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"Molding Minds: Evaluating the Therapeutic Impact of Sculpting in Mental Health Care in Kenya"

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Abstract

Background: Mental health care in Kenya, like in many parts of sub-Saharan Africa, remains heavily reliant on verbal and pharmacological treatments, with minimal integration of alternative, expressive therapies. Tactile-based interventions such as sculpting are underutilized despite their potential to enhance concentration, expression, and emotional regulation among patients with varying psychological needs (Malchiodi, 2012). Introducing such interventions could diversify therapeutic options and offer more inclusive, culturally sensitive pathways to healing. **Problem:** Patients often struggle to articulate emotional distress verbally, and current outpatient models rarely engage alternative therapeutic forms. Additionally, most mental health environments lack the tools, materials, and design logic required for therapeutic art-based interventions. There is limited research on how sculpting could be structured and evaluated as a viable mental health therapy within Kenyan settings. **Objective:** The main objective of the study was to develop, implement, and evaluate a sculpting-based therapeutic intervention for mental health patients at Oasis Mental Health Limited (OMHL), with the aim of enhancing patient concentration, emotional expression, and participation using low-cost, culturally relevant materials and facilitation strategies. **Design:** The study adopted a practice-based, qualitative research design, integrating sculpting activities with structured observation and participant reflection over a period of three weeks. **Setting:** The intervention was carried out at Oasis Mental Health Limited (OMHL), an outpatient psychiatric care facility in Nairobi, Kenya. Sessions were held in a customized

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outdoor environment within the facility compound. **Subjects:** The subjects of the study included 7 adult patients and 10 OMHL staff members who participated either directly or through facilitation. A total of 6 patients and 5 staff members completed post-intervention evaluations. **Results:** Results showed significant improvement in concentration levels among patients, especially during creative and autonomous sculpting sessions. Participants also demonstrated enhanced emotional expression through their work. Staff reported a positive impact on therapeutic communication and confirmed the safety and practicality of the tools and instruction formats used. Multimodal instruction delivery and flexible space use emerged as key design enablers for therapeutic engagement. **Conclusion:** The study concluded that sculpting is a viable and effective therapeutic intervention when carefully structured around accessible materials, flexible instructional modes, and safe spatial design. Its integration into mental health programs, such as those at OMHL, can improve therapeutic outcomes while expanding the expressive capacity of patients in low-resource settings.

Keywords: Design, Sculpting, Mental Health, Emotional regulation, Tactile Therapy

Introduction

The intersection of design, health, and psychosocial care presents a fertile ground for innovation in African contexts, where mental health infrastructure often grapples with underfunding, stigma, and limited access to alternative therapeutic modalities. Kenya, like many low- and middle-income countries, has seen growing recognition of mental health challenges-particularly among young adults-yet therapeutic interventions remain predominantly verbal, clinical, and standardized (Ngui et al., 2010). Within this constrained model, the potential of design-especially participatory, tactile, and expressive forms-remains largely untapped.

This paper responds to that gap by investigating how clay sculpting, as a therapeutic design intervention, can be effectively integrated into mental health care within community settings. Rooted in principles of patient-cantered design and art-based therapy, the project was conducted at Oasis Mental Health Limited (OMHL), an outpatient facility in Nairobi offering psychiatric and

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psychosocial services. Unlike conventional design-for-wellbeing projects which often prioritize aesthetics or technology, this study adopts a practice-based approach, using design to elicit, support, and analyse the therapeutic process itself.

Art-based therapy, particularly in sculptural form, provides a compelling alternative to language-centric models of mental health care. Clay, as a medium, engages the sensorimotor system, fosters grounding, and allows for symbolic expression that transcends the limitations of spoken language (Malchiodi, 2012). While studies in Western contexts have shown promising outcomes in art therapy for trauma and emotional regulation (Schouten et al., 2015), little work has been done to adapt these modalities to local cultural practices and health infrastructures in sub-Saharan Africa. Moreover, most interventions have neglected the role of design thinking-the careful orchestration of materials, space, tools, and instruction delivery-as a fundamental component of therapeutic success.

This paper examines the implementation of a structured sculpting therapy program designed specifically for the OMHL setting. Over a three-week period, patients participated in nine sculpting sessions that varied in theme, guidance, and group dynamics. The design of the intervention considered not only psychological needs but also practical constraints such as tool safety, outdoor spatial requirements, and participant autonomy. In doing so, it offers a model for low-cost, high-impact therapeutic design that is both contextually appropriate and scalable.

By documenting and analysing this intervention, the paper aims to contribute to the expanding field of design for mental health and to provoke a critical dialogue about the role of creative practice in shaping future African healthcare environments. It demonstrates that design is not merely a vehicle for aesthetic output, but a method of structuring healing, particularly when traditional clinical tools prove insufficient.

THEORY

The therapeutic basis of this study is grounded in interdisciplinary frameworks that bridge clinical psychology, creative expression, and design thinking. Central to the

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intervention is the understanding that healing-particularly in mental health-requires modalities that engage more than just the cognitive or verbal faculties. The use of art as therapy reflects a shift toward embodied, expressive, and non-linear approaches to mental health recovery. Within this framework, sculpting offers unique opportunities for tactile engagement, narrative construction, and emotional regulation, especially among patients who may struggle with direct verbal expression (Malchiodi, 2012).

One of the core theoretical anchors of the project is the Expressive Therapies Continuum (ETC), developed by Hinz (2009), which articulates how different artistic activities stimulate varying psychological and neurological processes. According to the ETC, sculpting falls under the kinaesthetic-sensory and perceptual-affective levels-making it particularly effective for grounding patients, stimulating self-awareness, and supporting emotional processing. Unlike drawing or painting, sculpting requires the use of both hands, promoting bilateral integration and full-bodied interaction with the material. This aligns with the findings of Schouten et al. (2015), who demonstrated the efficacy of art therapy in trauma recovery by engaging the sensorimotor system and offering symbolic distance from distressing experiences.

Additionally, the project is informed by principles of design for wellbeing, a subfield of design that emphasizes interventions aimed at improving individual and collective quality of life (Dewey & Di Russo, 2020). Here, design is not viewed as an outcome but as a process-one that shapes how care is delivered, how space is used, and how tools enable or restrict expression. This intervention integrates key design considerations: the selection of non-threatening materials and tools, spatial adaptability (e.g., outdoor use), and layered instruction delivery. Each element was intended not merely to support artistic output, but to scaffold therapeutic interaction, affirm participant agency, and minimize barriers to engagement.

The concept of psychological safety also plays a central role in the design logic of the intervention. As defined by Edmondson and Lei (2014), psychological safety refers to an individual's perception that they can

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express themselves without fear of judgment or harm. In the OMHL context, where many participants were engaging in art-making for the first time, the deliberate structuring of sessions to allow for choice, silence, movement, or non-verbal participation was essential. This is particularly relevant in cultures or clinical settings where mental illness is stigmatized, and emotional expression may be discouraged or difficult to articulate.

Taken together, these theories frame sculpting not simply as an activity but as an intentionally designed therapeutic system—where every component, from the choice of clay to the rhythm of sessions, plays a role in enabling recovery. The intervention draws on art therapy principles, cognitive neuroscience, and participatory design to construct a model that is culturally grounded, emotionally resonant, and therapeutically robust.

Methodology

1. Research Design

This study adopted a practice-based research design, with a qualitative orientation aimed at evaluating the feasibility, engagement, and therapeutic value of sculpting within a mental health care setting. Practice-based research, particularly relevant in design disciplines, emphasizes knowledge generation through creative action and reflection (Candy & Edmonds, 2018). In this context, the intervention itself-its materials, environment, structure, and experiential unfolding-served as both the object and method of inquiry.

The sculpting intervention was conducted over nine sessions spanning three weeks, each lasting approximately two hours and structured around diverse activities including guided sculpting, open-ended prompts, group-based construction, and individual reflection. This diversity in format allowed the researcher to observe the therapeutic implications of varying sculpting conditions and participant roles.

Data Collection Methods

Data was collected using multiple qualitative tools to ensure triangulation and richness of interpretation:

- **Participant Observation**: Active observation was carried

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out by the researcher during all sessions, focusing on behavioural cues, participation patterns, and emotional responses. An "excitedness scale" (1 to 5) was employed to record participant engagement at the beginning, during, and end of each session.

- **Attendance Records**: Daily attendance logs were maintained for both patients and staff, tracking fluctuations and helping to assess commitment, accessibility, and interest.
- **Semi-Structured Questionnaires**: Administered to both patient participants and OMHL staff at the end of the intervention, the questionnaires combined Likert-scale items with open-ended questions. They explored perceptions of comfort, tool usability, instruction clarity, emotional impact, and therapeutic effectiveness.
- **Sculptural Output Analysis**: Select sculptures were interpreted both through participant narratives and independent thematic analysis. Visual elements, symbolism, and structural decisions were evaluated as forms of therapeutic expression.

Data Analysis Methods

Data was analysed using a thematic analysis approach, suitable for exploring complex emotional and behavioural data in small sample, design-based interventions (Braun & Clarke, 2006). Observation notes and open-ended questionnaire responses were coded into themes such as *concentration*, *emotional expression*, *group interaction*, *tool safety*, and *instructional preference*. Patterns in the excitedness scale and attendance logs were tabulated and examined for behavioural trends. Select sculptures were used as anchor points to support emerging themes, linking material outcomes to participant reflection and staff feedback.

This integrated data collection and analysis approach enabled the study to address both the design dimension of the intervention (space, materials, delivery) and its therapeutic impact on participants.

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2. Geographical scope

The study was conducted at Oasis Mental Health Limited (OMHL), an outpatient mental health facility located in Nairobi, Kenya. OMHL provides psychiatric, psychosocial, and rehabilitation services to a diverse population of clients with varying mental health needs.

The intervention was hosted outdoors within the OMHL compound, taking advantage of open space, natural light, and ventilation. This choice was both intentional and practica-indoor spaces lacked sufficient lighting and were unsuitable for clay work. A temporary shade structure was erected to protect participants and materials from direct sunlight or rain. The physical space played a critical role in facilitating movement, minimizing sensory triggers, and supporting creative autonomy.

3. Population

The population involved two primary groups:

- **Patient Participants**: Adult clients enrolled in OMHL's psychosocial care programs. These individuals varied in diagnosis, age, and treatment duration. Many had no prior experience in sculpting or art-making, which allowed for unbiased observation of engagement and expression.
- **OMHL Staff Participants**: Including psychologists, psychiatric nurses, occupational therapists, and clinical support personnel. Staff were involved both as facilitators and observers, offering insight into patient responses and implementation logistics.

Participation was voluntary, and all ethical protocols-including verbal informed consent, anonymity, and emotional safeguarding-were upheld throughout the intervention.

4. Sampling and Sample Size

Purposive sampling was employed to select participants who were already receiving services at OMHL and were available to take part in art-based therapy during the designated intervention period. Willingness to participate, cognitive readiness, and basic motor function were considered in patient inclusion.

Across the sessions:

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- A total of 7 patients and 10 staff members participated.
- Attendance varied from 1 to 7 patients per session, depending on clinical schedules and personal availability.
- Staff participation was consistent, with at least three facilitators attending each session and five completing the end-of-study evaluation.

While the sample size was small, the depth of engagement, the layered data sources, and the reflective nature of practice-based inquiry provided sufficient ground for meaningful analysis.

Implementation

The implementation of the sculpting intervention was informed by principles of therapeutic design, participatory facilitation, and contextual adaptability. Each component-space, tools, materials, instruction, and session format-was deliberately planned to support patient engagement while addressing the operational realities of the clinical environment at Oasis Mental Health Limited (OMHL).

1. Space and Environment

The sessions were conducted in an outdoor courtyard within the OMHL compound. This decision was based on both practical and psychological considerations. Indoor facilities were not suited for clay-based activities due to inadequate lighting, limited ventilation, and sensitivity to mess. By contrast, the outdoor setting allowed for natural light, free movement, and reduced sensory pressure, which are particularly important in trauma-informed care (Van der Kolk, 2015).

A temporary canopy structure was installed to provide shelter from direct sunlight and rain. The space was furnished with plastic stools and tables, which were easy to clean and rearrange. Notably, participants often chose to stand or move during sculpting, indicating a preference for dynamic engagement over seated instruction. This spatial flexibility contributed positively to patient comfort and creativity.

2. Tools and Materials

Participants were provided with a basic clay sculpting toolkit, initially containing 30 tools. After consultation with OMHL staff, two sharp tools were excluded to mitigate

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safety risks, leaving a set of 28 blunt and rounded instruments. These included loop tools, shaping paddles, and smoothing tools suitable for beginners.

To maintain safety and accountability, tools were counted and tracked at the start and end of each session. Staff co-monitored usage, ensuring no items were misplaced or misused. No incidents of harm, aggression, or anxiety linked to tool use were reported, and both staff and patients affirmed the tools' usability and safety in the final evaluation.

The sculpting material was a standard water-based modelling clay, soft enough for hand manipulation without requiring significant physical strength. Participants were provided with disposable aprons, hand wipes, and a moisturizing cream to reduce the skin-drying effect of clay-an issue raised in mid-program feedback. Despite the lack of alternative materials, the clay medium proved sufficient for expressive exploration.

3. Instruction Delivery and Facilitation

Recognizing that participants had no prior experience in sculpting or formal art training, the mode of instruction was a key design consideration. The study tested a combination of verbal guidance, step-by-step written instructions, and illustrative visual aids (e.g., picture cards). Additionally, the facilitator provided live demonstrations during the initial sessions and upon request.

Feedback collected through questionnaires revealed a strong preference for multi-modal instruction. The majority of participants - both patients and staff - favoured receiving all forms of instruction simultaneously as this improved clarity and minimized frustration. Moreover, five out of six patients and four out of five staff members requested more frequent demonstrations, underscoring the need for embodied, scaffolded learning in therapeutic art settings.

4. Session Plan Structure

The intervention consisted of nine sessions organized into a structured progression from guided participation to autonomous exploration:

- **Days 1-3**: Introductory and guided sculpting tasks, including warm-up exercises and structured prompts (e.g.,

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sculpting from imagination, following instructions).

- **Days 4-5**: Group sculpting activities-one interactive (communication allowed), and one non-interactive (silent collaboration)-to assess interpersonal dynamics.
- **Days 6-7**: Thematic sculpting prompts and solo sculpting, allowing for introspective creation.
- **Day 8**: **Free-choice sculpting**, where participants selected their own themes and materials.
- **Day 9**: **Gallery-style exhibition**, where participants displayed and discussed their work, either voluntarily or through facilitator interpretation.

This progression was designed to build confidence, encourage creative autonomy, and allow for divergent emotional expression. Each session concluded with a short debriefing discussion or reflective check-in, depending on participant readiness.

5. Facilitator Role and Participant Autonomy

The researcher functioned both as a facilitator and observer, guiding the sculpting process while recording behavioural and interactional data. OMHL staff supported the sessions by assisting with setup, encouraging participation, and helping maintain a psychologically safe environment.

Importantly, autonomy was preserved at all times. Participants were allowed to opt out, modify tasks, or explore alternate interpretations of given prompts. This flexibility was essential to ensuring that the intervention aligned with therapeutic principles and individual readiness, particularly given the diverse clinical profiles of participants.

The deliberate integration of environmental, material, instructional and interpersonal design elements allowed the intervention to be not only therapeutically grounded but also logistically feasible within a real-world clinical setting. The following section will examine the results of this implementation, drawing on participant behaviour, sculptural output, and evaluative feedback.

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Results and Reflections

Results and Reflections

The evaluation of the sculpting intervention focused on observable behavioural changes, engagement levels, feedback from both patients and staff, and the thematic insights derived from the sculptural work. The qualitative nature of the study, aligned with a practice-based methodology, emphasized meaning-making, emotional resonance, and contextual analysis over statistical generalization.

1. Attendance and Participation Patterns

Participant attendance across the nine sessions fluctuated but maintained sufficient consistency to support continuity in therapeutic engagement. Seven patients participated at least once, with six completing the end-of-intervention feedback form. Attendance peaked during the first and final sessions, suggesting a combination of initial curiosity and end-stage reflection. The lowest attendance occurred mid-program (Day 6), possibly due to session fatigue or competing clinical commitments.

Interestingly, staff attendance remained stable, with three to five facilitators present at most sessions, providing continuous support and monitoring. Their consistent presence contributed to environmental stability and relational safety-factors that are critical in trauma-informed design (Hopper et al., 2010).

2. Emotional Engagement and Excitedness Ratings

Participants' emotional engagement was monitored using an "excitedness scale", rated from 1 (least engaged) to 5 (most engaged) at the beginning, middle, and end of each session. A notable increase in engagement occurred during creative autonomy sessions, particularly on Days 6, 7, and 8, where participants worked on thematic prompts, personal sculptures, or free-choice tasks. These formats appeared to foster greater ownership, expression, and emotional investment.

Conversely, structured sessions with rigid instructions (Day 3) and the non-interactive group activity (Day 5) were associated with a temporary dip in engagement, suggesting that over-prescription and communication restriction may suppress emotional

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spontaneity. These patterns reinforced the importance of adaptable, user-cantered instructional design in therapeutic settings.

3. Thematic Insights from Sculptural Output

The sculptural works produced across the sessions were both symbolically rich and emotionally expressive.



Figure 1: Pedi (Drug peddler) (Photo *by Researcher- 2025)*

Several pieces revealed deep narrative layers, either explained directly by the patient or interpreted in collaboration with staff. The following examples illustrate the breadth of thematic meaning:

- **Pedi:** One patient created a distorted bust and identified it as a representation of their drug dealer-an (see figure 1) object of both dependence and resentment. The occupational therapist noted that this act of personifying the source of addiction was a form of externalization, allowing for symbolic confrontation.
- **My Ex**: Another participant sculpted a stylized figure and attributed it to a past relationship. Despite skipping some sessions, they returned to reshape and refine the piece twice, suggesting an ongoing emotional processing loop. Figure 2 shows an image of the detailed sculpture by the participant.



Figure 2: The Lawyer (*Photo by Researcher-2025*)

The Lawyer: A spontaneous creation based on current events, sculpted by a participant reacting to political unrest. The piece had a fragmented base and gestural posture,

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interpreted by the group as a commentary on broken justice. In figure 3 is a sculpture showing a frustrated lawyer after finding out that a suspect he was prosecuting had stolen his phone.

- **Homestead Group Activity**: During the interactive group session, participants created a rural homestead scene with huts, a tree, and a water pot. This collaborative piece fostered dialogue, memory-sharing, and laughter, and was unanimously rated as the most enjoyable session.



Figure 3: My Ex (*Photo by Researcher=2025*)

- **Just a Girl**: A simple, recurring piece sculpted and re-sculpted by a patient across three sessions. The repetition was interpreted by staff as an attempt to reconstruct identity or retain emotional continuity.

These examples underscore sculpting's unique capacity to surface implicit memory, metaphor, and emotion without requiring verbal articulation. The pieces became objects of reflection, not just for the creators but for the community around them.

4. Instructional Delivery and Patient Preferences

Patient and staff responses indicated a strong preference for combined instructional modes-verbal, visual, and demonstrative-over singular formats. Written instructions alone were insufficient, especially for first-time sculptors. Moreover, five of six patients expressed the desire for more live demonstrations, which enhanced understanding and reduced performance anxiety.

This preference affirms literature on multi-sensory learning in therapy, where layered instruction not only supports comprehension but also creates a scaffold for self-efficacy and flow states (Csikszentmihalyi, 1990). Verbal prompting alone, without visual modelling, risked triggering self-doubt or disengagement.

5. Reported Therapeutic Outcomes

Oasis Mental Health Limited (OMHL) staffs were invited to evaluate the

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impact of the sculpting sessions using a structured feedback form. All five respondents reported a positive impact on the patients involved. Key areas of improvement included:

- **Concentration**: Noted as the most consistently improved domain, particularly in patients with previously documented attention difficulties.
- **Emotional Expression**: Several participants were observed expressing emotions through clay that they could not articulate verbally.
- **Communication**: Group activities supported the emergence of informal conversation, even among normally reserved patients.

Importantly, no negative impacts were reported, and all sculpting tools were deemed safe for continued use.

6. Emergent Reflections

Beyond formal metrics, the intervention revealed how sculpting can become a co-constructed language-where touch, form, and movement stand in for words. It demonstrated that artistic choice-making-even in the selection of a shape, a surface texture, or the act of starting over can be profoundly therapeutic.

Despite limitations in time and materials, the sculpting experience at OMHL was not merely tolerated but embraced, suggesting its strong compatibility with community-based mental health care in Kenya. Patients were not passive recipients of therapy, but active co-designers of meaning, identity, and emotional navigation.

Discussion and Design Implications

The results of this study reveal significant potential for sculpting as a therapeutic intervention within outpatient mental health care in low-resource contexts. In line with global findings on art therapy (Malchiodi, 2012; Schouten et al., 2015), this intervention demonstrated that tactile, expressive design practices can generate observable improvements in concentration, emotional articulation, and patient participation. However, what distinguishes this case is its integration of design logic-materials,

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space, instruction, and facilitation-into the therapeutic process itself.

From a design perspective, the intervention affirmed that the success of a therapeutic experience is deeply tied to how it is structured and delivered. This includes not just the what (clay sculpting), but the how: where participants sit or move, the nature of the tools in their hands, and the freedom they are given to interpret, reshape, or resist the task. Design here acts as a modulator of safety, agency, and creativity. Sessions with rigid instructional control, for instance, led to visible dips in engagement. By contrast, activities that invited choice, improvisation, and meaning-making fostered sustained participation and emotional depth.

One notable implication lies in the importance of multimodal instruction delivery. Participants showed greater confidence when verbal guidance was paired with visual aids and demonstrations. This supports inclusive design principles, particularly in populations with varied learning preferences or cognitive processing abilities. For mental health settings in Kenya, where therapy is still largely talk-based and often medicalized, the adoption of visual and tactile teaching strategies could significantly improve therapeutic accessibility.

Another insight concerns space and mobility. The outdoor environment, originally chosen for practical reasons, emerged as a critical enabler of comfort and psychological openness. Participants expressed a preference for standing or moving rather than remaining seated-suggesting that spatial freedom enhances cognitive and emotional flexibility. This contrasts with many clinical environments which impose stillness, silence, and control. The findings argue for more flexible, movement-friendly spaces in therapeutic design, particularly where body-based trauma or agitation is present.

The sculptural pieces themselves provided a non-verbal record of emotional processing, enabling a reflective conversation between patient, facilitator, and artifact. The narrative symbolism embedded in these works speaks to the epistemic value of making-an idea increasingly emphasized in design research. When a patient repeatedly reshapes a figure or spontaneously externalizes a

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painful memory into clay, they are not merely making art; they are scripting identity, negotiating emotion, and embodying recovery. This form of engagement is difficult to achieve through language alone, especially in contexts where expression may be culturally or personally inhibited.

However, the study also highlighted implementation challenges. The limited duration of the program constrained deeper exploration of therapeutic impact, and the singular material (clay) presented both physical discomfort and expressive limitations for some participants. Furthermore, introducing new patients' mid-way presented continuity challenges for both instruction and group cohesion. These issues point to the need for longer-term, modular programming and greater material diversity, including soft-textured or mixed-media options to accommodate varied tactile sensitivities.

In design terms, this study exemplifies the shift from "designing for" to "designing with"- an ethos where the user is not simply a recipient of care, but a co-author of the healing process. It invites future designers and therapists alike to consider how environments, objects, and instructions can be crafted to hold space for emotional risk, reflection, and re-creation.

Conclusion

This study demonstrates that sculpting, when thoughtfully designed and implemented, can serve as a viable and impactful therapeutic intervention in outpatient mental health settings. The use of clay as a tactile medium allowed for non-verbal emotional expression, improved concentration, and meaningful patient-staff interaction. Importantly, the project showed that even within material and logistical constraints, low-cost, practice-based interventions can generate high therapeutic value when rooted in participant feedback, safety, and cultural relevance. These findings affirm the potential of design as a functional and expressive tool in the evolving landscape of mental health care in Kenya and beyond.

Recommendations

Based on the implementation and observed outcomes of the sculpting-based intervention at OMHL, several practice-based recommendations are

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proposed. These aim to improve future iterations of similar programs and inform the integration of art-based therapy in mental health care settings.

1. Extend Session Duration and Frequency

Participants demonstrated higher engagement and emotional investment during later sessions, particularly those involving self-directed or thematic sculpting. However, the limited duration of the overall program-nine sessions over three weeks-restricted deeper exploration of therapeutic progress. A longer program duration with more frequent sessions would enable sustained relationship-building with the medium and allow for greater psychological benefit.

2. Maintain Flexible, Outdoor Space for Engagement

Participants showed a clear preference for the flexible outdoor setting over seated, static indoor environments. The ability to stand, move, and adjust posture during sculpting contributed positively to comfort and emotional openness. Future interventions should continue to use adaptable, open-air environments or simulate similar conditions indoors through modular layout and lighting considerations.

3. Incorporate a Wider Range of Materials

While the use of clay was central and effective, some participants reported discomfort due to its texture and drying effect on the skin. Introducing a broader palette of safe, tactile materials-such as soft wax, sand, or mixed media-could improve accessibility, comfort, and creative expression for participants with sensory sensitivities or physical limitations.

4. Provide Multi-Modal Instruction with Demonstrations

Participants responded most positively to sessions where visual, verbal, and hands-on demonstrations were provided simultaneously. Written instructions alone were insufficient for most beginners. Facilitators should incorporate all three modes-spoken guidance, image references, and live demonstration to support comprehension and engagement.

5. Support Continuity for Late Entrants

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One of the key challenges faced during the intervention was accommodating new participants who joined mid-program. This interrupted continuity and divided facilitator attention. Future programs should incorporate modular onboarding content or staggered entry plans that allow new participants to engage without disrupting group flow or requiring the facilitator to split focus.

6. Include Structured Staff Involvement

The consistent involvement of OMHL staff contributed significantly to session safety, emotional support, and participant comfort. Staff familiarity with individual patients allowed for subtle emotional monitoring during sculpting. Future implementations should preserve this structure and consider offering basic facilitator training to selected staff for long-term integration.

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