Goldsmiths
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STaCS Submission Front Sheet

STUDENT/ REG No **8 DIGIT NUMBER ON ID BADGE**	**33036107**
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PROGRAMME NAME & YEAR	**Ma Art Psychotherapy** **Year 3**
MODULE CODE	**PY71058B**
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WORD COUNT	**10900**

ASSIGNMENT DEADLINE	**15/05/13**
DATE OF SUBMISSION	**14/05/13**

Essay or Assignment Title

The Bodies in the room; loosing aspects of self through illness and becoming through art.

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The Bodies in the room; loosing aspects of self through illness and becoming through art.

'Illness threatens to undo our sense of who we are. Its darkest power lies in showing us a picture of ourselves - false, damaged, unreliable, and inescapably mortal - that we desperately do not want to see" (Morris, 1998; 22).

figure 1

Final Clinical Report

MA Art Psychotherapy May 2013

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"Illness threatens to undo our sense of who we are. Its darkest power lies in showing us a picture of ourselves - false, damaged, unreliable, and inescapably mortal - that we desperately do not want to see" (Morris, 1998; 22).

Abstract

Children with serious physical illness can experience complex psychological problems and distress affecting many areas of their lives. Developmental tasks, responsibilities for self care, family background all impact on managing, adapting and living day to day with serious illness. The cultural context within which illness, health and the body are understood profoundly influence how illness is experienced and responded to. Art therapy can offer a child a unique opportunity, a space to explore their emotional distress in relation to their illness and body. In telling their story and finding a voice through art therapy, a child can perhaps start to experience a sense of 'self'; of being more than an ill body or a patient in a hospital for 'sick' children. Art therapy in this setting is challenging; it evokes difficult and painful feelings for the art therapist in relation to the patient and setting. Taking care of one's own psychological and physical well-being by making good use of supervision, personal therapy and one's own art making are important factors in sustaining a professional art therapy practice with this client group. This report presents a case study of art therapy in a medical setting with a fourteen year old with Type 1 diabetes.

Introduction

figure 2

I have always been drawn to making art about the body. Artists that inspire me, like Jenny Saville, Freida Khalo and Louise Bourgeois use their own bodies to explore their sense of self and identity. In my own art practice broken, distorted (pregnant) or breached bodies and the inadequacy of skin holding inside emotions, feelings and memories are important subjects (see figures 1 and 2). My interest in anthropology and feminism make me curious about how the body is constructed over time, through art and other dominant social and political discourses. During my placement in a hospital for sick children, I have tried to draw on this background in order to make connections that help me understand 'illness' and the complexity of the issues that have arisen.

In the hospital setting art therapy offers children and families support in adapting and coming to terms with illness. In my view it also offers something unique; through the development of a trusting relationship and space to explore (perhaps for the first time) profound fears in relation to illness. Art therapy can give a child the chance to reclaim their body from the medical profession, to find a voice and tell their own story. In art making, using materials which themselves have a visceral quality, there is the possibility of constituting a more integrated sense of 'self', through an 'interweaving between mind and body' (Maclagan, 2001, Strand and Waller, 2010).

As a trainee I offered one to one and group art therapy to patients (and their families). My art practice, personal therapy and supervision played an important role in helping me process the powerful feelings evoked through this work and to become more aware of my need as an art therapist to look after myself.

In section one, the literature review explores art therapy practice with physically ill patients. I focus on themes in the literature that resonate with those in the case material that have helped me to think about this work.

In section two, I explore the organisational context of my placement in an NHS hospital for 'sick children', and the role of the art therapist.

The case study is presented in section three of art therapy sessions with a 14 year old with Type 1 diabetes.

In section four I reflect on my findings and thoughts about the case study in the context of the literature. In the conclusion I summarise what I think art therapy practice can offer children with illness in a hospital setting.

'Child' and 'young person' is used interchangeably in this report. All names have been changed to protect confidentiality.

Section 1

Literature Review

Introduction

In Illness as Metaphor, Susan Sontag writes, “illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner of later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place" (Sontag, 1978; 3).

Sontag explores how culturally negative associations with disease, stigmatise and affect a patient's self perception. The 'reputation of cancer' can add to suffering. In Aids and its Metaphors she refers to patients’ disgust and shame (Sontag, 1989). Sontag identifies a human tendency to use metaphoric thinking about illness reflecting attempts to make meaning of our own fears in relation to our bodies and the dehumanizing potential of illness and ultimately death and dying. A recent television advert, for example, described heart disease as 'lurking out there amongst the buggies and the bumps'.

This review reflects the complexity of theory and practice in relation to art therapy with illness. There's little literature that relates directly to 'sick children'. I start with this evidence base and then draw on Case and Dalley's analysis of development issues in adolescence and the Oedipal complex (Case and Dalley, 2008). I consider diabetes in the context of adolescent development. The mind body split in Western culture and Klein's ideas of splitting help to frame themes arising in the literature.

In 2010 Inscape dedicated an edition to art therapy with physical conditions (Weston, 2010). A point is made echoing Sontag referring to, 'TABs' or Temporarily Able Bodied people, referencing how equally vulnerable to illness we are (Learmonth and Gibson, 2010).

How the art therapist's own feelings in relation to illness, the body and fear of dying are evoked

in this work is a theme and a challenge, both in the practice of art therapy and writing about it. Particularly when thinking about children with ill bodies. This may be a factor in explaining why there is little art therapy literature with this client group.

Evidence base - children with illness

Gilroy urges art therapists to think, act and write with a political purpose in mind; including researching the effectiveness of art therapy and generating an evidence base (Gilroy, 2006). In my research for this report I found no specific British literature relating to art therapy with ill children. Although Wood, for example, refers to an increase in work with children with cancer and other life threatening illnesses, the literature she identifies is from the USA (Farrell Fenton, 2000, Teufel, 1995, Wood, 2005).

In America the tradition of 'medical art therapy' doesn't appear to be informed by psychodynamic theory or work with transference and countertransference (Skaife, 1993). It helps a medical team to understand a child's needs and treat the whole person, not just the disease or diagnosis (Councill, 2003, Malchiodi, 1999). In the UK, an art therapist working in a London hospital with children describes how the hospital setting itself can be like a 'foreign land' (Rudnik, www.cchs.org.uk).

Since diagnosis of a serious illness can come unexpectedly it can be a catastrophic blow to a family's fundamental sense of well being (Malchiodi, 1999). In trying to come to terms with a diagnosis, guilt, self blame, shame and punishment can become themes (Kirby, 1988). A child might feel they cannot tell their parents about their anxieties, and worry about upsetting them. Equally parents might try to 'protect' children by being cheerful and not talk about the implications (Judd, 1989, 1994).

These themes echo those in the art therapy literature with physical illness, but there are specific considerations when working with children. An art therapist cannot work in isolation from the child's family; which is often their main source of support (Edwards & Davies, 1997). The

child's age and development will influence their experience of illness. Depending on age, there are different concerns and so it's useful to think about 'developmental tasks'. For some, "coping with the demands of illness and treatment may push them to emotional maturity beyond their years", this can result in a feeling of difference and isolation (Edwards & Davies, 1997; 209).

Development tasks of adolescence with diabetes

Diabetes is a common endocrine disorder in children resulting from insufficient insulin production. Treatment regimen involves daily blood tests to monitor blood sugar levels and insulin injections which impose permanent restrictions on a patient's lifestyle. Together with ongoing risks of complications, this can cause stress for the child and family (Moran, Fonagy *et al,* 1991; 926).

Food intake, exercise, stress and emotions all have an impact on insulin requirements and can complicate treatment (Eisner, 1993). Emotional problems can disrupt glycaemic regulation and influence control. Anxiety, anger and other 'forms of emotional arousal' release stress hormones which interfere with insulin and can lead to hyperglycaemia (Moran, Fonagy *et al,* 1991).

Moran, Fonagy *et al* use the term 'willful mismanagement' to describe, "omitting insulin as a punishment for bad feelings" (Moran, Fonagy *et al*, 1991; 927). They suggest that unexpressed anger is internalised in the form of putting one's own body in danger. Diabetes complicates the normal adolescent stage of development; risk taking, rejecting parental influence, discovering independence and separation from parents. The future risks of unmanaged diabetes include renal failure, blindness and amputation. 'Forgetting' to test blood sugar levels may fulfill another need for escape from a difficult situation at home or challenges in making transitions into adolescence (Moran, Fonagy *et al*, 1991).

'Development stages' provide a framework of understanding for art therapists working with children. Case and Dally describe the 'normal development processes of the child' and how the work of art therapy with children and families is thereby influenced. Each stage has to be

negotiated by the child, it's not unusual for a child to “regress at times of anxiety and uncertainty” (Case and Dally, 2008; 1). 'Normal development' can be affected by internal conflicts or external factors. Serious illness has a significant impact on the developing child and the whole family.

Klein and splitting

Klein's model of early development explores internalised early relationships and good and bad feelings associated with them. It emphasises 'primitive mental mechanisms' of introjection, projection and splitting of good and bad breast, material object and/ or self. 'Splitting' is a defense mechanism, by which an infant can disassociate from uncomfortable sensations. Feelings of a 'bad mother' are split off and projected outside. Ridding oneself of unwanted parts of the self by unconsciously projecting them into another is called projective identification (Hinshelwood, 1989). The good feelings are introjected and kept inside, “but threatened by the return of the projected 'persecutory mother” (Bateman *et al*, 2011). This is the paranoid-schizoid position.

The depressive position for Klein, is when the infant recognises that the breast/ mother is only one object/ person and contains both good and bad bits. It has to cope with ambivalence that is, loving and hating the same person (Bateman *et al*, 2011). Dalley describes how, "the baby moves from the paranoid-schizoid position to the depressive position by working through the split, and only then can good and bad be tolerated" (Dalley, 2000; 86). The depressive position if not adequately worked through can lead to “unreasonable fears in later life that any hatred will damage a loved one” (Bateman *et al*, 2011; 133). Bloom connects this to the process of change in therapy (Bloom, 2006).

Klien's ideas highlight useful parallels between early relationships of the infant with mother and the relationship between client and therapist (Bloom, 2006). They also help to understand a relationship between emotional, physical and symbolic processes; that we are embodied selves. Ideas about splitting and loss of parts of the self in connection with illness and the body help to

understand how art therapy can bring disjointed parts of the self back together to 'heal the split' (Luzzatto, 1998).

The Oedipus complex and diabetes

Case and Dalley explore the Oedipal phase and its resolution as 'renouncing the intense emotional relationship with the mother' (Case and Dalley, 2008). In the Oedipal complex, “the boy's rivalry and ambivalence towards his father is relinquished by an acceptance of a father who can be emotionally available to him”. The 'resolution' involves coming to terms with the parents sexuality and moving towards relations with peers. Without resolution of Oedipal conflicts, “the relationship between mother and child remains enmeshed and interrupts forward development” (Case and Dalley, 2008; 5).

The adolescent's key tasks are separation from his/ her parents and development of identity. Rapid changes in the body and developing sexuality affect body image, how adolescents see themselves and relationships with others. Late development of puberty can be disturbing, and might indicate 'permanent difference' to a young person (Case and Dalley, 2008). Physiological changes accompanied by mood swings can make an adolescent difficult to live with (Eiser, 1993). The adolescent needs a “containing adult with the capacity for thinking about emotions” which might pose challenges for parents (Case and Dalley, 2008; 7).

Diabetes presents additional challenges in taking responsibility for self care. Stress can interfere with insulin regulation. The consequences of conflict with parents can become particularly intense and even dangerous (Eiser, 1993). The continual need for checking bloods, injecting insulin and managing food restrictions can further separate the young person from others and mark them out as 'different'.

Adolescent breakdown can result for young people who 'fail with the demands of adolescence' which can manifest in, “the relationship to the body and through the unconscious rejection of the representation of the body as sexual” (Case and Dalley, 2008; 8). This can lead to 'hatred of the

body' and action taken against the self. In diabetes this might be expressed via neglecting self care.

Art therapy can offer an opportunity to process these internal conflicts non-verbally through creative use of art materials. These help to, “make sense of thoughts and feelings that are negated, split off into action or repressed” (Case and Dalley, 2008; 9). Case and Dalley suggest that adolescent fears of being out of control are embodied in the artwork and present in the therapeutic relationship.

Illness and the body – the cultural context

The western medical model is a dominant discourse through which illness of the body is understood. Central to this is dualism, a hierarchical split between the mind and the body emphasising 'I' as mind rather than the material aspects of body (Bates, 2011). Bates argues, "we are our bodies and all our experiences are mediated through them" but we also employ the idea of dualism in our everyday lives, it permeates our very relationship to our body (Bates, 2011; 18).

Psychoanalytic ideas suggest different ways of thinking about developing personality as dependent largely on the relationship with one's body; from first perceiving it as a whole entity existing outside the maternal object (Levens, 1995; 3).

Thinking about the ill body, Bates suggests that it's only when our bodies 'dysfunction' that we actually begin to notice them (Bates, 2011; 18). We are confronted with the reality that our body is indispensable as our private subjective ill body becomes at once the public object of medicine. Fears in relation to our body, the dehumanizing potential of illness, and ultimately of death and dying are thrust upon us. The 'privacy' and 'taboo' of illness can further reinforce difference and a sense of being split off, from your body and society (Kaye, 1998, Miller, 1984, Vasarhelyi, 1989).

On the other hand, the ability to separate off the body from the mind can be useful (Fulton, 2000,

Kirby, 1988). Living with illness without a certain amount of splitting might be very difficult. The 'boundary of the self can be redrawn' to exclude the bad part which is treated with drugs or surgery (Fulton, 2000). Medical treatment may reinforce the split and help an ill person to disown a bad or dysfunctional part of their body. However, illness that is split off and treated isn't helpful when the patient needs to come to terms with and adapt to their illness, and take care of their whole well-being which is the case with diabetes (Kirby, 1988).

Vasarhelyi explores the idea of ‘illness behaviour’ in a 14 year old who develops leg pain which 'covers for psychological distress' in relation to a traumatic event. There is a mind body split. The leg is split off and the patient projects the psychological pain there and is treated for this. Vasarhelyi suggests that by keeping the focus on the physicality of leg pain he could also avoid terrifying feelings in relation to death (Vasarhelyi, 1989, 1990).

The social context of illness also influences the relationship between patient, therapist and art work (Connell, 1998, Kirby, 1988, Miller, 1984, Rogers, 2002, Wood, 1990). Wood wonders if attitudes towards AIDS reflect a society that can't tolerate the pain of its own mortality and its attempts to deal with fear of death and disease (Wood, 1990).

Schaverien describes the 'scapegoat' as a goat invested with community's burden being banished and so cleansing the community. 'Scapegoating' is a form of splitting; separating the good from the bad and disposing of the bad (Schaverien, 1992). It brings to mind how communities might operate collectively to impose and preserve cultural norms.

Language, illness and the body

Medical language and practices like the daily injections of the diabetic can lead to a person viewing their body as a product of the 'medical gaze' as their relationship to their ill body shifts and changes (Foucault, 1970, 2003).

Several authors explore the impact of becoming an object of medical processes and an imbalance of power. Receiving treatment affects identity and patients can struggle with the objectification

of their bodies as they are 'prodded and pocked and judged not to be working properly' (Tjasink, 2010, Learmonth and Gibson, 2010). The shame that accompanies a body 'found lacking' or that let's you down is also discussed (Kirby, 1988, Tjasink, 2010).

Menzies Lyth discusses institutional anxieties finding high levels of tension, distress and anxiety among nurses in constant contact with illness. Their struggle against anxiety led to the development of socially structured defence mechanisms in the hospital (Menzies Lyth, 1998). Interestingly, these were found to be ineffective in containing anxiety because nurses were not helped to 'work through' their feelings.

Similarly Rogers warns that institutional anxieties can lead to dealing with things at an 'emotionally superficial level'. She found patients needed real courage to make a mark and to find their own 'voice' and that the way illness is handled can rob a patient of their independence (Rogers, 2002).

Art and the body

A recent art festival entitled Sick! explored cultural ideas associated with illness. It bought together artists, medical practitioners, academics and the public to find new ways of talking about illness. To explore 'how our bodies and minds can act against us and against society's expectations of what is normal' (Medland, 2013).

The festival highlighted the importance of creativity in relation to body and illness. Creativity is an embodied process; the body is involved in making. The materials themselves may have bodily qualities or be used in ways that express physically what cannot easily be expressed; tightly held pencils, scratchy lines, texture, squeezing, rolling, thumping clay, thickly applied, dripping paint. In this way, art materials permit an exploration of the concrete issues concerning the body and their 'messiness' and tactile qualities can promote associations with feelings in and about the body (Levens, 1995).

An object made in art therapy can be seen as an extension of self, "a psychological double

capable of mirroring oneself" (Levens, 1995; 107). This is part of a process of becoming self; discovering self reflected back in the art work. Of ‘becoming through art' (Skaife, 1993). The artist puts unconscious projections into the image which then holds them. These can be re-introjected by the artist who can look at it as a newly created, separate object (Wright, 2009).

Some images convey more affect from the client and are described by Schaverien as 'embodied'. The transference is embodied in the art work when the relationship between the client and therapist feels safe enough and the patient dares to allow the image to lead (Schaverien, 1987).

Implications for art therapy practice

If working with illness can feel like "a trespass; worse like the violation of a taboo" what are the implications for art therapy practice (Sontag, 1978; 6)? How do the fears and anxieties evoked for both patient and therapist influence the therapeutic relationship and practice?

One important aspect of art therapy practice is the therapists own thinking and reflections on the depth of feelings evoked (Luzzatto, 1998, Skaife 1993, Szepanski 1988). The (perhaps unconscious) anxieties in relation to illness, death and dying reflect cultural, social and institutional attitudes and impact on the therapeutic relationship. Szepanski describes thinking hard about her own 'fears of physical handicap and death' (Szepanski, 1993). Confronted with the importance of the body in the therapeutic relationship, Luzzatto was challenged to give the body full attention and wonders if she perhaps wants to deny the existence of the body, physical pain and death (Luzzatto, 1998).

Another aspect of art therapy practice is medical knowledge. Without understanding of the complex and specific medical conditions and treatments, an art therapist might question the value of what they can offer and doubt their ability (Szepanski, 1988). In her art therapy practice, aware of the medical setting, Tjasink explores her clients own experiences of treatment, respecting their expertise and not thinking in terms of labels or diagnosis (Tjasink, 2010). She thinks it's important to find ways to enable clients to, “express, discover and play with their own

meanings and interpretations of their experiences" which can "affirm a patient's sense of self" (Tjasink, 2010; 76).

Skaife stresses the importance of holding the psychotherapeutic boundaries, enabling feelings in relation to 'difference' between therapist and client to be explored in the transference and countertransference. Adequate training, supervision and personal therapy are vital aspects of art therapy (Skaife, 1993, Waller, 2008), particularly where the art therapist works in a context where other staff lack adequate levels of support to 'work it through' (Menzies Lyth, 1998, Rogers, 2002).

Finally, the therapists own art practice is important in processing and containing material and the powerful feelings arising from work with clients (Brown, 2008, Byers, 2011, Ramm, 2005). By 'bringing unconscious dynamics to light' and processing the impact of transference and countertransference, it also helps the art therapist to "empathise more deeply with the clients experience" (Rogers, 2002; 60).

Outcomes of art therapy

The art therapy process is a 'valuable creative outlet' for patients with physical illness, leading to a sense of self worth. Mark making can help develop a sense of freedom; and self expression (Szepanski, 1988). Images can express a patients experience of coping with illness in ways that language alone might not. It can bypass the verbal defences of patients with eating disorders and enable pre-verbal communication (Levens, 1995). 'Picture making' can enable a patient to retain a sense of control while making more conscious the painful feelings (Wood, 1990).

The holding environment of the session can contain feelings of being 'out of control' and help develop a sense of potency (Kaye, 1998, Levens, 1995, Lillitos, 1990, Wood, 1990). Art therapy can provide an opportunity to "let go or relinquish control while being held and contained" (Lillitos, 1990; 87, Schaverien, 1989). Expression and release of anger, fear and grief in relation to illness and treatment may enable a patient to reach a partial acceptance or come to terms with

their diagnosis (Szepanski, 1988, Wood, 1990).

Section 2

Organisational Context

The medical setting for this placement was a large NHS teaching hospital, for 'sick children'. My transference to the setting put me in touch with sadness and vulnerability. The hospital appeared like a 'tower of pain' threatening to swallow me up. I doubted my abilities; and with little knowledge about illness I wondered what I could offer. As a mother of a child (born at the same hospital five years previously) I was reminded of my body in relation to a difficult childbirth and feelings of guilt in relation to my healthy child. I worked hard to stay with my transference in supervision, art-making and personal therapy which helped me to connect with how children and families might be feeling.

The hospital employs an Integrative Arts Psychotherapist (my supervisor) indicating some recognition that children with illness can experience psychological problems. A family counsellor based on the High Dependency Unit is funded by a local charity. The art therapist works at the 'interface between the medical and psychological'; liaising with doctor's and other hospital staff all of whom can refer a child to art therapy.

The art therapist's role includes supporting medical staff and parents in understanding underlying anxieties of patients. Holding firm boundaries and keeping details of sessions confidential while sharing something with a parent or doctor are important considerations. Psychodynamic approaches are combined with more targeted interventions like helping overcome needle phobias or manage panic attacks. The art therapist contributes to assessments of children in relation to child protection, readiness for treatment, unexplained symptoms and so on.

My supervisor adopts an unofficial role helping other staff to reflect on their own feelings ('work it through'). The hospital provides a well used counselling service for staff. Despite 14,000 referrals in three years, the head of service struggles to secure financial commitment. She referred to 'institutional anxiety' in a context of 'learning how to dissociate as part of the training'.

Despite the high take up of counselling, particularly by doctors and 'top layer' executives, there are a range of attitudes amongst the medical staff in relation to the significance of psychological distress for patients and some are more likely than others to refer a child to art therapy.

In the literature review I discussed the lack of an evidence base. Contact made with art therapists in Scotland, Sheffield and London working with physically ill children confirmed this. Creative Response (BAAT special interest group) is currently creating an evidence base from within their membership of effective practice in palliative care in anticipation of the new Health and Social Care Act 2012. However, there remains a need for British art therapists working with sick children in medical settings to develop a body of evidence reflecting their practice.

There are some clear challenges. With so few art therapists working with this client group, under socio economic pressures, there may be little time to contribute to the development of the profession. For example, my supervisor appears isolated from national networks, is employed three days a week and has a year long waiting list.

There's an opportunity for art therapists to articulate the health outcomes and benefits of art therapy in this setting, within the terms of the new Health and Social Care Act which shifts the focus from professionals to patients/citizens. Perhaps there's is potential here for art therapists to involve patients in sharing their views and evaluating impacts of art therapy outcomes. This approach may help with finding innovative ways to bridge the gap between art therapy practices and contributing to the evidence base.

Section 3

Case study

The following case study is based on eleven art therapy sessions with Mark; a 14 year old with Type 1 diabetes, diagnosed at three. Mark was referred to art therapy by the diabetes team who were concerned about risks of 'unmanaged diabetes'. Mark's blood sugar management had deteriorated over the year since Dad's epilepsy diagnosis.

An assessment meeting and first session took place before the Christmas break. These are described in detail. Sessions 3, 4, and 5 are followed by a review Session 6. A further five sessions were offered and the significant moments in each are described.

The room

The art therapy space, a social work meeting room, had a sink and cupboard for art materials (figure 3). Three chairs arranged around a round coffee table, a 2 way mirror and bright strip lighting gave it an institutional feel. A sand tray, dolls house and a good range of art materials helped transform the room for art therapy.

figure 3

Assessment meeting

In the assessment meeting which included Mum, Mark appeared shy, small for his age and struggled with eye contact. I shared what I knew from referral first so we could all be clear about the details and then invited them to think with me how best to use the session. Mark checked with his Mum before speaking; he wanted to know how to help his Dad's mood swings and strange behaviour which were upsetting him. Mark described how he found 'comfort eating' sometimes distracted him, but this contributed to 'sugar level chaos'. He hoped art therapy might help him deal with his feelings.

I sensed Mark's distress in a world made unpredictable by Dad's erratic mood changes. Mark sometimes 'felt like curling up in a ball'. Which he said he did in his head. I wondered how scared he might feel and if he was trying to block out an overwhelming situation. Mark was preoccupied with his Dad; trying to pre-empt his Dad in order to orientate his own behaviour accordingly.

Mark described how Dad could get angry, and although sorry, 'would do it again'. Mark couldn't blame him because 'Dad had no control over his behaviour' given his epilepsy. Mark was working hard to understand his complex situation and appeared mature beyond his years describing himself as 'turning older'.

Mum and Mark struck me as a married couple discussing a wayward son which felt uncomfortable, the roles seemed reversed. I sensed an unspoken resentment. From the referral I was aware that Mum had experienced depression following a still birth two years prior to Mark. They described life changing since Dad's first epileptic episode a year ago. Mum said she and Mark had to 'stick together'.

Mum appeared vulnerable and Mark seemed to take responsibility for her happiness. Was he expected to step up and take Dad's place? I wondered where Mark's adolescent, rebellious self was and I was curious that his diabetes was hardly mentioned.

Mark described hurting himself on the sofa as a way of coping. He asked me directly if this was something art therapy could help with. He couldn't hurt his Dad, but hurt himself. I thought about holding this in mind and bringing these feelings into the open.

It struck me that there was a strong Oedipal component in their relationship. Whether Dads epilepsy was holding back Mark's development? I thought about Mark's anxiety in relation to an emotionally unavailable father and how this plays an important role in the resolution of the Oedipus complex in formation of adolescent identity (Case and Dalley, 2008). The 'lack of control' implicit in this resonated with the reason for Mark's referral; taking his anger out by hitting himself and neglecting his blood testing.

Marks' concerns about the needs and vulnerability could make the developmental task of separating from his parents hard. Especially if he was leaving his Mum with an unpredictable potentially dangerous Dad. Taking on responsibility for his diabetes and struggling to maintain blood sugar levels might also connect with unexpressed anger towards his Dad, as Mark 'acting out'. Art therapy might help relieve some of the pressure and confusion so that managing diabetes wasn't such a burden.

I offered six sessions including a review with the potential to continue for five more as had been agreed with my supervisor. Mark and his Mum agreed dates and times and to meet the following week despite the proximity of Christmas. It felt important to start and both Mum and Mark seemed relieved. Writing to confirm session dates I felt a sense of containment in offering Mark a regular space and in having agreed this with them both. Safe guarding issues were discussed with my supervisor in relation to the assessment meeting.

Session 1

I met Mark, as arranged, in the reception area. He was sitting with his Mum. At the end of each session, I accompanied Mark back to his Mum, who was always there on time to meet him.

Mark and I sat. I told him about art therapy and established boundaries for the sessions; a regular

time, 50 minute duration and confidentiality (I would not discuss details unless concerned for his welfare). We agreed that I would look after his artwork and keep it safe. I explained that I was a trainee and was working out how best to use the room and suggested we could think about that together. I had added clay, recycled objects, inks and charcoal to the materials already available, and invited him to choose.

Mark chose pencils. He asked me if he should explain what he was doing and I said he could do. He wanted to make a 'sort of story board' to show me 'how it is at the weekend' (figure 4.). The three figures, Dad, Mum and him, appeared with similar spindly legs. Mum and Dad wore the same orange shirts. He explained that they would start out happy, but something might happen. He worried that Mum might get hurt if he 'got it wrong with Dad'. Mark explained that getting to sleep was difficult because he was scared about Dad getting angry going off and not returning. He drew himself inside a ball.

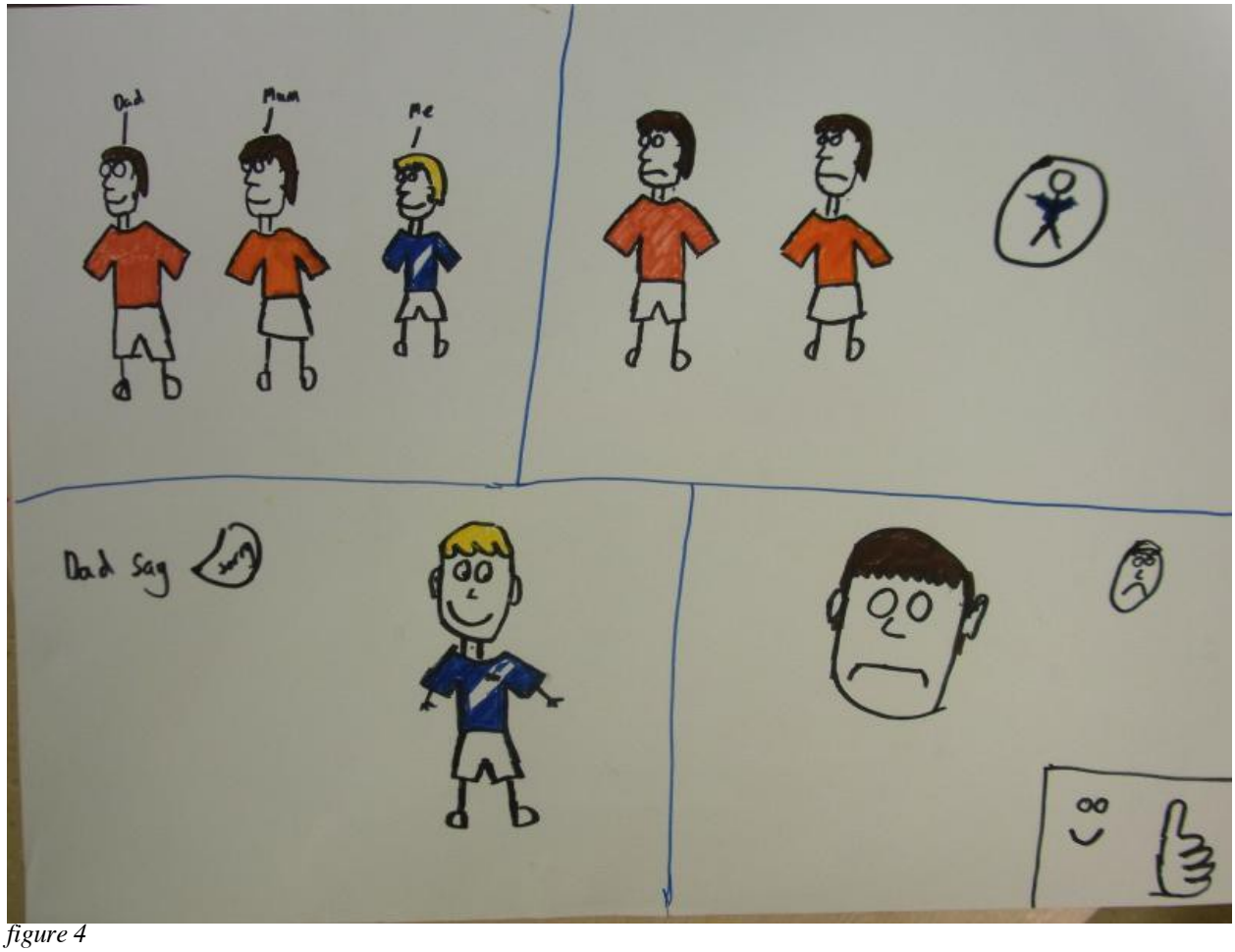

figure 4

I asked what would happen. He said he'd be left alone as Mum would go looking for Dad, which would be scary. Then quickly added that he didn't mind as it needed to happen.

Especially when feeling angry or sad he said he removes himself, going to his room to 'calm down'. He said he sometimes hurts himself and added that he curls up, in his mind, into a ball. He wanted to know how to cope and stay happy (like in his drawing). I wondered about him curled up in relation to Klein – and whether he was returning to the womb?

In my countertransference I felt anxious and confused. Mark was articulate and working hard to think. He spoke freely and intensely but also dispassionately, at odds with an internal world in conflict. It seemed he was splitting off his feelings in his presentation of self. He didn't mention his diabetes. He was preoccupied with the consequences of 'getting it wrong'. His intensity combined with vulnerability left me exhausted. In my supervision I worked to process these difficult feelings.

Mark's habit of removing himself when sad or angry also resonated with a theme in the literature about control and lack of control in relation to illness and the body, self and others. Could our sessions perhaps help Mark to “let go or relinquish control while being held and contained” (Levens, 1995, Lillitos, 1990; 87)?

Session 2

Mark seemed to know what he wanted to do and I offered him a choice of materials. He was drawing a picture of his bedroom while telling me how he wanted to be the perfect child so that his parents could be proud (figure 5). He spoke rapidly, almost incessantly, mostly about Dad. I felt bombarded and somewhat irritated and reflected on this later in supervision. I wondered if his talking was a form of splitting, holding painful realities at bay or at least obscuring them in a fog of words. He talked about being 'normal' reflecting the difficulties of difference in his stage of development, he didn't mention his routine of injection and testing that separated him from peers.

It struck me how intense his inner world must be. His development stage; being small for his age, his developing sexuality, and the relationship of these to his diabetes. The normal tasks of adolescent development are daunting enough for most teenagers. In the literature review I looked at the role of the family in balancing the adolescent's need for independence and autonomy with support for taking on self care. I felt that the Oedipal tasks in Mark's case had become compounded by his Dad's epilepsy. He spoke about wanting 'Dad and son time' and about wanting to 'hang out with friends' but feared this might 'set Dad off'.

Mark felt removed and his bedroom seemed symbolic of the place he'd withdrawn to. The emptiness of the space outside the bedroom seemed significant. His bed, placed in the corner, made me wonder how far away he needed to be in order to feel safe. His room 'like a ball' was a place to 'curl up in'. Mark had previously mentioned doing this 'in his mind' and was now saying that he did this in reality. Perhaps an indication that he was starting to trust me.

figure 5

My countertransference was to a rebellious angry adolescent. I thought about wanting to break the intensity of my anxious and overwhelming feelings by rebelling against both parents, to let the anger out and confront their power. I reconsidered the boundaries and containment as it was clearly so difficult for him to express feelings. I reminded Mark that there were no expectations, no right and wrong. In retrospect this was likely to be me responding from my countertransference. I was trying to think about how to make it safe for Mark but perhaps I was worried that he might unleash his unexpressed anger on me.

Session 3

Mark made two images. The first started in pencil, the drawing was precise and he used it to 'tell me about himself'. While making it (figure 6) he spoke about what makes him angry at school; cheating and rule breaking. He said he hated people not saying sorry. Unlike at home, where he feels he's often apologizing, even when it was not his fault. This is 'unfair'. School was difficult and friends described him as 'easy to wind up'. Despite this he was pleased that he could speak up if he felt something was wrong.

I asked if he could show me how this anger felt. He responded to this using religious symbolism, an angel and a devil floating, the devil slightly higher on the page (figure 7). He seemed to feel that if he was an angel and 'completely good' then perhaps he could be 'happy'. It occurred to me that Mark was expressing an unconscious feeling about his diabetes, the bad/ devil inside him separated off from the good person that he recognised himself to be.

figure 7

The session passed quickly again with much talking on his part. I noticed the irritation that I'd felt in the previous session. He talked about how he and Mum are alike. Was he splitting the good, idealised (Mum) and bad (Dad) parent? Feeling responsible for their happiness, was he

keeping the bad part of him (the angry, devil) split off from the good angel. I asked Mark what would happen if he brought his anger to the session; did he worry about how I'd react? He said, 'maybe'.

Was there a reference to me here in the transference as well as his Dad? Was he warning me not to treat him unjustly? Was he worried that I would think he was 'bad' if he expressed his anger in the session (towards me)?

Sessions 4 and 5

In sessions 4 and 5 Mark didn't know what to make which felt like progress. He appeared to have less need to control the outcome. Perhaps this reflected a growing level of trust? Was he more able to tolerate the anxiety of not knowing? Remembering last week, he said, “it was fun and good just letting the thing lead me”. He spoke more about Mum in this session. The hair he made for the clay figurines seemed important (figure 8). I asked about this and he told me that Mum likes to stroke his hair and that he finds it 'comforting'. I wondered again about an Oedipal component in his development. I asked if he gets annoyed with her and he replied that if he did he ‘chucks it out the window’. Splitting came to mind. He didn't want to be annoyed with Mum or perhaps couldn't afford to recognise such feelings given the shakiness of things with Dad. Was he now annoyed with me too for drawing attention to these feelings?

I asked about the star. Mark said Mum was like a star because she ‘lights up the room’. Perhaps to remind me, that he couldn't get annoyed with her and didn't want to upset her. What would happen if he upset Mum I asked? She might get really annoyed (and so might Dad) he replied. Previously he was concerned about hurting her and now seemed scared of her anger?

In my countertransference I noticed a lack of empathy with Mark. As though his fragility represented something difficult for me. I thought about this in personal therapy, growing up as the eldest daughter with three boisterous younger brothers and how that informs my expectations about adolescent masculinity. I wondered if this was a factor in the anxiety I felt.

figure 8

Mark's art work embodied his efforts to make everything OK. As he tried to stick the arms and legs back on they fell off. I was struck by the fragility of each figure and his efforts to keep them whole. Mark seemed more relaxed. He apologised for making a mess; I wondered how risky it was to mess up and how scary that might be. Perhaps his apology was part of looking after me (as a transference figure). Was he protecting himself from his own anger and my retaliation in the transference?

In session 5 he used recycled materials to make a dog which 'looked more like a cat' (figure 9.). This was 'funny'; Dad was allergic to cats. Maybe Mark had unconsciously made something dangerous to Dad?

Mark was clear he needed to control his feelings. He said he could use the cat as somewhere to

put his anger 'inside the cat in a sock'. 'Put a sock in it'; literally means be quiet or shut up! His artwork seemed to embody his need to control the expression of anger. I wondered also if control and chaos of the body were alluded to.

figure 9

Review Session 6

Mark and Mum both attended the review session. Mark expressed a desire to meet less often; every three weeks instead of weekly. The reason he gave was about missing too much school. I wondered whether there were deeper motivations. Perhaps he needed to protect her from feelings that had begun to emerge in the previous sessions. I wondered also about the art therapy process and whether Mark's Mum was finding it difficult or threatening.

I felt it important that we continue weekly and being unable to be flexible around meeting out of school hours on this day, I suggested we stagger the sessions, so he didn't miss the same lessons each week. I wondered later about my motivation in doing this. Was it more to do with my own needs or desire to be important to Mark and replace his Mum as a 'confidant'? On reflection (and

following Skaife, 1993) I think my motivation rested upon recognising my role in being responsive and adaptive, holding the therapeutic boundaries of the sessions and in validating the importance of the process for Mark.

Session 7

Half term had been 'good'. He'd been playing football and described himself as 'happy'. He used paints, marking the page with a big black smile (figure 10). His image seemed stifled, was it holding something in? As he continued his thoughts returned to his sense of injustice telling me how he got 'angry at the slightest thing'. His good and happy feelings seemed to be in conflict with bad and angry feelings as though two separate voices were vying for attention. Perhaps Mark was beginning to tolerate the good and bad feelings by staying with ambivalence and moving into the more mature depressive position?

figure 10

Watching his slow, methodical movements, mixing green paint, rinsing the brush, drying it on tissue – my earlier sense of frustration returned. I noticed my tendency or need for 'progress' and how difficult it was for me to just hold the space. I thought about the US literature where the art therapy approach is oriented more around intervention and wondered if the frustration and anxiety I felt was more deeply rooted. My instinct was to be more directive as I had been as a child when in charge of my younger brothers. I was willing Mark to express himself and explore his feelings but sat quietly listening and holding my countertransference.

On finishing the drawing Mark told me that he 'liked art therapy', this perhaps galvanised me into 'taking a risk' by encouraging him to use the paints he'd poured out. My intervention might have been intrusive and caused by the frustration I was feeling.

Mark then made two paintings using the colours in the palette and wrote his name across the middle (I haven't shown them for this reason). He grew absorbed in the mark making and intrigued by mixing colours saying, ‘this is fun’. He showed me a playful, creative side that I hadn't seen before. He spoke less and the atmosphere in the room became charged. His name was almost lost in the colour. He talked about camouflage and I asked if he was hiding his name? Mark described how he’d made the paintings, which marks came first, and I thought this might be a reference to camouflaging his feelings. I felt excited, these two paintings seemed to be holding/ expressing his transference, they were embodied; exciting, messy and perhaps even a little dangerous (Schaverien, 1987). The two paintings seemed to me a metaphor for a search for identity.

After the session I painted quickly to explore and contain the intensity and excitement from the session (figure 11). I used the discarded tissues Mark dried his paintbrushes on. I felt a desire to create a mess but was unable to. I became aware of my surroundings and felt restricted. I struggled to express myself.

In supervision, following this session, I thought about a parallel process. Mark didn't want to risk putting himself out there. Perhaps he didn't dare be himself or express 'difference'. He was cautious, in control, neat and tidy. Perhaps to avoid conflict and anger. In making art work to contain feelings arising from the session and to empathise more deeply with his experience, I became aware of my own difficulties in finding my voice and the courage to develop my art therapy practice. My countertransference was to a hypothetical critic, perhaps my tutor at college. I was anxious that my invitation to use the paint had been too directive. Exploring this as an Oedipal phenomenon, the critical supervisory voice could reflect countertransference issues relating to Mark's superego. With a female (Mum) supervisor at placement and a male (Dad) at college. Was I internalising two critical parents in my own anxiety about getting it wrong?

figure 11

On reflection, I could have stayed with Mark's concerns about getting paint on the table and picked up on his feelings about not being allowed.

Session 8

Mark recreated an image he'd made previously for Gran. He seemed excited and wanted to paint again because he'd 'enjoyed it last week' (see figure 12).

figure 12

This felt to me powerfully symbolic of both his physical and psychological fears and vulnerability. The large head reminded me of Mark's efforts to 'think' in order to control his fears in relation to adolescence, sexuality and his masculinity.

It can be difficult working in the symbolic when working with concrete bodily issues and a

challenge to get to the symbolism and metaphor of the feelings when they are so well suppressed. Levens describes the value of creativity as an embodied process involving the body in making. The materials themselves have bodily qualities and can be used in ways that express physically rather than with words, 'permitting' an exploration of concrete issues concerning the body (Levens, 1995).

I asked Mark how it felt 'stuck in the middle'. He showed me this by making a painting (figure 13). He took pleasure and surprise in mixing the colours to see what happens. He experimented with mixing colours and making different marks. He said this reminded him of clockwork; it was like inside his brain.

figure 13

In supervision I reflected on the pressure Mark felt; to save Mum and Dad, to preserve his happy

family, to be a man? In figure 12 he is caught between two places; neither is desirable, both are dangerous. Perhaps this danger is part of Mark's unspoken experience of his body and diabetes? His body is not perfect although he is a perfectionist (Sontag, 1989, Kirby, 1988, Tjasink, 2010). Perhaps to defend his fragile body, he retreats to his head to think – into 'cogs like clockwork' (figure 13).

The association of figure 12 with the potential future risk of diabetes made me wonder why he had talked so little in the sessions so far, about his diabetes. I wondered if this was something I had neglected to encourage him to explore – perhaps in my countertransference my own anxieties surrounding illness, death and dying had led me away from this thought?

Session 9

Mark was having teeth removed this week. He said he was scared about the pain and recovery which due to diabetes takes longer. He told me that his parents and a nurse in the diabetes team had discovered he'd not been checking his blood sugar levels. He told me he'd 'just forgotten' about it. He rolled and cut clay as he told me about difficulties at school checking bloods with people looking (figures 14, 15). He didn't want people to see; they 'asked silly questions'. He didn't want to be different.

figure 14

He folded up a cut-out figure of himself and squidged it into the bottom so it became part of the bowl. When I asked about this, he said he hadn't noticed doing it. In supervision I wondered if Mark was also showing me how overwhelmed he feels.

figure 15

Again I noticed how the realities of his condition, and how profoundly it effects his day to day, were entering the sessions. I felt out of my depth. Through a diabetes art therapy group I had been running I was learning something of the reality of living with diabetes. How episodes can be triggered by emotional states. I felt overwhelmed by the complexity of Marks life.

Session 10

During the week I met with Mark's diabetes nurse. She told me about a seizure that had added to the families stress and had caused complications for Mark's blood sugar control. I wondered if I had been colluding with Mark in not having found this out sooner, respecting his apparent privacy rather then finding ways to bring these issues to the surface.

I said to Mark that perhaps I had underestimated the seriousness of how he felt about diabetes and maybe he had too. At first he seemed to diminish this saying he hadn't had a seizure for nearly two years. When I asked if he worried about it he said 'yes a lot'. Mark said forcefully, he did not want to 'end up like Dad'. Mark talked about a 'daily fear of seizure' and that any feeling whether happy, sad, excited, angry, even bored could affect his diabetes negatively. He seemed very isolated in these feelings. Neither parent appeared to have the capacity to help him think about this. I wondered about my role and the place of art therapy in providing this.

I thought about the repression of the bad feelings, trying to keep them hidden, separate but also projecting them out, mostly onto his Dad. Perhaps this is what causes him to take his anger out on himself by hitting or neglecting bloods. Mark said he does not share these worries with anyone, but he was now sharing them with me.

Mark made a fort (figure 16). Perhaps a metaphor for the fortification of his mind over the disorder of his body? The fort keeps intruders out but also holds those inside captive.

He said he was worried about puberty and had blood tests before as doctors were concerned about his growth. Another source of anxiety, he felt small for his age. He was annoyed about school and I asked if perhaps he was annoyed with me about art therapy ending. He looked at me

and said, ‘yes a bit’ adding ‘but then it has to finish sometime’. He expressed a feeling and then took it back. Before it could damage me?

figure 16

He asked if his Mum should come to the final session and I wondered out loud about that. He reminded me that he tells Mum what happens in sessions. Did he have nothing to hide from her? I said the last session was for him; and if his Mum wanted to meet we could look at that. He appeared to be relieved and said ‘good’. I agreed with him that I would offer to meet with his mum. On reflection, it seems that Mark struggled with holding onto this as a space for him, separate from Mum again reflecting his challenge in separating from Mum? Without 'resolution' the relationship between mother and child “remains enmeshed and interrupts forward development” (Case and Dalley, 2008; 5). Without an acceptance of a father who can be emotionally available, the boy's rivalry and ambivalence towards his father cannot be relinquished. Without 'resolution' of this conflict Mark may struggle to come to terms with his sexuality and moving away from his parents towards relations with peers and will impact on his ability to take responsibility for self care of his diabetes.

The fortified castle appeared a particularly powerful metaphor for Marks feelings and how well protected they needed to be. I felt sad and drained. With the end in sight it was going to be difficult to end this work with Mark especially given the ongoing problem with his diabetes and no changes or resolutions in his home life.

Last session

Entering the room Mark said, “shall I take my coat off – yes or no”? He seemed uncertain and as he sat down he became tearful. He told me he felt sad because it was the last session and that 'it had really helped'. I suggested we could look together at his artwork. Together we put up the pictures on the wall and placed the objects on the table. As we looked at his artwork together, I held in mind the idea that Mark might discover something reflected back in the art work as part of a process of becoming self through art (Skaife, 1993, Wright, 2009). I thought about his artwork as a 'record of his inner thought processes' and the feelings that had evolved through art therapy (Ramm, 2005). I hoped this might also reflect back to Mark his personal journey.

Looking at the fort he'd made in the previous session he said that was where he could put his brain to keep it safe. I wondered about this in relation to Klein in his need to disassociate from his 'sick' body. I asked about the flag pole, noticing its prominence. He replied that maybe it was trying to get noticed? I asked if maybe that's a bit like you.

Looking at figure 12 I was reminded of all the work he does in thinking and trying to understand. He nodded and said 'yes, just in case' and he was looking at the sinking ship. He wanted to help Mum and Dad – but he might make it worse.

We looked at the change in his art work over the course of the sessions. The change from the early sessions to session 7 where he had begun to experiment and put his own name into the art. I wondered in relation to Schaverien about the idea of 'embodied art' if he could imagine thinking about his own feelings and if his artwork might help to remind him about the validity and value of his own needs and thoughts, that it might help to reconnect him to a whole sense of self.

My response to the final session was a mixture of thoughts and feelings. At one level I had found it difficult to connect with Mark and wondered about this in relation to my own anxieties about illness. Sontag's metaphor of a passport to 'that other place' as somewhere I don't want to go made me wonder about the importance of this in relation to art therapy in the context of illness. The complexity of Mark's life had at times overwhelmed me and made me doubt what I could offer through the art therapy process. Other thoughts were more hopeful. Mark's reflection on his art work seemed to hold potential for new connections and understandings. It appeared to me to demonstrate some of the 'visceral' qualities expressed in the literature.

End note

On finishing the session I asked Mark if he'd like me to arrange a final meeting with his Mum. I felt that our art therapy sessions had been a beginning and that Mark needed continued support with his journey into late adolescence. He agreed and this final meeting with Mum added to my understanding of his developmental history and the difficulties facing his Mum. As a result of

this meeting I was able to offer a referral to the family counsellor.

Section 4

Discussion

This case study highlights the emotional and psychological effects of physical illness in a complex family situation for a 14 year old young man; struggling with the management of his diabetes, deep underlying anxieties in relation to the development tasks of adolescence and difficult family circumstances. There was a sense in which Mark had lost himself; and was missing from the picture. Earlier in the process Mum appeared to be idealised, fiercely protected and his fears and anxieties were almost entirely projected onto Dad. Perhaps his preoccupations with Dad's unpredictable behaviour and epilepsy had served a purpose in protecting him from his own fears, shame and anger associated with a perceived under-development of his body and his diabetes. Later in the process he seemed to come to a more balanced view of Mum, tolerating both good and bad feelings about her and coming to terms with the 'ambivalence' of the depressive position.

This paralleled his tendency to use words and thinking in the earlier sessions to defend himself against feeling, as opposed to later sessions where he was able 'not to think' and to use art materials spontaneously. He developed an ability, evident in his art work, to more freely choose materials and mix colours. He played and experimented with making different marks and textures and his artwork became more embodied. This perhaps contributed to a growing sense of control in relation to the materials echoing ideas in the literature; 'through choosing and creating, gaining a sense of self; control of life and body' (Luzzatto, 1998, Malchiodi, 2007, Skaife, 1993, Waller, 1991). Through the process of art therapy, and perhaps as he felt more able to trust me and feel safe, Mark did seem to be beginning to reclaim a sense of self, putting himself back into the picture and starting to become the narrator of his own story.

This development through the sessions was also reflected in his transference. Mark seemed to want me to see how good he was and how hard he worked to think about everything; to present everything as OK and to find symbols for his family as a way of connecting them together. The

desire to hold onto what they had in common however, seemed to depend on a denial of difference; hiding his own needs, fears and anger. Particularly in the absence of a strong safe father to identify with. His sense of justice came across strongly, maybe as a warning to me not to let him down. In later sessions his transference was more towards me as the art therapist as he accepted that our sessions were coming to an end.

The feelings arising in my countertransference were complex and difficult to make sense of. Early in the process I discovered frustration, irritation and a desire for Mark to be more rebellious and to make a mess. Thinking about my own expectations of 'boyhood' in relation to my own family background helped me make sense of this. There seemed to be a pull towards thinking how he 'should' feel.

It was not until session 9 that diabetes came up consciously despite the fact that he had been referred to art therapy because of 'poor control'. Tjasink helped me to think about this. My approach was informed by not assuming that physical illness was the only thing going on. Tjasink argues that this can further objectify the patient and I therefore worked hard to stay with Mark's own experiences as he brought them to the sessions (Tkasink, 2010). The idea of working with 'where the patient is at now' and not where you might wish them to be helped me in not working with 'my own agenda'. Making art after sessions helped to connect with Mark's experiences. Through the art therapy process Mark began to explore the possibility of finding and expressing his voice through art making and with words. I was able to trust my developing ability to respond and adapt in building a containing therapeutic relationship.

In the art therapy literature regaining control and the experience of agency via creativity is a theme. For diabetes patients control of their body is an ongoing and necessary goal. The body can be felt as out of control and not working properly; a body in chaos, without medication, attention and care can become dangerous. Mark was perhaps overwhelmed by internal chaos within his body, and external chaos represented by the vulnerability of his parents. Within this he had to control the external reality of his parent's relationship, this fitting with his internalised

idea of being 'good'. This struggle perhaps created anxieties that also threatened his ability to care for himself and exasperated further his lack of control.

Running an art therapy group for young people with diabetes at the same time as working with Mark provided an opportunity for me to learn and gain insights into the experiences of living with diabetes, developing my awareness and understanding in parallel to the work with Mark. I'd been concerned about my lack of knowledge about diabetes. I had an opportunity to learn directly from the experiences of young people with diabetes in the group (Szepanski, 1988). On reflection, bringing the group into my thinking might have been a countertransference response where I was looking outside of the one to one relationship with Mark.

Writing this case study had been a challenge; its fullness and wordiness reflect the content of the sessions and the overwhelming issues facing Mark. I wanted to validate his effort to manage a complex set of issues. I also hoped he might find a way to relinquish some of the overwhelming responsibility he felt for his Mum and Dad and try and focus on taking care of his own needs. Malchiodi would describe this as becoming a more active participant in his own medical care (Malchiodi, 2007). To do this without feelings of guilt or being selfish would be very good indeed.

Lillitos describes the child releasing creativity, giving form to thoughts and feelings from within; "having what is inside oneself acknowledged and accepted by another, enables one to use one's capacities, to form relationships, to be creative and to make something out of one's life which had previously been struggling to achieve shape" (Lillitos, 1990; 87). I find this really quite beautiful. 'Finding' oneself reflected back in one's own creations and through participating in a process that engages fully one's mind and body might enable a young person to gain a sense of their self this is part of the magic of art therapy. Integrating mind and body.

Section 5

Conclusions

Art therapy can play an important and complimentary role to traditional medical practice within a children's hospital setting. The following summarises; the benefits of art therapy in this setting, some of the challenges involved and finally a few comments are made about the importance of the evidence base.

Art therapy can provide support in the process of coming to terms with diagnosis and treatment. By working with what the child brings to the sessions art therapy provides affirmation and validity giving them the role of 'expert' on their own experiences; their bodies and illness. It holds the potential for engaging them in decision-making about their treatment and practical involvement in their own care. The role of the art therapist in enabling medical practitioner's to learn from the child's own experiences of illness is also of interest. The medical setting and treatment of illness can all be objectifying and disempowering and art therapy can help a child connect with their own experiences, and to find their own language through making art to tell their story, and reclaim their narrative for themselves. Art therapy can also give a sense of agency through art making and the dynamic relationship with the art therapist over time can help the child to recognise and experience a sense of 'self'; and of being more than an ill body or a patient at a hospital for 'sick' children.

Art therapy in this setting can be challenging. Difficult and painful feelings for the art therapist are likely to arise in countertransference responses to patients and setting. Taking care of one's own psychological and physical well-being as an art therapist therefore become vital in developing and sustaining art therapy practice with this client group. Developing one's own art practice and making art work after sessions helps this process. Other types of challenges exist in connection to institutional and socio-economic circumstances. Funding is ad hoc and under prioritised and attitudes toward art therapy within the medical community vary.

The link between the institutional issues and need for evidence base within art therapy is

fundamental. Without an evidence base prioritisation of art therapy services is unlikely. Gilroy talks about creating our own evidence base that informs our discipline - to research the effectiveness of art therapy. There is clearly a need for the practice of art therapy with children and young people with chronic physical illness to be explored further (Gilroy, 2006). There may only be a few art therapists working with this client group but I believe that their experiences have much to offer the art therapy profession as a whole. Within the new Health and Social Care Act 2012 there are potential opportunities for art therapists to contribute in innovative ways.

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