# Drawing Together

*A trainee-led collaborative drawing group in a Mother and Baby Unit — an evobiopsychosocial approach to creative care*

*Central and North West London NHS Foundation Trust · Coombe Wood Mother and Baby Unit*

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SERVICE INNOVATION | TRAINEE-LED | PERINATAL PSYCHIATRY

## *In the complexity of the perinatal inpatient ward, might a shared creative task reach where verbal therapies alone cannot?*

Women admitted to Mother and Baby Units face a convergence of neurobiological disruption, trauma activation, and the demands of new motherhood. Verbal therapies often cannot reach where they are most needed. This project explored whether **collaborative drawing** — grounded in evolutionary biology, relational psychiatry, and perinatal neuroscience — could open a new channel for connection and care.

Emotion Regulation | Evobiopsychosocial | Relational Psychiatry | Non-verbal Expression

## BACKGROUND

*A window of profound vulnerability — and extraordinary neuroplasticity.*

The MBU brings together severe mental illness, early attachment trauma, and the neurobiological demands of new motherhood: oxytocin surges, cortisol dysregulation, sleep disruption, and the complexities of psychopharmacology alongside infant care. It is one of psychiatry's most demanding environments.

Verbal and cognitive therapies can be limited by **alexithymia, dissociation, trauma, or language and cultural barriers**. Drawing has been shown to activate a complementary neural pathway engaging the **default mode network** (supporting self-reflection, emotional insight and narrative integration) whilst reducing amygdala hyperactivity associated with threat states.[1,2]

Grounded in an **evobiopsychosocial framework**,[3] creativity, shared making, and collaborative play are evolutionarily conserved social behaviours that signal safety and activate affiliative circuits — functions of particular salience in the perinatal period.

Critically, this is **not art psychotherapy** — it is an *arts in health* intervention. It works collaboratively with art therapy by identifying patients who may benefit from onward referral, whilst remaining open to all without clinical criteria or referral thresholds.[4]

## AIMS

*Can clinicians use creative collaboration to reach patients where words cannot?*

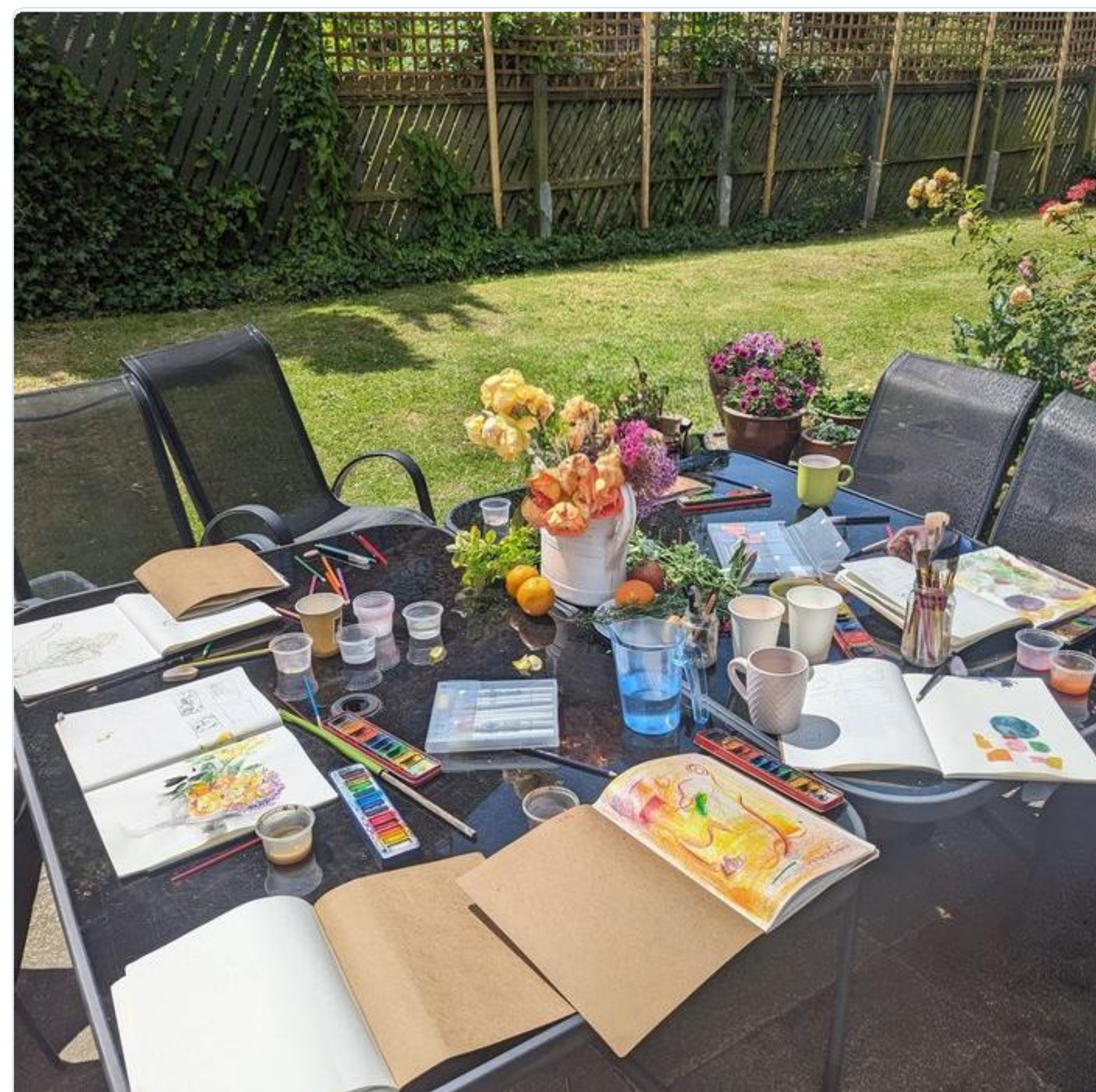
- Support **emotion regulation and non-verbal expression** during acute perinatal illness, particularly where verbal modalities are impeded by trauma, alexithymia, or language barriers[5]
- Foster **relational safety and reduce ward hierarchy** through a shared, non-evaluative creative frame[6]
- Enable **naturalistic clinical observation** — a formulation vantage point inaccessible in ward rounds or one-to-ones

**Working hypothesis:** That collaborative drawing, framed as shared rather than evaluative, would reduce barriers to participation and expression — ideally leaving participants with the possibility of continuing creative practice beyond healthcare settings.

## METHODS

**Project type:** Service innovation and reflective clinical project. Not a formal research study or RCT.

| | |
|---|---|
| **Setting** | Coombe Wood MBU, CNWL (inpatient) |
| **Format** | Weekly, 60-minute sessions |
| **Who** | All admitted patients with capacity; infants welcome |
| **Medium** | Personal sketchbooks; no skill required; optional themes only |
| **Led by** | Psychiatry trainee & occupational therapist (co-facilitation) |
| **Safety** | Therapy-approved materials; 1:4 staff-to-patient ratio; OT co-facilitation |
| **Cost** | Sketchbooks, pencils, pens, paints & ward space — no specialist equipment |



*Drawing group in session at Coombe Wood MBU — materials, shared space, and creative invitation*

## RESULTS — OBSERVED OUTCOMES

*Patients who declined verbal groups — and staff often entangled in clinical work — showed up, and kept coming back.*

*Observed clinical and relational outcomes from a reflective service innovation. No formal efficacy claims are made.*

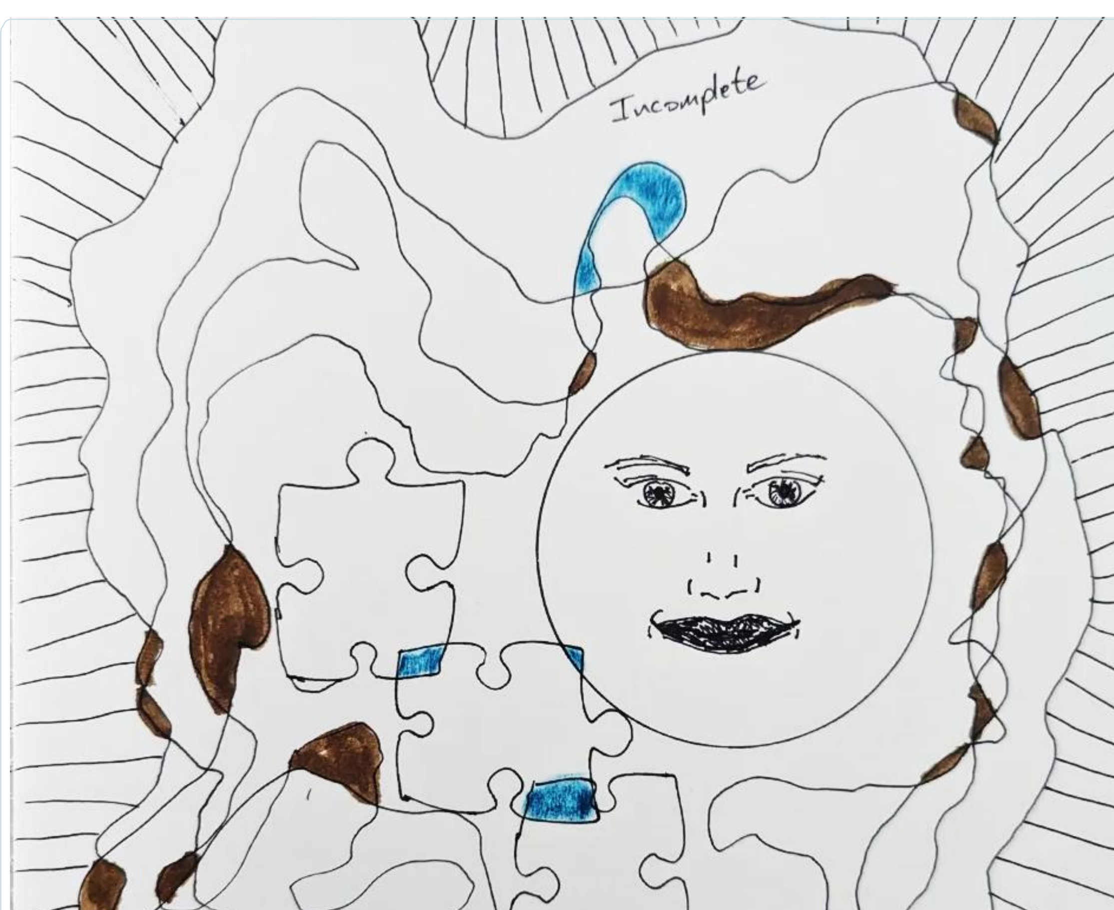
1. **Mothers and babies together**
   Infants were included at mothers' request, creating a less pressured, playful frame for dyadic bonding — similar to OT groups such as baby sensory or massage
2. **Relational safety became visible**
   Non-verbal communication and proximity behaviours shifted observably across sessions, consistent with emerging trust within the group
3. **Disclosure emerged without elicitation**
   Spontaneous narrative sharing arose naturally in the context of making — also offering a window to speak individually with patients and refer back to the MDT
4. **A new window for formulation**
   Flattening of hierarchy, turn-taking, spatial boundaries, and affect regulation were all observable in a naturalistic context — providing relationally meaningful data unavailable in formal assessment
5. **Meeting patients where they are**
   Patients with language barriers, those clinically very unwell, and those disengaged from verbal groups all engaged — in different ways — suggesting format, not motivation, was the barrier[4]

**Feasibility**

- Compatible with ward routine and acute admission turnover
- Low resource: sketchbooks, pens, pencils, facilitated ward space
- Deliverable by a trainee with MDT awareness — no specialist pathway needed

## EXAMPLES OF PATIENT ARTWORK

*Collaborative works from the group. Displayed with permission; no patient-identifiable information present.*




## CLINICAL INSIGHTS

*Five things a thinking clinician might not expect.*

1. **Drawing can help overcome verbal defences**
   Patients who intellectualise or hypermentalise in talking therapy may access affect more authentically through image-making as the visual channel can circumvent the linguistic-evaluative filter.[5] This is especially valuable where verbal communication is limited or emotionally charged
2. **Shared authorship dissolves self-criticism**
   Notably, this applied to staff as much as patients. "I'm just one part of this" restructures the psychological frame. When no one owns the outcome, perfection no longer applies — in perinatal illness, where self-criticism is often profound, distributing ownership reduced individual performance anxiety
3. **The clinician learns too**
   A dynamic exercise in holding a group of acutely unwell patients whilst modelling non-judgemental expression — inhabiting uncertainty in the creative act as a live metaphor for uncertainty in clinical practice. In watching staff struggle and try again, patients glimpsed not authority, but humanity
4. **Ancient circuits, modern ward**
   Shared rhythm and non-verbal cooperation predate language as human bonding behaviours. What Durkheim called *collective effervescence*[6] — the shared emotional intensity of group ritual — may be neurobiologically grounded in mutual affiliative activation
5. **An arts in health approach collaborates with art therapies**
   Operating outside formal therapy frameworks, it requires no referral pathway, no clinical criteria, and no waiting list — open to everyone on the ward, and a natural route to identify those who may benefit from specialist art therapy[4]

## SESSION STRUCTURE — 60 MINUTES

| | |
|---|---|
| **0–20 min** | **Free drawing time**<br>Participants arrive at any point; invited to make marks freely, at their own pace, independent of instruction |
| **20–45 min** | **Collaborative making**<br>Simple prompts given; sketchbooks passed around in rotation. Shared authorship eases judgement — process takes precedence over product |
| **45–60 min** | **Paired portraits**<br>The most challenging and often cited as most rewarding aspect: drawing each other. Where laughter replaced hesitation; shared vulnerability levelled the room |
| **Close** | **Grounding & closing**<br>Display all pages; circulate and share reflections; encourage ongoing sketchbook use beyond the session |

## CONCLUSIONS

*A low-cost, high-reach intervention that brings staff and patients together.*

- Creative group work bridges the gap between **formal psychological therapy and unstructured ward time** — fostering community within an intimate and complex ward setting
- The non-hierarchical frame cultivated **collective effervescence**[6] — a shared rhythm and co-regulation that extended beyond the session, shifting ward atmosphere
- **Scalable and trainee-deliverable:** no specialist pathway, minimal cost, compatible with acute ward turnover — adaptable across MBUs and perinatal settings

**Future directions**

- Prospective evaluation: affect regulation, mentalisation, therapeutic alliance
- Qualitative study of patient experience
- Multi-site comparison across MBUs

## Critical Reflections

*Much of what mattered most in this group resists measurement. The experience of making together, the shift in a room as a new image forms or when laughter replaces hesitation remains embodied. This is not a weakness of the intervention; instead a reminder that some of the most clinically significant things we do are precisely those hardest to quantify. Nonetheless, honest reflection on the boundaries of this work is important.*

- **Not a research intervention or audit:** this was a service innovation delivered in clinical practice. No formal hypothesis was tested, no control condition existed, and no ethical approval for data collection was sought. Observed outcomes are reflective, not evidential.
- **Attribution is complex:** the effects of drawing cannot be separated from group dynamics, OT co-facilitation, therapeutic rapport, or the broader rhythms of the ward.
- **Voluntary attendance and self-selection:** Though it was well attended, those who engaged most visibly may not represent the full patient population and those most disengaged remain, by definition, least observed.
- **A complement to care, not a replacement for it:** this group does not substitute for therapy, art therapy, or medication. Its value is in sitting alongside formal treatment: lowering the threshold for engagement and, at its best, opening the door for deeper clinical work to follow..
- **Sustainability requires substantive, ongoing support:** the collaboration with the occupational therapist was structurally critical. Without embedded MDT partnership, trainee-led initiatives risk disappearing with each rotation. Longitudinal commitment is the necessary condition for longevity.
- **Capacity and consent:** acutely unwell perinatal patients require careful, session-by-session clinical judgement. Participation must remain genuinely voluntary, held within a vigilant clinical frame.

## REFERENCES

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**DECLARATION OF INTERESTS**

The authors declare no conflicts of interest. No commercial or pharmaceutical funding was received. Undertaken as part of NHS clinical training.

**ETHICS & GOVERNANCE**

Service innovation and quality improvement project. No individual patient data reported. Delivered within CNWL clinical governance structures with consultant oversight. Artwork displayed with permission; no patient-identifiable information present.

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With great thanks to the patients and staff of Coombe Wood MBU, CNWL, that all contribute to a unique and therapeutic setting. With special thanks to to Kathryn Sheppard for her leadership, support and encouragement and who continues the group today. **Contact:** robert.hafes1@nhs.net