paper bags etc. are done at the centre. Therapeutic activities include counseling, self-help tools, parents' support group and the newly introduced, ABT.

14 participants attended the ABT sessions, of which data was collated for 7 participants who were part of the group for the entire 18 months. Individualized therapeutic goals for each participant were set (Table 2) and common therapeutic goals were identified as 'keeping attention here and now' for reality contact and increasing 'interpersonal engagement' for reduction in isolation.

Table 2: ABT Group background, symptoms and therapeutic goals

Participant (age in 2013)	**Background**	**Symptoms in 2013**	**Therapeutic Goals**
Avinash Male, age 50	Disorganized schizophrenia. Onset 1985. ECTs and medication. Tobacco addiction and diabetes.	No hygiene, auditory and visual hallucinations. Sudden outburst of laughing and muttering. No participation, no interaction	Make reality contact by keeping attention in the 'here and now' Being active/participative in ABT.
Arti Female, age 60	Paranoid Schizophrenia. Onset 1995. Given ECTs and medication.	Lack of concentration, confidence. Irritation and suicidal thoughts. Mood swings, irrelevant talk, poor self-care and hygiene. Persecutory delusions, OCD about food and touching.	Make present reality contact by being active in ABT Developing strength to feel worthy of living
Madhu Female, age 32	Schizophrenia. Sudden onset in 2010. Obsessive, irritation, poor social interaction. Borderline IQ.	Self-talk, auditory and visual hallucinations, sometimes violent. Guilt about past violent behaviour. Sometimes laughing uncontrollably and intense anger at times.	Control and express emotions appropriately Building interpersonal skills and interactions
Nikash Male, age 23	Intellectual disability and Psychosis. Onset 1998.	Catatonic features i.e. stiff muscles, long reaction time, poor fine-motor skills. Poor social interaction, barely audible. Delusions and OCD about eating, touching, poor hygiene as a result. Flat affect.	Improvement in gross and fine motor coordination Being attentive and audible thereby expressing himself clearly in the ABT sessions
Pratiksha Female, age 36	Paranoid Schizophrenia, onset 2002. On medication.	Tactile hallucinations, persecutory delusions. Poor hygiene (no bathing). No interaction at all.	Attention to the here and now Improvement in speech (volume and audibility) Meaningful interaction with others
Reena	Paranoid Schizophrenia,	Visual and auditory	Reduction in tension and

Female, age 41	onset 1991. ECT (once) & medication.	hallucinations, severe persecutory delusion. Not much interaction with others, anxious about her future. Has insight.	to be at ease Ease in interactions
Vikas Male, age 33	Epilepsy since age of 6 years, calcium deficiency and low IQ. Onset of schizophrenia in 2005.	Bursts of uncontrolled laughing, crying, swearing. Heavy (91 kg), very sleepy all the time. Repeating same thing over and over. Very little attention span.	To pay attention, to be present Increase span of attention on the here and now Developing some ability to interact with others in a specific, meaningful way

[1] All names changed

All except one participant showed direct signs of visual, tactile hallucinations. Four of them had severe symptoms of social withdrawal, were almost non-verbal, showing no interest in any activity or interaction. To varying extent, all were locked or engaged in alternative reality, lacking external reality contact. Three participants were verbal—one of them apprehensive of interactions due to persecutory delusions and another hyper-interactive, demanding but with limited verbal range. The group was diverse in severity of symptoms and the duration since onset of schizophrenia varied between 4 to 23 years when the study commenced.

Design and data sources

The premise for the study was to use ABT as an adjunct to reduce symptom severity. A total of 51 weeks of ABT sessions were spread out from September 2013 to April 2015, equally divided between the Pilot phase (12 weeks) followed by 3 phases of intervention (13 weeks each).

PANSS is a medical scale used to measure symptom severity; a 30-item, 7-point rating instrument that gives representation of positive and negative symptoms at increasing levels of psychopathology, where 1 = absent, and 7 = extreme (PANSS Institute, Kay et al 1987). The PANSS is widely used for 'strong psychometric properties in terms of reliability, validity and sensitivity' (Leucht et al 2005) and was selected for its accessibility and familiarity. SAA clinicians rated PANSS for participants once at the beginning of the ABT pilot project in September 2013 (AS1) and 4 more times during the next phases (AS2 – AS5), at an interval of 3 to 6 months.

Studies confirm that 'most PANSS items are either very good or good at assessing the overall severity, particularly items within the Negative Symptom subscale' (Santor et al. 2007). The criterion of 'schizophrenia remission', where a score of mild or less (less than 3) in case of the 8 selected criteria in PANSS for a minimum period of 6 months indicates remission (Andreasen et al. 2005, p. 447) have been recently in discussion. 'Remission is a new research outcome indicating wellness' (Yeomans et al. 2010, p. 86), and thus these sub-items have been analyzed separately. The clinicians also rated a Checklist of 8 items on 'Attention: here and now' and 'Interpersonal Engagement'. Higher scores under Checklist reflect better attention and interpersonal engagement.

A 5-point Rating Scale was modified from WCCL Foundation's earlier study (Daniel et al 2013b) and was rated 4 times during the intervention period by the ABT Practitioner. It is a holistic scale that records responses and behaviours in the sub-domains of Body, Attention, Group Interaction, Cognitive, Narrative Capability, Expressive Capability. The rating statements are positive indicators of well-being and, higher scores reflect better response. Qualitative Observations of responses and interactions within every ABT session were also recorded by the ABT Practitioner and by neutral observers.

Table 3: ABT Techniques for Attention

· Singing or prayers at the beginning and closure; memorizing them
· Name ritual: acknowledging and greeting self and others in a particular pattern
· Stimulation of attention through observations of objects e.g. bell (auditory), incense (visual, olfactory); of people e.g. clothes, colours, styles; of weather and seasons etc.
· Short sections of concentration on an object: e.g. focus on trees, on breath
· Ritual to be light: letting go and mentally/physically throwing away unwanted materials, thoughts and distractions
· Mindfulness ritual for 'coming back' here and now: reminders accepted from group and facilitator for this
· Sharing stories: listening to stories, recalling stories, narrating stories (participants and facilitator)
· Drawing with crayons: free drawing and colouring, theme based drawings, occasion specific drawings
· Breathing and relaxation

Table 4: ABT Techniques for Attention & Interaction

· Ball throw and ball juggle with partners, triads and the entire group
· Vocal warm-ups and voice exercises
· Physical warm-up and movement with music
· Games and group-work e.g. working with partners on embodiment activities, games structured around movement, attention and interaction
· Dramatic improvisations: Making interactive theme based scenarios and developing them, e.g. at the seashore, waking up and the beginning of the day, guests at school, visiting a restaurant etc.
· Narratives and Images: Verbal / physical work with images – identifying images, expressing them. Joining images into narratives or stories, using toys, clay, puppets to create

narratives

· Enactments: Scenes from a story enacted, playing with roles and dialogue

· Song-circles: Recalling series of songs on a particular theme and singing them together in group, e.g. season, journey, morning, nationalism, fearlessness, picnic songs, A. R. Rahman songs, light, lightness etc.

· Exploring variety of percussions, playing them with songs

· Planning and visualising: Listing activities planned for an ideal day, articulating personal intent for the year

· Creative conversations: Discussions about picnics and travels, about pets and animals, about friends and friendships

· Person in focus: Exploring metaohors for each group member's special qualities, observations from the group about 'what can each one improve' – done with extensive process and permission from each member

Apart from client-specific therapeutic goals, 'key concepts'—non-measurable positive aspiration for the participant group—are an important aspect of ABT intervention. At SAA, the quality of 'generosity' was the key concept, where the idea of 'giving' and 'sharing' was woven as a subtext for all sessions. This key concept is a vital step in mind training; it is also a logical progression towards harmonious, compassionate and successful social interaction. This key intent was integrated in all phases of intervention, and regular specific exercises were designed for it (table 5).

Table 5: Exercises based on 'Key Concept'

· *Acknowledgement*: Thanking every time someone does something for us; acknowledging others for their presence. Thanking everyone with eye contact at the closure of each session

· *Awareness*: List of who gives us what? what in oneself troubles others? what gives joy to others? Discussing significance of small acts

· *Aspiration* (Giving): If we have the means or imagination for it - what will you give to those in need? Imagination of how much of food water shelter and goodies can one give and keep on giving, to whom all? What and how much can I give to the group members here? Articulating creatively (even through songs) what it means to 'want good for others'

· *Action:* Making an intent for oneself, making greeting cards for loved ones and giving it to them, making action plan for days or week and following that plan

RESULTS

Overall, there is remarkable difference between the scores on 'negative' and 'general pathology' sub-scales when comparing September 2013 and March 2015 scores in PANSS. The correlations between PANSS, the Checklist and Rating Scale are notable, however the changes in the scores in the Rating Scale and Checklist would not be considered statistically significant. The statistical findings should be interpreted in conjunction with the qualitative

observations and limitations, discussed later.

Mean Differences

T-tests were conducted to check if participants did indeed show significant changes in symptom severity and wellbeing after having participated in different phases of ABT from September 2013 to April 2015. The changes on the ABT Rating Scale and the Checklist scores cannot be considered statistically significant, but there was a substantial difference seen on the scores for the PANSS. While the mean score in September 2013 was 90.428 (SD = 6.7), the mean score in March 2015 was 65.428 (SD = 18.78). In spite of unequal variance, this difference was found to be statistically significant in favour of improved health [$t(7.504) = 3.316$; $p < 0.05$].

This difference was further explored to reveal not all aspects of PANSS showed the same amount of change. While overall scores showed a distinct move towards better mental health, it was only the scores for negative symptoms and general pathology that showed a statistically significant improvement. While the group experienced a mean score of 28.57 (SD = 4.649) on negative symptoms in September 2013, this mean score had come to 18.143 (SD = 8.63) by March 2015. Again, this difference achieved statistical significance in spite of unequal variance [$t(9.213) = 2.815$; $p<0.05$]. Similarly, while the group showed an average score of 44.285 (SD = 3.98) on general pathology in September 2013, the mean score on March 2015 was 33 (SD = 10.01). This reduction in score was statistically significant although the variance was very different [$t(7.856) = 2.77$; $p<0.05$]. Both, the scores for positive symptoms and the composite score show a distinct improvement across the group; but these differences did not reach accepted levels of statistical significance.

There is a serious increase in the variance in scores between the initial and final testing. This suggests wide variation in the performance of the participants on different scales and test items towards the end of the testing period. Since there was far lesser variability in scores at the beginning of the data collection process, it could indicate that some participants benefitted from ABT more than others.

Correlations

Correlations were computed across different instruments used to collect data. It was seen that all the sub-scores on the four subscales of ABT Rating Scale significantly correlate to each other; suggesting there are some common factors that govern the extent to which participants demonstrate bodily awareness, interaction with the group, cognitive ability and narrative and expressive capacity.

All the sub-scores on the Rating Scale significantly correlate to the Attention sub-score on the Checklist. Logically this makes sense, since attention to the here and now is an important factor associated with—awareness of one's own body, the ability to interact with each other, and with expressing thoughts and ideas, and explaining them to others. On the other hand, only the group interaction score in the Rating Scale seems to share a significant relationship with Interpersonal Engagement sub-score from the Checklist - which is the only sub-score that it shares a meaning with. It is rather intuitive that better interpersonal interaction would be associated with enhanced engagement within the group.

From among the ABT Rating Scale sub-scores, PANSS as a whole reflects negative correlation with bodily awareness and narrative capacity. The relationship with group interaction and cognitive ability sub-scales—while strong and in the expected direction—fell just short of statistical significance. As participants do better on Rating Scale items, they report fewer and lower intensity of clinical symptoms in PANSS. This finding is reassuring, since it suggests as participants start having fewer issues, they also start experiencing improved wellbeing.

Although, as expected, while the values of the correlations are strong and negative, PANSS did not share statistically significant relationships with either of the Checklist sub-scale. This suggests that better performance on the Checklist is associated with somewhat fewer clinical symptoms; and the relationship may need to be explored with a larger

group to make sense of it.

What makes these trends heartening is they represent an interesting shift from the type of relationships seen among scores at the beginning of the testing period. Before ABT was introduced, all sub-scores on the Rating Scale and on the Checklist shared significant positive relationships; but none of these scores shared either a significant or a strong relationship with PANSS. But as some of the participants started showing improvements, these relationships started to become evident. Self-awareness and expression in particular, seem to improve as symptoms go down. To a lesser degree, attention, aspects of social interaction and cognitive process also seem to improve when clinical symptoms are lower.

PANSS Remission Items

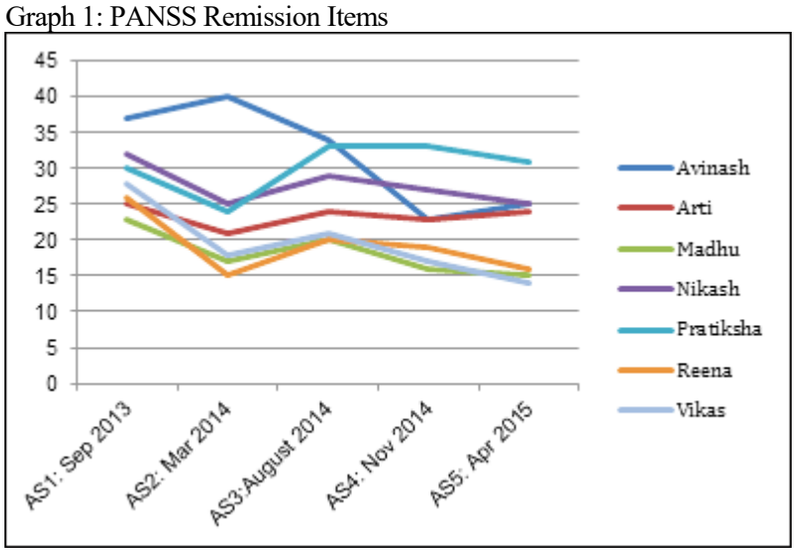
When the scores on the eight remission items are looked at specifically, out of the 7 participants 5 show reduction in symptom intensity, while 2 did not benefit across the testing sessions. For some participants in particular sub-items the initial scores were low and continue to stay low. For others, there is reduction in scores for some items, but not in others.

Table 6: PANSS scores on 8 Remission Items

	AS1: Sep 2013	**AS2: Mar 2014**	**AS3:August 2014**	**AS4: Nov 2014**	**AS5: Apr 2015**
Avinash	37	40	34	23	25
Arti	25	21	24	23	24
Madhu	23	17	20	16	15
Nikash	32	25	29	27	25
Pratiksha	30	24	33	33	31
Reena	26	15	20	19	16
Vikas	28	18	21	17	14

The chart for the same data

Graph 1: PANSS Remission Items



PANSS Severe Items

The impact of ABT becomes a little clearer when we identify items in the PANSS that had severe rating in September 2013, and isolate them from the others. For some participants, there were many such items, while others had a severe score on only a handful of items. The scores for all these items were tracked separately across different data collection sessions.

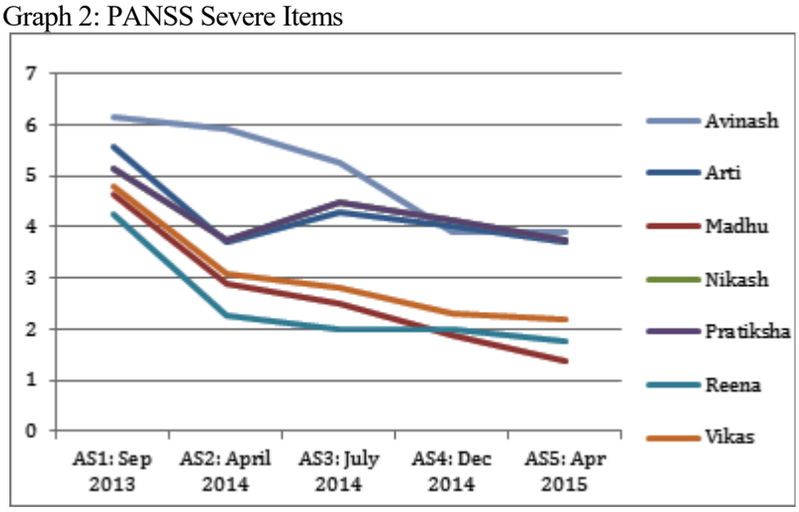
For ease in comparison, the scores across all tracked items were aggregated for every participant during each data collection session. This was done so that the number of items being tracked would not confound the trends being explored. As observed from Table 7, there is a distinct trend towards severity reduction as time progresses for most participants.

Table 7: Average Scores on PANSS Severe Items

	AS1: Sep 2013	**AS2: April 2014**	**AS3: July 2014**	**AS4: Dec 2014**	**AS5: Apr 2015**
Avinash	6.167	5.92	5.25	3.92	3.92
Arti	5.57	3.71	4.28	4	3.71
Madhu	4.625	2.875	2.5	1.875	1.375
Nikash	5.125	3.75	4.5	4.125	3.75
Pratiksha	5.33	3.67	3.89	3.56	3.67
Reena	4.25	2.25	2	2	1.75
Vikas	4.8	3.1	2.8	2.3	2.2

This trend is better understood through the following graph.

Graph 2: PANSS Severe Items



The observations by neutral observers and ABT Practitioner correlate with the statistical data. They reflect reduced symptomatic behaviours and an increase in the instances of attentive engagement with the 'here and now' and others. Qualitative notes for two participants are included here.

Notes for Avinash

Diagnosed with disorganized schizophrenia in 1985, and living with it the longest from within the group. Avinash was of 50 years of age when ABT started. He is married and has a daughter. In the initial period, Avinash never established eye contact or participated in any activity, and never responded verbally to any suggestions or instructions. He did not maintain hygiene, was lost in talking and laughing, engaged with auditory and visual hallucinations. His past treatment included ECTs at some point. Therapeutic goals for Avinash were set as 'bringing attention to here and now' and 'being participative in ABT sessions'.

Initially during the sessions, Avinash would be 'pacing about, mumbling, abruptly leaving the room'. These observations recur through the entire first phase. It took 6 months to make the first eye contact, first physical participation and first coherent response within the session. Another 6 months later 'leaving or pacing' was observed only once during the entire third cycle. ABT invited his attention and Avinash began to interact, sample this: 'Sitting in his typical 'head bowed down' position and mumbling, nodding, hallucinating. The facilitator called him out to join-in. He shook his head and said 'no'. The facilitator persuaded, he looked-up, said yes. The facilitator sat in front of him and threw a ball at him, he reached out for the ball. A game of catch-throw ensued'. Another ball was added, two balls simultaneously, 'Avinash smiled as he juggled the balls' notes the observer. Subsequent sessions build on this further 'Avinash played ball juggle with Pratiksha - he was alert, catching all the time, without dropping ball. He then invited the facilitator (who was on the side) to join-in. They played ball juggle, 3 persons, 3 balls simultaneously'. Eventually this moves on to spontaneous interaction in another session, 'played a long rally of balloon pass with the facilitator. Avinash, smiling gave a hi-five to the facilitator, then played in a triad with Nikash too'.

Avinash started participating in the ritual of greeting each person by name and making eye contact without being prompted to do so. It is also noted that he reminded Nikash or Pratiksha to 'fold hands and greet'! His reluctance continued, like a habitual response, but it gave way with a bit of insistence. There was some newfound inquisitiveness. Once as the facilitator arrived Avinash 'waved and smiled' and started a conversation of his own accord, asking the facilitator questions. In the session during a concentration exercise, he added his own observations to the group's, 'I see bluish colour in the smoke of incense, the incense stick is brown'. He was coherent in speech

and neater than before. Observations recur to note that he 'participated in prayer without prompt and did voice exercises on prompt' or that he 'smiled in response to a joke, not hallucinatory smile'. In one of the activities making drawings and intent for the year, Avinash declared 'I will participate in activities here!'

These notes coincide with PANSS scores—the sub-scale of 8 remission items show a notable decline in symptom severity (Table 5, Graph 1). While the symptom severity lessens, the Attention and Interpersonal Engagement Checklist indicates marginal increase in average scores. The Rating Scale also shows a gradual positive incline in the overall scores, indicating a tilt towards wellness. Consistent bettering in all scores coincides with period when Avinash did not miss a single ABT session (AR1 and AR2). There is a marginal fall in the last phase (AR3), during this period he had missed almost 40% of the sessions. The effect of this absence was noted in observations as well, 'Avinash came today after 4 weeks. Said hello, smiled, but seemed inside his own world again'. This suggests a connection between regularity in ABT sessions and response level, and thereby the therapeutic effect.

During one exercise in which each person named their own or others' 'extraordinary quality', the facilitator turned to Avinash and teasingly asked 'as you will not speak, may be we should assign you something - a high quality stubbornness….shall we say?' He promptly replied 'no' and pointed to his ears, tapped on them and said, 'listening, listening'. Everyone in the group saw and heard this, and laughed and agreed. In another session he explained a drawing meaningfully 'this is a lotus, and it grows out of the mud'. In these instances, his worlds, his tune and ours came close together.

Notes for Madhu

Madhu, age 32, experienced a sudden onset of obsessive thoughts and hallucinations 4 years earlier. She is the most recently diagnosed within the group. Her IQ was recorded as 'borderline'. Her parents are supportive, but she felt tremendous guilt for past violent outbursts towards them. She sometimes laughed uncontrollably and experienced sharp intense anger. She would mumble to herself, give instructions to herself, and suddenly retreat into her shell.

The therapeutic goals for Madhu were set as 'appropriate emotional expression' and 'building interpersonal skills'. She was enthusiastic in the ABT sessions right from the outset and enjoyed movement exercises, singing songs, drawing, and other artistic exercises. Early on, the observer notes that she was 'attentive herself, and urging others to pay attention as well'. Yet suddenly she would be adrift, 'mumbling, lost. Took time to orient herself'. During one of the ABT sessions, she said 'am feeling very angry, like hitting someone'. This turned into an activity of 'imaginary boxing' game, moved on to body movements with music. The ABT sessions opened opportunities to express what was difficult otherwise. During an improvisation exercise around the theme of 'guests', Madhu said, 'there's a presence…. she competes with me all the time. Whenever I want to do anything, the other one comes and takes space. She does all that I would like to do; I am upset because of this'. She spoke 'haltingly, grappling for words', records the observer. A conversation about being alert, and about handling wanted and unwanted guests ensued. In another session, with a drawing, she managed to define things that she wanted to throw away forever in a black hole: she explained them as her 'moods, negative thoughts, anger' and the surrounding chaotic lines as 'fear and difficulty around me'. In ABT, the art-loving Madhu seemed to find a way to clarify and express her experience.

Madhu was sincere and she took to heart the various artistic rituals created to keep alert, to say 'stop' to obsessions and telling the hallucinatory presence to 'go'. She reported 'I have been using the stop and go, especially when I get very angry, and it was useful.' She was always enthusiastic to narrate stories or enact them. Once, as she started telling one story of Birbal and his khichdi, mix of rice and pulses, she mixed the narrative with another story, and continued, and further mixed it up with yet another story. Everyone just listened. At the end of her narrative she quipped, 'I made khichdi (mix-up) of 3 different stories together!'

Another time the group was working with a Marathi folktale. Apparently it is a children's tale, with rhyme and chants, about an old woman who is accosted by predators on her journey to her daughter's place. She is going there to

rest and recover her health. On her way back, she gives a slip to the predators by hiding inside a pumpkin. Madhu was the first one in the group to identify it as 'a children's tale heard in childhood!'. Others caught on and memories of the tale were discussed. Madhu added her reflections 'I think it's a story about protection, when we are not well, to take care.' This was appreciated by the group and the facilitator. She spontaneously substituted the story's rhyme with a ditty of her own 'chal re mana aplya gava' (O mind, let's go to our true home). This was applauded by all. As the discussion went round from person to person, Madhu came back with another understanding, 'I think there is no pumpkin. When the old woman recovers from illness, she is a changed person. She is well-fed and her health is restored, so she has become large, like the pumpkin.' On this, much laughter ensued, but the myriad meanings were not lost.

Here was someone, riding on the back of traditional tale, uncovering an insight. The PANSS scores corroborate these shifts—in the sub-scale of 8 remission items, all items except one show stable low or consistent decline to below severity scores. PANSS sub-items that were severe for Madhu in September 2013, all without exception, declined, showing remission sustained for period of 6 months in subsequent assessments (Table 6). The Checklist and Rating Scale correlate, where the latter shows a positive jump in expressive capability and attention.

Many recurring observations note how enthusiastically Madhu sang songs and how they changed from sharp, shaky notes to more measured and accurate expression. 'She expressed happiness in dance movement, was alert in ball throw and made meanings in the stories' the observations note. Commenting on the African folktale of the Greedy Hyena and the Great Tree, she had the last word in the group 'the thoughts that trouble, like the hyena in the story, must be deleted forever'.

DISCUSSION

Limitations

Statistical techniques were employed in a bid to analyze the objective trends seen among participant scores. Although the findings suggest changes, it is necessary to interpret them in context. The sample size was extremely limited (n = 7); and the data collection for PANSS in different stages was done by 2 different clinicians - a factor that may have confounded the more subjective scores. It is important to remember that the group was heterogeneous to begin with, many participants were also on medication, and that this data does not reflect any special circumstances that could have confounded the scores at any of the testing sessions. The researchers accept that these factors reduce the value of the statistical findings; but nevertheless we have chosen to explore said findings as one part of a larger analysis. The study is also constrained by limitations of time and resources, and lack of availability of a matching control group.

Reflections

This project has been one of its kind long-term interventions within India. It has explored the capacity of the artistic within the Indian paradigm to be helpful to those with mental health issues in an institutional setting. ABT is uniquely situated; addressing personalized therapeutic needs, within the context of local patterns and possibilities of healing and rehabilitation. It works in complementation (not confrontation) with other therapeutic work that may be going on.

Given that ABT engages the participant in artistic and expressive modes, it is almost intuitive that it has had a remarkable change in negative symptoms and general psychopathology as measured on PANSS. Yet, studying carefully each participant's scores and notes, it is clear that actually for this particular group at SAA, the maximum 'severe' items were on the negative scale followed by general psychopathology in PANSS, and those are being addressed through ABT. ABT systematically focused on, and therefore dovetailed with the therapeutic needs of the participants. We can therefore safely assert that ABT positively impacts the 'therapeutic needs' of a participant. This is supported by initial observations of a second ongoing group of participants at SAA for a period of 6 months in 2015 that reported reduction in severity despite dissimilar symptoms than the earlier group.

The unique methods and approach of ABT create an artistic atmosphere. The sessions are fun, there is ease and laughter, and it relaxes the participants. ABT works with what one 'can' do, what is intact. A reassuring contact with artistic rituals, the known and unknown music, movements and paintings is possible. Participants can choose to relate or retreat as much as they want. The individual's safeguard's are protected, but prodded playfully. It was not burdensome to be persistent and make contact with Avinash because of this underlying understanding, and also because it was essentially a playful, 'arts-based' persistence.

It is recognized that the participants are unceasingly coping with the situation they find themselves in, and their coping is to be aided with appropriate modes and tools. In the sessions each one would make and shape experiences with voice, images, narratives, rhythms or tunes. This world there was manageable, even malleable. Getting a 'hold' over an experience can give a sense of charge over it. Madhu mixed-up narratives while telling her story, but navigated herself in that mix-up (others and she, herself, listened), and she did playfully quip that she made a mix-up! The process created opportunities to express, examine and evolve the coping energy into practical and useful explorations. The flexibility and rich variety of tools and techniques of multiple art forms enabled an eclectic, fittingly personalized approach.

ABT worked with a person rather than his/her diagnosis in the true sense. No matter how severe the symptoms or how difficult a person might seem, we strove to open a dialogue with the experience of the person. After 23 years of being increasingly locked-up inside his world, Avinash seemed to eventually trust, not the words or the show of respect, but the actual experience of an alternative space. His smiles and contact with us indicated a refreshing change. Madhu could listen or tell stories and eventually arrive at insights on her own despite the label of 'borderline' intelligence. Such potential is there in every session and each participant, all through.

Each small step took us to common, shared ground. Madhu enjoyed working with colourful clay, and then she told narratives about it, attention and appreciation from others encouraged her. Avinash was amused with ball-juggle and balloon-pass, and that got him to interact. His drawing of a lotus in mud said something. In successive sessions, attention rested—for one moment, briefly, or longer, as per person—in the here and now, leading to acknowledgement of self and others, and interaction.

It cannot be emphasized enough that trained ABT Practitioners don't approach mental health with merely a bag of artistic tools and techniques, but are informed with study of mind and training in compassion as a the preliminary mode of relating. ABT is not mere 'art activity'; it works with a decided and dedicated therapeutic framework. As a complementary therapy, it doesn't deny the role of other therapies and approaches. It works extremely well in suitable organizational and institutional environment.

This particular study is just a beginning of a journey. A plea for more trained ABT Practitioners is a plea for a systematic approach in the arts, informed with appropriate theoretical framework and culture-specific models of intervention. Considering holistic support, care and therapeutic work for those experiencing mental illness is an urgent and forcefully growing need. There is also need for more systematic long-term studies with larger sample size and in-depth qualitative and quantitative measures to underline and extend the mere notes of this present study into well-formed score of therapeutic work.

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