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Mandalas and Wellness Wheels with Persons with Severe Mental Illness

Maryellen McAlevey
Caldwell College, memcalevey@gmail.com
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Throughout this article, people with severe mental illness will be referred to as just that: people with severe mental illness. This nomenclature is in accordance with person-first language which stresses that a person is not his or her diagnosis, meaning that they are not schizophrenics or bipolars; they are people with an illness (International Association of Psychosocial Rehabilitation Services, 2003). Saks, a law professor, in speaking about destigmatizing mental illness, implored the public to remember that “these people may be your spouse, they may be your child, they may be your neighbor, they may be your friend, they may be your co-worker.” Furthermore, she stated that “the humanity we all share is more important than the mental illness we may not” (TEDGlobal, 2012).

Severe Mental Illness

People with severe mental illness (SMI) struggle with a thought disorder (e.g., schizophrenia) or mood disorders (e.g., major depressive disorder, bipolar disorder, schizoaffective disorder), and can have other secondary diagnoses such as personality disorders, anxiety disorders, and/or substance abuse disorders (American Psychiatric Association, 2000). Along with these mental disorders, people with SMI are at high risk for metabolic syndrome, which includes cardiovascular disease, diabetes, and pulmonary disorders, causing them to be at high risk for early death (Gill, Murphy, Spagnolo, Zechn, & Spagnolo, 2009). According to Hutchinson, Gagne, Bowers, Russinova, Skinar, and Anthony (2006), a conceptual definition of wellness must include the concept of health promotion, not just symptom amelioration.

Persons with SMI are more likely to die between fifteen and twenty years earlier than their peers without severe mental illness (Berren, Hill, Merikile, Gonzalez, & Santiago, 1994,
Swarbrick, Hutchinson, & Gill, 2008). This alarming statistic has served as inspiration for the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) *10x10 Wellness Campaign* (2010a), which aims to improve the life expectancy of people with mental illness by 10 years in 10 years.

Persons with SMI are also likely to experience psychosocial stressors such as alienation from family members and community, unemployment or underemployment, lack of housing or living in unsafe residences or communities, inadequate finances, legal issues, lack of education, and other issues (APA, 2000). Thought disorders occurring as a symptom of schizophrenia might impact on one’s parenting ability, resulting in alienation from a child. Mood swings occurring as a symptom of bipolar disease might result in poor job performance, leading to termination of employment, loss of living situation, applying for disability, possible medication non-adherence, and so forth. These are just some examples of the ramifications of psychiatric illness on day-to-day living.

**Art Therapy and Impact on Symptoms of Mental Illness**

One method of reducing the effects of these ramifications is artmaking. Persons in recovery from bipolar disorder cite artmaking as a strategy for eliminating or reducing symptoms and increasing self-esteem (Copeland, 2001). Furthermore, Copeland (2001) advocates for art therapists to be included in a client’s support team, along with medical doctors, psychiatrists, social workers, pharmacists, naturopaths, and the like. In interviewing artists with SMI, Spaniol (1998) discovered that creativity was more a component of wellness than of mental illness.

Due to the severity of clients’ problems (mental health or societal), confounded by issues such as war, trauma, brain injury, and addictive substances, “art therapy is needed as much as it
ever has been, if not more” (Slayton, D’Archer, & Kaplan, 2010, p. 108). The benefits of art-making on mood and/or symptoms are numerous and have been studied quantitatively and qualitatively, as cited below. In a randomized controlled trial, art therapy has been found to have a significant impact on reduction of negative symptoms in persons diagnosed with schizophrenia (Richardson, Jones, Evans, Stevens, & Rowe, 2007).

In their study of persons without SMI, Curry and Kasser (2005) found that coloring mandala designs significantly reduced anxiety compared to free form coloring. The anxiety reduction was found to return them to a pre-anxiety state. A replication study of psychology students by van der Vennet and Serice (2012) produced results that supported Curry and Kasser (2005). Students who colored a mandala design for twenty minutes had a greater reduction of anxiety levels than those who colored a plaid design.

A study of art-making after exposure to tragic images revealed that drawing images resulted in increased positive mood compared to copying shapes (De Petrillo and Winner, 2005). Similarly, Bell and Robbins (2007), using a randomized controlled trial, found that participants who created art had significantly greater reductions in negative mood and anxiety compared with a control group of those that only viewed art prints. Sandmire, Gorham, Rankin, and Grimm (2012) conducted a study that resulted in significantly decreased anxiety scores in college age students after artmaking. Art therapy was found to be beneficial in improving social, interpersonal, and task skills for an individual with schizophrenia (Schindler and Pletnick, 2006). Drapeau and Kronish (2007) discussed participants’ diminished suicidal ideation, improved quality of life and other benefits after participating in outpatient art therapy groups. Chandraiah, Ainlay Anand, and Avent (2012) offered weekly art therapy groups in an outpatient psychiatric
setting to clients with a range of psychiatric diagnoses including mood disorders, anxiety disorders, and schizophrenia. The study group demonstrated lower scores in depressive symptoms that were statistically significant. While not all of the participants in the aforementioned studies have SMI, it can be extrapolated that the positive outcomes of art therapy can be applied to participants with SMI.

**Recovery**

In spite of the medical risks and other odds facing persons with SMI (disengagement from family members, social isolation, undereducation, impoverishment, and other issues) recovery from mental illness is achievable, as evidenced in the writings of Deegan who offers the concept that she calls “a conspiracy of hope” (1987, p. 1). North (2003), a practicing psychiatrist who was diagnosed with schizophrenia while in medical school, authored the book, *Welcome Silence*, the title of which refers to the auditory hallucinations being diminished. Recovering individuals also include Swarbrick (2009) who devised the dimensions of wellness and Copeland (Copeland, 2001) who devised Wellness and Recovery Action Plans (WRAP) and has written numerous books on bipolar disorder. Jamison (1995), a professor of psychiatry at the Johns Hopkins School of Medicine, wrote *An Unquiet Mind*, a memoir of her struggle with bipolar disorder. Furthermore, Saks (2007) wrote about her treatment and recovery from schizophrenia in *The Center Cannot Hold*. In this autobiographical tome, the law professor progressed from frequent psychotic episodes filled with bizarre behavior and neologisms to writing a model statute against restraints that was published in the *Yale Law Journal*. After hospitalization, she posited that mechanical restraints are neither reassuring nor comforting and should not be used for the convenience of staff.
Recovery rates, as reported by the National Institute of Mental Health Council’s *Health Care Reform for Americans with Severe Mental Illness* (Deegan, 2003) are as follows: panic disorder, 80%; major depressive disorder, 65%; obsessive compulsive disorder, 60%; bipolar disorder, 80%; and schizophrenia, 53-68%. Community mental health providers currently focus less on quantitative measurement of recovery and shift the focus to how the consumer of services defines recovery. The nomenclature of “treatment plan” is being replaced with “individualized recovery plan.” Funding sources encourage community mental health services to interview consumers about their strengths and preferences for community living, their chosen valued role, and whether that role is worker/volunteer, student, family member, faith-based community member, or other identified role. Including such interview questions during an intake session sets the tone for the consumer as driving the treatment rather than being a recipient of services.

Recovery is a concept that should be embraced by clinicians working with clients who have SMI. Educating clients with SMI about the concept of recovery is as important as educating them about psychiatric diagnosis, symptoms, and medications. SAMHSA (2012) website and promotional materials include the working definition of recovery, which is: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012, “Definition,” para 2). Contrary to the NIMH statistics (Deegan, 2003), the current definition of recovery focuses on the process, and not an end-result.

Training programs for art therapists must shift focus from coursework that pathologizes clients with mental illness to coursework that embraces their self-directed recovery. Spaniol (2003) described recovery as one of the “necessary conditions” (p. 269) in which therapists must
be competent while working with persons with severe mental illness. “Recovery represents the therapist’s belief that people with mental illness can build lives of meaning and purpose despite their illnesses” (p. 269).

**Wellness**

Many persons with the lived experience of mental illness focus on the concept of wellness in their daily struggles with symptoms and recovery (McNamara, 2009). Currently, dimensions of wellness include: emotional, physical, social, occupational, spiritual, intellectual, and environmental (Swarbrick, 2009). Additionally, financial wellness is a dimension in some program approaches. SAMHSA’s Wellness Initiative (2010b) described the dimensions as follows: emotional or coping with life and creating satisfying relationships; physical or recognizing/improving the need for physical activity, diet, sleep, and nutrition; social or developing a sense of connection, belonging, and well-developed support system; occupational or personal satisfaction and enrichment derived from work or volunteerism. Other dimensions include: spiritual or expanding sense of purpose and meaning in life; intellectual or recognizing creative abilities and expanding knowledge and skills; environmental or occupying pleasant, stimulating environments; and financial or satisfaction with financial situations.

Dimensions of wellness abide by the strengths focus and treatment/rehabilitation, integration, and holistic approach principles of psychiatric rehabilitation (Pratt, Gill, Barrett, Roberts, 2007). Dimensions of wellness also abide by the holistic component of recovery (U.S. Department of Health and Human Services, 2005).

The principles of recovery are:

- Recovery emerges from hope—people can and do overcome challenges, barriers and
MANDALAS AND WELLNESS WHEELS

obstacles

- Recovery is person-centered—individuals define their own life goals
- Recovery occurs via many pathways—recovery is individualized based on a person’s needs, strengths, preferences, culture, trauma experience, etc.
- Recovery is holistic and includes mind, body, spirit, and community
- Recovery is supported by peers and allies—mutual aid groups assist with recovery vis-à-vis sharing of the lived experience
- Recovery is supported through relationship and social networks—the recovering individual must be surrounded by people who believe in the person’s ability to recover
- Recovery is culturally-based and influenced—culture is key in determining a person’s unique pathway to recovery
- Recovery is supported by addressing trauma—services should be trauma-informed to foster safety and trust
- Recovery involves individual, family, and community strengths and responsibility, all of which serve as resources for the foundation of recovery
- Recovery is based on respect—community, systems, and society must protect the recovering individual’s rights and eliminate discrimination. (SAMHSA, 2012, pp. 4-7)

Case Examples

The concepts of recovery and wellness are reviewed with participants of a particular partial hospitalization program in an urban setting. This message is reinforced in weekly
Recovery groups as well as when the client defines goals on his or her Individualized Recovery Plan (IRP). These methods appeal to verbal and kinesthetic learners, though, and this author wanted to appeal to visual learners. Therefore, tasks of wellness wheels and recovery-themed mandalas were introduced in a Creative Arts group for several sessions. Various art media (oil pastels, markers, colored tissue paper collage) were utilized with the intention of the members of the heterogenous groups to further adopt the message of recovery.

Two art therapy groups are facilitated weekly. One art therapy group is one hour long, and program consumers can select this group voluntarily (as one would pick a college course) or be recommended by their case manager. The other art therapy group is two hours long and is more psychotherapeutic in approach, and consumers are recommended by the treatment team or case manager. In addition to these two art therapy group sessions, art therapy is incorporated into several other weekly groups. For example, art therapy tasks and/or free choice sessions are facilitated during a three-hour life skills unit or co-occurring disorders (mental illness and substance abuse) unit, or one hour women’s issues or boundaries groups. The population is adults over the age of 18 with severe mental illness. Clients attend program for a minimum of two days weekly, and program meets for five hours per day.

Before mandalas were introduced in the one-hour art therapy group session, the group leader facilitated a group discussion about the meaning and significance of circles. The discussion centered on the Sanskrit origin of the word, the symbolism that a circle engenders, and where circles are found. Participants generally contributed answers such as a clock, sun and moon, the circle of life, a compass, hex signs seen in Pennsylvania Dutch culture, and so on. The facilitator added other meanings or symbolism of circles to illustrate the point. These
included that wedding rings (circles) are exchanged to symbolize that the marriage should have no beginning and no end and how the knights of the round table did not sit at a triangular or rectangular table to indicate that every opinion had equal value.

After this discussion, the group leader described the dimensions of wellness (SAMHSA, 2010b) and disseminated handouts with a wellness circle. The dimensions of wellness include: emotional, spiritual, physical, social, occupational, intellectual, environmental, and financial. Discussion ensued about the concept of wellness, the importance of attending to the whole person, and how clients are able to partake of these dimensions in their everyday lives. Then, one 12”x18” piece of drawing paper folded to a 45° angle and labeled with one of the dimensions of wellness was placed at a table or given to one group member (for a total of eight pieces of drawing paper). Group members were given a time allotment of approximately two to three minutes to draw and/or write ideas of how they fulfill that dimension of their lives before they pass the paper to the right for the next person to fill in. This pass occurs eight times until each person has had an opportunity to reflect on and fill in their idea on the sheet. Later, the sheets are assembled in pinwheel fashion, in order to make a whole (See Figure 1).

Figure 1. Wellness Wheel
One detail of the wellness wheel illustrates responses on the Spiritual section (See Figure 2). This group was comprised of approximately sixteen participants. Two individuals worked on a section at a time. This group included individuals with various levels of functioning and diagnoses, including thought disorders, mood disorders, and co-occurring disorders (mental illness and substance abuse). Some details included miscellaneous imagery of meditation, church, references to a client’s sacrament, and the phrases “into your hands,” “listen to music,” and “where did God go?” the latter of which was written by a woman who was referred by Drug Court and was new in recovery.

![Wellness Wheel detail—“Spiritual”](image)

At other times in the group, a sample wheel with eight spokes was drawn on the board or provided on a handout. The center of the wheel was labeled 0, and the outside of the spoke was labeled 10. Each spoke is labeled in increments from 0 to 10. Consumers were then asked to rate how well they do in each aspect of their lives by grading that dimension from 0 for not well to 10 for exceptional. Participants were then asked to connect the dots to see how inflated their
Another method utilized in this group was for participants to draw mandalas after a discussion about wellness. The group participants were provided with 12”x16” paper on which circles were pre-traced (to save time) and instructed to start at the center—as in to center oneself, and work outward to the edges of the circle, making a design with lines, shapes and colors. They were to cover the entirety of the paper with their chosen art media and to take the entire artmaking period to lend to relaxation and minimize placating behavior.

Sunflower was a tissue paper mandala created by a 51 year old single woman diagnosed with bipolar disorder (See Figure 3). She wrote about this piece: “The sunflower came to me instantly for my mandala. (1) It has many bittersweet memories of my mother’s mother—all of 5’1”. Sooo every now and then at least 1 sunflower would provide her shade or out-dwarf her. (2) I see the sunflower as always attempting to reach just a ‘lil bit higher.’ I also see it as the Grand Protector of the Garden for me? I hope the day will come when I can stand tall, straight & proud, have my Light as bright as the sunflowers (outer rim) and continue to protect what life has given me & then some.”

Figure 3. Mandala—“Sunflower”
Art therapists know that artwork created is autobiographical. This 51 year old *Sunflower* artist had mobility issues, and she was unable at times to stand straight without the assistance of a walker. She also saw herself as protector, as she took in and nursed abandoned cats and dogs, getting them homes with her peers when they were well. Since her discharge from program, this artist was seen to use her walker minimally, and she has become involved with a human service organization that helps persons displaced by Hurricane Sandy. The recovery principle that can be applied here is that recovery emerges from hope. This woman is overcoming her physiological challenges and helping others recover from the aftermath of the hurricane.

*Figures 4. Mandala—“Seasons”*

*Seasons* was a tissue paper mandala created by 46 year old single man with schizoaffective disorder (See Figure 4). This client, an avid gardener, remarked that he looks forward to the release of seed catalogs like a child looks forward to Christmas. Each year, he grows the seeds he purchased in disposable cups in his apartment, carrying the seedlings to the program and selling them to staff and clients alike because he had “no room to grow them all”
where he resides. He divided his mandala into four equal quadrants with apple picking with ladder and basket for fall in the upper left quadrant, snow for winter in the upper right, spring blossoms in the lower right, and summer with apples on the tree in the lower left. The recovery principle that can be applied here is that recovery occurs via many pathways. This gentleman is using his strength with his green thumb to assimilate in the recovery community.

*Key* was drawn by a 58 year old woman diagnosed with schizoaffective disorder (See Figure 5). She wrote: “We hold the key. This is the key to what is—Intellectual, Occupational, Spiritual, Social, Emotional, Social, Environmental, Financial. Program is the key that opens my door to these 8 parts of wellness” and “Program—one thing it does is open a locked mind and body to the light.” This artist stated about her drawing that she made a mistake and her attempts to correct it in marker got bigger and resembled a skeleton key which she perfected. This artist was finding healing in this period after the death of her elderly father in her artwork and in the physical act of riding her bicycle to the the ice cream shop in the shore community that she calls home. The recovery principle applicable in her case is that recovery involves individual, family (who pulled together when her father was ill and since his death), and community which serve as resources for the foundation of recovery.

*Figure 5. Mandala—“Key”*
Radiation was by a 48 year old single man diagnosed with schizoaffective disorder (See Figure 6). About his piece, he wrote “Radiation is used to express that what happens to one person affects all others, just like the noontime sun warms everyone.” He remarked in groups that he occasionally had a “poison feeling” that ran through his veins and in order to deal with this feeling, he practiced distress tolerance. This man had returned to work full-time after completing training at the local vocational rehabilitation program. He quit the full-time job cleaning bathrooms that he acquired through the vocational rehabilitation center for medical reasons and has since returned to program. He had no regrets about going to voc-rehab, taking the job, leaving it, or returning to program, and commented that attending the program was, for him, his job. His recovery is person-centered. He is defining his life goal currently as not working but attending the program. He is actively involved in Illness Management and Recovery (IMR) groups at the program in order to plot out his future after the program.

Figure 6. Mandala—“Radiation”
Since people learn visually, auditorally, and kinesthetically, the group facilitator had the group participants complete the mandala by getting up from their seats and walking in a clockwise fashion around the table slowly. This gave them the opportunity to view each others’ artwork closer, contemplate mandalas that provided visual interest to them, and internalize the circle that they just created on the page by walking in a circle.

**Conclusion**

Persons who have lived with severe mental illness for a significant portion of their lives can demonstrate iatrogenic effects or learned helplessness, meaning that they can rely on institutions and treatment facility staff to make decisions for them about treatment options, medications, program settings, group schedules, and the like. The mandala and wellness wheel projects are facilitated semi-annually as a reminder to clients to see how far they have come and to metaphorically move forward at least partially through their own means and choices. As wheels are used to transport, these wellness wheels can propel the client forward in their recovery.

Many of the clients who have participated in the art therapy groups have graduated from the partial hospitalization program, which is considered intensive, to a lower level of care. A group of graduates and soon-to-be graduates of this program recently had other pieces of artwork on display at a gallery show, demonstrating that artmaking is just as vital in structured, program time as it is in informal time away from program. Other program graduates attend a local clubhouse, which is a self-support model, and they are charged with facilitating art groups themselves.
Service providers might do well to learn that recovery from mental illness is achievable and to consider consumer preferences and empower consumers to exercise their rights of decision-making. The culture of treating persons with SMI must change from one of learned helplessness to “learned hopefulness” (Spaniol, 2005, p. 86). Working with adults with severe mental illness requires hopefulness, empathy, the ability to engage and inspire, creativity, and more. Being a change agent is not enough. One must be a hope agent as well. The decision-making processes that one utilizes in creating art can be a vehicle for hope in other aspects of life.
References


