Art therapy and the patient experiencing psychosis who identifies as an artist: An exploratory study

Clare Dash

Master of Arts (Honours) Art Therapy
University of Western Sydney
School of Social Sciences

July 2006
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signed: ___________________________  Date: ___________________________
Acknowledgements

To Bethan for encouraging this work to grow beside us and for giving the space for it to happen.

To Jill Westwood who I am indebted to for considerable assistance and unending support.

To Dr Adrian Carr for the academic direction and encouragement he has given to this work.

To the artists who have revealed themselves to me over many years of work together, it is from you that I have learnt how to begin to be a therapist.
Table of Contents

Abstract ............................................................................................................................................... viii
List of figures ......................................................................................................................................... viii
List of tables ......................................................................................................................................... viii

1. Introduction ..................................................................................................................................... 1
   1.1 Overview of the research .............................................................................................................. 1
   1.2 An introduction to Art therapy ................................................................................................... 4
      1.2.1 What is art therapy? .............................................................................................................. 4
      1.2.2 Transference, countertransference and art therapy .............................................................. 4
      1.2.3 The triangular relationship .................................................................................................. 5
      1.2.4 The holding environment ................................................................................................... 6
      1.2.5 Unconscious projection utilised in art therapy ...................................................................... 6
   1.3 Historical development of art therapy as a treatment of psychosis ............................................ 7
   1.4 Art therapy and institutionalisation ............................................................................................. 11
   1.5 Psychiatric art .............................................................................................................................. 13
      1.5.1 Psychiatric art and art therapy ........................................................................................... 14
      1.5.2 Art therapy and the creative process ................................................................................... 15
   1.6 Art Therapy and group work ....................................................................................................... 16
   1.7 Summary ..................................................................................................................................... 18

2. Literature Review .............................................................................................................................. 19
   2.1 Part A: Art therapy with the patient experiencing psychosis who identifies as an artist: A review of
      the literature .................................................................................................................................. 19
      2.1.1 Overview ............................................................................................................................. 19
      2.1.2 Detailed review of the literature .......................................................................................... 20
      2.1.3 The pioneering work of Margaret Naumburg ...................................................................... 21
      2.1.4 Art therapy with patients experiencing psychosis who identifies as artists ....................... 22
      2.1.5 Becoming an artist as a result of doing art therapy .............................................................. 26
      2.1.6 Art therapy and the artist identity ....................................................................................... 28
      2.1.7 Conclusions .......................................................................................................................... 29
   2.2 Part B: Review of the literature examining defence mechanisms as used by the patient
      experiencing psychosis who identifies as an artist in art therapy ................................................. 31
      2.2.1 Psychosis and defence mechanisms .................................................................................... 31
      2.2.2 Psychosis as a defence mechanism ..................................................................................... 32
      2.2.3 The artist defence mechanisms in art therapy ..................................................................... 33
      2.2.4 The artist is trained to defend .............................................................................................. 34
      2.2.5 The patient experiencing psychosis who identifies as an artist in art therapy ..................... 36
      2.2.6 The patient experiencing psychosis who identifies as an artist and ego strength ............... 36
      2.2.7 The patient experiencing psychosis who identifies as an artist and their inability
         to shift between the inner and outer world ............................................................................... 37
      2.2.8 Insulating the psychological with the aesthetic .................................................................. 38
      2.2.9 Concrete thinking prevents accessing psychological meaning ........................................... 39
      2.2.10 Loss of the ‘as if’ quality ................................................................................................... 40
      2.2.11 Loss of meaning in art therapy results in repetitive artwork ............................................. 41
      2.2.12 The patient experiencing psychosis who identifies as an artist and their inability to introject .......................................................................................................................... 42
      2.2.13 Rejection of art therapy as holding ..................................................................................... 42
      2.2.14 The patient experiencing psychosis who identifies as an artist is narcissistically
         driven ........................................................................................................................................... 44
      2.2.15 Conclusion ........................................................................................................................... 45
   2.3 Summary of review of literature ................................................................................................. 46
3. METHODOLOGY ........................................................................................................ 48
   3.1 Background ............................................................................................................. 48
   3.2 Method of study .................................................................................................... 48
   3.3 The setting ............................................................................................................ 50
   3.4 The case studies ................................................................................................... 52
   3.5 The search for collaborating evidence .................................................................. 53
      3.5.1 The development of the Table of issues .......................................................... 54
      3.5.2 Questionnaire rationale ................................................................................ 54
      3.5.3 Pilot study and pilot study implications .............................................................. 54
      3.5.4 Questionnaire development and implementation ........................................... 55
   3.6 Ethical considerations .......................................................................................... 56
   3.7 Summary .............................................................................................................. 56

4. RESULTS ............................................................................................................... 57
   4.1 Overview of the results ....................................................................................... 57
   4.2 The Case Studies .................................................................................................. 57
      4.2.1 Introduction to case studies ............................................................................. 57
      4.2.2 Case Study: Greg ............................................................................................ 58
      4.2.3 Case Study: Walter ......................................................................................... 64
      4.2.4 Case Study: Ben .............................................................................................. 66
      4.2.5 Case Study: Joseph ........................................................................................ 70
   4.3 Grouping the case study material as data ............................................................ 74
      4.3.2 Twelve similarities in the artists’ behaviour ...................................................... 78
      4.3.3 Seven further factors of artists’ responses in art therapy ................................. 79
   4.4 Questionnaire responses ..................................................................................... 80
   4.5 Summary of Questionnaire results ....................................................................... 91
   4.6 Summary of results .............................................................................................. 93

5. DISCUSSION ........................................................................................................... 94
   5.1 Defence structures of patients experiencing psychosis who identify as artists .... 95
   5.2 Aesthetics and the patient experiencing psychosis who identify as an artist ......... 100
   5.3 The art therapist’s own experiences as countertransference .............................. 102
   5.4 Questionnaire in relation to research ................................................................. 104
   5.5 Summary of discussion ....................................................................................... 105

6. IMPLICATIONS FOR PRACTICE ...................................................................... 107
   6.1 Introduction .......................................................................................................... 107
   6.2 Working with psychosis in art therapy ............................................................... 107
   6.3 Overview of working with patients experiencing psychosis who identify as artists in art therapy ................................................................. 109
   6.4 Recommendations to modify art therapy practice when working with patients experiencing psychosis who identify as artists .............................................. 111
   6.5 Summary of implications for practice ............................................................... 114
7. CONCLUSION ........................................................................................................ 115

7.1 Limitations of this study .................................................................................. 116

7.2 Further areas of investigation ........................................................................ 118

8. REFERENCES .................................................................................................. 119

9. APPENDIX ...................................................................................................... 127

9.1 Questionnaire ................................................................................................... 127

9.2 Rationale for each question in questionnaire ............................................. 130

9.3 Copy of the consent form used for case study photographs ...................... 133

9.4 Copy of the letter accompanying the questionnaire .................................. 134
ABSTRACT

This thesis explores art therapy with patients experiencing psychosis who also identify as ‘artists’, and arose from encounters in a psychiatric setting. It is argued that these patients struggle with art therapy in a way that is different from other non-artist patients and they may appear to have difficulties relating to the emergence of emotional aspects in their own or others’ artwork. This poses a potential problem for the art therapist who hopes to evoke insight for the patient, based on their artwork as self-expression.

This dilemma and the countertransference phenomena specific to this problem are, with one exception, unacknowledged in art therapy literature. Only one article, by Crane (1996), directly addresses art therapy with patients experiencing psychosis who identify as artists. This thesis reviews art therapy literature to explore possible defence mechanisms as used patients experiencing psychosis who identify as artists in art therapy. Four case studies of artist patients who undertook art therapy with the author are then presented. The psychological issues contributing to the artists’ experience and the issues facing the art therapist are investigated. This is complemented by comments made by other art therapists from a questionnaire based on this area of enquiry. Finally the thesis addresses the topic with reference to art therapy practice providing strategies to work with patients experiencing psychosis who also identify as artists. The case studies revealed that patients were more receptive to using art to express emotions when art therapy was experienced as containing and the research found that art therapy was generally supportive for artists when their defences were viewed as appropriate coping strategies.
Please note to protect patient identity images from this research cannot be reproduced in this publication at this time. A brief description of each image is provided in place of the image.

List of Figures ....................................................... Page

Figure 1, Greg, *Figurative image* ............................................. 59
Figure 2, Greg, *Sexualised image* ........................................... 60
Figure 3, Greg, *Fibreglass sculpture* ......................................... 61
Figure 4, Greg, *Death mask* .................................................. 63
Figure 5, Walter, *Portrait of fellow patient* .................. 64
Figure 6, Walter, *Poinsettias and eggs* ...................................... 65
Figure 7, Walter, *Copy of Vincent Van Gogh painting and signature* 65
Figure 8, Walter, *Portrait of Vincent Van Gogh* ....................... 66
Figure 9, Ben, *Portrait of Van Gogh* ........................................ 67
Figure 10, Ben, *School days* .................................................. 68
Figure 11, Ben, *Hell scene* ..................................................... 69
Figure 12, Joseph, *Face* ....................................................... 71
Figure 13, Joseph, *Red face* ................................................... 71
Figure 14, Joseph, *The half and half face* .............................. 72
Figure 15, Joseph, *Portrait of the art therapist* .................... 74

List of Tables .............................................................. Page

4.3.1 *Table of issues* relevant to case studies .......................... 75
4.3.2 Twelve similarities in the artists’ behaviour ......................... 78
4.3.3 Seven common responses of artists in art therapy .............. 79
4.4 Questionnaire responses .................................................. 80
1. INTRODUCTION

*Psychosis is not real madness, but is an excess of ego that fractures the envelope in which soul and self lie encircled in each other.*

Thomas Moore, Original Self.

One of the first issues in engaging a new client in art therapy can be expressed in the statement, “*but I can’t draw*”. The art therapist must address this hesitation to enable art therapy to ‘begin’. Imagine if the client is already an artist and experienced in art making. Imagine further if the client, identifying as an artist, has a relationship to the art-making process or the aesthetics of the end product and as such has mixed feelings about entering into art therapy. This research presents four case studies of patients experiencing psychosis, who also identify as artists. Their stories are explored alongside the countertransference experiences from the art therapy setting, and together with comments from other art therapists who have had artists as clients.

1.1 Overview of the research

In this thesis the phenomena of the patient who has psychosis and identifies as an artist in art therapy is explored. From a combination of a review of the literature and information from other art therapists, in the form of a questionnaire, this thesis argues that patients experiencing psychosis who identify as artists may have different responses than those not identifying as artists. In particular, this research finds that those patients identifying as artists have difficulty relating to the emergence of emotional aspects in their artwork when undertaking art therapy. This may pose a potential problem for the art therapist who hopes to evoke insight for the patient, based on their artwork as self-expression. This research suggests that this approach to art therapy maybe problematic to this patient group.

This thesis offers a psychoanalytical exploration of the topic as well as utilising a humanistic understanding of art therapy with patients experiencing psychosis who may have a poor capacity for gaining insight. The research begins with an introduction to relevant features of art therapy theory, followed by a comprehensive review of the literature. The literature review has been divided into two parts. The first details the work of twelve authors describing their experiences when working specifically with an artist in art therapy. Despite
Margaret Naumburg’s early account that the artist faces difficulties uncovering the meaning of their work in the art therapy process (Naumburg, 1958, 514), little has been written on patients experiencing psychosis who identifies as artists in art therapy with only one exception, Crane (1996), who directly addresses this topic.

The second part of the literature review examines defence mechanisms and the psychotic experience, from a psychoanalytical theoretical position. The literature suggests that, by attempting to keep their unconscious process controlled, the artist shows difficulty shifting from their outer to their inner worlds. Therefore they are unable to link the aesthetic with the psychological, creating a loss of access to meaning. Furthermore, the symptoms of psychotic thinking, such as narcissism and grandiosity, interfere with the artists’ capacity to experience art therapy as a holding environment.

The main argument of this thesis is that it is a combination of the artists’ psychosis together with their artistic identity that provides an intense set of circumstances that may lead to resistance in art therapy. Four case studies are presented which clinically explore this concept. The methodology involves both case study method and a self-reflective phenomenological approach. Responses from a questionnaire sent to and completed by practising art therapists complement the researcher’s thinking by offering comparisons of artists with non-artists as they experience art therapy.

In the results chapter the case material is presented, describing issues that arose in the four case studies. These are presented in a concise Table of issues. This material is then used to construct a discussion of the case material and questionnaire responses. Generalisations about the artists’ experiences are made and set against the art therapist’s own countertransference reactions as researcher. It is clear from the case studies that, initially, the patient experiencing psychosis who identifies as an artist may not find art therapy containing and thus they cannot access symbolic meaning in their own imagery. The results suggest that art therapy becomes more available to the patient once engagement has developed. The essential argument is that artists and art therapists could be in disagreement about the meaning of art produced in art therapy. In art therapy the message that art conveys is focused upon, because the art therapist believes that art communicates something, either consciously or unconsciously. The art therapist may be in conflict with the artist about this belief and furthermore may justify this by finding the artist is resisting therapy.

Thus the main conclusions reached are that there appears to be some differences working specifically with an patient experiencing psychosis who also identifies as an artist as opposed to the non-artist in art therapy and that both the artist’s artistic identity and their psychotic pathology play a part in defending against their capacity to utilise art therapy. Art
therapy, therefore, can only be experienced as therapeutic once psychotic symptoms are reduced. As the patient begins to be less defensive and maintains a stable ego function, art therapy can begin to be experienced as containing. The four case studies in this research provide evidence that this occurs, because all four artists continued to attend art therapy.

A series of recommendations to for effective art therapy practice are offered to take into account the needs of patient with psychosis who identifies as artists. Art therapy was found to be generally supportive for these patients and when the defences could be viewed as appropriate coping strategies. However, it would appear that art therapists working with artists, and specifically with patients experiencing psychosis who identify as artists, may need to take a more process-oriented approach that focuses on communication through art and on promoting the containing experience as a primary aspect of the therapy.

The thesis concludes with a discussion of the limitations of this exploratory study. This research highlights the difficulties within art therapy research to explore difficult aspects of clinical practice. As art therapy is a relatively new profession and research is still developing, it is hoped that this research will contribute to a greater discussion of the possibilities of art therapy.

Throughout this research the words ‘patient’ and ‘client’ are used interchangeably; however, the term ‘patient’ generally refers to someone attending art therapy who is an inpatient of a treatment facility. The terms ‘psychotic’ and ‘psychosis’ have been used to describe the formal psychiatric condition which includes thought disorder and hallucinations. However this thesis recognises that despite being given a formal diagnosis the person is subject to a fluctuating and episodic illness. Even those hospitalised with a psychotic illness will experience periods when they are more effected by symptoms than at other times. This changing nature of psychiatric illnesses makes it difficult to make generalisations and comparisons. However for the purposes of this research patients experiencing psychosis who also identify as artists have been described as an identifiable group as compared to those patients experiencing psychosis who do not identify in anyway as artists. This research wishes to respect the individuality of each person attending art therapy, and acknowledges that generalisations cannot fully explain the findings. This study also emphasises that each person’s individual background and personality highly influences how they experience the world and that art therapy treats all people as unique.

The introduction chapter provides an overview of art therapy as an entry to this thesis topic, since art therapy is a relatively new professional discipline, which is not yet widely understood. This chapter further outlines relevant aspects of art therapy theory and practice, historical developments and an examination of the concept of ‘art’ in psychiatry, in
order to provide a context for the study of patients experiencing psychosis who identify as artists in art therapy.

1.2 An introduction to Art Therapy

1.2.1 What is art therapy?

Simply put, art therapy uses creative expression within a therapeutic relationship; the art therapist facilitates a link between creative expression and personal explorations. The influence of early analytical writings of Carl Jung who studied the projection of the psyche of artists gave support to the concept that art was an important means of both conscious and unconscious communication (Jaffé, 1964, p. 250). Art therapy utilises a psychoanalytic framework, which recognises unconscious processes in art-making. It is through an exploration of the dynamics of both the therapeutic relationship and the art-making process that the client can work through issues that are important to them.

This thesis draws on the primary theories of art therapy; namely that art-making is a process of exploration and learning and that when art is made in a therapeutic relationship the patient can gain access to feelings that may not be consciously understood. The resulting image or art object may represent the transference and can become a receptacle for emotions that may be difficult to express, and as a result becomes a place of communication between the patient and therapist (Waller, 1993, p. 3).

1.2.2 Transference, countertransference and art therapy

Sigmund Freud developed a model of individual relationship, which used emotional insight to improve maladaptive internal processes. His techniques involving dream interpretation and free association facilitated unconscious material into consciousness via transference; this opened the doors for new forms of therapeutic intervention. It is by analysing the unprocessed, infantile projected feelings and desires, which are occurring within the therapy relationship, as transference, that deep-seated internal processes can be examined with a new self-awareness.

Freud (1961) describes transference as the revelation of “intense feelings which the patient has transferred on to the physician” (p.368). These feelings occurring in therapy are not accounted for by the physician’s behaviour, nor by the relationship involved in the treatment (Freud, 1961, p. 368). They are feelings previously formed in the patient in
relation to “some important figure out of his childhood or past (Freud, 1973, p. 31) and are as a result of the treatment, transferred on to the person of the physician.

Transference becomes important as it forms a resistance to the treatment and requires that attention be paid to it (Freud, 1961, p. 370). Freud goes on to describe how transference is central to the process of treatment stating,

The transference is overcome by showing the patient that his feelings do not originate in the current situation, and do not really concern the person of the physician, but that he is reproducing something that had happened to him long ago. In this way we require him to transform his repetition into recollection … so that with its help we can unlock the closed doors in the soul. (Freud, 1961, p. 371)

Transference is vital within the therapeutic relationship of art therapy, where the image also becomes a transference object. Schaverien (1992) argues that the picture is more than a description or illustration of the transference phenomena, but becomes a container in which transformation occurs (p. 7). When a picture brings the painter more in touch with their unconscious processes, it can “embody the transference and actually become a catalyst for its enactment in the therapy” (Schaverien, 1992, p. 90).

Countertransference similarly acts as a powerful force in art therapy. It describes the feelings the therapist experiences for the patient particularly in relation to responses to their transference (Eidelberg, 1968, p. 85). In art therapy countertransference often occurs in relation to the patient’s artwork, as well as to their expressed transference feelings. The aesthetics of the artwork can be evocative and significant information for the art therapist who is tuned to an understanding of making of artwork.

1.2.3 The triangular relationship

In art therapy, transference is expanded; not only is transference occurring in the therapeutic relationship, but also between the patient and the artwork, and between the therapist and the artwork. This three-way communication network or triangular relationship is an important structure on which art therapy is formed and the relationships to the artwork usually become the centre through which transference is examined. According to Case and Dalley (1992), the artwork holds the

significance of feeling, in that it acts as a receptacle for the phantasies, anxieties and other unconscious processes that are now emerging into consciousness for the client in therapy – it therefore must not only contain aspects of the transference relationship but a separate response also takes place in terms of the painting in its own right. (p. 62)
When transference is used therapeutically in art therapy, psychic projections occurring in both the artwork and interpersonally are interpreted, understood and integrated so that the patient more consciously controls unconscious difficulties. Feelings can be concretely depicted in drawings, clearly composed on paper, clay or other media. Importantly they can also be subtly hinted at in images in ways that are less consciously known. It is this unique aspect of using art-making, which is inherently linked to the unconscious processes as a means of communication that makes art therapy a powerful method of psychodynamic psychotherapy.

Case and Dalley (1992) suggest that the transference has a quality of illusion that requires the genuine receptivity of the therapist in order to become a reality (p.58). This receptivity is felt when a safely contained and therapeutic environment supports the client. Clear boundaries and a holding environment are essential for this in-depth work of the triangular transference relationship.

1.2.4 The holding environment

A therapeutic relationship can only take place where there is a feeling of safety and trust. The art studio, or place where art therapy takes place, becomes a contained space which, together with the therapist, provides physical, social and emotional holding. Making art in a contained environment can reduce anxiety, strengthen ego functions and foster self-esteem.

The process of engaging in art therapy itself can be a process of containment, since the art-making promotes expression of feeling and provides a concrete holding of this. The patient may have experienced inconsistencies in their life, but by entering into the consistent boundaries of art therapy, they can experience a protected arena in which to explore their own thoughts and feelings. Killick (2000) states that the art therapy room has the potential for containment. She likens the room to a skin that absorbs primitive processes. It is the physical environment, the therapist’s attention and the concreteness of the art materials, as opposed to just words, which hold the patient and enable them to access their own symbolic representations in art therapy. This approach is suitable for the chronically mentally ill patient who may be disconnected and experiencing inconsistencies in their sense of reality.

1.2.5 Unconscious projection utilised in art therapy

Utilising a psychoanalytic perspective, art therapy, makes use of unconscious processes that occur in the act of creating, and attempts to bring some insight as a result of
exploring the underlying meaning of the unconscious process. Case and Dalley (1992) state the creative process involves “tapping some inner reality of the person and therefore some expression of unconscious process” (p. 51). Art-making can be a conscious act and, as already stated, feelings can be concretely depicted in art, even though the portrayal of meaningful inner feeling states may result from more unconscious processes that the artist is not immediately aware of. Reflecting on the made image can produce some conscious understanding of the unconscious material projected on to the artwork. Reflecting like this, as one may on a dream, with another person forms the basis for the art therapy relationship. It comes not only from the image made, but also how it is perceived and accepted by the therapist. Art therapy, therefore, utilises creative expression within a therapeutic relationship; and the art therapist facilitates a link between the conscious and the unconscious and between creative expression and personal explorations, in an attempt to bring poorly understood feelings into clarity and order.

1.3 Historical development of art therapy as a treatment of psychosis

This thesis explores art therapy within the context of a psychiatric hospital. It is this particular environment where the psychiatric patient lives and undertakes art therapy that is the context for the thesis in this chapter. People have made use of art in hospitals well before art therapists encouraged them to do so. Art therapy practice has grown out of a rich culture of the arts, philosophy, psychology and medicine, with its origins dating back to the early 1700s. The literature written about art therapy and psychosis is substantial, and it is the intention of this chapter to provide an overview of the important aspects affecting the development of art therapy practice in psychiatric hospitals, so as to provide an understanding of the context given for the case studies in this research. This brief overview covers the historical developments, mostly in Britain and Europe, in order to illustrate the complex development of art therapy as a profession. The underlying theme provided in this chapter is the strong history of art therapy in treating patients in psychiatric facilities.

The emergence of art therapy as a profession came at the same time that psychodynamic theory became more widespread in health services, and although art therapy is highly influenced by its theories, it is an independent profession with its strong links to the art world. Therefore the historical origins of art therapy stem from the developments of both the arts and psychiatry. Accounts of the profession of art therapy acknowledge that the first art therapists were either artists, art educators or paramedical professionals using art in psychiatric and educational settings. These pioneers often had very different and even
conflicting views (Gilroy & Hanna, 1998; Hogan, 2001; Wood, 1997; Thomson, 1989). The history and development of art therapy is influenced by the climate of health services and intrinsically linked to the provision of mental health services. Wood (1997) has examined in detail the history of art therapy as a treatment for psychosis, and states that art therapists have continually been offering art therapy to people with psychosis since the 1930s (Wood, 1997, p. 144).

Adrian Hill was the first to use the words 'art therapy' in 1936, to loosely describe the therapeutic process he himself had experienced making art while as a patient hospitalised with tuberculosis (Thomson, 1989). Hill was instrumental in urging other tuberculosis patients to express themselves in painting. After witnessing “an improvement in their condition” he went on to bring art to a range of other patients (Thomson, 1989, p. 3). The first art therapy post was officially established in Britain in 1946 when Edward Adamson, an artist, was employed to offer art to patients with psychosis in a psychiatric hospital. Adamson initially founded his studio with a view that art-making would occupy the patients and his role was that of an advisor. However, he quickly understood that he was able to do much more to support the patients expressing their inner world. He found that a delicate role was required, as it was important not to comment on the work of these highly disturbed patients experiencing psychosis, but rather to provide an environment that accepted their work (Thomson, 1989). Around the same time E.M. Lyddiatt, an artist following a Jungian approach, set up art departments in hospitals following a “spontaneous painting and modelling approach”. The work of these early pioneers, influenced by developing psychoanalytic theories, led the move of artists to become art therapists.

The origins of art-making in psychiatric hospitals began well before Hill and Adamson. Thomson (1989) suggests that patients in hospitals were initiating creative activities in the early 1700s, as evidenced by the engravings of William Hogarth in 1735 that showed art on the asylum walls of Bedlam Hospital ward, in his work A rake’s progress (Thomson, 1989, p. 23). In the art world since the end of the nineteenth century there has been an interest in understanding the depth of the human psyche by understanding the experience of psychosis. The emotional content in artwork and what lies below the surface of human experience have promoted study in the art of the insane; this interest parallels the anthropological interest in primitive cultures and the philosophical notions of Romanticism in the arts. This concept will be further developed in the following chapter on psychiatric art.

It is the period after World War II that is recorded as the time art therapy had its beginnings as a profession. It is a pivotal period in history, where a number of new perspectives crucial to the philosophy of art therapy were being developed. Firstly, in the
decade after World War II, traumatised returned soldiers were viewed to need some form of rehabilitation for their mental distress; new services were developed to cater for these hospitalised people. Second, a new acceptance of the arts movement of Expressionism impacted the art and psychological worlds (Wood, 1997, p. 146). A tradition of art displaying strong emotional content and personal vision had become more popularly accepted. Not only artists and art critics, but also health professionals and the patients themselves began to explore their expression of feelings.

Furthermore, Wood (1997) points out, the climate of mental health treatment services changed in the post-war period. The introduction of new neuroleptic medications for the treatment of psychosis spelt a change in the philosophy of incarcerating the mentally ill, who were now also perceived as more psychologically available to make use of client-centred remediative services such as psychodynamic art therapy. It is during this period that art therapy established a practice within mental health settings, both in large psychiatric hospitals and in the newer community-based treatment centres.

It is interesting to note that not only did art therapists and health professionals develop new and more genuine treatment approaches to mental health in a changing post-war society, but the patients themselves, to some extent, extended a willingness to undergo new treatments. The significant changes in the art world during the several decades following World War II enabled art to become more accessible to the ordinary person, and the undertaking of painting in a hospital environment a more acceptable activity.

Art therapy has stemmed from the practice of the arts and has developed out of psychotherapy fuelled particularly by Sigmund Freud’s understanding of symbols. Which, according to Naumburg (1950) had a significant effect on both modern art and psychiatry (p.14). Art therapy also developed from the work of Carl Jung who further developed Freud’s concept that dream images can be understood symbolically when properly translated (Jung, 1990, p. 20). Jung believed that man unconsciously makes symbols of psychological importance as he expresses himself in language and in the visual arts (Jung, 1964, p. 232).

As artists began to be employed in hospitals, a theoretical system of therapy with art began to develop which gave rise to a conflict between the medical diagnostic perspective of art in psychiatry and that held by artists, who believed that art-making could be healing. This debate highlighted the difference between viewing a work of art as symptomatic of schizophrenia, and seeing the art as expressing one’s experience of such an illness. Art therapy began from both the efforts of these first artists and from physicians who recognised the healing potential of making art in hospital. At the same time, according to Gilroy and Hanna (1998), Jungian psychotherapists and psychiatrists interested in art of the insane were...
showing interest in the art made in hospitals and employed artists. These divergent views led to conflicts between the premises of art as intrinsically healing and that of art made in a psychodynamic relationship that brings about healing.

Art therapists are unusual amongst mental health professionals in their persistence in offering psychotherapy to people with psychotic illnesses. There is a general belief that psychotherapy, and consequently art therapy, cannot be tolerated by the acutely psychotic, and that their communications are bizarre and irrational. Nevertheless, art therapists continue to work with the psychotically ill, believing that they can have a healing effect and that the communications of psychotics are important. Wood (1997) goes further to suggest that perhaps there is a desire to unravel the apparently obscure meanings of psychotic art in order to discover universal truths (Wood, 1997, p. 161). Art therapy with the psychotically ill is often a difficult and existential realm, where the meanings of art made remain a mystery to the art therapist. Joy Schaverien (1997) describes this experience.

Contrary to the traditionally held view that psychosis produces powerfully inspired imagery, the pictures of psychotic patients are often repetitive, rudimentary and apparently devoid of meaningful imagery. Furthermore words written in the pictures seem to be a substitute for pictorial eloquence. (p. 21)

She goes on to say:

Through my own experience, and in supervision of colleagues, I have observed that the art psychotherapist may feel guilty and sometimes confesses a sense of near boredom when working with such patients. (p. 21)

Schaverien suggests that the pictures could embody the dulled state of mind, or absence of self, that the patient experiences. The therapist may be bored because the picture and the patient project this inner experience and she experiences their disconnection. More often than not, the chronically mentally ill patient in art therapy cannot verbalise meaning to their work. For the patient to actually talk about their work they have the difficult job of translating from visual image into words. This is further exacerbated by the symptoms of schizophrenia such as disturbed thinking, perceptual confusion, fragmentation and a disturbance of concrete or symbolic functioning.

It may be that it is the psychosis itself that creates difficulty in art therapy and steers the patient away from being capable of examining the meaning of their work. The art therapist must focus predominantly on the process of art-making, and on the environment it is made in, rather than its content. Art-making appears to offer a valid place for the non-rational process, where the art therapist, by accepting the art made, can accept the individual person.
The pioneers of art therapy varied in the origins of their practice: some began as artists, some as educators others as paramedical professionals. However, the core value of providing a place for the patient to communicate their own voice, through artistic expression, has always been the premise for art therapy. The role of the art therapist is to view and understand visual communications within the context of the therapeutic relationship, and to help the patient to express and communicate their internal world in an attempt to integrate split realities. This has been the basis of art therapy practice since the 1930s, and it has grown out of a rich culture of the arts, philosophy, psychology and medicine, with its origins dating back several centuries. Since World War II art therapy has continuously been offering a valid place for the non-rational process within psychiatric facilities. Institutionalisation and the medical model of psychiatry affect current provision of art therapy practice in such facilities.

1.4 Art therapy and institutionalisation

Institutionalisation plays an important part in any art therapy work with the hospitalised and chronically mentally ill. The symptoms of the patient, such as disordered thinking and loss of capacity for abstract thinking, may hamper the capacity of art therapy in this setting; moreover, the issues particular to the patient resulting from institutionalisation in large psychiatric facilities, in combination with symptoms of their mental illness, may affect the patients’ capacity to make use of art therapy.

Claire Skailes, a Jungian art therapist working with chronically mentally ill in England, described those living for inordinately long periods in psychiatric hospitals as the “forgotten people” (Skailes, 1997, p. 203). She states how they have been chronically ill for so long, that even their psychotic nature has become life-less; it is a state that is neither life nor death. She says, “ the actual psychosis from which they had suffered had become blurred which, combined with the medical treatment they received and their living an institutionalised life, had left them in a state that was often described as being a burnt out case” (Skailes, 1997, p. 203).

Art therapists have written extensively on their work in psychiatric facilities and much has been discussed about the conditions that patients live, informing art therapists as to how art therapy practice can be conducted under the various circumstances in large hospital environments (Patch & Refsnes, 1968; Young, 1975; Goodwin, 1978; Charlton, 1984; Edwards, 1986; Byers, 1988; Crane, 1996; Molloy, 1997; Skailes, 1997; Deco, 1998; Saotome, 1998 ). Art therapists have illustrated the difficulties and benefits of offering an
alternative to the institution through their work, and this has become a substantial part of art
therapy literature.

For the psychiatric patient, living for long periods in an institution can give rise to a
multitude of consequences, including living with other poorly functioning and aggressive
people in a large system, and a lack of privacy and control over their own possessions. An
individual in such a system becomes susceptible to constant hospital changes—in particular,
relationships are affected as staff are often rotated or leaving, there is often little contact with
family and the experience of connectedness is minimal except with other ill patients. The
people in psychiatric hospitals for long periods of time are rarely treated as individuals, but
rather seen only as a patient among many. There are constant losses and interruptions, which
leave the patient confused and powerless. They often have financial difficulties, surviving
on the remains of their pension money after hospital fees are paid, and the need for money
and other power becomes prominent over other ways of relating. Patients can become either
continually demanding or almost invisible, and are unable to make decisions for themselves
as they are herded to the clinic, bathroom or dining room day after day, with little semblance
of life in the outside world. Staff also are affected by years of psychotic transference and
become unable to shift from their own experience of institutionalisation.

The result of these experiences in combination with the effects of long-term illness
have been described by Warsi, an art therapist, quoted in Skailes (1997)

The former self may have been withdrawn altogether so that all
that remains is a dehumanised shell. The institutionalised self has
been stripped long ago of all the previously taken for granted
privileges of living in the outside world. His decisions are no
longer his own, there can be little sense of autonomy or freedom;
he is a feint surname on a large, bulky and impersonal case history
file. (p. 202)

Institutionalisation and the medical model affects the art therapist and art therapy
session, where there is little support for the provision of a containing environment. In my
experience it is difficult to integrate psychotherapeutic work with a medication-focused
treatment philosophy. In large hospitals the art therapist’s role is often conceived of as art
teacher, or as a resource artist for improving the hospital environment. Intuition and
creativity are constantly devalued and the old-style psychiatric care remains prominent
despite new graduates with modern concepts of holistic and individual approaches. The
psychosis of very ill people can also affect the therapist’s own mind, and the abstract nature
of disordered thinking often means with art therapy work it is very difficult to describe what
is going on and the gains made are usually gradual and small.
Despite this, art therapy provides an important role in psychiatric facilities. It challenges some of the long-term effects of institutionalisation by providing an alternative contained and supported environment where personal control, sense of belonging and meaning is actively sustained. It helps those people with disordered thinking to articulate their thoughts and to explore them, both through the physical act of creating art, but also in reflecting on the artwork with the art therapist, who can help concretise the experience counteracting a static psychotic state.

Art therapy can help provide meaning to life; where there is profound emptiness, disconnection and powerlessness, art therapy can offer creative growth and psychic nourishment to enable inner reconstruction by addressing underlying emotional conflicts and bringing a connection between the split-off parts and a form of reality (Molloy, 1997, p. 243). Art therapy enhances an active participation in the art therapy session, a sense of choice and control, and it can provide an alternative experience to the lack of privacy and control over their own possessions in simple ways such as providing an individual art folder safely kept in the same place.

For the psychiatric patient interpersonal relating is also significantly affected. Not only have they the result of years of institutionalisation living, but this in combination with chronic psychotic thinking makes it extremely difficult to work with the transference; according to Skailes (1997), it is near impossible. The insight-oriented approach of art therapy is not always easily accepted by patient or institution and it is often modified to better suit the typical patient experiencing psychosis who demonstrates an unwillingness to discuss feelings and shows difficulties with abstract thinking.

1.5 Psychiatric art

As already stated, the origins of art therapy stem from historical developments of both the arts and psychiatry. It is important to explore the specific role of arts in psychiatry, since it has profound effects on the attitudes to art-making and on art therapy in psychiatric facilities.

The links between art and psychopathology have been debated for over 2000 years, Plato and Aristotle viewed the artist as having qualities of a sick person, according to Esman (1988, p. 13). However, in Western Europe an interest in the art of the mentally ill started more formally in the late 1800s. It was at this time that patients’ drawings and detailed descriptions of how they were created were collected and used to establish a diagnosis of insanity. There was particular interest in the imagination and its connection to madness.
The artworks created by patients with schizophrenia came to represent, first for some psychiatrists and later of the general public, an image of deranged creativity that was at once fascinating and threatening (Maclagan, 1997, p. 131).

Psychiatrists as early as the 1870s began to study the art of the insane in an attempt to provide visual evidence of their psychopathology (Hogan, 2001, p. 57). Psychiatrists collected the art done by mentally ill patients and grouped them together according to certain characteristics such as unusual compositions, bizarre symbolism, the placing of one figure inside another and a complex use of text and texture (Maclagan, 1997, p. 131). The artwork was used to determine evidence of disease, which serviced to measure and document the nature of the mental disturbance. The early psychiatrists sought out patient artwork as diagnostic tools, but they did not consider it as having any therapeutic purposes.

Initially, artwork was of great interest to psychiatrists. In Europe, Hans Prinzhorn, a psychiatrist who had also studied art history, collected masses of patient artwork and published a book titled *Artistry of the mentally ill* in 1922. In the United States several prominent psychiatrists were writing about the characteristics of art made by people with schizophrenia in the 1920s and 1930s. However, things began to change as psychiatrists became influenced by the development of Freudian analytic therapy, and in the 1920s psychiatrist Edward Kempf commented that art was a form of sublimation and that it was also therapeutic to create. Another psychiatrist, Nolan Lewis, in 1925 postulated that art expressed unconscious motivation and defence mechanisms (Kramer, 1982, p. 75).

It was under Lewis’ direction after World War II, that American pioneer art therapist Margaret Naumburg (1950) developed her studies on the meaning of schizophrenic art. She focused on the value of using spontaneous art as a mode of therapy. It is from this time that art therapy began to take root in psychiatric facilities in the United States and in Europe.

### 1.5.1 Psychiatric art and art therapy

As already stated in this chapter, psychiatrists late in the nineteenth century studied the art of the insane in an attempt to provide visual evidence of their psychopathology. This belief was based on the assumption that the state of ‘madness’ was somehow closer to the primitive or unconscious human state—one that lacked restraint—and that the resulting art was pure or even that of genius.

Hogan (2001) argues that using art simply as evidence of pathology would mean art therapy was just a diagnostic tool for psychiatrists. Fortunately, art therapy has developed its own theoretical stance and professional identity. The belief that art can be evidence of
diagnosis is not the premise of art therapy; there is a deeper understanding of the purpose of art. Furthermore, the underlying concept that the art made by the patient experiencing psychosis can actually be translated into words at all, is best dismissed by art therapists, who find that such artwork reaches into the realms “beyond the intellectualised grasp of speech” (Hogan, 2001, pp. 87–88).

One of the aspects essential to the discussion of patients experiencing psychosis who also identify as artists engaging in art therapy is the concept of ‘mad art’ or artistic genius in connection with the art of the insane. Susan Hogan (2001) in her history of art therapy, devotes an entire chapter to discuss how expressive and ‘primitive arts’ have been linked with a degenerative mentality suggesting that there is something pathological in artwork that does not fit with those artworks done by people with higher social power (Hogan, 2001, p. 51). It is a common misconception that certain ways of painting or use of symbols are evidence of an artistic personality and conversely that people suffering psychosis are inherently going to produce fantastical art, and imaginative art like that of the mad artistic genius.

A good example is the popular portrayal of Vincent Van Gogh as a “misunderstood artist” and “mad genius” (National Gallery of Art, Washington, DC, 2006). Given the curiosity in understanding the art of the insane, audiences at a Van Gogh exhibition are tempted to study his art looking for signs of madness. As Butterfield (1998) explains in her website dedicated to amplifying this clichéd vision of Vincent Van Gogh.

The 19th century European society of Van Gogh's day was not ready to accept his truthful and emotionally morbid way of depicting his art subjects. His internal turbulence is clearly seen in most of his paintings, which set the stage for the direction of a new style of painting called Expressionism. It is characterized by the use of symbols and a style that expresses the artist's inner feelings about his subject.... Because Van Gogh was an Expressionistic painter, we know more about his internal life than we do about any of civilization's other Master painters. He alone has allowed us to peer into his mind, while he was in the act of creating his art.

1.5.2 Art therapy and the creative process

This romanticised concept of the ‘mad genius’ has occurred at different times in the history of European culture. It particularly suited the anti-psychiatry movement of the 1960s where treatment and cure were seen as beside the point (Wood, 1997, p. 159). The use of medication and other therapies were seen to be disruptive for the creative process of those rare geniuses. One can speculate that the work of Vincent Van Gogh may not have been as
creative if he had been treated for his madness. J. MacGregor published *The Discovery of the art of the insane* in 1989, although according to Wood (1997) it was written much earlier. In his text MacGregor encouraged psychiatrists to provide an environment where art could flourish. He wished that the creativity of the asylums of the last centuries could be afforded the psychiatric patients of today, and promoted less therapy and prolonged hospitalisation for the so-called mad geniuses as evidenced by their exceptional artwork. A discussion of whether psychotic art has now become extinct, as a result of modern psychiatric practices, can be further followed in Maclagan (1997).

Further interest developed in the creative processes of art with the mentally ill, particularly influenced by the writing of Carl Jung who having studied patients with schizophrenia, was convinced of the meaningful connections apparent in the individual use of symbols by patients diagnosed with schizophrenia (Jung, 1963, p. 125). Artists who began running art studios in hospitals after World War II highlighted the difference between viewing a work of art as symptomatic of schizophrenia, and seeing the art as expressing one’s individual experience of an illness. Art therapy began from the efforts of these first artists recognising and offering the healing potential of making art in hospital.

### 1.6 Art Therapy and group work

Group work is a significant aspect of art therapy as a treatment for psychotic illnesses. A substantial amount of art therapy literature focuses on group work with psychiatric patients, and much of it as therapy offered to long-term chronic patients (Wadeson, 1980; McNeilly, 1989; Greenwood & Layton, 1991; Waller, 1993; Crane, 1996; Wood, 1997; Greenwood, 1997; Deco, 1998; Skaife & Huet, 1998; Moon, 2002).

The rationale is more than economic, as group work emphasises human relating and communication processes in the *here and now*, both aspects often in deficit for the psychiatric patient. With groups of the chronically mentally ill, art therapy provides an opportunity for practising and developing communication skills in more indirect ways than conventional psychotherapy groups, because of the non-verbal processes available to art therapy. Those patients who are withdrawn and showing difficulty communicating, because of negative symptoms of psychotic illness, can work on their own in a group, although they are also making their art alongside others. This can lead to informal and safe social relating, with even such small communications as “pass the pencils”.

Waller (1993) suggests that art-making in the presence of a group may facilitate the patient to get in touch with early or unconscious feelings, as well as illuminate those
associated with the group and group dynamics. The private and often silent process of art-making in the group allows people to work together relatively unselfconsciously (Strand, 1990, p. 258). The roles acquired by patients in a group may represent those of their family of origin, thus feeding transference dynamics (Waller, 1993, p. 27). Furthermore, transference issues present in the artwork make it visible and available for the entire group to look at.

Art therapy groups often have a structured discussion time that is focused on concrete topics that relate to art made, and even those who don’t say anything can still relate to the group discussion, or just present their artwork. The structured and concrete nature of communication in art therapy groups is an ideal platform for providing human relating, which goes alongside the personal aspect of self-expression from art-making. The artwork, or lack of artwork, can speak for the individual and gives them presence in the group.

Art-making within a group context provides the opportunity to explore feelings and aspects of group dynamics that the group interaction brings to the surface. Art therapy offers a supportive and predictable environment which is ideally suited to the institutionalised, chronically ill psychiatric patients who often have immature egos and defence structures. Groups are an effective way to offer constancy, self-esteem and recognition in an environment often lacking this fundamental support for the individual (Greenwood, 1997, p. 124). Artists attend art therapy groups and can impact the group in many ways.

Despite art therapists having encountered artists in their work, very little has been written about the artist in art therapy groups. Crane (1996) wrote about psychotic clients with artistic identities in art therapy, and discusses the artist in the art therapy group. Specifically, Crane (1996) mentions the effect an artist can have on the group process and dynamics and also on the art therapist’s role in the group. Having a mix of artists and non-artists in a group can create difficulties. Crane describes the artists’ need to establish a “superior position in the group” (1996, p. 22) and to assert dominance and competition with others through art skill. One of Crane’s clients was described as needing to prove himself in the group and to “excite interest in himself from the group” (1996, p. 23). Crane’s artist clients showed preference to value only the artistic aspects of their work, and showed difficulty discussing the meaning in their own work, which resulted in the whole group suppressing feelings in relation to their own artwork. The introduction of patients identifying as artists in art therapy groups appears to add complexity to the group process and challenges for the art therapist.

The artist may expect the role of the therapist is to be more of a teacher than a therapist, with whom art skills can be discussed and developed, at the same time with
reluctance to explore any feelings produced in the group. Artists can have an unhelpful effect on the art therapy group, so much so that Crane considered it better not to mix artists and non-artists together. However, there seem to be some benefits to having artists undertake art therapy alongside non-artists. Crane states artists praised others’ work, and also gained self-esteem from the group who valued their artistic skill (1996, p. 22). Crane concludes that despite the destructive elements of the artists in the art therapy group it did not result in group members leaving; furthermore despite the tensions, having artists and non-artists in the group Crane was still able to provide fundamental containment for all (1996, p. 26).

The case studies for this thesis will provide further discussion on artists in art therapy groups, since group work is a common practice of art therapy. Art therapy groups are especially important for psychiatric patients who are often withdrawn and lacking communication skills; because groups provide the opportunity to explore aspects of group dynamics that the group interaction brings to the surface. When people work with others they find they have things in common; in groups there is recognition of the vital role relationships play, both negative and positive in developing self-awareness and self-esteem. Having a mix of artists and non-artists in a group can create difficulties, however; the introduction of patients identifying as artists in art therapy groups appears to add complexity to the group process and challenges for the art therapist. Patients experiencing psychosis who identify as artists may bring challenges to art therapy groups, but they may also bring rewards and gain from working with non-artists.

1.7 Summary

This chapter has provided an introduction to the context of this thesis topic. It has stated that art therapy utilises art-making within a therapeutic relationship that has been influenced by the work of Sigmund Freud and Carl Jung and has grown out of a rich culture of the arts and psychiatry. Art therapy with patients experiencing psychosis, may be challenging as the patient has communication difficulties resulting from the symptoms of psychosis exacerbated by institutionalisation. Historically, art made by psychiatric patients in hospitals has been romanticised by psychiatrists who used art for diagnostic purposes, and looked upon it as representative of unrestrained pure creativity. Contrary to this, art therapists often experience the art of patients experiencing psychosis as rudimentary and often devoid of meaning. These conflicting views have been presented to provide an introduction to the context of this thesis. The following literature reviews explore the ‘artist’ in art therapy and the theories of defence structures, which seem to be used by these artists in art therapy.
2. LITERATURE REVIEW

2.1 Part A: Art therapy with the patient experiencing psychosis who identifies as an artist: A review of the literature

2.1.1 Overview

A survey of the art therapy literature from the United Kingdom and United States of America has revealed very little written about art therapy with trained artists; and even less has been written about art therapists working with patients experiencing psychosis who also identify as artists. This gap in the literature appears surprising given that large numbers of art therapists work specifically with psychiatric patient populations. Twelve articles (Alter-Muri, 1994; Crane, 1996; Garai, 1973; Garai, 1974; Genser, 1985; Greenwood, 1994; Henley, 1992; Klorer, 1993; Muenchow & Arsenian, 1974; Naumburg, 1958; Naumburg, 1987; Ulman, 1975) were found which mention the art therapy process with an artist as a patient. Three dealt specifically with a patient experiencing psychosis who also identifies as an artist in art therapy (Crane, 1996; Greenwood, 1994; Muenchow & Arsenian 1974). The other nine articles address either professional artists in therapy who are not psychotic, or patients who developed an identity as an artist as a result of an art therapy experience (Alter-Muri, 1994; Garai, 1973; Garai, 1974; Genser, 1985; Henley, 1992; Klorer, 1993; Naumburg, 1958; Naumburg, 1987; Ulman, 1975).

These articles mention the effect of the artist on the therapy process and the effect on the therapist. Several articles (Crane, 1996; Greenwood, 1994; Henley, 1992; Muenchow & Arsenian, 1974; Naumburg, 1987) described how the artist in art therapy uses their technical skill to resist expressing spontaneous emotion in their art. They describe how the artist uses their art as a defence against interpretations of meaning, preferring instead to discuss the aesthetic aspects of their artwork.

Many art therapists described confusion or frustration when working with artists. Some art therapists felt they had to adopt a different role, such as an art educator or business manager, other art therapists became seduced by the aesthetics of the artwork or the developing talents of their artist client. When working with artists who were psychotic, several authors expressed the view that the therapy process needed to adjust to the needs of these particular patients. One author, Greenwood (1994), suggested the art therapy approach should focus on communication and several authors indicated that art therapists should allow art to act as the primary therapy. This said, the overall argument advanced in the literature review thus far is that, firstly, art therapy has been found to be nurturing for the artist and,
second, that an artist using their art as a defence against interpretations may actually be an appropriate coping strategy for someone experiencing psychosis. This literature review examined the twelve articles and discuss the themes, which suggest art therapy with an artist may be different from art therapy with a non-artist.

This literature review has been divided into two distinct parts. The first part reviewed the art therapy literature in relation to the phenomena of art therapy with an artist experiencing a psychotic disorder. The second part of the literature review dealt with psychological concepts that may account for the phenomena and examines defence mechanisms that may be in operation with a patient who experiences psychosis and also identifies as an artist undertakes art therapy.

2.1.2 Detailed review of the literature

There is a large body of art therapy literature that discusses the concept of the artist in therapy. Much of the literature comes from the United States (Amos, 1982; Esman, 1988; Garai, 1973; Honig, 1977; Langevin, Raine, Day & Waxer, 1975; Neimarevic, 1971; Rosen, 1975; Sommer & Cassandro, 2000; Stumpf, 1975; Ulman & Levy, 1968, to name just a few). These articles are mostly found to be in the art therapy journals from the 1960s onwards and tend to explore psychopathology and the creative process; often the authors were not art therapists.

There has been a long history of using art and the creative process to unlock the unconscious. Some of this literature specifically addresses the creativity of the mentally ill patient. Several articles traced the work of painters who had had a psychotic breakdown, their work was examined to demonstrate that the artwork after the breakdown was significantly different, and therefore indicative of their illness (Ulman & Levy, 1968; Neimarevic, 1971; Langevin, Raine, Day & Waxer, 1975; Sommer & Cassandro, 2000).

Only twelve articles were found that mention art therapy with an artist; they are Alter-Muri (1994), Crane (1996), Garai (1973), Garai (1974), Genser (1985), Greenwood (1994), Henley (1992), Klorer (1993), Muenchow & Arsenian (1974), Naumburg (1958), Naumburg (1987) and Ulman (1975). The majority of articles are not relevant to this thesis topic. Four authors describe the patient who becomes an artist as a result of the treatment with art therapy. Five articles deal with artists who were not diagnosed with a psychotic illness, who attended art therapy, often to help improve their creativity. The three remaining articles, Muenchow & Arsenian (1974), Greenwood (1994) and Crane (1996), are most relevant, since they are written by art therapists who have worked with patients experiencing...
psychosis who also identify as artists. Interestingly, the two most recent of these three articles were by British art therapists, whereas the bulk of the art therapy literature on this topic comes from the United States. In these twelve articles on the art therapy process with an artist, the majority mention some differences or difficulties working specifically with an artist as opposed to the non-artist.

Margaret Naumburg, the author of two of the twelve articles, was the first and the only art therapist to clearly state that “the approach to working with a professional artist must be different to that with a non-artist” (1958, p. 513). Naumburg, considered to be one of the pioneers of art therapy in the United States, believed that everyone, whether trained in art or not, has the capacity to use art to project their inner conflicts (1958, p. 511). In one of the earliest documents on art therapy, she wrote that art therapy is assumed to be most suitable for the artistically talented; however, the majority of successful treatments are with people who have not painted before (1958, p. 513). Naumburg’s research is worthy of further discussion as she has voiced arguments that are perhaps the most relevant to the research problematic addressed in this thesis.

2.1.3 The pioneering work of Margaret Naumburg

This belief that art therapy is for artists is a misconception, evidenced by the very little amount written about it and further by the difficulties that art therapists describe in their work with artists. Naumburg found, in her experience, that the artist, instead of readily utilising the art therapy process, uses their skill in art to defend against the expression of unconscious material (1958, p. 513). The artist will, according to Naumburg, face difficulties uncovering the meaning of their work and the success of art therapy may lie in the art therapist helping the artist to be free “from the tyranny of his technical knowledge” (1958, p. 514). In her book Dynamically oriented art therapy (1987), first published in 1966, Naumburg reiterated the difficulty of working with the professional artist, who resists working spontaneously or using art to release unconscious conflicts (1987, p. 4). The patient who is not experienced in art will do this more immediately, readily using their imagery as a symbolic communication of their inner world. Thus the non-artist is likely to utilise art therapy more readily than the artist.

In Dynamically oriented art therapy, Naumburg describes art therapy as a specific form of psychotherapy where the unconscious can be accessed through pictorial images, using case studies to illustrate her theories. One case study is with a professional artist who suffered from an ulcer and who sought therapy, as she experienced a block to her creativity. Naumburg states that, like many she had seen, initially the artist was fearful of art therapy,
believing that it may affect her creativity. Consequently the patient struggled throughout the therapy to not draw consciously. It took three months before the patient would spontaneously produce art, and even then she avoided responding to the art as an expression of her unconscious; instead she was excited by the new style of works being made and wished to turn them into serious art pieces (Naumburg, 1987, p. 59). Naumburg warned her patient against doing this, returning the focus to the process of art-making as an expression of her inner conflicts.

Having worked with many professional artists, Naumburg (1987) describes several elements specific to the artist in art therapy. First, being narcissistically identified with their art, the artist may be unable to separate himself or herself from their art and experience difficulty considering it as an unconscious representation (Naumburg, 1987, p. 3). Second, they may mistakenly seek art therapy as a therapy for artists when they experience a block in their creativity and conversely, at the same time, they may believe that by exploring their art in art therapy that the process will actually affect the originality of their artwork (Naumburg, 1987, p. 15). Third and finally, Naumburg stresses that the artists’ skill and knowledge in art tends to prevent a truly spontaneous release of unconscious material in their artwork (1987, p. 4). The artist may be so self conscious or defensive that they are unable to forget their art training and will concentrate only on the aesthetics of colour and form (Naumburg, 1987, p. 15).

It is interesting to note that of the ten other articles found on the artist as patient in art therapy, none referred to Margaret Naumburg’s ground-breaking work or used her ideas to further explore the process of the artist in art therapy. A few of the authors have described similar experiences and come to some comparable conclusions independently. Significantly, other than Naumburg, this review has found only a few casual references to the concept of the trained artist in art therapy literature (Welsby, 1998; Schaverien, 1993; Schaverien, 1997; Lyddiatt, 1970). This is despite the fact that Naumburg’s views were published in one of the pioneering texts on art therapy. Having discussed the ideas Naumburg has contributed to the literature on artists in art therapy, the concept of the ‘psychotic’ artist as patient in art therapy shall now be explored.

2.1.4 Art therapy with patients experiencing psychosis who identifies as artists

Art therapists have suggested that it is primarily the psychotic process that prevents the patient from seeking meaning in their artwork (see Mann, 1997, Maclagan, 2001, for instance, whose work shall be discussed later in this chapter). However, this literature review indicates that it is also the artist’s training and identity that brings about a defensive
reaction. It could be that a combination of psychosis and artist identity intensifies the defence mechanism. The most relevant three articles of the twelve previously mentioned are Crane (1996), Greenwood (1994) and Muenchow & Arsenian (1974). All three are written by art therapists who have worked with patients experiencing psychosis who also identify as artists. They each emphasise the patients’ reluctance to receive interpretations about their work and their defences against exploration of the meaning of their work.

Muenchow and Arsenian (1974) present a case study examining the art therapy treatment of a hospitalised patient experiencing psychosis who was talented and had attended art school prior to becoming ill. This patient seemed to defend at every stage against becoming involved with his art as an expression of his emotional world. The authors, one an art therapist and the other her consulting supervisor, describe the conflicts and complications as well as the frustration of working with this particular client.

There were specific aspects throughout the case study that were similar to Naumburg’s findings. For instance, the patient avoided viewing his art as an emotional expression and spoke of his artworks “only as artistic achievements”, talking around his artworks, not about them (Muenchow & Arsenian, 1974, p. 19). The patient, who was preoccupied with his art and grandiose about his talent, was clearly using his painting to resist accessing the therapeutic process on offer to him. At one time the patient demanded that the therapist develop the business end of his painting. The therapist became caught up in this dynamic, admitting to being more interested in the art than the patient (Muenchow & Arsenian, 1974, p. 19). The therapist appears to have become so exasperated that she eventually denied the patient access to art materials in an attempt to encourage him to talk about his works. In a somewhat macabre dance, this led to an escalation in his psychotic behaviour.

The patient’s strong reaction to this extreme therapeutic intervention suggests that his defence against interpretation of his unconscious conflicts was perhaps an appropriate and well-needed defence for his psychotic and fragmented ego (see the work of Mann, 1997 and Killick, 2000). One may also conclude that Muenchow and Arsenian (1974) did not allow the art therapy process to act as the primary therapy, instead pushing for verbal explanations to supplement the art-making.

However, the article, which has no references, does not come to this conclusion and clearly speaks of the art therapist’s frustration at the resulting confusion in her role and her difficulty addressing the patient’s unwillingness to use his art to seek insight into his unconscious projections. Muenchow and Arsenian (1974) conclude, like Naumburg, that “the psychotic artist was not able to separate himself from his artistic productions and that
his pathology both stimulated the art-making, yet it also interfered with his utilisation of art therapy”.

Art therapists have used the work of psychological theorists to understand their patients experiencing psychosis. In the second article of the three previously mentioned, Greenwood (1994) looks to another method to understand the artist patient’s defences and reluctance to receive the interpretations of art therapy.

Greenwood (1994) describes a case study of a woman with schizophrenia who had previously studied art for several years. This patient made ceramic pots that cracked. She struggled more generally with the art therapy process. Greenwood refers to the theories of Bion (1967) and Segal (1975) in order to explore the idea of containment in the cracking artwork occurring in the therapeutic relationship. Greenwood quotes Katherine Killick (1991) who states that a psychotic patient’s ability to use symbolic metaphor is disturbed, and this cannot be reformed until a containing relationship is developed (1994, p. 13). The patient, in the case study, was aware of the brokenness of her cracked pots, but could not see them in any way as a representative of herself, nor of her difficulty forming a relationship with Greenwood.

The artist patient attacked any interpretations offered by Greenwood and subsequently could not find meaning in her own artwork. She struggled with her difficulty when her pots cracked and ended up leaving the therapy because of her perception that she had lost her artistic ability. Greenwood concludes that art therapists, when working with patients experiencing psychosis, need to focus on the process of communication rather than on the content and meaning of artwork (1994, p. 13). Greenwood is suggesting that it is because the patient was psychotic that she defended against finding meaning, and she does not reflect on the patient’s identity as an artist, as a factor in this defence process.

Of the twelve articles, Crane (1996) wrote in greatest depth describing three case studies. He points out that there is a complex relationship between identification as an artist and defence mechanisms in art therapy. He questions the usefulness of doing art therapy with the patient experiencing psychosis who also identifies as an artist. He gives several case examples where the artist experienced difficulty with the art therapy process and he also found that group work was more difficult with an artist. Crane (1996) also examines issues pertaining to the role of the art therapist in relation to his case studies, where he was expected to become an art educator and artist at the expense of being a therapist.

Crane’s article gives a detailed account of the variety of issues he experienced in providing art therapy to three different patients experiencing psychosis who also identify as artists. Like other authors, mentioned in his literature review, Crane found that all those who
possessed a level of skill in art focused on the aesthetics in a defence against the art therapy process. The artist did not look for symbolic meaning in others or their own artwork and did not wish to discuss the meaning of pictures (1996, p. 22). The artists tended to relate to the art therapist as an artist, talking readily about exhibitions and attempts to sell the artwork (1996, p. 22); and tended to suppress expression of feelings in the quest for artistic ambitions (1996, p. 26).

Art therapy group work with an artist delivered its own complicating difficulties for Crane when the artists firstly tended to relate to other patients only via discussions of the fine art qualities of the pictures produced, secondly, tended to value ‘artistic’ patients over others, and thirdly, attempted to establish dominance and competition in the group (Crane, 1996, pp. 21-22). Crane states that the artists gained self-esteem from the group appreciation of their work (1996, p. 26), and this seemed to perpetuate the emphasis on aesthetic value at the expense of emotional self-expression for other group members. The taking of artwork from the group to be exhibited further amplified the difficulties for the group in valuing all art made equally. Two of the patients experiencing psychosis who also identify as artists showed some grandiose identification with famous artists such as Van Gogh and Mozart, and emulated known artists in style, subject matter and choice of materials, as well as a desire to exhibit. This created further problems for the group and the art therapist’s role.

Although the artist patient may refuse to engage in verbal discussion about expression of feelings in the paintings it was obvious to Crane that transference and strong feelings were occurring. This transference was not only in the symbolic content on display to the viewer of the art, but also in the sounds made while painting and in the treatment of the artwork (Crane, 1996, p. 23). One artist, despite a recognised skill in draughtsmanship, did not develop the majority of his pictures into full end-products, and tended to stop at sketches (Crane, 1996, p. 22). One might suggest that the patient’s lack of desire to continue with a piece reflects the lack of concentration and of the ‘draining’ uncontained experience of living with psychosis. However, Crane suggests that by not producing finished works of art, it is the patient’s acknowledgement that “although he may have received some art training, he is doing art therapy“ (1996, p. 22).

Despite Crane’s question about the usefulness of art therapy for the patient experiencing psychosis, he notes positively that the patient adjusted his creative process to utilise art therapy. Crane ends his article with some conclusions about creativity and art therapy, stating that although art therapy has been criticised for creating restrictions for artists and even destroying creativity, art therapy does actually provide a nurturing environment for the artist (1996, p. 27).
Art and creativity in psychiatric institutions has been documented in many forms’ however, with the exception of Crane (1996), Greenwood (1994) and Muenchow & Arsenian (1974), there is very little that specifically examines art therapy with the psychotic trained artist. The abovementioned three articles all emphasise that the patient experiencing psychosis who also identifies as an artist is reluctant to view the art as holding unconscious meaning, and instead the artist focuses on the aesthetics of their art. This has an impact on the art therapy process for the individual, the therapist and the group.

### 2.1.5 Becoming an artist as a result of doing art therapy

All the articles mentioned so far have expressed some difficulty working with the artist as patient in art therapy. It is interesting to note that these are the articles in which an art therapist has worked with a person who identified as an artist prior to the therapy, either through art training or years of practice. The following four articles describe art therapy situations where the patient has developed an identity as an artist as a result of doing art therapy; in this situation, the art therapist also finds some of the issues described in working with artists in art therapy.

It is not only the trained professional artist who defends with their art against insight-oriented art therapy. The artist who is not professionally trained brings a different element into the discussion. Alter-Muri (1994) describes a situation where her client acquired art skills during art therapy and then developed an identity as an artist. He then focused on the aesthetics at the expense of the art therapy using other defences, like sublimation, to keep himself distanced from the therapeutic relationship (Alter-Muri, 1994, p. 220).

Alter-Muri (1994) found that the artistic talent of this patient, with chronic schizophrenia, increased during three years of art therapy. Despite being an untrained artist he too defended against insight from his artwork. Alter-Muri, who takes a more humanistic approach, found that exhibiting this man’s artwork improved his feelings of self-worth. This man with chronic schizophrenia then developed a productive role as an artist and subsequently his psychotic symptoms decreased (1994, p. 223).

Alter-Muri, who made no mention of transference in her article, did note, however, that the patient refused to discuss or to make any attempts to gain insight from his art, in an attempt to defend his own disintegrated ego (1994, p. 220). She concludes that despite avoidance of interpersonal communication in the art therapy process, the patient, by actually
making the pictures, seem to be creating some kind of communication link with the therapist which revealed his inner emotions (1994, p. 221).

In a similar vein, Klorer (1993), an art therapist, explores the countertransference response she had to the differing roles she experienced when working with a young man whose artistic talent improved and dominated the art therapy. As the therapy continued Klorer admits she became seduced by her pleasure at facilitating such talent and was also seduced by the artworks themselves. As a therapist, Klorer found it was necessary for her to explore her countertransference response and she decided to stop offering art instruction to this client, particularly when he began drawing her as his naked model.

Like previous research noted in this chapter, Klorer found that when both herself and the patient focused on the technicalities and the aesthetics in art therapy it led to avoidance of the real issues present in the artwork. Moreover, as the patient became more of an ‘artist’ he had greater difficulties thinking that his art expressed anything of his inner world at all (Klorer, 1993, p. 223).

The following article describes how the patient uses his art as a defence against interpretations of meaning, in an attempt to focus on the aesthetic aspects of their artwork.

The aesthetics of art made in art therapy may change and develop over the course of therapy. Henley (1992) states he can determine the effectiveness of the therapy based on the perceived quality of the art made and uses his paper to defend this statement. The article, based on a case study, follows the therapy of a depressed 14-year-old boy who already considered himself to be a ‘true’ artist. As the client grappled with the split-off parts of himself, he also began to appropriately use sublimation in his artwork, which Henley consequently described as more sophisticated and more visually interesting (1992, p. 160). Henley concludes that once the boy’s ego was more secure he was able to play and to take greater creative risks in his artwork. Like Klorer, Henley seemed attracted to the aesthetic qualities of the art made by patients, which Henley believes reflects the progress made in art therapy. Henley, however, does not admit to the countertransference of the seduction of having facilitated an effective therapy, or connect this to his perception of an increase in aesthetic quality and pleasure in the patient’s art. It is interesting to note that Henley is implying that the more talented the patient became, the more he defended. Henley viewed the sublimation at least as an expression of emotion; it allowed the patient to keep a healthy distance from exploring his emotions before he was ready.

The last article describing art therapy where the patient develops an identity as an artist as a result of doing art therapy outlines the case example of a 16-year-old psychiatric inpatient, who developed artistic talent during art therapy. Ulman (1975) offered technical
help to the patient and emphasised art-making instead of words to be the therapy. Ulman, founder of the American Journal of Art Therapy, states she was the only one in the hospital who could relate to the patient, which was through the artwork. Ulman appears to take credit for the artistic development of her client, but unfortunately, due to her belief in the power of art as therapy, does not elaborate on the transference or develop the concept of the talented artist any further; nor does she mention any defence mechanisms in operation in the case study.

2.1.6 Art therapy and the artist identity

Garai (1974), Genser (1985) and Gordon (1983) all worked with artists who were not psychotic. Interestingly, none of these authors discussed any difficulty using art therapy with the artists and demonstrate some success in helping the artist. Garai (1974), an art therapist, worked with an art student who brought in his artworks to be examined by a verbal psychotherapy group, in an effort to seek personality integration. Garai (1974) provides a simple case study based on psychoanalytic concepts, with no reference to theory, nor does he explore the group dynamics or the transference. He provides a simplistic explanation that the artwork is a ‘translation’ of fantasies of his patient (1974, p. 163). While interpreting the images in a group situation Garai concluded that the artist benefited from this process, and was able to begin looking at the emotional aspects of his life through his work in the psychotherapy groups.

Genser (1985) developed a relationship with an aging patient who had suffered a stroke and could not speak. She found out the patient had previously been an artist and began engaging him in art-making. She claims this helped him to ‘return’ creativity to his life and to re-identify as an artist. Genser does not critically examine her work; she provides some simplistic values and assumptions that she applies to her patient such as “ultimately artists have to create” (1985, p. 99), without ever discussing the process of what was done or how the patient developed. Genser (1985) seems to subjectively elevate the creative process and the aesthetics, without providing evidence that this is what this mute man wished. Neglected also is any exploration of the transference that seemed to be evident in the case study. All non-verbal gestures were highly interpreted by Genser, whereas the process of the therapy conversely was not discussed.

Interestingly, Genser provides some discussion about the power of the artist’s identity in art therapy and that an artist, unlike the fearful first-timer, can readily engage with the art materials. Genser then argues that the patient’s previous history as an artist “was at once a help and a hindrance to the use of art as therapy” (1985, p. 97). Genser believed that
the patient’s initial rejection of art materials was because, having some disability through the stroke, he felt he could not live up to his previous expectations graphically (1985, p. 97). In the therapy, Genser describes the patient’s fear, without any objective evidence; she concludes that, as she has found herself, on completion of a work an artist may experience fear that the work is so good it will never be lived up to again (1985, p. 99). It is interesting to note that although this article was published in 1985, the article was written ten years earlier when Genser was a student on placement, which may explain some of the lack of rigour in the article.

Rosemary Gordon took part in a panel discussion titled ‘Does therapy disrupt the creative process?’, where she mentioned a patient who was a gifted artist. Gordon (1983) was offering a Jungian analytical approach and she encouraged the artist to paint in the sessions. She found that the patient recognised that the art done in the sessions was for a different purpose than the artwork she did professionally. Furthermore, the artist understood that the primary object of art-making in the therapy was to discover what was going on inside herself and to communicate this in the therapy (Gordon, 1983, p. 11). It is obvious from Gordon’s example that not all artists defend against using their art for self-discovery and that relatively healthy functioning artists can separate their professional artwork from that done for therapeutic purposes.

2.1.7 Conclusions

Many of these articles, from this literature review, particularly those published in United States and written in the 1970s, are not the result of carefully constructed research protocols or of transparent reflective consideration of the therapy literature. They often present a subjective view of the art therapy process. The case vignettes of Ulman (1975) and Alter-Muir (1994), for example, are vague and subjective, many statements are not accompanied by observations or clients’ words, and there is little accounting for the therapist’s responses or reasoning. In the 1970s the art therapy profession was still developing, publishing research helped to promote the profession and to provide an opportunity to build a recognisable theoretical base. Many art therapists were learning from each other before a recognised training became available. Given that research is difficult in the arts therapies, it is to be expected in the pioneering days that non-researched, simply reflective articles would initially be written on art therapy. This certainly makes it difficult to accurately explore art therapists’ experiences with artists. However, this does not adequately explain the gap in the literature, where articles on artists, even published after 2000, have not researched the area. The result is that in the art therapy literature little has
been written about art therapy with patients experiencing psychosis who also identify as artists.

This literature review examined twelve articles, three of which deal specifically with a patient experiencing psychosis who identify as an artist in art therapy. In these articles the artist often seemed to use their technical skill to defend against expressing their feelings and preferred instead to focus on the aesthetic aspects of their artwork. These patients experiencing psychosis who identify as artists appeared to present difficulties for art therapists, in particular their defence structures. However, art therapy was still found to be generally supportive for artists and the defence viewed as an appropriate coping strategy. It would appear from the literature thus far that art therapists working with artists, and specifically with patients experiencing psychosis who also identify as artists, might need to take a different approach, an approach that focuses more on the process of communication through art and less on the content and meaning and thus allowing the art-making to act as the primary aspect of the therapy.
2.2  Part B: Review of the literature examining defence mechanisms as used by the patient experiencing psychosis who identifies as an artist in art therapy

So far this literature review has found that working with patients experiencing psychosis who also identify as artists in art therapy has some difficulties and that the art therapist may need to take this into account when working with artists. Underlying this is a complex combination of the client having trained as an artist together with the experience of the symptoms of psychosis. It is these factors that create the unique defence mechanisms used by the patient in art therapy.

This next part discusses defence mechanisms and the psychotic experience from a theoretical and a psychoanalytical understanding, keeping in mind how the artist is defending in each instance in art therapy. The first issue to be discussed is the concept of how the patient experiencing psychosis attempts to keep their unconscious process controlled, and show that they have difficulty being able to shift between the inner and outer world, and therefore unable to link the aesthetic with the psychological. Next some of the symptoms of psychotic thinking that interfere with art therapy, such as concrete thinking, loss of meaning and abstraction, are discussed. This leads to how the patient experiencing psychosis who also identifies as an artist projects their unconscious into their artwork, but is unable to introject, thus preventing the art and art therapy from providing containment. Finally the narcissistic drives and grandiose features of these patients are discussed, in particular how this acts as another layer of defence mechanisms in art therapy.

2.2.1 Psychosis and defence mechanisms

Kaplan and Sadock (1991) define psychosis as having several persistent features these include thought disorder, a loss of reality*, hallucinations, delusions, regression of ego, personal role impairment, and social withdrawal (p. 227). Impaired ego and significant loss of reality are prime symptoms of the severely psychotic. They can prevent the patient from making sense of their artwork and relating effectively to the therapist. Such symptoms can leave the patient so overwhelmed that they act defensively to protect themselves.

The sense of emptiness and disconnection experienced with psychosis often means the patient can struggle with interpersonal relating; with poor emotional awareness they

* Although reality may be perceived of as a subjective realm, a loss of reality implies the person makes an assessment of reality that is inaccurate despite evidence that contradicts their perceptions of reality.
seem unable to communicate meaning from their artwork. A psychological knowledge of psychosis is an important way the art therapist can understand the defence mechanisms that the psychotic client might employ in art therapy.

The psychoanalytic understanding of psychosis is outlined in order to provide an overview of the psychological issues contributing to the defence mechanisms in art therapy by the patient experiencing psychosis who also identifies as an artist. As already stated these artist patients struggle with insight-oriented art therapy and, in particular, have difficulties relating to the emergence of emotions as expressed in their own artwork. For the psychodynamic art therapist who hopes to evoke insight for the patient, based on their artwork as self-expression, art therapy seems problematic. This part explores from a psychoanalytical understanding the defence mechanisms in art therapy and there is discussion on what might be going on in art therapy for the patient.

2.2.2 Psychosis as a defence mechanism

Psychoanalytic theory holds that all behaviour is motivated by unconscious drives. There is a constant monitoring by the Ego and Superego, as primitive unacceptable urges are in conflict with the socially acceptable or ideal self. When such unconscious aspects produce too much anxiety, defence mechanisms are developed for protection (Brown & Pedder; 1991, p. 24).

Psychosis itself can be viewed as a defence mechanism. Psychosis is diagnosed by the evidence of thought disorder, a symptom viewed by psychotherapy as a protective mechanism for a fragmented ego state. Wilfred Bion, a British psychoanalyst who worked clinically with schizophrenia, describes thought disorder as when the psychotic patient is unable to discriminate rational thought from fantasy. He states there is “a particular lack of resonance” (Bion, 1998, p. 15). The patient may articulate clearly, yet the speech has no sense of meaning; it leaves the listener unable to follow the psychotic patient’s train of thought (Bion, 1998, p. 15). Bion believes this dream-like state defends the ego against any attempts to make unconscious material consciously accessed (Bion, 1998, p. 16).

Otto Kernberg, a psychoanalyst and theorist, describes the patient experiencing psychosis as having overwhelming emotional reactions, and of living in a regressed state of symbiosis having lost the sense of being a separate self (Kernberg, 1992, p. 177). This is experienced as a frightening state of raw emotion, engulfment and confusion, where there is no boundary between the self and others. This is characterised by a loss of ego boundaries, a loss of a sense of self as separate from reality and of delusion formation. Kernberg sees the
psychotic patient as having trouble differentiating thought from behaviour and experience; it is as if they are all mixed together (Kernberg, 1992, p. 178). In therapy the patient experiencing psychosis cannot separate himself from the therapist, and they experience a “common identity with them” (Kernberg, 1992, p. 177).

This results in such defence mechanisms as splitting and projection to prevent complete dissolution or engulfment, which Kernberg states result in a reduced emotional awareness (1992, p. 173). Thus in art therapy the patient experiencing psychosis may present with thought disorder, have a fragmented ego state, feel a loss of sense of self or reality and be using primitive defences to protect themselves from conscious experience of their emotions. Kernberg (1992) warns that psychotherapy must be modified for the psychotic patient. The defences are an important coping strategy and interpreting personal and emotional material will bring about further regression (1992, p. 172). Paradoxically the defences, as resistance in therapy, enable a process of adjustment to occur.

Andre Green (1986), a psychoanalyst who followed a Lacanian approach to psychoanalysis, believes that using interpretation of transferences in psychotherapy with the psychotic patient can be experienced as intolerable pressure and as persecution (Green, 1986, p. 298). By a process of slowing “linking”, the unconscious can become conscious, and an adjustment to reality occurs (Green, 1986, p. 299). Both Kernberg and Green believe that therapy should be modified to reduce intense experiences of emotion and the therapist should use the powerful countertransference reactions to understand the patient’s experience, gradually creating a connection between what the patient experiences and the therapist’s reality.

Having described the defence mechanisms of the psychotic experience, the specific defence structures that may occur when the patient experiencing psychosis is an artist in art therapy are now discussed.

2.2.3 The artist defence mechanisms in art therapy

The act of art-making can be seen as a defence mechanism of its own. The painting process, according to David Mann (1997), a psychoanalytic art therapist, will embody the various defences the psyche itself employs. As such, art for the patient experiencing psychosis can be used defensively to avoid change (Mann, 1997, p. 73). It can be assumed that if the patient is utilising defence mechanisms, then artwork, which is an extension of the self, will be a further defence process. If interpretation of behaviour brings about regression for the patient, then similarly the interpretation of artwork will also bring about regression.
The defences used are there to protect the fragmented self from intense emotion and total dissolution. It therefore stands to reason that the patient will resist the exploration of emotional material in their artwork, and use their artwork defensively.

This premise, however, does not hold true of all patients experiencing psychosis who make art. It has been my experience that many patients will cope with sensitively placed remarks about the meaning of their art or even make their own investigations of the emotional content of their art. The patient experiencing psychosis who also identifies as an artist and who is trained or experienced in art prior to their psychosis, may react differently. There is an active resistance to seeking meaning in artwork, and a preference to view art as a product that can be discussed technically or in relation to its skill and aesthetic value. It seems that the psychotic ‘artist’ patient employs more defences toward artwork than by those patients who do not identify as an artist. It seems that it is the identity as an artist developed prior to illness that means that art becomes used as a tool of defence in a way that other non-artists do not in art therapy. It may be that the artist is deliberately trained to defend against the emotional aspects in their art.

2.2.4 The artist is trained to defend

Sigmund Freud, who studied artists and their work clearly believed that the artist used defence mechanisms. He wrote that the artist is probably “endowed with a powerful capacity for sublimation” (Freud, 1961, p. 314).

First of all he understands how to elaborate his day-dreams, so that they lose that personal note which grates upon strange ears and become enjoyable to others; he knows too how to modify them sufficiently so that their origin in prohibited sources is not easily detected. (Freud, 1961, p. 314).

Long before Freud however, Leonardo da Vinci reflected on the use of projection in artworks. Leonardo is said to have recognized that the artist “is inclined to lend to the figures he renders his own bodily experience, if he is not protected against this by long study” (Hammer, 1958, p. 8). Thus every drawing of a figure will have some element of self-portrait in it. Hammer (1958) quotes two professional artists who also support this: one says that the painter really paints two portraits, one of the sitter and one of himself; the other artist states “the artists does not see things as they are, but as he is” (Hammer, 1958, p. 8). Thus, the artist really only knows his own experiences and so will portray this in his work as a projection of himself. Leonardo also knew, though, that studying art taught the eye to see, and that the unconscious process of projection could be lessened by attempts to produce
realistic images. Therefore, the artist, through training, develops a defence against the experience of the self in art-making.

The identification and origins of defence mechanisms in art-making can be difficult to unravel. There are many theories on such a subjective topic. David Mann acknowledges that through art one can project inner experiences, although the image is more than just a direct translation of unconscious processes. Mann (1989) states that although painting will always hold an aspect of the self, the picture remains essentially outside of the self. The artist has a level of control that, unlike the dreamer, prevents a direct expression of the unconscious (Mann, 1989, p. 13). Mann attributes this control to the actual properties of the art materials as interfering factors that reside outside of the self, preventing the artwork from just becoming the self (Mann, 1989, p. 13). An artwork, according to Mann, always holds “elements of the other”—it has its own life, the paintbrush and the limitations of the paint can never be fully controlled.

Hammer (1958) also considers the artist is consciously controlling the art materials to defend against a total representation of the unconscious; and Mann (1989) suggests the unconscious can never be fully represented in the art, because the art can never be fully controlled. Both concepts contribute to explanations of how the artist is able to defend against representations of the unconscious in art-making.

Mickie Rosen, an art therapist, states that the artist removes the truth so as to make it acceptable (Rosen, 1975, p. 137). This is because, Rosen states, the artist who allows himself to believe that his art is the result of inner conflicts is afraid that resolving them will mean a loss of creative abilities (Rosen 1975, p. 137). Anna Freud, in the foreword to Joanna Field’s (real name, Marion Milner) *On not being able to paint* (1983), touches on this subject also. Freud describes the fear of the painter who puts pen to paper as a step into the unknown (Freud, 1983, p. xiii). Making art is a confronting process and there is an unwillingness to go into chaos or to suspend the perception of the external world. When there is too much uncertainty, the painter takes control of the process and so a scribble becomes a recognisable whole (Freud, 1983, p. xiii).

It is important for the artist to have a strong enough ego to be able to accept the fragmentation of making art, or else they must defend against the unconscious projections occurring at all. Therefore the artist learns to control projections in art-making, so as to not expose too much of the unconscious. They may even fear an exploration of unconscious process as it may affect the source of creative possibilities. If the artist is trained to defend, there can be a doubling of defence mechanisms when they have poor or fragmented ego such as in the experience of psychosis.
2.2.5 The patient experiencing psychosis who identifies as an artist in art therapy

The defences described above can appear as behaviour that acts as resistance in art therapy. This behaviour can be understood through the countertransference and can be interpreted as control over unconscious expression in art therapy. For instance, the artist may use repetitive images that lack spontaneity and may resist a desire to experiment. This preference to repeat familiar, seemingly safe artistic processes and to continue to use the same media has been noted in the art therapy literature. This is where the patient experiencing psychosis who identifies as an artist has a tendency to focus on the aesthetics or technical aspects of artworks alone. Various art therapists have experienced these defences in art therapy situations and this research attempts to understand the actions of the patient, with reference to literature on working with art therapy and psychosis.

2.2.6 The patient experiencing psychosis who identifies as an artist and ego strength

Sylvia Honig, an art therapist, suggests the patient experiencing psychosis will have with poor ego strength will not allow art to become an expression of the unconscious. Honig uses the work of Margaret Naumburg to outline her argument. She states that spontaneous art-making such as scribbling or experimenting is avoided by the patient experiencing psychosis, since it leads straight to their source of conflict (Honig, 1977, p. 99). Honig suggests that the greater the ego strength, the greater the ability to use art to express the self and to gain insight from doing so. Thus, the truly psychotic patient with disintegrated ego will not “accept aspects of their own pathology in their artwork” (Honig 1977, p. 99). Consequently, the patient experiencing psychosis who identifies as an artist who also has poor ego boundaries attempts to keep the unconscious under control and thereby ends up producing rigid, repetitive imagery that lacks spontaneity.

Interestingly, in my own clinical experience, non-artist patients experiencing psychosis, with poor ego boundaries, even those who are severely regressed, will with encouragement experiment making spontaneous uncontrolled artworks. Furthermore, as a plethora of literature on the benefits of using art therapy with severely regressed patients attests, the they will over time, begin to integrate unconscious content from the image. The patient’s increasing ability to express themselves in art becomes for them an objective measure of their expanding ego strength (Honig, 1977, p. 99). Seth-Smith (1997) states the
degree to which the patient can create an identifiable theme and organised composition is an
indication of the functioning capacity of the ego (Seth-Smith, 1997, p. 99). This then enables
the patient to begin to link experience and emotions for themselves. The patient
experiencing psychosis who identifies as an artist seems therefore less able to develop ego
strength and containment in art therapy, and continues to use art defensively against the
integrating of self and of gaining insight into unconscious conflicts.

Harriet Wadeson (1987) suggests that rigid or constrictive media can be used in art
therapy to support the regressed patient and to bolster defences. Conversely, less controlled
media or unfamiliar processes will challenge and confront the patient (Wadeson, 1987, p.
38). The art therapist can learn a lot about the patient’s level of ego functioning by their
approach to the image and the art materials and can use their observations to sensitively
promote the art therapy process. Patients experiencing psychosis who identify as artists must
be helped to feel safe and contained until they are able to use art therapeutically.

2.2.7 The patient experiencing psychosis who identifies as an artist and their
inability to shift between the inner and outer world

The following concept to be covered, in relation to the patient with psychosis who
identifies as an artist as they present in art therapy, has been developed by David Maclagan
in his book Psychological aesthetics (2001). Maclagan believes for the artist to have a
therapeutic relationship with their image, they must shift between being absorbed in their art
to then stepping back away from it (Maclagan, 2001, p. 90). Maclagan suggests that when
the artist can deal with the image both aesthetically and psychologically, moving fluidly
between these two different levels of consciousness, a form of self-therapy can occur
(Maclagan, 2001, p. 91).

The person with psychosis may have difficulties with such a process of shifting,
given the symptoms such as concrete thinking and poor ego strength. The patient
experiencing psychosis who identifies as an artist may struggle with this “uncomfortable
moment” which according to Maclagan is made more difficult by the public environment of
an art therapy setting (Maclagan, 2001, p. 91). In the privacy of an art studio the artist can
have a more personal relationship to their art. The patient identifying as an artist, may
experience a limited capacity to shift between the inner psychological and outer aesthetics of
the image, may reject being required to do so by the art therapist. It may be that the patient
experiencing psychosis who identifies as an artist is using the art therapy situation to
maintain a more private relationship to their art. They may wish to remain absorbed in the
image aesthetically, unable to shift to the psychological, and thus rejecting the audience of
the therapist, who is experienced as seeking to intrude and disrupt. Hence the patient identifying as an artist may defend against a shift to the inner psychological world of the art therapy process.

Joy Schaverien, an analytical art psychotherapist also supports the view that the artist maybe too conscious to let the unconscious develop in their work, as a result, she states artists maybe too defended to benefit from art therapy (Schaverien, 1992, p. 2). Maclagan (2001) explains that for art-making to be therapeutic it does need to be dealt with aesthetically; it is more than just a cathartic release of projected material for the artist (Maclagan, 2001, p. 90). In art therapy the art is made in an environment where it can be absorbing. Being in the act of art-making immerses the artist in the image, being present here and now in front of it. Maclagan (2001) believes that the next step is to shift to view the art as a psychological manifestation of the self. This is how the image connects us to our inner world and how it becomes a means for therapeutic change; the aesthetic leads to the psychological. It seems that the patient experiencing psychosis who identifies as an artist remains only with the aesthetic; it is both the psychosis and the artist’s attitude to art that prevents a therapeutic relationship with art occurring.

2.2.8 Insulating the psychological with the aesthetic

Linking the psychological and the aesthetic underpins the origins of art therapy and dates back to the early writings of psychoanalysis. Carl Jung wrote, “one of the basic principles of analytic psychology is that dream-images are to be understood symbolically” (Jung, 1990, p. 12). Jung, who encouraged his patients to use creative means to understand their unconscious material, conceded that some patients were not suited to this process, and furthermore, those who did make creative works in this way should not view these images as ‘art’ (Maclagan, 2001, p. 83). Jung also stated the patient should not even perceive themselves to be artists, as “this would spoil the effects of the exercise … it should not be a question of art” (Wood, 1997, p. 160). This concept suggests that perhaps those people who were faced with the psychological every time they did art tended not to continue making art, as it was too painful an experience. However, those who were not ‘suited’ to facing the psychological in their art were reinforced to view art aesthetically, and this then became for them the means for becoming an artist. This explanation may make clear why many artists, and in particular, patients experiencing psychosis who also identify as artists, focus predominantly on the aesthetic at the expense of the psychological. As Maclagan (2001, p. 83) suggests, both in therapy and for the artist generally, the aesthetic insulates the psychological.
A discrepancy appears between the patient experiencing psychosis who identifies as an artist’s understanding of why they make art and the art therapist’s. David Maclagan (2001, p. 90) distinguishes between a therapeutic relationship to the image and an aesthetic one. He indicates that few art therapists consider aesthetics as an important aspect in their work (Maclagan, 2001, p. 88). Both art therapy literature and training tend to put the therapeutic, and therefore the psychological, as central to art therapy. However, the patient experiencing psychosis who identifies as an artist is very obviously putting the aesthetic as primary in their engagement in art therapy, as well as distancing the psychological. This premise sets up a conflict between the artist patient and the therapist. Maclagan and other current art therapy literature (Case, 1996; Moon, 2002) indicate that art therapy can offer more by embracing the aesthetic aspects.

2.2.9 Concrete thinking prevents accessing psychological meaning

Having dealt with the concepts of the patient experiencing psychosis who identifies as an artist, controlling the unconscious, having poor ego strength, and being unable to shift between the inner and outer world. I shall now go on to explore the how the fragmentation of psychosis itself creates problems for the artist patient in art therapy. One of the reasons the patient experiencing psychosis who identifies as an artist finds difficulty perceiving a psychological aspect to their art is the concrete nature of thinking. Kane (1989) describes the psychotic condition as having “no symbolic functioning, no true imagination and no words for feelings and emotions” (p. 114).

David Mann (1997), an art therapist who worked with acutely psychotic patients, indicates that, as a distinguishing feature of psychosis, concrete thinking holds in suspension the capacity for metaphoric or symbolic thoughts (Mann, 1997, p. 72). There is a lack of ability to generalise, to be abstract or objective. Hence, Mann argues, art-making for the psychotic is not necessarily a creative undertaking but is used to act out defences (Mann, 1997, p. 72). He goes on to say, “I … take the view that everything an individual does is autobiographical. Everything he or she says, does or believes is expressed in psychological” ways (Mann, 1997, p. 73). Therefore the psychotic state of mind will be repeated in their artwork. “That is to say, whatever forms of defence the individual habitually deploys to cope with psychological distress and anxiety, such as projection, splitting, projective identification … will find expression in the painting process.” (Mann, 1997, p. 73) Art-making will therefore be experienced as concrete and without actual links to the inner world though metaphor.
2.2.10 Loss of the ‘as if’ quality

For David Mann (1997), psychosis means the loss of the ‘as if’ quality of experience. He gives a good example when he says someone with a neurotic disorder is concerned that people might be talking about them, or that you are like my mother; whereas the psychotic response would be they are talking about me and you are my mother (Mann, 1997, 72). Bion (1998) amplifies the loss of the ‘as if’ quality when he describes psychotic thinking as a loss of abstraction, so much so that words are experienced as things. He states:

… in some psychotics … the capacity for abstraction is destroyed. The value, for example, of the word dog, which does not refer to a specific animal but to a class, as a method of achieving abstraction and generalisation, is destroyed so that it can no longer be used as the name of a thing but is the thing in itself. (p. 52)

In an early article Katherine Killick (1991) warns the art therapist in describing the loss of meaning that psychotic patients experience in art therapy: “the psychotic patient’s imagery – if he or she produces imagery at all – can often appear seductively rich in symbolic meaning to the therapist wishing to ‘organise’ the material into ‘knowledge’” (p. 4).

Killick then quotes a psychoanalyst who worked with acutely psychotic patients and used the approach of Bion:

What passes for symbol may be an elemental sign of distress and horror. The psychotic patient signals rather then symbolises his ongoing sense of catastrophe. The material he uses may resemble symbols but they are used to point to an unnameable psychic reality. (M. Eigen, cited in Killick, 1991, p. 4)

When applying this line of thinking to art therapy, the art therapist must tread carefully. The patient experiencing psychosis who identifies as an artist appears only to be making ‘art’ and not making a representation of their inner expression. The artwork cannot be read and understood by the art therapist. In the severely psychotic patient their art is meaningless. The loss of the ‘as if’ in thinking becomes so profound that nothing makes any sense and nothing seems to exist. In this state art is unable to convey anything and cannot have any meaning. When the artist patient is not able to uncover the psychological aspects of their artwork, because of concrete thinking and a loss of symbolic thinking, there will be a significant inability to find personal meaning. The artwork as a representation of self cannot be accessed or even thought about.
2.2.11 Loss of meaning in art therapy results in repetitive artwork

When defences are in place to protect the fragile ego and there is an absence of a sense of meaning, the conscious and unconscious cannot link together and as a result interpretations or attempts to find meaning by the therapist will have to be delayed until there is a capacity for symbolic meaning. Artwork that is often repetitive and rudimentary appears to the therapist “devoid of meaningful imagery” (Schaverien, 1997, p. 21). Schaverien suggests that such pictures could embody the dulled state of mind, or absence of self that the patient experiences. The therapist may even be bored by the imagery because the picture and the patient project their inner defended experience and the therapist experiences their disconnection (Schaverien 1997, p. 21).

At times, the chronically mentally ill patient cannot verbalise meaning from their artwork in art therapy. For the patient to actually talk about their work they have the difficult job of translating from visual image into words. This is exacerbated by symptoms of schizophrenia such as perceptual confusion, and disturbed and fragmented thinking. The therapist is cut out from understanding the meaning and sense of meaninglessness cannot be communicated.

Fiona Seth-Smith (1997) likens this process to translating languages. She says what is understood by the patient and therapist is not equivalent; in the same way, no two languages comprise of words with exactly the same meaning. Furthermore, images may possess layers of meaning; each having their own form and structure, much like musical forms, which by their very nature can be spoken about, but never be translated into a linguistic code (Seth-Smith, 1997, p. 90). Irene Champernowne, a Jungian analyst and pioneer in the art therapy field, stated in 1971:

The ego is already too drowned in the unconscious experiences itself to be illuminated by that which has been created … it is rare for the painter already swallowed up by the flood of images to come through to a conscious grasp of his own creation… (cited by Wood; 1997, p. 158)

The patient experiencing psychosis who identifies as an artist in art therapy may be unable to grasp any conscious meaning and may feel threatened when required to do so. This loss of meaning also acts as a defence structure for the artist patient who is therefore unable to utilise the insight-oriented art therapy process.
2.2.12 The patient experiencing psychosis who identifies as an artist and their inability to introject

The psychotic patient may feel threatened because what they have done is project their unconscious fears into the artwork and they are not ready or able to reclaim them. When these unwanted psychical contents are expelled into the external world through the artwork, the projected elements are no longer experienced as part of the self (Mann, 1997, p. 74). The artwork therefore cannot be connected to the self, nor safely linked to consciousness. The therapist’s task is to digest such projections and then to facilitate a process where the patient is able to introject this material by linking it to the conscious experience, thereby making sense of it and allowing change to occur. The patient with a history of psychosis who identifies as an artist may reject the holding capacity of the artwork or indeed the therapist, since they are unable to introject and unable to use the process of interpretive linking. When putting all these concepts together it seems that the features of psychosis actually promote a fixation to the aesthetic and a rejection of art therapy. Furthermore the patient, who is unable to introject, seems to be actively rejecting the holding capacity of art therapy.

2.2.13 Rejection of art therapy as holding

When the contents of an image has been distressing, the patient may destroy the image or attempt to remove it from a psychological gaze (Wadeson, 1987, p. 39). The patient experiencing psychosis who identifies as an artist may be attempting to destroy the containing capacity of an image, or that of the therapist, by focusing on aesthetic aspects and avoiding the psychological. In my experience it seems that the artist patient struggles with the containment of art therapy and may even attack the art therapy process. I shall discuss how this can occur and how the patient experiencing psychosis who identifies as an artist seems different from the psychotic non-artist patient in art therapy in the discussion later in this thesis.

Katherine Killick (2000), who uses the work of Bion to understand the art therapy processes with the severely ill psychotic patient, states that psychosis is a state of un-integration, where the patient experiences being “without a space inside the self in which experiences can be held, and potentially digested” (Killick, 2000, p. 100). When emotional experiences are not held for the patient experiencing psychosis, they may experience trauma and severe anxiety and this threatens to destroy the self. Being projected out from the self
defends against this internal anxiety. Projecting in this way leaves the patient fragmented and depleted.

Art therapy can be a helpful process in re-establishing and re-integrating a sense of self. In a contained art therapy environment the patient can safely project anxieties or unwanted painful experiences into their artwork—this occurs unconsciously. The artwork, the art room and the therapeutic relationship ‘holds’ these experiences and contains something of them for the patient. The therapy process ‘contains’ the artwork and the art-making process, absorbing the impact of projected primitive affective states (Killick, 2000, p. 99). This holding experience is coupled with the therapist’s attempts to make sense of these projections.

In the course of art therapy a ‘personal’ metaphorical language is developed to relate experiences to the therapist. A sense of self as a separate being begins as the patient re-absorbs these modified emotional states experiencing a sense of wholeness as a separate individual.

Schaverien (2000) concurs with this process, stating:

For some clients, relating via the mediation of an art object permits the development of the ability to symbolise. Thus, eventually, the ability to relate as a separate person and even to use language in relationship may be developed. (p. 67).

Art-making in combination with a therapeutic relationship enables the psychotic patient to begin to communicate and develop their own symbolic language. The patient introjects these previously projected unwanted experiences back into themselves, thus reincorporating the experiences, which have been held and digested by the therapy creating a more whole and concrete experience of the self.

When exploring the patient’s experience of the holding environment there seem to be extra stumbling blocks resulting from their identification as an artist. They may even attack the containing capacity of art therapy. Patients identifying as artists who are also suffering chronic and severe psychotic illnesses seem to have particular difficulty, not only in finding meaning in the artwork and in utilising the artwork as a way to communicate meaning, but in also allowing the art to be contained by the art therapy process. Katherine Killick (1997) states that removal of artwork from the setting could be seen as the patient’s attempt to concretely evacuate from the mind unconscious material held or expressed in the object (Killick, 1997, p. 43). The removal acts to destroy the containing capacity of the art and of the therapist. Killick reassuringly states the patient will indicate when they bring back artwork that they are ready to face the material projected into artwork. (Killick, 1997, p. 43)
2.2.14 The patient experiencing psychosis who identifies as an artist is narcissistically driven

Having looked at how defence mechanisms and concrete thinking contribute to the difficulties which the patient experiencing psychosis who identifies as an artist may find with art therapy, I shall now explore how narcissistic elements of the these patients occur in art therapy. The patient with a regressed ego state or with a poor sense of self will utilise primitive processes in attempts to keep a sense of self together. This may be expressed as grandiosity, exhibitionistic and narcissistic qualities. The artist may overvalue their artistic skills, wish to be admired as omnipotent, idealise others and show perfectionist traits. These qualities are informally thought of to represent the artistic identity and may be heightened by the primitive state of the patient with psychosis who identifies as an artist.

Mildred Lachman-Chapin (1979) uses the theory of Heinz Kohut, a Self Psychologist, to understand narcissism in art therapy. Kohut showed an interest in the creative act, which he believed to be a way of restoring the ego. He believed the creative act itself was narcissistically driven and thus involves an over-concern with the Self, and is demonstrated by exhibitionistic or grandiose views of the artist (Lachman-Chapin, 1979, p. 3). Kohut (1966), a psychological theorist, wrote:

creative artists … may be attached to their work with the intensity of an addiction, and they try to control and shape it with forces and for purposes that belong to a narcissistically experienced world. They are trying to re-create a perfection that formerly was directly an attribute of their own (as cited in Lachman-Chapin, 1979, p. 6).

Kohut’s theories suggest that it is through a narcissistic investment in creativity that change and individuation can occur; however, if there is not a robust ego, the art-making may not help support a healthy growth of the individual. The egocentric artistic identity, preferred and idealised by the patient experiencing psychosis who identifies as an artist, may even exacerbate psychotic features, further contributing to the resistance of art therapy.

Ellen Spitz, a lecturer in aesthetics in psychiatry, makes links between the artistic identity and psychiatric disorder. She states “narcissism, idealisation and magical thinking are … endemic both to creativity and to certain forms of psychopathology” (Spitz, 1989, p. 243). Although Spitz (1989) is referring specifically to addictive behaviour and psychosomatic illness, the patient experiencing psychosis who identifies as an artist, also tends to utilise the non-rational processes of magical thinking, narcissism, and idealisation, often identifying as a ‘creative genius’. The artist patient seems to be using their encounters with art to magically heal narcissistic wounds. This is done, according to Spitz, through self-
aggrandisement or grandiosity (1989, p. 246). Spitz compares the intense relationship of the artist to their art with an infant who seeks to recover lost narcissistic perfection by finding perfect union with the other. This blissful state becomes the motivator for creative acts, which have the potential to heal, but also to further defensively split, the ego (1989, p. 246).

Narcissism and grandiosity feature heavily in the patient experiencing psychosis who identifies as an artist’s, presentation in art therapy. They seem to continually express a desire to produce something aesthetically worthwhile and to seek acknowledgement from the therapist and others. Their search for self-approval is demonstrated by their focus on the technical and aesthetic values, and by strong desires to sell or to exhibit art which is heavily invested in proving self-value. Repetitive art-making, as already described as a feature of the artist patient, can serve as a magical act “maintaining the illusion of external synchronicity” (Spitz, 1989, p. 250), where the psyche is momentarily held together in the struggle to heal. However, before reunification can occur, the unconscious projection must be consciously understood through the processes of symbolisation, which as indicated earlier, is unavailable for the patient experiencing severe psychotic symptoms. As the patient makes art in art therapy, they appear to maintain the delusional notions of self-aggrandisement and grandiosity, unable to heal their narcissistic wounds but to continue them through art-making.

2.2.15 Conclusion

In this part I have shown that the patient experiencing psychosis who identifies as an artist, who is trained or experienced in art prior to their psychosis, is somehow reacting differently from the non-artist in art therapy. They are putting the aesthetic experience of art as primary in their engagement in art therapy and distancing the psychological, unable to shift between the inner and outer worlds. There appear to be particular features in the behaviour of these patients which act as resistance to art therapy. Poor ego strength and a loss of a sense of meaning leaves the patient experiencing psychosis who identifies as an artist unable to introject, and it seems that they may even attack the containing element of the art therapy process. The creative act can also be viewed as a narcissistic search for perfection, in which the patient experiencing psychosis who identifies, as an artist is grandiose and further unable to make sense of the unconscious material projected in their artwork.

The patient experiencing psychosis who identifies as an artist is operating under a complex defence system in art therapy that is different from the non-artist. This results from both their experience of psychosis and of identifying as an artist. This is further complicated
by a discrepancy between the artist patient’s understandings of why they make art and the art therapist’s. The art therapy literature has not adequately dealt with this concept nor connected these aspects together. It is through research of this topic that the art therapist can have knowledge of the defence structures employed in art therapy, and to find ways to modify their approach in order to work effectively with the patient experiencing psychosis who identifies as an artist in individual or group art therapy sessions.

2.3 Summary of review of literature

As stated previously, little has been written about art therapy with patients experiencing psychosis who also identifies as artists although there is much written on artists in the art therapy literature. The first part of this literature review presented the work of twelve authors describing the differences and difficulties working specifically with an artist as opposed to a non-artist in art therapy. Much of the literature presented is not the result of carefully constructed research or of transparent, reflective consideration. This makes it difficult to accurately explore art therapists’ experiences with artists. However, Margaret Naumburg’s early account is precise and informative. She argued that art therapy is assumed to be most suitable for the artistically talented; however, the majority of successful treatments are with people who have not painted before. She clearly saw a difference between the artist and non-artist, although she believed that everyone, whether trained in art or not, has the capacity to use art therapy to project their inner conflicts. Naumburg argues that the approach to working with a professional artist must be different to that with a non-artist.

The literature review then discussed art therapy specifically with patients experiencing psychosis who identified as artists. There is a dearth of research into this area, with only three articles relevant to this topic. All three articles describe how the patient experiencing psychosis who identifies as an artist uses their technical skill to defend against expressing their feelings in art therapy. These patients appeared to present difficulties for art therapists, however art therapy was still found to be generally supportive for artists and the defence viewed as an appropriate coping strategy. It would appear from the literature thus far that art therapists working with artists, and specifically with patients experiencing psychosis who also identify as artists, might need to take a different approach, focusing more on the process of communication through art and less on the content and meaning allowing the art-making to act as the primary therapy.

The second part of this literature review examines defence mechanisms and the psychotic experience from a theoretical position and in particular from a psychoanalytical
understanding. The artist may appear to struggle with art therapy. The literature suggests that by attempting to keep their unconscious process controlled, the artist has difficulty being able to shift between the inner and outer world, and therefore unable to link the aesthetic with the psychological, so there is a loss of meaning. Furthermore the symptoms of psychotic thinking interfere with art therapy, such as narcissism and grandiosity. The patient experiencing psychosis who identifies as an artist also is unable to introject, thus preventing the art and art therapy from providing containment.

This literature review asserts that it is the psychosis together with the artistic identity that provides an intense environment for resistance in art therapy. Art therapists have usually described the psychotic process that prevents the patient from utilising art therapy. However, this literature review indicates that it is also the artist’s training and identity that brings about a defensive reaction. It could be that a combination of psychosis and artist identity intensifies the defence mechanism. Nevertheless, whether trained in art or not, every patient can benefit from art therapy.
3. METHODOLOGY

3.1 Background

The focus of this thesis was developed out of my experiences of conducting art therapy work with artists who experience psychosis. This work has been written up into case studies to form a central part of the investigation. The central issue of the thesis is that the patient suffering with psychosis who also identifies as an artist will experience art therapy differently from the psychiatric patient who does not identify as an artist, and also presents particular issues for the art therapist. This thesis has grown out of my own work as an art therapist with hospitalised people diagnosed with chronic mental illness. It is through close observation and analysis of relevant cases that the data has been gathered. This shall be examined to offer insights and knowledge into this unexplored area of art therapy practice. Additionally, data from other art therapists’ experience as derived from a questionnaire is considered alongside the case study material.

3.2 Method of study

The two areas of research presented in this thesis are the case studies data and the material gathered from questionnaires from art therapists. Case study method is the primary methodology applied to this research. It brings much to art therapy research because it treats each client as an individual; it embraces diversity and complexity and enables multiple explanations, including the opinion of the therapist alongside the research data (Edwards, 1999, p. 6).

David Edwards (1999), an art therapist, states that case study method is a reliable and valid research tool that uses the subjective experience essential when researching the phenomena of transference (p. 4). He goes on to say that although the case study is a subjective method of enquiry it still “has the potential to enable art therapists to rigorously examine and explore key aspects of their clinical practice” (p. 2). Gilroy (1996) argues that research based on case studies actually gives credence to the capacity of art therapists as experienced clinicians to be critically subjective of their assessments of patients in treatment (p. 55).

In this thesis clinical case material has been reflected upon and data selected to develop detailed case descriptions into four coherent stories of artists who undertook art therapy. Story telling is an important part of case study method as “it is through stories that meaning is created and shared both inside and outside the clinical setting” (Edwards, 1999,
The material chosen for the case studies has been informed by the literature review and resonates with prominent issues that have arisen from the clinical practice of art therapy with these four artists. This material forms the Table of issues (see Table 4.3.1). Furthermore, the case studies are considered in light of the therapist’s own story, reflecting upon the case material she has actively participated in.

The case studies are further presented in a quasi-historical style where the context of the case material is explored reflectively to enable a full examination of the terrain for this study within this developing field of art therapy. It is important to examine a broad scope of the case studies so as to comprehend the complexities of this area of study. Behaviour of the artists must be seen in the context of their own past behaviour in order to examine links and meaning for that person. In many ways the case studies speak for themselves and the comparisons made are implicit rather than explicit.

As more than one methodology has been used in this study, triangulation has been employed, to bring to bear different approaches to the same research questions. For instance, despite an overall Freudian or psychodynamic approach to reflecting on the case material, a humanistic approach also affects reflection, so each person is envisioned as a unique individual.

In this research a phenomenological approach has also been used. John McLeod (2001) states that phenomenology seems to have an easy affinity with the applied fields of counselling and psychotherapy (p. 40). He states the qualitative research tool of phenomenology is grounded in self-reflection (McLeod, 2001, p. 40) and “involves using language to describe what lies beyond language” (McLeod, 2001, p. 36). It offers a description of everyday experience that has been explored from many angles and reduced down to its essential components, the essence of the phenomena. Rather than reach definitive conclusions, this research uses a summation of the observations from the case studies and questionnaire data to reach interpretations and exploratory generalisations for this research enquiry. A phenomenological approach is appropriate for this open-ended and loose exploratory research of individual artists undertaking art therapy, as it reflexively regards the findings to “comprise a truth rather than the truth” (McLeod, 2001, p. 38).
3.3 The setting

In this thesis I have attempted to address research questions through examination of case material from my own art therapy clinical practice. It is necessary to briefly describe the setting and context for the case study material before providing the case study accounts. All of the case study material is from art therapy sessions that took place in an art studio space located in a large psychiatric hospital. This art therapy studio is one of eight rehabilitation programs in the hospital, and the art therapy aims to assist in the exploration and development of non-verbal self-expression. The patient is encouraged to reflect on their experience of art-making and they may begin to use their artwork to represent their feelings. The art studio is in contrast to a classroom or the routine of the ward; it is free from judgments about ‘good’ art and relatively free from intrusions of hospital life. The art studio provides physical, social and emotional holding in an attempt to enable patients to make use of their own symbolic representations.

An artist who had been employed by the hospital had previously run the groups for many years as art classes. Therefore as the first art therapist replacing an art teacher in this position I had to develop the groups to fit more of a therapeutic framework and cautiously began to introduce art therapy. The issue of how to run art therapy with patients who had previously worked with an artist introduced me straight away to considering my role as an artist and therapist, and the patient’s role as artist and group member. As a new graduate of art therapy I gradually developed confidence and found ways to integrate my ethics and theoretical framework with my perception of the patients’ needs and have ended up with a humanistic approach with a psychodynamic underpinning. Nevertheless, my struggle with the artist in the art therapy has continued throughout the ten years’ continuous work in this hospital.

The therapeutic approach offered in the art therapy sessions was generally based on psychoanalytic principles: one that recognised the unconscious process and explored this in the context of the group issues as well as the dynamics of the relationships of the therapist with the patient, in addition to their artwork. This approach, which focused on the emotional depths of individuals, did not fit well within the hospital, which centred on a Medical model, and concentrated primarily on medication and treatment through a medical, primarily physical, perspective. The art therapy had to seek a balance where the work was relevant to the patients but also understood by the hospital. For this to occur a humanistic approach was also utilised. As most of the patients were relatively low functioning, with little capacity for insight, the therapy focused mostly on improving quality of life and of providing an experience of people working together in the *Here and Now*.
According to Garai (1987), a humanistic approach values the whole person as a unique individual. The subjective experience of clients is primary in their search for self-actualisation and self-knowing. The focus of therapy is not conflict-driven but rather promoting the individual’s own strengths and self-worth, and in letting the individual discover their own sense of meaning and personal identity. The therapist is empathetic and promotes choice and freethinking. By offering consistent boundaries of therapy such as the same time and place, the patient can experience a protected arena in which to explore their own thoughts and feelings. Killick (2000) states the art therapy room has the potential for containment. She likens the room to a skin that absorbs primitive processes. It is the physical environment, the therapist’s attention and the concreteness of the art materials, as opposed to just words, which also holds the patient and enables them to access their own symbolic representations. This approach is ideal for the chronically mentally ill patient who may be disconnected and experiencing inconsistencies in their sense of reality.

The case material is derived from two different group art therapy sessions. One group was a closed, undirected art therapy group conducted in collaboration with another staff member, usually an occupational therapist. This group included a formal group discussion focused on the art-making and group dynamics at the end of each session. The other session was an open studio set up specifically for artists with a focus on the product rather than the process of art-making. The small group was open to anyone; individuals worked alongside one another in an atmosphere where people were motivated to develop their own art practice. This undirected open studio group was well attended by several of the artists presented in this case material. One of the four artists attended the closed group regularly for over ten years, while the other three cases attended from one to four years and usually attended both of the described sessions.

Permission was sought from these four artists to photograph their artwork in the context of writing about the art therapy. Maintaining confidentiality is intended in the presentation of this case material, although this is problematic when reproducing the artwork of practising artists. The style and nature of the illustrations of these four artists may be known since they have each sold and exhibited work publicly within their community. Illustrations have therefore been selected to reduce exposure and maintain anonymity, and some pictures in the case material have been described rather than reproduced for this reason.

The results chapter will describe the issues arising from the case examples as comparable data. Details of the art therapy sessions and the behaviour of the four case studies in relation to me as their art therapist are now presented as case material.
3.4 The case studies

The four case studies are of patients in the psychiatric hospital who identified as artists, and attended art therapy. Each has a different personal background, yet they shared similarities which link to them each being artists with a psychotic illness.

The first case example is of a man in his early fifties called Greg. He has a diagnosis of paranoid schizophrenia and a long history of mental illness, having been hospitalised since he was about 25 years old. He completed several subjects in art school and possesses obvious drawing skills. He presents with a strong identity as an artist, but his mental illness prevents him from further developing his abilities—making art seems to just maintain his skills. Greg has attended one art therapy group per week for over ten years.

Walter, the second case study, is a 25-year-old man diagnosed with schizophrenia. He presented to art therapy having previously trained in art and his skills in drawing were quickly acknowledged. He was initially guarded and thought-disordered. Despite his interest in art, he was generally unresponsive to art therapy. After some time Walter became more involved, drawing portraits of those around him and copying from books. He spent one year attending art therapy groups, due to a relatively short stay in hospital. In art therapy he never wished to discuss the meaning of his work. It seemed that being an artist making art was enough.

The third case study is Ben, a man in his late forties, who has a diagnosis of chronic schizophrenia. He has been skilled with art since school and has studied painting for many years at art schools. An initial psychotic breakdown at age 19 set him back; he has had many admissions to hospital since. Ben first began art therapy during his most recent admission to hospital following the death of his mother. Despite treatment Ben suffers torment from hallucinations and seems to inhabit a complex psychotic world, which both fuels his art and hinders him. Ben has attended art therapy regularly twice per week for about six years.

Joseph, the final case study, is a 34-year-old man diagnosed with chronic schizophrenia, is slightly different in that he did not train in art. He first experienced symptoms of schizophrenia at age 18 and spent a long time in institutions as a result. He brings another perspective to the case studies, because he taught himself to paint. His approach to art has been highly valued with exhibitions and sales of his work. He shows no interest in discussing meaning in his paintings, preferring to view them as a product to keep and to exhibit. Joseph states that painting makes him happy and only after six years of art therapy has he acknowledged that he can express emotions through his art-making.
This research wishes to make explicit the use of the term patient experiencing psychosis who identifies as an artist as a way of describing the patient group being examined. The research acknowledges that patients who experience psychosis are subject to the episodic nature of the illness, and at times may find their symptoms and consequently defensive structures tend to fluctuate. As a result the individual may change with times that they cope well with art therapy and times when their illness dominates. Within this research there is a respect for the individuality of each patient described in the case studies. Even though they were each an inpatient diagnosed with a psychiatric diagnosis, they were, at all times viewed as unique people. A diagnosis of psychosis indicates that the person suffers from a distinct set of symptoms it does not suggest that any two people can have the same experiences. Each patient’s background and personality highly influenced how they experience their lives. Great care has been taken in applying generalisations in this research to respect the individuality of each patient described in the case studies.

3.5 The search for collaborating evidence

The literature review has shown that the patient experiencing psychosis who identifies as an artist, who is trained or experienced in art prior to their psychosis, is somehow reacting differently from the non-artist in art therapy; furthermore, the review of the art therapy literature revealed very little specifically written about art therapy with artists; and even less has been written about art therapists working with patients experiencing psychosis who identify as artists. This gap in the literature is surprising given that large numbers of art therapists work specifically with psychiatric patient populations. The literature of note in this area is in one of art therapy’s pioneering texts, the writing of Margaret Naumburg, who worked with many professional artists and describes particular defence mechanisms which operated in art therapy.

Together with Naumburg’s work and the other three relevant articles it is the information from practising art therapists that will be explored to enquire into this topic. It is through my own work with psychiatric patients in art therapy, some of whom identify as artists, that I have seen defence mechanisms as described by Naumburg. Importantly, it has also been in clinical discussions with other art therapists that similar difficulties pertaining to artists in art therapy have arisen, so to explore the topic from another source of evidence a questionnaire was developed and sent to art therapists.
3.5.1 The development of the Table of issues

An analysis of the case studies, informed by the literature review, revealed specific issues pertinent for these artists as they undertook art therapy. The artists showed behaviour that was, in many instances, different from the non-artists in the art therapy groups. Twenty-two themes of difference were identified (see Table 4.3.1). This material then informed the rationale for the questions used in the questionnaire. The questionnaire was developed to ascertain if other art therapists had experienced similar behaviour and could identify differences between artists and non-artists.

3.5.2 Questionnaire rationale

The purpose of the questionnaire was to gather art therapists’ opinions, knowledge and experience and to formalise this information as evidence. To obtain more detailed information that either supports or counters it, the questionnaire was designed to acquire specific data, but also be sufficiently broad to capture unexpected or new material.

3.5.3 Pilot study and pilot study implications

A pilot study was developed to trial the questionnaire and to obtain data that may have bearing on the topic and provide relevant responses. The questionnaire was tested to ensure ease of use so as to get a good response rate. For the pilot study one trial questionnaire was sent to an art therapist and the responses were reviewed.

The pilot study results implied that the questionnaire responses would resonate with the kinds of material I was trying to capture. The questionnaire also seemed sufficiently broad to gather some new information which could be relevant to my research question. The pilot study also helped to develop useful methods to collect the data. Two important areas emerged: firstly, that of ascertaining data that could be relevant to the hypothesis, and secondly, obtaining responses that were specific to the various topics of inquiry which had arisen in this research.

The outcome of the successful pilot study was that the original questions remained unchanged and that ten art therapists were asked to complete the questionnaire. Based on a response rate of eighty percent, the questionnaire responses were collated into a table (see results chapter). A comparison of the responses in relation to the research questions is presented below as the questionnaire results and further developed in the discussion chapter.
3.5.4 Questionnaire development and implementation

The majority of the questions were based on gathering information related specifically to important issues of difference between artists and non-artists as identified in the analysis developed in the cases studied and summarised in the Table of issues (see Table 4.3.1). The wording and structure of two of the questions in the questionnaire has been informed by ideas from Gilroy (1995). In her article Andrea Gilroy measured change in art therapy students in experiential training groups, she adapted a sociometric questionnaire to find specific ways to measure behaviour and reflect upon change in the students. I needed to design questions that enabled the art therapist to consider their psychological response to emotional content of the artists’ work in therapy.

The questionnaire is also informed by the assumed art therapy principle that art can reveal something of unconscious material and that a primary purpose of making art in art therapy is to express and seek an understanding of the self. The art therapist is trained to engage the client in the emotional content of their work; art is not specifically made in art therapy for diversion or just for art’s sake.

The questionnaire is designed to be brief, with general answers requested to gain an overall impression from the respondents. The majority of questions are open-ended in an attempt to obtain data that is both objective in relation to the clients’ behaviour and subjective so as to gather relevant remarks from each art therapist in relation to the research question. Using open-ended questions presents some disadvantage as the answers may not be easily compared and are more subject to bias. Flexibility within the responses, however, does enable the possibility of gathering a broad range of art therapists’ opinions, knowledge and experience in areas specific to the research question. A full rationale for each question used in the questionnaire is included in the appendix.
3.6 Ethical considerations

Every attempt has been made in this thesis to respect the confidentiality and privacy of the participants involved. Identifying information about the individuals in the case studies has been disguised or altered. Names of the patients have been changed, and identifying features, the name of the treatment facility and dates of treatment have all been withheld. Written permission has been obtained by each artist in the case study for photographs of their artwork to be made for educational purposes only. This was done by each signing a consent form which was independently witnessed by someone other than the art therapist. (A copy of the consent form used has been included in the appendix.)

The treatment facility concerned was approached regarding the ethics of undertaking research based on observations gathered from the usual art therapy sessions that the art therapist was undertaking. The representative of the treatment facility’s ethical advisory committee verbally stated that as the research was not doing anything specific to the patients and that the art therapist was only writing about the observations of the sessions, no further ethical approval was required and that the research could go ahead.

Consent was implied in the letter inviting the respondents to return the questionnaire. Identifying information about the art therapists and their clients has been withheld, and the respondents were requested to not include any information that may identify their clients in their replies. (A copy of the letter accompanying the questionnaire has also been included in the appendix.)

3.7 Summary

The review of the art therapy literature revealed very little specifically written about art therapy with artists; and even less has been written about art therapists working with patients experiencing psychosis who identifies as artists. This study has developed out of the experiences of these case studies of four different artists in art therapy. Triangulation of the case study data with that gathered from questionnaires compiled by art therapists holds the potential for a rich source of insight and a more embodied or holistic appreciation of the patient experiencing psychosis who also identifies as an artist.
4. RESULTS

4.1 Overview of the results

The results present detailed accounts of the case studies with illustrations of artwork produced by the patients who identified as artists. This material is presented in this chapter and is the backbone of this research—it invites reflective consideration of the context for each individual. It is the direct result of working with these patients in the manner described in the methodology. The case studies material is then grouped as data in the Table of issues that demonstrates that these patients with a psychotic illness, who identified as artists, behaved differently from non-artists consistently in many instances. The responses of each artist in the case study are considered with regard to the 22 specific issues of the Table of issues. These responses were then identified as twelve specific similarities, concerning ways that artists tend to respond in art therapy to specific matters.

This chapter presents the results of the two evaluations explored in this research. The case study was the first area of evaluation; it led to the identification of a series of issues that then informed the pilot questionnaire. The pilot results led to a questionnaire, which is the second area of evaluation in this research. The questionnaire went out to art therapists practising in the same area as the case study material. The results of the questionnaire and the responses themselves are documented in this results chapter. A discussion of both the case studies and the questionnaire is presented in the following chapter.

4.2 The Case Studies

Please note to protect patient identity images from this research cannot be reproduced in this publication at this time. A brief description of each image is provided in place of the image.

4.2.1 Introduction to case studies

The case study approach taken throughout this thesis is idiographic. This means evidence for the thesis has been gathered through clinical descriptions that deeply explore a specific aspect of clinical material. The case study research will therefore “characterise the individual to demonstrate existence not incidence” (Ansdell & Pavlicevic, 2001). The documentation of these case studies develops a body of evidence on which to centre the enquiry.

The case studies are of four different artists who undertook art therapy sessions in an inpatient facility. The case studies consist of narrative descriptions of behavioural
occurrences, illustrations of artwork made, observations and statements from the artists, together with corresponding transference and countertransference responses from the therapist. The case studies are presented below as narrative stories, and the information will be summarised into specific issues as comparable data, and then further analysed and compared in relation to the literature review in the discussion chapter of this thesis.

It is important to note that this case material is ‘naturally’ occurring in art therapy sessions and is not as a result of interventions brought about for research purposes. In fact, it is as a result of these experiences that this research came about. The material included in this thesis is of specific examples gathered over a ten-year period of continuous art therapy sessions.

4.2.2 Case Study: Greg

The first case example is of a man in his early fifties; I shall call him Greg. It is my encounters with Greg that brought me to consider the artist in art therapy. Greg has a diagnosis of paranoid schizophrenia and a long history of mental illness; he has been hospitalised consistently since he was about 25 years old. His drawing skill and competence early in his life meant he was able to study drafting and engineering as well as complete several subjects in art school; however, Greg’s mental illness is characterised by grandiose ideation, unstable mood and uncontrollable impulsive acts that prevented him from graduating or working in any of these areas, and continues to affect his ability to gain control of his life or to return to living outside of the hospital.

Despite this he does have opportunities to leave the hospital and uses public transport to get around making regular visits with his mother. Although Greg has the debilitation of his mental illness, he on first impression appears as a highly functioning, well-dressed and intelligent man, yet behind this impression, he is also guarded and difficult to reach. Like many of the patients Greg rarely speaks about his illness, although he does acknowledge that he is hospitalised, and he will sometimes talk about his difficulties. His inappropriate behaviour and bizarre thoughts often appear incongruous with his smart presentation.

Although Greg attends a two-hour group session, he tends to do so spasmodically, with difficulty committing to regular attendance. During the sessions he generally needs much support and containment. He has a strong identity as an artist and this plays out in many ways that both help him participate in the art therapy group and also hinder him. Greg is preoccupied with his identity as an artist. This is evident in his behaviour toward the art
therapist, with group’s members and also in his art-making. It seems that art therapy can never quite contain him. His view of himself as an artist intoxicates and motivates his behaviour.

For instance, Greg asserts himself as different from the others in the group. He never leaves his artwork in the folder provided for him in the art studio, but takes his artwork to sell or keep in his own room. Additionally, it took many years of reinforcing the boundaries of the group—for example, the appropriate time for morning coffee—before Greg, who always requested special treatment, accepted the group boundaries.

When he joins the art group he has a strong impact on the non-artist members of the group. Most patients admire his work and he elicits praise from them, which often interrupts their own art-making process. They may comment, “I am not an artist”, or “I wish I could paint”. The purpose and safety of art therapy must then be re-established, so to equally value and take seriously the work done by all group members. Care must also be taken to not offend Greg’s sense of self-worth so obviously linked to his artwork.

It often appears that Greg’s is repeating his artwork. The themes and style have remained the same (see Figures 1 and 2) with sketches of female nudes, bizarre abstract images or his mechanical “anti-gravity machine” reproduced over and over, to the point that even he has acknowledged the group’s boredom with his presentation at the end of group discussion.

Figure 1 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 1** Figurative image. A figurative outline of reclining nude with few facial or identifying features. The image clearly shows female breasts and is suggestive of male genitals.

Black paint on paper, approximately 1900mm x 1100mm.
Figure 2 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 2**

*Abstract image. An abstract image suggestive of male genitals.*

*Black ink on paper, approximately 1500mm x 900mm.*

The persona of artist is highly important to Greg, giving him meaning and a place in his community. The art world and sculpture feature prominently in his thoughts. Greg is comfortable discussing the technique and artistic value of his work in the art therapy sessions, and he avoids attempts to discuss his art in any way other than fine art terms. Discussions also lead to saleability of his art and implausible plans to display and achieve recognition through his art. For instance, he may request my assistance in casting his work in gold, suspended it by an elaborate series of steel cables or making it four metres in size. Greg’s desire and longing for achievement and success are important for anyone, an artist or not; and his plans, although they may have a delusional nature and may be unrealistic in a hospital environment, are supported as part of his creative process.

Greg seems compelled to be recognised as an artist and sometimes this is even humiliating or damaging to him. As mentioned, he regularly takes his art to sell to staff or other patients. One day he explained that he had sold a framed work, and was later told that the purchaser had thrown out the artwork, only to reuse the frame. He also met an art student on the bus and invited him back to the hospital to look at his work. The student came the very next day to the art studio and outside Greg sold his entire portfolio for a very meagre sum. He later regretted this, but the impulsivity was uncontrollable; however, he lamented that at least the work might be understood and valued by a fellow artist.

Generally, Greg suffers negative symptoms of schizophrenia. His motivation is poor and his time engaging in art is short, often doing a few lines and using many sheets of paper. This pattern of behaviour generally means Greg has lost a lot of his art skills over the years and he is often disappointed in his work. His grandiose thinking creates unrealistic expectations, as well as loss of confidence. This further interferes with Greg’s thoughts, mood and attention and affects his ability to complete his work; he often just stops, unable to continue what he was working on.

Although Greg can be polite and amiable, he often sits alone for much of the group or is found sleeping in a chair or on the ground—his interactions in art therapy are usually minimal. However, when any new staff or student joins the art group Greg tends to be more animated. He introduces himself and engages them in discussions about his art, and in particular he shows them a large fibreglass sculpture made in art school, which is displayed...
in the studio courtyard (see Figure 3). These interactions are characterised by Greg dominating and manipulating the new staff, pushing the boundaries and always asking them to purchase his sculpture. Greg’s insistence requires constant maintenance of boundaries, which is a challenge in the art therapy sessions.

Figure 3 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 3**  
*Fibreglass sculpture. White abstract shape, suggestive of sea shell or the folds of female genitals, sculpture shows signs of wear and tear. Fibreglass, approximately 2000mm x 650mm.*

Once over three weeks he spontaneously created a series of very large ink drawings on paper of his regular subject, the female nude. These works were engaging and his interest in producing them appeared to give him more energy and motivation to exhibit them. I was drawn into helping him to achieve recognition and organised an exhibit of this work. It was all Greg could talk about for months. Things happen slowly in a large hospital and eventually a space and time was found. There was no funding to properly frame the works, but the twelve ink drawings were hung over two days and many people attended the exhibition.

Greg enjoyed the attention and was hopeful of sales. Many staff were curious and supportive of the hospital artist and so they accepted the invitation to see the work. A staff member bought one large distorted nude. Greg was upset that his dreams of selling his work were not fulfilled. He became severely depressed for several months after that and has not worked in the same bold, consistently large way since. It is known that artists may feel depleted after the hard work and expectation of an exhibition, and this hit Greg particularly hard, as he seemed to invest every part of his ego into his identity as an artist. Yet Greg continues to attend the art therapy groups, and continues to ask me to exhibit and frame and help him to sell his work. Greg is supportive of others in the group but seems sure that his art is better and more worthy than any others, even that of other skilled artists in the group.

Inappropriate boundaries have always been an issue for Greg in art therapy. He uses his intelligence to push and challenge the therapist and other group members. One day Greg continued a discussion about his desire to spend a substantial amount of money and was
again trying to enlist my help in refurbishing his old sculpture in the courtyard. He had explained that he saw himself as a “great” artist and described his vision of making art in a professional studio, of exhibiting, and his resulting fame.

Within this conversation Greg’s grandiosity meant he resorted to the belief that if only I could see how wonderful his artworks were, I would have no hesitation in giving him all the resources in the world. Following no verbal resolution to this conversation (just as in previous weeks), I invited him to draw some of the artworks he may have produced in his imaginary art studio. He produced images which looked like previous work done both in his past and during the years in the group; these are figurative and suggestive of female genitals, or copulation.

Greg’s behaviour suggests that he does not have a safe contained experience in art therapy. He shows little insight into his effect on others and the following example demonstrates that his focus on the aesthetics of his pictures acts as a defence against considering his art as an expression of his own feelings.

In the past his production of almost pornographic images has created problems for others in the group. His continuation to push this boundary, together with sexual harassment of the therapist and other female group members, meant Greg was asked not to draw nudes in order to show in the group. It was suggested that this was something he could do in his private time, as there was an element of sexual gratification being elicited from these drawings and the group found them inappropriate.

Despite being asked not to, Greg showed his sexually explicit work during the end of group discussion. As usual he showed little interest in others’ work, closing his eyes or appearing to go to sleep until it is his turn. Greg then got up and showed his work, wanting everyone to pay close attention as he stood right in front of them, holding the art at waist level, with his back to the rest of the group members. This behaviour came across as intrusive and confronting, particularly because of the sexualised nature of the images.

He accepted my request that he sit back in his seat and then proceeded to showed his image up close to the woman sitting next to him. She responded forcefully, saying, “That’s disgusting—I don’t want to look at that. That’s a vagina, isn’t it?” She looked at me. “Don’t show me that.” This comment was out of character with this usually calm and polite group member. Previously she has said Greg’s nude women are disgusting, but had never confronted him so directly.

Greg was defensive and laughed at her; he came up with an argument about nudes being well represented by the great artists, like Michelangelo in churches, and accused her of not being able to look at Art. The group sat in shock looking to me to come up with a
resolution. I said everyone had their own beliefs and we had to respect each other. The student art therapist in the group directly asked Greg if he could accept that others had a different opinion, and he agreed. It was then the end of the session.

Later the woman from the group approached me; she was visibly shaken and upset. She told me that she always found Greg’s work and his presence in the group difficult, and it made her feel vulnerable and at times violated, and she did not wish to return to the group. The experience in the group seemed to provoke her own delusions around her responses, and she said that Greg was actually harming her. She also stated she had been raped and when young had been affronted by a ‘dirty old man’. I concluded that the image and behaviour by Greg had brought up these memories in her and she felt unsafe. Greg continues to make art which challenges the boundaries of the group.

Figure 4 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 4** Death mask. Figurative outline of head and face with closed eyes. Painted in red paint, some of which drips like blood. Upper right portion of background is filled in solid dark blue, as if unfinished. Rest of background is left blank.

*Enamel paint on canvas, approximately 1400mm x 1100mm.*

Over the years aesthetics and the artistic value of art seem to be the primary purpose of art-making for Greg; however, there have been a few rare occasions when he has deliberately and consciously created images that portray important meaning for him. Furthermore, he has chosen to discuss this with the art therapist. For instance, one year while a war was raging in his native country, Greg drew fighter jets and wrote a statement about death. He had not mentioned his feelings about the war in the art therapy sessions, yet he readily spoke about the artwork and the painful feelings he had. Another time following the death of his father, Greg brought in a blank canvas and some paints and began a large image of a face. He later described it as a death mask (see Figure 4) and then continued a conversation about his feelings both positive and negative about his experiences of his father. It is in these insightful moments that Greg was able to let go of his artistic persona
and use the safe containment of art therapy to communicate something of his distress through his unguarded real self.

Not all the aspects that relate to Greg being an artist in art therapy are common with other artists who attend art therapy sessions at the hospital, although it is clear from the Table of issues (see Table 4.3.1) that there are many elements that are common for these four case studies of patients with chronic schizophrenia who identify as artists. These commonalities shall be analysed in relation to the literature in the discussion chapter further on in this thesis.

4.2.3 Case Study: Walter

Walter is a 25-year old man diagnosed with schizophrenia. He presented to art therapy with long hair and a relaxed composure; he stated that he had previously trained in art and when he joined the art therapy group his skills in drawing were quickly acknowledged. He was initially guarded and generally unresponsive to art-making. Despite an obvious ease with art materials he preferred to sit and look at art books, and sometimes did a small sketch in the last moments of the session.

Figure 5 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 5** Portrait of fellow patient. Drawing of male head and shoulders, depicts realistic features and a likeness of the sitter.

Black ink of paper, approximately 600mm x 400mm.

It became apparent that Walter’s behaviour was related to his thought disorder, much to the frustration of his nursing staff who brought a talented young artist to sit week after week, not producing work, in art therapy. After about five months Walter became more involved, although he remained mostly silent, he regularly drew those around him and copied from books (see Figure 5). Walter’s youth and unassuming nature meant others easily warmed to him and they were keen to sit while he drew their portrait.
Then Walter began working on a painting of poinsettia flowers (see Figure 6). Like much of Walter’s work this painting was inspired by the work of Vincent van Gogh. Walter worked on the painting over three weeks, copying from an art book and altering the work to make it his own. One day he put his painting up on the easel and said something about the “subconscious”. When questioned about what he had meant, Walter said, “You can pick the flowers or you can break the eggs,” referring to the images in the picture. He then angrily stated how wrong it was to rape dogs by desexing them, and then quickly moved on to a series of topics which seemed unrelated to any earlier remarks. Walter seemed to be trying to say something about his work, and was able to communicate his frustrations and anger.

Figure 6 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 6**  
Poinsettias and eggs. A painting of yellow flowers and green foliage in a yellow jug. Foreground suggests that the jug stands on red table. A cluster of three white egg shapes are depicted in front right of the jug. Upper background is blue.

*Oil on canvas, approximately 1000mm x 750mm.*

He appeared almost compelled to keep perfecting his poinsettias, and eventually seemed finished with it. This process of working and re-working became a method for Walter, and he requested oil paints and canvas on which to do this. He made many large copies of Van Gogh’s paintings, some of which he sold to staff in the hospital; others he took and gave away. In art therapy Walter also continued his sketches of people in the room and continued to copy portraits of Van Gogh (see Figures 7 and 8). When asked about drawing spontaneously, without looking at books, Walter replied that he didn’t like drawing a face from his mind, as it looked “too schizophrenic”.

Figure 7 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 7**  
Copy of Vincent Van Gogh painting and signature. Line drawing of postman in cap and jacket. Demonstrates a likeness of the Vincent van Gogh portrait which was copied. Image includes a copy of the signature “Vincent” in lower right corner.

*Black ink on paper, approximately 600mm x 400mm.*
Figure 8 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 8**  
*Portrait of Vincent Van Gogh. A Line drawing of a Vincent Van Gogh self portrait. Demonstrates a likeness of the portrait which was copied.*

*Black ink on paper, approximately 600mm x 400mm.*

Walter spent only one year attending art therapy groups, due to a relatively short stay in hospital and discharge into a community setting. Walter was well liked and staff readily bought his artworks, which gave him a source of pride. In art therapy he never wished to discuss the meaning of his work. It did not seem relevant to him. Walter came to the art therapy sessions, made artwork, showed it in the groups and left. It seemed that his belief that he was an artist was acknowledged in every group, Walter made his art and the art backed him up. Walter, it seemed, had a secure enough ego to believe in himself, and although he did express his emotions during the sessions, he did not seem to seek any further insight from art therapy. Art therapy was a place to make art and no pressure was applied.

### 4.2.4 Case Study: Ben

Ben is a kind and gentle man in his late forties, who has a diagnosis of chronic schizophrenia. He began art therapy during his most recent admission to hospital following the death of his mother. He was experiencing an increase in psychotic symptoms and a general inability to cope. Ben, who states “I had a pencil in my hand at two”, has been painting all his life. His mother always encouraged him to paint and both parents supported his obvious talent.

Ben won prizes for art during his school years; coming first in a youth art award meant he was on television and was introduced to other artists. An initial psychotic breakdown at age 19 set him back, and although he also had subsequent admissions to hospital, he trained in art over many years, yet never obtained any finishing diplomas. Ben’s technique and ability to draw and paint realistically improved and he often sold and exhibited his work.

During his most recent time in hospital Ben spoke of the demons and hallucinatory visions which terrify him. He loves horror and science fiction films and comics, and they have influenced his art stylistically, yet they also are a source of torment. It seems that the
themes of Ben’s artwork are particularly more violent when he is mentally unwell. He describes demons instructing him on what to paint, and visions that taunt him about his worthlessness. This complex psychotic world both fuels Ben’s art and hinders him. He described ghosts who tell him he is the only “real” artist “these days” and that he believes looking at others’ artwork, even in art museums, is not worth the bother since none are as good as him.

Ben attended art therapy regularly as an inpatient, and then also continued once he was well enough to be discharged, coming to the art room twice each week from his home to participate in groups. One group is an open studio session, specifically designed for motivated patients to make art independently in a studio atmosphere alongside other practising artists. The other session is a closed group with formal boundaries and a group discussion at the end of the session.

Ben has a very strong identity as an artist. At home in his own private space, he regularly paints very large pictures, bringing them in to be kept at the art studio. It is interesting to note that Ben’s parents maintained a bank account with enough money to frame his work once completed, even after he left home. Now that fund no longer exists Ben continues to seek a holding for his work in the art therapy studio. He says he fears he may end up destroying his if he was left in charge of it.

Ben is often preoccupied by achieving fame and in his own genius. He expresses disappointment that he is still not a recognised artist and may never be celebrated on television again. He laments, “I always wanted to be a great artist like Van Gogh”. Ben is generally scathing, although sometimes tolerant of other art, preferring only a select few of history’s ‘greatest’ Renaissance artists such as Caravaggio and Rembrandt. “Mum always wanted me to paint as good as Rembrandt”. His artwork is often copies of his favourite artists (see Figure 9).

Figure 9 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 9**  
*Portrait of Vincent Van Gogh. A Line drawing of a Vincent Van Gogh self portrait. Demonstrates a likeness of the portrait which was copied.*

*Coloured pencil on paper, approximately 300mm x 200mm.*
Once while attending a group outing to an exhibition of abstract style of art, Ben confronted the artist with “How can you live with yourself?”, affronted as abstract art and not his own was adorning the walls of art galleries in this modern era. Ben’s complex relationship to his imagery and artistic identity became apparent through transferences and his gradual insight into what art therapy could offer him.

Initially in art therapy sessions Ben showed little interest in understanding any meanings in his artwork. When asked why he chose this subject or what motivated him, he would usually answer in a monosyllabic way, “Oh gee, I don’t know. I just liked it, I suppose”. He seemed to prefer to focus on discussions of the aesthetics of his picture and their value as a demonstration of his talent and genius. Over time Ben began to be responsive to communicating a meaning in art therapy. Tormented scenes prevailed in much of Ben’s paintings while he was hospitalised.

One day after working together for a year, Ben walked into the open studio session with a new painting (see Figure 10). I was astonished by the content of the painting but felt I could not ask about the things that interested me, as it would be too confronting. Ben excitedly explained to me that he had done the painting he had mentioned some weeks earlier of his father teaching “little rabbit” mathematics. I was expecting him to do a different painting we had discussed and was impressed that he had actually taken up a more personal angle with his art. What struck me straight away was the likeness of him in the image of his father, and then that he had created an image of his father at all. As an adult in his fifties Ben remains very strongly located with the dynamic of his parents, for the want of any other significant others in his life.

Figure 10 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 10**

*School days. Painting of character:ature man with large nose, wearing a suit and tie and holding a ruler. The man looks out of the picture from the left. On the right a soft toy rabbit is depicted holding sheets of mathematic sums in its mouth. The rabbit looks up at the man. Background is textured with yellow.*

*Acrylic on hardboard, approximately 650mm x 600mm.*
Ben has described the hostile reception he gets from his father, who he describes as “a cranky old bugger.” He experiences his father as rejecting, who does not want to see his artwork, and yet keeps Ben’s previous work given to him. On the other had his mother was highly influential in Ben’s artist life. She encouraged him and even used his images in her work teaching children. Ben has described the hole in his life after his mother died, in the full Oedipal sense; she was his “inspiration”.

Ben seemed to understand my surprise about the theme of the painting, although I had said nothing, and indicated to me that he had been able to do this painting because of me. I reflected that I thought the work had come from him, but perhaps coming to the art room had helped. I resisted taking the full responsibility of acting out his mother transference. Ben has openly admitted that he is looking for someone to replace his mother, and at the very least a wife to nurse him. He is also struggling with the hospital’s wish to discharge him, due to the improvement in his mental state, and place him in community housing and his own struggle of individuation and to mother himself.

The content of the picture is different also as it more openly reveals his past issues and his inner feelings. Ben has described this image of his father teaching the vulnerable little rabbit. His father is masculine and rejecting of the toy animal world Ben shared with his mother. Ben physically represents the gentle giant, and has had to dealt with being seen as a big monster of a man, yet he likes the child’s world of stories and often draws toy animals. In this picture are the fierce father and the vulnerable animal put together in an ambivalent way. Ben seems to be working with his own image of himself, like his father—an ambivalent wish to be strong and capable, to stand as a man—and his joy and vulnerable self who connects to his mother by playing toy animals. Ben’s family dynamics have affected him significantly and seem to continue to play out in the transference of the sessions. After many years developing the therapeutic relationship Ben is able to bring these very personal issues into his images, and seems to be beginning to deal with these issues in art therapy.

Figure 11 has been removed from this publication to protect patient identity and is replaced by a brief description.

Figure 11  Hell scene. Large painting depicting eight male human figures surrounded by fearsome creatures: a bat bearing its teeth; a wolf with bone in its mouth while suckling a snake; a hooded figure and another creature gnawing a bone. In the centre of the picture two humans are seated in a large cauldron heated by fire beneath. A dark forest is in the background and skulls are in the foreground.
Once, after two years into the therapy, when asked about a very large painting depicting a hell scene, which included a boiling cauldron full of captured humans in a fearful forest of demons (see Figure 11), Ben initially said, “Some people might see this picture and think I’ve seen too many movies.” Later when asked about his motivations for the theme he admitted that as a school student he fantasised about putting his hated teachers in a pot to be eaten by cannibals. Despite the imaginative notion of boiling his teachers, it was obvious that the ideas for this picture had actually scared him, as the terror depicted in his art and experienced by his hallucinations is embodied for him.

A fellow patient, listening into this conversation asked whether it was a wolf in a hat he had painted on the right. Ben said that it was, and then quietly murmured, “Huh, it reminds me of my Dad”—as if it had only just occurred to him then. These glimpses into Ben’s internal world paralleled his developing engagement in art therapy. Slowly, as Ben’s mental health improved and as trust and engagement developed, he was more ready to seek genuine meanings and to break down the defences between his conscious and unconscious processes.

After five years of art therapy Ben has begun to make more confident comments in relation to the meaning of his artwork, or at least what a picture might be communicating in therapy. Although superficial comments like “It’s just a picture”, “Something I thought up”, “Do you think there is enough detail here?” or “Do you like it?” still occur, Ben is also able to openly discuss connections between his life and his images. In Ben’s work, which is mainly figurative images of characters with stories being depicted, I often see resemblances to Ben himself in the characters. The emotional content that may occur to me and others who look at the work is usually denied, or at least refuted with comments like, “You can say that if you want”, and with a shrug of his shoulders he appears to dismiss the comment. Yet, sometimes he will spontaneously say, “That’s a picture of my Mother”, or “I drew a picture of Dad last night.” It still seems that Ben is somewhat intrigued by the therapist’s consistent interest in his artwork, and he seems to accept more and more of my comments.

4.2.5 Case Study: Joseph

Joseph, a 34-year-old man diagnosed with chronic schizophrenia, shows yet another perspective in being an artist in art therapy. He taught himself to paint in another institution, where he was encouraged to spontaneously put paint on canvas. His original and untrained
approach to his art was highly valued, to such an extent that he had two exhibitions and every work was sold and his work reproduced in the newspaper. Following his transfer to the hospital, Joseph dismissed the art therapy groups; he found he could not make art in the same way and remained aloof and reluctant to make art in the sessions. However, he stated he wished to make art in his own room and although he took art materials away, it seems he never actually did.

Joseph had had a difficult family life; he immigrated to Australia in his early teens and then worked on the family farm, never continuing school. He first experienced symptoms of schizophrenia at age 18 and spent a long time in institutions as a result. When he began art therapy groups his English was still poor and this further distanced him from relating to others. His art appeared bizarre and paintings often ended up a muddy chaos (see Figures 12 and 13). He initially paints a bold outlines of a face or figure, then he fills in the outlines, in layers of colour, and then without washing his brush he slaps and splashes on further brush strokes right across the canvas to ‘brighten’ it up.

Figure 12 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 12**  
Face. Loosely painted face with some radiating shapes. Many colours are used which make the facial features and the background appear similar.  
*Acrylic on paper, approximately 600mm x 400mm.*

Figure 13 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 13**  
Red face. Red painting with blurred texture, several purple splotches are suggestive of eyes and nose.  
*Acrylic on paper, approximately 600mm x 400mm.*

Joseph shows little interest in speaking about the content of his work—when questioned he might name it as “a duck”. He might ask if I thought it was a good picture or not, but generally he showed no interest in communicating any sense made of the process or content of his paintings, preferring to view them as a product to keep and to exhibit (see Figure 14).
When Joseph took part in art therapy groups he tended to dominate, finding it hard to adjust his original euphoria as an artist to the rudimentary life of attending groups in a psychiatric hospital. In groups he was unusually critical of others’ work and his withdrawn attitude meant that he was not well liked and he remained isolated in the sessions. The art he made looked bold but also appeared fragmented, tormented or frightening. He often painted faces, one of which, as it was drying on the table, scared another patient in a later session so much she asked that it be removed from the room (see Figure 13).

After about six months Joseph refused to attend and was not seen again in the art room for many years, during which he had been discharged and was living in the community. One day he requested to return to art and began to come in weekly to a studio group that has just been set up. Joseph always worked on his own, regularly bringing in his own canvas to paint on. He stated that art-making was very important for him; it helped him to relax and to feel happy about himself.

While taking part in the studio group Joseph exhibited in several exhibitions, but despite optimistic hopes to sell his artwork, has not sold work any work since those original sell out exhibitions years earlier. Despite this he has continued to make art and his identity as an artist remains strong. Joseph’s approach to his art is similar each week—almost a routine process. He paints a colour all over the canvas as a background, and then before it has dried he begins his outlines of figures as already described.

It seems that this is the approach with which he first enabled himself to become an artist and with it he seems to keep trying to recapture his original success; however the method tends to result in muddy-looking, complex and fragmented artwork. When they are dry they tend to fade into a mass of difficult-to-look-at colour, despite the vibrant process which it took to create them. After several years of making this kind of art Joseph began to try other approaches. He attempted suggestions to experiment with colour on paper, rather
than to make finished pictures each session, and he attempted realistic still-life drawing of fruit in a bowl; however, his fall-back position is to return to his original style with similar results.

After two years of regularly attending the open studio as an outpatient, and one year after an exhibition which the studio group participants put on in a local art gallery, Joseph showed a shift in his art-making. He seemed more able to use his art to express something of the transference occurring in the sessions—particularly, a positive transference to the art therapist. That day Joseph entered the art studio holding a framed painting which he had taken home the previous session. This was the first framed painting that he had taken home and he was excited about hanging it in on his apartment wall. When he returned it to the art room Joseph explained that his mother was staying with him and did not like the painting. He said no more about what had happened and just left the painting inside the door of the art studio. Then he sat down for a while, as he usually does.

We had been working on developing ways to promote his art and I presented him with a typed list of his exhibitions, designed for Joseph to use to approach art galleries. He seemed please with this and put it in his bag to take home. Next he organised himself to make a picture, and without requiring any assistance, he began to paint a face on paper at the easel. The image looked clear, the lines stood out with contrast and the form was more organised than his usual work. As he added hair, I was struck—I thought, “This looks like a nice person”, and then I thought, “This is a woman. This is me!” (see Figure 15). Joseph confessed it was me he was painting with a shy smile and continued to finish the picture, and even checked my eye colour.

The finished painting was quite different from his usual style and demonstrated the care he had taken with the process of producing the picture. He had worked calmly, the paint colours had not all mixed together, he took care to wash his brushes as he worked, he did not paint in a background but left it white so a contrast of colours meant the image remained crisp, and he did not add last-minute splashes as in previous work. The image of the art therapist and the calm methodical process with a clear and interesting result suggested that Joseph had integrated something of the therapy relationship. Given that it occurred on the day he was dealing with his own mother’s rejection, it showed Joseph was able to process his current emotions through his art-making.
Figure 15 has been removed from this publication to protect patient identity and is replaced by a brief description.

**Figure 15** Portrait of the art therapist. Portrait of female head and shoulders in a coloured garment and outlined in black paint. Skin toned flesh is realistically depicted and the background left blank so the image is clearly delineated.

_Acrylic on paper, approximately 1100mm x 700mm._

### 4.3 Grouping the case study material as data

Various issues arose in the clinical practice of art therapy with patients experiencing psychosis who identified as artists. These issues were consistent enough to compare ‘artist’ patients with non-artist patients over 22 aspects. The four case studies of artist patients were then assessed as to how they individually reacted to the set issues. The following *Table of issues* represents these comparisons and demonstrates that the artists reacted differently from the non-artists. With these specific twenty-two issues the artists reacted differently from the non-artists eighty percent of the time.

These issues also relate to the therapists own perceptions of working with the artists in art therapy and they allude to the strong countertransference responses occurring with artists in art therapy. These issues are listed in the results and form the basis to considerations in the discussion chapter.
4.3.1 *Table of issues* from case studies (patients as artists’ responses in art therapy)

<table>
<thead>
<tr>
<th>Issues</th>
<th>‘Normal’ psychotic patient behaviour</th>
<th>Psychotic ‘artist’ patient behaviour</th>
<th>Reasons why</th>
<th>G Yes Or No</th>
<th>W Yes Or No</th>
<th>B Yes Or No</th>
<th>J Yes Or No</th>
<th>Percent of artist as different</th>
</tr>
</thead>
<tbody>
<tr>
<td>Studied art</td>
<td>School level only</td>
<td>At art school, even for small amount of time</td>
<td>Proves they are an artist</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>75%</td>
</tr>
<tr>
<td>Art materials</td>
<td>Will use what is supplied in room</td>
<td>Requests formal fine art materials</td>
<td>Proves they are an artist</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Exhibit work</td>
<td>No specific interest; some are pleased if asked to contribute</td>
<td>Frequent requests; some preoccupation with this</td>
<td>Proves they are an artist</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>50%</td>
</tr>
<tr>
<td>Spontaneity</td>
<td>Generally spontaneous</td>
<td>Tends to repeat past themes and styles</td>
<td>Use formula for past success, own style</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Directives</td>
<td>Will accept new challenges and ideas from therapist</td>
<td>Tends not to explore new style or to add to artwork (eg tone, head)</td>
<td>Concrete thinking, fixed style, success</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>75%</td>
</tr>
<tr>
<td>Seeks approval</td>
<td>Tends not to seek approval of art</td>
<td>Seeks approval of art made from therapist; actively will show art to new staff and students</td>
<td>Need to prove they are an artist</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Portraits</td>
<td>Never interested</td>
<td>Sometimes seeks to draw portraits of others</td>
<td>Prove they are artist (give art away, sell)</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>50%</td>
</tr>
<tr>
<td>Formal qualities</td>
<td>Rarely interested in discussing formal qualities in artwork</td>
<td>Predominant focus of discussions, quality, ‘good’ art</td>
<td>Proves they are an artist</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Meaning, theme</td>
<td>Willing to explore themes and meaning of artwork</td>
<td>Seems to avoid or not comprehend questions about meaning or themes</td>
<td>Difficulty viewing art as reflection of emotional self</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Famous artists</td>
<td>Rarely mentioned; sometimes likes to look at art made by artists</td>
<td>Often compares self to famous artists, sees self as genius artist</td>
<td>Art is about high art, grandiose tendencies</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>75%</td>
</tr>
</tbody>
</table>
### Table of issues from case studies

<table>
<thead>
<tr>
<th>Issues</th>
<th>‘Normal’ psychotic patient behaviour</th>
<th>Psychotic ‘artist’ patient behaviour</th>
<th>Reasons why</th>
<th>G</th>
<th>W</th>
<th>B</th>
<th>J</th>
<th>Percent of artist as different</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep art in room</td>
<td>Usually leaves art to be kept by therapist; some take at discharge</td>
<td>Usually takes art and shows to others, sells or gives</td>
<td>Don’t value therapist keeping their work</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>75%</td>
</tr>
<tr>
<td>Bring in made art</td>
<td>Very rarely; this is only place they do art, process is in art room</td>
<td>Often takes materials to make art in room, does art elsewhere</td>
<td>Artist makes art in many places</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Sell artwork</td>
<td>Never seeks sales of artwork</td>
<td>Regularly desires money for art made; covertly art seems to be made for this purpose</td>
<td>Role as artist, grandiosity</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>75%</td>
</tr>
<tr>
<td>Emotions in art</td>
<td>Usually willing to see emotional issues reflected in art</td>
<td>Generally unwilling to see art as reflection of emotional world</td>
<td>Defensive</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Focus on art as product</td>
<td>Tends to follow therapist’s lead to view artwork in different ways</td>
<td>Tends to see artwork as product</td>
<td>Art is only about finished product</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Focus on process</td>
<td>Tends to follow therapist’s lead to discuss experience of making art</td>
<td>Tends to discuss technical aspects of process over experience</td>
<td>Technical aspects keep art at distance</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Realism</td>
<td>Finds realism too difficult; abstract art is accepted and seen as easy</td>
<td>Uses realism as major theme in art, especially figurative</td>
<td>Realism demonstrates skill</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>75%</td>
</tr>
<tr>
<td>Abstract art</td>
<td>Readily makes abstract art</td>
<td>Tends not to make abstract art,</td>
<td>Sees abstract art as putting all at same skill level, not good art</td>
<td>Y &amp; N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>75%</td>
</tr>
<tr>
<td>Metaphor</td>
<td>Readily seeks metaphor in artwork</td>
<td>Doesn’t seek metaphor in own art</td>
<td>Not looking for meaning</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Continued Table of issues from case studies**

<table>
<thead>
<tr>
<th>Issues</th>
<th>‘Normal’ psychotic patient behaviour</th>
<th>Psychotic ‘artist’ patient behaviour</th>
<th>Reasons why</th>
<th>G</th>
<th>W</th>
<th>B</th>
<th>J</th>
<th>Percent of artist as different</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time spent</td>
<td>Varies; some make multiple quick art, some spend more time on one</td>
<td>Tends to put effort into one piece; then rests in session</td>
<td>Grandiose view of own art; putting effort in is tiring</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>50%</td>
</tr>
<tr>
<td>Sexualised</td>
<td>Rarely done in public</td>
<td>Often makes nudes, sexualised images of body parts</td>
<td>Life drawing real art; not sublimating well</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>50%</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>Generally seems to find art therapy satisfying and enjoys art-making</td>
<td>Often not satisfied with own art; frustrated it’s not a masterpiece</td>
<td>Much invested in art; it displays disintegrated self and illness</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>75%</td>
</tr>
</tbody>
</table>
4.3.2 Twelve similarities in the artists’ behaviour

The list documents the consistent cluster of factors that have emerged when comparing the four artists in the case study from the *Table of issues*. A series of generalisations have been made in order to compare the responses of the artists with those of non-artists in the art therapy sessions. This data suggests that there is significant difference between the artists and non-artists. From this comparison twelve similarities were identified, where all four artists display the same kind of behaviour in art therapy sessions, or at least in the initial year of the art therapy. The twelve similarities in are listed below.

**Table 4.3.2 Twelve similarities in artists’ behaviour**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The artist requests use of different, formal or fine art materials rather than use the materials readily on offer in the art therapy sessions.</td>
</tr>
<tr>
<td>2</td>
<td>The artist tends to repeat past themes and styles in their imagery, appearing less spontaneous than non-artists in art therapy.</td>
</tr>
<tr>
<td>3</td>
<td>The artist actively seeks approval of art product, from therapist and new staff or students.</td>
</tr>
<tr>
<td>4</td>
<td>Discussion around the art-making is predominantly about the formal or aesthetic qualities of art.</td>
</tr>
<tr>
<td>5</td>
<td>The artist tends to avoid or not comprehend questions about meaning or themes arising in their artwork.</td>
</tr>
<tr>
<td>6</td>
<td>The artist often makes art in other places and brings this to art therapy.</td>
</tr>
<tr>
<td>7</td>
<td>There is a desire to sell artwork made in art therapy, and to make art for this purpose.</td>
</tr>
<tr>
<td>8</td>
<td>The artist seems unwilling to see art as an emotional expression.</td>
</tr>
<tr>
<td>9</td>
<td>The artist tends to view artwork only as a product that is created.</td>
</tr>
<tr>
<td>10</td>
<td>The artist tends not to explore the art-making process as an experience in therapy.</td>
</tr>
<tr>
<td>11</td>
<td>The artist does not seek to discover metaphors of their own life in their own or others’ artwork.</td>
</tr>
<tr>
<td>12</td>
<td>Artists tend not to take part in the more insight-oriented individual art therapy sessions.</td>
</tr>
</tbody>
</table>
4.3.3 Seven further factors of artists’ responses in art therapy

These comparisons have been developed from the generalisations of artists from the case studies in this research, although not all of these issues have been presented as examples in the case material. A further seven comparisons are now presented here; these are less prevalent than those above, and relevant for only three of the four artists in the case studies. However, they are still important results and present a picture of the artist in art therapy sessions.

Table 4.3.3 Seven common responses of artists in art therapy

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Artists frequently request exhibiting of their artwork.</td>
</tr>
<tr>
<td>2</td>
<td>The artist tends to remain with their own style of art, not taking up new ideas or suggestions from others.</td>
</tr>
<tr>
<td>3</td>
<td>The artist often compares themselves with famous artists, and desires such recognition</td>
</tr>
<tr>
<td>4</td>
<td>The artist usually take their artwork away from the art in room, appearing not to value the containment provided by the art therapist keeping their artwork.</td>
</tr>
<tr>
<td>5</td>
<td>The style of the artist tends to be realist and figurative.</td>
</tr>
<tr>
<td>6</td>
<td>The artist does generally not make abstract art.</td>
</tr>
<tr>
<td>7</td>
<td>Generally, the artist is not satisfied with their art, seeking to create a masterpiece.</td>
</tr>
</tbody>
</table>
4.4 Questionnaire responses

The following table provides the exact responses by the eight art therapists to each question posed in the questionnaire. This questionnaire offers further insight into the artist in art therapy, following on the case study. The art therapist’s anecdotal statements have become an effective tool in the exploration of these phenomena. A short summary of the results of the questionnaire follows the actual answers to each question.

**Question 1: Have any of your clients identified themselves as an artist?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Yes. I have had some clients who have identified themselves as artists before commencing art therapy, and others (long term clients) who so identify with the process of art-making during therapy that they come to identify as artists later. I am assuming that you are interested in the first group, however if you want to know about the others you are welcome to follow up with me.</td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>G</td>
<td>I can give a clear ‘yes’ to one in recent years, but there have been several who have had some art background, who paint and sell some work, or who want to complete their art school training who would not identify themselves as ‘artists’ but as someone who has an interest/ability in art – I wouldn’t say that ‘artist’ defines their identity.</td>
</tr>
<tr>
<td>H</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Question 2: How many artists have you worked with?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Recall only 5</td>
</tr>
<tr>
<td>B</td>
<td>Four for a significant amount of time in the past five years b. Many in art therapy workshops (too many to count)</td>
</tr>
<tr>
<td>C</td>
<td>2</td>
</tr>
<tr>
<td>D</td>
<td>Four</td>
</tr>
<tr>
<td>E</td>
<td>Three</td>
</tr>
<tr>
<td>F</td>
<td>Ten</td>
</tr>
<tr>
<td>G</td>
<td>Can’t be accurate here – I have not attempted to record this and it is very hard to remember. Rarely more than one at any given time.</td>
</tr>
<tr>
<td>H</td>
<td>Several, as I have worked with several such clients and I am doing so currently, answers will be general.</td>
</tr>
</tbody>
</table>

**Question 3: Did these artist clients participate in group work or individual work?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1 x individual work; 4x group work</td>
</tr>
<tr>
<td>B</td>
<td>Individual work and group workshops</td>
</tr>
<tr>
<td>C</td>
<td>Individual work</td>
</tr>
<tr>
<td>D</td>
<td>Individual</td>
</tr>
<tr>
<td>E</td>
<td>Both</td>
</tr>
<tr>
<td>F</td>
<td>I have had three of these clients participating in individual work in my private practise; six who been involved in both group and individual work in hospital settings and one who was involved in group and individual work in a community rehabilitation setting.</td>
</tr>
<tr>
<td>G</td>
<td>Mostly individual</td>
</tr>
<tr>
<td>H</td>
<td>Group work</td>
</tr>
</tbody>
</table>
The responses to question 1 indicate that these eight art therapists have encountered more than one artist in their practice and in question 3 over half of the art therapists used group work with the artists. This suggests that the respondents’ experiences were similar to those of the case studies and therefore valid comparisons between the two can be made. All of the art therapists had worked with at least one artist, although the average number of artists seen by the respondents was four. Having worked with more than one artist suggested that the art therapists were able to make generalisations comparing artists with non-artist clients based on their experiences of the two.

**Question 4: For each of these clients what, in your opinion, enabled them to identify as an artist?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>I think all of them had some art school training and then practised as an artist from this basis.</td>
</tr>
</tbody>
</table>
| B     | 1. already a graphic artist, then later on went to art college to do BA in visual art  
       2. had already done TAFE course in ceramics, then after art therapy, did Masters in visual art  
       3. being institutionalised, he had no other sense of identity, so seeing himself as an artist gave him a sense of himself as someone of value  
       4. used art primarily as therapy, but also saw part of herself as an artist |
| C     | trained and practised as an artist                                    |
| D     | All four practiced or had practiced as artists. Three had trained in visual arts. All had exhibited artwork. |
| E     | Client (a) – both trained in visual arts and practiced as an artist  
       Client (b) – practiced as an artist  
       Client (c) – practiced as an artist |
| F     | client's 1-8 - majored in visual arts for HSC and identified as artists  
       client's 9-10 - trained in visual arts and practised as a professional artists  
       All of these clients presented with dominant artist identities and saw art-making as an integral part of themselves irrespective of how unwell they might have been. |
| G     | Mostly had an art background – incomplete training, trained, practiced. The clear ‘artist’ was elderly and had lived via art and taught at art school. Some with no formal training at all but a deep commitment to art. |
| H     | Both, my clients have trained in visual arts and practiced as an artist. |
**Question 5: Did any of these clients also have a formal psychiatric diagnosis?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
</table>
| A    | Yes: One with Bipolar – Male; One with Schizo-affective Disorder – Female  
Two with Schizophrenia – Male; One with Anxiety & Depression – Female |
| B    | - Would be given a diagnosis of PTSD if she went to see a psychiatrist (which she has not done)  
- Had diagnosis on depression in the past, but not when I was working with her  
- Autism, OCD, movement disturbance disorder and communication difficulties, Dissociative Identity Disorder |
| C    | No |
| D    | One was diagnosed with schizophrenia, one with clinical depression and one with dementia |
| E    | Client (a) – Dual diagnosis – depression and AOD  
Client (b) – Depression  
Client (c) – Depression and PTSD |
| F    | Six of these clients are diagnosed with Schizophrenia; two with Anorexia Nervosa and two with major Depression. |
| G    | All my clients have a formal psychiatric diagnosis – they were inpatients or outpatients in a psychiatric hospital. Diagnoses included BPAD, depression, schizophrenia etc. Mostly inpatients and mostly schizophrenia. |
| H    | Chronic schizophrenia, schizoaffective disorder, bipolar, depression and personality disorders. |

The art therapists all defined an artist as someone who had trained in art, although in question 1 a respondent, as in the art therapy literature, described clients who developed an identity as an artist as a result of undertaking art therapy (see Alter-Muri, 1994; Henley, 1992; Klorer, 1993). All of the questionnaire respondents, except one, described work with artists that had also had been given a formal psychiatric diagnosis, and 60 percent of the art therapists had worked with artists with a psychotic diagnosis. This further suggests that similar comparisons can be made between the respondents’ experiences and those described in the case studies, since the majority of respondents worked with a similar client group—namely, people identifying as artists who also had a history of psychosis.
**Question 6: Did you notice any differences working with an artist compared to someone who did not identify as an artist?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes, the experience of using art was something they already had an established relationship to. It was part of their identity and self-image. Whereas other clients came to the process much more undetermined by this background but often found a sense of the ‘artistic’ capacity within them by the end of therapy.</td>
</tr>
<tr>
<td>B</td>
<td>Generally, they would need no persuasion to participate in art activities, they would be very confident and motivated and looked forward to sessions, they understood working on personal issues as being ‘different’ to their usual art practice</td>
</tr>
<tr>
<td>C</td>
<td>Yes they were very confident with the materials, were able to use different materials for different effects. they both looked for meaning but were also very aware of aesthetic considerations</td>
</tr>
<tr>
<td>D</td>
<td>The client who was dementing found it difficult to use materials and have an unfamiliar or unsatisfying response. The one with depression had strong preconceived ideas of art-making and use of materials, and once she actually started using something other that black charcoal, she struggled with the concept of what was “good” art probably more than a client without training. The one with schizophrenia – in a manic phase he thinks that all of his efforts should be applauded as “good” art, on other days it is like he is approaching the media for the first time. He has an idea of what he calls “classically” good art and in some ways aspires to it, yet when he’s working his own highly personal style takes over. Occasionally he has delusional moments of making vast amounts of money from his work, although many of us wish for that with the delusional state! He becomes highly and quite irrationally critical of other people’s work. The client without a diagnosis often “covered” her process with her skill. By this I mean that she was always able to produce an image (which is not necessarily the case in all art therapy situations). She often wanted to talk about the image from an aesthetic perspective, and had some resistance to experimentation.</td>
</tr>
<tr>
<td>E</td>
<td>Artists appeared to have a heightened anxiety in relation to the finished product, in comparison to non-artist group. They appeared to exhibit more frustration in achieving the desired result, but once, and if achieved, they appeared to take pride in their work and the frustration and anxiety was followed by a sense of achievement and a relaxation in tension and mood.</td>
</tr>
<tr>
<td>F</td>
<td>The main difference I noticed is in their resistance to doing &quot;Art Therapy&quot; kind of Art i.e. process oriented Art as opposed to product oriented Art. Only one of the client's engages in process oriented Art as he is older, psychotic and hospitalised with long term chronic Schizophrenia. Sadly he is fully aware that his drawing and painting skills have deteriorated but as he still needs to find a way to express himself and communicate his complex ideas, thoughts, humour and memories he uses text and collage as mediums of expression. A client who does not identify as an artist will generally show less resistance and self-criticism when engaging in the art-making process.</td>
</tr>
<tr>
<td>G</td>
<td>Non-artists fear that they ‘can’t draw and avoid participating in the first place because of this - but often gain confidence quite quickly once engaged. Because they don’t have an ‘art’ framework they sometimes work expressively more easily than artists. ‘Artists’ often compare their current work unfavourably to their previous work and can be put off by this. It can be hard to encourage art as an expressive outlet because clients are busy producing a ‘good’ painting. This is more so with older or untrained ‘artists’. People who have gone through art school since the rise of ‘conceptual art’ tend to be looking at their work more in terms of its meaning as a matter of course. Non-artists can be thrilled to discover art and less self-critical than artists (remembering that these people are inpatients, and inpatients are likely to be performing at less than their normal level.) It can be therapeutic for an artist to recapture the level of artistic skill that he/she had before, and to help them resume the life of an artist.</td>
</tr>
<tr>
<td>H</td>
<td>Yes, aesthetic awareness, knowledge of the arts / technical skills.</td>
</tr>
</tbody>
</table>
The respondents’ perceptions of whether an artist was different to a non-artist varied. This question required generalisations to be made, which is difficult when the sample size is small and when art therapists treat each client as an individual. Given this, all of the art therapists noted some difference. Several found artists to be much more ‘confident’, can be more critical of art and showed greater aesthetic understanding in sessions. Two of the comments were directly similar to the experiences of the case studies and both of these came from experiences with clients who were associated with severe mental illnesses. The first similar comment was that one art therapist noted art was the source of delusional ideation for the client. The other one commented that the “main difference I noticed is their resistance to doing ‘Art Therapy’ kind of art, i.e. process oriented Art as opposed to product oriented Art.” These comments parallel the experiences of the case study and provide anecdotal support which validates this research.

**Question 7: Did the artist use art therapy in the same way as someone who did not identify as an artist?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Various responses, some artists found the use of art therapy very facilitating as it used a mode of expression they were fluent and proficient with, in these cases they took to the process more easily. The differences or resistances I noticed were with 1 or 2 artists who seemed to find the possibility of reading the content of the images as reflecting various aspects of themselves as quite overwhelming or threatening to the pre existing relationship to their art-making and themselves. One comes to mind particularly who I saw for individual sessions he had a diagnosis of schizophrenia found the process difficult. The structure of making work within the session time frame and with me present followed by the process of reflection and discussion of the image was quite different to his mode of practising art. This shift from art practice to art therapy seemed to challenge something within this client that was counter productive to his sense of well being and sense of self with relation to art-making.</td>
</tr>
<tr>
<td>B</td>
<td>Everyone uses art therapy differently, but these clients may have been more willing participants in art therapy</td>
</tr>
<tr>
<td>C</td>
<td>Yes. They both used it to explore difficult areas of their lives</td>
</tr>
<tr>
<td>D</td>
<td>Yes I think so. People are so individual in the ways they access therapy.</td>
</tr>
<tr>
<td>E</td>
<td>Two out of the three appeared “stuck” in their artist identity and the desire to perform. Client (a) was easier on herself and appeared more able to work symbolically and use the process to explore her feeling states</td>
</tr>
<tr>
<td>F</td>
<td>The artist client from my clinical experience always identifies with their artistic identity as the core of their being and especially when they are young find it difficult to engage in art-making purely as self-expression or to work through the issues that have brought them to therapy by &quot;letting go&quot; of their art style. A non-artist client is more able to express themselves through art-making and are usually less judgemental about what they have created.</td>
</tr>
<tr>
<td>G</td>
<td>See question 6.</td>
</tr>
<tr>
<td>H</td>
<td>For some, engagement in creative activity appears to be pure release, others more concerned re aesthetic qualities that may hamper therapeutic process. The fact that such clients have creative ability – seems to allow for this even more so, it seems to be a natural tendency for many clients not identifying as artistic, as they have the intrinsic understanding of artistic process. (However those that don’t identify as artists are sometimes hampered by their perceived inability.)</td>
</tr>
</tbody>
</table>
Seventy-five percent of the respondents agreed that the artist used art therapy differently from a client who did not identify as an artist, although this statement was somewhat diluted by the prevailing belief that each individual would always use art therapy differently anyway. The art therapist respondents used reasoning to explain the differences, but they had not fully questioned why the artist may be different. These comments that the artist is different further support the phenomena described in the case studies, and the difficulty in stating why artists are different suggests why little research has been done in this area.
**Question 8:** In general how did the artists respond to the emotional content of their artwork? In your opinion did the artist client/s view their art as a representation of their own unconscious expression?

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Following from the comments above some found connecting to the feeling content of their images or viewing the images as reflections of themselves as this quite engaging and facilitating. However for the 1 or 2 others they seemed to find the process of art therapy too personally delving and withdrew from the process of reflecting on themselves through the images or process.</td>
</tr>
<tr>
<td>B</td>
<td>I would say they generally saw it as a representation of their conscious expression, the thoughts and the feelings they were already aware of, but which they were having trouble expressing verbally, more than unconscious expression.</td>
</tr>
<tr>
<td>C</td>
<td>One did, the other did not make links with unconscious expression.</td>
</tr>
<tr>
<td>D</td>
<td>The client with dementia came to respond to just handling materials as a soothing and possibly reflective experience. The client with schizophrenia responds emotionally to the making of an image especially to a portrait. He seems to view his work as a representation of his CONSCIOUS expression rather than his unconscious. The other two responded strongly to the emotional content, and were generally able to come to exploration of the unconscious within the session.</td>
</tr>
<tr>
<td>E</td>
<td>Artist (a) was able to use her imagery to lead in to an exploration of emotional content – process became circular with emotional content being facilitated by her imagery, and future images then enlivened by that exploration. She was well able to make links between her internal (conscious and unconscious) world and external environment. Artist (b) appeared overwhelmed by his illness and appeared to struggle with his artwork in parallel to his struggle with his illness/depression. He did not appear to be conscious of the unconscious elements being expressed through his work – but I can’t be certain of this – he was angry and sad and would easily “give up.” Artist (c) – was quite concrete in his style of working, not in touch with his emotions or any real sense of his unconscious processes. However, I was interested to see that he responded in an emotional way to another’s patient’s imagery – this patient was also diagnosed with PTSD and artist (a) seemed quite struck by and drawn to this patient’s work – a powerful image which expressed attachment difficulties in relation to his mother (mother turned away tending her garden), but was overlaid with a sense of a similar feeling response in relation to being a soldier/prisoner of war in Vietnam.</td>
</tr>
<tr>
<td>F</td>
<td>I have only had a few artist-clients who have seen their art from this perspective. Mostly I have seen that these client’s stay primarily focused on their art as &quot;product&quot; rather than &quot;process&quot; which restricts the spontaneity of unconscious expression. I had one artist-client who made significant steps in her recovery from depression and self-harm thoughts once she was able to engage in her art from this deeper level and &quot;let-go&quot; of her artist's ego. She found this very liberating.</td>
</tr>
<tr>
<td>G</td>
<td>Very hard to generalise – some did, some didn’t. One - the professional artist - often worked abstract and gave his work titles linked to his environment. He was more likely to link it to memories and experiences than to ‘unconscious material’ – but where is the dividing line? I thought that there was a lot of unconscious expression going on, but people did not always view it as that and could not always put it into words.</td>
</tr>
<tr>
<td>H</td>
<td>Some clients have been able to and some unable and some not willing. There are also clients that can address emotional content in their work (part of which is due to their connection with creative process) but this isn’t always the case.</td>
</tr>
</tbody>
</table>
When asked to comment generally on how the artists responded to the emotional content of their artwork as a representation of their own unconscious expression Three quarters of the art therapists found that some artists, had found it difficult to respond to their emotional content in their art. The art therapists also stated that many of the artists preferred to stay with the visual product of their artwork rather than view their art as a visual representation of their own unconscious.

Question 9: In general can you comment on the following comparing the client/s who identify as an artist with the non-artist client?

(i) Choice of art materials

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
</table>
| A    | Artist – tend to know the qualities of art materials and have preferred media and ways to handle the materials  
Non artists – tend to be much more tentative as they are often not confident with the media and need support and encouragement to practice and develop their activities with media, but not in all cases. |
| B    | Less inhibited, more willing to experiment in using different media such as paint or clay |
| C    | this varies from individual to individual can't make a differentiation between artists and non-artists |
| D    | A greater sense of familiarity with particular materials often guides the artist’s selection. There is also a greater expectation that the therapist will have particular materials of a certain quality available. |
| E    | Artists more confident in choice and use of art materials. |
| F    | When there is resistance to the art-making process from artist-clients I find they do tend to prefer materials they have more control over e.g. felt-tip pens, graphite pencil etc. also artist-clients will tend to stay with a material they know they are good at using rather then be more experimental and open to trying different materials. |
| G    | Non artist – limited range, less adventurous Beginners rarely choose thick paint. Clay is popular but more often used to make a vessel than a sculpture .  
Artist – more use of mixed media, more likely to work larger and to use thick paint boldly. |
| H    | More knowledgeable, wider selection, more inventive, materials they know and love, experimental. |

Question 9 (ii) Spontaneity in approach to art-making

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Can’t say I’ve noticed any significance differences</td>
</tr>
<tr>
<td>B</td>
<td>More spontaneous than other clients</td>
</tr>
<tr>
<td>C</td>
<td>this varies from individual to individual can't make a differentiation between artists and non-artists</td>
</tr>
<tr>
<td>D</td>
<td>Generally there is greater deliberation in terms of image content and stylistic features.</td>
</tr>
<tr>
<td>E</td>
<td>Spontaneity of artist varied</td>
</tr>
<tr>
<td>F</td>
<td>They can be less spontaneous in art-making because they are always judging their work in the majority of cases as art products and are very self-critical initially.</td>
</tr>
<tr>
<td>G</td>
<td>Again hard to generalise, but I’ll try. Artists more confident and spontaneous than non artists.</td>
</tr>
<tr>
<td>H</td>
<td>Not necessarily, depending sometimes on illness, especially chronic clients, but more so than non-artist clients.</td>
</tr>
</tbody>
</table>
Question 9 (iii) Desire to exhibit artwork

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Artists – with insight usually don’t want to emphasise this. Non artists – it varies but some do like to put work on the walls that they feel good about, although not for public exhibition. As I think about this I have the idea its more about levels of insight and self awareness that being an artist or non artist.</td>
</tr>
<tr>
<td>B</td>
<td>Keen to show work (in some cases) but more to teach people about art therapy than for ‘aesthetic’ reasons</td>
</tr>
<tr>
<td>C</td>
<td>No answer given.</td>
</tr>
<tr>
<td>D</td>
<td>Yes – this desire is greater.</td>
</tr>
<tr>
<td>E</td>
<td>Desire to exhibit strong in all three artists in comparison to non-artist group.</td>
</tr>
<tr>
<td>F</td>
<td>This is extremely important to the majority of artist-clients I have worked with and where possible I have arranged or encouraged the exhibition of works as exhibiting is so closely connected to their issues of self-identity, self-worth and self-esteem.</td>
</tr>
<tr>
<td>G</td>
<td>Not that commonly expressed by the people I see, though some. I can’t recall an ‘artist’ who was actively planning an exhibition, though the one professional (above) did have an exhibition that someone else organised. Some prefer to avoid the issue. Non artists exhibiting work can have unrealistic expectations re selling it and no idea of the processes involved. I think many of my clients would love to sell their work if it were possible and would be happy to exhibit to achieve that end. There was a period about 10 years ago when the hospital had an art gallery and public exhibitions, and both artists and non artists were keen to participate (we paid for the framing). At that stage we employed a Publicity officer who did all the practical things re running the gallery and I only had to find the work. When they abolished her job I refused to do the lot for obvious reasons.</td>
</tr>
<tr>
<td>H</td>
<td>Yes, more so than non-artist clients.</td>
</tr>
</tbody>
</table>

Question 9 (iv) Discussion on aesthetics or formal qualities of the art made

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Artists – tend to be more informed about these aspects Non artists – generally not that focussed in a sophisticated way but often concerned if the image is ‘ok’ or ‘good enough’</td>
</tr>
<tr>
<td>B</td>
<td>This would never be the primary focus of discussion, although it might be made in passing</td>
</tr>
<tr>
<td>C</td>
<td>maybe the artists were more involved in aesthetic qualities</td>
</tr>
<tr>
<td>D</td>
<td>Yes – this is certainly a factor.</td>
</tr>
<tr>
<td>E</td>
<td>Artist more keen to discuss and have feedback in relation to aesthetics/formal qualities – also evoked in me a sense of needing to respond in relation to these aspects with increased sensitivity.</td>
</tr>
<tr>
<td>F</td>
<td>All of these clients have discussed the formal and aesthetic qualities of their art work at some stage of the process whereas non-artist clients rarely discuss these qualities. Artist-clients discuss these qualities less once there is a strong therapeutic alliance between therapist and client.</td>
</tr>
<tr>
<td>G</td>
<td>Much more in ‘artists’.</td>
</tr>
<tr>
<td>H</td>
<td>Yes, more so than non-artist clients.</td>
</tr>
</tbody>
</table>

Four of the prominent issues of difference between artist and non-artists, derived from the Table of issues (see Table 4.3.1), made up question 9. These are choice of art material, level of spontaneity, desire to exhibit and discussion of aesthetics. Again some art therapists found it difficult to make generalisations and the comments varied, with few significant similarities to the results from the Table of issues. The one exception was that artists tended to discuss the aesthetic more often, and this is to be expected given they are more likely than non-artists to be familiar with this type of discussion.
**Question 10: Did the artist client appear to find art therapy useful?**

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Some, those with capacity to use the process did find it very helpful. One who had schizophrenia found the shift or clash of perspectives between art and art therapy too challenging. I read this as a threat to the sense of self and fragility in looking too closely at the self.</td>
</tr>
<tr>
<td>B</td>
<td>Definitely in all cases they told me it was very beneficial</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Yes. Even though their approach may be different in terms of use of materials, this doesn’t detract from the therapeutic relationship established with the therapist.</td>
</tr>
<tr>
<td>E</td>
<td>Artist (a) and (b) did. Artist (c) felt he was an established artist and saw himself as contributing to the art therapy group more than finding it useful for himself.</td>
</tr>
<tr>
<td>F</td>
<td>Yes (see answer to Q11)</td>
</tr>
<tr>
<td>G</td>
<td>They kept on coming, and I still receive requests from outpatients (who I am unable to accept) wanting to return. Although there is a big push towards moving people on to community resources, there is nothing equivalent in the community. Yes. Partly because of the availability of studio space and materials, (most participants are on social security benefits and many live in small flats or boarding houses) Partly for the social contact with others making art, partly for the relationship with the therapist. For those who consciously used art to look at their lives and work through issues, this was valued. There must have been others who didn’t find it useful – but I didn’t see them for long enough to have a clear memory. I can recall one ‘artist’ who didn’t engage because he painted at home and he didn’t want to ‘pollute’ his art by linking it with the hospital experience.</td>
</tr>
<tr>
<td>H</td>
<td>Helped to further understanding of art-making as helpful and healing.</td>
</tr>
</tbody>
</table>
Question 11: Do you have any comments or thoughts about artists undertaking art therapy?

<table>
<thead>
<tr>
<th>Name</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The artists can be at either end of the spectrum in finding art therapy useful or counter productive to their sense of self. I wonder if the artist who has psychosis is another specialized category to define from within this general group?</td>
</tr>
<tr>
<td>B</td>
<td>It has only been positive in my experience, but we are talking about private practice where people have chosen to come to an art therapist. They have been some of the most committed and long term clients I have worked with and I have felt we were very much speaking the same language</td>
</tr>
<tr>
<td>C</td>
<td>I think that it can be very helpful if that is what people want for themselves</td>
</tr>
<tr>
<td>D</td>
<td>I’ve never really thought about artists’ not undertaking art therapy. The legitimacy of professional art-making, while far from separate from the exploration of the unconscious, is not in conflict with or a substitute for, the engagement of artist as client with therapist as therapist (not artist) and art materials as tools for the personal as well as for the professional.</td>
</tr>
<tr>
<td>E</td>
<td>Think art therapy can assist artists to deepen levels of insight and develop meaning in terms of their art-making – can also greatly assist them to use their imagery to get in touch with their emotional world.</td>
</tr>
<tr>
<td>F</td>
<td>I have been able to work very successfully with artists undertaking Art Therapy. It can be a challenge from the art-making perspective but once a rapport has developed I have found this client type to benefit enormously from the therapeutic relationship that unfolds when there is such a natural understanding as artists between the artist-therapist and the artist-client. This is in spite of initial resistance to aspects of the art-making process. For example one artist-client who I have been working with for four years in a long-stay residential setting in a psychiatric hospital has demonstrated to the team increased self-esteem, humour and periods of joy and stability. Initially this client was extremely resistant to Art Therapy and very scathing of “therapy” being attached to art until he realised and accepted that all of us (including the other art therapist who works with him) are artists first and patients or therapists second. He now calls our art group “Art Therapy” and says that art is the only medicine that works for him. I am currently working with a young artist-client in private practice who is completely resistant to engaging in any art-making at this stage of his recovery from his first psychotic episode but feels he can talk to me about it and all the other underlying issues because I am an artist as well as an art therapist.</td>
</tr>
<tr>
<td>G</td>
<td>Hard to generalise. The majority of the people I see are not voluntary patients and they have not sought out art therapy as a means of working on issues (it must be wonderful to work with motivated artists!) My overall impression is that it is a bit harder to engage ‘artists’ in ‘art therapy’ rather than in ‘art’. The professional artist did resume painting and exhibiting.</td>
</tr>
<tr>
<td>H</td>
<td>We as art therapists understand the power of art-making and connection to therapeutic properties / processes, I view it as vital for artists in connecting with selves and healing the soul.</td>
</tr>
</tbody>
</table>

These last two questions revealed the most interesting responses from the questionnaire and affected the direction of the research. Some art therapists found that artists had definitely found art therapy useful, particularly the link between art, artist and therapy. For example, one art therapist wrote:

I am currently working with a young artist-client in private practice who is completely resistant to engaging in any art-making at this stage of his recovery from his first psychotic episode but feels he can talk to me about it and all the other underlying issues because I am an artist as well as an art therapist. (Question 11, F.)
Another art therapist wrote, “I think art therapy can assist artists to deepen levels of insight and develop meaning in terms of their art-making [; it] can also greatly assist them to use their imagery to get in touch with their emotional world” (Question 11, E).

However, there were also comments that artists had found art therapy difficult. Several respondents pointed out that, if the artist did not have the ability to process their experiences, art therapy was not as useful—for example, one comment was, “I can recall one ‘artist’ who didn’t engage because he painted at home and he didn’t want to ‘pollute’ his art by linking it with the hospital experience” (Question 10, G). Another art therapist who had worked with psychotic patients stated, “One who had schizophrenia found the shift or clash of perspectives between art and art therapy too challenging. I read this as a threat to the sense of self and fragility in looking too closely at the self” (Question 10, A).

Several art therapists made an important point when they linked the capacity to find art therapy useful with the quality of engagement and rapport.

It can be a challenge from the art-making perspective but once a rapport has developed I have found this client type to benefit enormously from the therapeutic relationship that unfolds when there is such a natural understanding as artists between the artist-therapist and the artist-client. This is in spite of initial resistance to aspects of the art-making process. (Question 11, F)

One art therapist stated, “My overall impression is that it is a bit harder to engage ‘artists’ in ‘art therapy’ rather than in ‘art!’” (Question 11, G). It is worth noting that two art therapists saw a connection between a focus on aesthetics and the level of trust with the therapist. They suggested that once engagement was established there was less discussion of aesthetics occurring and the focus could be more on the therapy.

4.5 Summary of Questionnaire results

The questionnaire results revealed that there were significant similarities between the client groups of the art therapist respondents and those of the research. The questionnaire results also provided evidence that art therapists had noticed differences working with an artist compared to someone who did not identify as an artist.

In keeping with the research topic several art therapists found that some artists whom they had worked with struggled with the benefits of art therapy. However, the majority of art therapists commented that the artist did find art therapy useful. The questionnaire also provided valuable new insights into the research questions, such as
corroborating comments that patients experiencing psychosis who identify as artists, and who also experienced poor levels of insight, struggled more than other artists in art therapy.

The questionnaire results generally supported the research hypothesis, with respondents finding that in art therapy a focus on aesthetics was more important for artists. The majority of respondents commented that artists were more interested than non-artists in discussing the aesthetics of their work with the art therapist. It was noted that artists were more likely to do this because they were more informed about aesthetics than non-artists. In contrast to the direction of the research, the questionnaire revealed that discussions with the artists about the emotional content of their work was not seen as an important issue for the art therapists. Almost all of them stated that although some artists struggled with the benefits of art therapy most artists were able to respond to their own emotional content in their art. They did not find that a focus on aesthetics excluded the artist from also focusing on the emotional content of their artwork.

The issue of engagement was revealed as a crucial factor, with one art therapist commenting that artists in general were harder to engage. Another reinforced this, stating that artists are more of a challenge because of an initial resistance in art therapy. One art therapist thought that patients experiencing psychosis who identify as artists seemed to be different to other artists in comparison to non-artists. Art therapists also commented on the commonalities between the artist client and the artist in the art therapist herself as an interesting issue occurring in the therapy.

The results revealed a major limitation of the questionnaire. That is, those general comparisons between artists and non-artists are particularly difficult to make. Not only is each individual different, but the variety of individual artists’ circumstances in undertaking therapy makes for a significant difference, as opposed to just the difference between artist and non-artist.
4.6 Summary of results

This chapter presented data for the results of the case studies and the questionnaire responses. The results have been grouped together to provide material that can be compared and so that some generalisations can be made. These results clearly demonstrate that the patient experiencing psychosis who identify as an artist patient behaves differently from the non-artist patient in art therapy. The process of the individual artist has been presented in the descriptions of the four case studies. The case studies, as results in themselves, were then compared over 22 issues specific to artist’s behaviour in art therapy. The results presented artists as a group reacting differently 80 percent of the time, in relation to the 22 issues, from the non-artists in art therapy groups. Twelve similarities of patients with psychosis who identify as artists were then presented, further reinforcing that artists can be grouped together as behaving differently in art therapy from non-artists.

Finally, the responses of art therapists to the questionnaire were presented. These further confirmed that other art therapists had noted differences when working with artists as compared to non-artists. The implications of these responses and the results of the case studies shall be discussed in the next two chapters.
5. DISCUSSION

Images produced by psychotic patients do not serve a symbolic purpose until a containing relationship is formed. (Killick, 1991, p. 6.)

Art therapists are in a unique position when offering therapy—they have access to the verbal psychotherapy arena and an insight into the therapeutic qualities of the creative process. These two dimensions bring different perspectives on the therapy encounter, including countertransference responses. As already noted earlier in this thesis, art therapy literature has not adequately covered the concept of the artist undertaking art therapy. This discussion will analyse the findings set out above and reflect on aspects of the data collected to bring together the theory and practice in regard to the patient experiencing psychosis who identifies as an artist in art therapy. This discussion provides an exploration of the phenomena and arrives at outcomes that have implications for the practice of art therapy.

This research began as a result of my personal struggle when working with patients experiencing psychosis who identify as artists. These phenomena were not covered in the art therapy literature: only one article appeared to discuss a similar client group, yet when talking to other art therapists there was an acknowledgement that the phenomena did exist. I wanted to understand the generality of this therapeutic environment and specifically how the phenomena affected my own practice and countertransference. I found myself trying to create a framework from the odd fragments of experience I had gained training as an art therapist. Like scattered bones I collected information, piecing together connections that have provided some strategies for understanding. This has resulted in the exploration set out in this thesis.

This chapter is a discussion of the results in order to explore the artists’ defence mechanisms using the case studies and relevant literature. I shall describe my own experiences, discuss the case material in relation to the defence structures of patients experiencing psychosis who identifies as artists, briefly explore aesthetics and countertransference occurring in the material and end with a discussion of the questionnaire results in relation to the research. Ultimately this discussion will explore art therapy’s capacity to work with the patient experiencing psychosis who identifies as an artist and will lead into a exploration of the implications of this study for art therapy practice with this client group.
5.1 Defence structures of patients experiencing psychosis who identify as artists

This complex and often paradoxical phenomenon can be observed when psychotically ill artists take part in art therapy. Both the literature review and the case studies have shown that there is an intricate relationship between the patient’s artistic personae and their psychotic defences. The artistic identity seems to fuel the psychotic defences and the defences in turn generate grandiose power in the artistic personae.

In art therapy these defences are specifically problematic as they resist the art therapy process. Subsequently, the artist patient appears not to be able to use art therapy. It is clear from the case studies that, initially, the patient experiencing psychosis who identifies as an artist cannot find art therapy containing and they cannot find symbolic meaning in their own imagery.

It seems that the patient experiencing psychosis who identifies, as an artist does not find art therapy containing until they are stable enough not to rely so much on their defences. Art therapy, therefore, can only be experienced as therapeutic once psychotic symptoms are reduced. Although the containment of art therapy is defended against, it seems to actually help reduce the experience of psychotic symptoms. The case studies have shown that as the patient experiencing psychosis who identifies as an artist begins to be less defensive and maintains a stable ego function, art therapy can begin to be experienced as containing. It is then that art can have a symbolic function.

This important liaison between the conflicting and healing elements of art therapy with patient experiencing psychosis who identifies as an artist has not been adequately covered in the art therapy literature. As this is an exploratory study this discussion is an attempt to broadly see the phenomena in operation and contribute to an understanding of the many layers of this complex relationship between art therapy and the these patients.

The four case studies in this research provide evidence that in art therapy patients experiencing psychosis who identify as artists display prominent defence structures. The literature review indicates that it is psychosis that is primarily responsible for these defences. In fact, defence mechanisms are psychotic features and are to be expected in this client group. Thought disorders such as concrete thinking and primitive ego structures have been found to contribute to the protection of the patient from connecting to their often frightening, unconscious or internal world. Making psychological explorations and finding symbolic meaning in art may therefore be impossible for the patient experiencing psychosis who
identifies as an artist. Psychosis seems to be at the core of their defence structure. It promotes primitive projections and prohibits the artist from using information about their projections therapeutically.

These four case studies highlight that patients experiencing psychosis who identify as artists are different from non-artists in art therapy. For each case the artistic persona enabled them to be different from others, highly defended, and reluctant to explore meaning in their artwork and to challenge the boundaries of art therapy. After many years, when there was a strong enough therapeutic rapport, sometimes the defences were able to come down and the artist able use art more therapeutically to express feelings in the session.

However, as already stated it is not only the psychosis producing defence structures, the ‘artist identity’ also plays an important part. Crane (1996) wrote about psychotic clients with artistic identities in art therapy. Crane describes the artists’ need to establish a “superior position in the group” (1996, p. 22). Partly this is done by a preference to value only the artistic aspects of their work. This creates difficulties when the artist tends to relate to other patients via discussions of the fine art qualities of the pictures produced. Crane states that the artists gained self-esteem from the group appreciation of their work, which further perpetuated the grandiose identification with famous artists such as Van Gogh and Mozart, whom two of his case studies emulated in style and subject matter.

It is interesting to note that an artistic identification with Van Gogh, in particular, was also evident in the case studies of this research. Two of the artists’ copied Van Gogh’s work and one heavily identified with him. These results suggest that the popular image of Van Gogh as a “misunderstood, mad artist” (see National Gallery of Art, Washington, DC, 2006) is an acceptable way for an artist, also confined in a psychiatric hospital, to seek a bearable identity. Connecting themselves to Van Gogh, makes being “mad” and an artist recognisable and even something to aspire to. The artist can produce pictures that may not be understood on the premise that although Van Gogh was not understood in his own time, he is admired in culture today (see Butterfield, 1998).

The literature review discussed that the artist has been trained to defend by maintaining some control over unconscious projections in their art. By focusing on art as an aesthetic the artist is defending and resisting any therapeutic processing of art. As suggested in the literature review, artists maintain control by using their training and skill to defend against self-expression in their art made in art therapy. It is specifically the training that makes the artist different from the non-artist, and the letdown of the training is that it hinders the use of art as a capacity for personal change. The artist will also resist art therapy
strategies, such as working spontaneously or free association, and will consciously dismiss exploration of meaning in their artwork.

Another common theme of the patient experiencing psychosis, who identifies as an artist, is their difficulty allowing art therapy to be containing. For instance, Greg always takes his art with him, keeps it in his room and regularly attempts to sell his drawings. Initially, he left his artwork in a folder in the art room. Then one day he sold his entire folder; he stated that he regretted this but was also ambivalent about it, as he had gained some recognition from making a sale. Now only a few forgotten artworks end up in the folder in the art room. Greg does not value keeping his artwork in the art room; art therapy cannot hold or contain Greg’s artwork in a way that contains his feelings.

Holding the artwork for later understanding is not relevant to Greg, for he is not creating his art for unconscious projections or understanding meaning about himself. The other three artists have a more fluid relationship to the holding capacity of art therapy. Some artworks are left and some taken, some are given to family, and some are also sold, but unlike Greg, they each have a sense that the art therapist is involved in their artwork being kept.

Maybe the ego of the artist patient is too fragmented to allow the artwork to be held and digested, or they are too fragile to allow these unwanted projections to exist. As already outlined, the patient experiencing psychosis who identifies as an artist experiences art therapy differently from the non-artist, particularly when the ego is heavily invested in the artist identity.

Each of the case studies has described how the artist tries to keep control of their unconscious process modifying it to keep unwanted issues from arising to be exposed in artwork. For example, each artist preferred to use only familiar art materials and tended to repeat the same themes, thus reducing any challenge or confrontation from new or spontaneous art-making.

Repetition is also a key element in all four case studies. Each of the artists tended to rely on familiar themes and imagery not seeming to develop or expand the theme but repeating it over and over. Greg drew similar nude torsos, resisting adding the rest of the body parts. Walter copied and re-copied Van Gogh’s paintings. There have been times when Ben has drawn the same figures of monsters or teddy bears week after week, and Joseph has used the same schema for each painting. Each artist tends to use the same art materials, rarely trying anything new.

Repetition itself can be seen as a defence strategy of patients experiencing psychosis who identify as artists who maybe trying to keep hold of a sense of an integrated self by
repeating familiar images. Repetitive imagery is seen as an indication of a fragmented and withdrawn state where one is unable to move into a more healthy integration. It can also be evidence of concrete thinking and loss of capacity for abstract thinking, which is required for developing meaning from images.

The defences, such as repetition just described, which originally act as resistance in art therapy, can also paradoxically enable a process of adjustment to occur. It is worth considering that the psychotic patient may repeat important symbols in order to sustain a connection with reality. The continuous production of repetitive imagery can actually promote the development of the capacity to symbolise, thereby growing a sense of meaning and greater sense of reality.

This discussion has illuminated the dual structure of defences in operation by patients experiencing psychosis who identify as artists in art therapy. This combination of psychotic and artistic defences brings a further dimension, as it seems the two defences work together. Psychotic defences fuel the defences of the artistic personae, which in turn further fuel the psychotic defences.

In the case studies the artist is prone to exaggerated displays of an artistic identity. Each of the four artists exhibited grandiose and delusional traits associated with them being an artist. The artists’ background of either studying to become an artist or being proclaimed an artist, as in the case of Joseph, has consolidated their artistic identity. This in combination with psychotic process becomes a defence structure in itself.

The artist persona also incorporates narcissism as a defence, where the artist becomes so involved in their art it appears that they cannot separate themselves from it. Narcissism is a feature in psychosis and further exacerbates the patient’s preoccupation with their identity as an artist. Several of the artists in the case studies invested their entire ego into being an ‘artist’.

Heinz Kohut, as cited in Lachman-Chapin (1979), states that

Creative artists … may be attached to their work with the intensity of an addiction, and they try to control and shape it with forces and for purposes that belong to a narcissistically experienced world. They are trying to re-create a perfection that formerly was directly an attribute of their own. (p. 6.)

The patient experiencing psychosis who identifies as an artist may experience art therapy as challenging this important attachment to being an artist, which provides much support for the disintegrated psychotic patient. All four case studies have demonstrated a series of defence mechanisms that are characteristic of this group of patients, showing that there is a complex tension between the psychosis and the artists’ identity, where the defences
of one fuels the other. The combination results in patients experiencing psychosis who identify as artists having difficulties accessing symbolic meaning and in using art therapeutically in the art therapy process.

It may seem that art therapy is therefore severely limited for patients experiencing psychosis who identify as artists. However, this is worthy of further investigation because the artists in the case studies all continued to attend art therapy. Greg, even though he was struggling, regularly attended art therapy for ten years. Walter, although he seems to be experiencing severe psychotic symptoms and at times did not produce any work, still continued to come. Art therapy was obviously offering something which was an alternative to the hospital ward, and was obviously not too confronting to the patient’s fragile and defended ego.

Katherine Killick (1991) states that “images produced by psychotic patients do not serve a symbolic purpose until a containing relationship is formed” (p. 6). This was seen in three of the case studies who continued with art therapy. When the symptoms of their illness were reduced, the artists were more able to cope with art therapy. This could not occur until, over substantial time, art therapy had begun to be experienced as containing.

These three artists consciously found ways to engage with their art symbolically, as an expression of their feeling and of the transference operating in the therapy. The artist may defend initially when they are unwell, but over time and when they become less acutely ill, the artist can engage in the art therapy process. When this happens they experience the containment of art therapy and are then more receptive to using art to express themselves. Some are then able to use symbolic meaning in their art, which previously they defended against.

This may be an occasional conscious experience such as when Greg drew his jet fighter planes which represented his feeling about war, or when Greg painted his Death Mask and talked about his father’s death. Ben gradually developed ways to safely incorporate his feelings about his family while discussing his paintings, and Joseph painted a portrait of the art therapist in response to difficult feelings about his mother.

It is worth noting that in each of the case examples, the artists tend to use their defences more prominently when psychotically ill. This is particularly true of the time when they began art therapy and had been recently admitted to hospital, or at various times when their illness became worse. It is during these times that the artists specifically resist attempts to find meaning and are unable to make connections between their inner and outer worlds by exploring the meaning of their artwork. In summary, there is a complex relationship of defences both psychotic and artistic in origin, which make art therapy problematic for
patients experiencing psychosis who identify as artists. A reduction in symptoms and a robust ego can help the patient allow art therapy to contain their experiences and ultimately art can have meaning.

In this discussion it is important to remember Katherine Killick’s warning to art therapists that was mentioned in chapter 3. It is all too easy to become seduced into trying to organise and make sense of the psychotic patients’ artwork, when it is in fact meaningless. The loss of the ‘as if’ quality must not be underestimated. A loss of abstraction occurs with the acutely psychotic patient, so much so that images are experienced as things in themselves and are not representations. The images are signs, signs of distress, and not symbols of inner communication.

Working with the patient experiencing acute psychosis who identifies, as an artist is complex, as their artwork holds their artistic skill. The patient’s images maybe carefully created and composed, while the aesthetics of the work can be seductive to the art therapist, who may wish to want to read the artwork as symbolic. However, the patient may not be making a representation of their inner expression; the artwork may not ever be able to be read or understood by the art therapist. Furthermore, the patient experiencing acute psychosis who identifies as an artist is not able to uncover or communicate their personal meaning of their artwork.

The art therapist may experience frustration at this process and countertransference experiences may be very powerful when working with psychotic patients. The art therapist must be able to wait, allowing the artist to continue to make art. The art therapist must respect the mystery of the process, resisting the temptation to be drawn into trying to make sense of aesthetic and well-constructed artwork. The trained artist brings the extra element of aesthetics to art therapy, but the defences of the psychotic processes are also operating.

5.2 Aesthetics and the patient experiencing psychosis who identifies as an artist

This discussion has explored the phenomenon of the patient with psychosis who identifies as an artist in art therapy as well as the internal conflicts about the psychological process of artwork made by these artists in art therapy. Several difficulties of the these patients in art therapy sessions have already been explored, such as the challenging of therapeutic boundaries, when the artist is unable to process a personal meaning of their work and also when the artist is unable to find art therapy to be containing. The importance of aesthetics in art therapy with the patient with psychosis who identifies as an artist is worthy
of more detailed consideration in this discussion. Maclagan (2001) suggests aesthetics need to be carefully considered by art therapists. He states that in traditional Freudian analysis aesthetics is viewed as a cosmetic lure to disguise the underlying psychological conflicts in artwork (Maclagan, 2001, p. 25.)

The artwork of psychotic patients tends to be crude and rudimentary; it may involve a peculiar style or bizarre use of text within the picture. More often than not the chronically mentally ill patient cannot verbalise meaning to their work, and so it remains a mystery. For the patient to actually talk about their work they have the difficult job of translating from visual image into words. This is further exacerbated by the symptoms of schizophrenia such as disturbed thinking, perceptual confusion, fragmentation and a disturbance of concrete or symbolic thinking.

However, the art made by artists in art therapy stands out as different. It is often well composed and it can be aesthetically interesting or appealing. The artwork of psychotic patients who are trained artists seems more able to be understood, because of the use of aesthetics, a familiar language to both artists and art therapists. However, due to their psychotic state, the artist, however subtly approached, is not available for making or sharing meaning.

Aside from the seduction of the aesthetics, a patient with psychosis who identifies as an artist’s transference and manipulative personality may further undermine and challenge the art therapist. Art therapists may have powerful and unusual responses to their artist patients (see the work of Alter-Muri, 1994; Klorer, 1993; Muenchow & Arsenian).

The therapist must acknowledge that their role and therapeutic boundaries may be challenged, and find ways to support art therapy. The art therapist may find that the patient is even more talented than themselves, and become seduced or frustrated when working with the patient with psychosis who identifies as an artist. Despite the remarkable aesthetic qualities of the artwork made by such patients in art therapy, it may not bring them closer to the psychological arena of therapy. It can be confusing and a struggle to work with the patient with psychosis who identifies as an artist, because, while this psychotic material may have been written about it may never be fully understood. This is the nature of working with not only psychosis but with the emotional world and the realm of the imagination.
5.3 The art therapist’s own experiences as countertransference

As a way of integrating the case studies with the theory this section will describe some of the countertransference experiences of working with one of the case study artists, Greg. My own journey with this patient is an interesting reflection of how countertransference effects the patient, for as I grew to understand what might be going on for the artist in the therapy sessions, he seemed able to cope with art therapy.

Initially I struggled, as a new graduate in art therapy, to work with Greg, a man in his fifties who had had a long history of psychotic illness. He showed a strong identity as an artist, but it was a great effort for him to make art and when he did he only wanted to focus on the aesthetic aspects of this work. I had not encountered such defences in my training and Greg seemed totally unwilling to consider his art as an expression of his personal meaning. Greg seemed overly dominated by his identity as an artist and I found myself confused offering art therapy to him. Of all the many different patients I worked with, I kept finding Greg continually challenged my role as an art therapist.

It is not uncommon for psychotic patients to find art therapy challenging. Art therapy asks us to trust and to use our unconscious; this can be very threatening to people experiencing the world as frightening already. Similarly, thought disorder characteristic of psychosis seems to also bar the path to finding symbolic meaning in artwork. Despite these difficulties, generally there are ways to engage even acutely psychotic patients, so that they feel safe and contained in art therapy sessions (see Greenwood, 1997; Killick, 1991; Seth-Smith, 1997).

It is the artist patients that have come into art therapy who reject and challenge my role as art therapist. They seem not to find art therapy containing, and although they persist and even may enjoy being in the art sessions, in my countertransference I experience frustration, as if something is not satisfying. It is my feeling that I want to focus on here, for the countertransference is what guides the therapy and has enabled changes in my attitude to occur.

At first I strived to make sense of my experience. I was frustrated, thinking I was taking the wrong approach to art therapy and I began to question myself. An examination of my experiences in supervision helped me to consider that there was more going on. Next I tried to understand more about the patients’ perspective, and concluded that the artist identity was essential to these institutionalised artists who had suffered losses in their lives and like anybody needed a role to sustain them.
I began to see them foremost as artists and that as an art therapist I could empathise with this. I decided to listen to their desires and offer more practical support. I took Greg to several foundries to discuss the process of casting his work in bronze, so that he could consider the fuller picture of his ideas. I followed up his persistent request for a used tractor tyre in which to display his sculpture. I took seriously his desire to make large cardboard artworks, and to print and frame his computer graphics. I took artists on trips to art galleries and set up exhibitions. Somehow each time I felt I had missed the point, and the artist seemed to be never satisfied—something was still missing.

As it turned out the tractor tyre was not enough, visiting the foundries did not develop Greg’s concepts, the large artworks were never made and his computer graphics plans turned out to be limited scribbles that had taken two minutes and were never extended into anything further. The trips to the art galleries were particularly dissatisfying because the artists all really preferred to sit in the café, smoking cigarettes and looking like artists, to actually looking at anyone else’s art. Greg usually accosted people to discuss his art, trying to find buyers or asking to see the top gallery director. Once Greg even asked to see the work of—and he gave his own name. The assistant looked him up in the records and stated that they did not have any work by him.

My frustrations grew. This kind of support I gave to artists did not feel therapeutic to me. I felt as though I was compromising my role as therapist, and although other staff felt that the artists were getting the right kind of help; it felt like the artists were seducing me and corrupting my view of art therapy.

I felt the artists continued to be unable to conceive that their artwork may express personal meaning and that to this end no-one was gaining from my efforts. My next step was to look further into the literature. This research process provided me with some relief and some new direction in my thinking. Interestingly, changes began to occur for the artists as well. Reading about defence structures helped me further my understanding and I found I became aware that things were not really unchanging. It is a two-way process, for as I have been researching I have continued my work with the artists. As I have developed my understanding, changes occurred in myself and as I became more accepting of these patients the artists seem more accepting of the art therapy process.

In undertaking this research I have shown that a phenomenon does exist. There are dual defence systems at work, those of the patient experiencing psychosis, and those of the artist. The two systems fuel one another and because of the combination of the psychological and the aesthetic the artist defences are most powerfully experienced in art therapy.
The presented case material demonstrates that the three artists who continued in art therapy longer than one year were able to find conscious and deliberate ways to express their feelings in art, and to make this known verbally in discussion with the art therapist. Greg consciously explored his feelings on only a few occasions, using representative art—for example, when he drew fighter jets and painted a death mask. Ben painted his father and talked about his feelings, and Joseph consciously explored transference in a painting of the art therapist. My approach to understanding the patient in art therapy put me in a better position to further understand what might be happening for the patient with psychosis who identifies as an artist.

This research hypothesises that the psychotic patient who identifies as an artist behaves differently from the non-artist in art therapy and explores the phenomenon from both theoretical and clinical viewpoints. These patients appear to operate from a complex system of defences, where the artistic identity is paramount, as it tends to fuel the psychotic defences.

5.4 Questionnaire in relation to research

Finally, this discussion will explore the material from the questionnaire in relation to the research. The questionnaire was sent to art therapists recognised for their work in the mental health field. The questionnaire responses supported the findings of the research from the four case studies and also what could be found in the review of art therapy literature. Ninety percent of the respondents described noticing artists as different from non-artists and 75 percent reported that artists have more difficulty responding to emotional content than non-artists. The results of the questionnaire provided enough similarities with those of the researcher for the data to be considered highly relevant to the research.

Many of the respondents also described similar responses to those mentioned in the literature review. However, it is the differences in opinion provided by the respondents that have given new impetus to this research. The major finding from the questionnaire was that respondents found artists, in general, were able to respond to the emotional content of their own artwork in art therapy. The artists generally were said to find art therapy useful. Despite this, some of the respondents did describe a few examples where the artist was highly defended and struggled with art therapy, and these tended to be those patients with poor capacity for insight, such as with chronic psychotic conditions.

The statements provided by the questionnaire, that artists did make use of art therapy, enabled a reconsidering of a fixed position where the artist was considered not to benefit from art therapy. Importantly, two of the questionnaire respondents reflected that that artists may be more responsive once engagement had developed, and this was after an
initial period of resistance. This information, not stated in the literature at all, enabled a
greater exploration of the artists’ responses to art therapy as a fluid process. I began to
consider the importance of each of the artists having continued to attend art therapy, one for
as long as ten years. Suddenly it stood out—it was not all the time, but there were times
when the artists had specifically and consciously used art therapy to process a particular
emotional state. There were deliberate occurrences of this kind with three of the four case
studies. The case study artists had been able to find art therapy useful.

This is a very complex area and it is easy to seek simple explanations and
generalisations. It is also very easy to portray the phenomena as the artists’ problem and to
label it as a defence. The differences of opinion provided by the questionnaire responses,
none of which was available in the art therapy literature, became an effective tool in the
exploration of this research. It also became evident that the perceived struggle of the artist in
art therapy has a lot to do with the art therapist’s countertransference. It is also worth
questioning what is really different about the artist, for as mentioned many times by the
questionnaire respondents everyone uses art therapy differently, artist or not. The anecdotal
information provided by fellow art therapists have validated this research and also provided
new directions in thinking.

5.5 Summary of discussion

This research hypothesises that the psychotic patient who identifies as an artist
behaves differently from the non-artist in art therapy. This discussion has explored this
concept in relation to the results of the case material, the questionnaire and the art therapist’s
own countertransference experiences. A dual structure of defences of the patient with
psychosis who identifies as an artist in art therapy has been described where the psychotic
defences fuel the defences of the artistic personae, which in turn further fuels the psychotic
defences. This complex and paradoxical phenomenon can be observed when psychotically
ill artists take part in art therapy. In art therapy these defences are specifically problematic
because they resist the art therapy process. Subsequently, the artist patient appears not to be
able to use art therapy. It is clear from the case studies that, initially, these patients cannot
find art therapy containing and they cannot find symbolic meaning in their own imagery.

Art therapy, therefore, can only be experienced as therapeutic once psychotic
symptoms are reduced. As the patient with psychosis who identifies as an artist begins to be
less defensive and maintains a stable ego function, art therapy can begin to be experienced as
containing. This important liaison between the conflicting and healing elements of art
therapy with these patients has not been adequately covered in the art therapy literature. The
four case studies in this research provide evidence that this occurs in art therapy, since they all continued to attend art therapy.

When the symptoms of their illness were reduced, the artists were more able to cope with art therapy and more receptive to using art to express themselves. This could not occur until art therapy began to be experienced as containing.

This study has discussed a multiplicity of views in relation to this phenomenon, and reflects the process of the research and personal reflection from being involved with patients with psychosis who identified as artists in art therapy. The issues seem to stem from the artist who is housed in a fragile psychotic ego state. However, it is important not to reduce the phenomenon to specific diagnosis or defence structures, but to see the many layers of the phenomenon. The case material is from actual sessions with real people, who at some level cannot really be reduced to comparable data.

This research began as a result of my struggle working with patient with psychosis who identifies as an artist. The countertransference, or the art therapist’s reactions to the artist as patient, has led this discussion and also produced a new and productive line of thinking. The artist patient may experience art therapy as challenging and despite the remarkable aesthetic qualities of the artwork made, it does not bring them close to the psychological arena of therapy. However, patients with chronic mental illness can change. The case studies suggest that defences can reduce when the patient feels held in a therapeutic environment and that art therapy can help to process emotional states.

In this discussion I have explored this concept together with what the artist may need to make use of art therapy. The following chapter, 'Implications for practice', outlines some specific strategies and thoughts for art therapists working in this area, and seeks ways to address the problematic in everyday art therapy practice. It suggests strategies for art therapists to be better prepared to work with patients with psychosis who identify as artists, and furthers the capacity for art therapists to challenge assumptions set by cultural traditions of the artist, from art therapy training and clinical climate.
7. CONCLUSION

Traditionally, art made by psychiatric patients in hospitals has been romanticised and looked upon as a representative of some kind of pure inner creativity. Opposing this, art therapists often experience the art of psychotic patients as devoid of meaning and content. These conflicting positions are the core of this thesis. Art therapy is assumed to be suitable for the artistically talented and yet this topic has not been covered adequately in the art therapy literature. Furthermore, this thesis has provided evidence that this is not the case. The results of this thesis clearly demonstrate that the patient with psychosis who identifies as an artist behaves differently from patients who are not artists in art therapy.

The case studies and reports of other art therapists quoted in this thesis show that the artist may have specific struggles in art therapy. There may be a difference between the artist and non-artist when they are patients in a psychiatric facility. This thesis asserts that it is the psychosis together with the artistic identity that provides resistance in art therapy. It could be that a combination of psychosis and artistic identity intensifies the defence mechanism. A dual structure of defences by the patient with psychosis who identifies as an artist exists, where the psychotic defences fuel the defences of the artistic personae, which in turn further fuels the psychotic defences. This complex and paradoxical phenomenon can be observed when psychotically ill artists take part in art therapy that may result in resistance to the art therapy process. Subsequently, the artist patient may appear to have a compromised ability to use art therapy.

The literature suggests that by attempting to keep the unconscious process controlled, the artist has difficulty being able to shift between the inner and outer world, and is therefore unable to link the aesthetic with the psychological. A loss of meaning results. It is clear from the case studies that, initially, the patient with psychosis who identifies, as an artist cannot find art therapy containing and this compromises their ability to find symbolic meaning in their own imagery.

However, those with a serious mental illness are capable of subtle and sophisticated changes, even though this is difficult to evaluate or validate. This thesis has found that art therapy was generally supportive for artists when their defences were viewed as appropriate coping strategies. The case studies suggest that defences can reduce when the patient feels held in a therapeutic environment, and that art therapy can be experienced as therapeutic once psychotic symptoms are reduced. When the symptoms of their illness were reduced, the artists in three of the case studies were more able to cope with art therapy and more
receptive to using art to express themselves. This could not occur until art therapy began to be experienced as containing.

When examining this topic it is important not to reduce the phenomena to specific diagnosis or defence structures, but to see the many layers of the phenomena. The case material is from actual sessions with real people, who at some level cannot really be reduced to comparable data. Art therapists tend to believe everyone, whether trained in art or not, has the capacity to use art therapy to project their inner conflicts. The patient with psychosis who identifies as an artist brings many difficulties to the session as transference and countertransference can be intensified and defensive activities played out in the art media. The patient’s ability to express themselves in art may be a measure of their developing ego strength. Art therapists are required to examine their aesthetic countertransference more closely when working with artists, because powerful transference has been characteristic of the artists in art therapy sessions.

The approach to working with patients with psychosis who identify as artists must be modified to allow for the specific requirements of psychosis, which bring a concrete nature and a tendency to attack the therapy process. Containing experiences and care with the intensity of interpretation are required, allowing for a gradual connection between the patient’s experiences and therapist’s reality. The art therapist must be prepared to work with the patient’s limited capacity to use symbolic communication and make containment the primary focus of therapy. Despite the difficulties of this form of treatment, it is clear that art therapy can work with patients experiencing psychosis to process their emotional states through art-making.

7.1 Limitations of this study

This exploratory research has many limitations, which curb its usefulness and flag further areas of investigation. Firstly, this study has been narrow in its scope. In particular, it has focused only on those attending art therapy as psychotic patients who identify as artists. The implication here is that the case studies are of hospitalised people with severe experiences of psychosis. It is important to note that the severity of the illness is seen to be highly influential in the defensive structures that attack art therapy. The conclusions of this study may not, therefore, easily translate to other types of artists in art therapy.

This research is further limited by the small case study sample of only four. This may influence the validity of the results, since there is not sufficient data to make conclusive comparisons. It also lacks a degree of ‘objectivity’, because the research is based on the
descriptions of the therapist’s own experiences and those of the patients who become the case studies. Although this is an exploratory work only, a broader study of the phenomena of the patient with psychosis who identifies as an artist in art therapy practice may yield further insight into the complexity of this subject.

The language used in this research is also limiting. Art therapy language has been used to describe art therapy, in a context of discussing both creativity and identity. These terms are often complex and slippery to investigate. Furthermore, the entire work has used a limited perspective that of the psychoanalytical and Humanistic approach. This can hinder further avenues of understanding through its particular perspective, language and thinking. A broader examination of this phenomenon in art therapy is required to adequately investigate this topic.

Although this is not quantitative research, the questionnaire also was limited in many ways. It represents only a preliminary investigation into art therapists’ thoughts on this topic. Again only a small sample of responses were used, which may not accurately reflect a larger group of art therapists’ views on this topic. The questionnaire was further limited by a lack of specific inquiry into the countertransference responses of art therapists who had experience of the topic.
7.2 Further areas of investigation

This exploratory research has given rise to a multitude of topics which have only just been touched upon, but which would broaden the investigation of this topic immensely. The impact that group dynamics have upon patients with psychosis who identify as artists, and the art therapist’s own countertransference in relation to this topic, are worthy of further investigation.

As noted in the literature review and case studies, the powerful personae of the patient with psychosis who identifies as an artist, can have an impact on art therapy group dynamics. The impact of manipulative or grandiose behaviour by artists toward group members has been documented in the art therapy literature (see Crane, 1996), and often involves competitive behaviours and value judgements about artwork. This study, limited by its exploratory nature, has not given adequate attention to effect of groups on the artist, and artists on groups. This would be another area for further investigation.

A full exploration of countertransference would be worthy of further investigation. In view of the evident frustrations and capacity to be seduced by the aesthetics of creative patients, the art therapist’s own issues will play powerfully into the therapeutic relationship. Factors that have not been covered in this exploratory study but can be acknowledged here are the way in which (in my own case) my persona as an artist is played out in the transference. Second, the impact of having a female art therapist with male patients, each experiencing mothering issues. The issue of my own dilemmas of working with patients with psychosis, who identify as artists, may be unconsciously projected into the art therapy sessions. Given the focus on transference issues in this study, it could be further expanded by an investigation of countertransference of this research.

The final interesting area of further investigation would be to explore the reasons why the art therapy literature has not explored the topic of this research. This observation is made in the context of the recent shift in art therapy literature toward bringing back the focus of aesthetics into the profession of art therapy (see, for example, Killick, 2000; Maclagan, 2001; Moon, 2002). The concept of the skilled artist fully using aesthetics in their artwork, defensively or not, is conspicuously absent in the art therapy literature. This research also highlights the difficulties within art therapy research to explore its negative and difficult aspects. As art therapy is a relatively new profession and research is still developing, it has been focused on promoting the profession with the positive and successful experiences of art therapy; the negative aspects have only just begun to be studied.
8. REFERENCES


9. APPENDIX

9.1 Questionnaire

Questionnaire researching into art therapy with clients who identify as artists.

Please return this questionnaire in the reply paid envelope by Friday June 2005.

Think back over the various clients who you have offered art therapy, and without providing identifying information, please answer the following questions:

1. Have any of your clients identified themselves as an artist?

   If you answered no to this question please move to question 11

2. How many such clients have you worked with?

3. Did these artist clients participate in group work or individual work?

4. For each of these clients what, in your opinion, enabled them to identify as an artist? For example, client (a) trained in visual arts, client (b) practiced as an artist.
5. Did any of these clients also have a formal psychiatric diagnosis? Please describe.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

6. Please think back to your experiences of offering art therapy to the artist client/s, did you notice any differences working with an artist compare to someone who did not identify as an artist? Please elaborate.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

7. Did the artist use art therapy in the same way as someone who did not identify as an artist? Please comment.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

8. Please comment in general on how the artists responded to the emotional content of their artwork. In your opinion did the artist client/s view their art as a representation of their own unconscious expression?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
9. In general can you comment on the following comparing the client/s who identify as an artist with the non-artist client?

- Choice of art materials

- Spontaneity in approach to art-making

- Desire to exhibit art work

- Discussion on aesthetics or formal qualities of the art made

10. Did the artist client appear to find art therapy useful?

11. Do you have any comments or thoughts about artists undertaking art therapy?

Thank you for taking the time to fill out this questionnaire.
9.2 Rationale for each question in questionnaire

**Question 1**  Have any of your clients identified themselves as an artist?
To filter out any art therapist responses that have not worked with artist/s and to introduce the topic.

**Question 2**  How many such clients have you worked with?
To gain an impression of their experience with artists in general. If it is just one artist, it is hard for the respondent to generalise. Issues arising working with an artist may be idiosyncratic to that artists rather than across artists in any generalised way.

**Question 3**  Did these artist clients participate in group work or individual work?
To gain a better understanding of the type of situations the therapist has worked in, so as to compare them to the area of research. Can the hypothesis extend into the area of group work specifically, as a factor?

**Question 4**  For each of these clients what, in your opinion, enabled them to identify as an artist? *For example, client (a) trained in visual arts, client (b) practiced as an artist.*
To clarify what the therapist’s ideas were in calling the client an “artist”. To help speculate how the identity of the artist comes about. Examples have been included to help guide the therapist with answering the question.

**Question 5**  Did any of these clients also have a formal psychiatric diagnosis? Please describe.
To clarify any if any of the artists have a psychotic illness so that data collected my is relevant to the research question.
Question 6  Please think back to your experiences of offering art therapy to the artist client/s, did you notice any differences working with an artist compare to someone who did not identify as an artist? Please elaborate.

This open ended question is designed to gather initial ideas of whether the therapist themselves have identified the artist client as different, and to be specific about what they noticed.

Question 7  Did the artist use art therapy in the same way as someone who did not identify as an artist? Please comment

To ascertain initial ideas on if the therapist had thought the artist was different in relation to the art therapy specifically. To build upon question six focusing on the artist in art therapy.

Question 8  Please comment in general on how the artists responded to the emotional content of their artwork. In your opinion did the artist client/s view their art as a representation of their own unconscious expression?

This is a deliberately leading question about the psychological response to emotional content of the artists’ work. It is informed by the assumed art therapy principle that art can reveal something of unconscious material and that a primary purpose of making art in art therapy is to express and seek an understanding of the self. There is an assumption that the art therapist can engage in the emotional content with the client, that art is not made for diversion or for arts sake. The responses to this question should help identify if the art therapist approach can be compared with the research question.

Question 9  In general can you comment on the following comparing the client/s who identify as an artist with the non-artist client?

To seek more specific information about how artists cope with the limits of art therapy.

Choice of art materials

To obtain information about the artists’ response to the boundaries of art therapy as set by the limit of materials on offer, and the artists rigidity in their use of materials.

Spontaneity in approach to art-making

To obtain information about the artists’ risk taking behaviour in relation to their art and the possibility of uncovering unconscious material.
Desire to exhibit artwork

To obtain information regarding the issue of exhibiting art made in art therapy, did this provide an area of conflict with the art therapy?

Discussion on aesthetics or formal qualities of the art made

To follow up more detail from question eight, to obtain more specific information about the approach the art therapist undertook engaging the artist in art therapy.

Question 10 Did the artist client appear to find art therapy useful?

This question is more subjective, requesting the art therapist’s own opinion to gain more collaborative evidence to support the research question.

Question 11 Do you have any comments or thoughts about artists undertaking art therapy?

To provide an opportunity to follow up any further thoughts or conclusions triggered by the questionnaire, that may be not already thought about by the researcher.
9.3 Copy of the consent form used for case study photographs

HOSPITAL (name withheld)
Address of hospital (withheld)

Consent to Photograph Artworks

I, (name of patient) _____________________________________________
of ward ______________________________________________________
hereby give permission to Clare Dash (name of staff)
to photograph or show original artwork for educational purposes only.

I understand that no reference will be made to my identity, and confidentiality
will be maintained.

Signature of patient: _____________________ Date: _____________

Signature of staff: _____________________ Date: _____________

Signature of witness: _____________________ Date: _____________
Dear Colleague,

Re: Research into art therapy with clients who identify as artists.

As some of you know I am currently undertaking an Art Therapy MA Honours thesis at University of Western Sydney. As part of this study I wish to include the experiences of other practising art therapists.

I would appreciate it if you could please give me 20 minutes of your time to complete the enclosed questionnaire. All replies will remain anonymous and in keeping with confidentiality please do not include any identifying information in your answers.

Where possible please return your questionnaire in the reply paid envelope by date.

In anticipation of your help may I take this opportunity to thank you for your time.

Yours sincerely,

Clare Dash