Art Therapy and the Recovery Process:
A Case Study of a Person With Schizophrenia

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A Thesis Submitted in Partial Fulfillment of
The Requirements for the Degree of
Master of Arts in Art Therapy & Counseling

Ursuline College Graduate Studies
May, 2008
Ursuline College

Graduate Studies

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Acknowledgments

I would like to thank Betty Durham L.I.S.W. for her constant encouragement through the educational process of the last 10 years.
Abstract

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This case study illustrates the therapeutic alliance of a man with schizophrenia and an Art Therapy and Counseling student who also has schizophrenia. Although the diagnoses are similar, and their journeys in their recovery have taken similar paths, there are major differences. The most noticeable difference is the degree of anhedonia, or the inability to seek pleasure in the client. Furthermore, the study also explores having an addiction along with schizophrenia, a dual-diagnosis. The therapeutic alliance began two years prior to the study, when the student was completing an internship at a non-profit family based social work organization, where he had also been employed for the previous fourteen years. Both the student and the person involved in the study were clients of the organization.

The artwork contained within the study had a dual role. First, the art facilitates the insight into the illness, schizophrenia, and the recovery process. Secondly, the art therapy is a factor in the actual recovery.
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CHAPTER I

Introduction

Overview

My life for the last twenty years has been defined by terms such as artist, worker, mental health worker, schizophrenic, denial, sick, and alcoholic, among other things. Living with the illness of schizophrenia has been a challenge, a failing, and for the last fifteen years, a bright recovery. In my recovery, even with the voices in my head, I had to accept and manage the twist and turns of one of the top ten most debilitating illnesses in the world, according to the World Health Organization (National Alliance on Mental Illness [NAMI], 2007, para.2).

I have been featured in the print media, along with television and radio, doing my part to speak about how art has helped give me an identity and feelings of accomplishment that few people with schizophrenia have experienced. After being unable to concentrate enough to attend college, I returned to finish my undergraduate degree in 1998 and afterwards started working towards my masters in art therapy and counseling in 2001. As I know personally, the stigma and denial of this illness are hard to fathom. Insight into the illness is the key to starting on the road to recovery, which is a lifetime’s path.

Statement of the Problem

There are over two million Americans, or approximately one percent of the population, diagnosed with schizophrenia. Schizophrenia is a brain disorder that
affects a person’s cognitive ability, or thinking process. A common problem associated with schizophrenia is the lack of insight into the condition itself. Denial is a part of the illness for many people (NAMI, 2007, para.7).

Purpose of the Study

The case study not only focused on the art and personal recovery story of the participant, but my story. I hoped that in sharing my story with the participant that he also would gain insight into the problems of recovery, particularly the stigma and inability to seek pleasure or anhedonia.

Research Questions

My research was guided by the following question:

How can art as therapy be used to assist a person with schizophrenia, enabling him to gain insight into his illness?

Definition of Terms

Anhedonia The inability for persons with a mental illness to seek pleasure.

Cognitive Symptoms Symptoms that relate to the thought processes of people with schizophrenia. They include the inability to prioritize tasks, loss of memory functions, and difficulty organizing thoughts (NAMI, 2007, para.7).

Denial An aspect of schizophrenia that has baffled people for years. Basically it is built into schizophrenia, and the ill person does not accept that he or she is ill. Because of this, the process of recovery is slowed and the ill person will often relapse. However, denial is usually the first stage of recovery.
Family Advocate Term used by the agency where the research is being conducted to describe the Licensed Independent Social Worker (L.I.S.W.) who works with the client and his or her family in the recovery process.

Insight Mental penetration or discernment, as in the ability to discriminate between reality and illness. Usually a person with schizophrenia will lack insight (Tolton, 2004, p.469).

NAMI National Alliance on Mental Illness (NAMI) is a grass roots organization started in 1979 by families of mentally ill people to advocate for their loved ones. The organization has chapters in all fifty states, and has lobbied the government and pharmaceutical companies for better funding for research as well as laws to help protect people with mental illnesses.

Negative Symptoms Symptoms that take away from normal functioning, such as flat affect, inability to concentrate, and lack of motivation (NAMI, 2007, para.6).

Positive Symptoms Symptoms of schizophrenia that include psychotic features, such as auditory and visual hallucinations, and delusions. These are called positive because they occur when normally they should not (NAMI, 2007, para.5).

Schizophrenia A severe and debilitating brain disorder that features delusional thinking, hallucinations and paranoia. People with the illness are believed to have a genetic predisposition for the illness. Many times there is a major crisis in the
life of the person with schizophrenia, such as moving out of the family home, the
loss of a friend or family member to death, or the end of a relationship that
precipitates the onset of the illness. Schizophrenia is usually diagnosed in the late
teens and early twenties. It can be diagnosed as early as childhood and as late as
forty years old. It is considered a lifelong illness that keeps the person from
functioning normally in society (American Psychiatric Association, 2000).

Stigma From ancient Greek, a mark or wound placed on a person to indicate
that they were less than equal to a citizen. In modern day it applies to the
perception of people with an illness, mental or physical that they are less than a
whole person due to the view of society. There have been many recent
breakthroughs in medications and therapy for people with schizophrenia, yet a
major problem has been the stigma that is attached to the illness. A good thing is
people can and do recover from schizophrenia. It takes time, money and usually a
network of support from professionals and family.

Delimitations and Limitations

One limitation for this case study was that we only worked for sixteen
sessions. Each session lasted between an hour-and-a-half to two hours. Another
limitation was that the art room at the agency was not available for the study;
therefore an offsite studio was used where the client was comfortable doing art.
CHAPTER II

Procedures

Characteristics of Qualitative Research

Unlike quantitative research, qualitative research starts with the premise that
the person is part of a culture with a social history that needs to be explored. The
way to explore this history is with open-ended questions. This form of inquiry
gives a unique voice to the data that is the backbone of qualitative research
(Creswell, 2003).

Specifically, qualitative research will hopefully be more accurate than if the
research was of a quantitative nature. In fact, to do a quantitative research I would
have had to find a large number of people to participate in my study. This was not
feasible, especially with no budget and the time constraint. According to Creswell
(2003), qualitative research asks open-ended questions in order to obtain data.
Because of this style of inquiry, the questions I researched were refined as the
research project unfolded. I know that stigma has been a big reason for denial in
our society, however as the project progressed, I realized that the problem of
denial was not the main issue with the client. Instead, anhedonia became a more
significant concern, with anhedonia also being one of the major problems with
schizophrenia. I hope that qualitative research captured the essence of the
problems that the participant faced in his recovery.
Qualitative Research Strategy

The strategy of inquiry was a narrative case study. In this case study the process of recovery from schizophrenia, starting with the denial of the illness and then turning to the problem of anhedonia was explored through the use of art as therapy. The narrative was derived from the therapeutic alliance between the participant and the researcher, who is also recovering from schizophrenia. The research focused on the stigma placed on the participant, and how this has affected his acceptance of the illness.

Role of the Researcher

Over the last sixteen years I have had multiple roles at the non-profit organization where the research was conducted. First, I am a mental health consumer who meets weekly with my social worker to do our therapy sessions. I understand the importance of the alliance and the help I have had from three different licensed independent social workers in this period. My favorite, and most successful alliance has been with the worker I have had for the last eleven years.

I have also been employed for the last fourteen years as a social recreation aide. I work for a family based non-profit social service agency that specializes in helping families with adults who are diagnosed with various major mental illnesses. I am a social workers’ helper and peer counselor combined with an activities worker. One of the activities I have been involved in is the art class. It is
an open studio with an art as therapy approach. The art class is facilitated by an experienced Registered and Board Certified Art Therapist (ATR BC) and another retired ATR who volunteers in the art room when she is in town during the spring and summer months.

I know many of the clients and their families and the ups and downs that most of us face. I have learned over the years to understand the symptoms and actions of many different people. In the art room I also have been exposed to the art of people with mental illnesses.

I served two three-year terms on the board of directors of the agency. I reported on the social recreation program at the monthly meetings. I also helped with long term planning at board retreats for strategic planning and made house calls with another board member to our new families.

One of my roles has been as a peer counselor. I have shared my story with a number of clients who were stuck in the recovery process, usually due to lack of medicine compliance. Mental health professionals have often labeled persons with mental illness as being in denial. This labeling has not helped the situation in my opinion, even if it is true. I have had success with some clients, and it makes having this “damn” illness a little more palatable.

*Data Collection Procedure*

*Setting.* Since the agency was family based in its conception it has been able to be innovative in its approach to recovery. The agency prides itself in
believing that people with all major mental illnesses can and do recover. People are often encouraged to come to social recreational activities offered by the agency. Some of these take place at the office and others take place in the community.

With the approval of the agency, the research was conducted in my studio in a suburb of a city in the mid-west due to lack of opportunity to use the art room at the agency. My studio is approximately twenty feet by fifteen feet and has ten-foot high ceilings. It is on the second floor of my home. The room is lit by a large set of windows on the north side, a small window on the west wall and two small lights in the wall. The research was conducted at a drawing table with two comfortable chairs, one for the participant and the other for myself. The materials used for the artwork were part of the agency’s supplies, but also included my own paints. The participant also brought in his own supplies.

**Participant.** The research was conducted with a forty-nine year old adult male diagnosed with schizophrenia, paranoid subtype. We had worked together during one of my previous internships at the agency two years prior to this study. The participant did not have an art background. But with encouragement from his family advocate, he attended small group sessions that I ran on Friday nights. He continued to come to the art classes offered at the agency when my internship was completed.
Method of Gathering Data. The data was gathered during sixteen art sessions. They were scheduled twice a week for two hours. At each session the participant was asked to create art based on a theme of the recovery process. The art was then discussed between the participant and the researcher. Much of the data was collected in notes during each session.

Data Analysis Procedures

An art therapist who volunteers at the agency, and facilitates the Monday night and Wednesday morning art classes helped to analyze the data. The findings mainly were the stories and art that came out of the sessions. The self-report of the participant about his understanding of his journey and the problems he faced were the focus for the case study.

Strategies for Validating the Findings

The findings in a case study narrative are not measured in the same way as a clinical study. So, the findings were validated by comparing them with the existing literature on the topics of denial, stigma, recovery and anhedonia. In addition, the input from the ATRs also validated my findings.

Narrative Structure

The narrative of this case study covered conversations between the participant and myself. This included discussions about the art made during the sessions, as well as my personal reflections on my recovery. Also included are images of the art created by the participant as well as my interpretation of his thought process.
Anticipated Ethical Issues

The agency was aware of the ethical issues of confidentiality and followed all government regulations concerning the rights of the client. I was supervised by the art therapist on site as well as an off site supervisor, and a Licensed Professional Clinical Counselor (L.P.C.C.). The participant signed a release form for the artwork created during the study to be used in the thesis. The client’s name and any other identifying information were concealed to ensure confidentiality.

Significance of the Study

There have been several studies written about people with schizophrenia and the use of art therapy. But, the fact that I also have the illness will give this study a unique perspective. Perhaps the case study can inspire hope for other persons with mental illness and their families. It may also inspire therapists to work with this population.

Expected Advocacy/Participatory Changes

As someone who has benefited from the changes made in the modern era of medicine, advocacy groups, and family involvement both locally and nationally, I know that I am not a chain, but a link. I plan to write a book about my life experience. Using the thesis project as the backbone for the book, it would make a useful contribution to our society and the families dealing firsthand with the illness. This is more like a calling than just a project that I would have interest in,
and I hope it will eventually turn into a recovery paradigm for therapists to practice art therapy on a grand scale.
The topic of this case study is the use of art therapy with a person who is dually diagnosed with schizophrenia and alcoholism. There is a historical perspective to be reviewed on the topics of art therapy and schizophrenia. First, the topic of schizophrenia will be covered; next the current literature will review the work of therapists using art therapy with patients diagnosed with schizophrenia.

**Schizophrenia**

The descriptive features of schizophrenia are defined in the Diagnostic and Statistical Manual of Mental Disorders Fourth edition TR 2000 as a mental disorder where the individuals may have displayed inappropriate affect, such as laughing or smiling when there was a lack of appropriate stimuli. Anhedonia was common and was manifested by a loss of interest or pleasure. Dysphoric mood may have taken the form of depression, anxiety or anger. There may have been disturbances in sleep patterns, and lack of interest shown for food as a consequence of delusional beliefs. And often times there was an abnormality in psychomotor activity. Difficulty in concentration, attention, and memory were frequently evident.

A majority of individuals with schizophrenia had poor insight regarding the fact that they had a psychotic illness. Evidence suggested that poor insight was a
manifestation of the illness itself rather than a coping strategy. Depersonalization, derealization and somatic concerns may have occurred and sometimes reached delusional proportions. Anxiety and phobias were also common in schizophrenia.

There were five subtypes of schizophrenia listed in the DSM IV TR, including Paranoid Type, Disorganized Type, Catatonic Type, Undifferentiated Type and Residual Type.

Paranoid Type was marked by the presence of delusions and auditory hallucinations.

Disorganized Type was marked by disorganized speech, disorganized behavior, and flat or inappropriate affect.

Catatonic Type had motoric immobility, excessive motor activity or mutism.

Undifferentiated Type was indicated by the lack of symptoms of other subtypes.

Residual Type also had no symptoms found in other subtypes, yet had continued evidence of the disturbance.

Life expectancy of individuals with schizophrenia was shorter than that of the general population for various reasons. Suicide rate was 10% that actually succeeded and 20%-40% of people with schizophrenia that made an attempt (DSM-IV-TR, 2000).

Torrey (1983) noted that schizophrenia is a brain disease affecting approximately one percent of the population in the United States, with its onset
usually occurring in late teen age to early twenty year olds. The research found that the schizophrenia was directly tied to the limbic system, which is the part of the brain that regulates internal and external perceptions.

Schizophrenia was a costly illness, with regard to economic and social loss. In a review of sixty-two studies worldwide on the economic cost of schizophrenia, Knapp, Mangalore and Simon (2004) found that the cost of illness studies could identify three main categories of cost. First, direct cost of payments for services rendered, secondly indirect cost of loss of resources, and finally the intangible cost of the illness, such as depression and pain due to the illness. The highest cost was found to be the direct cost of inpatient admissions to hospitals.

Other significant costs found were the loss of productivity, mortality cost and cost to the criminal justice systems worldwide. Due to this high cost, and the problem of repeated relapses in schizophrenia, there has been a shift in the focus of services from hospital care to community mental health.

People can and do recover from major mental illnesses, including schizophrenia. Torrey (1983) described six factors in schizophrenia that may have pointed to poor or good outcomes for the person. The first factor was the history that the person had in social situations prior to onset of the illness. If a person was well adjusted and able to make friends and do well in school they may have had a better outcome. If they were always considered a strange child then the outcome was predicted to be poorer. The age of the onset could also predict outcomes, with
a person who became ill in his early teens having a poorer outcome than a person who became ill in their mid twenties. If the illness came on suddenly out of nowhere, the person had a better chance to regain their functioning. If there was a precipitating event that happened just prior to the onset the outcome was believed to be better. Torrey listed four clinical symptoms that also predicted positive outcomes. Catatonic symptoms, paranoid symptoms, the presence of depression or confusion were all good signs. Conversely, absent or flattened emotions, withdrawal, apathy, and the presence of a marked thinking disorder were signs of a poor outcome.

An aspect of schizophrenia that baffled researchers was how a person with the illness could believe that he or she did not have the illness. A person was said to be in denial when he or she did not accept the condition. In the book *I’m not sick, I don’t need help!* Amador (2000) believed that a person with schizophrenia had a deficiency in the brain that made it hard for a person with schizophrenia to understand that he or she had it.

In research conducted by Wong, Chi-yue, Mok, Wong and Chen (2006) the authors found that there was both a lack of knowledge and a motivated denial on the part of the person with schizophrenia in identifying symptoms of the illness. A reason for the motivated denial may have been the societal pressures against many mentally ill people and their families. The stigma of having a mental illness or having a relative with one could be devastating. Lefley (1989) described how
mental illness, especially schizophrenia has been treated by medical means, but is still believed to be the fault of the behaviors of others, especially families. The etiology of schizophrenia, although still unclear, leaned toward a stressful event causing the onset of the illness in people who were predisposed to having schizophrenia. The organizational/systems model, which viewed the symptoms of a schizophrenic family member as a way of the family maintaining homeostasis, was contrasted by a biologically based stress/vulnerability paradigm. The latter paradigm viewed the family behaviors as coping strategies.

Mental health professionals who also had chronically ill family members did not differ from lay family members in prioritizing their needs, which included education about symptoms and medications, behavioral management techniques and support groups as the most important services offered to families (Lefley, 558). The clinicians also voiced their concern about the etiological theories in their early training and the insensitivity of some colleagues to family pain.

Grant (2002) believes that the genetic framework influences the experience of psychological development. Meanwhile, he theorizes that people with schizophrenia fail to understand the internal origins of conscious experiences.

In two articles, Luchins (2004), and Corrigan & Watson (2004), state that the issue of calling mental illnesses a brain disease to reduce the stigma faced by the mentally ill would in fact confuse the issue. The authors felt that by changing the
name, the perception would be that that mental illnesses, like schizophrenia, would be seen as only having a genetic component. The authors believed that the illnesses also had an environmental component to them and that they needed to be understood equally.

A major problem for people with schizophrenia has been the use and abuse of addicting substances. Thoma, Weibel and Daum (2007) pointed out that nearly 50% of all schizophrenic patients fulfilled the criteria for having a dual diagnosis, which is a substance use disorder and schizophrenia. The goal of the study was to determine if response inhibition and cognitive flexibility were different in schizophrenics and dual diagnosed schizophrenics. The majority were males, with alcohol and cannabis having been the most used substances, followed by narcotic drugs, and cigarettes and caffeine. This they believed lead to higher incidents of unemployment, homelessness, and shorter life span overall.

The common function in the brain of both substance abuse and schizophrenia has been the dysregulation of dopamine in schizophrenia and elevated activity in dopaminergic activity to achieve the level of reinforcing affects in the dual diagnosed schizophrenics. Positive symptoms, such as hallucinations and disorganized thoughts were higher in dual diagnosed schizophrenics. Negative symptoms, such as anhedonia, were reported lower than in non-substance using schizophrenics.
Some of the findings were similar to previous studies by Krystal et al., (2006), Compton, Weiss, West & Kaslow, (2005), and Janiri et al., (2005), in that the executive function of the dual diagnosed schizophrenics was actually higher than non-substance using schizophrenics. It was speculated that this result was found partly due to the young age of the subjects used in the study. It noted that prolonged use of substances had a negative affect on the executive function of normal subjects who were older. Also the pre-morbid state of the dual diagnosed schizophrenics might have been higher in order to plan ahead to get the substances. The view of schizophrenics having used a substance to “self-medicate” may be in part due to the effects of substances to increase the dopamine and reduce executive dysfunction in the brain of dual diagnosed schizophrenics.

Mohamad, Kasckow, Golshan & Jeste (2006), studied the effect of alcohol on the older schizophrenic population. The age range between 45 and 54 was compared to younger dual diagnosed clients. The study found that the persons with a dual diagnosis had a decrease in cognitive function, compared to the younger dual diagnosed and also older alcoholics without schizophrenia. The study concluded that the longer a person with schizophrenia abused alcohol, the less quality of life they had.

In another paper from the Institute on Drug Abuse, Sokolov (2006) pointed to similar abnormalities in the brain of post-morbid schizophrenic and post-morbid
alcoholic brains. Although a larger study was needed, the findings suggested that there might have been a genetic connection between both disorders.

*Deinstitutionalization*

There have been three major events that now shape our current landscape in the treatment of schizophrenia. The first event was deinstitutionalization. Second, there was the beginning of a grass roots family movement partially due to the burden of the family becoming the caregiver for the ill family member who no longer lived in institutions. Third, there was the development of second generation neuroleptic medication for the treatment of schizophrenia.

According to Davidson et al. (2001) deinstitutionalization became a reality in 1954 when eighty percent of mental patients living in hospitals were released into the community. Since this time, the number of admissions to hospitals has increased over 90 percent with the number of readmissions accounting for over 70 percent of these. The most defining mental health policy initiative of the last half-century was not just to depopulate overcrowded and decaying state institutions, but also to get and keep people out of psychiatric hospitals. In their opinion we have fallen far short of the mark. The policy has resulted in higher homelessness and increased victimization of the serious mentally ill and an increase in their incarceration in penal institutions.

In a study on deinstitutionalization, Mossman (1997), argued both sides of the belief that the urban homeless problem in America came from the government
policy of deinstitutionalization. The author took the stance that changes need to be made in the commitment laws and involuntary hospitalization, not only to alleviate the homelessness problem, but also to help the mentally ill.

Due in part to the failed policy of the past, and the growing burden on the families of the mentally ill, a grass-roots movement was started in Wisconsin, which has spread throughout every state under the rubric of the National Alliance for the Mentally Ill (NAMI) and is now found in over 1100 communities. Their mission was “to eradicate mental illnesses and improve the quality of life of the mentally ill” (NAMI, 2007). They strove to do this through education of the community, family and peer support, and advocacy on behalf of the mentally ill and their families.

The next major step in helping people with schizophrenia was the development of newer medications. The clinical study and approval in 1989 by the Federal Drug Administration of Clozapine started a wave of research and development of drugs aimed at dopamine receptors in the brains of schizophrenics. The new medication was a breakthrough for treatment-resistant schizophrenics. Subsequent studies also proved its effectiveness in suicide prevention, cognitive improvements, and improvements in both positive and negative symptoms (Meltzer, 2002).

The movement for promoting change on behalf of the mentally ill has spread throughout the world. Many people advocated for a change from treating mental
illness within a medical model that emphasized diagnosis and treatment resulting in a reduction of symptoms, thus ending the need for treatment. What emerged was a social model whereby the lifelong recovery became the focus for treating the mentally ill (Heenan, 2006).

Beresford (2002) argued that in a global world, there was pressure against making adequate funds available for those people who were marginalized, but not seen as posing a public threat. A medical model with the emphasis on treating the mentally ill with only psychotropic medication has become outdated. The emphasis needed to change from rehabilitation of the mentally ill to challenging discrimination toward them. The medical model of cure, care and recovery needed to be replaced with a social model of support, personal assistance and non-medical treatments.

Another aspect of the consumer support movement was the need for work opportunities for the mentally ill. Kruger (2000) suggested the need for a new vision of gradual recovery from mental illness, which would mean the inclusion of the mentally ill in the work place. Kruger thought that the negative symptoms of schizophrenia, apathy, withdrawal, and lack of interest in the world around them might have been due in part to lack of work. The “prosumers”, or people with mental illness who were also professionals in the mental health field have brought a high level of empathy to the care team. Also, the hierarchy of the
traditional doctor patient dynamic has given way to a healthier interaction between doctors and more informed consumers.

**Art Therapy and the Treatment of People Diagnosed with Schizophrenia**

It is often thought that there is a connection between madness and creativity (Currie, 2003; Jamison, 1993). Morris (2002) describes mental illness as being a part of the spectrum of human variables. In life, when we experience displeasure, art, like fantasy, can impose a sense of balance and harmony in ourselves.

With the advent of functional Position Emission Tomography (PET), and functional Magnetic Resonance Imaging (MRI), scientists were able to explore the regions of the brain that were stimulated by art therapy. In an attempt to understand the effects of art therapy, Lusebrink (2004) studied the brain’s processing of emotions, motor information, and memory. The findings were that most of the stimuli were processed unconsciously. Also brain structures provide alternative paths for accessing and processing visual motor information and memories. Art therapy aids in processing visual and emotional information along different paths of the brain. The conclusion was that the effects of art therapy were found in different parts of the brain depending on the processing of emotions, memory or motor-information.

In a study using college students, both with art backgrounds and without, De Petrillo and Winner (2005), studied the effects of art making on the mood of the subjects. In the study the subjects were shown a short film in which the images
were of negative emotional events. Next, half of the subjects were given an art task, while the other half was given word puzzles. Not surprisingly the half given the art intervention were able to improve their mood. This they contend was due to being given an open-ended task in which the subjects were able to express their personal feelings. Although the study was only run once with small groups, the findings point to the cathartic release of emotion that improved the mood of the participants.

In Wadeson’s work with chronic schizophrenic clients who lacked insight, her own goals for the therapy were for her to be in the moment emotionally, to be supportive and provide continuity of the art therapy in hopes of the client having insight in the future (1995). Also, according to Crawford (2007), the goal of art therapy was to aid in self-expression, promote self-awareness and increase insight, thus enhancing the person with schizophrenia’s overall well being. Crespo (2003) reiterated these ideas and also made the claim that art therapy aids people with schizophrenia in expanding verbal communication. Art therapy has been used in the treatment of schizophrenia since its inception. In a study by Richardson, Jones, Evans, Stevens, and Rowe (2007) the usefulness of art therapy for treating schizophrenia was explored. In a short-term pilot program lasting only 12 sessions, the findings were significant in treating the negative symptoms such as anhedonia, or lack of emotion, in people with schizophrenia.
Edith Kramer (1958) wrote of her work with abused children and how letting them make art was in itself healing for them. The need to understand materials and what they can evoke was necessary for an art therapist. Most importantly what we learned from Kramer was that the psychic process of art and the alliance between therapist and client was crucial to an art as therapy approach.

In Schizophrenic Art, Naumburg (1950) wrote about the ability of the patient to express him or herself in art thus gaining ego strength. Using spontaneous art expression the patients found their way to the source of their conflicts. This approach could be used with persons who have schizophrenia who were able to respond quickly to the spontaneous art therapy approach, but not with the chronic, regressed or deeply psychotic patients.

Art therapy has been perfect for people living with schizophrenia in that it offers a non-threatening, non-verbal approach to self-expression. Honig (1977) described working with regressed patients and found that the best approach was one that was reality based, such as depicting the human figure, landscapes or ordinary objects. She felt that the loose, spontaneous approach caused more anxiety and confusion in patients. Her approach was slightly confrontational, directing the patient to a reality based understanding of their work by looking at the art and discussing what they created. The goal of the session was to give confidence to the patient and create a trusting relationship between patient and therapist. The use of a confrontational approach in art therapy could open verbal
communication, as well as lead the way for self-actualization. There were three areas of importance when working with this population, that being the symptoms of the patient, the overall characteristics of their art work, and then the art therapy technique she used with them.

In more recent times, Allen (2001) sees the goal of the art therapist as being two-fold: first, to be open to his or her own learning, and secondly, to do no harm. She does not agree with the view that the therapist is there to aid in gaining personal insight, or to facilitate learning. The spiritual aspects of art making, in her opinion, were between the maker of the art and the creative force in nature. The members of an art therapy group, including the therapist, were there to become a service to the creative source and to one another.

Summary

The literature review provided education about the mental illness, schizophrenia, and the problems that many people living with it face. It also examined the therapeutic approaches of art therapy and how art therapy helps people with schizophrenia in the recovery process. Next, chapter three will introduce the agency and subject of this case study.
Chapter 4

Introduction to the Agency

Prior to writing about the case study I will introduce you to both the agency and the client, Ed, (a pseudonym) who was the subject of this case study. Without the agency, the client and I never would have met, and quite possibly I never would have gone into the mental health field and found my way into art therapy. As it is these things did happen and I will tell you about them.

The history of the agency is fairly unique in that the failure of our community mental health system became a blessing for our mental health agency. Our agency started when four families with adult mentally ill children borrowed the idea from an agency that they heard about at a National Alliance for the Mentally Ill (NAMI) conference. The families were part of a local support group that went annually to the conference. The consensus was that they, the parents, were not going to live long enough to see a cure for their ill sons and daughters and that they needed to act now to ensure that their children would be taken care of in the future.

The agency formed by the families is a 501(c) 3 non-profit agency. Each family has an equal share in the agency, with one vote for electing the board of directors. The board of directors has legal and financial oversight of the agency. They hire the executive director and review his or her performance annually. The board works with the director to make decisions for the present and future policy
of the agency. Every five years the board holds a retreat to work on a strategic plan for the agency’s next five years with an outside planning consultant. The board is made of many family members, some staff, and some community members who have expertise in an area, or who believe in what we are doing and want to help out. The board does not get paid and there are many volunteers in different positions.

Some programs the agency offers are long term, and some programs are short term. Much of the programming revolves around the socialization of the clients, but also includes educational therapy. Another service provided is a support group for the families to help them live with an ill relative, and also for planning for the ill relative’s future by recommending estate planning. The real hope is that we are a family for one another and that we hope to help people stay the course of recovery even when their parents are not able to or are deceased.

Our executive director is fond of saying, “the future is not five years from now, but is five minutes from now.” There have been a lot of people buying into that philosophy for eighteen years now. There are many things that make our agency unique. First, the government does not fund us, so we are not reliant on the local mental health board to allocate funds for us. The agency receives its funding from client fees for services including third party payments, donations, grants and an annual giving campaign. We have paid the bills, and expanded our
services from a social work agency to a well-rounded holistic approach to recovery.

The most unique aspect of our services is the flexibility of our staff of Licensed Independent Social Workers (LISW). They have been going to see their clients in their own homes, apartments and even hospitals when necessary, instead of the client going to an agency to meet an overworked social worker. Because the social worker can see the client in his or her natural setting, the worker can better gauge the client’s needs, and help in the person’s recovery process.

Another service provided by the agency is housing for about ten of the male clients, with a current push by several families to start another house for women. The housing program is by all standards one of the best in our area. The houses are kept clean, clients are expected to maintain their rooms, and have help with laundry as well as help with weekly cleaning chores. Staff members, who also monitor medication compliance, prepare healthy, nutritious meals.

Many of our clients have jobs, either working for pay or as volunteers. Torrey (1983) claimed that a having a job could transform a person from being on the outside of society looking in to having feelings of belonging and self-worth. The agency has hired several clients over the last fifteen years to help with the social recreation programs, secretarial work, and even helping with counseling. The agency has a volunteer coordinator who also works with clients to find vocational training and eventually paid or volunteer positions in the community.
Over the years our agency has served, with the support of many families, numerous clients with different diagnoses. The reason the families have joined our agency was in reaction to the trend of mental health professionals, which often would wrongfully blame the family and then would exclude them from the decision making process concerning their ill relative. We also believe in a recovery paradigm, in which people can and do recover from major mental illnesses, such as schizophrenia and bipolar disorder.

One of the major stumbling blocks for anyone recovering from a mental illness is taking the prescribed medication. One way to combat this is to see clients more often than the every three months that one might see a worker at the local government agency. Our LISW will see an individual client weekly during the first year of joining, and then bi-weekly after that if it makes sense to do so.

For many people, using the government assistance programs is a needed step to maintaining health, but can be frustrating at times for them to manage the red tape. Social workers at the agency also help clients navigate the government social benefit system, both at the federal level, i.e. Social Security, and locally at the county level of government for food stamps and medical assistance.

Another large problem for the mentally ill is social isolation. In the early years the agency had a steady base of about twenty families, who after a short time challenged the executive director to add some social programming for the clients. The first of the social activities was a lunch group, which was hosted by a client
who opened her apartment for the other members and the executive director. This would later transform into a bi-monthly dinner club, which is still very active today, but takes place at any number of restaurants in the city.

The executive director, a social worker himself, has been on board since the agency’s inception. He has worn many hats along with having a caseload of clients and overseeing the daily operation of the agency. His ability to interact in social settings like lunch or supper club, bowling and weekly softball has in a way demystified the client therapist alliance. He has shown a world of care and dedication to people that has left an indelible mark on many lives. My life has been altered for the better because of his dedication, compassion and friendship.

My family got involved in the agency sixteen years ago when we last faced the crisis of my psychotic break. I had been diagnosed with schizophrenia, paranoid subtype, in 1986, then suffered a long break and hospital stay in 1987. I was able to go to school a bit, working on a degree in art, as well as holding a job or two in the restaurant field. I, like so many other mentally ill persons, ended up non-compliant with my medication and suffered a relapse. I spent the summer in a state hospital, but prior to going there I met the executive director of the agency, who came to my apartment for a visit. I was not at all receptive. In the hospital a worker from the agency would visit weekly. As I stabilized on medication, and it became closer to my discharge from the institution, I had to agree to go to meet with my worker and attend group therapy in order to live at my parents’ home.
The social calendar for the agency was not large at the time, as all they had to offer was a weekly softball game and dinner out twice a month. I had to attend these in order to live at home too.

I was always a baseball player, so the softball was a place to go and actually meet other mental health consumers who were doing something fun. As Davidson points out (Davidson et al., 2001), the three components of life still missing for people with schizophrenia are in the area of friendship, self-worth and feelings of a hopeful future. This was a novel idea for many of us who were part reluctant and part hopeful to meet other people. I was also employed at the pizza shop that I worked at prior to my hospitalization that summer. After a few months I had made a couple of friends and would have them over to the pizza shop and show them how to make dough and bake a pizza. We all had different life experiences, but were trying to recover and recognized the power of friendship that we had been missing. After a year and a half, I was asked to become the first of many social recreational aides for the agency.

Some of my duties included driving people to appointments, attend the growing number of activities, and free-lance my time with some of the families. Our agency started a newsletter to connect the group members as well as their families to what the agency was all about. In any given week I would play volleyball or softball, attend a supper club, go bowling and work with other
members in the agency’s office to help put out the newsletter. I worked everyday for over a year at one point.

I was also asked to join the board of directors to give the perspective of a client, and to learn more about how our agency operated. It turned out our agency was part of a network of agencies across the country. There was a director for all of them, which numbered about twenty at the time. Our agency was growing and we eventually moved into our own office. Prior to the move, the office was a room at the executive director’s house and the bills were paid to a P.O. box connected with a law firm where one of the board members worked.

With our new office we now had an identity that included a place to do volunteer work, such as putting out a monthly newsletter, and a place to have our art class. Our art class was originally started at one of our member’s mother’s home. We would do art in the basement with the executive director’s wife leading the class. She is a registered art therapist and still volunteers her time today.

I have attended the art class since its inception. This is where I learned about art therapy. In the hospital there was some art therapy, but the overall stay in a psychiatric hospital can be so negative that most people are turned off from art if they are only exposed to it there. I enjoyed myself and saw how other people were able to express themselves through art when asked to make art about their feelings, or their hopes. Much of the art showed hope for the individual artists, who were taking steps in the right direction, and who would otherwise be
marginalized because of their illnesses. Certainly the art gave people the ability to explore other possibilities to their lives through nonverbal communication. McNiff (1981) makes clear the importance of art, writing that, “the more one interacts with art, the more one relates to the world around them” (p. 155).

At this time things were going well for me. I had tried to attend college again with little success. I finished a few classes in art and psychology but I did not have the focus I needed to get my undergraduate degree at the time. Part of this was due to my lifestyle of working hard for others and not moving myself forward. I had come to a standstill in my own growth. I needed change in order to grow, and things would change. I started working with a newly hired LISW who got me an appointment with the Bureau of Vocational Rehabilitation to see about funding in order to finish my undergraduate degree, and hopefully one day go on and get my Masters in Art Therapy. I also changed medication around this time from a first generation typical neuroleptic medication to an atypical or second-generation medication. On the new medication I was able to concentrate for longer periods of time, which helped with reading and being able to focus on assignments. In three years I finally earned my undergraduate degree in art and started working on my degree in the art therapy and counseling program.

Medication was a hard thing for me to accept in the first four years of having it prescribed for me. For many mentally ill people it remains a stumbling block to their recovery. I stated how the newer medicine helped me, and I should mention
that many people at our agency were part of the research on the first of these medicines (Meltzer, 2002). The medicine, Clozaril, was key in that for many people with schizophrenia there was no hope for recovery because the first generation medicines did not keep them stable. For many, they often relapsed and spent long stretches of time in hospitals or nursing homes.

This is where the case study really started. Ed, an assumed name, was living in a nursing home when his family joined our agency. They had all but lost hope for their son and it took the dedication of a very talented social worker to help him. The first change for him was medication. Then he was moved from the nursing home to an assisted living home in town. He was still very delusional, hearing voices, and was socially isolated. His social worker had me meet with him to encourage him to believe that he could recover. I have done this type of mentoring as part of my job for a few years. I try to connect people to our social recreational program or to meet with people who were resistant to meeting a social worker. Sometimes it fails and other times it pays off. For Ed, just knowing that other people did get well and live productive lives was important. He then moved to a new group home jointly owned by several families from our agency and has lived there for the last ten years.

Ed has remained out of the hospital all this time. He has not only stayed sober but has been able to quit smoking, which is a hard thing to do for many people who are mentally ill. I would talk to Ed occasionally and stay informed about his
slow recovery and inquire about his social network. I have asked him in the past to come out for social events such as hikes, bowling or art class. He was always friendly, but always reluctant to do these things.

The agency at one time offered a group therapy for the clients. In this group, I originally met other members of the agency and became aware of how I wanted to be treated as a person, through interacting with other people with mental illnesses for my first time outside of the hospital setting.

Because many people at our agency had lead stable lives for some time, the executive director was challenged by several families to find new ways to improve the clients’ lives. Because we are not tied to the government for funding we are able to be more flexible. So, if people have a need and want to pay for it, we can be accommodating.

The director had heard of a new therapy that was started out of state. While many of the clients worked, attended social activities, and improved in many ways because of their involvement with the agency, some families still felt that the clients were in need of growth. The executive director and a few families went to see firsthand what this new therapy was about. They believed that this therapy would be key to improving the lives of our people, so they brought its co-founder, Sam Flesher, PhD, to an annual meeting to introduce to the members of the agency his new therapy. Within a year’s time we had moved to expand our programming to include him. He would drive here and train our staff, and also
help run groups in the new therapy. Cognitive Enhancement Therapy (CET) is psychodynamic, educational group therapy that involves learning about the brain disorder, schizophrenia, and the problems that many people with the disorder have (Hogarty et al., 2004). Computer exercises help with socialization because the work involves working with a partner to complete tasks. These tasks help with concentration and short-term memory, which help to strengthen mental skills, such as cognitive flexibility and forethought, while reducing dysinhibition. The group meets once a week for two hours, with one half of each session being devoted to computer exercises, and the other half involving group discussion about predetermined topics. These topics include sharing of homework exercises, and an exercise that reinforces the topic for each session. Each group is lead by a different member of the group each week, which builds social skills.

I was part of the third CET group and Ed was part of the fourth CET group. After I completed the group I was asked to help train people in the next group on the computer exercises that are part of the therapy. I worked closely with Ed and his computer partner at this time. When he graduated from CET, he would then volunteer to train people on the computer as I had done with him. It was while he was at the office one day for his volunteer session that I asked him if he would be interested in joining me in a Friday night art group. I told him I would be working at the agency as part of my internship from school. I told him we would be
working with a digital camera. He said, “he would like to do it, and that Friday night would be fine for him.”

Our group consisted of four or five regular members, but was open to whomever I could persuade to join us. I would have to pick up Ed at his group home and sometimes other members, while a few members who drove would meet us at the agency office. At first I thought we could make collages out of digital pictures. Somehow I got the idea to print the images in black and white and hand color them with colored pencil. The group would go to different parks to shoot photographs with members getting the opportunity to use the camera and color pictures. We all enjoyed the process as well as the socializing. For some, just being out on a Friday night was a new adventure.

This is one of Ed’s first and quite possibly his best hand colored photographs made that fall (Figure 1).

Knowing how Ed was isolated socially I encouraged him to try one of the art classes, where there were art therapists who might help him differently than I was able. As my summer internship progressed, Ed became more adventuresome in his art and finally went to the office on his own by taking a bus for the Wednesday morning art class.

We continued our working together that Fall. He had wanted to learn to paint, and before I finished my internship I had brought him to my home studio to first
learn how to build a stretcher, stretch canvas, and then gesso it for painting. His images at that time were based on simple patterns and color fields. He continued to go to art class even when I was not doing my internship at the agency anymore where he was encouraged by the volunteer art therapist to make art.

As I began to think about my thesis project, I decided I wanted to work with someone who was not only interested in exploring art, but who would also be reliable. So this was how we got to work together again, as Ed seemed to be the appropriate candidate for this work.
Chapter 5

Beginning of the story

In the beginning of our work together Ed was reluctant to do art because he thought he lacked artistic abilities, but he was willing to use a camera. As mentioned previously, our work, which lasted over a year, started in the small group on Friday nights during my first internship with the not-for-profit agency that we are both part of as clients.

We have similar diagnoses, paranoid schizophrenia, and are similar in age, both in our forties, with a history of alcohol and drug use. Much of Ed’s recovery has come from Alcoholic Anonymous (AA), and working with the same Licensed Independent Social Worker who has helped me in my recovery. We are both sober and medicine compliant, and also have concerned and involved families that have been a major reason for our initial involvement in the agency.

As much as we have in common, we are very different. Ed has a very docile lifestyle compared to my busy schedule. I have been an artist for twenty-five years and Ed had no background in art. Ed lives in a group home with two roommates and no longer drives, whereas I live alone and drive frequently.

Ed’s social circle is small, consisting of roommates, AA sponsor, and family. He stands five foot ten inches tall, average weight on a slight build, with short black hair, glasses and has his usual two-day growth of gray speckled beard. Normally he wears a printed t-shirt, sweatpants and soft-soled shoes. He is usually
quiet, speaking when spoken to, honest, kind and humorous at times. He often
calls me “bub” and enjoys the time we spend together.

The goals for Ed were to be less isolated socially, and to learn how to enjoy
his day better. As stated previously, anhedonia, or lack of seeking pleasure, is a
major problem with people who have schizophrenia. In addition, a goal for our
sessions was to demonstrate how art as therapy could aid in the recovery of
people with schizophrenia.

Our meeting times were in the afternoon on Tuesdays and Thursdays. On
Tuesdays I would pick Ed up at his group home, and on Thursdays I would pick
him up at the agency’s office. Our work together was completed at my house in
the living room that I use as a studio for drawing, printing and watercolor
painting. We had initially wanted to use the studio at the agency, but the space,
due to expansion of programming and lack of new space for the agency, made the
art room a multipurpose room. We cleared the use of my studio with the art
therapist who supervises me at the agency. Ed would often bring a frozen dinner
for lunch that I would cook in the microwave when he needed a break in the
therapy session. The time driving was also often therapeutically productive.

Session One

Ed lives in a group home a few miles from my house. He heard me lightly
honk and came out dressed very casually, in t-shirt, sweatpants and comfortable
shoes. Our time in the car was part necessity and part therapy. Today he was
excited to start doing art with me again. He liked the one on one session for various reasons. One, he was able to do art with me, and he did not have to put up with anyone else in the room. Our art space at the agency had been reallocated to house volunteer projects, the music therapy hour twice a month, and a weekly poker game. Compared to the business of the agency and uncertainty of who might disrupt the art class, my studio was better suited for our needs.

The art materials either came from the agency art room or my personal materials, and later Ed would repay me for purchases of materials that he requested. For our first session I asked Ed if he would like to “pull” some monotypes off a piece of glass on a drawing table. He was willing to try almost any media. First, using water based oil paint; he brushed several designs, and splattered the paint with a brush. Then with my help we laid the paper on the glass and rubbed the back of the paper. He then pulled the paper off and made an image that is not easily controlled. Using this technique was an easy way to get Ed started again. First, it had spontaneity, something that was missing from his life most of the time. Secondly, you could not make a mistake, and no failure means success. This was something Ed often lacked in his daily life. My mantra for Ed was that what we did in the art room, we could also do in the rest of our life. Like being successful and having fun, setting boundaries, or breaking them, our goal was to use art in our recovery.
I gave a theme for Ed to think about while working today, which was the idea of denial, stigma and isolation, three things that were key to me and also to many other people with this illness. I asked him to try to make a self-portrait if he could. He could not, so I encouraged him to make any image.

Figure 2. Monotype from our first session.

He kept on making monotypes all session long (Figure 2), but I asked him to try different paints. Using watercolors and a clear liquid called acrylic matte medium he made several more. The tools I offered him were a few bristle brushes, sponge brushes and a spray bottle. He liked spraying the paints and making them
run together. “Kind of neat,” he said. Ed would experiment with how he made his marks, even dripping from small cans of house paint onto the glass. Ed pulled eight prints that afternoon and really enjoyed himself saying, “I love art!”

As we processed the afternoon’s art, I referred back to the idea of denial, and how it is a stage we all go through in our recovery. We can use our art to see ourselves more clearly, because it both reflects us, and in some ways like denial, the art buffers us from the outside world.

In the first few years of my illness I was pretty slick about how I presented my illness. It was still good old denial, but it would be in the form of pity. I would tell people I had schizophrenia, usually when we were half drunk. I knew that the person was not well informed about the illness. They would say the thing that I wanted to hear, that it was the people who labeled me with schizophrenia who were crazy, not me.

I was not isolated from alcoholics, potheads, and other fools at the time, but I was isolated from other people with schizophrenia who may have helped me get a better grip on the things I had to do to stay well.

*Session Two*

I took a piece of paper I had dripped acrylic ink on, which was dry now, and told Ed we were going to make a collage, and tore the paper into pieces. A look of shock came over his face. “But first, let us look at what we did last week and review what we are thinking about. Stigma, denial, isolation and recovery are the
ideas that we are using to guide this project,” I said. It took Ed a minute to realize that I wanted him to tear up the drip monotypes he made in the first session. I suggested that he could use scissors, which he accepted, saying, “I’d like the scissors, they have more control.” Ed cut up two of the monotypes, saving the ones he actually used the brushes on. Next I gave him a full sheet of white drawing paper, 22”x30”, as a base for the collage.

The idea for using collage at this point instead of another round of the monotype prints was simple. Ed had a lot of success with prints because they were spontaneous. I wanted Ed to create order out of chaos, much the metaphor for how we recover our senses after being ill. I also wanted Ed to make an image that took time so he could reflect on his recovery. I thought of the self-portrait as a way of giving an identity to our project. Ed was reluctant to attempt a realistic portrait.

For the collage he used acrylic matte medium, a form of acrylic paint that dries clear and can be painted over. Using sponge brushes and the medium I showed Ed how to attach the torn paper to the big sheet. “You can use as much of the paper as you want, but you might want to start in the middle of the paper, and if it is too big we can cut it down in size,” I told Ed. As he worked on the collage, we talked about the parts of his life I knew he would be comfortable talking about, like his AA sponsor. I gave him a couple of ideas I use when working on art that help make an image interesting. “If you put a piece of paper next to one
with a little space in between that can make the space become a shape all its own,” I told Ed. Also I pointed out how the colors on the monotype pieces could be used to create a new line when pasted together. “Wow, that’s neat, thanks Bub,” was Ed’s response.

After an hour of steady work and talk Ed was tired and told me he was done for the day. “It’s time for my nap. I get grouchy without my fourteen hours of sleep and my two hour nap.” We put the lid on the medium and went into the kitchen to clean the brushes at the sink. “I’ll show you how and then you have to clean them as you use them.” Ed agreed to the condition of cleaning the brushes.

We went back to the studio and I asked him to tell me about his collage. For some people this might have been an invitation to open up. For other people it could be too deep a pool for wading.

“I like it, I like working with my hands. It relaxes me,” was Ed’s response. This is a truthful, but safe answer that I have heard from Ed in the past.

“I know, I like using my hands too, but the mind gets used as well, and it helps if you use them together,” I told him. As I held up his picture (Figure 3) for Ed to get a good look, he said it looked like a person kneeling. Then I turned it and he found another figure.

“Some people think of color as having a meaning unto its own. You like black and red. Does the black strip mean anything to you?” After thinking about it
for a while he said the red could be hell. “Or it may be the red sky at night is the sailors delight. It may mean a nice day tomorrow.”

Figure 3. The start of Ed’s collage.

He then decided it could be, “an alcoholic praying to get out of hell.” For some people this could be a breakthrough. But for Ed who is a recovering alcoholic, this is a safe place to go, or at least to talk about in a therapeutic session.

The idea of making a self-portrait using the themes of denial and stigma was brought up last session, and I encouraged Ed to do one this session. It will take time to uncover an image that is Ed. I told Ed about art coming from our subconscious, or unconscious, to which Ed said he didn’t believe in the unconscious, and showed signs of resisting other ideas that I brought up. I thought
about why this might be. First, I thought the idea was one that was accepted by the general public, and that he was resisting the idea because it was a psychological expression. People who are treated poorly by the medical professionals in the name of psychology tend to not accept any idea that is connected to psychology. The issue of stigma works a lot of ways. People who have an illness do not always like the cure or help they receive. Ed may feel uncomfortable about discussing psychology or his illness. Schizophrenia is hard to accept, and delusions are hard to get away from.

The second idea that came to me was that Ed, who presents himself as fairly normal, might have a hard time controlling what goes on in his head. To think that there might be an unconscious part to his nature, something he really cannot control, like hallucinations, might be too much to think about for him. We both agreed that working on recovery was hard work.

At one point during the questioning, he asked if I was going to take him to the “psych ward.” “No, I can’t look at your art and know what’s going on in you, I have to ask.” This may be paranoia or could have been brought on by a fear of authority, which I myself still go through at times. The look of distrust meant Ed had some feeling that was sudden and uncomfortable to him.

Session Three

Today started normally for us, and on the ride over he talked about a nephew just back from Iraq whom it sounds like will have a hard time adjusting to
civilian life. Ed also had been thinking about his art, and how he would like to do 12 portraits for each step of AA but was not sure if it would be appropriate in the eyes of AA. Instead, he said he wanted to do portraits of recovery from alcoholism and schizophrenia.

“Hey, that sounds great,” I said. It was encouraging to me to know that Ed had ideas floating around in his head and was excited by them. “Let the art you make reveal itself. It’s great to have an idea to start, but let the process bring out the portrait,” I told him.

Working with the piece he started in session two (Figure 3), he said he wanted to add his higher power in the upper right hand corner. “I want it to be bright,” he said. Then he took a monotype from our first session and tore a piece from it and said, “I’m not so rigid.” He then cut many squares from the print, which was made in gold and cranberry red. He next turned the picture around to work on the top, which now was closer to him. We talked as he worked on the collage with the squares and the acrylic medium for over half an hour. The conversation centered on what we were working on with this project. “Isolation, denial, resistance are all part of recovery. I’m not trying to reinvent the wheel with you, just make it turn a little,” I said. I also hoped that by doing the art that Ed would get some insight into himself.

“I enjoy working with my hands, it really relaxes me. I think it’s great that you are going to school, I thought about going back, but every time I open a book
the damn voices start up again. I don’t think I could sit through a lecture and hear
the damn voices at the same time,” Ed said.

I told Ed, “I still hear voices when I am trying to fall asleep, but over the
years they have decreased, partially due to the new medicine, and also because I
don’t let them get the best of me. I talk to them sometimes. Why not? They’re
mine.” For many people with schizophrenia, just to mention to someone that they
hear voices is a big step in recovery. I know how fearful I was in the past,
thinking that I would be hospitalized if I mentioned that I was hearing voices.

I also explained my basic philosophy on art, that creativity is overrated, and
how the word, “sweat” is more important. A professor in college told me that if
you only have two hours every Sunday to make art, and use that time to make art
then you are an artist. If not, then you are not an artist. Art is healing, it’s our
health that we work on when doing art, and everyone, not just ill people, need to
do art.

When Ed had finished his “higher power” (Figure 4), he said he wanted to
make the red area more hellish looking, “like a monkey on someone’s back”. So I
got out the watercolors and he chose a red, and painted over the area that was
already red, and filled in the spaces and made the cloud larger. “It’s too red,” he
said, “I want to add purple to it.” So I showed him on a scrap of paper that by
adding blue to red the color changes to purple. Next he painted purple lines in the
red cloud, “Hey those are the same lines I always make,” he said.
“Why not make curved lines,” I suggested.

So Ed added circular lines to the red cloud. “I don’t know, I think I messed it up, what should I do?” he asked.

“How about spraying it with water now?” I told him handing him the spray bottle. So Ed sprayed the collage, and as the colors ran I picked up an edge and the colors ran together. “Pick it up and run them yourself,” I told Ed. Which he did and stated, “wow that’s neat, but I think I really messed it up now. What should I do?”

“Here, “ handing him a paper towel and squeezing out some yellow watercolor, “add some yellow over the cloud and let it run together.” Ed worked with the towel and added yellow, then sprayed the picture again. “Now let it dry, or the paper will fall apart,” I added.

We were finished with the collage for the day, and spent the rest of our time cleaning up and talking. Ed told me about a wedding he attended over the weekend, and how there was a lot of booze. “The worst thing to me is that people will get behind a wheel after drinking all night long,” he said.

I told him, “the worst part to me is having some half drunk relative, or friend breathing on me, and smelling the booze on them.”

Ed brought up the fact that his illness did not strike him until he had been sober a few years in his late twenties, and how people he was sponsoring would
get their lives back together and his fell apart. I told him I got ill in my early
twenties, that it happens mostly to people in their late teens, but can range from

![Figure 4. “Alcoholic’s Hell”: Phase one.](image)

childhood to people in their forties. I think it is usually a traumatic experience of
some kind that sets off the illness. He explained that his brother died when he was
23 and he spent the next few years drunk. It wasn’t until he sobered up that he got
ill. “You were self medicating, or so that’s what it’s called. When you dried up, it
hit you and you were in touch with all the feelings of loss, maybe that’s what set
off the illness,” I replied.

Kubler-Ross points out that one of the stages of dying is called bargaining.
That is a stage that most people with schizophrenia are all too familiar with. “If
only I would have been here instead of there, or if only my mother would have called me by my proper name.” These are a few of the reasons I have heard over the years as to why people get schizophrenia. We replay the loss of our sanity, until we believe we have figured out where it all went wrong. Then armed with the “facts” we decide we are not ill, and go off our medication, which results in a relapse. It is important to think it through, but it is best to draw the conclusion that the illness is mine, and the need for medication is real. Armed with this knowledge is how one begins to recover.

So how can art therapy help us recover? First, we are able to choose what we want to do. As mental health consumers we often lack the ability to choose. We have to go to appointments, take medicine, and live with the side effects. Art also helps build an identity that many people with schizophrenia lack. Ed for example loves to do art, but prior to me getting him started two years ago never thought of going to art class, or that he could do art, other than maybe a childish stick figure. The image Ed was creating came about because of the process of making some chaotic image and reworking it. Here he is able to talk about his alcoholism and actually connect an image to it. Expressing ideas is the goal of an artist. This process gives control to Ed and he does not have to feel uncomfortable in the face of chaos. It being on the paper may be cathartic for him, a release of his unconscious in an acceptable way.
Session Four

I picked Ed up at the agency today. He volunteers there, helping people with computer exercises that are part of a rehabilitation program for the clients. Ed and I both graduated from the program, and now Ed goes once a week to help people work on the exercises. This is a big step for Ed whose social calendar is limited to phone calls with family, sponsor from AA, and the people at the group home. So to catch two buses and arrive in clean clothes, on time is a big deal. To make connections with people is a challenge for those of us with schizophrenia. Ed didn’t get ill until his late twenties and he may be ahead of people who became ill in their teens because Ed had a few more years of social awareness than an ill teenager.

Other problems faced by people with schizophrenia include the lack of drive to seek out new and exciting things. The term, anhedonia, or lack of seeking pleasure, best describes this condition. For Ed even the best laid plans of what to do in a week often fail. He is fond of saying, “Rome wasn’t built in a day.” To which I reply, “but it was built.”

I can understand the need for something to do, so why not art? Ed is now fond of saying, “I love art!” His reasons are it relaxes him working with his hands, and he is learning that it is more than a cathartic release; it does something for his mind and spirit.
He told me on the way over to my house that he is working on a secret project at his group home. All he is willing to divulge at this time is that it has to do with computers. But he had an interesting observation that the more he works on his project the more he learns about it. I told him that his top-secret work is like art, and that the process of making art is how we learn. After Ed had a frozen dinner for lunch, I had him look over his painting. He explained it again as “a person on his knees reaching up to his higher power, with a hellish addiction on his back. I want it to look more hellish, blood running and dripping off the addiction.” So he asked for red watercolor, which I got out and he asked how to make it look like blood.

“Well, if you use it straight out of the tube without a brush you may get that effect. Here squeeze lightly and paint with it like a marker,” I told him as I demonstrated on a palette. He followed my directions only he squeezed out blobs of color on his painting in a row. He asked what to do next, and I handed him the spray bottle, which sprayed down the paint and then asked me lift my end to make the paint run (Figure 5).

He loved the effect, but told me he wanted to show his higher power as rays streaking into these areas, pointing around the figure and above the addiction.

“I’ll give you some gold paint. Hey, have you ever painted with anything other than a brush,” I asked.
Figure 5. “Alcoholic’s Hell”: Phase two.

“What do you mean?” he said. So I also gave him a craft stick, which is like a Popsicle stick, and instructed him to use it to paint. He started slowly, first dripping out a little paint, then actually using the stick to paint short marks that eventually filled the whole paper except the white area under the figure. We talked about how recovery is recovery, whether it is from an addiction or an illness like schizophrenia. He noticed in the painting that there was a bit of yellow paint in the hellish addiction, which represented his higher power. “My higher power didn’t abandon me, I walked away from it,” he said. When he finished with the stick he asked for a brush, “I want to make my higher power appear stronger than it does now. So with the brush he painted a gold sun and added rays all
around the figure. I asked him how he ever came to AA, and he told me his story, probably similar to many others. It had a lot to do with the timing of everything. A person who he used to drink with had started to recover and called him seemingly out of the blue the same day his boss threatened to fire him. He went to the meeting, met a man who would be his life-long sponsor, and heard things he needed to hear.

He went back to talking about his painting and how the figure needed to be coming out of an abyss. “Well what color is the abyss?” I asked him.

“Probably a brackish brown, but looking at the drips of red I should have painted it before dripping the red. Well, I’m tired, I can do that next week,” he said. I told him art is not just physically tiring, but emotionally tiring. We worked on a lot today.

Session Five

This was a slow moving day for Ed. He wanted to finish his picture of the “Alcoholic’s Hell” by painting black underneath the figure (Figure 6). Then he wanted to add rays of gold metallic paint to the gold background to show a higher power that reaches all around him. I told him I would have to get the metallic paint from the office, and that I would have it for next week.

We discussed the idea for the day, that using one’s hands helps us to feel in control of our lives. “When I was drinking I tried to control the world, but obviously couldn’t,” was Ed’s best insight.
“Yes,” I told him, “art gives us choice and with that choice we can let out how we feel. This can become a much needed dose of reality.” I explained that when I started I was a woodcarver, and would not call myself an artist. I did things with my hands, and it gave me a lot of identity. When I got sick I really lost control of my being, my life. For the next four years I did minimal amounts of art and no woodcarving, and I had no way of relating to what I went through. I drank daily and had a hard time accepting the illness. I think I had to fail to some degree in life to believe in other people changing for the better.
I have learned a lot from Ed. When we started our work together he was uncertain and rigid in the art he would try. Now he says, “I love to do art!” And he does. What I witnessed was his willingness to become engaged in the art process and try new techniques, like painting with a toothbrush. I know this can lead to real change in his day-to-day living, by seeing life as a process like art, with choices that sometimes work out, and sometimes do not. Still in the end making art can give encouragement to the artist to try new things in life. Right now he is content, maybe a little too content with his life. I would love to see him in a studio with other people creating for the same need, to have fun and choices as part of their recovery. That’s all of us to some degree.

After finishing the “Alcoholic’s Hell” painting for the day I brought out an earlier piece he started in the second session (Figure 7). He painted on this monotype, but did not get far that day. I told him to, “relax and let go and not to force it.” As he painted, we talked more about how positive it can be to just paint, regardless of how we feel about the image. Not only can we feel in control by making art, but also we can feel out of control in a healthy manner. “Wow,” he thought about this, then said he was done for the day. In looking at the image I realized we would run out of black paint the way he was applying it. I saw how stiff the lines were, and how he was trying to make a pattern instead of working with the image on the paper. It is hard to get Ed to really loosen up. It just was not how he worked that day.
Ed was glad to see me today, and when we got to my house he was ready to start painting saying, "I love art!"

"Why do you love art so much, Ed?" I asked him.

"Well, I like working with my hands, and it also relaxes me," he stated. I had brought the metallic paint from the art room at the office for Ed today. He got right into it, painting short fat metallic gold lines all over the gold in his
“Alcoholic’s Hell” picture. “I want it to glow, that’s how I feel when I think about my recovery and believing in a higher power.” Finally, when he said he was done, I held up the painting and stepped back so he could get a good look at it.

“Finished! But what about the white over here,” pointing to the addiction, “and also my stomach” (Figure 8).

“I think it gives the composition some balance, and at this time it would be hard to change it and not mess up the painting,” I told him. He agreed, took one more, long look at it, and asked, “what next?”

Figure 8. “Alcoholic’s Hell”: Finished version.
“How about the picture from last week?” I said. He agreed, and I brought him the picture and water-soluble oil paints. He worked at squeezing out colors on the palette then started to paint, “I’m not going to think about this one, just paint it for fun!”

“We all need to have fun,” I said. As he painted he decided to use the colors to go with certain shapes, yellow triangles, green circles, red squares, and orange for rectangles. I showed him how to use the primary colors to make secondary colors of green and orange by mixing them on the palette. After the shapes, he painted using the rest of the paint on the palette, to fill in areas of white (Figure 9). “I’m done, do I have to clean the brush?” he asked.

“Yes,” I told him, and got the brush soap for him. I realized that for Ed the little things like asking for help mixing color, cleaning the brushes, and even squeezing out the paint show that he really does love to do art. Also being able to ask for help in the art therapy sessions was a step in the right direction for his mental health recovery. In recovery, asking for help is a paramount to having a vested interest in therapy. If we think of therapy as having a beginning, middle and end stage, Ed being able to engage me for help shows me he has moved to the middle stage of therapy.

I asked him about the recovery process in regards to his mental illness, but he seemed more comfortable talking about his recovery from being an alcoholic. I
told him on the way home how much I liked his painting, and really all of his work to date. Then I asked him to think of an image that has to do with recovery from mental illness. I realized that our time spent together this month lead to growth for both of us. Ed was becoming an artist with knowledge of how art could express his personal battles, and I was once again reminded that the process, the actual doing of art, can and does heal.
**Session Seven**

Today on the way over to my house Ed said he had been thinking about his recovery from his mental illness. “Wow,” I thought, “he thought about what we were talking about last week. Great.”

His idea was to make a graph, or line that showed his life before and with his illness. “I’ll show things as peaceful at the start. Then things start to get squirrely, and then all hell breaks loose. Then after a long time I start to recover,” he said.

I suggested he use different colors for the line to indicate changes. I asked if he had an image in mind, which he didn’t, just the idea for it. “I don’t know what it will look like,” he said.

“Good,” I told him, “better to let the doing of the art bring out an image for you.”

I had been thinking prior to today’s session about giving Ed a different media to work with in his art. I wanted to see if he could adapt to change and how well he would explore the new media. Today, I told him, “I have watercolor crayons that are real neat to use. Want to try them out?”

He was eager to do it, drawing his line on a sheet of 30”x22” paper, and then adding more lines as he explained his story. He had worked a number of years prior to getting ill as a computer technician. His drinking had begun as a young teen, “I was fourteen, and I was getting drunk in the woods. I used to hunt
with friends and we were all drunk and high. When I quit drinking, I quit hunting.”

The watercolor crayons give control if used dry. They also can be used wet, or after drawing with them, one can use a wet brush on the image to give it a watercolor effect. Watercolor paints are hard to control, so the crayons are good introductory media for it.

After drawing for half an hour Ed looked up and asked what to do next. “Well, you can use a brush and water and blend the colors if you like?” I explained.

He was into the process in no time and after a few minutes started to scrub with the brush. He proceeded to scrub the whole half of the picture from where his illness started to the present for over half an hour (Figure 10).

Time went quickly and I watched, wishing I was doing art. Ed’s image, with the scribbles before he used the brush, evoked a feeling of anxiety in me. I wondered to myself if Ed was also feeling anxious. Once he began the brushwork it became clearer to me that he was feeling relaxed, maybe I was feeling anxious?

After cleaning up the brush he used, I asked Ed how he felt about the work today. He reiterated the idea and what it meant to him, but he avoided the answer to my question. “How do you feel having worked on the image?” I said.

He felt relaxed doing the work today, especially the scrubbing with the brush on the paper. Art has been recognized as a healthy form of therapy. According to
De Petrillo and Winner (2005) art expression improved mood in art tasks that were cathartic, or that would redirect the artist emotionally. I have experienced both of these dimensions in art making, and now it looks like Ed has too. In his thinking about how to make this picture and how to show parts of his life symbolically, he redirected his emotions. Then in the art process itself, he was able to release more emotions cathartically by the actual movements it took to make the picture.
Today was wonderful for Ed and me. I realized that the goal for Ed was for the art process to help him to understand himself. Watching him work on this piece with the watercolor crayons made me envious, but it also gave me inspiration to use the watercolor crayons myself. I noticed during Ed’s session that day that I had been in need of a lift in energy. By painting a picture later that evening I was able to experience the healthy release of making art for myself (Figure 11).

Figure 11. Daryl’s watercolor.
Doing my piece did a few things for me. First, my anxiety of his project was put aside for an evening while I created. The second, was how my view changed about the way I think about projecting. Maybe it was what I wanted to do when I set out the watercolor crayons for Ed. My idea of gestalt in therapy changed too. Before this session I felt the Gestalt was in a vacuum, the creator and his image. Now I felt there were other influences, mainly the needs of the therapist. I am reflected in the process by what I do. It is an extension of my needs, or feelings. Maybe, now, I thought, the thesis project will help me clarify my view of my role in the therapeutic alliance.

It is important to remember where one has come from. I was scared at the beginning of my own art career. I felt I had one chance to prove I could do art, and that nobody had my back, so to speak. Authority figures were always difficult for me at the age of 20, which made for an interesting time in my first art class at the college level.

Thinking in those terms, I looked at Ed and realized his needs were probably no different than mine when we first started two years ago. The therapeutic alliance was different than my first school experience, partially because I knew Ed, but more so because I believe we all need art, whereas in art school the goals were different. McNiff (1998) wrote that many times people were encouraged to make art in their childhoods only to have art taken away if they did not show signs of having talent in art.
Something to think about is that almost all people who have spent any amount of time in a psychiatric hospital have been exposed to art therapy. It could have been the right thing at the wrong time, and therefore could leave a negative impression on people.

![Ed's watercolor crayon painting: Finished version.](image)

*Figure 12. Ed’s watercolor crayon painting: Finished version.*

What we did in the first seven sessions was to reunite our working alliance, and give Ed confidence in the mastery of his art expression. In the next few sessions I hoped Ed would expand in conversation, and think on a deeper level about what he was doing and why.
Session Eight

During many of our sessions, we talked about whatever came to mind. Today was different in that Ed worked diligently finishing the watercolor from session seven by scrubbing the unfinished half of the picture with a small brush and water to blend the watercolor crayons (Figure 12). It took nearly an hour for him to do this, working mainly in silence and concentrating on the image. I thought of Ed’s silence today. He can be talkative, usually asking for encouragement, but today he seemed to be in control of the process, almost oblivious to me sitting across from him at the drawing table. In therapy the therapist needs to be an active listener, but today I needed to just honor the process and be an active watcher. He was relaxed and I too felt comfortable just taking in his actions. When he finished we talked again about the story behind the image and also how the energy he used today in making the image made him feel good. He was also hungry, so we went to the kitchen and heated up his frozen dinner in the microwave.

After eating, Ed switched to painting on his second monotype by working into it with the watercolor crayons. It has a lot more harmony to it, much more than any other piece I have seen of Ed’s (Figure 13). Here Ed was using what was on the paper already, following lines and creating interesting spaces. The harmony of repeated motions with the watercolor crayons was reflected here also in that the palette he used was a balance of warm and cool colors, giving a well rounded or even grounded feeling to the work.
Session Nine

Ed was in slow motion today, but like a real trooper he came to the session. He comes partly, he admits, because I give him a ride, partly because he wants to. It is a large commitment and I am very thankful for him doing it. He worked on the monotype that he was starting to rework last session. He used watercolor, added black water-soluble oil paint, and then finally some of the metallic paints, choosing silver to paint a thin line in middle of the picture (Figure 14). I thought this was his best work to date. It was very harmonious in the use of shapes and
colors, and much different than the images of geometric symbols that he had been previously painting. Ed was not as excited by the outcome as I was and had little to say about it. “I’ll look at it next time,” he said, “maybe I’ll think differently about it then.”

I asked if the silver line was a path in the picture, and where it might be going? “I don’t know,” was his only response. Later on the ride home when we talked about media, I asked if he was enjoying what he was doing? “Yes,” he thought for a moment, then asked if I had finger-paints.

“No,” I said, “but I can get them for the next session.”

Figure 14. Ed’s second monotype: Finished.
Session Ten

Finger-paint can be a regressive media for the user. Ed suggested it and I wondered why? He did not know. Regardless, I thought this could be a break in the resistance. He was resisting talking and making images of himself as a mentally ill person in recovery. Some people might call this his denial. But I have read that people like us with schizophrenia are thought to lack awareness of our illness, and our brains might be affected in a way that we just do not understand it (Amador, 2000). Denial is an easier explanation for me.

To prepare for finger-painting I covered the drawing table with newspaper, and laid out the paper. A special paper is used for finger paint. Then I wet the paper and opened the four colors of paint: red, blue, yellow, and green. He had wanted to use his opposite hand last session, having brought it up two sessions ago, but we forgot at that time. Today we remembered and he painted using his left hand index finger. He made three lines, one red, one blue, and one green, from the top of the page to the bottom. “These are fireworks and this is the trail they leave behind them.” His use of the non-dominant hand came from the work he did on co-dependency years ago. This had to do with getting in touch with his inner child. The use of the left hand and the finger paint may have been a way for him to get in touch with his youth. Carl Rogers’ philosophical approach to therapy was that the client knows what she or he needs (Rogers, Gendlin, Kiesler, & Truax, eds., 1967). Well, maybe Ed knew this. But, it may have come up from the
unconscious that he doesn’t believe in, or it may have just been the serendipity of the art process.

He filled the sky with alternating colors, mixing them a little on the paper. He talked about seeing fireworks as a child and how his father’s birthday is the Fourth of July. “I would have messed up my dad if he were my son. I would have told him the fireworks were all for him,” he said. (Figure 15)

![Figure 15. Ed’s fireworks in finger-paint.](image)

“Why three fireworks?” I asked Ed. He was not sure. I threw out the ideas of it being a holy trinity of fireworks, or could they be people or trees?
He opened up and talked about his family. He is the youngest of four boys and the next oldest brother had died in his sleep prior to Ed’s illness. He said his eldest brother was in a foxhole in Viet Nam and decided right then and there to become a lawyer. “He didn’t want to be on the bottom,” he said. He worked hard, finally filling the paper and then said he was tired and wanted to call it quits. “You did a lot of work today, it isn’t just physical, it is emotional energy too,” I explained.

Session Eleven

Today was another good day for Ed and me. I bought a large pad of finger-paint paper so Ed could work on a larger scale, at his request. To my surprise, the paper turned out to be in neon colors. Ed said he would have to be cognitively flexible, a term we were familiar with from the cognitive therapy course we both took. The course was designed to help people with schizophrenia learn about their illness, and how to better understand social situations. This is where I learned about anhedonia, a fancy word for the, “I’m not having no fun blues.” Having fun is what I have advocated for people with any mental illness for the last fifteen years at the agency. Ed told me recently that the big breakthrough for him is having fun doing art. He has energy and looks forward to our time together. He is learning that there is a difference between our emotions and our thoughts from his art experience. He still refuses to see an unconscious, which I told him was fine.
So today Ed continued his finger painting, using the big pad of colored paper. On an 18”x12” piece of lime green paper Ed started painting with his left index finger. I asked him to think about the stigma he has faced when he painted today. He first painted a red circle in the center, then blue around that, and next yellow, all the while talking about experiences of stigma (Figure 16). “What are you painting?” I asked.

Figure 16. Ed’s target in finger-paint.

“How, it’s a target,” Ed said jokingly, realizing the connection a target has with stigma. “Or it could be a big eye if you were feeling paranoid,” I replied jokingly. Then Ed grew more serious as he painted and talked about the trouble he faced with stigma. He said in AA that he had an episode and people were
uncomfortable telling him to take his mental illness elsewhere. Also on the job that he still had, he could talk about being an alcoholic and joining AA, but did not dare mention schizophrenia.

“What about friends and family?” I asked.

“Well, I had just sobered up six months prior to my first break, and I didn’t have any sober friends. As far as family, (big sigh) I felt that they were frustrated and didn’t understand what was going on. I spent a lot of time in and out of hospitals and finally a nursing home. If it was not for the social worker I know from the agency, I don’t think my family would be as close to me. I remember hearing at the time I got ill how many people with schizophrenia commit suicide, and worried that it might happen to me.”

The art therapy really helped Ed open up, maybe because the focus was on the painting, or that he let down his guard a bit because of the media. In Robbins (1987), he wrote that when working with schizophrenic patients, the art becomes a bridge for deeper communications. The art may also help with the patient’s ability to clarify his or her past. In painting with finger-paint and using his non-dominant hand, Ed regressed emotionally when he created his pictures. Regression as a Freudian (1995), concept can be applied to Ed’s use of the finger paint today. Freud believed that a person’s regressive thoughts go back to their raw material, or a primal part of the psyche. In looking at the second image he created that day I could interpret it as a breast used to nurture his inner-child.
I asked Ed about his illness in the present. “Do you hear voices?” He said he hears them a lot, everyday, and that it can be hard to concentrate on things like riding the bus. He says it is frustrating, but that he feels he has “it” pretty good now.

Ed’s use of his non-dominant hand and finger-paint really helped him get in touch with his inner child today. Toward the end of our session he asked me if I knew a Christmas song called, “I want a Hippopotamus for Christmas.” Laughing out loud, he sang and repeated the verses several times.

Ed has opened up like never before. Wow, I am going to remember this day for a long time. Letting someone in on the fact that you hear voices is never an easy thing for a person with schizophrenia. The authority, whoever it is, can use this information to make our lives miserable by putting us in the hospital, or at least we feel it is that way.

Another factor is what the voices say to us. It is as individual as our fingerprint. I do not know what Ed hears in his head. Sometimes we hear how great we are, or how negative the smallest thing we have done wrong has turned out. I give talks explaining this phenomenon, and I tell people that when I was hearing voices constantly, I knew all the answers, but the only problem was I was not asked any of the questions.
Chapter 6

Second Half of the Summer

Before I get into what happened today, I will let you in on a secret. Therapy is not always fun. After a session that leaves us singing all the way home, we usually come back and have a flat session so to speak.

Session Twelve

Ed was in a confrontational mood today. He said he was joking, but I also thought it could be a defense or some of his unconscious coming to the surface. I have asked Ed to paint a picture of his recovery several times this summer. Today he decided to try a symbolic portrait. Working on a large sheet of orange finger-paint paper, he painted a blue circle to indicate his mind, next a few green lines to indicate a body, and finally a red triangle to show his spirit (Figure 17). “I want to paint with the metallic paint, if that’s all right,” he said. I brought out the metallic paint and he went to work painting silver lines radiating from the head, bronze lines around the body, and gold around the triangle. Next he painted inside the symbols. First he painted a gold cross inside the triangle, next to show his sickness he painted zigzag line in the circle. I told him he could put a Band-aid on it to show how he is recovering. He said he would think about that. I am accustomed to working with fellow artist on projects where we talk out ideas. In
Ed’s sessions I need to refrain from that and help Ed come up with ideas for his art.

Figure 17. Portrait of recovery: Number one.
We processed the image he had made, and I told him I thought he was using symbols in a much more personal way than he did in the past. With Ed, what you see is what you get. He still doesn’t go beyond the explanation of what the painting looks like.

He liked the picture so much he wanted to make one using AA concepts (Figure 18). Starting with a gold triangle to show his higher power, he then painted a silver circle with a line in the middle from top to bottom to show how other people helped in his recovery. Then it came time for him to paint himself and he stared blankly at the image saying, “I’ll have to get back to that one.” He finished the session by painting a gold arrow down from the higher power to the silver circle, and a silver arrow to where his self would be.

**Session Thirteen**

We got out the recovery portrait from last session for Ed to finish (Figure 18). He told me he was going to add an “i” to show how humbling recovery has been for him.

When he started to paint I was curious because I thought he meant he was going to paint an eye. I told him about my misunderstanding, and we laughed a little. “You thought I was going to do what? Paint an eye. Now that would be something,” he said. We joked about the clear eye, blurry eye, and closed eye of a drunkard’s portrait.
As he finished, I realized what the colors he used were about, “Oh, I get it! Gold, silver, and bronze, like the Olympic medals.”

*Figure 18. Portrait of recovery: Number two.*
“That’s the way I planned it. I was a real son-of-a-bitch when I was drinking, now I’m doing pretty good” he responded. This is part of the problem of anhedonia for Ed and many other people living with a major mental illness. He is content not to do much. His weekly commitments include one AA meeting that he has to walk a half of a mile to, his volunteering at the agency, and our twice weekly art time. He has a membership to a gymnasium, which he rarely uses. His big invention, a computer device that he works on periodically is a nice hobby, but it isn’t realistic to say he could ever run a business. He could work in a sheltered work environment, but lacks the motivation needed to do that. The illness is a constant, and it can be tiring, and a real hardship. How does one tell someone that they are not capable of running a business? But on the other hand there is reality, which can be evasive for people with schizophrenia. Art is a safe place to dream. It is also healing.

Ed wanted to finish his painting by using a toothbrush and the water-soluble oil paints. I told him I loved the fact that he paints with a toothbrush, that this is how he as an artist begins to have an individual identity. He felt the painting had too much empty space and was not finished. So using the toothbrush he painted horizontal stripes on either side of the image. From the top down he painted red, orange, yellow, lime green, and dark green, then he reversed the pattern and continued to the bottom of the page. Next he painted a black border around the outer edge. He was pleased with his painting, and wanted to continue with another
piece. Usually Ed has enough energy to do art, but feels fatigued after an hour. We had lunch, his usual frozen meal that he cooks in the microwave.

“Ed, did I ever tell you about being in Cleveland Psychiatric Institute in 1991? Well, I came to the room on the floor where they served us meals. I was too sick to get off the floor, and at breakfast everyone started trading their food with each other, the coffee for the grits, hard boiled egg for the orange, and things like that. Well, I looked at my tray and they had taken all my food. I complained, but to no avail. Well, I was just thinking while your lunch is cooking how grateful we should be for our food.”

He told me about the nursing home he was last in, saying that if it were not for the help of his social worker he would still be there. “I wasn’t even on the right medicine, now I’m on Clozapine and thank God for that.”

“What made you stay on the medicine?” I asked him.

“Well, to tell you the truth I didn’t have much choice in the matter. It was either take medicine or leave the nursing home. My family was not going to take me back, especially if I wasn’t medicated.” For myself, I was leaving the Cleveland Psychiatric Institute and realized my need for medication saying to myself, “I don’t care if I have schizophrenia. I don’t care what I’ve got. I know I have to take medicine.”

Ed’s second picture that day was also painted with the toothbrush. He used black water-soluble oil paint and filled an 18”x12” pink piece of finger paint
paper with curved lines spaced about two inches apart. Next we opened up the jars of finger-paint and he used his right hand this time to paint curves in a crossing pattern. “I’m tired of using my left hand,” he said. Maybe he was tired of his inner child?

I asked him to title it for me, which usually results in a limited response. But, this time he gave the painting the title of “Freedom Flight” (Figure 19).

Figure 19. “Freedom Flight”. 
“Where is the flight to?” He was vague about a concrete place, but said it was more to do with just being free. I told him at this point that his art was more personal than ever. The shapes are taking on meaning. We talked about how we were wrapping things up in the next week, and if the weather was nice we might work outside on a drip painting if he liked.

Session Fourteen

I picked Ed up at the office and asked if he would like to go to Burger King. “Sure, why not,” was his response. We ate and talked about our time winding down. We had talked a week ago about painting outside if the weather was nice. It had not rained all summer until yesterday and today, so our plans to work outside were foiled. Ed didn’t mind and upon arriving at my house said he had something for his portrait. I wasn’t sure what he was talking about, but I got out the art he had made this summer for him. He located the portrait (Figure 17), with the cracked mind and produced a small Band-aid, putting it on over the zigzag lines.

“There I’m all better now!” He was proud to have remembered the Band-aid. I thought it showed real caring about the image, and the meaning of it for him. He told me at lunch how he wrote himself a note to remind himself of how well he was feeling lately. “I’m going to tell my social worker how I have been feeling lately.”
He finished his recovery portrait number two (Figure 18), with the AA theme today by painting two shades of blue around the gold triangle. I explained how for an artist it is important to do two things: first, to be able to put a work aside, and second to be able to come back with a fresh idea, and finish it. He was not sure if it was finished because there was still some white in the upper half of the painting. So I shared with Ed the idea of rest in a work of art. Also, I thought the white highlighted the gold triangle, which could show the viewer how important the idea of a higher power is to him. He looked at it, and agreed with what I had told him.

I had been asking Ed to paint a self-portrait since the beginning of our sessions almost two months ago. His work so far has been abstract or symbolic portrait, mainly using the AA themes he is accustomed to. Today he partially agreed to paint a face. “How about I paint a picture of you?” was his response.

“That would be fine,” I said, “what would you like to use?” He had brought a bag with cotton swabs and cotton balls to try painting with today. Choosing a lime green 18”x12” piece of finger-paint paper, he proceeded to paint me, “the teacher” (Figure 20). Making an outline in blue finger paint with a cotton swab, next he used a cotton ball to paint what is left of my messy hair. Finally he added red lines to give me a smile. “Finished!”

“How about a self-portrait?” I asked.
He spoke in the third person about the inner child, “sometimes the inner-child is unhappy, but today he is happy!” he said in a childish voice. It didn’t take him long to paint his self-portrait, but it was taxing on his energy. Perhaps he may have made a breakthrough today letting out his inner-child because for people who have a mental illness, schizophrenia specifically, we often fail to integrate our live from prior to illness to ill, to recovering. Throw in the teenage alcoholism and Ed may need to express his inner-child, which is buried deep inside. The process was relatively quick but captures a lot of the person.

*Figure 20. Portrait of the teacher.*
Art therapy is an ideal place to regress safely into our past. It was Ed who had the idea to paint with the finger paint, to get at his inner-child. “Well, I’ll try to paint my inner child today,” he stated, which he did on orange 18”x12” finger paint paper using Q-tips and finger-paint. (Figure 21)

Figure 21. Portrait of Ed’s inner child.

He painted one more picture today experimenting with the cotton balls and finger paint. It took longer than both portraits combined and he worked hard at getting the image to look “good” in his mind (Figure 22). He painted on orange
18”x12” finger-paint paper using a cotton ball and finger-paint. I also think the process of the painting was a way to put some distance between the inner-child and the present. “I’m bushed,” he said. “Can we stop now?”

I doubt he was physically tired, but emotionally he may well have been. In the last piece he had more intellectual choices such as what to make the mark with, no longer using his finger, opting for cotton swabs and cotton balls to blend the colors together, and also what type of image to make, one that was not recognizable to him. The use of his fingers was a regressive way to paint today coming from Ed’s inner emotional side. I believe he changed the art approach to regain his composure, or let his inner-child rest.

Session Fifteen

Therapy has its ups and downs. Last session Ed was a child again for some of the session, a real breakthrough. I wondered before we started if in today’s session if Ed would close up again. I saw this phenomenon when I was a patient in a group therapy years ago.

Again it was raining, so our work was carried out indoors today. Ed finished painting his picture from the last session, which he titled, “Autumn Wheat” (Figure 22). He really got lost in the process of this painting. He laid down broad stripes of color over the colorful under painting and then blended the stripes together with the cotton ball. It might have been Ed’s unconscious at work covering the under painting, or he may have been on the defensive using
intellectualization to cover up, or he just might have enjoyed the movement and paint. For those of us with schizophrenia the fear of letting people know what is going on in our mind often times will close us up. There is still a lot of stigma in our society towards people with any mental illness, even though in our lifetime this has changed greatly. Part of it is due to new medications that enable people to recover from schizophrenia. For Ed admitting he is an alcoholic is not hard to do because of the way society views it. Openly talking about his mental illness is not that easy, even with a fellow journeyer with schizophrenia. This is where stigma and denial overlap in our lives.

Figure 22. “Autumn Wheat”.

I asked him about the way in which his family reacted to his illness. He briefly told me about his sister.
“Wow, Ed, I didn’t know you had a sister?” I said.

“Yes, she’s a year younger than me,” he said. He doesn’t go into deep detail about the past, so it could be too painful to revisit now. Or maybe he doesn’t feel the support in therapy with me if he got into something too deep, especially now knowing that our sessions were coming to a close. It is hard to talk about the past from where we come. For some of us the illness never lets up; for some the change of outlook is hard, and takes time.

Ed’s second picture today was a wonderful piece that I really like. He painted it using the toothbrush and water-soluble oil paint on a green sheet of finger paint paper (Figure 23).

Figure 23. Oil painting with toothbrush.
He likes the toothbrush for painting. It is a pleasant surprise when someone who doesn’t have a lot of choices in life any more is given free range to create.

It was a simple design like many of Ed’s works in the art class. He doesn’t know how to paint a likeness of a car or person, which may have hindered him from actually trying to paint a self-portrait that wasn’t symbolic. When our work began two years ago I enticed Ed to try art by offering to use a camera. I believe his aesthetic value has changed a lot and he is rather comfortable putting paint on paper. This would be an example of his work where I felt he was intellectually in control.

Session Sixteen

Ed came out of his group home today with a large sheet of black poster board measuring 22”x28”. It was in his room and he wanted to use it to do a final collage piece. Once we got to my house I got out the monotypes from our first session and Ed decided he would cut them into triangles. He then cut the triangles into smaller triangles by folding over the paper and cutting with scissors. It took some energy and finally he had cut them into approximately three-inch long triangles. Next he sorted all the triangles into piles based on what color was on them. He then produced a glue stick and started to glue down the pieces onto the poster board. He used pieces with green on them and made what he called a path running through the picture. I thought how symbolic this was of the journey he has taken this summer and in his lifelong recovery from schizophrenia. He next
added triangles with red and then purple to fill in the paper. When he was finished he asked for the metallic paints to paint lines in between the triangles. He was careful and explained that he didn’t want to paint around all the pieces entirely, but that he wanted to leave empty spaces (Figure 24).

He has come full circle in creating this collage by using the left over pieces of monotype prints from our first session giving the whole experience closure. The choice of a triangle is interesting in that it is the sturdiest of building shapes, and also it makes an arrow when laid out in a path the way Ed did today.

*Figure 24. Ed’s collage from the last session.*
His choice of using green triangles to make the path could show a path of growth in the image. Also not painting around all the triangles equally may be an aesthetic choice, one of theme and variation he has learned in our time together.

I thought he did a great job today. First, was his mastery of the process by thinking ahead of time to bring the paper and even the glue stick, but mainly the use of a collage to put the pieces together. To wrap up our time we reviewed all the work Ed had made this summer. He had forgotten about many of them and was amazed at what he had accomplished.

Our work together has been fruitful for both of us. It is always amazing how the art process as well as the final work can improve a person’s outlook, and general psyche. Ed benefited from the open studio, art as therapy approach. One reason is that it is less threatening than verbal therapy and even an art as psychotherapy approach. We were both able to learn about different art media, but more importantly we connected and met on an equal plane as co-creators.

Much of what we know about mental illness in general, and schizophrenia specifically, we have learned in the last twenty years. Once we were not even given much hope at staying well. Now the paradigm is that people can and do recover from schizophrenia. Ed has a long way to go if he is to realize his full potential. Continuing in the open studio at the agency will be an important step to take for him.
Chapter 7

Conclusion and Recommendations

Conclusion of our work together

For Ed, the experience hopefully will build him up and help guide him along a healthy recovery. He did join the Wednesday art class after our last session, but that lasted just two months, when his mother took ill and was admitted to a nursing home. He now spends a whole day riding the buses to see her and to return to his group home. I talked to him recently, letting him know what a great thing it was for him to be able to do that for his mother. I also let him know that the art class was ongoing, and that no matter when he came back to the class, he would always be welcomed. He appreciated the support and promised to rejoin in the future. That is the beauty of our agency. It is our philosophy to be supportive in long-term therapeutic relationships, which we feel is necessary for the recovery from mental illness.

In this project my hope was to put a face, or faces on the idea of stigma and denial because I felt it was the major reason that people fail to seek help and recover. It may have been less successful than planned in that respect but from a serendipitous stand point what Ed and myself were able to do has turned out be very positive. I also had asked to discover if art therapy could help gain insight into the schizophrenia for people with schizophrenia, a question that I knew from my own recovery to be true. Stumbling across anhedonia and seeing how art
therapy could motivate a person with schizophrenia may have been the high point to this case study.

People living with paranoid schizophrenia have a problem with feeling in control of their lives. Ed, through the art therapy learned that he was the force behind what was created in our sessions. This alone was very empowering for him. The work he did with his recovery from alcoholism also opened up the feelings that he had not explored too often around his mental health recovery.

Having choices was key to his growth in our work together. Choosing to make art gave Ed the ability to express feelings about his illness. Talking about the illness personally was a way to take ownership of his recovery.

Much of what Ed did artistically in our sessions helped him gain insight into his current state of being. He created images to express his relationship to the higher power, and the help he gets from AA still to this day. He was able to try new media and experiment with tools that he brought in, such as the cotton balls and cotton swabs. It gave him pleasure that he lacks in much of his day-to-day life, while adding to his social calendar. Yes, Ed had said, “Rome was not built in a day,” but it did get built.

Anhedonia, is the inability to have pleasure in one’s life. Ed certainly enjoyed our time together. Not all our time was spent working on art and talking about recovery. We also talked in the car, on the phone and had many lunches together. It was part of the therapeutic alliance that helped Ed let down his guard.
This level of contact with a client was an extension of the agency’s philosophy of seeing clients in their own environment and in activities outside of therapy sessions.

I wrote earlier about our executive director’s involvement in the social recreation programs that we have at the agency. In fact, all of the family advocates and the staff social workers are involved in some aspect of what is now called holistic recovery. Their involvement in these programs serves two purposes. First, their involvement lets the advocate get a better understanding of how our clients are impacted by their illness by seeing the client in a non-clinical environment, like a supper club. Second, it also helps the clients to relate to the advocates on a person-to-person basis instead of the traditional client to therapist relationship.

I believe the arts also help alleviate the strain of the traditional therapeutic alliance, which is naturally higher for people like Ed and myself who have a diagnosis that includes paranoia. As a whole, people who come to therapy for the first time are naturally suspicious, partially due to the stigma associated with the mental health field. In my first internship, Ed was not only suspicious of the newness of art therapy, but he was reluctant to try art for the first time in many years, possibly since childhood.

Therapists need to be aware of these hang-ups that our clients may have, and recognize that they may be defenses that are necessary to survive in the stigma
filled landscape of the mental health field. I must add that some of this stigma is taught to mental health professionals in their training. As recently as 1993, Izhakoff wrote that the etiology of schizophrenia is traced back to an underdeveloped mother-child symbiosis, and that this results in a lack of individuation on the part of both the mother and child. This certainly mimics the schizophrenic mother theory of the 1950’s, and that belief certainly placed the blame on the family, which resulted in creating a climate ripe with stigma from the people who are trying to help.

Seeing therapy from both sides of the therapeutic alliance has made me aware in a more personal way of the need for defenses in order to survive. I for one can be very guarded when it comes to using words to express my illness, yet I feel free to explore my illness in my artwork. I realized Ed’s dream of running a computer business would not happen; yet as an art therapist I realized what it is to encourage a client to dream.

For myself, the experience opened my eyes once again to the power of personal expression, and how art therapy is a two-way street. I felt this the most when I questioned my own intent about what I was asking of Ed in session seven, and was then motivated to make art for my own betterment. Allen (1992) explains that the problem a lot of art therapists faced was that they quit making art themselves, and became clinicians only. Doing this they lost the main component that separated the art therapist from the psychotherapist.
Sometimes for myself I feel too close to the forest to see the trees. I’m around the mental health field in a personal and professional way daily, and often forget that most people do not share my knowledge of mental health. The story between Ed and myself really came across in a way that I hope will add to the literature in a unique way. We are people first, artists second, and living with schizophrenia. I know this can help families and friends of people with schizophrenia, and hopefully those people who are living with schizophrenia.

Recommendations for the future of art therapy

I have big dreams myself, wanting to get people into an art studio to have fun, fight the winter blues, express anger, and make art. McNiff (1981) wrote that the strength of the visual arts was the permanence of the object, and how the object transcends the moment. The object becomes not only a personal symbol, but gives lasting order and balance to the artist. Socially we need art. Art can be made by anyone willing to try, and I personally believe all people have a need to try.

Art therapy can give equality to the disenfranchised if therapists are willing to see people with illness, disabilities, or trauma as equal partners in the therapeutic alliance. We can transcend the problem of the modern world and follow the simple thought that art heals society as well as individuals.

I hope in the near future, say four to five years, to have a studio funded and running. It would be great to share my first love, woodcarving, with people. I also
will get involved with my local NAMI to pitch the idea that art works for all people, but especially for the mentally ill. There needs to be more jobs available to art therapists, and hopefully that through a large studio, or several large studios, our city could model for the world how art was meant to be made.
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ART THERAPY RELEASE

I, ________________________, hereby agree that my art work or representations of my art work may be used in professional or educational training. I understand that my name will not be used in conjunction with the presentation or discussion of the work.

_________________________________     __________________
Signature      Date

_________________________________    ___________________
Witness     Date