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Contents

Early Psychosis Intervention Programme Singapore, art psychotherapy open studio: A year in review, 2016–17

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Abstract

In April 2016, the Early Psychosis Intervention Programme (EPIP) at the Institute of Mental Health Singapore decided to set up an art therapy open studio on its mixed inpatient ward. This article reviews a full year of activity of the open studio sessions as an innovative and relatively new project in the Singaporean context of inpatient closed wards in psychiatric care. The article examines a definition of the open art studio against the backdrop of local Singaporean politics, the geography of the space used, and the art media contents. It describes a typical weekly session, looking at motivations behind patient participation, recurrent patterns in the use of art media, and patient interaction and project reception in the ward at large. The author also considers her constantly shifting role as an art therapist: throughout the year, within the three-hour session, and as an outsider to the EPIP multi-disciplinary team. The cultural differences revealed by being a Western therapist in an Asian therapeutic setting are discussed as well. Lastly, through a compilation of patient evaluations, the author reflects on the possible benefits and consequences of the EPIP open studio, and expresses a hope that the format will continue, enabling the open studio experience to grow and thrive in Singaporean mental health institutions in the future.

Keywords

Art therapy, Singapore, inpatient psychiatric care, censorship, cultural differences.

Patient looking at the art therapist's clay bust of a woman

P: *She looks from another time. She's from the olden days. What do you think?*

AT: *Hmm I don't know, she just emerged really. What time would you say she's from?*

P: *I think Victorian (silence). But what is she saying to you?*

AT: *Wow, that's a good question, I hadn't quite finished so I didn't have a good look at her yet.*

P: *But I know what she is saying!*

AT: *Oh yeah? What's that?*

P: *I think she is saying: Hello there and welcome here, how are you feeling today?*

Introduction

Art therapy group work has seen a surge in popularity in Singapore over the past decade, and has been accepted as a valid and investment-worthy therapy by many public and private institutions, such as hospitals, schools, nursing homes, hospices, agencies and charities. Although there are some open studio programmes, most art therapy work done in mental health in Singapore is led by one or two art therapists around a clear set of directives and in a limited time period. I was unable to find open studio models in inpatient psychiatric health care, which is perhaps not surprising in Singapore, where interdependence, conformity, identification with the collective, adherence to group norms and consensus are the cornerstone of Eastern society (Essame, 2012; Sathya Devan, 2001). Essame (2012) has described how, in the East, value placed on hierarchy immediately turns the art therapist into 'a figure of authority', an 'expert' and hence someone who is expected to 'direct'. There is also still a strong belief among many caregivers in Singapore that the open studio is perhaps only "meaningful for people who are at a sophisticated level of personal growth and who do not need constant reassurance or guidance" and that it is too "evolved to be used by psychiatric patients or by the psychologically weak or faint-hearted" (Bram, 2016, para.29).

My experience in setting up the open studio for Early Psychosis Intervention Programme (EPIP) has been entirely contrary to this belief and will, I hope, serve as a positive precedent for more open studio spaces in mental health care in Singapore. In this review, I reflect on twelve months of activity of the open studio. After a brief introduction and definition of EPIP services, I examine the daunting and culturally challenging task of defining the open studio experience against the backdrop of authoritarianism in Singapore. Next, I consider how building a proper open studio model in a multi-functional space was achieved, as well as the anatomy of a typical weekly session. Although an in-depth analysis of the artwork and patient–therapist interaction is not the goal of this review, some of the recurrent patterns and themes are touched upon, together with an exploration of the role and the cultural differences I faced. Lastly, I consider patient evaluations and requests, together with the potential for future open studio experiences in Singapore.

> In this article, I use the word 'patient' to indicate the male and female service users of the EPIP ward. In Singapore, the words 'client' or 'service user' are hardly ever applied in the case of hospitalisation, either by medical caregivers or by the service users themselves.

EPIP Singapore

The EPIP was set up some 16 years ago at the Institute of Mental Health Singapore. The programme aims to provide "accessible, empowering and individualized evidence-based care in the least restrictive environment" and wants to use "innovative approaches" (EPIP, 2017, para.3) to promote advocacy and recovery. Having always been a part of the general psychiatric wards at the Institute of Mental Health, EPIP decided two years ago to move its patients to a separate building. This move was justified by evidence-based research in the field (Edwards, Harris & Bapat, 2005) that recommends a more youth-appropriate setting and a higher staff–patient ratio. This in turn was key to a better prognoses and better long-term outcomes for people suffering from psychosis or schizophrenia. A space separate from the hospital's general psychiatry wards also allowed for more specifically trained staff and lower restraining rates, thanks to, for instance, the creation of a 'serene room'.

Each year, EPIP welcomes 200 to 250 new unit cases and sees approximately 734 patients. It serves patients between the ages of 16 and 40, who have experienced a first episode of psychosis or have had a relapse during the first year following a diagnosis. The most common diagnoses seen at EPIP are schizophrenia spectrum disorders, affective psychoses, and brief psychotic disorders. The multi-disciplinary caregiving team is composed of psychiatrists, case managers, psychologists, occupational therapists, medical social workers, pharmacists and nurses, as well as a peer-support group. In 2016, EPIP wished to include an art therapist to run weekly groups to allow for a non-verbal, creative mode of expression and a safe space and outlet for

patients. After discussion, we decided to set up an open studio, rather than a directive-led closed group, due to the high turnover of patients and the brevity of their stay on the ward. The average length of stay is anywhere between two and six weeks, during which time many patients also attend a variety of other directive-led groups by occupational therapists, peer-support groups, medically oriented psycho-education groups, or inpatient groups. It seemed essential to offer a space with no expectations or prerequisites, where patients were given sufficient time to express freely the range of emotions that arise from being warded with other people suffering from a mental health breakdown. The open studio was thus set up to take place every Tuesday from 2pm to 5pm.

Defining the open studio in the Singaporean context

Wood (2000), Moon (2002) and Brown (2014) all argue that the open studio model is heavily dependent upon context, whether environmental, institutional or political. It could of course be argued that an open studio should ideally be portable and that it should adapt to context, people, culture and beliefs (Kalmanowitz, Potash, & Chan, 2012), but ultimately this means that the art therapist bears a greater weight upon their shoulders to hold both interior and exterior spaces. This is especially true when the exterior space is fraught with political conflict, or inhibits personal freedoms such as freedom of speech, religion or sexual orientation. Yaish (2017), in her work with Syrian refugees in Jordan illustrates, very clearly this constant aggravating encroachment of the outside upon the portable studio she is trying to set up. Usually, in the studio space, individuality and personal expressiveness are encouraged (McGraw, 1995) in a non-judgemental and inclusive atmosphere where the focus is on process rather than on the finished product (Allen, 1995). The open studio has also often been defined in art therapy as a collective, dynamic, fluid and resilient space, where bonding and feelings of community help confront the stigma of, for instance, a mental illness, or where social action can emerge (Allen, 1995; McGraw, 1995; Moon, 2002).

Defining an open studio in an authoritarian state such as Singapore, and then writing about it in an international publication, is very difficult for an art therapist who is not of the dominant culture and whose visual and verbal language will remain steeped, to some extent, in Western philosophy and thought. In 2017, Singapore's art scene and exhibitions are still heavily censored and rigidly curated. The director of the International Arts Festival in Singapore, Ong Ken Sen, recently told *The Guardian* that, although Singapore has become a culturally healthier place thanks to better funding opportunities, these come with strings attached in the shape of government intervention at every single step of a creative venture (Harmon, 2017). Any representation of racial or religious content, 'non-mainstream lifestyles and behaviours', violence, nudity, or sexual content is banned from art and media in Singapore. It is common knowledge that books, art and movies are regularly banned, and that many Singaporean artists have made the choice to leave the country. Singaporeans often mention that the art education they received in schools up to recently was still influenced by the scrupulous techniques of Chinese calligraphy, painting and pottery, and was very directive in its pedagogical approach, which often opposed mess-making, symbolic exploration and free expression. Last year, while enrolled in a sculpture certification course, I was shocked to discover that the teacher would systematically destroy all of my work, sometimes after two hours of sculpting, because I had not been able to apply his instructions to the letter.

Having to define the open studio *a priori* was thus an impossible task, as I simply did not know what to expect. My initial doubts were numerous as I explained the concept to the team. How would an open studio function in this particular context? What would the expectations of the patients be? What would the expectations of the institution be? How would patients react to a lack of instruction and absence of a clear figure of authority? How would they react to someone who behaved like an equal but who was not of the dominant culture? How would they react to a focus on process rather than product? Sathya Devan (2001) has written about the colossal challenge of running any psychotherapeutic

group therapy in Singapore, due to the culturally determined discipline of respecting strict hierarchical relationships and elders, which often results in a failure to self-disclose, prolonged silences, or a complete absence of intimacy and meaning.

Hence, I set forth with an undefined open project for an open studio. I wanted to meet patients, doctors, nurses, families, the institution and – last but not least – the actual geographical space, to see where each one stood and what I could build with it in terms of studio art therapy. Interestingly, psychosis may have been a tremendously liberating and unifying aspect for the open studio experience, in the sense that it helped transcend the censorship mode and allowed for more acceptance of daring and individualised creative expression, which otherwise may have been proscribed by both medical caregivers and the patients themselves. I have been able to compare the EPIP studio experience with work that colleagues and I have done in other group settings; it is safe to say that we were able to reach a certain freedom of expression, unhampered by the outside world. The second ingredient that allowed engaged and free art expression to happen was, as I explore below, my own approach: my inclusiveness and non-judgemental attitude when faced with visuals representing subjects censored in Singapore, such as sex, homosexuality, suicide and abuse.

Building the open studio space: containing, boundaries, constancy

The EPIP ward harbours several multi-functional spaces and rooms that are used for meetings, karaoke, movie nights, Wii gaming, baking, pilates and yoga. Every Tuesday afternoon, one of these rooms needed to be transformed into an art therapy open studio. Fortunately, the same room was available every week at the same time. We used mobile furniture and collapsible tables to create the same geographical space, thus allowing for consistency and a "place to return to" (Wood, 2000). During the session, the window blinds facing the garden were kept down for privacy. Art supplies were arranged in such a way that newcomers immediately understood the purpose of the space as they entered. Two tables were arranged in the centre, with ample room to move around, and a separate table placed further off for those needing more personal space. A sign on the door signalled that the art therapy studio was in session and open to patients only. The doors were left unlocked and slightly open to give newcomers a sense that they could walk in, but at the same time dissuading family members and friends from entering. Although McGraw (1995) encourages the participation of family and friends, in a country where the collective and filial duty always have priority, it seemed like a welcome change to offer a space for individual experience and expression.

The main difficulty with the space was its multi-functionality: because the room also sported a television set, a Wii and beanbags, patients sometimes strolled in, hoping to watch a movie or catch a nap. Another problem was caused by switching on the air-conditioning for the three hours of the open studio sessions. Singapore has an extremely hot and humid climate, and its inhabitants often look for the nearest cooling-off area. Understandably, the open studio became a much sought-after space, with some patients coming in only to enjoy the cool air. Fortunately, this sometimes served the cause of art therapy, as patients seeking cooler temperatures ended up taking part in unplanned creative activity.

Another inconvenience was that water and rubbish bins were located outside the room, in the kitchen area. This meant multiple comings and goings, in addition to patients walking in and out. More confronting, however, was the entrance of nurses to check on patients' presence, administer medication, take blood pressure readings or note behaviour. Early on, nurses would sometimes even comment on the artwork, or sit down to watch patients create. After several discussions with the multi-disciplinary team, and my insistent requests to nurses during sessions, these interferences became less and less frequent, and we were slowly able to build a more protected therapeutic space for patients. Creating the potential for creative flow without chatter and constant interruption seemed essential and was appreciated by most patients, who would say things like "it's always so calm and quiet here", or "I like to be here because I forget the ward".

Because new patients came in every week and sometimes left the studio after only half an hour, there was little capacity to establish a list

of rules. My welcome and introduction to the space were kept to the bare minimum, and some rules were hinted at mid-session or as situations arose. We kept the space radio-free (there was music in the kitchen just outside the room) and I regularly reminded participants not to touch other people's work – or else to ask permission to do so. Rules were often understood very quickly and applied through mimicking the art therapist or those patients who had already spent more time in the studio. It was not unusual to hear a patient say to a newcomer, "we try not to analyse someone else's work", or "just start with colours, don't worry so much about making something look good". Respect for others and respectful inquiry into other people's work were cardinal. Other than that, eating and drinking in the studio were allowed, but whoever was in the studio was asked to engage creatively in any way they wanted. This might be making something with art media, copying from existing imagery, or even reading an art magazine or looking at art techniques in books. Artworks were dried and stored in cupboards, and patients regularly asked to retrieve work from previous sessions, whether to continue working on it or as inspiration for a new project.

The room, like the rest of the ward, was painted in neutral colours. Initially I was asked to refrain from putting any art up on the walls. I describe below how the open studio art progressively spread outwards and affected the ward, and how art gently invaded not only the room's walls but also the ward as a whole.

Art media

The average Singaporean is unfamiliar with buying expensive art paper or art media, so discovering the different media provided in the open studio often presented an opportunity to discuss my own origins, my intentions for the studio, and the financial aspects: Who was paying for it all? Where had all these books come from? Why did I bring old towels from my home? Did I wash them myself, or did I have a helper to wash them? Asking about the price of something is considered perfectly acceptable in Singapore. People regularly ask me how much money I make, what my rent is, or how much I've paid for something. So it was no surprise that these questions emerged in the open studio.

I have always made a point of providing good-quality papers alongside cheaper ones, because I find it affects the way we value the art-making, the nature of the work and what we ultimately decide to do with the art. Patients had access to acrylic paints, and drawing papers in different sizes, as well as oil pastels, soft pastels, charcoal, gel pens, markers, colour pencils, various coloured and patterned papers, pre-cut collage elements, rice paper, origami paper, glue, three-dimensional elements such as wood sticks, gelatos, gouache, Indian ink, watercolours, glitter-glue, sequins, natural elements (bark, moss, shells), terracotta clay, wooden planks, cardboard boxes, prefabricated masks, and a few canvases. Sharps were not allowed on the ward, so we had no scissors, needles or cutters. This often proved annoying to people who wanted to work on collage. We tried using rulers to 'cut out' pieces of paper, or simply tore paper by hand. Interestingly, patients regularly brought in objects and materials to use as art media, such as books, magazines, colouring-sheet printouts from the nurses' station, food, plants and rocks from the garden, but also make-up or other personal items such as hand lotion, a comb or spectacles.

Some art supplies, such as paints and clay, were kept on the tops of low cupboards for easy access; others, such as pencils and markers, were kept in tidy containers on the table, for those patients who found getting up and choosing their art media too overwhelming. Although no paper was taped or prepared on the table systematically, I offered to prepare this for them when they decided what they wanted to work on.

Old local newspaper was used to cover the tables, which we were asked to keep clean because they served other purposes such as meetings. Sometimes this old newspaper became the start of an artwork: Patients completed pictures, underlined language, or copied from newspaper images.

The anatomy of a session

The open studio started at 2pm, during post-lunch resting time. Nurses went to the dormitory to announce that art therapy was starting, and brought interested participants to the room. Patients were free to leave if the studio did not appeal to them. No specific referrals were made

by the multi-disciplinary team, but I was warned when certain patients were deemed too unwell to attend.

Groups comprised between about five and twelve people. Usually more people strolled in after 3pm, as tea-time was held just in front of the studio. Both newcomers and aficionados were given a brief introduction or welcomed back. I always emphasised that no specific talent was required, no permission was needed to enter or leave the room, and no directives would be given, but that if participants felt they needed help to get started this was of course on hand: they could ask me or other patients for help. I briefly showed patients the art media, together with a few succinct examples of what could be done with them.

Sometimes returning patients liked to show their work from previous sessions; this often helped newcomers feel at ease. Art magazines and books were important props to alleviate stress and help ease people into the session when the lack of directives seemed overwhelming. It is very unusual in Singapore not to be given a directive in a group activity, and patients were accustomed to receiving activity directives in EPIP peer-support groups or in case manager–led groups. Interestingly, though some found it difficult to settle into an art activity, most patients took the lack of directives on board and seemed quite pleased upon returning to engage in free creation. Some reacted by ignoring me completely, while others questioned my role and *raison d'être*.

Having led approximately 45 sessions at EPIP, I can safely say that no two sessions were alike. Energy could be high or low, depending on group dynamics such as friendships that had been struck outside the studio or arguments that had erupted just before. Some patients had just arrived in the unit and were still in active psychosis; others had started to settle down and were able to focus slightly more; yet others were very drowsy from medication. Some were purposefully disruptive, or simply expressive: Interjecting, shouting, singing, dancing, praying and even hula-hooping all happened in the studio this past year. Some patients came in for a while, stood around and then left. Some did this for five to seven weeks in a row before coming in and trying to make something. Some would get up and leave, up to 15 times in a single session, while continuing their artwork. Other patients who had been coming for many weeks were able to put newcomers at ease or bring them to art therapy. Some sessions were silent, some sessions were loud.

Each open studio session seemed to have two or three waves of 'flow', during which creation absorbed everyone and creative energy was tangible in the room. It was generally quieter during this 'flow'; people whispered more and seemed careful about disturbing their neighbour. When tea was served at 3pm, many left, apologetic, offering to bring back some tea for me. They usually returned with heightened energy. Sometimes there were new additions. An artwork was reconnected with or a new piece was started. Some patients finished but returned many times to look at their work ("Is it dry?", "Has it changed?"), or to show it to a family member outside, another patient, or a nurse.

I gave ample warning to signal when the session would be coming to a close. Although there was no obligation for patients to clean up, for some this came naturally and they helped me until all was clean again. Some left brushes, paints and smudges because they were not in a mind-space where cleaning was a possibility. Depending on the degree of mental illness a patient was experiencing, I might not say anything, or I might ask them to clean one small element or encourage them to clean up their table. While cleaning up, patients generally felt they could have some one-on-one time with me. They asked about specific situations, about art therapy or art in general, or they left messages to be delivered to doctors, nurses, case managers or family members. Many talked about the experience of being warded, or, if they were feeling better, their plans for the future.

Recurring patterns

Though it is not the purpose of this review to offer an in-depth analysis of artwork created during the open studio sessions, even a quick glance shows that there were recurring patterns in choice of media and subject matter. Again, it is not my aim here to theorise on the reasons behind these occurrences, but they are noteworthy and may constitute the subject of later case studies.

Prefabricated masks and boxes were extremely popular. If available, they were usually used up by almost all present, in a single session. Ready-made surfaces or elements may appeal to people who are unfamiliar with making art; they may seem reassuring in a sense that they make it hard 'to go wrong'. Masks often displayed marks across the forehead and were often divided into two distinct parts, illustrating perhaps the schizoid split in self, ongoing chaotic thought processes, or the imbalance between yin and yang. By way of contrast, patients would often take boxes home; they said that the boxes would serve to keep special objects in their rooms or cubicles. The box thus became an object with a purpose, as well as being an art piece.

Relatively few patients used pre-cut **collage** elements, which surprised me at first. However, observing those few patients who did venture into the collage box, I realised that looking at a multiplicity of images was often exhausting for anyone struggling with hallucinations, and that choosing elements was extremely difficult for many.

Stockmar watercolours proved extremely popular, on both wet and dry paper. Most patients enjoyed observing me prepare each colour in a separate bowl from the small bottles. These watercolours, together with **Djeco gouache**, were used zealously, and the abstract paintings that resulted were admired by all.

I often used **terracotta clay** to work alongside patients; this sparked quite a bit of interest. Many patients felt overwhelmed by not knowing what to sculpt, but were open to 'just feeling' or 'just shaping', rather than trying to make something specific. Clay work often revolved around pieces that were constantly mended or made more solid over the weeks. Food and containers were popular subjects, as well as faeces or genitalia. Clay was also used to imprint things (leaves from the garden, fingers, objects). Some clay work was painted in later sessions. Foster (2013) has suggested that patients with psychosis who get involved with clay "often do so only once or make intermittent contact with the materials" and that "such contact is often terminated with expressions of distress or sudden disinterest" (p.55). She also mentions a frequent expression of disgust and a desire to destroy the object. Interestingly, I rarely observed this, and found that clay was an extremely popular choice among patients, whether they were actively psychotic or starting recovery. If anything, clay seemed to be used more by men than by women, which might have been a cultural matter in this case. Overall, clay offered tremendous stress release for many, and a sense of bringing the fragmented self together in a cohesive shape, sometimes over several sessions.

More typically **Asian** creations were common, in the form of religious themes in drawings or paintings (Buddhist, Taoist), Chinese characters, manga cartoon drawings, the use of calligraphy with black ink on rice paper, origami, drawings or paintings of koi fish, bamboo forests, cabbage (indicating prosperity), dumplings, lotus flowers or dragons. These were more common around local holidays and often sparked a discussion in Mandarin or a desire to educate me.

Lastly, **copying** drawings or patterns from magazines or books was a frequent way to get started, and often led to a completely individual and original creation. 'How to draw' books were popular, as were **Zentangle** methods. Some patients came in every session to simply look at art books, only starting to make something after four or five sessions. Some patients requested journals in which to continue their work outside the studio, and were able to bring in weekly projects so as to link studio work back to their ward activities. The ward itself seemed to start vibrating, with bits and pieces of art spilling over from the open studio, encouraging more patients to create – albeit in a space that they chose and away from curious eyes.

At the margins of it all: the art therapist

Ang moh is a racial epithet often used in Singapore to describe white people. It literally means 'red-haired' and is traced back to a term meaning 'ghost man'. The term is used derogatorily and can seem racist in certain situations, but it is also used with humour on many occasions. I was thus the *ang moh* on the ward – the only non-Asian person. I was also a woman in her forties sporting a tattoo on her arm, which is still considered quite risqué for many older-generation Singaporeans. Overall, most patients reacted with surprise and openness

to finding in the studio a Westerner, who often wore dungarees and disregarded the rules against dangly earrings. In those first few seconds where a person in a very fragile mental state decides whether to give therapy a shot or to leave, the appearance of the therapist plays an essential role. In that split second, we both have to face Singapore's colonial history and multiple layers of cultural, religious and gender issues. Humour and some Singlish were generally on my side, and a great asset when reassuring patients. My appearance and dress also helped to put patients at ease: here was an 'artist' (I usually dressed in 'arty' clothes and always had some paint or other media remnants on my hands) – in other words, not a psychiatrist, psychologist or other therapist who was going to ask a lot of questions. Furthermore, my brief introduction, the presentation and use of media and space, as well as the non-directive nature of the studio, always sparked the same questions: "But are you going to analyse us?", "How long have you been here?", and soon, "Will you be here next week?".

I sometimes felt that my being a Westerner meant that patients would attempt new things because I had a culturally different way of understanding art or looking at art. They also felt sufficiently at ease to ask personal questions that often demonstrated a curiosity to find out more about me as the 'other'. At times, patients offered questions as a way to build a bridge, to find a common ground where communication was possible. In Singapore, this often revolves around food: "Do you like local food?", "Have you had laksa?" and so forth.

Once creative flow started, most of this talk fell away as we engaged in triangular communication and conjoined looking at the artwork. Once everyone was at work, I usually started on my own art, often clay or multi-media. This served several purposes. Firstly, it gave patients the space to create without a scrutinising gaze from me. Singaporeans tend to avoid direct and prolonged eye contact and are not at ease looking at each other intently. Making art also served me, as it allowed me a space to get away from the occasional anxiety created by a cultural or language gap. Making art together also introduced more equality, and is something Singaporeans are familiar with. Although much less common today than 52 years ago (the advent of Singapore's independence), there are still many instances in Singapore of sitting and making art together, perhaps more than in Western countries, because of the prevalent collective-over-individual experience. There are still many calligraphy groups, pottery groups and traditional crafts ateliers. In this respect, the open studio model is culturally more adaptable than, for instance, one-on-one art psychotherapy sessions.

Another reason for making my own art was to show techniques that patients could imitate. I found that this was often easier than a verbal explanation. I also left old work at the studio to serve as a model.

Thirdly, my own artwork often sparked interest and brought about a conversation about making and moving away from trying to please aesthetically. Many patients had not done any creative work since primary school, and needed much coaxing and reassuring that art can firstly be what the hands need to make in the moment, rather than what the head plans for. We talked about the sensory experience, about making mess – something most Singaporeans abhor, as extreme hygienism is valued highly and is almost a national duty. Once liberated from the old primary-school or junior-college art lessons, upon observing, for instance, a clay sculpture or a multi-media collage, many felt free to jump in and try new things. This introduced what Marshall-Tierney (2014) has described as more "toleration for ambiguity and uncertainty" and heightened acceptance of "not-knowing" (p.99). This in turn could often be linked to a patient's sense of being able to tolerate insecurity about their health condition, the length of their stay on the ward, or their future outside the ward.

I required a huge amount of flexibility and energy to contain the experiences and needs of between five and twelve people, all at various levels of psychosis and healing, their comings and goings, their anxieties and sometimes rage, their outbursts and sadness. Sometimes I was too busy containing this whirlwind to do any work of my own. Some patients requested constant attention, others needed reorientating or redirecting, yet more wanted to understand techniques or requested practical help.

Usually, when patients felt sufficiently safe, I ventured around the room to look and ask questions about their work. These questions were

often intended to spark self-reflection, symbolic thought or mentalisation where possible. Some patients in turn took to asking questions about my or other patients' work, using the same non-judgemental openness and observation. With some long-stay patients, we could do small reviews of past work and look at progress together, either at the end of a session or during the session if they so requested.

Crisis intervention was almost never needed and I stopped wearing my alarm one month into the programme. I felt that the alarm was an object that belonged to medical staff and signalled to patients that a staff member belonged to the institution. To avoid institutional transference, I wore my freelance status like a badge. This meant that patients knew I did not know their background story or why they had come to the ward, that I could not open doors for them (I did not have an access pass), or advocate for a faster discharge. I did, however, participate every week in meetings of the multi-disciplinary team, during which I gave some feedback about behaviour or anything that was worrisome or posed a threat to a patient's well-being. I often found it hard to translate the open studio experience during these meetings. How does one isolate one patient's experience from the group, and how does one avoid the pitfalls of medical lingo when art is the object of our attention, but it needs to be translated back for the open studio to become a valued experience in treatment? I tried as much as possible to lift the positives and highlight progress where visible. In several cases, observations from the studio proved helpful in refining diagnosis, changing medication or pushing for a different discharge plan. I often felt frustrated by my inability to render the depth and richness of the experiences of the open studio during team meetings. As the container of much fragmentation, paradox, incoherence and ramblings, which was often no doubt perceived in my own language during these meetings, I was pleasantly surprised to receive private messages of interest from team members, doctors, case managers and social workers, regularly asking about patients' experiences and progress.

Overall, although I was physically and mentally exhausted after each session, I felt that I was able to see my shifting role in the patients' use of language. First I was 'nurse', then 'doctor', then 'teacher', then 'Miss therapist' then 'Sandra'. From there grew the possibility of sustaining the position of an equal rather than that of a superior authority, even when it came to making art. In Asian societies like Singapore, the collective experience is still valued above all, and hierarchical figures are strictly respected. Nevertheless, I found that by practising constant humility, openness and tolerance for whatever emerged in the moment, there was a possibility to deflect from this authority position in which, initially, I was systematically placed. As a keeper of the safe space – which I protected ostentatiously against intrusions from nurses, family and friends – I became a trusted face around the ward; patients would often come up to me outside studio hours to say hello, to show me their journals, or to ask me about the next session.

Lastly, I felt that the psychotic experience or the hallucination always came first and that the cultural gap between us was pushed to the side. I felt that I first had to learn the language of each patient's psychosis. Only then came the manner in which that psychotic experience was embedded in the dominant culture – Singaporean Chinese, Malay, Indian or Eurasian – and how I could respond to it from the place of my 'Third culture'. It was almost as if there was a cultural levelling through the experience and language of psychosis. I carried the openness forward, allowing for instance the sculpting of a penis or faeces, the representation of sexual abuse or homosexuality, to happen without intervention, and with impartiality and receptiveness. I sometimes translated these visuals, which for Singaporeans could be shocking or taboo, back to the multi-disciplinary team as an expression of psychosis, rather than as something that needed to be censored immediately or even punished by removing the patient from the studio, which was suggested at several occasions. After working on taking myself down from the pedestal on which I had initially been placed, I was able to play the roles of therapeutic ally, silent witness and facilitator (Luzzatto, 1997), and the patients were able to move out of a submissive position to a more egalitarian one, which helped free their creative expression.

Evaluations, recommendations and conclusion

Patients' oral feedback on the experience of being in an open studio often demonstrated an understanding and appreciation of my role, and the desire to prolong creative activity outside the hospital, upon discharge. In general, patients were encouraged to fill in evaluation forms at the end of their stay on the inpatient ward. These forms referred to all group activities, including the art therapy open studio, asking patients to give a score to the activity, from zero to five. The forms also left space for patients to comment or make suggestions if they wanted to. Between April 2016 and April 2017, the open studio was consistently scored at four or five out of five (see Figure 1).

As mentioned previously, it was heartening to see art spilling out into the ward, whether through journals or unfinished pieces that patients wanted to keep working on. In the second half of the year, senior case managers implemented a number of patient suggestions from the evaluations and requests coming out of the open studio. For instance, patients often asked to exhibit their artwork on the studio walls, elsewhere in the ward, or even around the hospital. In March 2017, large acrylic boards were purchased for patients to showcase their art safely, both in the studio and on the ward. EPIP also participated in the *Affordable Art Fair,* to raise funds for the open studio by creating and selling tote bags featuring patients' artwork. In December 2017, EPIP will hold an art exhibition and competition inside the Institute of Mental Health, to raise funds for the open studio. Case managers have also continually encouraged patients to use art around the ward to create inspirational banners and posters. They have recently run an eight-week, art-based Acceptance and Commitment Therapy (ACT) course for outpatients, some of whom had participated in the open studio. After working in the open studio, several patients reconnected with their studies in the area of art, or said they wanted to enrol in weekly art classes. Others decided that they wanted to try journalling, either as a way of keeping track of their mind's chatter and moods, or simply for art's sake.

It was gratifying to see art bloom and take root with such vigour in an inpatient ward, only a year after the introduction of the open studio. Whereas Brown (2014) was bewailing the loss of studio spaces in the UK, perhaps in Singapore there is now a potential for building such a space for the first time.

Thanks to a year of extremely positive evaluations and comments from patients, my freelance contract was renewed for another year, and the open studio will continue. I hope that, if evaluations remain positive and art projects continue to bloom, the open studio's geographical space will become more permanent, helping to ground the patients' experience. Although the multi-functional space did, unfortunately, place me as art therapist at the centre of the project, especially in an authoritarian system such as Singapore, it seems that I could deflect the focus back to empowering patients, by working with the multi-disciplinary team to translate, revitalise and re-interpret the space and the self at the same time through art. Perhaps this outward-moving 'vitalisation' is also a way to bring the open studio into Singaporean inpatient psychiatric wards as a more definitive space.

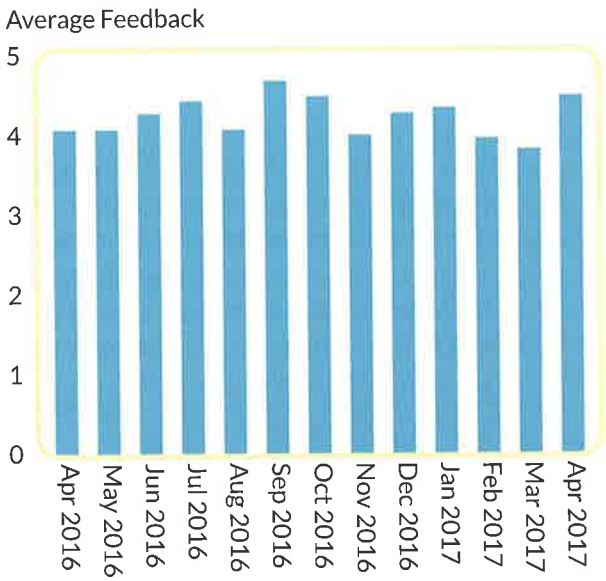

Figure 1: Average patient feedback scores for the open studio, April 2016 – April 2017.

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References

Allen, P. (1995). Coyote comes in from the cold: The evolution of the open studio concept. *Art Therapy: Journal of the American Art Therapy Association, 12*(3), 161–166.

Bram, E. (2016, July). *Speak out: Pat Allen's open studio as a form of group art therapy*. Retrieved from http://www.arttimesjournal.com/speakout/summer_16_a_form_of_group_art_therapy.html

Brown, C. (2014). The lost studio: 'You don't know what you've got till it's gone'. *ATOL: Art Therapy Online, 5*(1).

Edwards, J., Harris, M.G., & Bapat, S. (2005). Developing services for first-episode psychosis and the critical period. *The British Journal of Psychiatry, 187*(48), 91–97.

EPIP (2017). *EPIP Early Psychosis Intervention Programme.* Retrieved 28 September 2017 from http://www.epip.org.sg/?services.html

Essame, C. (2012). Collective versus individualist societies and the impact of Asian values on art therapy in Singapore. In D. Kalmanowitz, J.S. Potash & S.M. Chan (Eds.), *Art therapy in Asia: To the bone or wrapped in silk* (pp.91–101). London: Jessica Kingsley.

Foster, F. (2013). Fear of three-dimensionality: Clay and plasticine as experimental bodies. In K. Killick & J. Schaverien (Eds.), *Art, psychotherapy and psychosis* (pp.52–71). London: Taylor and Francis.

Harmon, S. (2017, September 9). Art v government at Singapore festival: 'I fear once I leave, they will punish me'. *The Guardian.* Retrieved 9 September 2017 from https://www.theguardian.com/world/2017/sep/09/art-v-government-at-singapore-festival-i-fear-once-i-leave-they-will-punish-me

Kalmanowitz, D., & Lloyd, B. (2005). *Art therapy and political violence: With art, without illusion.* Hove, East Sussex: Routledge.

Kalmanowitz, D., Potash, J.S., & Chan, S.M. (Eds.) (2012). *Art therapy in Asia: To the bone or wrapped in silk.* London, UK: Jessica Kingsley.

Luzzatto, P. (1997). Short-term art therapy on the acute psychiatric ward: The open session as a psychodynamic development of the studio-based approach. *Inscape, 2*(1), 2–10.

Marshall-Tierney, A. (2014). Making art with and without patients in acute settings. *International Journal of Art Therapy, 19*(3), 96–106.

McGraw, M.K. (1995). The art studio: A studio-based art therapy program. *Art Therapy: Journal of the American Art Therapy Association, 12*(3), 167–174.

Moon, C.H. (2002). *Studio art therapy: Cultivating the artist identity in the art therapist.* London: Jessica Kingsley.

Sathya Devan, G. (2001). Culture and the practice of group psychotherapy in Singapore. *International Journal of Group Psychotherapy, 51*(4), 571–577.

Wood, C. (2000). The significance of studios. *Inscape, 5*(2), 40–53.

Yaish, S. (2017). Art therapy with Syrian refugee children in Jordan: Difficulties of containment. *ATOL: Art Therapy Online, 8*(1). Retrieved from http://ojs.gold.ac.uk/index.php/atol/article/view/443.