

SCULPTURE: A VITAL OCCUPATION
A STUDY OF SCULPTURE AS A SIGNIFICANT OCCUPATION
AS OPPOSED TO A PASTIME, FOR PEOPLE WITH CANCER

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ABSTRACT

Art related activities are frequently offered to patients in healthcare as therapy, for pleasure, as diversion or pastime. This research proposes that art has a more 'ancient purpose' which may be of significance in healthcare. Here, the vital nature of art is explored. Art, like work, may maintain purpose and identity, therefore sustaining meaning. However, art may also communicate beyond the individual. When illness removes the expectation, and ability, to work personal identity and purpose are challenged. To explore these theories, people with life-threatening illness (cancer) were invited to participate in making sculpture. The significance of making was measured by the amount of precious time they were prepared to spend, as opposed to pass.

Over two selected time periods patients receiving palliative care took part in making sculpture. From an initial starting point of replication in a permanent medium, the sculptures were advanced, becoming temporary, fragile and more complex in concept. The opinion of the patients was ascertained using observation and interview, and the verdict of art professionals was sought to evaluate completed sculpture.

Sculpture was found to convey patient identity better than any other object they possessed. Profound differences in the responses of men and women were discovered, suggesting that the monumental function of sculpture was of more significance for men than women. There was evidence to suggest that if art can maintain identity and create meaning then it may sustain quality of life, if not maintain life itself. While patients noted the importance of maintenance of identity they also reported a sense of expansion and elevation through making sculpture, to the extent that they were 'spiritualised'. The patients reported that making sculpture was more than pleasurable. They detected significance in the activity, comparing building sculpture to building the pyramids.

Findings indicate that art may make a significant contribution to palliative care. The research also proposes an alternative way to measure the value of art. The research provides empirical confirmation of theories concerning the value of making, establishing that a vocabulary of significance, as opposed to pastime is of value when life is short.

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Chapter 1

Introduction

1.1. Introduction

'Art, properly so called, is no recreation, it cannot be learned at spare moments, nor pursued when we have nothing better to do. It is no handiwork for drawing room tables, no relief for the ennui of boudoirs; it must be understood and taken seriously or not at all. To advance it men's lives must be given, and to receive it, their hearts.'

(Ruskin, 1905 p.26)

Rather than a diversion or hobby, art is said to be a significant activity, capable of communicating from one to another, and metaphorically extending the individual. In addition, art is said to reinforce the identity of the maker, allowing meaning to be forged in the life of both individual and community. As art may maintain identity, without which, it is claimed, meaning is not possible, so it may also maintain health. In the following research theories concerning the vital nature of art are examined by inviting people for whom time is precious, patients with incurable cancer who attend a hospice day-centre, to participate in making sculpture. It is recognised today that the worth of a work of art is equated with its financial value, being measured in pounds. By involving people with life-threatening illness in making art, another currency of evaluation is proposed. The value of making art is determined by the amount of precious time seriously ill patients are prepared to give.

Art activities are frequently offered to groups and individual patients in a variety of health care settings. The purposes of these activities include resolution of psychological conflict, decoration of the environment, improving concentration and co-ordination, encouraging conversation and group interaction, building confidence, diversion and passing the time. Having worked in this oeuvre in a mental health setting the researcher

noted an innate difference in the activities offered to patients and her experience of making as an artist.

While patient enjoyment of art media and techniques was apparent, they were not given the opportunity to experience the distinctive ambition involved in making art. The art activities which patients were offered had only the materials and techniques in common with art. While the former can be pleasurable and satisfying it does not give new perception or understanding. While the health worker might teach a range of art activities with planned, achievable aims, the artist's job is always new. It is a process of discovery to develop and select the best vocabulary through which to communicate a new insight.

Whilst most day-care health facilities offer some kind of art activity, and there are organisations which exist to bring together art and health care, there is a discontinuity between the art techniques offered to hospital groups and the experience of making, and the quality of, mainstream art. This research aims to address this divide by investigating the responses of patients when invited to assist an artist in making sculpture. There is a tradition of collaboration in art. Artists and artisans have created joint projects since at least the Middle Ages (McCabe, 1984). Apprentices were trained through close attention to their master's work and more recently, professional artists have sought to involve the public in their work. These activities provide a model for a practice not used before in health care.

A review of art in healthcare literature is first presented to describe the field and isolate deficiencies. A description of the difficulties faced by cancer patients delineates why this population is relevant for the research. A review of theory concerning the vital nature of art asserts that art has greater purpose beyond pastime. Through this review the relationship between art, identity and health is explored. This provides a framework with which to examine the purpose of art, as opposed to hobby, in a health care setting. The aims of the inquiry are defined. In the second chapter methods of investigation are

described. The following chapters present the results of two stages of art making and patient response before conclusions are drawn concerning art as a vital, as opposed to a pastime, activity.

1.2. Literature Review of the Field:

Current Art-Related Practices in Health Care

There are a variety of practices employed in health-care settings, facilitated by a number of organisations. The following presents the research field and identifies the need for new research. Although categorised, the following practices have commonalities.

1.2.1. Occupational Therapy

Art-related activities are frequently employed in hospital and hospice settings by occupational therapists or care assistants. The activities employed are diverse, but are usually described as crafts (Dorner, 1985). Activities are employed in order to facilitate rehabilitation:

‘Some crafts (e.g. macramé, stool seating and woodwork) provide finger exercises which are useful for arthritic patients or those recovering from strokes or accidents. Others (e.g. pottery, painting and textiles) provide an opportunity to explore the subconscious.’

(Dorner, 1985, p.14)

As described, occupational therapy uses art-related activities to encourage improvement of health. In hospices, occupational therapists use art-related activities to *‘build patients’ confidence, improve communication skills, to alleviate anxiety, to stimulate interest and encourage physical stamina’* (Liverpool Marie Curie Centre Occupational Therapy Statement of Intent). Little emphasis is put on the quality of the product.

Occupational therapy is *'an area where aesthetics cannot come first'* (Dorner, 1985) as the well-being of the patient is primary.

There is continued debate concerning whether the activities employed by occupational therapists are diversional. Here 'diversion' implies that through activity the patient is 'diverted' from being aware of problems. There is further debate concerning the value of diversional activities. Frampton states:

'Some people have attempted to produce diversional programmes for patients with cancer which are useful as far as they go but diversion does seem to suggest the idea of looking the other way while something nasty happens.'
(Frampton, 1985. p.104)

The aim of occupational therapy is not to make art but to use art techniques to improve the well-being of the patient. Activities are intended to be appropriate to the interests of the patients. Leading craft activities is a small part of the occupational therapists role. In contrast the use of art is central to the practice of art therapy.

1.2.2. Art Therapy

Art therapy is,

'A term used to describe a collection of diverse practices, held together by their practitioners' belief in the healing value of image-making.'
(Waller, 1991, p.3)

This activity is employed in health-care settings, particularly in mental health and in some hospices. Art therapy evolved as a result of social changes at the end of the nineteenth century, when artists and theorists rebelled against what they perceived to be academic, elite art conventions, preferring to retain 'natural' creativity (Waller, 1991). The art of children, the 'insane' and primitive peoples became valued for their 'natural' (Waller, 1991) expressive qualities and their 'outsider' status. In the 1930's art educationalists' ideas began to merge with psychiatrists' growing interest in the images

produced by patients and, by the 1940's, a link between art and medicine was established and the practice developed (Waller, 1991). In 1963, the British Association of Art Therapists (BAAT) was formed. The BAAT defines practice thus:

'The focus of art therapy is the image, and the process involves a transaction between the creator (the patient), the artefact and the therapist. As in all therapy, bringing unconscious feelings to a conscious level and hereafter exploring them hold true for art therapy, but here the richness of artistic symbol and metaphor illuminates the process.'

(Waller, 1991, p.3)

The profession of art therapy and other creative therapies rest on

'A basic assumption that people will use the medium in a way which reflects how they are thinking and feeling'.

(Payne, 1993, p.xi)

Art therapists believe that everyone, irrespective of artistic ability or experience, is capable of projecting information in visual language. The client and the therapist use the image as the focus of discussion.

Although less apparent now, in the history of art therapy there has been a distinct split between two schools of thought: one placing emphasis on the therapeutic value of making art, the other considering that primary importance lies in the images produced as therapeutic transference. Today the latter position is taken by most art therapists. There has also been a long-standing debate concerning the art status of the objects produced by patients. Lydiatt states that, *'the work produced in art therapy should never be viewed as art'* (Waller, 1991). Concerning the same issue the BAAT states:

'Aesthetic standards are of little importance in the context of art therapy- rather the expression and condensation of unconscious feelings that art-making engenders are at the heart of therapeutic transference.'

(Waller, 1991, p.4)

The prime aim of art therapy is to use the image as a means of communication between patient and therapist. As in occupational therapy, little or no emphasis is placed on the quality of completed work as art. However, since the 1900s there has been a tendency for the products of therapy and 'Outsider Art' to be valued for the lack of artistic sophistication associated with the work of trained artists. The interest in 'Outsider Art' continues, as in 'Outsiders' at the Hayward Gallery (Cardinal, 1979), 'Art Beyond Reason' (Hayward Gallery, 1996) and 'The Musgrave Kinley Outsider Collection' (Irish Museum of Modern Art, 1998). The difference between the products of art therapy and cultivated art continues to be explored. Maslow (1977) states that *'art therapy is concerned with art as a subjective experience'* and, Peter Fuller demarcates the difference thus;

'The mentally ill individual is solipsistic and expresses his own inner feelings; the artist's work has societal meaning that evokes significant reaction in his audience.'

(Fuller, 1988, p.229)

Criticism of art therapy frequently comes from art therapists. Henzell (1996) criticises the growing use of overtly literal translation of patients' images, describing it as a *'restrictive inventory'*. He describes how this leads to meaning being confused with reference. Hillman (1995) criticises therapy for its *'exclusive preoccupation with the personal soul of the self'*. Hillman states that therapy does not lead one to examine ones place in society. He further considers that the *'interiorising of the emotions'* in therapy leads to passivity; a way to cope with, rather than to solve, problems.

Art therapy is used differently in hospice care because patients do not generally have a mental illness or an abnormal problem. Frampton (1989) records the quantity and nature of art therapy work in UK hospices. He lists the aims of one therapist as: *'expansion of life'*, *'creating an opportunity for non-verbal expression'*, *'to aid appreciation of objects outside ones self'*, *'creating opportunities for memories to be relived'*, *'to remove the patient role, if only for a short while'*, and *'to have created something,*

however lowly, that can be kept, or given, to someone close'. Aldridge (1993) and Edwards (1993) describe the use of art therapy with AIDS and HIV+ patients. Both recognise that AIDS challenges identity, and art therapy can be used to maintain integrity and hope,

'To do something positive, to create, to play, is to take life seriously. The creative act is to take the opportunity to live. The creative act gives us the possibility to realise something of value in the world.'

(Aldridge, 1993, p.289)

Aldridge (1996) describes how the making of art, in this case music, is an act of identity construction where we 'make ourselves real'. This is recognised as being beneficial, and even essential for health as *'positive emotions are known to be beneficial for the immune system'* and for maintenance of hope:

'Purpose and meaning in life are vital, and all too often are not questioned when we are in good health. But should we fall ill, then purpose and meaning become crucial to survival.'

(Aldridge, 1996, p.224)

Art therapists believe that all people can communicate effectively through a visual medium. Art therapy uses the images produced by patients as a conduit through which patient and therapist can explore issues. Art therapy is a private conversation between patient and therapist. The works produced are not to be seen as art as the quality of the work is irrelevant. Criticism of the profession concerns the focus on the individual's problems rather than their relationship to society. In contrast, the 'art in hospitals' movement addresses the hospital environment.

1.2.3. Art in Hospitals

There is a tradition of criticising the unwelcoming, clinical atmosphere of hospitals, for which the introduction of art is an attempted remedy (Miles, 1994). Art was

traditionally placed in hospitals to record patronage. One of the earliest paintings in a hospital was Piero Della Francesca's 'Misericordia' in the fifteenth century, commissioned by the burghers of Sansepolcro (de Vecchi, 1967). Another example is the painting 'Christ at the Pool of Bethesda' placed by Hogarth in St Bartholemew's Hospital, London in 1735 (Senior and Croall, 1993). In 1959 the Paintings in Hospitals scheme was introduced, enabling hospitals to rent a continually changing collection of paintings (Senior and Croall, 1993).

There are several contemporary organisations which introduce art and artists-in-residence to hospitals. These include Arts For Health, Hospital Arts, Hospice Arts, British Health Care Arts and the smaller organisation Celebratory Arts for Primary Healthcare. While they have similar titles the roles and practices of the organisations differ. The following describes the activities of the two largest organisations, Arts for Health and Hospital Arts, and the work of Hospice Arts.

1.2.3.1. Arts for Health

Arts for Health is an organisation initiated by Peter Senior in 1973 (originally known as the Manchester Hospital's Art Project) to introduce artistic intervention in hospitals. Arts for Health recognises that there are historic links between art and health and cites the Ancient Greek practice of placing amphitheatres next to hospitals. By introducing art into hospitals, Arts for Health aims to *'provide for the basic human needs, for beauty, humour, relaxation, harmony and spiritual uplift'* (Senior and Croall, 1993). Its hypothesis is that a person's need for art is increased when faced with a difficult situation;

'If the arts have a value in society, they must have a special part to play in places where people are facing unusual or distressing circumstances, restricted movement, birth and death.'

(Senior and Croall, 1993, p.4)

Arts for Health considers that the improvement of the hospital environment can have a significant effect on the progress of healing and refers to the 1984 Ulrich study as evidence (Senior and Croall, 1993). This study proposes that patient recovery rates quicken when the bed faces a view through a window. Arts for Health aims to raise the morale and self-confidence of both patients and staff by improving the quality of the hospital environment. Arts for Health evaluates its projects through photographic documentation and the collection of opinions from a cross-section of those involved.

The artists commissioned by Arts For Health are chosen for their popular appeal or admired craft rather than professional status. Peter Senior advises that,

'Artists have to be educated to look at art in a different way. Too much of it is self-centred, artists are being trained who cannot communicate at a basic level.'

(Senior and Croall, 1993, p.7)

Senior suggests that the artists employed by Arts for Health are expected to fulfil different criteria from other artists, that they must communicate at a *'basic level'* rather than have a developed, refined language. Senior implies that the works of art made for hospitals should perform a different function from art which is placed in galleries and museums. Indeed, the artists commissioned by Arts for Health are instructed to follow particular guidelines;

'Avoid creating angry surrealist paintings or abstract works that might remind patients of internal organs or blood.'

(Senior and Croall, 1993, p.32)

The work commissioned by Arts For Health often features local scenery or it is abstract, with the intention of inducing a calm atmosphere for patients. John Smalley (1976) criticises this approach to art in hospitals,

'The vetting of images that may disturb the patient, the rejection of form that may present analogies with subjects of an unsuitable nature (particularly death) has resulted in the presentation of a type of art that is almost devoid of any depth of meaning.'

(Smalley, 1976, p.77)

Smalley suggests that the Arts for Health policy of avoiding confrontational or difficult imagery results in art which is anaesthetic and shallow.

The aim of Arts for Health is to improve patient and staff well-being by enhancing the healthcare environment with the addition of art. There is debate concerning the works produced, suggesting that the desire to appeal to all results in works which communicate without profundity. Those involved in Hospital Arts were once part of Arts for Health, however the group splintered into two.

1.2.3.2. Hospital Arts

Like Arts for Health, Hospital Arts also aims to improve the health-care environment but it emphasises participation. In addition to the completed work of art, working collaboratively is seen as both aim and result. Hospital Arts works in primary care, with elderly residential patients and the mentally ill, in secure units and other settings. The artist encourages participants to initiate projects, to develop ideas, and to make works which remain in the hospital. Its aims are,

‘Participation and education, encouraging meaningful and enjoyable arts projects which cross fertilise the skills and resources within the hospital environment and through these projects enhance the social and physical environment.’

(Chapman, 1996)

Like Arts for Health, Hospital Arts evaluate their projects through collection of comments from those involved. Arts for Health and Hospital Arts both work in a variety of healthcare settings. In contrast, Hospice Arts focuses on environments for care of the seriously ill.

1.2.3.3. Hospice Arts

Unlike Hospital Arts, Hospice Arts places professional artists in hospices. The artists are expected to pursue independent practice, but to involve patients when interest is demonstrated. The process employed by Hospice Arts focuses on the artist's impact on people in the hospice rather than on environmental improvement. In 1989 artists Benthe Norheim and James Thrower, graduates from the Royal College of Art, were artists in residence in St John's Hospice, Lancaster (Crimmin, Shand & Thomas, 1989). The artists were given a bathroom in which to make and present art. The project received mixed reactions. Many observers felt provoked to consider the illness and death with which they were already surrounded. Some who were initially hostile became enthusiastic after spending time talking to the artists. Contact with the artists was a crucial part in the positive reception of the art. One hospice worker said,

'I began to realise that they were depicting things that mattered, not pretty pictures. They were speaking in a language which we did not really understand and yet it's a really basic language.'

(Crimmin, Shand & Thomas, 1989, p.39)

Unlike the two larger organisations, Hospice Arts published the results of a more thorough evaluation of the project at St John's. The conclusions drawn were firstly, that, although the work did not always elicit positive reaction, it acted as a focus for the consideration of difficult subjects. It was resolved that mixed reactions should not stop difficult imagery from being introduced in future but that it required mediation. Secondly, that time given to the work was recognised as influencing a positive reaction and, thirdly, that in-patients were more appreciative than out-patients.

1.2.4. An Alternative Model for Art in Healthcare

The introduction of art to health-care settings involves diverse practices and aims. Occupational therapists use art techniques to aid well-being and in some cases to pass time. Art therapy uses the art medium as a tool through which personal conflict can be revealed and addressed. The 'art in hospitals' organisations aim to enhance the environment and improve health. Amongst the groups there are differences. Arts for Health criticise artists for their inability to communicate in a 'basic language'. In contrast patients involved in Hospice Arts projects recognise that artists depict 'things that matter' although it is in a 'basic language' that they do not always understand. One project attempts to speak in a familiar, undemanding visual language, while the other acknowledges the power of an unfamiliar, dense vocabulary.

All the above activities, except those of Hospice Arts, take place outside the art mainstream as *'mainstream contemporary art is frequently perceived as being far removed from the concerns of the public'* (Kelly 1984). It is suggested that art which involves the public must have different qualities to mainstream art. However, there is a tradition of mainstream artists involving others in their work. The Apprentice and Atelier systems enabled a pupil to learn by following the practice of a senior. Today a number of artists involve the public as an essential component in their work, including Anthony Gormley who invited groups to make the figures in 'Field' (Hutchinson, Gombrich & Njatin, 1995), Stephen Willats who designs a new art language for public interaction (Jones, 1994, Kearton, 1996) and Gillian Wearing who invites the public to collaborate in photographic projects (Savage, 1994, Bonaventura, 1995).

'New Genre Public Artists' (Lacy, 1995) specialise in involving the public in their work to facilitate social change. New genre practitioners address the problem of the artist's role in society, and aim to make works which are of more value than *'just another class of consumables'* (Gablik, 1995). New Genre theorists note that a public art based on bureaucracy and capital has lost *'the visionary potential of public art, its ability to*

generate social meaning' (Lacy, 1995). The aim is to revive this capacity and to *'understand the essential intertwining of self and other'* (Gablik, 1995) by involving the public in making art.

'It reconnects culture and society and recognises that art is made for audiences, not for institutions of art.'

(Jacob, 1995. p.54)

Jacob (1995) argues that new genre practices present a threat to cultural institutions as the expected individual ownership, and sometimes authorship, is absent. The art cannot be collected or bought because it is owned by many. The involvement of the public is thought to threaten the elitist or exclusionary conventions of art establishments who believe that works which engage the public must, by necessity, use a less sophisticated vocabulary or lack universality.

'Perhaps the greatest fear is that elitism will be destroyed, that the function of art will once again be recognised, that freedom of expression will carry the impulse and stark beauty of our first breath, and that our own relevance as human beings will come to be seen in the meaning of our acts.'

(Conwill Mäjozo, 1995, p.90)

New genre practices involve the public but the product is intended to communicate with a clarity equal to works made by a single artist. Neither these practices, or the participatory fine art practices described have previously been used in healthcare.

Currently, art is used in hospitals as a tool, either for transference and analysis or as a means of encouraging a sense of community, to improve the clinical environment, or as diversion or 'pastime'. No activity is utilised which involves making art for its *'ancient purpose'* (Hamilton, 1991) as visual vocabulary, and as substantial activity beyond therapy. A variety of practices resemble art but do not fulfil the same purpose. While art may have a therapeutic function, this is not the only way to measure its value. As the art in health projects evaluate the health benefits for the patients, rather than the communicative significance of the activity, the collaborative art processes described above may provide a preferable model for evaluating significance.

People with life-threatening illness receive palliative (*to cloak, or disguise*) rather than curative treatment, enabling them to experience maximum possible quality of life and to maintain a sense of meaning at a critical time. When time is short, activities to 'divert' and 'pass the time' may not be relevant. Rather, an activity may be required which can imbue the moment and the future with meaning. No art-related activity used in palliative care fulfils this requirement at present. The following reviews the palliative care literature to describe the situation faced by seriously ill patients.

1.3. Literature Review: The Importance of Making for the Seriously Ill

If making has a vital function in life then when there may be little life left this may be when the most significant of activities is needed. When time becomes most precious and life presents the most final of problems, the need for making may be more urgent and acute.

Patients who can no longer be offered a cure are often given palliative care, a specialist branch of nursing and medicine. Palliative care is:

'The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anticancer treatment.'

Palliative Care:

- affirms life and regards dying as a normal process;*
- neither hastens nor postpones death;*
- provides relief from pain and other distressing symptoms;*
- integrates the psychological and spiritual aspects of patients care;*

-offers a support system to help patients live as actively as possible until death;

-offers a support system to help the family cope during the patient's illness and in their own bereavement.'

WHO definition.

(Scottish Partnership Agency for Palliative and Cancer Care, 1995, p.vi)

People who face life-threatening illness may undergo many changes. Palliative care seeks to maintain or restore quality of life throughout these changes. Frequently the parts of life which change are of personal importance which may only become apparent when lost. People who can no longer expect cure from medical intervention may experience '*multiple losses*' (Frampton, 1985, 1986). They can no longer work, their role in the family may change, as may their appearance. Occupation, role and appearance are part of the construct of identity, and the '*loss of self*' (Charmaz, 1983) impacts on the person;

'As his or her personal sense of identity may well have been tied up with many of the things which have been lost, there may cease to be much obvious reason for staying alive.'

(Frampton, 1985, p.103)

Repeated stays in hospital may also challenge the perception of self and the diagnosis of a medical complaint may result in the restructuring of identity (Aldridge, 1996). The construction of an individual's gender may also be affected, either through the impact on the ability to perform certain tasks, or through a direct effect on a particular part of the body, as in breast cancer,

'In facing a potentially fatal disease, a woman also faces the loss of a precious part of her body that is deeply embedded in her sexuality and femininity'

(Aldridge, 1996, p.218)

The lack of physical strength and mobility resulting from serious illness may have a profound affect when the individual becomes reliant upon others, so experiencing a diminished sense of competence and control. Movement and function are an '*expression of will*' (Preece, 1990), therefore a sense of autonomy may be lost. A changed relationship to the body may be experienced, the '*integrity*' (MacNamara, 1997) of the body challenged, being no longer perceived as whole or reliable.

Not only do multiple losses affect perceived self-worth, they may also remove the individual from social contact, resulting in isolation. This is exacerbated if the individual suffers pain, which may prevent focus beyond the body. Scarry (1985) and later, de Zegher (1998) describe how the inexpressible nature of pain removes the individual's ability to speak about it;

'Since the voice is a final source of self-extension beyond the boundaries of the body in a much larger space, inflicted pain and blanks in speech contract the universe down to the immediate vicinity of the body or swell the body to fit the whole universe. World, self and tongue are lost through the annihilating power of pain.'

(de Zegher, 1998, p.9)

Pain disassociates the individual. According to Scarry, when means are found to objectify or to express pain, some of its aversiveness may diminish. In de Zegher's (1998) essay on the work of Nancy Spero, she suggests that through art Spero aims to objectify pain (both her own and that of others) to diminish it. While Scarry explores how the expression of pain can reduce it, Sontag (1991) dissects the popular moral that illness, especially cancer, develops due to individual repression of communication and creativity.

The accumulation of multiple losses may result in the loss or change of identity, consequently the individual may have difficulty finding meaning in life, prompting self-examination:

'The physical and emotional challenges faced by terminally ill people, their diminishing social contacts and ability to perform customary roles, raise perhaps the most the difficult question of all: who am I?'

(Stanworth, 1997, p.19)

The seriously ill person may find that the elements of life that constructed identity and that gave it purpose and meaning, such as work, are lost. Here meaning is defined as,

'Having a purpose or intent, to have formulated some value(s) that determine actions and imparts a significance to life.'

(Edwards, 1993, p.326)

Meaning suggests that life will continue to have value in the future and that the value of life will continue to be affirmed. Meaning is thus related to hope; hope is *'the expectation of some good in the future that is personally meaningful'* (Scanlon, 1989). Factors seen to foster hope include *'interpersonal connectedness, lightheartedness, attainable aims, a spiritual base, uplifting memories, affirmation of worth and personal attributes'* (Herth, 1990). Camus (Gablik, 1991) considered that humanity could not live without a sense of meaning;

'I have seen many people die because life for them was not worth living. From this I conclude that the question of life's meaning is the most urgent question of all.'

(Gablik, 1991, p.29)

Meaning is vital. Frankl (1984) considers that *'the striving to find meaning in one's life is the primary motivational force in man'*, described as a *'will-to-meaning'*. Believing this to be a primary force more than Freud's *'pleasure principle'* or Adler's *'will-to-power'* (Frankl, 1984). Frankl explains that striving to build meaning is an essential task;

'What man needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task. What he needs is not the discharge of tension at all cost but the call of a potential meaning waiting to be fulfilled by him.'

(Frankl, 1984, p.127)

People with life-threatening illness are experiencing the difficulties all must face, but at their most acute. The loss of meaning may be profound. Art is an activity which seeks and makes meaning, hence art should be valuable for people who face death. The immediate knowledge that death approaches may lead the individual to seek meaning for that situation;

'In pondering death, the agony of self-hood is not endurable for most of us without resources, be they transcendental, inspirational or existential.'

(Feifel, 1990, p.541)

What is proposed is not a new therapy specifically for the seriously ill, but a means of discovering the significance of making for all people through an examination of the needs of those who face a shortened life. The following section presents a review of theory concerned with art as a vital, as opposed to a pastime, activity. The theory explores the significance of art, which then provides a framework for the exploration of patient response.

1.4. Literature Review of Theory: The Substantial Nature of Art

The significance and value of making, *'the fitting of natural substances to human wants'* (Fischer, 1971) has been the subject of lengthy historical debate. 'Making' encompasses a range of activities including both employment and leisure activities, and mechanical, electronic and manual methods of production. However, the term usually implies some physical engagement with a medium.

The term *'significance'* refers not only to *'importance'*, *'worthy of consideration'*, but also to the capacity for meaning to be communicated; *'that which carries a meaning'*, *'indicative'*, *'sign'* (Chambers English Dictionary, 1990). In reference to art, Barthes (1976) emphasises that meaning does not lie in literal translation, but in the experience created; *'what is significance? It is meaning, in so far as it is sensually produced'*.

Making art may involve similar processes to the production of utility items and in earlier times the distinction between art and other objects was less clear (Arnheim, 1992). However, while the goal of industrial making is now to produce multiple utility goods, the aim of making art is communication. The means of making art is part of its vocabulary so 'making' is of fundamental importance. Arnheim suggests that art remains the only arena where the meaning invested in objects through making continues to operate:

'In a world like ours in which objects, limited to practical function and endowed with artificial values, no longer speak, works of art require a special dispensation to do their duty.'

(Arnheim, 1992, p.14)

The significance of making has been explored by artists and theorists and many describe art as a substantial activity, rather than as entertainment or novelty.

'The end of art is as serious as that of all beautiful things- of the blue sky and the green grass, and the clouds and the dew. They are either useless, or they are of a much deeper significance than giving amusement.'

(Ruskin, 1905a, p.144)

By comparing art with the sky and the grass, Ruskin implied that art has a vital, life-sustaining value for humanity beyond 'amusement'. Ruskin also gave specific examples of what he considers to be the purpose of art,

'To stay what is fleeting, and to enlighten what is incomprehensible, to incorporate the things that have no measure and to immortalise the things that have no duration.'

(Ruskin, 1905b, p.62)

Morris, like Ruskin, considered art to be of vital importance. He stated that if humanity is prepared to live without it then it must be '*content to be less than men*' (Morris, 1883). Ruskin and Morris were associated with the Arts and Crafts Movement, an organisation which aimed to introduce a creative approach to daily work,

*'The democracy of art, the ennobling of daily and common work,
which will one day put hope and pleasure in the place of fear and pain.'*
(Morris, 1883, p.112)

The Movement considered that to unite art with industry and to re-establish making as a beneficial part of life would provide the lives of people with meaning, since removed by division of labour and new industrial practices (Morris, 1883). The Movement intended to reduce the separation between art and work. Industrial manufacture approached with the care and attention required of a work of art would enable the worker to experience reward; while the artist's work would be recognised to be as necessary as the labour of the industrial worker.

Ruskin saw this new vision of manufacture as a '*higher economy*' (Triggs, 1971) where the product is vital not financial. The Arts and Crafts Movement perceived in 'work' as 'art' '*the grand cure of all maladies*' (Triggs, 1971), proposing that purpose and identity were essential to the health of producers,

'Life is energy, we feel ourselves only in doing, and when we enquire what a man's value is, we ask what is his performance- to do nothing is to be nobody.'

(Spalding, in Triggs, 1971, p.180)

The Movement aspired to return to the methods and philosophy of craft guilds (Black, 1984), where art was produced collectively and was inseparable from the production of utility objects. This emphasis on the value of work may seem irrelevant in the changing workplace of post World War II Britain. However, in more recent studies, the value of work and its relationship to health is maintained. Littler (1985) states that,

'For many people (though certainly not all) paid employment acts as a psychic glue; it holds an individual together in terms of aim, purpose and identity.'

(Littler, 1985, p.2)

Fischer (1971) substantiates Ruskin's argument by describing how art fulfils a human need. Unlike the Arts and Crafts Movement, however, Fischer states that art and work

are not the same. Although both are *'purposive activity'*, art enables the individual to experience the universal:

'The permanent function of art is to recreate as every individuals' experience the fullness of all that he is not, the fullness of humanity at large.'

(Fischer, 1971, p.223)

Through the unique capacity of art to refer to *'something which is more than 'I''* Fischer recognises works of art as *'moments of humanity'*, reaching beyond the contribution of the individual. Dissanayake (1995) agrees, describing art as *'a vehicle for group meaning'*, and the practice of art as *'making experience special'*. Aldridge (1996) sees art (in this case music) as a way to connect the individual with the whole. He describes the problems which ensue when individuality is valued, but *'exhausted of significance'* when disconnected from society.

Scarry (1985) considers the vital quality of art to be social and at one with other made objects when exploring the value of making. Scarry proposes that the body of the maker is projected into the object in its construction, purpose and material. Thus fabric is a materialisation of skin, as a photocopier is memory. This confirms the Arts and Craft Movement's proposition that making is conducive to a sense of identity and health. As in Scarry's theory, the identity of the maker and humanity in general, is visible and recorded in the made object. The benefits of making are further explored in an analysis of the word, *'work'*. Scarry (1985) credits the manufactured item with the ability to communicate,

'It consists of both an extremely embodied physical act (an act, which even in non-physical labour, engages the whole psyche) and of an object which was not previously in the world... a sentence or a poem or a paragraph where there had been silence.'

(Scarry, 1985, p.170)

Both Scarry, and later de Zegher (1988), trace the historical meaning of *'work'* noting that the term is a *'near synonym'* (de Zegher, 1998) for both labour and the created

object. By suggesting the projection of the maker into the object made, Scarry proposes that the body itself is remade,

'The now free-standing made object is a projection of the live body that itself reciprocates the live body; regardless of the peculiarities of the object's size, shape or colour.'

(Scarry, 1985, p.280)

The projection of the maker into the made object causes the object to reciprocate and 'feed back' not only to the maker but at large. Through the made object, including that mass produced, 'the collective human salute' is transmitted,

'The object is only a fulcrum or lever across which the force of creation moves back onto the human site and remakes the maker.'

(Scarry, 1985, p.307)

As reciprocal communication becomes magnified, so what is transmitted by the object becomes greater than that projected into it. Not only the maker but all humanity is in receipt. Scarry (1985) refers specifically to the function of art in relation to the function of other objects. She states that objects only exist for the purpose of recreating our general or specific (as in art) signature, but that reciprocation is for humanity rather than only the maker.

The distinction drawn by Scarry (1985) between what is called art and other objects is that in art the signature is that of the individual maker. The maker sees his/her identity reflected while in the mass-produced 'non-art' object the reflected identity is that of humanity. Aldridge (1996) also explores the relationship between the body and art, describing the latter as '*embodiment of culture, corporeality of expression*'.

Scarry (1985) describes how, through artefacts, the presence of the individual is recorded, allowing it to '*inhabit a space much larger than the small circle of his immediately present body*'. Thus making reaches beyond the boundaries of the body, as in Browning's dictum, '*that a man's reach should exceed his grasp*' (Hunter, 1996). Through the artefact the individual is recorded but also projected into the social;

'moving beyond the boundaries of his/her body into the external, shareable world' (de Zegher, 1998). Marx recorded how the embodying of the individual in the object enables that individual to be extended (Scarry, 1985).

'The made world is the human being's body and having projected that body into the made world, men and women are themselves disembodied, spiritualised.'

(Scarry, 1985, p.244)

The function of objects, as communicator of identity but also extending beyond the individual, is explored by Ashford (1998) in a practical analysis of dominant museum practices with art students:

'We talked about how our possessions build our identity by objectifying our ongoing invention of memories. By presenting the photos to each other, the students exposed their constructed selves and experienced a transcendent notion of identity that is prepared to live beyond its material life. This was understood literally as our possessions survive our passing, and figuratively, as the formation of a description that will always precede us. In other words, objects both outlive and describe the subject.'

(Ashford, 1998, p.33)

Thus the process of making and the ensuing reciprocation is declared to be of fundamental human importance. This contrasts with Marx's analysis of capitalism where individuals are involved in the manufacture of objects but, being denied reciprocation, are alienated. In art the vital reciprocation between maker and humanity remains.

The significance ascribed by Scarry (1985) to the relationship between the made object and the body verifies Nietzsche's concept of art as an *'affirmation of life'* (Alcopley, 1994). Like Scarry, he links the act of making with physiological force. He describes art as a conduit through which vital physiological passions such as desire and will are propelled as *'an outflow of blooming corporeality'*. Likewise, Aldridge (1996) describes how art forms a channel between body and society, *'meaning provides a*

bridge between cultural and physiological phenomenon'. Williams (Fuller, 1988) also notes that the relationship between art and the body is significant,

'art work is itself, before everything else, a material process; and that, although differentially, the material process of the production of art includes certain biological processes, especially those relating to body movements and to the voice, which are not a mere substratum but are at times the most powerful elements of the work'.

(Williams, in Fuller, 1988)

Like members of the Arts and Crafts Movement, Joseph Beuys considered art to be the key to the *'survival of mankind'*, suggesting that art is necessary for the maintenance of health (Shaw & Wilkinson, 1996). Beuys used an expanded definition of art, believing that all activity is *'social sculpture'*, shaping the environment to the needs of humanity: *'every human work has to be seen as a kind of art'* (Kuoni, 1981).

Art as the search for meaning and its creation (Gordon, 1978) is further connected to well-being by Jung (Gablik, 1991):

'Meaninglessness inhibits fullness of life and is therefore equivalent to illness. Meaning makes many things endurable-perhaps everything.'

(Gablik, 1991, p.29)

If art is a meaning-making activity, then it is suggested that it has an important role. Jung considered the *'search for meaning'* (Gordon, 1978) to be an instinct, while Gordon refers to the instinctive desire to *'make it (the discovered meaning) flesh'*. Collingwood declares that art has a purpose for the health of the community rather than the individual; *'medicine'* for *'the community'* (Lewis, 1995) and assigns artists a special responsibility,

'It is their business to tell the audience at the risk of their displeasure, the secrets of their own hearts....every work of art will contribute to the well-being of the community by bringing to light what people might wish to neglect or disdain.'

(Lewis, 1995, p.215)

More recently, the relationship between art and health has been investigated in the field of psychoneuroimmunology. It was found that the involvement of patients with disorders of the immune system in '*positive envisioning*', a technique using drawing to record visions of their cells, may result in a significant increase in cell numbers (Achterberg, 1985, Wood, 1995).

The substantial nature of art is indicated through different arguments. Art is credited with the capacity to connect the individual with others and to allow experience of the universal by the communication of the '*collective human salute*'. Art enables the individual to aspire, to be metaphorically extended and elevated by projection into an object which acquires an existence beyond the maker. Through art, meaning is sought and made flesh, and vital forces which epitomise what it is to be human are transmitted using visual vocabulary. In addition, art, like work, is credited with maintaining the identity of its maker; the individual is manifest in the made object. The capacity to reinforce identity, and to forge meaning in the life of both individual and community indicates the relationship between art and health¹. However it is Ruskin's comparison of art with the sky and grass which most succinctly presents the vital nature of making. These natural essentials have importance beyond good health. They signify survival and the meaning and significance the individual and the community finds in life. No empirical research based on these theories has yet been published.

¹ The definition of health is under constant debate. Fulder (1995) describes the most frequently used definitions. The definition used here is the WHO model; '*a state of complete physical, mental and social well-being*'

1.5. Aims of Study

In Chapter One the substantial, life-giving function of art is explored through an appraisal of relevant literature. The notion of art as a serious, as opposed to a pastime, activity is raised. It was decided to explore these theories and address the value of art in a hospice setting, through practical experiment. Life-threatening illness challenges identity and consequently the meaning an individual may find in life. By involving people who can no longer work in making art, the need to make, and the relationship between making and identity can be explored. The discipline employed is sculpture. Sculpture requires an involvement with materials and an investment of physical energy; it demands a relationship between the body of the maker and the material. The practice of sculpture may involve materials, processes or routine in common with industry, enabling the need for purposeful occupation to be explored.

There is an historic tradition of monumental sculpture. Sculptures made in long-lasting materials record the life and authority of deceased illustrious figures.

‘Commemorative figurative monuments in their imperishable materials of stone, bronze or steel appear to guarantee eternal fame, while reminding the spectator of their mortality’.

(Ades, 1995, p.56)

The memorial function of sculpture may be significant for those who recognise life will be short. The uses of temporary and permanent sculpture mediums will explore the capacity of art to *‘stay what is fleeting’* and to *‘immortalise the things that have no duration’* (Ruskin, 1905b).

Through this research substantial activity will be introduced to health-care to explore its significance. The capacity for art to be *‘of much greater significance than giving amusement’* (Ruskin, 1905a) will be evaluated in a hospice setting. This activity is new to palliative care and its aims are:

1. To establish the extent to which sculpture is a significant occupation, as opposed to a pastime, for people with life threatening illness.
2. To generate sculpture. Methods of engaging people in this practice will be developed, and their perceptions of its value explored.
3. To establish the relationship for the patient between the act of making and identity.

The following chapter describes the methods used to fulfil the aims. After this, description and analysis of the initial making period follows, allowing early hypotheses concerning the significance of making sculpture to be formed. As a result of findings, further sculptures are made and their progress documented, enabling conclusions to be drawn regarding the relationship between making and identity. The final chapter draws ultimate conclusions and makes recommendations.

Chapter 2

Method

2.1. Introduction

To examine the possible vital nature of art, people with life-threatening illness were invited to take part in making sculpture. A suitable site and an appropriate study group were selected. Established qualitative research methods were considered to enable a systematic exploration of patient participation and opinion and to collect the opinion of art professionals. A number of research questions were defined, enabling the more penetrating research aims to be met (Table 2.1).

Table 2.1. Research Questions

I.To what extent do the patients value making sculpture? How much time do they commit and what reasons do they give?
II. What is the patients’ perception of the longevity of the materials used in sculpture?
III. To what extent do patients ‘make themselves’ when they make sculpture?
IV. How significant do patients find the relationship between sculpture and occupation?
V. Do patients develop a visual vocabulary and in what ways is this of value to them?
VI. Do patients perceive any difference between the activity of making sculpture and taking part in other art-related activities?

The aims of the research are described in Chapter One. Questions I, II, III, IV, V and VI are used to realise Aim 1, Questions II and V are used to achieve Aim 2, and Questions III, IV, V and VI are used to fulfil Aim 3 (Appendix 1, Table 1).

2.2. Research Site

As the research involves making art with people who face death hospices were chosen. The chosen site was required to provide access to a range of seriously ill patients from which the study group could be selected. The required site should provide a suitable sculpture studio larger than ten square metres, with washable floor-coverings. It should not be used for other purposes. The site should be no more than ten miles from firing facilities for ceramics to enable movement of materials and delicate work. Academic support in the field of palliative care, interest in the project and assured support throughout was needed.

The Liverpool Marie Curie Centre (LMCC) was chosen because the Centre demonstrated interest in, and commitment to, the research. The LMCC is one of eleven units in the Marie Curie organisation, which is a network of centres providing medical, social, psychological and spiritual support for people with serious illness, predominantly cancer. The LMCC has out-patient, day-patient and in-patient services, thus fulfilling the need for access to a range of patients. The Centre was only able to provide a multi-purpose work space, already used for craft activities with day-patients. The building was designed and purpose-built in 1992 and despite negotiations with management, a facility for serious art work could not be provided. Space would influence the nature of the developing work, reflecting the environment in which it was made. However, the commitment and academic support of the Centre was essential. The LMCC and the art facilities at Liverpool Art School (LAS) were chosen as joint sites of research.

2.3. Study Group

LMCC in-patients include those who are in terminal stages of illness, who are too ill to be cared for at home or who have come to the Centre for respite for themselves or their carers. The out-patients attend a clinic for therapies and consultation with doctors. The

day-unit facility provides a social environment where people with cancer, who live at home, can meet other patients and receive support. Day-patients also have access to out-patient services. All patients receive palliative care.

As in-patients would be too ill to participate, the day-patient group was selected. Day-patients live at home, alone, or are cared for by family. Day-patients, with the occasional exception, can no longer work due to illness. As the study was concerned with the relationship between work, or making, and identity, the patients inability to work was pertinent, allowing the value of art as purposeful occupation to be examined. There was an already established pattern of group attendance in the day unit, which provides care for a maximum of ten people per day. Most attend weekly. The groups include men and women except on Tuesday when only men attend and Wednesday with only women. As the research concerned the relationship between making and identity it was decided to study the two single-sex groups. Male and female work experiences would be likely to differ and would vary in relation to the identity of the individual. The importance of making for men and women might differ. The majority of patients were aged between thirty and eighty.

The composition of the day-group would change with time due to death, ill-health, de-referral or because patients no longer wished to attend. Thus the research design required flexibility to allow for a changing population. The method needed to enable data collection at regular intervals, to maximise the amount of information which could be gathered in a short period.

Before experiment could begin permission from two ethical committees was obtained. Liverpool John Moores University (LJMU) gave formal consent on 13 October, 1995. The Royal Liverpool University Hospital Ethics Committee gave formal approval for research when further information on patient evaluation methods was provided, on 15 November 1995.

2.3.1. Patient Inclusion

All patients in the Tuesday and Wednesday day-groups were invited to participate in the research. There were no inclusion or exclusion criteria. The patients who took part were self-selecting as the desire to participate was to be one measure of the value of the activity. Prior to project inception, written information describing what the study would involve was issued to all patients. However, owing to the rapid change in group composition, and patients' frequent disinclination to read, standardised verbal descriptions were more effective. These were given to every new day-patient.

Initially a LJMU research subject form was used to obtain informed consent from the patients, as traditionally recommended by Institutional Review Boards (Rubin & Rubin, 1995). The form explained that patients were free to refuse and that confidentiality was assured. However, the literature suggests that the written consent form may be inappropriate in some qualitative research as data collection methods may change as the study progresses. It may not always be appropriate or possible to tell the subject all that the research will involve (Punch, 1994). In addition the 'formal' and 'legal' quality of the consent form may confuse the subject and disrupt the research (Rubin & Rubin, 1995). Indeed, Reiss (1979) notes that formal consent may reduce participation. In addition, patients' concerns about commitment might discourage them from participation. Patients who might gradually become involved might be discouraged by the form, fearing they were not skilled enough to commit to taking part. Accordingly, instead of written consent, verbal consent was required before any participation. This followed the verbal explanation of processes and methods to be used.

2.4. Design of Sculpture

The initial ideas for sculptures were developed by the researcher to ensure that the patients would be introduced to art which reflected the aspirations of an artist. This would inform the patients’ understanding and expectations. Table 2.2 shows the criteria for sculpture determined by the researcher.

Table 2.2. The Criteria for Sculpture determined by the Researcher

Criteria for Sculpture
1. The content of the sculpture will be determined by the researcher as a result of contact with the patients. The initial subject will be relevant to the patients, but through making led by the researcher, the works will gain depth and richness beyond the subject.
2. The degree of craft skill required will be determined by the researcher. The less refined craft skill of the patients will be utilised as elements of vocabulary. Where patients have craft skills learned in other disciplines they will be encouraged to use them. The skill involved is ultimately the researcher’s ability to utilise the patients’ existing craft skills. Through making the visual vocabulary of the patient may develop.
3. Precise presentation with consideration to context will ensure that sculpture is understood as visual language, rather than pastime or therapy.

An initial pilot (Janesick, 1994) study involved the design of three sculptures (Phase 1). Following this, new sculptures (Phase 2) were designed in response to discoveries in the first phase. Each sculpture developed as a result of issues raised by the previous work and patient responses to it. This is consistent with methods employed by most artists, who ‘problem find’ in order to propel one work into the next (Getzels and Csikzentmihalyi, 1976). The constant appraisal of previous works to develop new ones is consistent with ‘reflective’ research practice (Schon, 1983, Smith, 1994, Stake, 1994). Stake clarifies his use of ‘reflective’ by preferring to call it ‘interpretive’, to emphasise that it is not merely observing, but creating, meaning. As the development of new sculpture involves interpretation or analysis of the former, Stake’s term is most accurate.

2.5. Introducing the Project

Once the collaboration with the Liverpool Marie Curie Centre was established, preliminary contact with patients was made. The researcher attended the day unit every day for one week, beginning 16 October, 1995, to gain understanding of the environment. The project was introduced in detail to the chosen male and female groups as described in Section 2.3.1.

The researcher described to the groups how help was needed to make sculpture and that any assistance offered was welcome. A description of possible materials and themes was given. A selection of slides of the researcher's previous sculptures gave an indication of the themes and processes which might be used. The patients were presented with an initial design for the first sculpture. The first design was given to define the degree of ambition the sculptures were to involve, and to establish that the aim was to make significant sculpture, as opposed to giving a therapeutic experience. The patients were invited to employ their varied experiences and skills in the making of sculpture. Design of sculpture was to remain the concern of the researcher although varying degrees of responsibility were devolved to patients to explore how much they wanted to affect the meaning of the sculpture. At various stages the patients were given decisions to make which would affect the final work.

A flexible approach to making sculpture was taken to encompass the abilities of the rapidly changing population. Patient health would determine the speed at which sculpture could be completed, the scale and mediums used, and how the workspace was used.

2.6. Methods to Determine the Value of Making

In traditional research, methods are used to ensure that an experiment can be repeated and the outcomes will be consistent. In this study, the methods may be repeated but the outcomes need not be the same as it concerns the responses of a small group. In this case study approach (Stake, 1994, Huberman & Miles, 1994), the designing of sculpture by the researcher with patient participation was a subjective process (Reason & Rowan, 1981). Although no other artist would or could make the same sculpture, the methods of making and development of ideas were recorded so to become evident. In addition, the responses of a particular group of day patients at a Liverpool Marie Curie Centre would not produce theory which could be applied generally. In this instance the research was an '*instrumental case study*', the examination of a particular case '*to provide insight into an issue or refinement of theory*' (Stake, 1994).

It was recognised that sculpture would evolve as the project progressed. Patient participation would be affected by the researcher's actions and the design of new sculpture would be affected by patient participation. Hence methods to record this reflective or interpretive practice of '*ongoing monitoring and feedback*' (Webb, 1996) were required. The researcher took the position of 'participant-as-observer' (Liptrot & Sanders, 1994) or 'practitioner as researcher' (Schon, 1983), making sculpture with patients and also recording responses. This enabled the researcher '*both to understand the situation and to change it at the same time*' (Schon, 1983).

As a new activity was to be introduced to the day-care patients, 'participative inquiry' (Reason, 1994, Oleson, 1994) methods were surveyed. 'Co-operative inquiry' (Reason, 1994) was not a suitable model because the patients were not to be co-researchers, but were guided by the researcher. In this study, the participants would be involved in making art, but not in the research methods. Payne (1993) notes that participatory

research is not the most appropriate term to describe relationships in arts therapies research. Rather,

'Interdependent research might be a more appropriate claim to make or aspire to than participatory research. It suggests a differentiation of roles...a two way exchange with different rewards for both groups.'

(Payne, 1993, p.28)

As patient and researcher do have different roles in this research, Payne's *'interdependent research'* is a more appropriate description. The difficulty of finding established methods for research in art practice is recognised (Payne, 1993). However, ethnographic researchers like Janesick (1994) compare the problem of research design to the process of art, noting that both *'force us to think about how human beings are related to each other in their respective worlds'*.

Methods to evaluate the importance of making to the patients were needed. Patients might find making pleasurable but gratification could not be used as a measure for meaning, as pleasure does not necessarily equate with significance or importance. In capitalist systems currency is the measure of the value of an item or a service. For the patients time is a precious currency, therefore their willingness to spend, as opposed to pass, time was a prime measure of value. It was recognised (in conversation with patients) that they did frequently engage in activities to 'pass' the time. Therefore, patient verdict of the activity was used to differentiate between time 'passed' and the commitment to 'spending' time. A number of methods were needed to obtain patient response and to ensure validity. Denzin (1996) states that triangulation, or the use of multiple methods, is not a tool or strategy of validation but an alternative to it:

'The use of multiple methods, or triangulation, reflects an attempt to secure an in-depth understanding of the phenomenon in question.....The combination of multiple methods, empirical materials, perspectives and observers in a single study is best understood, then, as a strategy that adds rigor, breadth and depth to any investigation.'

(Denzin & Lincoln, 1994, p.2)

The triangulation involved in this study is data triangulation and methodological triangulation (Denzin, 1994, Janesick, 1994). How each method addresses the research questions and ultimately the aims is reported and summarised in Table 2.3.(Appendix 1).

2.6.1. Observation and Record

The time patients were prepared to commit to making was the most reliable indicator of the importance of the activity. How many patients participated, how long they took part, extra time committed outside of the Centre and desire to persist were indicators of value. These factors were recorded in a diary. Immediately after each workshop the number of patients who attended the Day Centre and the number who participated in making was noted in the diary (Barker, 1996). Comments by patients pertaining to the activity were recorded. These were not predetermined by categories of measurement or response such as observational rating scales (Barker, 1996) as it was uncertain at the outset what response was sought. Rather, *'concepts or categories arising which appeared meaningful to subjects'* (Adler & Adler, 1994) or the researcher were noted. As a 'participant observer' (Liptrot & Sanders, 1994) or 'interdependent researcher' (Payne, 1993), the researcher understood that observation is not objective, although the recording of attendance times and numbers was an objective indicator. The researcher was not only a participant but her actions also influenced those of the group. Lipson (1991), Fontana & Frey (1994) and Holstein & Gubrium (1994), describe this approach as 'reflexive',

'(referring to observers/interviewers being part of, rather than separate from, the data and exploiting self-awareness as a source of insight).'

(Lipson, 1991 p.75)

Possible problems in participation such as physical impediment, lack of co-operation from staff or patient and lack of desire to take part were documented. Diary entries noted the mood of the participants and recorded impromptu comment from patients, staff and volunteers. The diary was also used, with studio notebooks, to record significant changes in the sculpture and the patients' growing understanding. Continuation and completion of the research was dependent on collaboration with the Centre. Periodic negotiation with staff to change conditions, or to work collaboratively towards specific projects and events, often for publication, were recorded in the diary as insight into how art intervention in health-care may proceed. Information recorded in the diary was not coded but was later subjected to coded content analysis (Benton, 1996) throughout Phases 1 and 2. Diary notes were referred to throughout the making period to monitor progress and to enable reflectivity.

2.6.2. Photographs

Weekly photography recorded work in progress. The researcher took photographs of patients as they participated. Approximately five photographs were taken per session. The photographs provide a record of the environment in which the work was made and how the patients worked in it. Some photographs give an indication of the relationship between researcher and patient. However, most do not include the researcher as she was using the camera. This gives an inaccurate picture of the group, suggesting that they are always working independently of the researcher. It was intended that patients would assist by taking pictures, but none felt able to. Ultimately, photographs of patients were omitted from the thesis for confidentiality. The progressive construction of the sculptures and the works when complete are documented and included in the thesis.

2.6.3. Gathering Opinion

The opinions of patients and art professionals were required at key stages. The observation of patient participation was combined with patient verdict of making to discover reasons for participation. Although questions were designed to be pertinent, patients would not necessarily have a fluent vocabulary with which to describe the new experience of making art. Stanworth (1997) describes a similar difficulty when patients seek to describe spiritual concerns. This was another reason why emphasis was placed on participation and commitment as a measure of value, with voiced opinion as supporting data. Appropriate methods for gathering opinion were selected as follows. Table 2.4 (Appendix 2) records when data collection took place.

2.6.3.1. Questionnaires

Questionnaires were used throughout the study to allow for anonymous responses and to avoid 'interviewer effect' (Parahoo, 1997). To introduce the researcher to the Centre staff and environment, a questionnaire was sent out to every member of staff in October 1995 (Appendix 3). The questionnaire enabled initial contact with a large number of people and generated a defined amount of data. Otherwise questionnaires were primarily used to gather responses to completed works.

In March 1996 the completed Phase 1 Sculpture was exhibited. A short self-administered questionnaire was designed to gather patient opinion (Appendix 5) to afford patients confidentiality and to avoid bias. Each questionnaire was accompanied by an explanatory letter which had the patient's name on it. The letter was to be removed before the questionnaire was returned. As there was a close relationship between the researcher and the patients it was crucial that patients responded anonymously (Rubin & Rubin, 1995). The questionnaire contained only open questions and did not use any rating or attitude measurement scales (Parahoo, 1997, Preece,

1994, Edelman, 1996) as it was not to be used for quantification. No systems were used to suggest vocabulary to patients since their choice of words rather than the frequency of prescribed words would be studied. The questionnaire was administered by post, two weeks after the patients visited the exhibition. As described by Parahoo (1997) a postal questionnaire was used so patients could respond in their own time and in comfort. A disadvantage of this method was that patients who have difficulty in reading may not be able to respond.

A short questionnaire was designed to gather the response of art professionals who visited the Phase 2 exhibition. This was a peer review enabling the quality of the sculpture to be gauged. A series of open questions was combined with a request to choose three words to describe the project. This would enable respondents to supply the vocabulary with which to describe the exhibition whilst also allowing quantification of the frequency of certain words. A semantic differential scale (Parahoo, 1997) to measure the perceived 'success' of the exhibition was used. It was recognised that 'success' would have different meanings to respondents, which would be apparent in their review of the exhibition in the previous questions. The semantic differential scale was used to provide an instant and quantifiable measure of the professional's verdict in combination with the open questions (see Appendix 7).

All responses were explored by content analysis (Benton, 1996, Denzin & Lincoln, 1994, Manning & Cullum-Swan, 1994), seeking key words or categories. After the frequency of key words was examined, greater attention was given to the context in which the respondent used them. Barker (1996) reports that the commonest problem with questionnaires is low response, particularly 'blunt refusal' to respond. Questionnaires may be perceived as official, which can dissuade response, or prevent frankness (Parahoo, 1997). In this study, therefore, questionnaires are used to generate anonymous data to support interviews, rather than being the prime data creator. While such questionnaires remove 'interviewer effect' bias, they also limit the richness of the

data to be collected (Parahoo, 1997). Therefore, semi-structured interviews were the primary method of data collection.

2.6.3.2. Interviews

Structured interviews would generate no more depth of data than that collected in questionnaires (Parahoo, 1997, Barker, 1996). In addition, through observation it was noted that commitment to making differed from one patient to another, thus the same structured questions would not be appropriate for all the patients. Completely ‘unstructured’ (Parahoo, 1997) interviews were considered to be potentially lacking in objectivity and would make it difficult to compare responses (Parahoo, 1997). Semi-structured interviews would provide standardisation and some ‘flexibility to ‘probe’’ (Parahoo, 1997). The language used by the participants was important as associations and connections might be made which would not appear if the interviews were more strictly directed.

The researcher elected to carry out interviews in person. An external interviewer was considered but Centre staff advised that previous experience had shown this to be ineffective. The Centre found that patients were suspicious that negative comments might jeopardise their treatment, so were cautious. This adverse consequence is noted in the literature (Barker, 1994). It was acknowledged that the personal characteristics of the researcher, and her relationship with the patients, might bias the response (Sudman & Bradburn, 1974, Cartwright, 1986 [cited in Parahoo, 1997], Rubin & Rubin, 1995 and Payne, 1993).

‘Informants make judgements at many levels about what is safe and acceptable to tell researchers. At first they may judge the researcher in terms of such external characteristics as cultural background, age, gender and social status, obvious personality features and, perhaps, professional background. As

relationships deepen, the personality and culture of the researcher have more impact than 'externally obvious' characteristics.'

(Lispon, 1991, p.78)

The patients' experience of making would be inextricably linked to their perceptions of the researcher. There was no means of removing this from the researcher, therefore a qualitative approach was chosen to encompass it.

The familiar, close relationship that developed between the patients and the researcher allowed patients to feel comfortable and to give frank answers. In this situation it was not possible to separate the relationship between the patients and the researcher, so their familiarity was seen as a positive tool. As is noted by Parahoo (1997) *'trust' and 'give and take' 'brings people closer when they know that both of them have some experience of the same phenomenon'*. The researcher interview would also be more efficient since the subject area was familiar to both interviewer and interviewee. Explanation of techniques and other details would not be necessary. At the time of interview, the researcher would be sufficiently familiar with the patient that digression in the interview could be pursued and related to the central inquiry (Rubin & Rubin, 1995). To avoid making patients feel obliged to give a favourable report (Lipson, 1991, Payne, 1993, Parahoo, 1997) a verbal statement was issued requesting honest answers and describing how the outcome of the research did not reflect on the researcher (Barker, 1997).

Interviews were carried out in the day unit to encourage informality. If background noise caused difficulty a small, nearby treatment room was used. Interviews were recorded and transcribed the next day. Patients were free to refuse interview. For patient convenience the interviews were conducted over a two month period. A sympathetic, flexible approach allowed for occasional absence. One year after completion of Phase 1 interviews (February-March 1996), questions were repeated in Phase 2 (February-March 1997). This enabled comparison between the first group and a second. Over the year membership of the groups changed due to death, illness and

absence. Repeat interviews established whether or not patients new to the research shared previous perceptions.

It was anticipated that the sculptures in Phase 2 would demonstrate a progression from Phase 1. The project was designed to advance the sculptures from pseudo-reality, which had been the starting point. Interviews were repeated to see how opinions of the new sculptures compared with the first. The opinions of surviving participants from Phase 1, who continued to participate in Phase 2, were particularly important.

The semi-structured interview schedule was based on a list of questions. Questions were open, with a few exceptions to allow for some quantification. The questions were designed to allow for unpredicted themes to arise from patient comment, in a Grounded Theory (Glaser & Strauss, 1967) approach (Appendix 4). All data generated by interview were subjected to content analysis. Data were analysed through stages, as described by Rubin & Rubin (1995) and as in phenomenological methods, as described by Parahoo:

- '1. All interviews are transcribed verbatim and read in order to get a feel for them.*
- 2. Significant statements and phrases that pertain to the experience under investigation are extracted.*
- 3. Meanings are formulated from significant statements.*
- 4. Significant statements are organised into clusters of themes.*
- 5. The themes are used to give a full description of the experience.*
- 6. Researcher returns the description to its original source for confirmation of validity.'*

(Parahoo, 1997, p.355)

A full transcription was used to capture nuances of conversation and particularly word usage. The categories were not pre-determined but developed as coding took place (Rubin & Rubin, 1995). Coding was undertaken for themes, concepts and ideas (Rubin & Rubin, 1995).

The opinions of patients were gathered to determine whether they valued the experience of making and, if so, their reasons. A different semi-structured interview schedule was used in Phase 2 (Appendix 6), to determine whether sculpture recorded individual identity and whether they considered this to be significant. Patient opinion of the value and the longevity of the works was sought. Interviews were carried out after patients had visited the exhibition of Phase 2, in the same environment as for previous interviews. All interview data were subjected to content analysis.

2.7. Summary

Chapter One defined the study aims. Chapter 2 describes the methods to be used to fulfil the study aims. A study site was chosen, groups selected and given information about the project. Patient consent was obtained by appropriate means. Criteria for the design of sculpture were determined by the researcher. The time committed by the patients was considered the most reliable indicator of value, with patient opinion to substantiate. A flexible and sympathetic schedule for data collection, using a variety of methods, was necessary in the hospice context. Appendix 2, Table 1 records the timetable for the research.

The following Chapters present the results of the research. The initial intentions regarding each sculpture is recorded first and is followed by the patients' participation and the resulting changes in the sculpture, their perceptions of making, and opinion of completed sculpture. Data is used to examine the extent to which sculpture is a significant occupation, as opposed to a pastime, for people who face death.

Chapter 3

Phase 1 Sculpture

3.1. Introduction

Phase 1 was a five month period in which initial contact was made with patients attending the LMCC day-unit. The aim of this phase was to generate sculpture whilst discovering whether patients were prepared to commit to its making. Phase 1 consisted of making three substantial and three subsidiary sculptures. From an initial starting point of pseudo-reality, the sculptures were developed through a consideration of subject, scale, and the representation of individuality, as opposed to homogeneity. The participation of patients also affected the developing sculpture.

In Section 3.2. a description of the sample is given, followed by a record of the progression of the sculptures in Section 3.3. The design and making of the three sculptures is described as a continuous narrative, demonstrating how each sculpture evolved as a result of the previous. While each sculpture is described separately and chronologically, the planning and making of several pieces were frequently concurrent.

When patients were invited to give their opinions of making sculpture, and the completed works, they frequently referred to the entire body of Phase 1 rather than to individual pieces. Therefore, after the making of Phase 1 sculpture is analysed in Chapter Three, the patients' perceptions of making and completed objects are discussed in Chapters Four and Five.

3.2. Sample

All patients were invited to participate. The male group had ten members with ages ranging from early forties to over eighty. Of the ten men, one used a wheelchair, one

used walking sticks, and two could not move without assistance. There were five in the women's group and ages also ranged between forty and eighty years. Two women could not walk. The sample was a self-selecting group of patients who chose to participate. The self-selecting group gave informed consent after receiving information about the research. Membership of the day groups fluctuated over the Phase 1 period.

Whilst familiarity between the researcher, staff and patients at the Centre was being established, designs were developed for the first sculpture. From introductory contact it was apparent that the patients valued the opportunity to be with others, especially as some of them lived alone or could do little at home. Generally, activity was not a predominant factor in patients' reasons for attendance, but they valued contact with others as a stimulant. The patients expressed appreciation of the caring, comfortable Centre environment.

3.3. Beginning Phase 1 Sculpture

The initial intention was to make sculpture to be incorporated into the built environment of the Centre. The building was surveyed and possible sites were identified. The inclusion of the sculpture in the interior spaces presented difficulties. Firstly, an interior sculpture would not be possible because of the limited space and the ambient decor. Secondly, as the building was new anxiety was expressed by staff towards change. The building managers and architects were consulted. In view of the problems, any sculptural intervention in the Centre would have to be outside. The only space available was the courtyards. Other exterior grounds were not suitable, all space being designated.

The initial theme of the sculpture was intended to convey positive and negative associations. The subject matter would be familiar and of relevance to the patients. As

the relationship between occupation and identity was to be explored 'making' was chosen as an appropriate starting point.

3.3.1. Design

An anvil was chosen as the subject of the first sculpture and preliminary drawings were made. An anvil was chosen as a positive symbol, being the site where humanity shapes malleable metal, to fit its needs. However, the anvil also has the negative associations of tedious, exhausting labour and even pain. The anvil was seen to epitomise the 'reciprocation' of objects which Scarry (1985) describes, as the maker benefits from the object produced by the investment of labour. Nowadays anvils are becoming obsolete, reflecting the fate of trades some patients had pursued in youth. Indeed, the redundant anvil might also allude to the patients' inability to work. Although working on an anvil is traditionally a male domain, as a symbol of making, the women might also find it a relevant subject.

Having noted the patients' desire for company, it was decided to make a monolithic sculpture on which several patients could work simultaneously. The sculpture was based on an actual foundry anvil which had a purpose-built cast iron base. Therefore, a base was designed which was, like the plinths of Brancusi (Geist, 1968), integral to the work.

As the sculpture was to be sited outside, a strong, impermeable medium was needed. Ceramic stoneware was chosen. Clay work demands that the maker physically engages with it. Through its manipulation patients may exert their will. As patient perception of the act of making was sought, it was thought that clay would present the most direct and involving experience of making. Clay would also be an easy material for people with less strength to manipulate and control. When fired to a high temperature (stoneware) clay becomes impermeable and permanent. Rawson (1971) describes how

clay records every mark made in it, '*It thus becomes an external testimony to his (man's) existence.*' Hence the memorial function of clay might be of significance. The patients' opinions on the permanence of medium were to be sought.

The scale chosen for the sculpture was life-size, so that there was only one fundamental difference between an anvil and the sculpture; the anvil sculpture was made in brittle ceramic so could not function. A familiar subject matter had been chosen and depicted but it was not a replica. Through making, the sculpture would transcend its subject.

3.3.2. Making

During the making of *The Wheatfield* there was a fluctuating number of patients and membership of the groups changed over time. Attention is given to the numbers of participants in Section 4.1. Introductions were made to the chosen male and female group, followed by a presentation of the anvil design and a basic clay construction workshop. A discussion discovered each patient's previous occupation. From this point the sculpture of the anvil was constructed with varying degrees of participation by both male and female groups.

Following the occupation-related discussion of the first week, several of the men brought items to aid or inform the project, including a set of manual die-cutting tools and a drawing of shackles made in work. In conversation it became apparent that three of the men had been smiths in their youth. One woman was particularly interested in the clay, as she had an interest in archaeology, and brought in a collection of ancient ceramic pot sherds.

Pre-rolled slabs of clay were cut by the men according to prepared templates for the anvil walls. Brief experimentation with clay followed. The men were encouraged to sample different marks made in clay by using familiar tools. The experiments were

repeated with the women's group several weeks later. Women patients were invited to consider the anvil top, and how its surface should be treated. In a series of drawings, the women experimented with colour and images. One woman drew an anvil top covered in butterflies to represent, she said, '*metamorphosis and change*'. Women who were not engaged in physically making the sculpture frequently offered ideas; the researcher considered imprinting the anvil surface with their crocheting and one woman suggested pressing ivy leaves into the wet clay. When the slabs were sufficiently dry the women began to construct the form. The two groups continued constructing the anvil form over a period of two weeks.

The patients were engaged in exploratory drawing concurrent with the making of the sculpture. The men were invited to draw tools using wax resist technique; by using colourless wax they were unable to see the drawings as they were made. One man made additional drawings of a shield and a trophy. The women were asked to draw using an adhesive, made visible by dusted pigment.

One man, who had worked as a terrazzo floor layer, worked on the surface of the form when the construction was complete. Being dissatisfied with the surface made by the tools provided, he developed new tools by using the handles rather than the blades to burnish the sculpture. The four to five men who had been engaged in assembling the sculpture stopped work to allow him to treat the surface.

The men demonstrated increasing concern that the sculpture should be a replica of an anvil. When asked to consider the surface of the sculpture they described how it should be coloured with a metallic glaze to mimic solid iron. The researcher, concerned that the sculpture would become a mock anvil, suggested that it should be cut in half to reveal the finger marks recorded inside. The men disapproved. One suggested photographing the inside of the sculpture then printing the inside images onto the outside. Another suggested that the 'bending hole', found on actual anvils, be cut into the hollow sculpture to reveal the inside, while not disrupting the form. As a result of patient

feedback, subtle but significant changes were made and the inside of the sculpture was revealed by opening the 'bending hole'. The base of the anvil was made by the men.

When the form of the sculpture was complete the researcher stamped LMCC XXI (Liverpool Marie Curie Centre twenty-one) into the clay to record the work that the twenty-one patients had invested in the sculpture. The participating patients were invited to sign the sculpture with a drawing of a hammer. One man said he would prefer to record his name, rather than a hammer drawing, in the clay. To cater for male patient desire to record their names, a ceramic plaque, *List of Names*, was made to accompany the sculpture. Patients who were present wrote their names in the clay. The names of patients who were absent were recorded with stamps by fellow patients.

To decide the surface of the sculpture, test pieces were made, including a miniature anvil. To distance the primary sculpture from an actual anvil it was glazed white. The title *The Wheatfield* was developed in collaboration with a participant. When asked to consider whether other elements could be placed with the sculpture one man stated 'a loaf of bread'. He explained that on an anvil a plough blade was formed. With the blade the earth was prepared for the wheat. The wheat was then harvested, and with the wheat, bread was made. On the basis of this description, the researcher chose the title to reflect how the anvil had been placed within the suggested life cycle (Plate 1).

After completion of the anvil an idea for new sculpture was sought in which the patients could contribute individual components in one sculpture, designed and directed by the researcher. It should also have relevance for the women patients. While *The Wheatfield* had been designed by the researcher before the patients became involved, it was decided to discover whether a new work could be developed, through drawing, with input from patients.

Drawing workshops were used. Both men and women were asked to make designs for the next sculpture. The men demonstrated significantly less enthusiasm to draw than for

using clay. In contrast, participation was high in the women's group. One man who had been involved in making *The Wheatfield* drew a sundial with a clock face of Roman numerals. Another drew a grotto while another suggested a bird-table. The women also drew items connected with the garden including a fountain and a bench. It appeared that the patients connected *The Wheatfield* to garden furniture or monuments.

Plate 1. *The Wheatfield*



As the aim was to make one sculpture which combined disparate units reflecting the patients as individuals, it was not possible to use the patients' drawings as a source. They all suggested monolithic images. It was hoped to expand the patients' perceptions of sculpture beyond association with garden ornament. Detecting the patients' eagerness to start working in clay again, the researcher returned to *The Wheatfield* and initiated a workshop inviting patients to make clay 'hammers'. The patients made diverse hammer forms. The men independently wrote their initials in the models, an action not repeated by the women. While working on hammer variations one woman made a hand-held clay 'armchair' with three 'cushions'. The same woman became very ill and requested clay to take home or use in the ward before she died. Another made two 'Viking ships' which were later re-presented by the researcher as a public exhibit.

As the researcher was seeking ideas it was unclear, as yet, how the clay 'hammers' might be used. A written critical assessment from the project Director of Studies (Appendix 8) advised that 'hammers' should not be used in conjunction with *The Wheatfield* as the sculpture already implied hammering. The combination would be tautological. The male patients were asked to consider this aesthetic criticism. One man felt that the viewer of the sculpture would want to see the tools with *The Wheatfield*, to learn about past making methods. However, another agreed with the critical comment and considered the tools to be irrelevant in relation to *The Wheatfield*.

As a result of the discussion it was decided to make new work with the hammer shapes. The researcher requested ideas from the patients but none were forthcoming. The researcher examined the 'hammers' independently and developed *Meta* (Plates 2 & 3). The heads of the ceramic hammer forms were dipped in a white semi-matt glaze and fired to stoneware. The 'hammers' were placed in a horizontal line, with heads touching. Mirrors at either end of the line formed unending repetition. The title was given by the researcher and the patients did not see the complete work until the exhibition at the end of Phase 1 (March 1996).

Plate 2. *Meta*

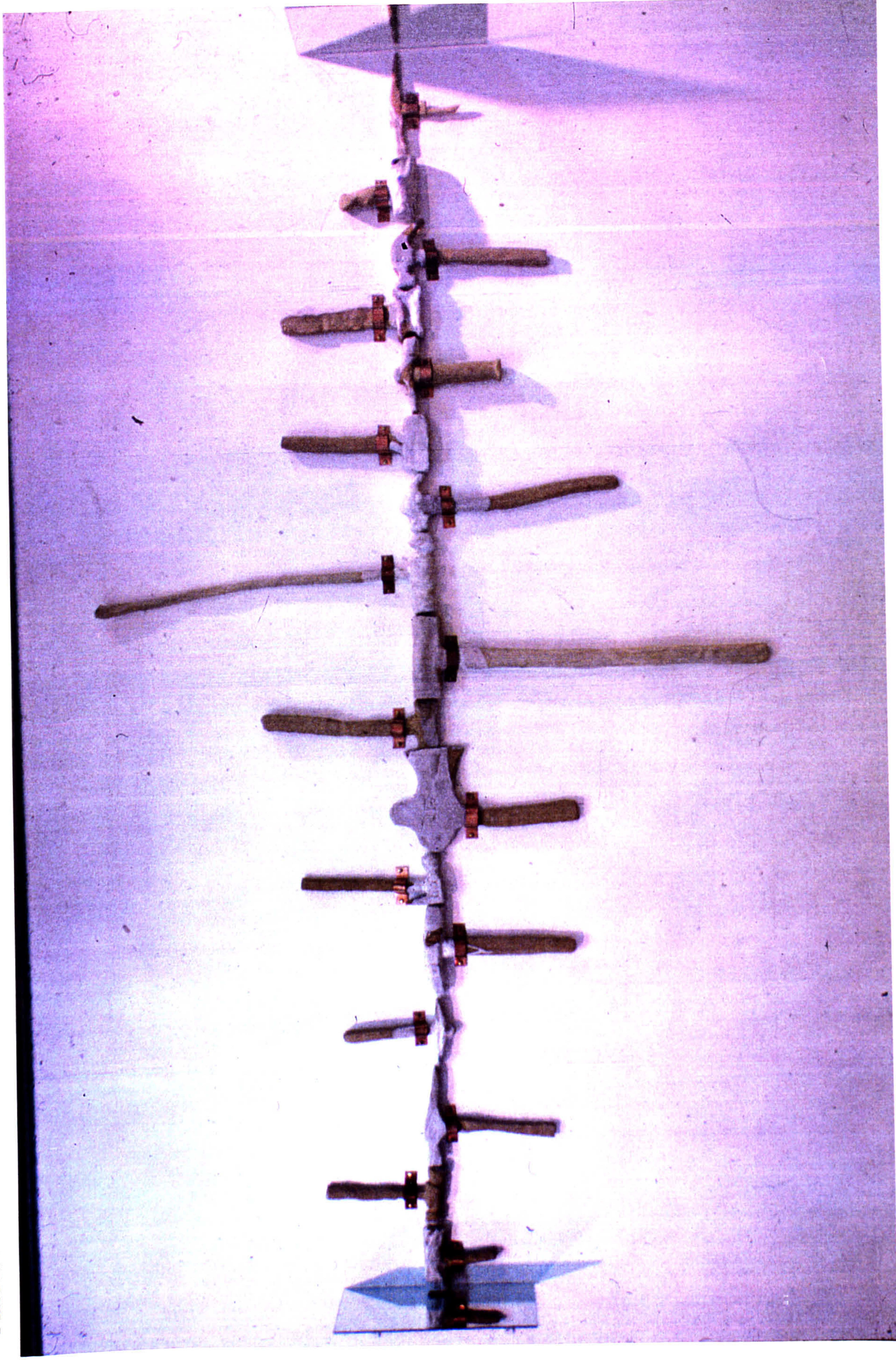
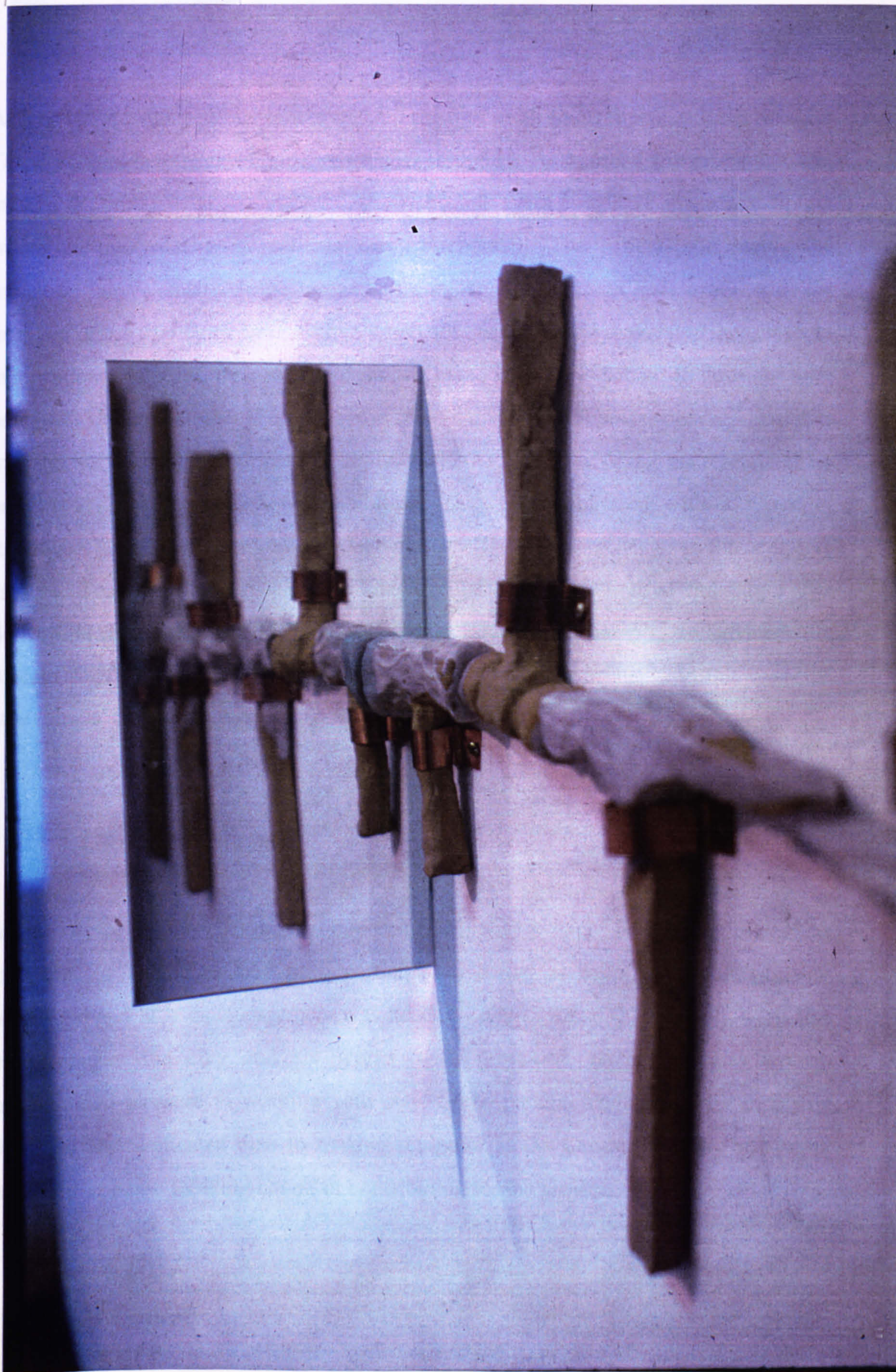


Plate 3. *Meta* (detail)



The percentage of participation is discussed in Chapter 4.

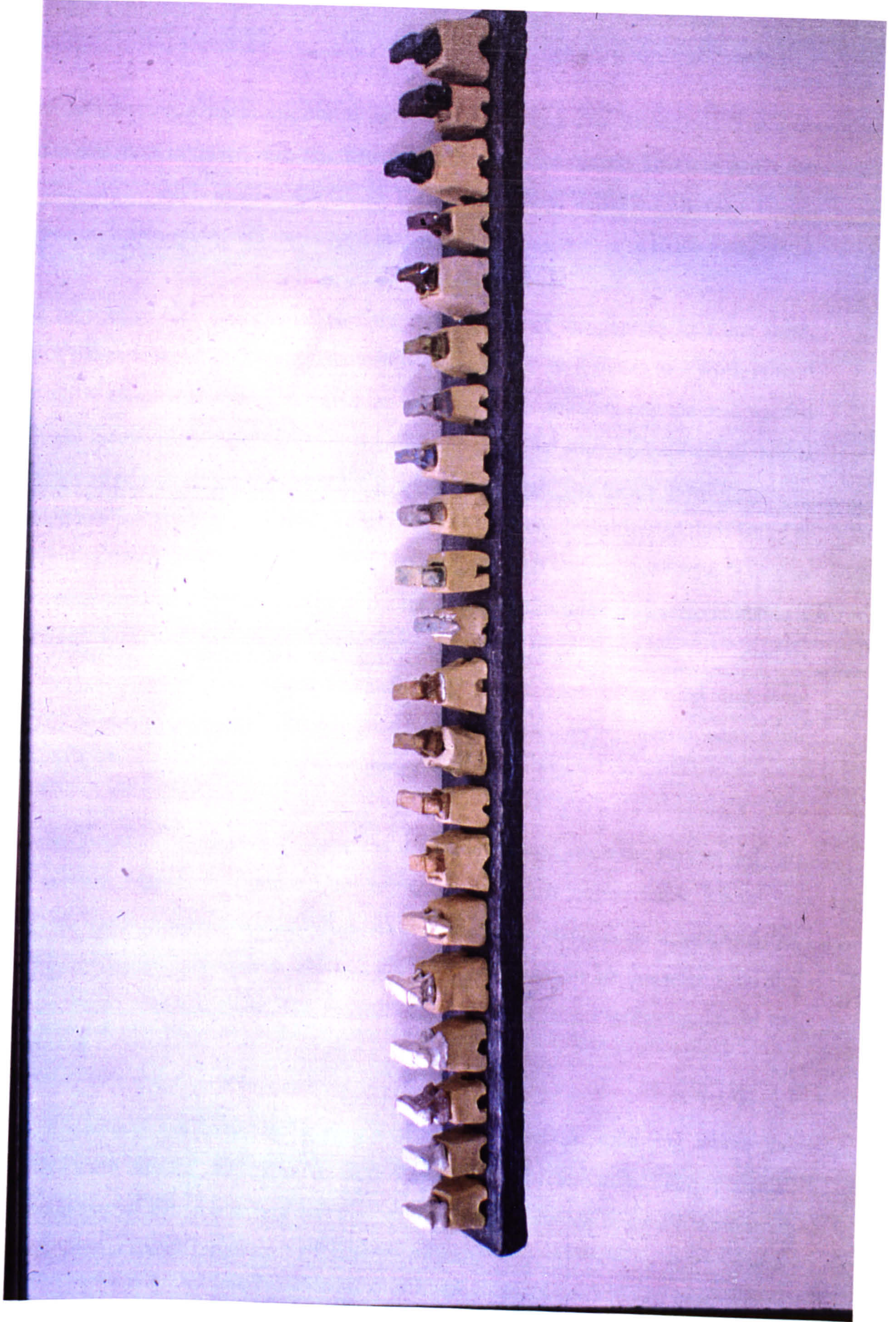
As a result of patient enthusiasm to make more, the small anvils (made as test pieces for *The Wheatfield*) were developed into a new sculpture. As in *Meta*, the researcher was initially uncertain what the outcome would be but again sought to make a sculpture where the individuality of patients was incorporated. The patients, on seeing the miniature 'anvils' made by the researcher, compared them to '*a little army*' and '*the forts out of the film Beau Geste*'. While it had not been intended to develop these tests as independent sculpture, the patients' desire to make led the researcher to consider their potential. Unlike the other sculptures, the small individual elements encouraged patients who did not normally participate to join in. As in the making of *Meta*, the researcher represented the little 'anvils' for exhibition. They were coloured with a range of stoneware glazes and arranged on a lead-clad shelf. The researcher gave the sculpture its title. The little 'anvils' were 'in advance' of the completion of the larger *The Wheatfield* (Plate 4). The title 'In Advance of...' refers to Duchamp's, 'In Advance of a Broken Arm' (Lebel, 1959) where a shovel indicates a later accident. In this case, the little 'anvils' predict a forthcoming 'harvest'.

3.4. Results of Making

While hospice staff had expressed concern that patients might be nervous of making sculpture, or unable to take part, participation began as soon as the activity was introduced and little encouragement was needed². It was found that patients were able to manipulate the clay and six works were produced. Both men and women demonstrated pleasure in working with clay. Some patients contributed by supplying ideas. Patients dedicated time to making sculpture at the Centre, but they also spent extra time at home thinking about, or contributing to, the project.

² The percentage of participation is discussed in Chapter 4.

Plate 4. *In Advance of a Wheatfield*



Men and women patients responded differently to making *The Wheatfield*. The male group was more involved with *The Wheatfield* than was the female. This was partly due to the larger, more regular number in the men's group, and their stronger health. However, it also seems that the subject matter was of more relevance to the men.

The monolithic *The Wheatfield* fused the individuality of the patients into one mass, which the men found rewarding. The men responded with enthusiasm to a work-related theme, which generated less interest in the women. It was apparent that the men wanted to make a copy anvil but the women were less preoccupied with representation, indeed they appeared less concerned about the product altogether. The men's unwillingness to change the 'integrity' (which was, in fact, fake) of the anvil demonstrated their belief in the replica function of the ceramic anvil, which contrasted with the researcher's aim to refer rather than to replicate. Although the men appeared to think they were imitating a real anvil, both men and women demonstrated an ability to develop ideas connected to the sculpture which transcended replication. The men were determined that their identity as makers should be communicated by signature, a drawing was not considered sufficient. The women demonstrated no such desire.

The men responded with enthusiasm to the monolithic image, while the women did not. The women may have preferred to work on individual components. Therefore, sculpture which enabled individuals to work separately was planned. As it appeared that the women found subject less relevant, methods were sought to discover what the women would chose to make. The women began to make works independently of the researcher.

The Wheatfield had presented a clearly identifiable goal. In following works the patients were invited to consider development and presentation. The patients' understanding of *The Wheatfield* and their desire to make garden ornament contrasted with the researcher's aspirations for further sculpture.

In the making of *The Wheatfield* the patients were invited to contribute to a pre-determined sculpture. In the making of *Meta* an attempt was made to involve the patients in the fluid 'problem finding' (Getzels and Csikszentmihalyi, 1976) process used by the artist when working independently. Although the patients were encouraged to develop ideas it was apparent that they were repeating what they already knew. Therefore, to make *Meta* the researcher manipulated the artefacts produced by the patients as 'found objects' or 'ready-mades' (Lucie-Smith, 1995).

The patients' enthusiasm, and their desire to create with clay, led to an unexpected new sculpture, *In Advance of a Wheatfield*. As in the making of *Meta* it was necessary for the researcher to re-present the objects made by the patients, to resolve individual contributions as a cohesive statement.

3.5. Discussion

The patients dedicated time to the development of sculpture and committed extra time away from the Centre suggesting that the activity was of some value to them. The patients had worked with a degree of autonomy on *The Wheatfield*. In the following works, when asked to develop ideas for presenting individual components in concert, they could not. However, more patients took part when smaller individual items were made as opposed to the larger, homogenous *The Wheatfield*. It may have been that patients were less intimidated by the smaller works, feeling more confident to contribute. However, it might also be that they preferred to make individual items, which contributed to a whole.

The male patients' desire for realism ensured that the anvil of *The Wheatfield* remained as one piece. A difference between the men's and the women's responses was apparent; the men recorded their names in most works, while the women did not. Group and individual identity as preserved in *The Wheatfield* appeared to be of particular value for

the men, suggesting that the monumental function of the sculpture was of greater significance to the men than to the women. In *The Wheatfield* the men sought to make a replica of an anvil. However, it may also be that the strength and unity represented by *The Wheatfield* was of value.

While the men readily participated in work-related themes determined by the researcher, the women chose to develop work which reflected their own concerns. The model of an armchair made by one woman could be read as a rebellion: unlike an anvil it was soft, comfortable and a place of rest (Plate 5). The same woman chose to continue working independently in clay until her death, suggesting that the activity was rewarding. The 'Viking boats' made by another woman were suggestive of travel, as opposed to a static anvil. Although *Meta* involved individual components, they were all 'hammers'. In the women's decision to make disparate objects they demonstrated personal concerns. The women referred to the aspects of work which were part of their lives, making a home for a family and investigating history. The women's desire to make personal items, alongside the anvil form, suggests that the portrayal of their identity was of importance. However, unlike the men their identity was not communicated through work, but through the home and interests. They were unconcerned with the preservation of their name.

The participating patients' commitment to making sculpture suggested that they found it to be an engaging activity. However, their verbal opinions would be sought for substantiation. Chapter 4 records patient opinion of making.

Plate 5. *The Little Armchair*



Table 3.1.

A Summary of the three primary sculptures made in Phase 1, and the subsidiary works.

Title of Sculpture	Scale	Making Process
<i>The Wheatfield</i> The title was provided by a patient, who saw the anvil as part of the food production cycle, 'where the plough was made'. The Wheatfield was also used as a title to recall 'The Force that Through the Green Fuse..' (Thomas, 1972), conveying insistent vitality.	100cm x 60cm x 60cm, including plinth to raise the ceramic elements 40cm from the ground.	A ceramic sculpture of an anvil was made in stages. Clay was rolled, patterns cut, and then the slabs fitted together by the patients. The sculpture was glazed with a zinc white feldspathic glaze. A steel plinth was made by the artist. A weather-proofed wooden plinth later replaced this when the sculpture was placed outdoors.
<i>Meta</i> A title given by the artist to convey a sense of change; the resulting work becoming more than a sum of parts.	Whole piece: 2m x 60cm x 30cm Each hammer- between 10cm and 70cm long.	Patients were asked to make individual hammers in clay. These were then fired and glazed with a proprietary Vellum glaze by the artist. The hammers were then fastened to a wall with copper brackets in a horizontal line. Mirrors were placed at either end, causing infinite repetition.
<i>In Advance of a Wheatfield</i> The little anvils were used to resolve <i>The Wheatfield</i> , so in this sense they were 'in advance' of. However the 'wheatfield' also refers to the fields of soldiers graves.	Each anvil: 6cm x 5cm x 5cm. Whole sculpture, including shelf: 1m x 10cm x 10cm	Small (average 6cm high) ceramic anvils were made by the artist to test glaze. The patients expressed interest in these so more were made (n=21). These were glazed in a variety of glazes by the artist and presented upon a lead covered shelf, made by the artist. This was fastened to a wall, 70cm from the ground.
<i>List of Names</i> (see Plate 6)	40cm x 30cm x 2cm	On a clay plaque made by the artist, all the patients involved wrote their names. Those present wrote their name by hand. For the names of people who were absent, or who had died, stamps were used to imprint their names.
<i>Products of Industry</i>	Each tile 10cm x 10cm. Entire sculpture including grid: 80cm x 40cm x 7cm	On uniform (8cm x 8cm) clay tiles the patients made images using tools that were familiar to them, e.g. knives and forks, chisels, combs. These were fired without glaze and presented on a welded steel shelf made by the artist.
<i>Viking Ship</i>	10cm x 5cm x 4cm	Individual ship made by female patient.
<i>Little Armchair</i>	8cm x 6cm x 6cm	Individual armchair with three cushions, made by female patient. Lead base added to ceramic for protection, by artist.
Tool Drawings	Each one 60cm x 40cm	Drawings of familiar tools made in a variety of media including paint, wax, PVA medium and powder paint.

Plate 6. List of Names



Chapter 4

Response to Phase 1 Process

4.1. Introduction

The time the patients wanted to spend making sculpture was a primary measure of value. Rates of participation are reported below. This is supported by the patients' reasons for the time they committed.

4.2. Level of Patient Participation

As described in Chapter 2, participation was the best indicator of the value of the activity. Twenty-seven different patients attended the day unit groups over a five month period. Of these, twenty-one patients took part in making sculpture at some point. Appendix 9 (Tables 1, 2, 3 and 4) records participation at every workshop throughout the research. Appendix 10 (Tables 1 and 2) records detailed individual participation levels. Table 4.1 shows the average participation rates of individual patients in the men's and women's groups. Out of an average of 7 patients attending the day unit per day, 4 participated. The overall percentage of patients taking part was 60%.

Table 4.1 Average Participation Rates of Men and Women in Phase 1³

Patient Group	Average No. Groups Attended	Average No. Workshops Participated	Average % Participation Rate
men	9	4	44
women	4	3	75
men and women	7	4	57

³ All averages calculated are an arithmetic mean. For more detailed information see Appendices 9,10 and 11.

4.2.1. Participation Rate According to Gender

Table 4.1 shows that male and female participation rates were different. On average, 9 men attended each group, out of which 4 participated in making (44%). The average number of women attending the day unit group was 4, out of which an average of 3 participated (75%). Although there was a higher rate of female participation in making, the number of men attending and participating was higher. It was necessary to adjust the data collected for the women's group. There were 8 women who attended the day unit only once⁴. Depending upon whether they participated or not their rates were 100% or 0%. As they only had one opportunity to take part in making it was not possible to see whether the activity was of any value to them. Therefore their attendance and participation rates are removed from the data.

The pattern of participation for individual men and women differed (Appendix 10). In the men's group there were five patients who had high (70%+) participation rates, whilst the remaining patients participated rarely or not at all. This distinction was not apparent in the women's participation. Every woman (who attended LMCC more than once) participated at least once. The levels of female individual participation are spread across the scale, some occupying the middle, without the polarisation between frequent and nil participation seen in the men's.

4.2.2. Participation According to Age

There was no obvious distinction between the ages of those who participated and those who did not. Any distinction was between those who were more well and mobile, and those who were less. Reasons given for non-participation were frequently health-related.

⁴ The short attendance of these women was usually due to death or hospitalisation.

4.2.3. Participation According to Occupation

Most of the men participants had had more than one occupation. Most had, at some time, done some kind of manual (skilled or unskilled) work, varying from engineering, building, being a smith, to working on a production line. There was no notable significance in the past occupations of the women patients. The response from patients (elicited from interviews) only gives attention to gender differences.

4.3. Participation Rates for each Sculpture

Appendix 11 (Tables 1 and 2) depict the patients' participation rates when taking part in the making of different sculptures. Patient participation was highest when making those works which involved individual components, *Meta*, *In Advance of a Wheatfield* and *List of Names*. In addition, women's participation when making these works was double that of the men. *The Wheatfield* encouraged a higher female than male participation rate. In addition, a high (70%) level of women took part in drawing exercises. In contrast only 43% of men were prepared to draw.

4.4. The Nature of Participation

In the above data the women's overall participation rate is significantly higher than the men's and there were both men and women who had high (70%+) rates of participation. However, the data does not reveal the different nature of the men's and women's participation which was apparent through observation. There was a core of three to five men who were eager to take part every week, and worked together as a group, particularly on *The Wheatfield*. This group motivation was not observed in the women's group. While the rate of male participation increased after *The Wheatfield*, the

enthusiasm apparent when making *The Wheatfield* was less for subsequent works. Patient opinion was gathered to clarify their reasons for the rate and nature of participation.

4.5. Patient Perception of Making

At the time of interviewing the two groups comprised thirteen patients in total. Even though not all participated, all thirteen patients were invited for interview, of whom nine agreed. Those who declined said they were unwell or, as one man said, 'had no ideas'. In the following report quotations from patients are recorded as they were spoken, with punctuation added where necessary. Patient verdict is presented in emerging themes.

4.5.1. Pleasure

All patients, including those who had not physically taken part, expressed how making Phase 1 sculpture had given them pleasure. Pleasure was the most frequently voiced response. As one woman participant described, '*I was surprised when I found how interested I was; I mean, how much I enjoyed it*'. Participants and non-participants alike said that they would like to be involved in making further sculpture;

'It was interesting work. I loved getting involved in it. I'd like to do something else- you know, similar to that, another venture in clay.'

4.5.2. Achievement

Of the nine patients interviewed five claimed that much had been achieved by the completion of *The Wheatfield*. They considered the completed sculpture to be of superior quality to what they had expected. Several described how making sculpture

made them realise that they were capable of achieving more than they expected; one woman emphasised the satisfaction she gained through making,

'Actually doing something and getting something from it, actually producing something yourself....it meant something'.

Three of the seven participants described how they initially did not think themselves capable of contributing; they approached the activity with trepidation, which was later overcome.

Although the questions asked were intended to discover patients' perceptions of making, the sense of achievement expressed concerned their expectations of the quality of the finished sculpture more than the means of making. At this stage the patients had not actually seen the completed works. Non-participants expressed particular enjoyment in seeing the sculpture develop. One participant expressed enjoyment in making but emphasised completion;

'When I see it getting built, you know, stage by stage, as I said before, I'll just be glad to get it finished.'

For the participants, the emphasis remained on the finished sculpture, while non-participants were interested in development.

4.5.3. On Making

When asked whether the project was what they had expected all patients, except one, said that it was not. Two said that they did not expect the activity to involve three-dimensions. Another man described how he had expected the activity to be making pots.

Participating patients were asked whether the activity of making sculpture reminded them of anything. Four people made comparisons with other activities. One woman likened the activity to the *'playground as a child'*. Two men referred to other activities; project work as a school teacher and woodwork at home, but both stated that there was

no comparison between the activities, *'it doesn't really compare in its conception'* and that the project *'was beyond my expectation'*. A woman compared the activity to *'archaeology, digging pieces, stones'* as she was familiar with ancient ceramic archaeological finds. Two men, who had been smiths in their youth, referred directly to memories evoked by their involvement,

'It took me back all those years-being at school and working in the stables as a farrier...'

When asked what they thought about the material (clay) the patients referred to the ease with which they could handle it. As one woman stated,

'It's good because you can actually do something with it, move it....its easier to stick things in your hand than it is to put things on paper.'

Other patients had no particular opinion of the clay, saying it was *'all right'*, or they referred instead to the finished sculpture. Patients were asked whether, overall, there was anything they had particularly enjoyed. They referred to the physical act of making: *'working with the clay, I've never done anything with clay before.'* The patients were asked whether there was anything in particular they would remember of the project. Both women interviewed referred to the activity of making, *'I'd remember actually doing something and getting something from it'*. The women also said that they would remember the people who took part. The men who were asked this question said that they would remember *The Wheatfield*. However it was not possible to ask all patients this question.

4.5.4. Realism

The patients' interest in the replication of an anvil, as described in Section 3.4, was also apparent in their interview responses. Four of the nine patients interviewed referred to the 'realistic' nature of the anvil in different ways. One man thought that the sculpture's 'realistic' quality would be a reason for visitors to appreciate it,

'Everybody knows about anvils and blacksmiths, and if it's put somewhere where people can recognise right away what it is... with an anvil everybody knows what it is and it will attract people to look at it.'

When asked where the sculpture should be sited one woman participant suggested that it should be at the gates of a steel works.

In the earlier part of the interviews the patients were asked to give their opinion of making but their answers consistently returned to their enthusiasm about the finished sculpture. The only sculpture they described was *The Wheatfield*, the only piece which would not require re-arrangement to be presented. When asked what he thought about the project so far, one man said, *'I love it, I can't wait to see it when it's finished.'* The same man, when asked whether he would have liked to work in an alternative material, chose to refer instead to the completed work and the imprinting of the patients' names rather than hammer drawings on *The Wheatfield*.

4.5.5. Permanence

Several of the patients referred to the permanence of the object they were making. Again this referred to the completed sculpture, rather than to the process. One non-participating man said of the anvil,

'It's a fast growing world and times and moods alter, but art as it is presented today, I think it will always stand out. It will leave some of those other art in the cold.'

He considered the sculpture as an addition to the history of art. One woman said, *'It's hard and sturdy, it'll last a lifetime'* referring to the longevity of both an anvil and the sculpture. Another woman said that in the sculpture she could *'see something solid for what you had put in'*, identifying the sculpture as a repository for her energy. On beginning to build *The Wheatfield* several men hoped they would live to see the sculpture completed. Conflated with patient perception about the permanence of the

sculpture, were comments relating to its presentation and what other people would think of it. As these issues related specifically to the completed sculpture this is dealt with in Chapter Five.

4.5.6. Scale: 'The Big Venture'

All nine patients interviewed described, in different ways, how the project went beyond their expectations. The scale of the project was perceived to be large. *'I didn't expect it to be such a big project'*, as one man said. Of the nine patients interviewed, four men mentioned scale. When the men mentioned scale they referred to both the sculpture's actual size, and also to their notion of the scale of the project as a *'big venture'*,

'Mostly when you expect to be doing things you think of two dimensional paintings, drawings, and even when you're making small models, you're not thinking of anything in the scale you [the researcher] did. I think it opened up prospects.'

The men referred to the amount of work and degree of commitment that had gone into the sculpture, *'to actually get involved in doing it, it's a big thing'*. One man made a comparison with the anvil which did not refer to scale directly but by association,

'The pyramids, the structure going up before my very eyes, and it unfolded and revealed itself in an anvil.'

4.5.7. Transcendence

As seen in the pyramid comparison, the male patients frequently spoke of the anvil sculpture as something which was beyond the ordinary. One participant said, *'I wouldn't believe ordinary people had done that.'* In the language used by the men, there are frequent references to the sculpture reaching beyond the ordinary, *'I've....*

never dreamt of doing anything like that.’ It was described by one man as being beyond the comprehension of viewers,

‘There’s more gone into that. It’s put out there on its own and people see it. It will take some grasping.’

Comments regarding the extraordinary nature of the sculpture were made predominantly by men.

4.5.8. Discussion of Phase 1 Making

4.5.8.1. The Value of Making

60% of patients committed time to making sculpture, suggesting that it was of some value to them. Patients took part most frequently when making works which had individual components such as *Meta*, suggesting that they either preferred to make individual components, or it was simply easier to work independently. The men appeared to be either fully committed to completing the project, or not at all, while the women were more moderate, taking part if they wished and without urgency.

All patients described how they had found the act of making pleasurable and how it had given them a sense of achievement, which was said to give meaning. When giving their opinions of the making process, some patients referred to their pleasure in the malleable properties of clay. While women frequently took part in drawing, the men appeared to prefer the manipulation of clay. The women valued the act of making and said that it would remain in their memory in the future. In contrast, more men said that they would remember the completed sculpture, *The Wheatfield*. However, because not all the men were asked the same question, the comparison is not conclusive.

Ideas of process were conflated with opinion of product suggesting that the value of making was inseparable from the nature of the product. It was not just ‘doing

something', any activity, which was of value, but the intention to make sculpture which meant that patients were 'getting something from it'. The patients frequently referred to the future, when the sculpture would be finished, rather than the present making, suggesting that the full potential of the activity was not realised until completion.

When patients referred to completed works they only mentioned *The Wheatfield*. At this stage the patients had not seen *Meta* and *In Advance of a Wheatfield* complete, so did not regard the components they had made as sculpture. The patients understood that a collection of components are not sculpture until they are resolved in presentation. Due to its monolithic form, the patients had some indication of the final appearance of *The Wheatfield*.

4.5.8.2. Significance of Sculpture

By comparing *The Wheatfield* to the pyramids a patient alluded to its relative physical scale, its permanence, its team of builders and, significantly, the seriousness of the undertaking, the degree of commitment and the ambition of the venture. He saw the pyramids as mysterious and mystical, beyond the labour of mortals. When the patient made this comparison he used an image which conveyed the physical qualities of *The Wheatfield*, such as permanence and the form. However, he also alluded to its significance. The male patients viewed the sculpture, both its making and its complete form, as something beyond the ordinary, stretching both the understanding of makers and viewers. This is not apparent, to the same extent, in the responses of the women patients.

The male patients found the 'realistic' nature of '*The Wheatfield*' to be of significance, while the women showed little concern with this. Patients not only valued the malleable property of the clay but also its ability to record identity. This was of particular value to male patients.

4.5.8.3. Perceived Relationship between Making and Occupation

For the three 'core' men who had been smiths making sculpture was associated with their positive memories of work. When describing what the making process reminded them of, three men referred to prior employment, while another, along with two women, described reminiscence of leisure activities. In one woman's association with childhood she expressed the notion of creativity. The patients understood the activity as occupation, but a leisurely and voluntary occupation. However, several indicated that making sculpture was 'beyond' these activities.

The results of Phase 1 making show that the making process was of value to the patients but not in isolation from the sculpture they believed they were completing. The value of the making process was seen in relation to the success of the finished piece. The completed works are evaluated in the following Chapter.

Chapter 5

Phase 1 Sculpture and Identity

5.1. Introduction

This chapter explores patient reaction to the resolved, exhibited sculpture, to determine further to what degree value lies in making or in the presentation of the product. By studying the patient's verdict of the sculpture, it may be possible to propose a relationship between sculpture and identity.

5.2. 'A Vital Occupation'

In Phase 1, as a result of patient interest and commitment, three complete sculptures were made. To evaluate the reactions of both patients and viewers to the completed sculptures, it was necessary to exhibit. The patients were familiar with seeing the developing sculptures in the hospice, alongside items made in occupational therapy. A gallery was sought to encourage the patients to relate the sculptures to their experience of mainstream fine art rather than to therapeutic by-product.

A venue for the exhibition was sought for March or April 1996⁵. A space was sought which was no larger than eighty square metres and which had access for the disabled. A variety of spaces were considered and the Myrtle Street Gallery at Liverpool John Moores University was chosen⁶. It has limited public access but has a satisfactory entrance for the disabled. The exhibiting area comprises one sixty metre square room with a three metres high ceiling, and an L-shaped foyer.

⁵ As it had not been predicted that sculptures would be ready to exhibit so soon, no advance arrangement had been made, which meant hire at short notice.

⁶ The Gallery was available for one week only, 25-29 March, 1996. An opening event was arranged for Monday 25 March from 5-7pm.

The exhibition was entitled 'A Vital Occupation'. Publicity for the exhibition in the form of two hundred posters was funded by LMCC. The image used for the exhibition posters was a drawing made by one of the male patients. It was selected by the researcher with the permission of the patient. Supporting information was also provided (Plate 7).

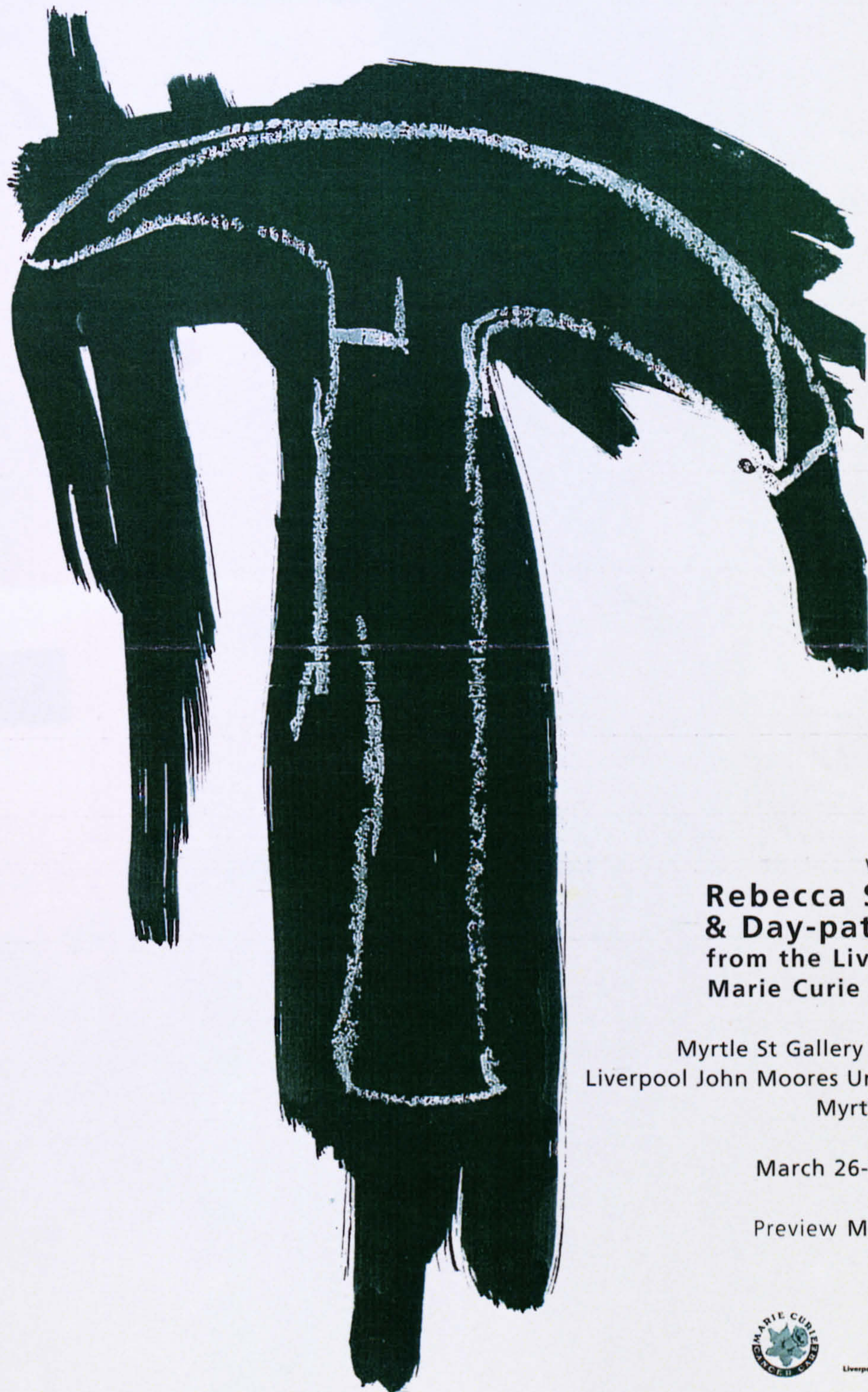
Responsibility for the placement of sculptures was the researcher's alone. An arrangement which would ensure impact and clear communication of the meaning of the sculptures was essential (Plates 8, 9 & 10). Patient's verdicts were obtained after the exhibition (Appendix 5). More detailed response was gathered when the patients were interviewed about the making of Phase 2 sculpture.

5.3. Observed Patient Response

Although invited, no patients attended the opening of the exhibition. The Centre had arranged to bring them to the gallery later in the same week. Both men and women patients were brought on the day they usually attended the Centre. Seven men visited the exhibition. They expressed surprise when they saw *The Wheatfield* because they thought it appeared smaller than when they remembered it in the Centre. They questioned whether the sculpture had been replaced by another. Several of the patients discussed how they had enjoyed making the work, and one man said he would have left the Centre had the project not started when it did. However, it was noted that the atmosphere felt 'flat' and the patients lacked enthusiasm.

Plate 7. Poster for 'A Vital Occupation'

A VITAL OCCUPATION



Work by
**Rebecca Shaw
& Day-patients**
from the Liverpool
Marie Curie Centre

Myrtle St Gallery & Foyer
Liverpool John Moores University
Myrtle St, L8

March 26-29 1996
9-5pm
Preview March 25
5-7pm



Plate 8. Exhibition View



Plate 9. Exhibition View



Plate 10. Exhibition View



Five women (two of whom were new patients at the Centre) visited the exhibition. The researcher's diary notes that the women appeared more enthusiastic than the men, and two said that they were pleased with what they saw. However, it was also noted that the women looked uncomfortable in the gallery and that away from the activity of the project and the Centre, their illness was more apparent. Male patients also appeared uncomfortable in the gallery. For some of the patients an art gallery is not a familiar place. The patients also appeared unenthusiastic towards the sculptures.

5.4. The Patients' Verdict

Patients' perceptions were gathered using the method described in Chapter 2. The return rate of the questionnaires was low. Of the thirteen questionnaires administered only five were returned. One of the five was blank and accompanied by a letter of apology from the patient's wife explaining that her husband's eyesight prevented him from completing the form. Although the return was supposed to be anonymous, the four forms that were completed were returned by hand in the same envelopes. Consequently it was possible to see that all the returns were from participating men. The responses to the questionnaires are analysed below.

Recorded first impressions included a description of the gallery as a *'busy place with a continuous flow of incoming and outgoing people'*. Other responses referred to the sculpture; *'some care taken to make the most of the exhibits within the available facilities'*. The other two responses were positive; *'I thought the way our work was displayed was very good'* and *'wonderful'*. One man described how he had expected a more compact display of the sculptures. When asked whether there were any features which they liked or disliked about the exhibition, two patients said they liked everything and one of these said he felt proud. Two of the patients felt able to offer constructive criticism regarding the display of the sculptures;

'Considered the shelves were a little congested. Use of table for siting the models would have improved visual awareness.'

Another said,

'I thought the anvil was displayed in a room which had too much height thus making the anvil to appear much smaller than it is. The displays of the small anvils and the tools were most effective.'

Both patients and researcher recognised that the composite sculptures *Meta* and *In Advance of a Wheatfield* gained from presentation more than did *The Wheatfield*.

When asked whether the exhibition evoked associations three patients referred to the memory of the sculptures being made. All patients related the sculptures to their experience of making or the theme. When asked what they thought should happen to the sculptures, all patients wanted them to be given a new audience. As one man said, *'we should let other people see it'*. Another said, *'a new site should be chosen for permanence'*. Two men stated that the sculpture should be placed in the Liverpool Marie Curie Centre (LMCC). One man said he thought that photographs of work in progress should be included with *The Wheatfield*, as he was eager that the identity of the makers should be known. Some patients were also eager that the audience should know the health condition of the makers.

The questionnaire responses were low and of little detail. However, when the patients were interviewed again⁷ on making Phase 2 sculpture, those who had also been involved in Phase 1 referred to their experience of 'A Vital Occupation' exhibition. In interview, three of these (two men and one woman) referred to the exhibition and to *The Wheatfield*. They spoke primarily about the experience of seeing the sculptures exhibited;

'You say to yourself I never thought I'd be able to do that. When you see it with the anvil and that, the way you (the researcher) put it up, laid it all out, that was just brilliant. It was good to go and see. When you're making it you're

⁷ Interviews were repeated between February and May 1997.

just making it and that's it, but when you see the finished product its amazing and it really lifts you.'

and

'Even those pictures when they were framed, when I first done one I thought it was a load of rubbish. When I saw them on the wall they looked brilliant.'

The patients noted how presentation had changed their opinion of the sculpture. They were eager that other people should see the sculptures. The importance of the impact on an audience was innate to the patients' understanding of art. If the sculptures did not transmit significance other than to the makers, its value would only be the pleasurable experience of making to the maker and its function would be solely therapeutic. For these reasons, the opinions of visitors to the exhibition were gathered to determine whether the sculptures were of significance to others beyond the makers. Their responses are reported in the following section.

5.5. Audience Opinion

If the sculptures in 'A Vital Occupation' were not found to be comparable with works by established artists, then the sculptures would be of only particular value. Therefore, the opinions of art professionals regarding the sculptures was sought. Art professionals would provide objectivity regarding the communicated aesthetic success of the sculptures, in contrast to relatives and associates of the patients and Centre who might assess the sculptures as therapy.

Forty people attended the opening night of the exhibition. They consisted of art professionals, therapists, and health experts. Sixty people signed the comments book during the week of the exhibition. The comments were favourable but none was detailed. The comments are recorded below.

A lecturer in health studies stated that *In Advance of a Wheatfield* imparted a sense of 'solidarity' and *Meta* conveyed 'eternity'. The verdict of five fine art lecturers, chosen for their expertise in sculpture, was sought. The first lecturer consulted said that the entire exhibition conveyed a sense of 'melancholy' and the 'human tragedy' when people die and their knowledge and unique experience is lost. He also referred to the particular capacity of artists to live on through their works. However, he felt that the aim of 'A Vital Occupation' was to produce sculpture which could be appreciated without taking account of the illness and identity of its makers, and he thought the exhibition had achieved this.

Problems in presentation and the relationship between the sculptures were noted by all the other lecturers. One described, like the first professional consulted, how the exhibition conveyed 'a sense of memory and lost experience'. However, she felt that *The Wheatfield* failed when it was presented with other ceramic objects, as the particularity of a ceramic anvil was dissipated. She felt that the message of *The Wheatfield* was undermined because the audience's perception of its fragility was lost; therefore the association with the fragile and temporary nature of memory and experience was not communicated. The lecturer expressed interest in *The Little Armchair* and remarked upon how the supposedly trivial could achieve greater impact than an object which was supposed powerful (*The Wheatfield*). The works she considered to be of most interest were those where the researcher had re-presented individual units made by the patients, because the sculpture communicated as a whole. She detected problems in the display of the patients' drawings. They had been made without the awareness of the patients regarding how the images would communicate. To become articulate, their display required further consideration by the researcher.

5.6. Discussion

The data generated by questionnaire was poor, suggesting that the method was either inappropriate or administered ineffectively. The low level of return of questionnaires may have been due to its official and impersonal nature, or because the patients' opinions had previously been sought by interview. Patient ill health may have prevented completion at home. Another factor may be the delay in administering the questionnaire; if it was not delivered soon enough following the exhibition the patients' recollections may not have been clear. As responses were low, no generalisations about the patients' perceptions as a whole could be drawn. In addition to the low level of return, responses lacked detail.

Only men returned the questionnaires. This may be because men had participated more actively. By the time of exhibition, several of the women participants had either died or were unable to attend due to illness. Indeed, only one of the women who attended the exhibition had been participating since the outset. These factors may explain the low female response.

Additional data from later interviews allowed for a more comprehensive understanding. The length of time between the exhibition 'A Vital Occupation' and Phase 2 interviews had enabled the patients to assimilate the effect of the exhibition and to give a definite response; seeing sculptures publicly presented had provoked them to consider the work anew.

It was apparent that when patients spoke about the future destination of the sculptures, they only referred to *The Wheatfield* suggesting that other sculptures were of less import. The men reacted strongly to what they perceived as the diminishing of *The Wheatfield*. When fired, the ceramic sculpture had shrunk by up to 10%. However, it is unlikely that this change accounted in total for the men's perception. The sculpture was made in cramped conditions in a busy environment. In the still, quiet, high-ceilinged

space of a gallery, the apparent scale was diminished. In addition, the sculptures had been presented in a way that the patients did not expect. The changes the sculptures had undergone may have resulted in the patients no longer recognising them. The men's inability to accept the lesser scale of the presented sculpture was possibly due to their perception of the project as a '*big venture*'. The men's perception of the sculpture's significance caused them to aggrandise it, envisaging it as larger than its 60cm x 60cm x 120cm mounted dimensions. When presented in a public gallery the sculpture was objectified and the men were forced to see the actual, rather than the imagined, scale of the sculpture. There was no indication that the men recognised that *The Wheatfield* was not large by sculpture standards.

Patients wanted *The Wheatfield* to be given a permanent site where many people could view it. They wanted their identity to be recorded with it. The men patients wanted their names and their image, in photographs, to accompany the exhibition. However, the patients also wanted the audience to recognise that ill people had made the sculpture, and were still capable of achievement in spite of illness. This suggests that the patients did seek a therapeutic effect in the exhibition.

The sculptures were seen by patients primarily in terms of their involvement, not as works of art to be considered objectively. Responses to the sculptures related to the enjoyment experienced in making and the industrial associations of the anvil. However, there was some appreciation of the sculptures as art, as shown in the criticism of the presentation. As discussed in Chapter Four, patients continued to record a sense of elevation when viewing the sculpture. Patients' growing understanding led them to notice how presentation changed how their contributions communicated.

The men's initial dismay at the apparent shrinkage of *The Wheatfield* reflected the relationship between the sculpture and perceptions of self. They had expected to see their identity recorded and communicated in a strong, large pyramid-like sculpture. The diminished sculpture did not communicate greatness as expected. The ideal placement

of *The Wheatfield* in a permanent, public site reflected the men's desire for their actions to be preserved through the sculpture. These desires were not demonstrated by women patients. Possibly this sculpture did not convey the identity of the women. Further sculpture was required to address the relationship between sculpture and identity. Chapter Six describes the focus of new sculpture.

The sculpture did convey meaning to an audience of art professionals as seen in the corresponding responses of those consulted. However, one art professional considered that the sculptures were of value because they did not reflect the identity and condition of the makers, but experience in general.

Chapter 6

Phase 2 Sculpture

6.1. Introduction

Results of Phase 1 indicated that the patients wanted to make, and to continue making, sculpture and they dedicated precious time to the activity at, and away from, the Centre. The men stated that making *The Wheatfield* had been an elevating experience, inferring that the activity reached beyond the individual to '*something which is more than 'I'*' (Fischer, 1971). Response to group making also suggests that, as Dissanayake (1985) proposes, sculpture can be a vehicle for group meaning. The patients' experience of 'elevation' was seen in their comparison with the pyramids. Barthes (1976) uses the same metaphor when describing the '*unspeakable*' effect provoked by certain texts: '*does the text of pleasure speak the same economy as the pyramids of Egypt?*', suggesting that the 'bliss', or '*jouissance*' provoked is beyond pleasure. The patients' reference to 'elevation' parallels Marx's assertion that the individual becomes disembodied and spiritualised through making. In his analysis of pleasure Barthes suggests that the bliss evoked by certain texts is immediate, and not as a result of analysis or understanding; '*what pleasure suspends is the signified value; the good cause*'. Likewise, the patients' pleasure in both making and reviewing *The Wheatfield* was not dependent on understanding all that had been involved in the developing sculpture.

Regarding the materials used, the patients described their pleasure in manipulating clay. For male patients in particular, the enjoyment in making was inseparable from their concept of completed works. For women, the pleasure of making did not depend as much on the completed sculpture.

The relationship between making sculpture and occupation was studied. The keen group participation of the men, especially those who had been smiths, reflected how making had occupied an essential place in their working lives, and the value they placed on being involved in purposeful making. The men were hesitant when faced with an uncertain outcome, reflecting their expectation of the work place, where the end product is determined. The men valued the permanent, monolithic, aspiring, recording, nature of making sculpture, while the women demonstrated greater interest in the processes of making it. This may reflect the different status and permanence of the products of male and female labour (for people of the patients' generation). While men's products are visible, often permanent and enter the marketplace, women's produce is frequently temporary (food, cleanliness etc.) and becomes invisible, invested in future generations.

The patients began to develop a visual vocabulary, as seen in several discussions about the resolution of sculpture. However, the patients could not develop new works independently, as in *Meta*, where they were unable to provide solutions to resolve the sculpture. Without guidance they could not yet determine meaning.

A second aim was to generate sculpture, while developing methods of engaging people in the practice. This was documented in Chapter 3. A third aim was to explore any relationship between making and identity. Patients' rate of participation was highest when invited to make individual components, suggesting that the communication of their individuality was of importance. Gender was found to be an important issue, as seen from the different responses between the men and the women. While the men appeared to value monolithic emblems of strength, women did not. The men's emphasis on *The Wheatfield* suggests that the depiction of strength and vitality was important to them. While their bodies were weak, the men were keen to affirm their '*blooming corporeality*' (Rampley, 1993). The men's emphasis upon realism, while probably reflecting their expectations of art, might also be connected to their desire to maintain the reality of their presence,

'In this way we realise what we are: that is we make ourselves real, and this is demonstrated through creative activity.'

(Aldridge, 1996, p.163)

The male patients' desire to leave their signatures on all work suggested that, for them, the activity had a memorial quality, supporting Ruskin's proposition that the function of art was *'to stay what is fleeting'*, and *'to immortalise the things that have no duration'*. Although for the men sculpture was seen to communicate beyond the individual, the communication and preservation of individual identity in the object was important. For the women there was a need to depict objects of concern but less need to record individuality. Possibly the women had an extended temporal view of their daily activity, seeing it invested in generations not objects. The women's view of work was more akin to an Oriental philosophy of passing skill through generations. In contrast, the men's desire to preserve individual identity reflected a post Industrial Revolution Occidental outlook (Leach, 1967). Despite these differences, all patients found public display to be rewarding.

From the patients' responses to Phase 1 it was possible to affirm that making sculpture is a significant activity; the patients found it to be both important and meaningful. Like work, making sculpture was seen to sustain identity, and to communicate beyond the individual. Scarry (1985) indicates that reciprocation, the *'collective human salute'*, from an object is a vital process. The patients experienced a reciprocal reward from the energy they had invested in sculpture, therefore the value of reciprocation is implied.

From August 1996 to July 1997 new sculpture was designed to build on, test or qualify the above findings. Testing the Phase 1 findings by making sculpture with other qualities would decide if the patients would find advancing the sculpture significant. Further sculpture would investigate whether patients continued to value sculpture which was not permanent or robust. Materials other than clay would determine whether the malleable physical and metaphorical 'bodily' nature of clay added to its recording qualities. Materials which were less permanent than ceramic were chosen, to discover

whether the perpetuity of the mark was a factor in its perceived value. The patients' verdicts of materials would establish whether the strength of the object determined the value placed on it.

In Phase 2, sculpture was made which combined individual elements made by the patients. This would further determine the importance of the presentation of individuality. Unlike previous works, Phase 2 sculpture would have ephemeral, non-figurative, personal qualities. Phase 2 sculpture would enable the distinction between male and female responses to be explored, to determine whether consistency with Phase 1 would be maintained. As the works in Phase 1 had elicited a greater degree of response from the male patients, new sculptures would be designed to have less gender specific subject matter. Phase 2 covered a period of twelve months, August 1996-July 1997, in which nine sculptures were devised and made at the LMCC.

6.2. The Sample

As the researcher had been absent from the Centre for four months, the composition of the groups had changed except for five men and three women who had all been participants in Phase 1. As some members of the groups had never been involved in making sculpture, introductory workshops were conducted. When work commenced on 6 August, 1996, there were six men, three of whom were familiar with the project. On 7 August there were four women, two of whom had previously participated.

6.3. Design of Sculpture

Nine sculptures were produced in Phase 2. Section 6.3. is a report in the form of a chronological narrative describing the primary aims in the development of each sculpture and the key responses of patients. The aim of Phase 2 was to make sculpture

which had different qualities, so extending the patients' understanding of art. This process, unlike other art-related activities employed in health-care, might enable the patients to gain insight into visual vocabulary.

The aim of the new sculpture was to encourage the patients to think beyond imitation and to incorporate individual input. To facilitate this, Phase 2 began with an appraisal of *The Wheatfield*. Part of the appraisal involved a series of collage exercises where patients were invited to construct new two dimensional anvils. However, this did not result in a new perception of an anvil. Therefore, the researcher decided to explore the role of an anvil, as transformer, rather than solely considering appearance. Considering an anvil as a site of change provoked comparison with chemical change. Levi (1988) uses The Periodic Table as the structure for a series of autobiographical stories. In response to this, the new sculpture would evoke change and time using Mendeleev's Periodic Table to encompass patients' visual autobiographies. After preparatory drawing exercises, the new sculpture, *The Periodic Table*, was made. This involved inviting patients to draw previous experiences of their lives, in clay, and to indicate with a stamped number, their age at the time of this experience. The depicted ages corresponded with the atomic numbers of the elements (Plates 11 & 12). These were used to form a ceramic floor sculpture (Plate 13).

Plate 11. The Periodic Table Drawing

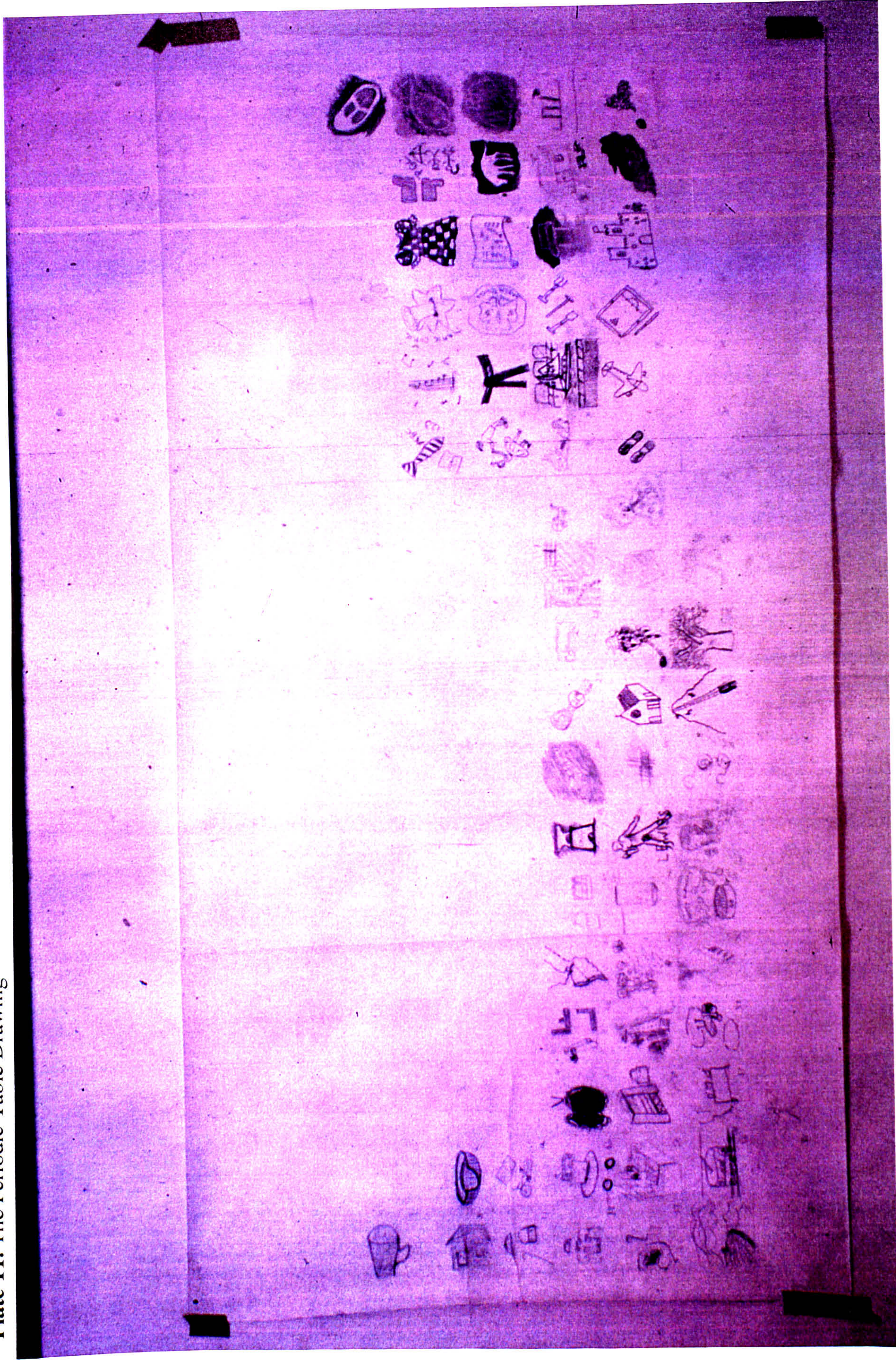


Plate 12. The Periodic Table (detail)

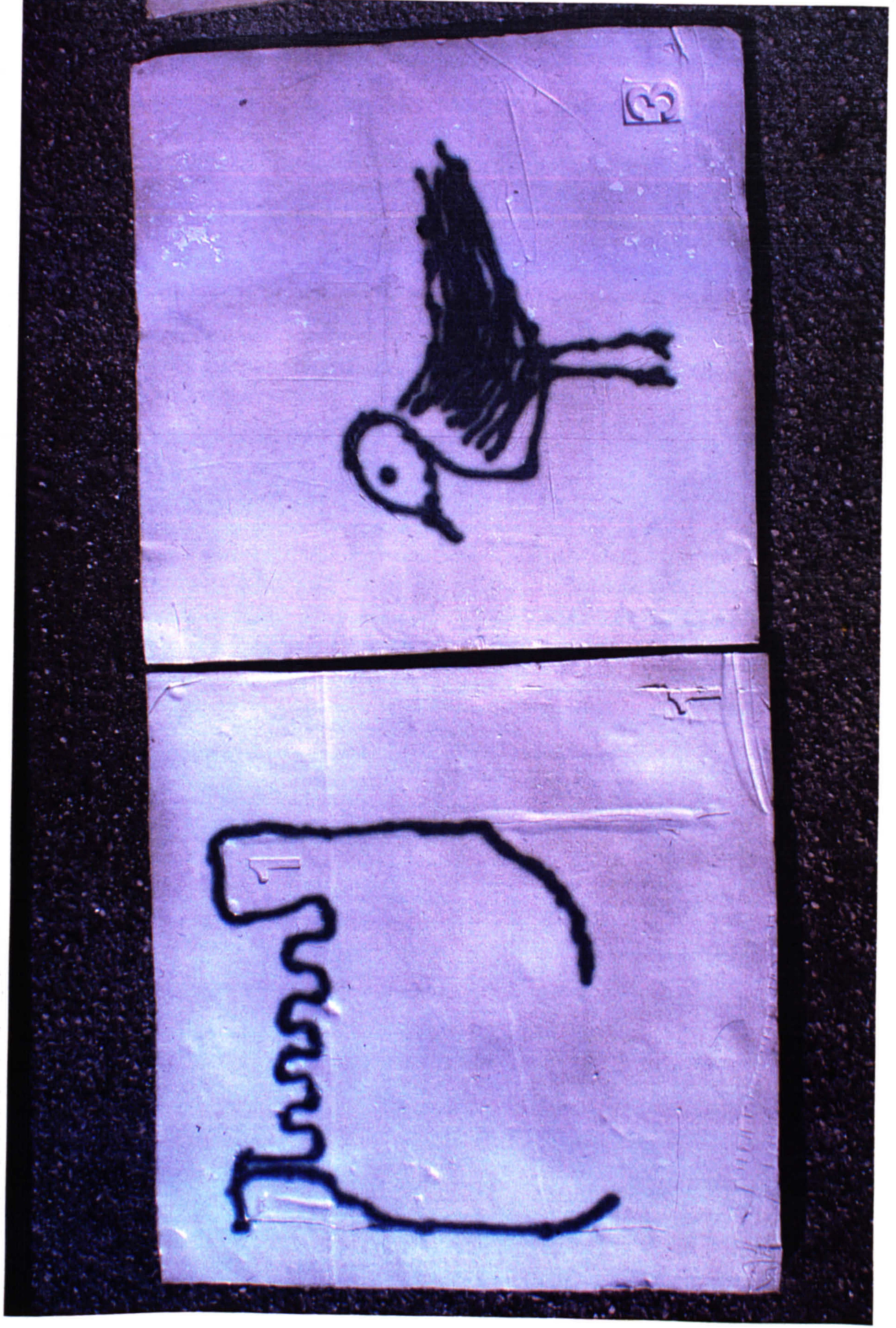


Plate 13. *The Periodic Table*



Following this work a different representation of the Periodic Table was planned. Unlike *The Periodic Table* the new work would be impermanent, allowing the patients' responses to permanence and impermanence to be investigated. The medium used for the new work was handkerchiefs- a humble, homely, intimate medium, in comparison to clay. A handkerchief would be used to represent each element. As elements are primary units of fundamental importance, primary human impulses such as mark-making were considered. Sewing was chosen as a drawing medium. The patients were not familiar with handkerchiefs as a traditional fine art medium and sewing was associated with repair work or craft rather than art. The responses of the patients would indicate whether they could only accept these media in their usual role, or were prepared to accept them as elements in a visual vocabulary. The patients were invited to make an accumulating number of stitches on seventy handkerchiefs. They could make images when stitches were many but when stitches were few, patients could only make abstract gesture, providing an alternative means of recording identity to the literal images used in *The Periodic Table*. Women only were invited to take part in making this sculpture, in response to discussion about previous occupation. While *The Wheatfield* had avoided stereotypical female activity, this activity would explore it. When presented as pages in a book, the work was entitled *Messages from the Front* (Plates 14 & 15).

A further work was made also using handkerchiefs. Women patients were invited to solidify copies of the original stitched handkerchiefs using clay slip so that comparison could be made between responses to the use of actual handkerchiefs (*Messages from the Front*) and handkerchiefs rendered permanent by a traditional fine art medium (*Hankies to Wave off the Sailors*, Plates 16 & 17). Unlike in the making of *The Periodic Table* and *Messages from the Front*, the outcome of this work was uncertain so patients were invited to problem solve, or 'find' (Getzels and Csikzentmihalyi, 1976) with the researcher.

Plate 14. *Messages from the Front (detail)*



Plate 15. *Messages from the Front*



Plate 16. *Hankies to Wave off the Sailors* (detail)

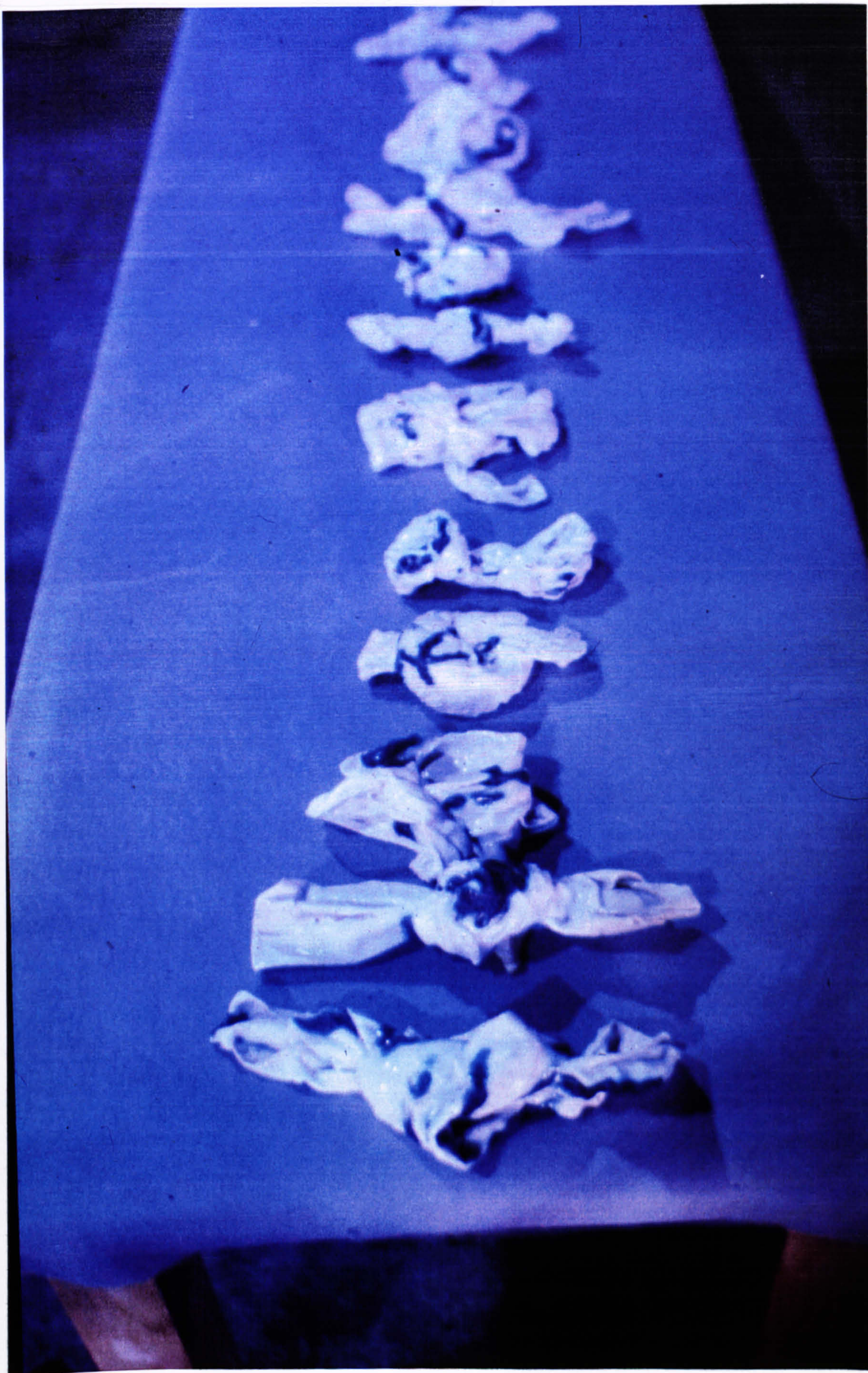


Plate 17. *Hankies to Wave off the Sailors*



As the two previous pieces involved women patients in making sculpture which communicated through gesture and used a work-related method, men were invited to produce components for a sculpture using the process of hammering. An accumulating number of marks, in this case hammer blows, were added to seventy squares of clay. The outcome was uncertain. Unlike in Phase 1, where clay was used for its strength, in this piece, *Hammered Out*, the clay became as filigree, more intricate and fragile as it was hammered (Plate 18). Hammered tiles were presented as a 'cloth', 'draped' over wood and steel supports.

As the previous sculptures had involved a non-literal representation of identity, new work was planned which directly asked the patients to consider the presentation of their identity. In Phase 1 one man had made drawings of trophies and shields. Therefore, Heraldry as a system of recognition in battle and to represent people or families when no longer present, was used as a source. Patients were asked to make two kinds of heraldic shields: one torso-sized and in clay which used texture and pattern as identification and titled *The Call to Arms* (Plate 19); and one in salt dough which required the patients to use personal heraldic motifs to represent themselves, called *The Common Jewel* (Plates 20 & 21).

The two works demanded differing degrees of personal representation, one narrative the other more abstract. While *The Call to Arms* was, as a shield, strong and permanent, *The Common Jewel* was fragile and temporary. While clay is from a fine art tradition, salt dough has homely and hobby associations. The patients' reactions to the salt-dough would be evaluated.

Plate 18. *Hammered Out*



Plate 19. *The Call to Arms*

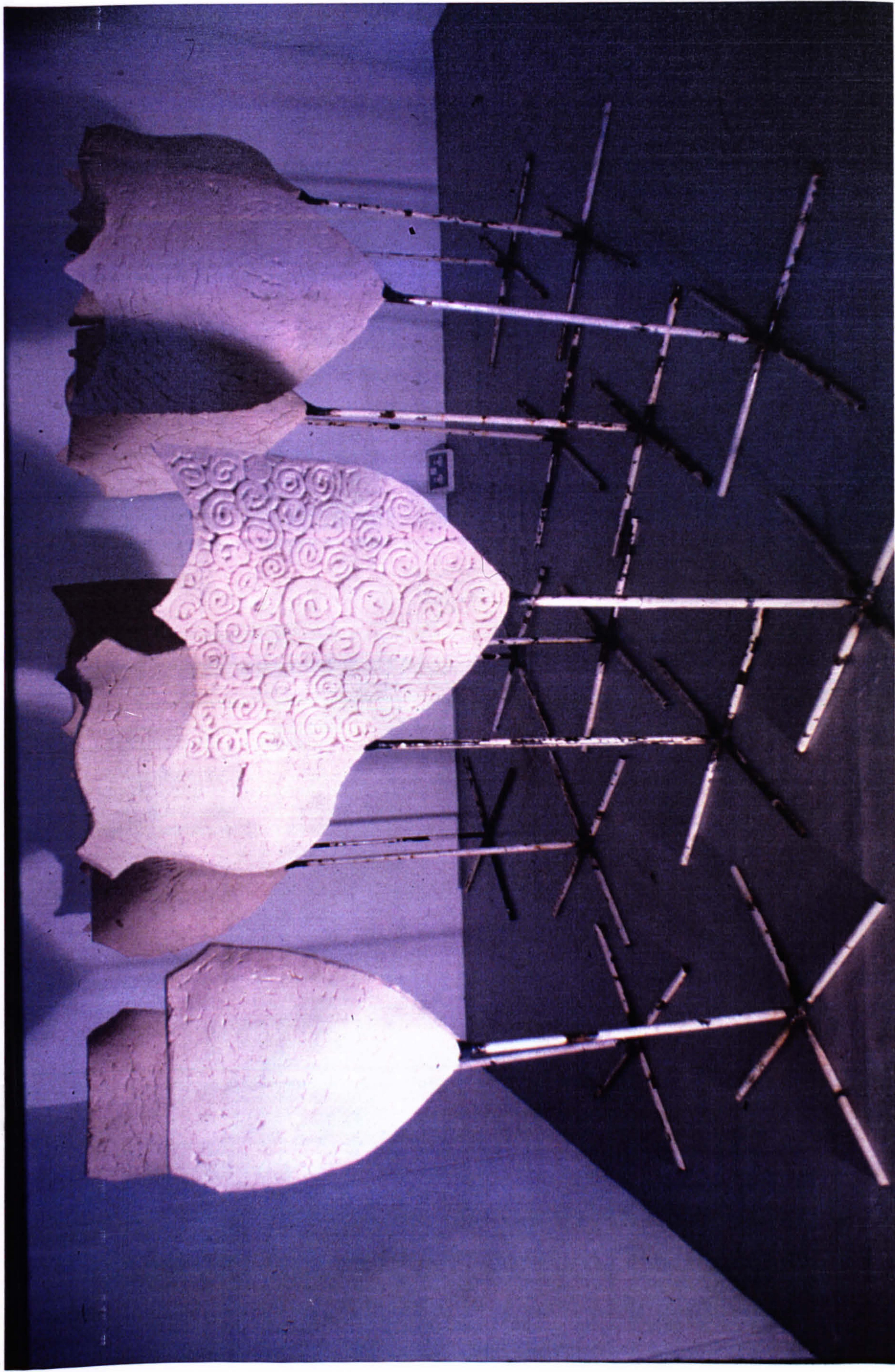


Plate 20. *The Common Jewel*



Plate 21. *The Common Jewel* (detail)



As several of the previous sculptures had involved adding imagery to a flat surface, a sculpture was planned which required the patients to make three-dimensional objects. A realistic source was chosen to see if the patients welcomed the return to figuration, or approached it differently after making the more abstract *Messages from the Front* and *Hammered Out*. The patients were invited to make models of birds. At a later stage the researcher asked the patients if their birds could be cut in half, so inviting the patients to go through the same process of decision-making experienced in *The Wheatfield*. The patients' reaction at this stage, after being involved in the progression of increasingly more challenging works, would be compared to their reaction to the suggestion of cutting open the clay anvil at the beginning of research. The new sculpture was entitled *Parting Gifts* (Plates 22, 23 & 24).

None of the previous works had directly encountered the patients' illness. A new sculpture, *Things we No Longer Use*, was planned which would enable the patients to reflect upon their illness if they wished to, but if not, would convey changes and loss which all experience through age. The men and women patients were invited to draw items they no longer used on pillows, in the traditionally feminine medium of dress-making pins, not usually associated with art. The patients' response to the increasingly personal subject matter, and the feminine media would be evaluated, to examine the relationship between making and identity (Plates 25, 26, 27, 28, & 29).

Although the sculptures in Phase 2 were less strong, permanent and realistic than those of Phase 1, all occupied space and were tangible objects. Therefore, the final sculpture made, *Sovereignty* (Plate 30), had a reduced physical presence, using sound as one of its media. Patients were invited to make a soundtrack using their recollections. This was accompanied by ten, palm-size ceramic armchairs, also made by the patients. Through making this sculpture, the importance of three-dimensional presence for the patients would be evaluated. Table 6.1 (end of Chapter 6) summarises the nine sculptures made, listing the media, patient involvement and presentation for each one.

Plate 22. Parting Gifts

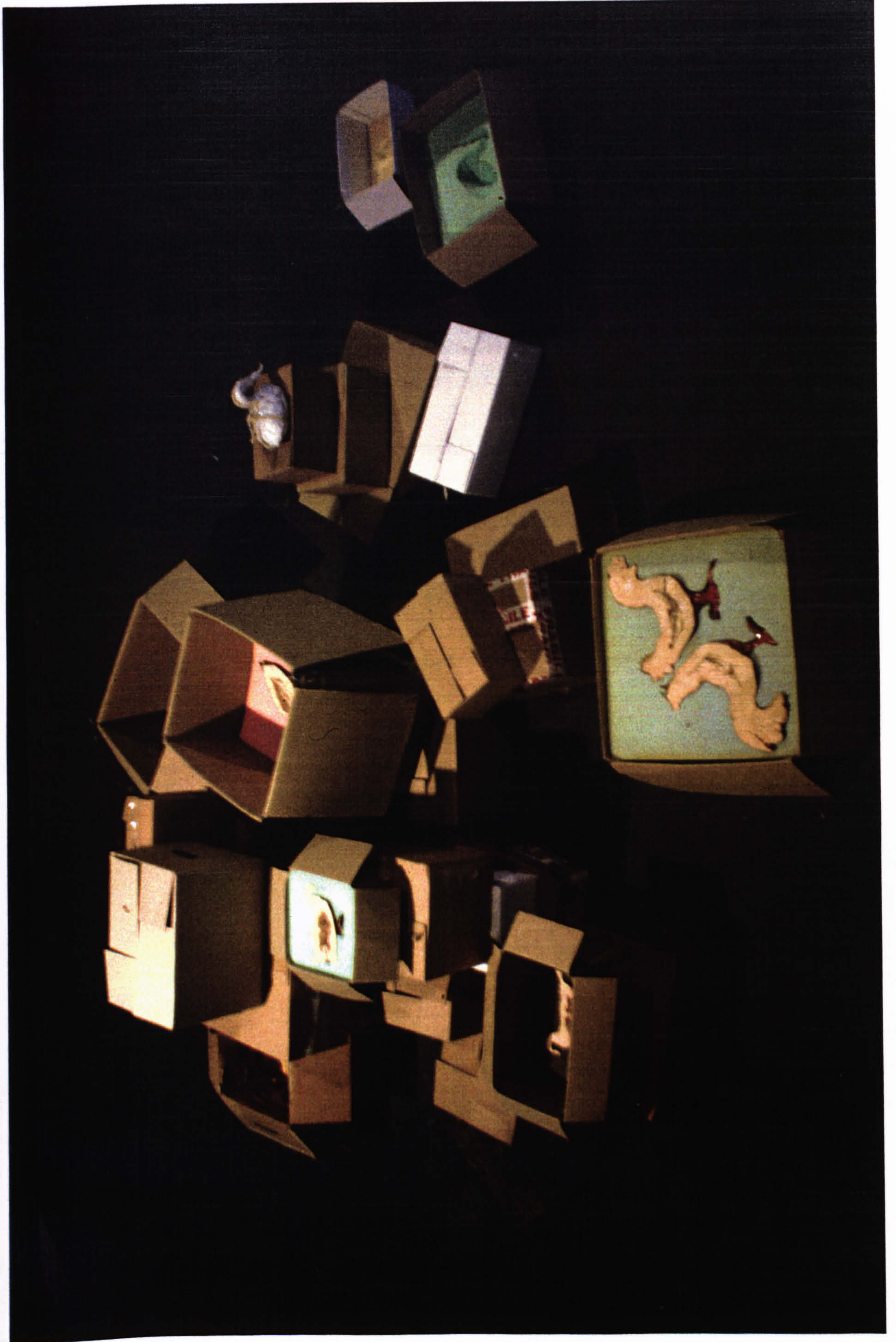


Plate 23. *Parting Gifts* (detail)



Plate 24. *Parting Gifts* (detail)

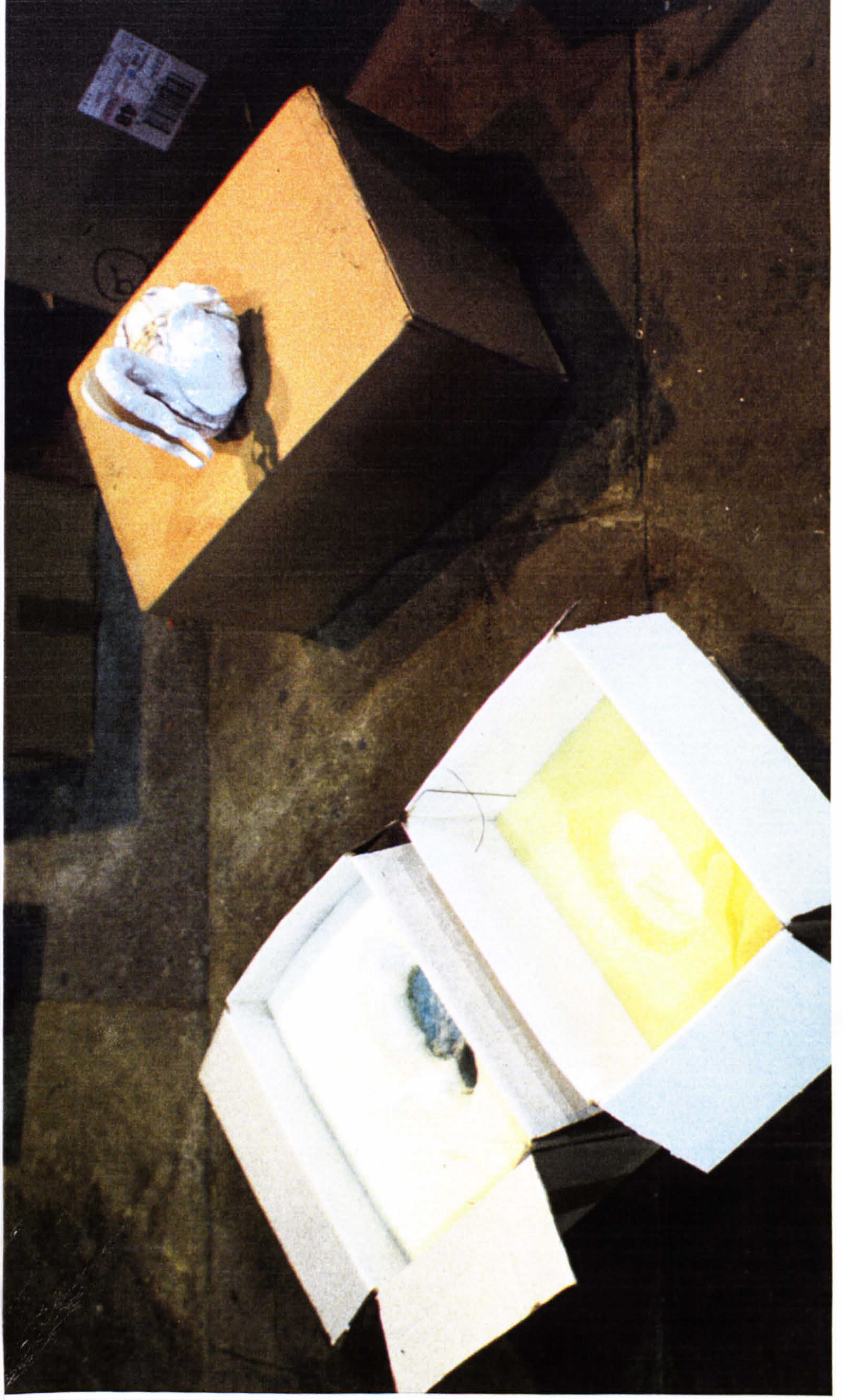


Plate 25. *Things we No Longer Use*



Plate 26. *Things we No Longer Use* (detail)



Plate 27. *Things we No Longer Use* (detail)



Plate 28. *Things we No Longer Use* (detail)

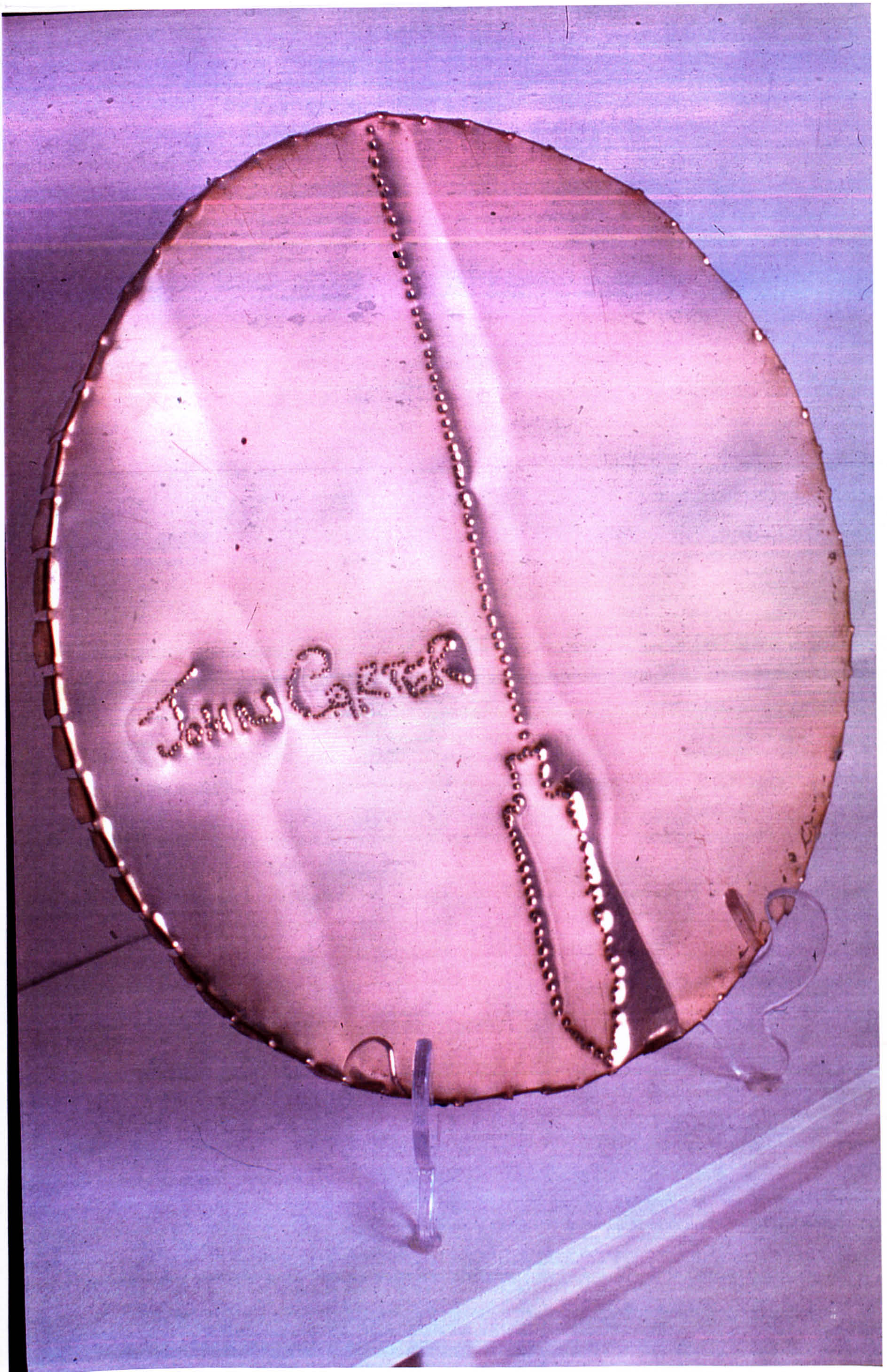
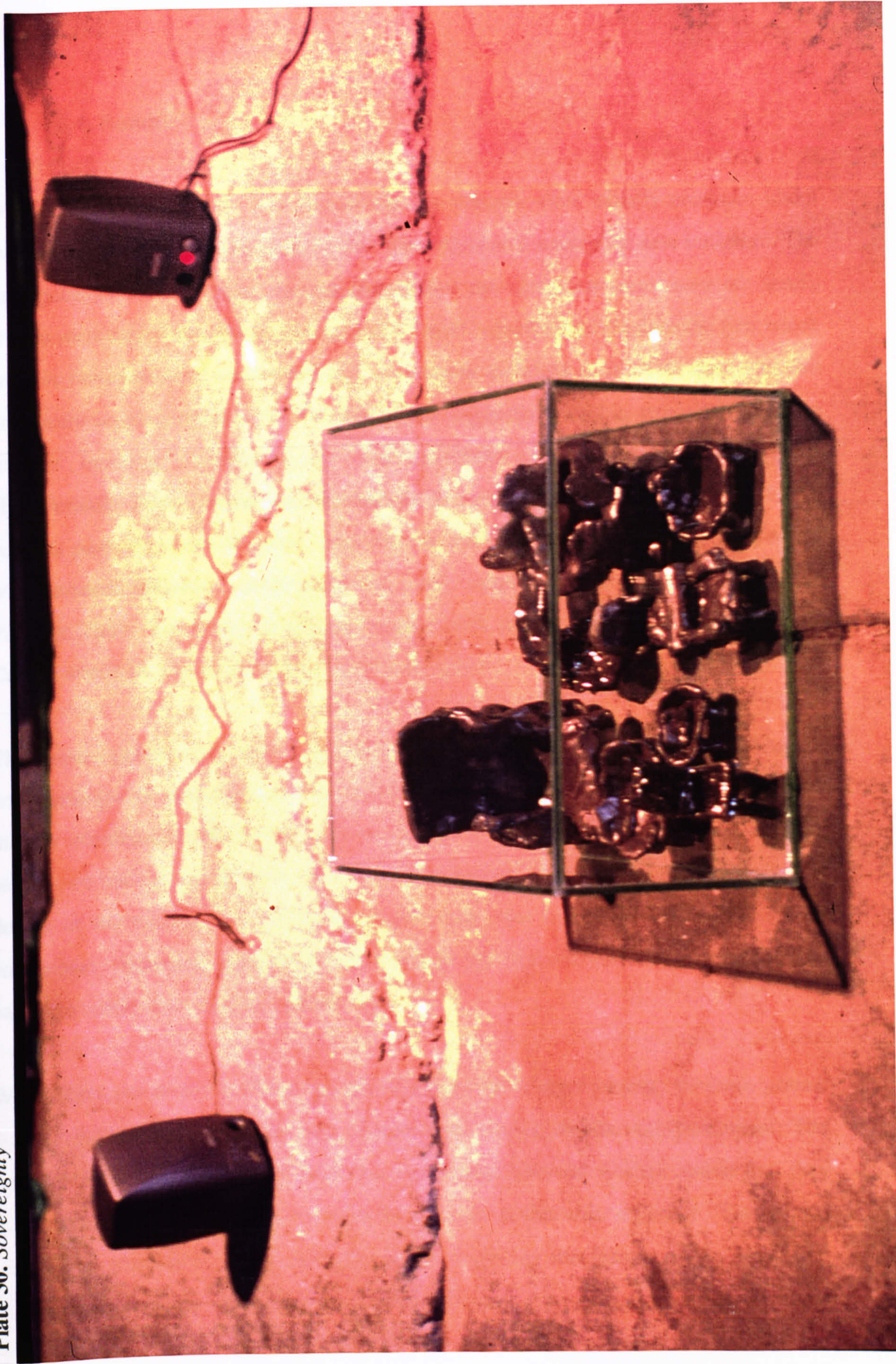


Plate 29. *Things we No Longer Use* (detail)



Plate 30. Sovereignty



6.4. Results

When *The Periodic Table* was introduced, the patients were initially uncertain about evaluating the ideas encompassed by *The Wheatfield* as a source for new sculpture. The male patients were unhappy, one suggesting that the new ideas were '*over his head*'. Others were concerned about making a new 'anvil' which might displace the first which was '*in remembrance*' and which had '*everything attached to it*'. The man who had previously supplied the title for *The Wheatfield* suggested that this new work be called '*cermet*', meaning '*a combination of ceramic particles and a metal matrix*'. He felt that 'The Periodic Table' theme was appropriate to a cancer unit, where chemistry is '*an integral part of cancer therapy*'. However, he thought that the replacing of elements with personal drawings would make the work '*confusing*' and '*obtuse*'. While *The Periodic Table* was being developed another male patient suggested that 'Liverpool Castle' would be a suitable subject for new sculpture.

The women patients appeared to agree with the proposal for a different kind of 'anvil' and participated enthusiastically in making a preparatory drawing. The men were initially unenthusiastic and were keen to see *The Wheatfield* installed in the courtyard, as planned but not yet possible. However, they became enthusiastic when the technical details of tile making were discussed. Later both men and women participated with enthusiasm, becoming particularly interested in the representation of memories from early life, rather than middle, and old, age.

When *Messages from the Front* was introduced to the women patients, all three women present participated, including one woman who was a regular non-participant. The handkerchiefs were completed over two workshops. Several women stated that they normally did not like to sew but wanted to take part as this was '*different*'. The women sewed with confidence and a lack of concern regarding the finesse of the completed handkerchiefs. They experimented with different stitch forms to make some handkerchiefs three-dimensional. When clay slip was used to make *Hankies to Wave off*

the Sailors only two women volunteered, others describing it as 'too messy'. Those who did take part were happy to experiment and expressed pleasure in the manipulation of the liquid clay and cloth.

Three men chose to hammer tiles to make *Hammered Out*. The activity was introduced as an experiment to find out how many blows the clay would hold before disintegrating. Although the activity tired them, the men expressed enthusiasm and were determined to complete the required number. One man delighted in the intricate clay forms produced.

The patients found pressing clay into the large moulds of *The Call to Arms* tiring, so worked in pairs. As a result of the demanding work participation was not high. However, after one set of shields cracked the patients were keen to make replacements. The patients experimented with images to build into the shields. When the shields were bisque fired the patients voiced a preference that they should remain pink in colour rather than being glazed or fired to a higher temperature. This coincided with the researcher's desire to keep the shields a flesh tone. A lack of enthusiasm amongst long-standing, constant participants was detected when making *The Common Jewel*. It was predominantly new members who took part. Two men who had been part of the 'core' of Phase 1 participants initially declined to take part.

Seven 'birds' were made for *Parting Gifts*. One man sought to make a branch on which his owl could stand, as commonly seen in domestic ornaments. When the halving of the birds was suggested patients agreed, with the stipulation that the models would be fastened back together if they did not like the result. The patients found the opened birds interesting and thought they should be presented accordingly. However, one woman insisted that her swan be presented closed, so the two halves were tied up with string.

When asked to bring in items from home to draw for *Things we No Longer Use*, the patients brought in a box camera, keys to a first home, a wedding ring, old pyjamas, a

babygrow, a cigarette lighter and a plumb line. Those who had forgotten their items made drawings from memory, of a right shoe, a favourite blouse, their mother's tea cup, a clock and a pocket watch. It is interesting that most of the items drawn by the men were for use outside of the home, whereas the women's drawings concerned home life. The patients were asked to make their drawings in pins, on pillows, to permit easy change or erasure. Two women patients completed their pillows independently, away from the day unit.

When asked to make their drawings on pillows, the men refused on the grounds that it was too feminine, '*girly*'. When asked what support they would prefer they chose metal, suggesting that the drawings be made by scratching or hammering. The men beat out their drawings in sheet copper, using the point of a nail. When asked whether the sheet copper should be manipulated into a three-dimensional form, the men were uncertain, so the researcher proposed to turn the drawings into the faces of 'coins', out of which a sculpture would be made.

Only women were prepared to make the hand-held ideal chairs required for *Sovereignty* but both men and women made recordings describing their experiences.

6.5. Discussion

Phase 2 consisted of nine sculptures which were developed by considering differing degrees of permanence, moving beyond imitation of reality and consequently attempting to stretch the patients' understanding of art. Throughout Phase 2 sculptures were made, of which some were related to occupation. Materials were of differing permanence, traditional status and manufacture. Varied subjects and methods of mark-making were used to convey individuality.

Patients continued to take part in making the new sculpture. As in Phase One, patients committed time both at, and away from, the Centre. The male patients participated but were initially hesitant. They showed little interest in discussing ideas but enthusiasm increased when making began. The men were concerned by the new way of thinking about the 'anvil'. They feared that the combination of personal images and chemistry would be conceptually beyond them, '*over their heads*'. They recognised that new works were no longer literal but becoming emblematic. The men's desire to stay with the certain, the solid and the realistic, was demonstrated in their suggestion that Liverpool Castle would make a good theme for sculpture. 'Liverpool Castle' was not built as the aim was to progress the sculpture beyond imitation of reality. The new sculpture moved away from the familiar, the work related and the realistic, and they found this transition difficult. While the men had expressed no difficulty with the gradual progression of Phase One, Phase Two demanded a greater leap in understanding. The women expressed little anxiety concerning the new way of working, continuing to suggest that permanence, realism and intelligibility were of less importance to them. The women's lesser concern may also be because they were less committed to Phase 1 work. The men's desire to repeat *The Wheatfield* verified the meaning this sculpture had for them.

After the initial difficulty in accepting *The Periodic Table*, as Phase 2 progressed both men and women patients continued to find satisfaction in making, even when unsure of the outcome. The patients were prepared to hammer clay, sew stitches in handkerchiefs and knot handkerchiefs in wet clay, without any indication of the result.

The patients demonstrated increasing understanding of visual vocabulary, as demonstrated in their choice to leave the shields of *The Call to Arms* without additional colour. The women recognised a difference between sewing for necessity or therapy and sewing for sculpture. Even those who did not like to sew took part because of the aspirations of the exercise.

Men and women, particularly those who had also been involved in Phase 2, showed little enthusiasm when they considered the activity to have become like a pastime. This is exemplified when commonplace dough was used. When *The Common Jewel* was made, the patients were required to make simple drawings of recognisable images. In the previous works the patients had been using abstract gesture such as stitches or hammer blows to communicate. It is possible that they felt disappointed when asked to communicate in such a conventional way. The simple drawings were a less sophisticated language than the one the patients were becoming accustomed to and they may have perceived it as retrogressive.

Male participants continued to respond with greatest enthusiasm when the activity was related to working life, possibly because of satisfying memories of making and activity. When making *Things we No Longer Use* the men refused engagement in activities which they considered feminine, suggesting that they were keen to convey their masculinity through the sculpture. To a greater extent than in Phase 1, the women began to associate the activity with their personal experiences of making, as became apparent when making *Things we No Longer Use* where the women drew objects from their home, the site of their creative lives. When a sculpture was made which involved little physical engagement, as in *Sovereignty*, little enthusiasm was shown by any patients. It could be that they valued the physical exchange of strength needed to invest their precious energy in a substantial object.

A significant step in the patients' developing understanding was apparent when making *Parting Gifts*. In Phase 1 the men had been unwilling for the form of *The Wheatfield* to be altered by dissection. However, in Phase 2 the groups, including several who had been involved in making *The Wheatfield*, gave little resistance to the halving of the 'birds' for *Parting Gifts*. Patient response suggests that for most realism had become less crucial⁸. However, the patients' reactions also suggest that they had begun to trust

⁸ For the women who made the swan, its realism remained important. She objected to the dissection and her concerns were addressed.

the researcher, and to recognise that unexpected actions sometimes led to new discoveries.

The results of making Phase 2 sculpture suggest that patients continued to find making sculpture rewarding when the process was uncertain and when the product was ephemeral, non-permanent, intangible and contained personal elements. However, it took the male patients longer to become comfortable with this outlook. Both men and women patients were prepared to practice craft-related activities only if they were contributing to a less familiar vocabulary. Mediums and methods which required physical engagement generated more interest than those that did not, such as *Sovereignty*.

It was suggested in Phase One that the value of process was inseparable from the understanding and anticipation of the completed work. The results of Phase Two appear to contradict this as some patients were able to value making without any vision of the complete sculpture. It is possible that the patients continued to value the aspiration to develop a visual vocabulary. The aspiration was inherent in the complex tasks they were asked to do, rather than a concrete picture of the completed work, as Lacy (1995) describes '*processes are also metaphors. They are powerful containers of meaning*'.

Unlike in Phase 1, Phase 2 sculpture encouraged the women to record their working lives, as the processes used had greater resonance. The men's refusal to participate in activity considered feminine suggests that making is one of the channels through which masculine identity is expressed. The following Chapter reports patient attitude to Phase 2 making.

Table 6.1. Summary of Making

Title	Media	Task of patients	Patients' Input	Presentation
<i>The Periodic Table</i>	Clay Copper wire Glaze Chalk Kiln props	To make drawings in copper wire, on 60cm square clay slabs. Drawings are of events in their lives corresponding to atomic numbers on Mendeleev's Periodic Table.	The patients made slabs over six workshops. Forty was the final number, no more was made, to avoid monotony. It was hoped to avoid repetition of numbers, but patients' desire to make certain numbers lead to some being repeated, while others were ignored. It was frequently childhood numbers which were repeated and adult numbers neglected.	The forty clay tiles were glazed with a white semi-matt glaze, through which the copper lines appeared as green. The tiles were placed back into a 300 x 160cm periodic table, drawn in chalk on a stone floor. Repeated slabs were placed as near to their intended place as possible. Gaps were left where tiles were missing. Slabs were raised off the floor with 3cm high kiln props.
<i>Messages from the Front</i>	Handkerchiefs Blue cotton thread Ribbon Wooden desk	To make sewn drawings on seventy handkerchiefs using cotton thread. On the handkerchiefs an accumulating number of stitches were made, from one to seventy.	The women completed all required handkerchiefs. Small numbers of stitches resulted in abstract lines, whilst large numbers enabled the women to draw images including flowers, a pram, animals and fruit. They also experimented with stitches to create three-dimensions.	Handkerchiefs were put together in a book, fastened with burgundy ribbon. These were placed on a 50 x 70 x 110cm writing desk.
<i>Hankies to Wave off the Sailors</i>	Handkerchiefs Copper wire Clay slip Wood Carpet underlay	Stitches made in the above piece were copied in copper wire, onto new handkerchiefs. Patients were then invited to dip these in clay slip and experiment with forms.	Patients discovered that knot forms were more likely to survive firings than flat or pleated forms. Seventy ceramic knots were made.	The knots were glazed with a shiny white glaze, through which the green copper oxide showed. The knots were placed in an order of increasing green colouration, on a 230 x 40 x 40cm wooden bench, covered in a grey rubber underlay.
<i>Hammered Out</i>	Clay Wood Steel	Men were invited to hammer 10cm square slabs of clay with an increasing number of hammer blows, from one to seventy.	Patients hammered seventy squares, which became increasingly more fragile.	These were fired to bisque and presented on a 100x 70x 70cm wooden and steel frame, as if they were a tablecloth.
<i>The Call to Arms</i>	Clay Steel	Patients were invited to construct clay shields by press-moulding clay, in any chosen pattern, into moulds made by the researcher.	The size of the moulds tired the patients, so most worked in pairs to complete a shield. Whilst most patients made abstract patterns, some made images, such as names, stars and a daffodil.	Patients chose to leave the thirteen shields produced without glaze. They were presented on 150cm high steel stands, at torso height. The shields on stands were arranged in a group covering an area of 250x 300cm.
<i>The Common Jewel</i>	Salt-dough Food colouring Cotton sheet	Patients were invited to design and make heart-sized, personal coats of arms in salt dough.	Thirteen dough shields were completed.	The shields were laid upon a white bed sheet, placed on the floor.
<i>Parting Gifts</i>	Clay	Patients were invited to	Seven birds were made,	The outside of the birds

	Cardboard Packaging foam	make clay models of chosen birds.	including an owl, a kingfisher, a crow, a duck, a swan, a grouse and a cockerel. After examining the clay models, the researcher asked the patients if the birds could be cut in half, explaining that this would reveal the insides of the birds, never seen before. The patients agreed to this.	were glazed in appropriate colours (e.g. blue for a kingfisher). The halves of birds, with the exception of one, which was tied closed with string, were presented open, packed in cardboard boxes and supported by packing foam.
<i>Things we No Longer Use</i>	Pillows Dress-making pins, Copper plate Plastic plate stands Steel shelves	Patients were invited to make drawings of items they no longer use in pins on pillows.	Women responded by drawing a teacup, keys, a wedding ring, pyjamas, a blouse and a babygrow. The men refused to use the pins and cushions, requesting instead to hammer their drawings into metal. They hammered drawings of a shoe, a pocket watch, a car, a clock, a plumb line and a camera into 0.1cm copper sheet.	The researcher cut and folded the copper sheet on which the men had drawn, turning them into 'coins' (max 40cm diameter). These were presented on a 160 x 340 x 100cm shelf, while the women's pillows were placed directly onto a stone floor. The work occupied approximately 400 x 300cm floorspace.
<i>Sovereignty</i>	Sound recording and broadcasting equipment Clay Glaze Glass box	Patients were invited to record their verbal descriptions of things they make, or used to make. They were also invited to make hand- held clay models of their perfect chair.	Patients made sound recordings describing patching worn clothes, laying a terrazzo floor, making a rug, operating a machine press and being a ship's engineer. Only women patients made the tiny chairs.	The tiny chairs were glazed with a metallic grey glaze and placed in a sealed 30 x 30 x 10cm glass box. The sound recording was broadcasted with 15cm high speakers.

Chapter 7

Response to Phase 2 Process

7.1. Introduction

Patient verdict of Phase 2 was collected to discover if making ephemeral, temporary and non-ceramic sculpture was of equal value to making in Phase 1. In Phase 1, patients had valued the way sculpture conveyed and preserved their identity. Phase 2 sculpture required more personal contributions from patients, enabling the relationship between making and identity to be explored further.

7.2. Level of Patient Participation

Over the eleven month period of Phase 2, forty-two different patients attended the two groups. Of these, thirty-three participated in making sculpture at some point. Eleven patients had continued attending the group since Phase 1. Of these, 9 had been regular participants in Phase 1, and, with the exception of one, continued to be regular participants in Phase 2. Appendix 9 (Tables 1, 2, 3, and 4) records participation at every workshop throughout the research. Appendix 12 (Tables 1 and 2) records the participation rates of individual patients. Table 7.1 shows the participation levels of patients in the men's and women's groups. In Phase 1 there were some people who attended the groups only once, and their data was removed from the tables to avoid bias (Section 4.2.1.). In Phase 2 this also occurred, so the data was adjusted for consistency. Out of an average of 8 patients attending, 5 patients participated. The overall percentage of patients taking part was 63%. The participation rate in Phase 1 was 57%, showing an increase in Phase 2.

Table 7.1. Average Participation Rates of Men and Women in Phase 2

Patient Group	Average No. Groups Attended	Average No. Workshops Participated	Average % Participation Rate
men	8	4	50
women	8	6	75
men and women	8	5	63

7.2.1. Participation According to Gender

Table 7.1 shows that male and female participation rates were different. On average, 8 men attended the group, of which 4 participated in making (50%). The average number of women attending the day unit was also 8, out of which an average of 6 participated (75%). As the same average number of men and women attended the day unit, the differences in participation can be examined with greater legitimacy. In comparison with the Phase 1, the women's participation rate remained constant, while the men's increased slightly (6%).

In Phase 1 there had been notable differences in the patterns of male and female participation. In the men's group there had been a 'core' of keen participants, but many who did not take part at all. The participation in the women's group had been more evenly distributed. In Phase 2 this difference was no longer apparent, the patterns of men's and women's participation becoming more similar.

In the men's group, those patients who had been present and active participants in Phase 1, continued to be the most frequent participators in Phase 2. There was one exception. A man who had been an almost constant participator in Phase 1, now rarely took part. Likewise, in the women's group, of the 4 women who had taken part more

than 10 times, 3 had also been keen participants in Phase 1. Those who have been involved the longest appeared to continue to participate with greatest frequency.

7.2.2. Participation According to Age and Occupation

As in Phase 1 age had no bearing on those who took part and those who did not. The previous occupation of the patient was not a factor in the level of participation, except for the men who had been 'smiths' in Phase 1, who continued to be frequent participants in Phase 2.

7.3. Participation Rates for each Sculpture

Appendix 13 (Tables 1, 2 and 3) records the patients' participation rates when taking part in the making of different sculptures. Participation was high (60%+) in both men's and women's groups when they were invited to record events in their lives in *The Periodic Table* and the periodic table drawing. In contrast, participation for both men and women was low (-50%) when making *The Common Jewel*. As in Phase 1 men's participation rates were much lower than women's when invited to experiment with drawing. The most significant difference in male and female participation was when making *Things we No Longer Use* and *Parting Gifts*, when the men took part much less frequently than the women.

7.4. The Nature of Participation

In Phase 1 there had been a core of men who were keen participants. However, in Phase 2 there was a core of enthusiastic participants in both the men's and women's groups. The patients who formed the core were frequently those who had also taken part in

Phase 1. While there was a group of committed women participants, they did not appear to function as a team, so did not appear as a ‘core’ in the same way as the group of men did.

7.5. Patients’ Perceptions

Patient opinion of making Phase 2 Sculpture was sought. Interviews were conducted from February 4 to May 14, 1997. Patients arriving new to the project in this period were given a month to participate before being interviewed. Table 7.2. records the number of patients interviewed, and reasons for non-interview.

Table 7.2. Number of Patients Interviewed, and Reasons for Non-Interview

Patients Interviewed	16
Patients who died before interview	15
Non-attendance	2
Total Participating Patients	33

7.5.1. Responses Consistent with Phase 1

Many of the patients’ responses to Phase 2 were consistent with Phase 1. Patients continued to describe the pleasure of making sculpture, and particularly the physical involvement. Patients also continued to refer to a sense of achievement. One man noted that this had led him to regain his interest in life,

‘When you’re in a situation like myself and most of the others, you seem to lose a lot of interest in life. But when you start getting shown things, what to do, and you achieve things, you see the finished product, and it lifts you. That’s the only way I can explain it.’

Completing the sculpture, when there was little time left, was perceived as a source of pride. As in Phase 1, some patients (who had not been involved in Phase 1) described their trepidation at making sculpture. All three went on to say that this had been resolved, and that they had been pleasantly surprised by their own input.

Patients continued to reference scale. In contrast to Phase 1, however, less emphasis was given to the physical scale and more to the conceptual size. The sculpture had 'more' in it; the aspiration was greater. The same woman compared the sculpture to the 'spider diagrams' she had seen which link many ideas to a central theme. She said,

'If you put spider work with an oil painting two hundred years old you'd only get two or three legs wouldn't you? How many legs would you get with your work. You'd get thousands wouldn't you, in the end, because there's so much going off it.'

The patients continued to describe how both making sculpture and seeing it complete provided an elevating experience. One patient commented: *'When we saw the exhibition it was just out of this world really'* and another said *'You inspire us to art- take us to our limits'*.

7.5.2. Differences in Responses Between Phases 1 and 2

7.5.2.1. Challenge

Unlike in Phase 1, the patients described making sculpture as a mental challenge, *'It stretches your mind but it doesn't physically take a lot out of you.'* Another described how the challenge in the activity lay in not knowing what the result would be. Eight patients (five men and three women) expressed how the activity was *'different'*. It appeared that the unusual nature of the project was viewed as positive and this novelty was something to be valued.

7.5.2.2. Involvement in the Medium

The patients made more references to materials and the physicality of taking part. Although materials other than clay had been used, including handkerchiefs and paper, the patients only referred to clay and its messiness and the manual engagement required,

'I used to do a lot of baking. I don't have the need to do it now, I also can't stand and do it now, so I like delving in with my hands.'

The patients used a predominance of terms which conveyed physical involvement, describing it as being 'in' the activity. As one man said, *'we were right in it, not just as a spectator, or receiver, but a doer'*. Other descriptions included *'something to get a bit more stuck into'* and *'you lose yourself in it'*. There was an indication that the patients thought the clay demanded more investment. One man said, *'When you're working with the clay you have to put more into it, you're working more.'*

7.5.2.3. Relation to Work

In contrast to Phase 1, when asked if making sculpture was similar to paid employment most patients felt that it was different because it was enjoyable. As one man said, *'the sculptures were done for pleasure, whereas work is a drudge really'*. Even those patients who had compared making sculpture to work in Phase 1, now said that there was no comparison. When patients were asked whether making sculpture was the same as, or different to, occupational therapy activities, the patients said of the latter, *'You'd give them to a child to do,'* and *'It's all sort of what you did at school'*.

More patients compared sculpture with childhood play, than in Phase 1. One patient compared making sculpture to being a child at school and two compared it to a child playing freely. One woman compared making to work in the home.

7.5.2.4. Individuality

Patients referred to how making sculpture, and the completed object, conveyed their individuality. Two women described how coming to the day unit and taking part was a time to concentrate on themselves, as one said,

'This is where I'm [patient's name]. This is my coming out and being in the world.'

Both regarded making sculpture as a means of communicating about themselves. One compared sculpture with occupational therapy,

'It [a gift item made by the same patients in Occupational Therapy] doesn't say anything about anybody, it doesn't say anything about me, whereas that pillow that you've (the researcher)- it says everything.'

7.5.2.5. Understanding

In Phase 1 there were many references to realism and permanence. However, in Phase 2 neither realism or permanence were mentioned. Four patients spoke about their sense of a growing understanding of art. Of these four, two had also been involved in Phase 1. Patients commented that they thought the activity strange at first,

'When I saw some of them things I thought "Oh my God". When you explained it all, it come easy. I was surprised how easy it did come. It's just not knowing or understanding it. I've never had anything to do with art before, apart from painting railway models, that's my art. Yours is totally different, but once I understood, anything is possible, you just go on don't you.'

One remaining participant also from Phase 1 explained how his understanding had changed when making *Hammered Out*,

'You could put sixty holes in that bucket. Now that sounds stupid, might look stupid, but at the end of the day when you see it, it looks good.'

In addition, one woman described how her participation had widened her understanding of what art was. She was new to the project.

Although the patients detected a new understanding gained in Phase 2, they continued to value the work of Phase 1. When asked whether they thought that in the future there would be anything particular they might remember about the project, eight (four women and four men) said that elements of making the sculpture would be memorable, while several referred to the people involved. The remaining five people who answered this question said that the completed sculpture, and *The Wheatfield* specifically, would be what they remembered:

'The anvil overall. It just turned out so well, and the exhibition, I think I'll always remember that.'

7.6. Discussion

The level of participation in Phase 2 was greater than Phase 1, suggesting that patients found the latter stage to be of equal, if not more, value to the former. While the composition of the groups changed almost completely over this period, the increasing level of participation suggested that enjoyment was not limited to a few individuals. The core of men, the 'smiths' from Phase 1, survived and continued to participate throughout Phase 2. The women who participated in Phase 1 were also frequently involved in Phase 2. However, none of these survived until the project conclusion. It might be that the surviving patients were fitter at the outset so had a greater desire to make. Alternatively, the survival of the keenest participants might suggest that making was a factor in their survival. As one man described, his interest in life had been renewed by making sculpture.

Those who had been involved longest appeared to continue to participate with greatest frequency. This was partly due to the rapidly changing group population. Those who

came late to the project were often those with lowest participation rates. This was because they did not have the opportunity to take part in as many sessions. However it might also be because, arriving at an advanced stage in development, they found the activity harder to comprehend.

The participation rate of women in Phase 2 stayed constant with Phase 1, while the men's increased slightly. The number of women attending the day unit had increased since Phase 1. Unlike in Phase 1 more patients valued the process. This may be because it was less clear what the outcome would be, and also because the processes themselves became more complex and demanding. However, it might also be because a greater number of women took part in Phase 2, and, as discovered in Phase 1, they were more likely to value process.

Both men and women participated frequently when making those works which recorded their lives in clay. However, when invited to make works using a commonplace material and a mundane method, participation fell, suggesting that they had grown to value a more complex visual language. As in Phase 1, men continued to disregard drawing, showing their continuing emphasis on a three dimensional product.

Consistent with Phase 1, patients continued to express pleasure, and describe a sense of achievement. They also continued to remark on 'scale' and the amount of 'content' in the sculpture, even though the sculptures in the two Phases had differing qualities. The sculptures in Phase 2 varied in dimensions from 20cm x 20cm x 7cm to 300cm x 250cm x 170cm, yet all were referred to as having 'scale'. Unlike in Phase 1, the patients no longer sought realism or permanence, suggesting that these qualities were not a precondition for the valuing of sculpture.

The patients continued to describe how making the sculptures was beyond the 'ordinary' and one woman described a metaphorical extension beyond her body. The 'scale' that the patients described was ambition and elevation, present in both Phases,

irrespective of the actual size, medium and permanence of the works. However certain works, such as *The Wheatfield* were regarded with greater significance (by the men patients) than others.

In contrast to Phase 1, patients could no longer compare making sculpture to work. The activity had moved beyond the familiar. Rather, the patients reflected on the child-like delight they found in making sculpture compared to the toil and responsibility of work.

Clay remained the material most valued by the patients because of the physical and mental absorption required to manipulate it. In the vocabulary used to describe making with clay, the patients implied that they had invested themselves in the material. Patients suggested that complete sculpture conveyed their individuality. Patients, particularly women, thought they, and their situation, could be communicated to others through the sculptures. One suggested that the difference between sculpture and occupational therapy was that, unlike sculpture, therapy did not provide a vocabulary for transmitting the personal.

Chapter 8

Phase 2 Sculpture and Identity

8.1. Introduction

Unlike in Phase 1, in Phase 2 patients were asked whether they saw the identity of themselves or others in the sculpture. Patients were asked their opinion of the materials used, to determine whether value depended on a permanent record. Evidence of growing understanding of the completed work was explored to elicit the impact of making sculpture on the patients.

8.2. 'Heraldry'

As in Phase 1, Phase 2 sculpture was exhibited to elicit patient and viewer response. It was planned that the sculptures would be exhibited at the LMCC, so opinions of the hospice community could be gathered. However, it became apparent that the site was not appropriate. The quantity of sculpture and its scale discounted exhibiting in the allocated space. Phase 1 clearly indicated that appropriate presentation was valued by participants. Since the perceptions of participating patients and art professionals were of greater importance than those of the whole hospice community, it was decided to exhibit the work in a public gallery.

An appropriate exhibition space was sought for September 1997. The Grand Hall, Albert Dock, Liverpool was agreed. It commands a central position in a colonnade of shops and the Liverpool Tate Gallery. The Grand Hall is a renovated warehouse previously used in the dock industry. The Grand Hall's industrial past made it a pertinent venue for the sculptures, while its area afforded each work ample space in a

contemplative atmosphere. The space is approximately 30m x 20m; larger than was needed. It has stone floor and red-brick walls, to which nothing must be attached.

The period of exhibition was September 24 to 30, 1997, with an opening event on September 23. A title for the exhibition was discussed with the patients, and ideas for a group name were sought. One man suggested the group name 'Day' or 'Dayze', to represent the day unit. Finally, the researcher gave the exhibition the title, 'Heraldry', referring to the heraldic imagery used in *The Common Jewel* and *The Call to Arms*, and to the representative function of heraldry. The exhibition was advertised with posters (Plate 31) presenting images of the sculptures. All participants were listed and brief information about the sculptures was given.

Curation and presentation was the task of the researcher alone. Consideration was given to how the sculptures related to the hall. Features of the hall guided the arrangement; alcoves, windows and available lighting determining the optimum placement of the work (Plate 32) for example, the coins in *Things we No Longer Use* required direct light to maximise the reflective capacity of the copper. Further information for visitors and photographic record of the artist and patients at work was provided with questionnaires to gather audience opinion.

Plate 31. Poster for 'Heraldry'

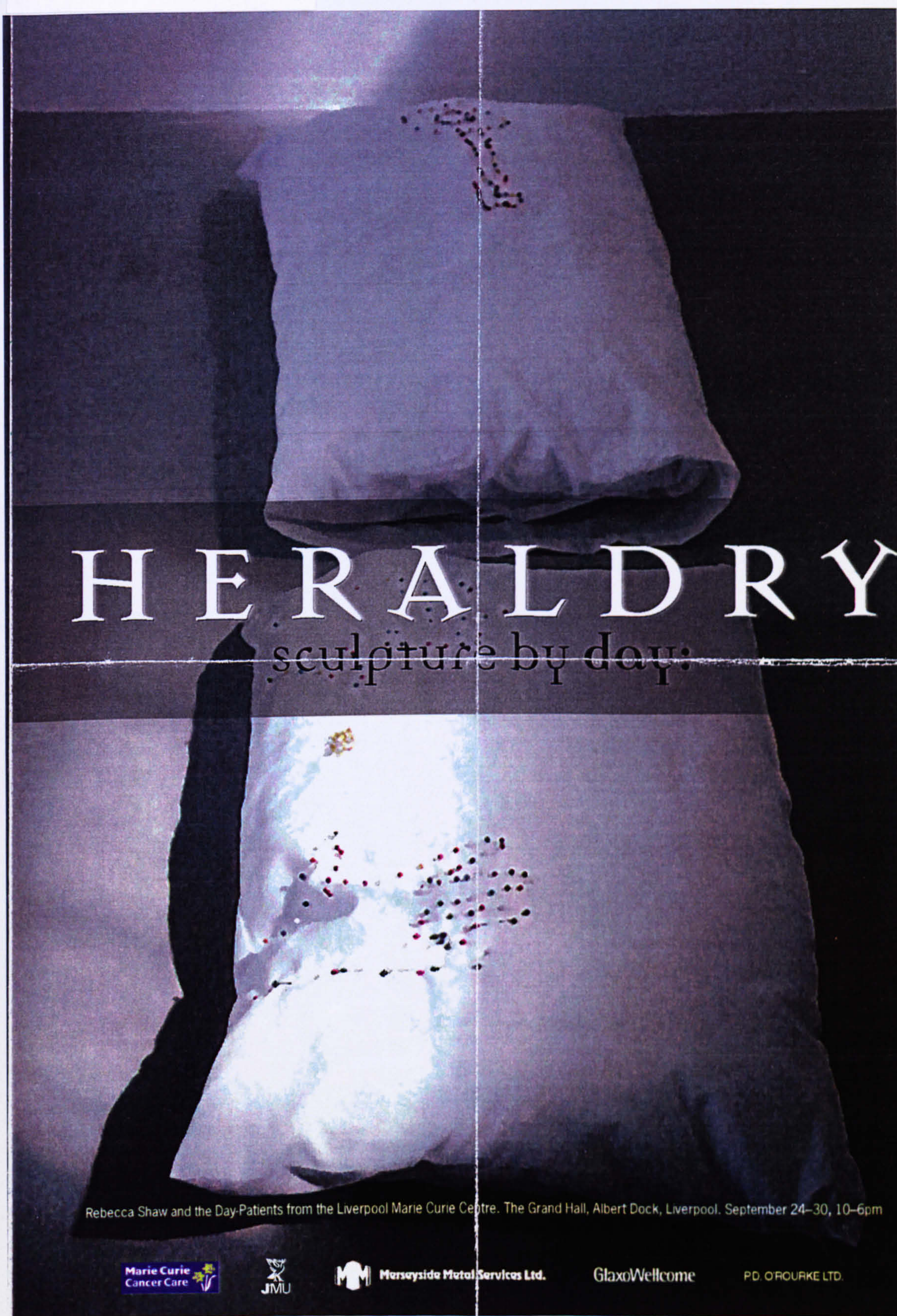
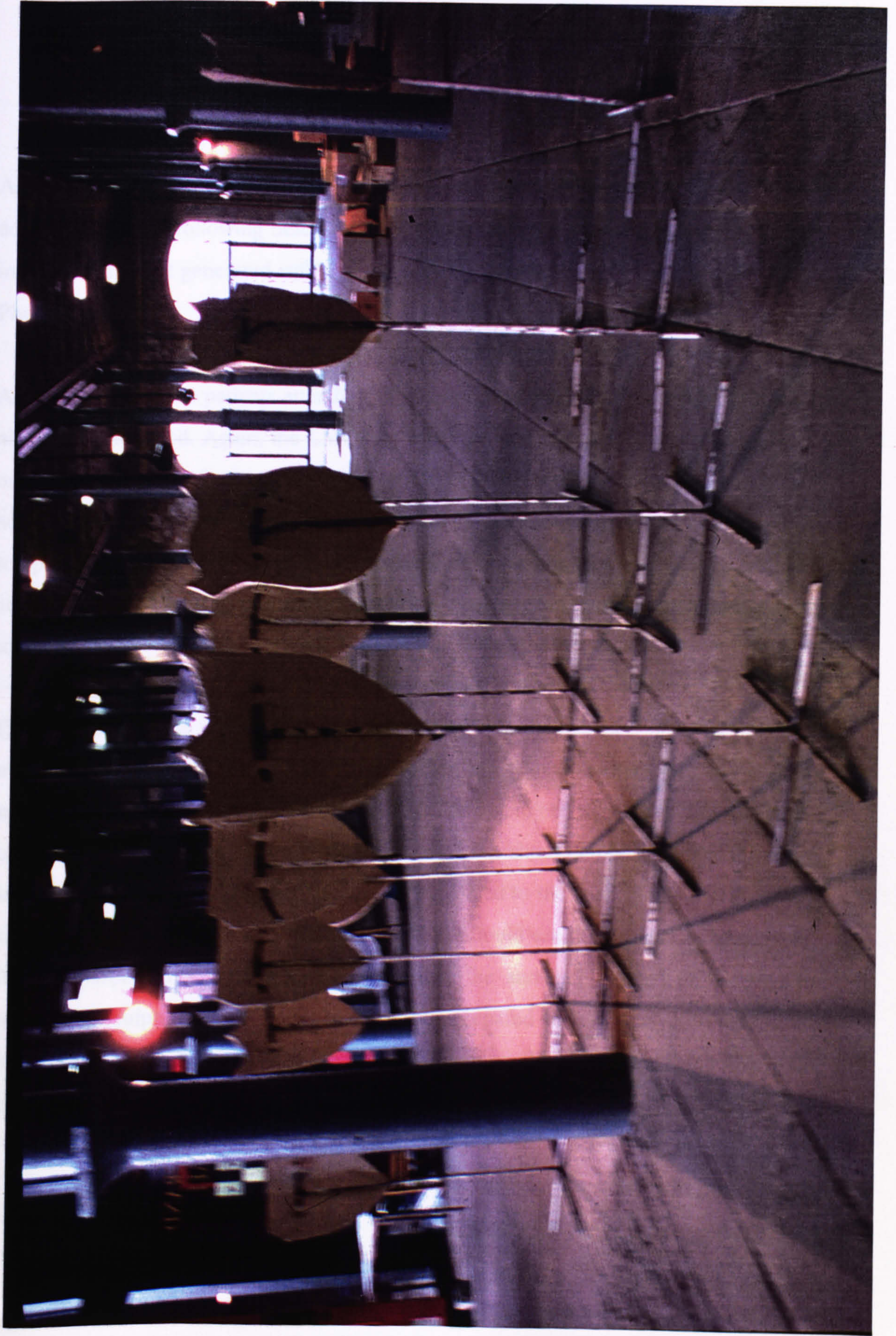


Plate 32. View of Exhibition



8.3. Observed Patient Response

As in Phase 1, the patients' visit to the exhibition was observed and interviews administered. The following describes the patients' verdict. As the questionnaires used in Phase 1 had not generated sufficient data, the proven interview method was used for Phase 2.

As in Phase 1, all the patients attending the day unit were invited to attend the opening night. Two attended. Again, the LMCC brought the day-patients to visit the exhibition on their usual days of attendance. Five of the men attended and their enthusiasm was noted. One, who had also participated in Phase 1, expressed surprise at the number of sculptures presented. Eight women patients visited, including two new women who had not been involved in the project. Some women participants were embarrassed by the sound of their voices in *Sovereignty*.

The non-participants commented that the gallery appeared empty, and did not have enough in it. The two non-participating women also felt that there was not enough information displayed outside to draw visitors. They were concerned that people did not know the exhibition was on and thought information should emphasise that ill people had made the sculptures. The researcher had explained to the participants that emphasis was not put on their illness because the audience should see the sculptures objectively. The non-participating women also thought that the audience needed information to explain the sculptures. The researcher was not prepared to add this information, but instead an additional sheet was added to the others on the table, describing how each sculpture was made and how the patients had contributed.

8.4. The Patients' Verdict

The patients were interviewed on their next visit to the Centre (one week later), using the new semi-structured schedule (Appendix 6). Due to non-attendance, some were interviewed the week after. With one exception, all patients who had attended the exhibition agreed to be interviewed. One woman refused, being too ill to speak. Another, who had attended the exhibition, was too ill to attend the Centre for several weeks, so was not interviewed. The new interview method generated more detailed data than the method used in Phase 1.

Those patients, both participants and non-participants, who felt that individual sculptures were particularly memorable, referred primarily to the copper 'coins' in *Things we No Longer Use*. Others referred to *Parting Gifts*, *The Periodic Table*, *The Call to Arms*, *Messages from the Front* and *Hankies to Wave off the Sailors*. No one favoured *The Common Jewel*, *Sovereignty*, *Hammered Out* or the pillows in *Things we No Longer Use*. To present a coherent report of the patients' responses a description is given of initial responses to the individual works. Following this, data is presented according to themes: the patients' opinions of the materials used; the degree of individuality they considered the sculptures to convey and their opinions of the significance of the making process and the completed works. Attention is given to notable differences between the perceptions of the men and those of the women patients.

The Periodic Table was received with positive reactions. Several men described how they had not expected the tiles to be so effective when completed. As in *Parting Gifts*, the patients frequently commented on, and admired, the contributions of their fellow patients.

The two pieces made with handkerchiefs, *Hankies to Wave off the Sailors* and *Messages From the Front* received little response from the men. The women responded with more enthusiasm. One said of *Hankies to Wave off the Sailors*,

'Such a small effort into tying a knot and for them to look so beautiful afterwards, that was my favourite.'

Another woman paid particular attention to *Messages from the Front*,

'I tend to dream about them (the handkerchiefs). It's like turning over the pages if you like. I remember the odd picture, but I think I must put my own pictures into it.'

Like the men, several of the women appeared to regard *Messages from the Front* as of little significance, both in the effort needed to complete it and the completed sculpture. Several non-participants failed to comprehend the desk and handkerchiefs as one sculpture, saying *'I thought it was where the security was sitting.'*

Two of the participating men expressed how they were pleased with the final presentation of *The Call to Arms*. However, a non-participating man said he was disappointed and *'surprised that there weren't any colours on them'*. Another non-participating man reflected on the contribution a fellow patient had made;

'Maybe a knight would put his name in a shield like that and Ron put his as big as it could be and that was the one I really liked.'

In contrast, a non-participating woman disliked *The Call to Arms* and its association with protection;

'I didn't like them, the big ones, they were utterly meaningless to me. I didn't know why they were there. I was thinking of protection from the outside world, but I didn't like the idea of that.'

The same woman preferred the small shields of *The Common Jewel*, because *'they seemed to say more'*. However, many more patients referred to the large shields of *The Call to Arms* than the small shields of *The Common Jewel*. Some patients did find features of interest in the later piece. One non-participating man said, *'each one had a*

little bit of thought behind it.' One woman found that *The Common Jewel* reminded her of home and cosiness.

Parting Gifts elicited a range of responses, often referring to the presentation of the ceramic birds in foam packing. One non-participant said that she thought the sculpture looked like it was still being unpacked, while one participant thought that the packaging materials could have been exploited further. A man who had made one of the ceramic birds thought the presentation was effective and a woman described how the colour of the ceramic birds appealed. A participating man described his interest in the exposed interior space of the ceramic birds;

'The birds I thought were excellent. It did represent something of not being touched. No one had touched it (the inside) but it turned out as representing something.'

The copper plates in *Things we No Longer Use* were described frequently. One woman admired the concentration required to hammer the copper plates, while another sought to find personal significance in the drawing of the clocks on the coins, *'you tend to think how much time have we got left, so time means a lot to us now'*. Others preferred this piece because it appeared *'more finished'*. Little attention was given to the pillow components of *Things we No Longer Use*, as one man said *'I didn't appreciate the pillows'*. A woman who made a pillow drawing said that the subject of her drawing, her old pyjamas, had become important to her now because she had portrayed them in sculpture.

The pieces least mentioned by the patients were *Sovereignty* and *Hammered Out*. Two of the men who had taken part in making *Hammered Out* recalled its making and one non-participating man commented on how the makers must have enjoyed hammering the clay. One woman said, *'I couldn't get anything from that one'*. Only one woman mentioned the sound recording that accompanied the ceramic chairs; *'It put a bit more*

background to it, of the people you actually worked alongside with.' One man mentioned the ceramic 'chairs' of *Sovereignty*;

'I didn't really appreciate the chairs. I think there's a bit of sadness about someone's favourite chair because, you know, the people who have sat in the chairs. Who really wants to think about that?'

The patients responded with enthusiasm to the exhibition as a whole. The sculptures, *Things we no Longer Use*, *Parting Gifts* and *The Periodic Table* generated greatest interest. *Sovereignty* and *Hammered Out* were received with least interest.

8.4.1. Patient Opinion of the Media Used

The patients were asked to identify which medium used in the exhibition had greatest effect, and which they had preferred working with. The materials mentioned by the patients were copper and clay; no other medium was referred to. Most patients named the medium they preferred to work with as the one which was also most effective.

The copper in *Things we No Longer Use* was perceived by patients to be more long lasting (and therefore possibly of greater financial worth) than clay. Permanence may have been a factor in the differing appraisal of the sculptures by the men and women. The men responded with less interest to sculptures like *Sovereignty*, which were small, and sculptures using fragile or traditionally feminine material such as handkerchiefs or dough. They responded with interest to sculpture which was larger and which inferred permanence, such as *The Call to Arms*. In contrast, the women appreciated sculpture which was smaller and appeared fragile. Over all, however, both women and men valued the more permanent and physically substantial sculptures.

Both men and women (with one exception) showed little interest in *Messages from the Front*. The worked handkerchiefs were presented on a familiar object, a writing desk, and had required little skill to complete. Unlike *Hankies to Wave off the Sailors* where

the handkerchiefs were dipped in the traditional fine art medium of clay, the handkerchiefs in *Messages from the Front* had not been subjected to further process to make them 'permanent'.

While the patients did not always show a preference for long-lasting materials, they did hope the sculptures could be preserved. One woman said,

'I haven't got a preference, but I would like to see them kept.. It's like part of us has been left behind with these. I haven't got a preference with materials because I don't know that much about them. I know the copper will last forever, probably the clay won't.'

The completion of the sculptures was seen as significant because the patients' invested achievement would be preserved in them:

'At the end of the day, although we've maybe never achieved anything in life we've achieved something by doing that, by just making something. And that will last forever. And the point is, we won't last forever.'

One woman preferred long lasting materials because the sculpture could continue to be viewed by others.

One man expressed no preference for permanent materials but thought the works should be looked after to preserve them. The patients' belief that the sculptures should be preserved suggested that they thought the works were important, of more worth and status. The same man described how, although he did not have a preference for permanent materials, he did prefer the more permanent Phase 1 sculptures:

'I did prefer the first batch because it (The Wheatfield) was a construction of something which was a visible thing which ...would endure for a long time.'

Indeed, of the four men interviewed who had previously participated in Phase 1 sculpture, three continued to name it as the most rewarding to make and the most satisfying completed sculpture;

' Given the chance I would like it long lasting. The likes of the clay, which is the anvil [The Wheatfield], that is the be all and end all as far as I am concerned. That was the icing on the cake.'

8.4.2. Identity Conveyed by Sculpture

The patients were asked to describe whether they felt any of the sculptures represented them. Several of the patients said that they were unable to answer the question. The patients who did answer used different approaches. One woman thought her contribution to *Parting Gifts* represented her;

'I think the swan because I like looking at birds. We used to have swans on the lake, you know, Sefton Park. There's none left now. The fishing lead and all that. Because they're my favourite bird.'

The swan represented her because it was her favourite and it also represented her memories. The woman was the one participant who had wanted her bird sealed, not displayed open. One man (who had been a terrazzo floor layer) thought the act of making, rather than the finished sculptures, represented his desire for perfection.

Other patients answered the question differently and referred to how the sculptures represented their illness. One woman stated how the handkerchiefs in *Hankies to Wave off the Sailors* reminded her of her tears. Another thought her contributions to *Things we no Longer Use* and *The Periodic Table* represented her as she was now, not in health. Also, she believed her contribution to *The Periodic Table* represented her because for the first time she had made an image of a recurring dream she had had all her life. She asserted the importance of seeing her individuality represented through a hand-made object,

'That is going to be there when I'm not, which is nice....I know there's lots of things we can leave behind, but it's not what we made ourselves. This we've took part in.'

Those sculptures which consisted of gestural, as opposed to individual pictorial marks, including *Hammered Out* and *Messages from the Front* received less interest and no individual input was commented upon.

8.4.3. The Patients' Evaluation of Making

Six patients were asked whether they found the experience of making the sculptures or seeing them completed, more satisfying. Men's responses continued to differ from women's. Two women considered making to be of greater importance, as one said,

'I think the making of it, because we're creating something. It is nice to see the end product, but I think the making part. It gets you using your mind, and your enthusiasm, to think what to do.'

Two men believed seeing the completed object to be more rewarding;

'Doing it is all right as well, but when they're finished it's more exciting. When you're finished it's more exciting to see what you've done, and then you bring pleasure to the people.'

The two remaining people, a man and a woman, thought making and viewing to be of equal importance.

The patients were asked to consider whether they perceived any difference between making sculpture and taking part in occupational therapy. The predominant difference expressed by the patients was that making sculpture was a challenge,

'It gave me an appetite. It's a challenge to go a bit higher, to try something better, more complicated, out of clay. Before you [the researcher] came we were just sitting around. There was nothing challenging or interesting, it was just sitting round with the lads. That was the end of the story- silly flowers and things like that, girly things. I'd sooner get into the likes of the clay and that, and produce something.'

The patients' responses to sculpture showed an understanding of the researcher's role.

As one man said of the coins in *Things we No Longer Use*;

'The way you [the researcher] cut them out I think made them. By cutting them out like that and shaping them the way you did them, really brought the thing out of itself, the picture itself out.'

Several patients recognised the difference between their role and that of the researcher.

One woman described the time when the birds of *Parting Gifts* were cut in half;

'You find a different meaning to us, but this is where we benefit when you explain...if we opened that bird and probably think, "Oh I've made a mess of it". But you look at it in a different way, because you're looking for something inside it.'

Another woman was asked to define whether the birds were the result of the patients' or the researcher's 'creativity'. She replied;

'They followed you... but it was their birds that they done...you just put the idea into their heads.'

The patients were less interested in the sculptures which did not demonstrate skill. *Messages from the Front* was not recognised by the patients as a sculpture, possibly because it involved ready-made objects which did not receive the application of what the patients perceived to be artistic skill.

'And the hankies, there wasn't so much challenge, I don't think. Just doing it as you requested it, so many stitches per person, there was more imagination to have gone into the likes of the birds, even with the hankies in the slip.'

The patients were asked to consider what qualities constituted an exceptional work of art, and to measure the sculptures they had made against these criteria. When asked what kind of art interested them the patients referred to objects made of 'glass' and 'paintings', 'pictures', 'paintings of rustic scenes', 'three dimensional art', 'modern sculptures with holes in it' and 'statues'. Some patients stated that they had no interest in art beyond that which they did within the project;

'Apart from what we do here I haven't any interest to be honest, I'm just a DIY man, I like knocking down walls and rebuilding walls.'

The man related his enjoyment of sculpture to his own experience of making, rather than to the art he had seen in galleries. Others commented that they had never had the opportunity to look at *'a good piece of art'*. When asked what qualities they sought in an accomplished work of art, two patients said that they sought an accurate representation of reality. Others sought *'lasting qualities'* and *'physical things with a form and a substance'*.

When asked how the sculptures they had contributed to compared with the works of art they thought were accomplished, the patients reactions varied. Non-participants, more than participants, evaluated the sculptures favourably. One thought the sculpture made at the LMCC was equal to other art she had seen. One non-participating man who had named *'lasting qualities'* as a desirable characteristic said of the sculpture made at the Centre,

'In comparison with 'The Thinker', and things like that, well, I'd like to think that this what you've done will be here years because it meant something to all the men and women who did it.'

The participating patients did not evaluate the sculptures objectively, without considering their own contribution:

'I buy a piece of glass, especially cut glass and look at it, see the colours in it and it's beautiful, but mine, my little piece of work is still beautiful, just as beautiful because I created it myself.'

Several patients thought their inexperience had to be accounted for in evaluation, as one participant said, *'I think ours is very good for people who aren't used to doing anything'*.

The patients were asked to indicate what, if anything, they believed to be the purpose of art. One woman was asked to describe whether she thought the rug she was making from a prepared kit, in occupational therapy, was art. She was clear that it was not;

'To me, art is creating things. I never created that rug, I made it, and to me it's a difference. It was already there for me. Someone else has imagined that pattern, where, to me, art is your imagination.'

In their explanations many patients mentioned the concept of *'self expression'*. Some patients referred to art's function as drawing from the personal. One man described how the role of art was to communicate the personal to others,

'I just think it's to express yourself, it's what's inside you and you can't explain it to people, but if you can make something of what's inside you, well people will know then-'

Patients saw benefit to the audience rather than for the maker, and described the purpose of art as; *'to look at and relax and enjoy looking at'*, to *'show people'* and as *'something of beauty'*.

When asked whether their involvement in making sculpture had any effect upon their view of art, most patients said that it had not. However, two recorded a change,

'I've never regarded myself as being an artistic person but I have decided since then that everybody, including myself, has some artistic values in them.'

and,

'I will see it in a different light from now on, I would have gone and looked, probably to a museum, and...think..I can't see anything in that, but now I will look because of the effort and thought that's gone into it..... and try to think what was on that person's mind when he did that.'

8.5. The Audience's Response to 'Heraldry'

The total number of people who attended 'Heraldry' over the week was 538⁹. Although the responses of all visitors was sought (using a questionnaire, Appendix 7) only the verdicts of art professionals were used. Although the rate of completion was satisfactory (average 41%) the results were of little use because the sample collected was too wide. Visitors were asked to state whether their main occupation involved the arts but it was clear from the amateur response that the definition was too wide. Most were clearly inexpert. Therefore the majority of the results of these questionnaires could not be used. A brief summary of the questionnaire responses is presented below. The terminology used by art professionals to describe the exhibition is presented in Appendix 14.

The respondents were asked to give three words to describe the exhibition. Their choices indicated that they found the exhibition to be of interest. They found the sculptures emotive and the atmosphere of the exhibition contemplative. Many respondents described the exhibition as original and eloquent. Several referred to the sculpture's vital, permanent presence. While the opinions of art professionals were diverse and often contradictory, most had an intense reaction to the exhibition. Some considered the exhibition to be depressing and melancholy but questioned whether this was as a result of the sculptures or knowing the circumstances of the makers. The respondents indicated that *Hankies to Wave off the Sailors*, *Things we No Longer Use*, *Messages from the Front*, *Periodic Table* and *Parting Gifts* were the sculptures they considered to be of greatest interest. Qualities they valued in these sculptures included the clarity of the visual vocabulary, the simplicity, variety and symbolism. The respondents described how the sculptures not only represented the individuals involved, but also had a universal quality; alluding to '*the symbolic lives lived*'. Some respondents

⁹ The number of visits varied from day to day between 7 and 164. The average daily number of visitors was 67.

criticised aspects of the presentation; one recommended more effective lighting and some considered that a more prestigious venue would have been more appropriate.

To gain a more reliable measure of the sculptures *Things we No Longer Use* was exhibited in a group exhibition at Bluecoat Gallery, Liverpool, which enjoys a well-informed art clientele. Artists of international standing were asked to review the sculpture. One thought that the sculpture was eloquent because it did not have 'terminal angst'. It did not appear as the work of 'terminally ill' people, but at the same time it was not 'light-hearted'. Another said;

'The small images of everyday objects take on a powerful resonance. There is no melancholy or self pity there but affirmation of life at its fundamental level-when faced with death. It is poetic.'

8.6. Discussion

Patients continued to value sculpture which was impermanent, fragile and non-figurative, however they did respond to the differing qualities of each work. While visual replication had been named as an important feature in Phase 1, when the new sculpture ceased to mimic in Phase 2, the patients continued to value it, suggesting that it was the aspiration to make sculpture which was elevating rather than particular features. However, some works were found to communicate better than others.

In Phase 2 the response to permanence changed. While most men and women stated a desire for their works to be preserved, they were less interested in the actual permanence of the objects. The patients valued the sculpture which appeared to be of most financial worth, partly because its material value suggested that it would be looked after, and also because this implied status and importance. The patients valued those pieces which had materials or methods associated with a fine art tradition. This was seen in the response to the two handkerchief pieces. The later one, *Hankies to Wave off*

the Sailors was valued more highly than *Messages from the Front* because *Hankies..* utilised a traditional material, clay slip, which rendered elements more permanent.

Although Phase 2 sculptures were valued, the men continued to view *The Wheatfield* as the pinnacle of their achievement. An anvil, on which *The Wheatfield* was based, is cast iron used, in turn, to form iron, having both strength and longevity. A ceramic anvil, however, has no more permanence than the other ceramic sculptures. When the patients valued the permanence of this sculpture it was not only due to the actual longevity of the stoneware, but also to the perceived strength of the subject and thus the communicated permanence of the sculpture.

While the women were more comfortable than the men with works which were fragile and less permanent, they did prefer those works which were more physically substantial, for instance, the coins in *Things we No Longer Use*. While the patients did recognise that preservation did not depend on actual permanence, they preferred those works which communicated permanence.

It appears that *The Wheatfield* was esteemed by the men, above other works because it communicated the qualities of strength, solidity and permanence which they valued. The men refused to participate in activities they considered feminine (Chapter 7). Likewise, their masculinity was represented through *The Wheatfield*. In contrast to the women, the men continued to value the completed work more than process. The men recognised completion as an indicator of success, whereas the women recognised that value and meaning could lie in development. However, the process had to be directed towards an ambitious goal.

The continued appreciation of works perceived to be more permanent reveals how patients sought the preservation of identity through sculpture. There were many references to how the objects made by the patients would remain after they had gone. The sculpture made by the patients was seen to convey their identity better than any

other object they possessed. Some quality of the individual was transmitted into a material through making, and then preserved for others to experience.

The patients' emphasis upon the vital, permanent presence of some sculptures, demonstrated how making is important when the body is weak. As in Scarry's (1985) notion that all objects are a projection of the body, the sculpture recorded the sentient bodies of the patients. Through making the patients asserted their vitality and presence. In answer to Spalding's (Triggs, 1971) statement '*to do nothing is to be nobody*', the patients could '*feel themselves in doing*'.

While the patients had found the complex, abstract tasks required to make *Hammered Out*, *Messages from the Front* and *Hankies to Wave off the Sailors* rewarding, they placed less value on the finished sculptures. In the gestural marking with hammers and knots less of the individual could be conveyed. In contrast, *The Common Jewel* required a literal representation of the person, but few patients valued this work, suggesting that presentation of the individual was not the only factor in the patients' verdict.

The patients described their pleasure in seeing friends represented by their contributions. When asked what aspects of the individual were recorded in the sculpture, patients described memories, their illness and their actions. The relationship between making and identity is evident in the different responses of men and women. The men continued to seek to be represented by strong, permanent works, while the women found fragile and personal works to be of relevance.

Non-participants and those who had made sculpture responded differently to the exhibition. Non-participants thought the hall looked empty and wanted an explanatory text emphasising how ill people had made the work. The non-participants found works which did not comply with their expectation of art problematic. In contrast, participants were impressed with how much work they had made, requested no additional information, were unconcerned whether the audience knew of their illness and had less

difficulty with these works. Involvement in making the work had given participants an insight into its meaning and had developed their understanding. In Phase 1 participants had wanted the audience to know of their illness but in Phase 2 they did not, suggesting that their interest in therapy had diminished.

Few patients said they had reconsidered their opinion of art since their involvement in the project. However, the few that had reconsidered art felt that they had gained in understanding, become more appreciative of art and had a different view of the world, as in one woman's belief that her old pyjamas were now special as she had represented them in art. One man linked his understanding of art to his experience of DIY, demonstrating his perception of art as purposeful making.

The patients sought and valued qualities in art which were, generally, different from the qualities manifest in the sculpture they had participated in making. Their experience of making was beyond their previous understanding of art. Patients noted that the difference between making sculpture and occupational therapy was the challenge provided by the former. Some patients believed that the purpose of art was to find personal content. In the previous interviews and conversations no patient had used the term 'self-expression' or 'expression', but did so in Phase 2. Since the completion of the sculptures, LMCC had employed an art therapist to work with the patients. It is possible that the patients had become acquainted with this term in their activities with the therapist. One man later named the purpose of art as representation, inferring a means whereby the personal is *re-presented* to the audience.

The patients demonstrated an awareness of the researcher's role in comparison to theirs, describing how the researcher was '*looking for something inside*'. Some patients accepted that works which demanded no traditional fine art skill, did not imitate reality, or looked unfinished communicated significance, while others could not accept this. However, all patients now disregarded those works which they thought involved a mundane vocabulary. The sculptures made in Phase 2 involved less 'traditional' skills

and materials than Phase 1, but the patients continued to value them. While some patients found the Phase 2 works more difficult to comprehend, they did find value in the works, suggesting that perceptions had been stretched since Phase 1. If further sculptures could have been made, perhaps the patients' appreciation would have grown further.

Although data collection methods were not initially successful, final collection of the opinion of art professionals indicated that the sculptures communicated eloquently, and beyond the situation of the individuals involved in making. While patients' identities were invested in the sculptures they also noted, as did the art professionals, that the sculptures communicated more than individual identity. Through sculpture the patient did move *'beyond the boundaries of his/her body into the external shareable world'* (de Zegher, 1998).

Chapter 9

Conclusions

The primary aim of the study was to establish the extent to which sculpture is a significant occupation, as opposed to a pastime, for people with life-threatening illness. As making might be intimately connected to individual identity, it might also affect health. The following discusses the findings of Phases 1 and 2. The research design is appraised noting innovative, successful and unsuccessful methods. The impact of the research findings on theories concerning the substantial nature of art and palliative care are discussed. This is followed by an examination of the effect of the results on art in health practices, and recommendations for the future.

9.1. Research Design

The research design was novel. No other published research attempts to explore theories concerning the importance of art using empirical methods. The value of art was gauged with an innovative instrument: the amount of precious time the patients were prepared to spend. In addition, there is no previously published research on collaborative fine art practice in healthcare.

Methods used included observation and record in a diary, photography, interview and questionnaire. The observation and record of patient participation was successful, providing an accurate record and rich data. Problems occurring lay predominantly in questionnaires. In Phase 1 the questionnaire was either inappropriate or administered too late, providing insufficient data. In Phase 2 the sample required to complete the questionnaire was too large and unspecific, so the results were of little use. This was rectified by a further exhibition and a selected group of respondents.

As the research adopted a 'case study' approach, the findings are specific to this group, and not generally applicable. Further research, as is later described, is needed to establish which elements of the findings are applicable in other contexts.

9.2. The Substantial Nature of Making

The findings of the empirical research reinforce and extend aspects of theories concerning the substantial nature of art. Scarry's (1985) belief that, through making, the body of the maker is projected into the made object was supported by evidence. In the research, patients valued the experience of making and described how they put themselves into the medium as they worked, to the extent that they '*lost themselves in it*' and '*part of*' them was '*left behind*' in the work.

Making was described as pleasurable. If the pleasure of making was the only reason why patients valued making sculpture, then any practical activity would perform the same function. The same pleasure might be experienced when making crafts in occupational therapy, when mending clothes or building a house. However, patients rarely valued process without any anticipation of the ambition of the work. Even the women, who valued the experience of making more than did the men, recognised that the same process was different depending upon whether the intention was to make art or to give therapy. Although patients did find process enjoyable, most found making sculpture more than pleasurable, as they detected a leap in perception. Making sculpture was found to be '*of a much deeper significance than giving amusement*' (Ruskin, 1905a). The patients detected the same difference between craft activities and art that Barthes identifies between literature which is pleasurable and that which is significant; that which '*speaks the same economy as the pyramids of Egypt*' (1976).

A predominant theme in the literature was the significance of art and its ability to record and communicate the identity of the maker. Scarry (1985) notes that while all

manufactured objects communicate the general signature of humanity, art conveys the signature of the individual maker. The results of this study also found the communication of identity to be important. Sculpture was found to convey patient identity better than any other object they possessed. However, the study also revealed evidence of differences between men and women regarding the communication of identity.

The previous theoretical research does not investigate gender differences. However, as gender is an obvious component in identity, the differences may be implicit in the literature. However, in this research they are made explicit. Profound differences in the responses of men and women were found. Men sought to record their names and also their masculinity through sculpture, preferring those works which imparted the stereotypical masculine values of strength and solidity. Not only was identity recorded in the sculpture, but the men also sought communication of masculinity through process, refusing to do activities considered feminine. The women were less concerned about the record of their individuality but sought to represent aspects of their roles as mothers and wives. In comparison with the men, the women appeared less concerned with representing their femininity. However this lesser concern with asserting their identity may be a stereotypical feminine quality. The results suggest that for patients the transmission of identity is an important function of art and that the communication of gender is of particular significance to seriously ill patients, especially to men. This transmission of identity is connected to the preservation of identity, which is discussed further on in Chapter 9.

Members of the Arts and Crafts Movement aimed to reunite art and work, to re-establish making as a beneficial part of life. They believed that through work the purpose of the individual was maintained, and that this was essential to health. Work was the '*grand cure of all maladies*'. Charmaz (1983) suggests that without a sense of identity, meaning is hard to establish, and as the Arts and Craft Movement and Jung insisted, meaning is essential to health. In this study the patients were unable to work,

and for some this may have had a profound effect on identity. The core of three men who had been smiths continued to value the 'anvil' sculpture above all others. Unlike nearly all other patients these three men continued to participate, surviving the duration of the project. If making sculpture can reinforce or record identity, or give meaning and purpose, then it may play a role in survival, or at least maintenance of quality of life. While no claims can be made for the life-sustaining function of sculpture in this qualitative case study research, the findings demand that further research be focused here.

The men and women approached making differently. While men sought to make tangible, permanent products, women valued process and took more interest in the development of the sculpture. The men and women may have approached making sculpture in the same way as they approached work when they were well. For men, energy was invested in the workplace, into visible items, with measurable worth. For women work was invested less immediately. Effort was invisible, but made substantial in the new generation rather than in commodity. This suggests that the patients approached art like work, as *'purposive activity-the fitting of natural substances to human wants'* (Fischer 1971). Fischer states that art and work are not the same, as art, unlike work, results in products which communicate universally. However, Scarry (1985) states that art and work do have similar functions as both involve extremely embodied physical acts and both result in objects which were not previously in the world. She sees both the product of work and that of art as *'a sentence.. where there had been silence'*. In this study the patients initially saw similarities between art and work, however as the sculptures progressed in Phase 2 they no longer saw similarities, believing art to be moving beyond the mundane, servile aspect of employment. Like work, making sculpture was found to be purposeful and able to sustain aspects of identity, however the prime difference was the capacity of art to move beyond the familiar.

In this research the patients' accounts of making are anomalous, describing the 'bodily' relationship of making whilst also reporting an expansion beyond the body and the individual. The exhibition audience detected the same phenomenon, seeing the record of individual identity, while at the same time determining that the sculpture communicated beyond those involved. The patients thought the work had a 'scale' beyond the size of their contribution, enabling the individual to *'inhabit a space much larger than the small circle of his immediately present body'* (Scarry, 1985). The same dichotomy is found in the literature. Scarry (1985) notes that through making we are *'more intensively embodied'* and then *'disembodied'*. In this instance sculpture performs the function that Aldridge (1996) recognises, providing *'a bridge between cultural and physiological phenomena'*.

The expansion described by the patients is a movement from the individual towards connection with others, *'more than 'I''*. As one patient described, through art she experienced *'coming out and being in the world'*. Scarry (1985) reports the same journey from the individual to the social. Individual input in sculpture is converted into an object which communicates to others, *'reciprocation is for humanity rather than only the maker-by nature social'*. Illness may frequently be isolating through the loss of social roles and also through severe pain. But as Scarry (1985) and de Zegher (1998) predict, through art the patients were able to *'speak'*, *'a final source of extension beyond the boundaries of the body'*.

Whilst the patients described an expansion from the individual to the collective, they also reported a sense of elevation. Making sculpture was, like the pyramids, beyond the ordinary and *'out of this world'*. Contrary to the physical 'bodily' pleasure experienced in making, the patients were, as Marx (Scarry, 1985) stated *'disembodied and spiritualised'*. The sculpture had a 'scale' or a 'reach' which was beyond *'measure'* (Ruskin, 1905a). Men patients commented most on the sense of elevation, either because they had previously experienced it through work products or because the sense of elevation experienced correlated with the degree of individuality invested. It may also

be because men valued permanence more, and elevation is connected with a sense of continuity through time.

Permanence was a means of extension, enabling the patients to continue after they were no longer present. The sculptures could physically carry the lives of the patients into new places (better than any other object they possessed), while also extending them across time, immortalising *'the things that have no duration'*. As Ashford (1998) describes, *'a transcendent notion of identity prepared to live beyond its material life'*. Their identity was preserved in the sculptures, but greater than this, it could be communicated to others.

Throughout the research there is repeated dichotomy: between the non-art item and the art object, between process and complete object, between the body and the exterior, between the bodily and the spiritual, between pleasure and *'jouissance'*, between the individual and the social, between the present and the future and between the familiar and the unknown. As Scarry describes, the made object is *a 'fulcrum or lever across which the force of creation moves back onto the human site'*. Energy invested is magnified and transformed.

9.3. Impact of Results on Palliative Care

The effects of making sculpture are positive, and suggest a valuable contribution to palliative care. Palliative care practitioners place great emphasis on maintenance of quality of life and there are many systems of measurement (Griffiths & Beaver, 1997; Bowling, 1991; Specia, Robinson, Goodey & Frizzell 1994 and Holmes 1998) although little consensus on its definition. As discussed above, making sculpture may provide one more avenue through which quality of life can be maintained or increased. In this research no system of quality of life measurement was in place at the outset of the

project. However, the qualitative case study results suggest that a controlled quality of life test on making sculpture should be implemented in the future.

Several of the aims of palliative care concern affirmation of life and enabling patients to live as actively as possible until death. In this study the patients' investment of precious energy into a medium was found to be significant. In controlling a medium they were reasserting their individuality, vitality and '*blooming corporeality*' (Rampley, 1993). Not only did patients find investing energy in the present rewarding, but they were also aware that through making something was surviving beyond death.

Much literature is concerned with the effect of 'multiple losses'. Serious illness may affect many of the elements which construct identity including appearance, occupation and family roles, sexuality, strength and autonomy. The identity provided by occupation was found to be particularly important in this study. Male patients' desire for purposeful, meaningful activity was related to their sense of masculinity. Through sculpture these qualities could be made visible. A lack of physical strength may lead to a diminished sense of autonomy and independence. As described above, patients valued the opportunity that making provided to assert their strength through a medium, into an object which then recorded and magnified their effort. Another effect of multiple losses may be the isolation of the individual from society, exacerbated by pain. This proved to be one of the most significant functions of sculpture for the patients, as it was found to reconnect the individual to others.

It is recorded in the literature that, without the elements which construct identity it is difficult to find meaning and consequently there may cease to be much obvious reason for staying alive. If sculpture supports individual maintenance of identity, and particularly a connection to society, then it can be said to build meaning. Camus (Gablik, 1991) stated that meaning is essential to life. In this study those patients who appeared to find greatest satisfaction in making, unlike others, survived the length of the project, suggesting that the meaning created was vital to life. However, as noted

previously, it is not within the parameters or methods of this study to consider the curative capacity of art.

Meaning was found to be essential to hope, and again hope was crucial to survival, *'when hope ends, so does life itself'* (Miller, 1989). Particular qualities found to foster hope include 'affirmation of worth' which making sculpture was found to encourage, and 'interpersonal connectedness' which is a prime function of art. One vital quality of life found by Frankl (1984) was *'the striving to find meaning'* and *'the striving and struggling for a worthwhile goal'*. In this research the patients found making sculpture to be an activity that often stretched their understanding as they progressed through the project. This complexity was found to add to the significance of the activity.

The difference between art and other art-related activities is that it is a vocabulary which projects beyond the individual. Feifel (1990) stated that in facing death people require *'resources, be they transcendental, inspirational or existential'*. Patients found that making sculpture took them 'beyond' and 'out of this world', comparing it with the mysterious pyramids. They perceived a spiritual quality to making. This may be due to the recording quality of the sculpture, extending the patients' beyond their body and beyond the present. The spiritual aspect of making supports Scarry's findings:

'the deepest psychic categories, our bodies and our God, are at stake in the created realm of the objects we inhabit.'

(Scarry, 1985, p.244)

While not enough research has been done to name making sculpture as a transcendental or inspirational resource for the dying, the evidence suggests that this could be one aspect which could further contribute to the growing literature on the importance of spiritual care (O'Rawe Amenta, 1997; Hawkett, 1997; Froggart, 1997; Cawley, 1997 and Edassery & Kuttierath, 1998). A 'spiritual base' is also a factor known to maintain hope. One definition of spirit is of a 'vital principle' (Chambers, 1990), therefore essential to life.

9.4. Effect of Results on Art in Health Practices

No prior research in the 'Art and Health Field' has involved hospital communities in 'mainstream' collaborative art. This research aimed to explore the '*ancient purpose*' (Hamilton, 1991) of art as visual vocabulary.

In palliative care occupational therapy, art therapy, and 'art in hospital' practices are used. Making sculpture was introduced as a new activity, fundamentally different to these. It is common for the craft practices of occupational therapy to be mistaken for art as they may use the same materials and techniques. When asked to carry out tasks similar to those used in occupational therapy, patients recognised a different purpose. In sculpture they were developing a visual vocabulary with which to explore and communicate concepts. The patients noted that through art identity could be communicated and preserved. They also recorded how making sculpture was a challenge which stretched them beyond the familiar, rather than remaining in the everyday or that which is considered appropriate.

Making art is inherently different to art therapy, particularly as the products of therapy are not intended as art. Theorists have described how one function of art, absent in art therapy, is to create societal meaning. In this research, the patients may have been isolated, for a variety of reasons, and discovered, through making, an ability to move beyond the individual and 'speak'.

Arts for Health chooses artists with popular appeal or admired craft, believing that artists with professional status cannot communicate at the 'basic level' required by the public. In contrast, the findings of this research indicate that the public (in this case, patients) are receptive to, and come to desire, works which communicate beyond a basic level. Indeed patients' verdicts of particular works corresponded with the responses of art professionals, familiar with assessing art.

Arts for Health considers that 'difficult' or 'unsuitable' subject matter should be avoided. The findings of this study indicate that as '*the artistic symbol negotiates insight not reference*' (Aldridge, 1990) the patients' understanding was subtle and some chose to seek, and found reflections of their situation. Hospice Arts discovered that in a hospice environment contact with the artist was a crucial part in the reception of art. In the LMCC study, involvement in making with the artist led to greater understanding.

It is assumed that art which involves non-artists must have different qualities to art made by a professional artist. However, New Genre artists, amongst others, argue that collaborative works can communicate with equal clarity. In this study the art professionals who evaluated the 'Heraldry' exhibition detected no decline in intelligibility as a result of the patients' input, supporting the New Genre argument. Theorists claim that art has lost its ability to generate societal meaning and there is a lack of awareness of the interconnection of individual and society, artist and public. This research indicates that sculpture can both harbour the individual and transfer them beyond, connecting with 'more than 'I''.

9.5. Recommendations for the Future

9.5.1. Introduction

While engaged in the programme of study to establish the vital nature of art making, in this case, sculpture, a number of further questions in allied areas were touched on. Further study of these areas is required.

9.5.2. Public and Academic Status

Current criteria for the judgement of art are not published. At the outset of this research established public art arbiters were asked to provide criteria for use in the research. None were forthcoming. The unavailability of criteria supports the belief that art is a matter of whim, and perpetuates public mystification. The research indicates that aims should be made clearer with the position of artist as contributor to knowledge. Significantly, the public, as opposed to the academic, art establishment did not attend the two major presentations of this sculpture. For example, the 'Heraldry' exhibition was in a major gallery one hundred yards from the Liverpool Tate, yet none of its invited personnel attended. The vital and collaborative nature of the sculpture, produced as research, was treated most seriously by artists and public; but it was removed from the current paradigm of the patronised art mainstream. The research does not tackle the above issues, but indicates where further research into the vital measure of art is needed.

9.5.3. Authorship

One area for future research arises from the ownership and authorship of the collaborative sculpture produced. Whether this sculpture belongs to the makers, the researcher or the patients; the commissioners (the University); the hosts (the hospice), or the director of the study, is not addressed. The sculpture accentuates and exemplifies issues inherent in all production and publication. The issue of ownership specific to art, whether contractually delineated or not, has not previously been addressed.

The popular myth of the artist proposes the Romantic 'lone genius' (Kelly, 1984; Coleman, 1988; Gablik, 1997) whose ideas arise from nowhere, with no influence from others. Such an artist does not reason, but is at the mercy of impulse. Art, as stated in Chapter 1, has always been made in collaboration, yet the 'lone genius' myth prevails.

This research does not measure the value of collaboration but draws attention to the implications of it. Whether collaboration diminishes or enhances art, or whether there is an optimum number for collaboration should be investigated. The 'special touch' of the 'lone genius', in contrast to team effort, should be given new attention.

9.5.4. Health

The findings indicate that artists have a role to play in hospice settings. Making art involves patients in the development of a refined visual language, significant for those who have little life left. In recognition of this, Liverpool Marie Curie Centre (LMCC) have now employed an art therapist and a first year combined honours art student. Recommendations from this research concerning the placement of artists in hospices are as follows:

1. As art is new to hospice, there is a need for specialists to advise on the selection of suitable artists, and to identify essential resources.
2. When employing nurses or doctors no applicant is considered who lacks proven professional status. When employing artists, as with nurses or doctors, only applicants with proven professional status should be considered.
3. Architects and planners should be made aware that suitable space should be provided for artists to work in hospices. The Liverpool Marie Curie Centre, although a new building, had no designated space for serious, substantial making. At present in hospice planning, no space is allocated for consequential art activity. Squeezed into existing facilities, its status is defined as 'pastime' or after-thought.

4. Works produced should be presented outwith the hospice, as the presentation of work beyond the hospice was found to affect its perceived status. Alternatively work should address the hospice context.

5. Where possible artists should be encouraged to conduct, or to contribute to research programmes. This not only deepens understanding, but also identifies the artist as a contributor to knowledge alongside researchers in other disciplines.

To ensure the findings of the research have impact, a Code of Practice for art in hospice and healthcare will be prepared and presented, together with papers, in healthcare publications. The opportunity to give papers at healthcare conferences will be sought to ensure palliative care practitioners are familiar with art as a substantial activity rather than as a pastime. A symposium concerning art and palliative care is planned by LMCC for 2000. In addition, there is a need for appropriate distribution of the sculptures produced during this research programme.

To extend the findings, further research is recommended. Patient response might differ with different artists and diverse media. A research programme should place a variety of artists in the eleven national Marie Curie Centres. Multi-disciplinary research involving palliative care specialists would enable fresh insight to inform all collaborating fields. The objectives of new research should be defined in conjunction with medical staff. Suggested areas include a Quality of Life Test to examine the life-maintaining/improving capacity of making art, collaboration with a semiotic analyst to examine patients' word usage in greater depth, and further exploration of gender difference and life stages.

The Marie Curie Centre was the only context tackled. Results could be further refined by taking the same question into other areas of health. The responses of the patients were particular to geographical location, the Centre, type of illness and age. Further

research is needed to establish to what extent context affects response. The research method should be repeated in different settings, involving patients with different life-threatening illnesses. By comparing the response of a patient with chronic illness to a patient with 'terminal' illness the need for preservation and communication of identity could be tested. Further research might also involve patients with other life-threatening illnesses such as AIDS, which is considered to have a pronounced effect upon identity. It was the aim of this research to establish whether art was vital, not to ascertain whether it aided healing, although it could be implied. By repeating the experiment in other areas, in collaboration with clinicians, the healing capacity of art might be examined.

9.5.5. Practice

The relationship of art to the quality of, or perpetuation of life demands closer attention using a range of methods. Evidence implied that three dimensional art is of particular significance to patients (Sections 3.4 and 8.6). It might follow, therefore, that purely conceptual art (where '*all ideas need not be made physical*' [LeWitt, 1969]) would be of no value. This should be tested. Two dimensional, three dimensional, time-based and conceptual art should be investigated for their relative value.

Evidence indicated that patients found the monumental, memorial capacity of sculpture to be significant (Sections 4.5.5., 5.4. and 8.4.1.). This conclusion should be examined further through the measuring of the responses of invited participants, when working in time-based media, or when invited to make works where disintegration is integral. It would be of interest to discover if the need for preservation was general, and when the monumental was of significance even when the maker/s was not facing death.

Here, sculpture was made using tactile media, predominantly clay and textiles. These required manipulation by the patients. It is possible that the haptic qualities of making

sculpture are of particular value to people with life-threatening illness, or who suffer pain. All the senses are mediators between the body and the world, and further research should address this through the use of activities which involve different senses. The test for vitality was with people who were fragile. To test the importance of touch, people with a lack of ability to touch, or who have an extreme need to touch (such as people with visual impairment) should be the study group. Whilst establishing further the significance of scale, the monumental and the haptic qualities of making, discrete attention should continue to be paid to gender, social status and age.

9.5.6. Contribution of Further Research

Value is established by cost, financial or otherwise. Value is accrued in the object by the time invested, where money is equated to time. Cost is also determined by scarcity, the rare object. In this research sculpture programme, patients were invited to spend time, their scarce currency. As Ruskin suggested, this measures the value of art as a '*higher economy*' where the gain is vital, not financial, and '*of a much deeper significance than giving amusement*' (Ruskin, 1905a).

Tackling the research areas described above would result in further understanding of the vital nature of art. It appeared that public and artists understood art to be a vital activity, but this capacity was not recognised by the public art arbiters. The discrepancy between the beliefs of those who make and receive art, and those whose role is to mediate art leads to misunderstanding. Further research in this area and establishment of criteria would bring benefits for both art and public, resulting in demystification, education and therefore, the infusion of art into the wider world beyond the gallery or public podium. The joint ownership of collaborative art presents challenges to the art institutions which nurture a market dependent upon the solo artist as 'lone genius'. Exploration of collaboration, the traditional working process, would contribute to the understanding of art rather than personality.

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Further study of the significance of making for health would result in greater comprehension of art as vital activity. Research into the integration of art, not as after-thought, in the planning of hospitals, would reinforce the understanding of art's vital status. New investigation into the value of scale in art, the temporal qualities of media and the relative importance of the senses would engender understanding of how art is conceived and received.

The sum contribution of the proposed new research would reinforce the recognition of art as vital.

Appendices

List of Appendices

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- 3. Questionnaire to elicit staff opinion of the LMCC environment**
- 4. Semi-structured Interview Schedule used to establish patients' perceptions of making**
- 5. Questionnaire about the exhibition 'A Vital Occupation'**
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- 10. Individual Rates of Participation in Phase 1. Tables 1 and 2.**
- 11. Individual Participation Rates for Different Activities/Sculptures in Phase 1. Tables 1 and 2.**
- 12. Tables Recording Individual Rates of Participation in Phase 2. Tables 1. and 2.**
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- 14. Words used, and the frequency of use, by art professionals to describe 'Heraldry'.**

Appendix 1. Table 1. Summarising Purposes of Methods

Aims of Research	Research Questions designed to fulfil aims	Methods used to answer Research Questions
Aim 1 To establish the extent to which sculpture is a significant occupation, as opposed to a pastime, for people <i>in extremis</i> .	I	observation photography interview
	II	interview post-exhibition interview
	III	interview post-exhibition interview peer review questionnaire
	IV	photography interview
	V	observation photography interview post-exhibition interview
	VI	interview post-exhibition interview
Aim 2 To generate sculpture. Methods of engaging people in this practice will be developed, and their perceptions of its value explored.	II	interview post-exhibition interview
	V	observation photography interview post-exhibition interview
Aim 3 To establish the relationship for the patients between the act of making and identity.	III	interview post-exhibition interview peer review questionnaire
	IV	photography interview
	V	observation photography interview post-exhibition interview
	VI	interview post-exhibition interview

Appendix 2. Table 1. Timetable

1995												1996												1997											
J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O							
Background reading/theoretical research																																			
Contact with hospital arts organisations																																			
negotiation with centre and patients																																			
Independent practice																																			
observation and record						making with patients						making with patients																							
photography						PI						E						PI						E						PI					
Data review and analysis																																			

Key to Table 2.4. PI: Patient Interviews PQ: Patient Questionnaires PR: Peer Review Questionnaire E: Exhibition

Appendix 3

Questionnaire to elicit staff opinion of the LMCC environment

Liverpool Marie Curie Centre

I am Becky Shaw, an artist, currently working towards a Ph.D. and I will shortly be working at the Liverpool Marie Curie centre with patients, making artwork for the centre. Before I can begin this work it would help me a great deal to have an understanding of how you feel about your working environment and your opinions of its interior design, as some of the artwork may be incorporated into the building. I would be most grateful if you could take time to fill in both sides of this questionnaire, it should take no longer than ten minutes, and return it to the General Office in the envelope provided by Monday October 9th. Your help is greatly appreciated.

Many Thanks

1 In what department do you work?

.....

2 Does the building design restrict you in any way in carrying out your duties?

Please indicate

yes/no

If yes, please give details

.....
.....
.....
.....

3 Give three words to describe how you feel about the centre environment/ interior design.

.....

8 What do you dislike about the pictures?

.....
.....
.....

9 Would you like to change the building in any way? yes/no

If your answer is yes, please describe what you would change and why.

.....
.....
.....
.....

Many Thanks for your help,
Becky Shaw

Appendix 4

Semi-structured Interview Schedule used to establish patients' perceptions of making.

1. Have you made art before?
2. Were you ever interested in art?
3. Can you compare this with anything that you have done before?
4. Is this project what you expected?
5. In what ways is this the same or different to other activities you do at the centre?
6. What do you think about the project so far?
7. What do you think about the materials used?
8. Do you think the artwork has a theme and does it mean anything to you?
9. Do you think it is suitable for a hospital?
10. Would you like to make anything else?
11. Do you have any ideas for what we might make next?
12. Who do you think the sculpture belongs to ?
13. Would you have done anything differently?
14. Do you think the finished work will serve any purpose at the centre?
15. What do you think other patients and visitors will think?
16. If the sculpture could be put anywhere , where do you think it should be put?
17. If you were to look back on this project in the future do you think you would remember anything in particular?

Appendix 5
Questionnaire about the exhibition ‘A Vital Occupation’

1 When you arrived at the gallery what were your first impressions?
.....
.....
.....

2 What were your expectations about the exhibition and were these fulfilled? Please give details of anything which differed from your expectations.
.....
.....
.....
.....
.....

3 What did you like and /or dislike most about the exhibition?
.....
.....
.....
.....
.....

4 When viewing the artwork what were your thoughts? Did any of the work remind you of anything? If so, please describe.
.....
.....
.....
.....

5 What do you think should now happen to the pieces of work which made up the exhibition?
.....
.....
.....

Many thanks for your time. Your opinions are extremely valuable to me.
Becky Shaw

Appendix 6

Semi-structured interview schedule to gather patients' opinions of 'Heraldry'

1. What sticks in your mind most clearly about the exhibition?
2. Could you go through the photographs of the sculptures and say a little about each.
3. Have you a favourite sculpture (including all that we have made)?
4. How have you found the experience of making sculpture?
5. Is it the experience of making sculpture, or the finished object which is most important? Which gives you the most enjoyment?
6. Do you have a favourite material, which and why?
7. Which material do you think is used most successfully?
8. Do you have a preference for either long-lasting or more short-term materials?
9. Do you identify with any of the sculptures in particular, and in what way? (do you think any of them in particular represents you)
10. Which sculpture did you enjoy making most, and why?
11. Did the experience of making sculpture remind you of anything?
12. In what ways is making sculpture similar or different to employment?
13. What kind of art do you usually like?
14. What qualities do you think a good piece of art has?
15. What do you think the purpose of art is?
16. How does this sculpture compare with the art you think is good?
17. Has the experience of being involved in making art had any effect upon your opinions of art and in what way?
18. How do you view making sculpture, compared with other activities you do at the centre?

Questionnaire used to obtain audience opinion of 'Heraldry'

Dear Visitor

Thankyou

What are your reasons for visiting this exhibition?

Do you have a favourite sculpture in this exhibition and if so, why do you like this one in particular?

At any art exhibition, do you think knowledge about the artist affects your appreciation of the works on display? Please give reasons for your answer.

The aim of this project was to give a framework within which the day-centre participants could represent themselves through sculpture. On a scale of 1-10 please ring how successful you think the project was:

[illegible]

Please describe your reasons for your rating.

Your response to the exhibition will be of great help. Thanks again, Rebecca Shaw

Appendix 8: Letter from Research Director

Liverpool John Moores University
School of Design and Visual Arts

INTERNAL MEMORANDUM

31 January 1996

To: Becky Shaw

From: Marilyn Smith
Professor of Fine Art

Cc:

Extension: 2143

RE: _____

Thank you for the report on your progress, which is considerable, not least because you seem to have found a very talented group with whom to collaborate. Well done!

My thoughts on the interview methods are that you do not indicate if you have considered established forms or recommendations by experts. I'm sure you have but have not made reference. You must do in future, more formal, reports. Richard Gant can help with this if need be. The formulation of questionnaires is one of the major tools in his research and he is expert in their use. I know your situation differs from his but the means of avoiding elicitation of answers which please is one that he will have a formula for dealing with.

The sculpture is a great success so far and I am sure you look forward to seeing it installed. The hammers are another matter and I can think of few more effective ways of compromising an otherwise poignant work. Does it need additions? And if so should they be so predictable? At this stage please consider the formal qualities of your work. It is *not* an anvil. It is a work of sculpture *about* an anvil. The narrative is already difficult to subsume but so far it has been well handled and is open to contemplation on many levels. Over-description will diminish an otherwise powerful image. I would suggest that any addition — if any is required — should be counterpoint rather than tautology.

'Don't mistake the subject for the content.' — Susan Hiller

I suggest that you discuss this criticism with your collaborators and/or others.

I look forward to our next tutorial.

Appendix 9

Participation at each Workshop (Tables 1, 2, 3 and 4)

Appendix 9, Table 1.

Record of Male Participation in Phase 1

(Each letter symbol represents an individual patient)

Date	No. attending	Patients Attending (Each represented by a letter/symbol)	No. participating	Participating Patients	Work in progress
7.11.95	10	a b c d e f g h i	6	b c d e f g	<i>The (W) Wheatfield</i>
13.11.95	10	a b c d e f g h i j	4	b c e f	W
21.11.95	10	a b c d e f g h i j	5	b c d e f	Drawing
28.11.95	10	a b c e f g h i j k	2	c e	W
5.12.95	8	a c d e f g h i	4	c d e f	W
12.12.95	8	a b c e f g h i	3	b c e	W
19.12.95	9	a b c d e f g h i k	5	b c d e f	W
9.1.96	8	a b c e f h i k	3	c f k	Drawing
16.1.96	8	a b c e f h i k	4	b c e f	<i>Meta</i>
13.2.96	8	b c d e f g h i	4	b c e f	discussion
5.3.96	4	d f g i	3	d f k	<i>In Advance of a....</i>
12.3.96	6	a b c d f g	5	a b c d f	plaque

Appendix 9, Table 2.
Record of Male Participation in Phase 2

Date	No. Attending	Patients Attending	No. Participating	Participating Patients	Work in Progress
6.8.96	6	b d g C' D' E'	2	b d	Drawing
13.8.96	7	c f g i C' D' E'	2	c C'	Drawing
3.9.96	6	b c d f i C'	3	b c d	Drawing
10.9.96	5	b d f C' J'	1	b	clay (ce) experiment
29.10.96	7	a b d f i C' H'	4	a b d C'	periodic drawing (pd)
5.11.96	8	a b c d f i C' N'	3	b c d	ce
12.11.96	4	b c f C'	3	b c f	pd
19.11.96	3	b f i	1	b	drawing
26.11.96	4	b d f i	0		drawing
10.12.96	6	b c d f O' P'	3	b c O'	Periodic Table (PT)
21.1.97	6	d f i R' S' T'	4	i R' S' T'	Hammered Out
11.2.97	6	b c f R' S' T'	3	b S' T'	Periodic Table
11.3.97	7	b c f R' S' V' W'	7	b c f R' S' V' W'	Drawing
1.4.97	7	b c f R' V' W' Y'	2	b c	Call to Arms
21.4.97	7	b c d f R' V' W'	7	b c d f R' V' W'	Call to Arms
6.5.97	7	b c f R' V' [a] [b]	3	b R' [a]	Common Jewel
13.5.97	7	c d f R' V' [a] [b]	2	c d	Parting Gifts
3.6.97	5	c d R' W' [a] [b]	4	d R' W' [a]	Periodic Table
10.6.97	6	b c R' W' [a]	5	b c R' W' [b]	Drawing
17.6.97	7	b c d f R' V' [b]	0		Things we.. (pillows)
1.7.97	6	b c d f V' [b]	4	b c d V'	Things we.. (coins)

Appendix 9, Table 3. Record of Female Participation in Phase 1

Date	No. attending	Patients attending (each represented by a letter/symbol)	No. participating	Participating patients	Work in progress
8.11.95	5	l m n o p	3	l n o	<i>The (W) Wheatfield</i>
14.11.95	6	l m n o p q	3	o p q	drawing for W
29.11.95	5	l o p q s	3	l o q	drawing
13.12.95	5	l o q t u	4	l o q t	clay (ce) experiment & W
10.1.96	3	l q v	3	l q v	drawing
17.1.96	5	l o v w x	5	l o v w x	<i>Meta</i>
24.1.96	4	m o q x	2	o x	ce
6.3.96	4	m o q y	4	m o q y	<i>In Advance of...</i>
13.3.96	5	m o z A' B'	4	m o z A'	plaque

Appendix 9, Table 4.
Record of Female Participation in Phase 2

Date	No. Attending	Patients Attending	No. Participating	Participating Patients	Work in Progress
7.8. 96	4	m o t A'	3	m o t	drawing
14.8. 96	7	o t A' F' G' H' I'	7	o t A' F' G' H' I'	ce
11.9. 96	8	o t A' G' H' I' K' L'	3	o K' L'	ce
16.10. 96	5	o t A' F' L'	4	o t F' L'	Periodic Table (drawing) & ce
30.10. 96	5	o t G' I' L'	2	o G'	Periodic Table (drawing)
6.11. 96	4	o t A' G' L'	4	A' G' t L'	Periodic Table (drawing)
20.11. 96	3	m t A'	0		ce
28.11. 96	4	m o t A'	3	m o A'	ce
4.12. 96	3	o t A'	3	o t A'	Messages from..
11.12. 96	4	m o t A'	3	m o t	Messages from..
15.1. 97	6	o t A' F' G' L' Q'	5	A' G' t L' Q'	Hankies to Wave..
22.1. 97	4	o t L' Q'	4	o t L' Q'	Messages...& Hankies...
5.2. 97	4	F' G' Q' U'	1	Q'	Hankies to wave..
12.2. 97	6	o A' F' G' Q' L'	4	o G' Q' U'	Periodic Table
26.2. 97	7	o t A' F' G' Q' U'	6	o t A' G' Q' U'	drawing
12.3. 97	7	o t A' F' G' Q' X'	6	o t A' G' Q' X'	drawing
26.3. 97	5	A' F' G' L' X'	2	A' L'	The Call to Arms
2.4. 97	6	A' t L' Q' X' Z'	3	L' Q' Z'	The Call to Arms
9.4. 97	7	o t A' G' L' Q' Z'	4	A' o Q' Z'	Messages.. & Hankies..
23.4. 97	5	A' t L' Q' Z'	4	t L' Q' Z'	Common Jewel
30.4. 97	5	A' t L' Q' Z'	2	t Q'	The Call to Arms
14.5. 97	4	o t A' [c]	4	o t A' [c]	Parting Gifts
5.6. 97	7	o t A' Q' Z' [d] [e]	7	o t A' Q' Z' [d] [e]	Periodic Table
11.6. 97	5	t A' Z' [d] [e]	4	t Z' [d] [e]	Things we no Longer Use drawing.
26.6. 97	5	t A' L' [d] [e]	5	t A' L' [d] [e]	Things we No Longer Use (pillows)
2.7. 97	8	t A' L' Q' [d] [e] [f] [g]	2	t [f]	Things we No Longer Use/ Sovereignty

Appendix 10

Individual Rates of Participation in Phase 1 (Tables 1 and 2)

Appendix 10, Table 1. The Individual Participation Rate of Men During Phase 1

Patient (each man identified by a letter)	Number of groups attended ¹⁰	Number of workshops participated ¹¹	Participation Rate (%) ¹²
a	9	1	11
b	10	8	80
c	11	11	100
d	8	6	75
e	10	9	90
f	12	10	83
g	10	1	10
h	10	0	0
i	11	0	0
j	3	0	0
k	4	1	25
Average:	9	4	44

¹⁰ Each figure is rounded up to the nearest whole number.

¹¹ See footnote 3.

¹² As attendance and participation figures have been rounded to whole numbers, the final average participation rate is therefore also rounded.

Appendix 10, Table 2. The Individual Participation Rates of Women in Phase 1

Patient (each woman identified with a letter)	Number of groups attended ¹³	Number of workshops participated ¹⁴	Participation Rate (%) ¹⁵
l	6	5	83
m	5	2	40
n	2	1	50
o	8	8	100
p	3	1	33
q	6	5	83
s	1	0	0
t	1	1	100
u	1	0	0
v	2	2	100
w	1	1	100
x	2	2	100
y	1	1	100
z	1	1	100
A'	1	1	100
B'	1	0	0
Average:	3	2	66
Adjusted average	4	3	75

¹³ See footnote 3.

¹⁴ See footnote 3.

¹⁵ See footnote 5.

Appendix 11

Individual Participation Rates for Different Activities/Sculptures in Phase 1 (Tables 1 and 2)

Appendix 11, Table 1. Male Participation Rates for Different Activities in Phase 1

Activity/Sculpture	Attending	Participating	Rate (%)
<i>The Wheatfield</i>	10	6	60
	10	4	40
	10	2	20
	8	4	50
	8	3	37
	9	5	55
			Total Rate 44%
<i>Meta</i>	8	4	Total Rate 50%
<i>In Advance of..</i>	4	3	Total Rate 50%
<i>List of Names</i>	6	5	Total Rate 83%
Drawing	10	5	50
	8	3	37
			Total Rate 43%
Discussion	8	4	Total Rate 50%

Appendix 11, Table 2. Female Participation Rates for Different Activities in Phase 1

Activity/Sculpture	Attending	Participating	Rate (%)
<i>The Wheatfield/clay experimentation</i>	5	4	80
	4	2	50
	5	3	60
			Total Rate 63%
<i>Meta</i>	5	5	Total Rate 100%
<i>In Advance of..</i>	4	4	Total Rate 100%
<i>List of Names</i>	5	4	Total Rate 80%
Drawing	6	3	50
	5	3	60
	3	3	100
			Total Rate 70%

Appendix 12

Individual Rates of Participation in Phase 2 (Tables 1 and 2)

Appendix 12, Table 1. The Individual Participation Rate of Men during Phase 2

Patient (each man identified by a letter)	Number of groups attended	Number of workshops participated	Participation Rate (%)
a	2	1	50
b	17	15	88
c	15	11	73
d	13	8	61
f	18	3	16
g	2	0	0
i	7	1	14
C'	7	2	28
D'	1	0	0
E'	1	0	0
J'	1	0	0
H'	1	0	0
N'	1	0	0
O'	1	0	0
P'	1	1	100
R'	10	6	60
S'	3	3	100
T'	2	2	100
V'	7	5	42
W'	5	4	80
Y'	1	0	0
[a]	4	2	50
[b]	5	1	20
Average:	5	2	40
Adjusted average	8	4	50

Appendix 12, Table 2. The Individual Participation Rates of Women in Phase 2

Patient (each woman identified with a letter)	Number of groups attended	Number of workshops participated	Participation Rate (%)
m	4	3	75
o	15	15	100
t	23	17	73
A'	23	12	52
F'	8	2	25
G'	11	7	63
H'	2	1	50
I'	3	1	33
K'	1	1	100
L'	13	9	69
Q'	12	11	91
U'	2	2	100
X'	3	1	33
Z'	6	5	83
[c]	1	1	100
[d]	4	3	75
[e]	4	3	75
[f]	1	1	100
[g]	1	0	0
Average:	7	5	71
Adjusted average	8	6	75

Appendix 13

**Individual Participation Rates for Different Activities/Sculptures in Phase 2
(Tables 1, 2 and 3)**

Appendix 13, Table 1. Male Participation Rates for Different Activities in Phase 2

Activity/Sculpture	Attending	Participating	Rate (%)
Drawing	6	2	33
	7	2	28
	6	3	50
	3	1	33
	4	0	0
	7	7	100
	6	5	83
			Total Rate 46%
Clay experimentation	5	1	20
	8	3	37
			Total Rate 29%
<i>Periodic Table drawing</i>	7	4	57
	4	3	75
			Total Rate 66%
<i>The Periodic Table</i>	6	3	50
	6	3	50
	5	4	80
			Total Rate 60%
<i>Hammered Out</i>	6	4	Total Rate 66%
<i>The Call to Arms</i>	7	2	28
	7	7	100
			Total Rate 64%
<i>The Common Jewel</i>	7	3	Total Rate 42%
<i>Parting Gifts</i>	7	2	Total Rate 28%
<i>Things we..</i>	7	0	0
	6	4	66
			Total Rate 33%

Appendix 13, Table 2. Female Participation Rates for Different Activities in Phase 2

Activity/Sculpture	Attending	Participating	Rate (%)
Drawing	7	6	85
	4	3	75
	7	6	85
			Total Rate 81%
Clay experimentation	4	3	75
	3	0	0
	7	7	100
	8	3	37
			Total Rate 53%
<i>Periodic Table drawing</i>	5	4	80
	5	2	40
	4	4	100
			Total Rate 73%
<i>The Periodic Table</i>	7	5	71
	6	4	66
			Total Rate 69%
<i>Messages from the Front</i>	7	5	71
	3	3	100
	4	3	75
	4	4	100
			Total Rate 86%
<i>Hankies to Wave off the Sailors</i>	6	5	83
	4	1	25
			Total Rate 54%
<i>The Call to Arms</i>	5	2	40
	6	3	50
	5	2	40
			Total Rate 43%
<i>The Common Jewel</i>	5	4	Total Rate 80%
<i>Parting Gifts</i>	4	4	Total Rate 100%
<i>Things we../ Sovereignty</i>	5	5	100
	8	5	25
			Total Rate 63%

Appendix 13, Table 3. The Participation Rates of Men and Women for Different Activities in Phase 2

Activity/ Sculpture	Men's Average Rates of Participation (%)	Women's Average Rates of Participation (%)	Average Rate of Participation for Men and Women
drawing	46	81	64
clay experiment	29	53	41
periodic table drawing	66	73	70
<i>The Periodic Table</i>	60	69	65
<i>Messages from the Front</i>		86	86
<i>Hankies to Wave...</i>		54	54
<i>Hammered Out</i>	66		66
<i>The Call to Arms</i>	64	43	54
<i>The Common Jewel</i>	42	80	61
<i>Parting Gifts</i>	28	100	64
<i>Things we no Longer.... /Sovereignty</i>	33	63	48

Appendix 14

Words used, and the frequency of use, by art professionals to describe 'Heraldry'

Word Used	Frequency	Word Used	Frequency	Word Used	Frequency
interesting	15	communi- cative	1	patients	1
beautiful	5	community	1	physical	1
moving	5	conceptual	1	plaster	1
thought-provoking	5	contemplative	1	plenty	1
different	4	constructive	1	poetic	1
sensitive	4	courageous	1	positive	1
thoughtful	4	curiosity	1	pot	1
touching	4	democratic	1	presence	1
clever	3	disturbing	1	primitive	1
fascinating	3	diverse	1	questioning	1
good	3	dry	1	quiet	1
intriguing	3	easy-to-read	1	reflective	1
peaceful	3	earthy	1	rewarding	1
poignant	3	engaging	1	sad	1
new	3	enterprising	1	sculpture	1
artist	2	esoteric	1	sensuous	1
colourless	2	exciting	1	serious	1
confusing	2	fine	1	ship	1
dry	2	fresh	1	softish	1
excellent	2	funny	1	sparse	1
fascinating	2	gentle	1	static	1
ingenious	2	great	1	surprising	1
insight	2	group	1	symbolic	1
simple	2	heraldic	1	tangible	1
stark	2	high-content	1	textured	1
unusual	2	honest	1	time	1
affirming	1	humorous	1	therapy	1
amazing	1	ideas	1	thought-evoking	1
amusing	1	identity	1	uncertainty	1
archaic	1	illuminating	1	uneasy	1
artistic	1	individualism	1	under-used	1
badly-lit	1	innovative	1	unified	1
bicycles	1	involvement	1	unorthodox	1
bits and pieces	1	lively	1	unusual	1
bizarre	1	local	1	variety	1
bleached	1	lots	1	warm	1
bold	1	material	1	weight	1
brave	1	meditative	1	well-placed	1
cheerful	1	millennium	1	wonderful	1
clay	1	minimalistic	1		
cold	1	mysterious	1		
colourful	1	nostalgic	1		
comfy	1	ordered	1		
communal	1	original	1		

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