Art Making and its Interface With Dissociative Identity Disorder: No Words That Didn't fit

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Abstract

Studies point to promising developments in expressive arts therapy work with clients who experience dissociation as one of a constellation of symptoms of trauma. Individuals diagnosed with Dissociative Identity Disorder, however, may be hesitant to engage with long-term therapy and its relationship. This article presents the case of one such individual, a participant in a narrative phenomenological study who was able to develop her own visual art-making practice. Reflections on this practice revealed that it offered a safe place for her to explore the voice of her "parts" hitherto silenced. Her narrative has implications for professionals working in the expressive and talking therapies.

Keywords: mental wellbeing, phenomenology, Dissociative Identity Disorder, Art making, creativity in counseling

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Dissociative Identity Disorder (DID), known as multiple personality until the DSM-IV gave the condition its current, less dramatic and somewhat more descriptive name, has long been associated with controversy (Boysen & VanBergen, 2013) and has its historical roots in the no less controversial concept of hysteria (Brand et al., 2016; Hudziak et al., 1996). Aetiologically associated with a combination of developmental and cultural factors including severe childhood relational trauma, DID is a complex disorder with a prevalence rate said to be 1% to 3% of the population (Johnson, Cohen, Kasen, & Brook, 2006). Lack of agreement regarding the characteristics of DID, as well as dispute regarding the features it shares with Borderline Personality Disorder (Ross, Ferrell, & Schroeder, 2014) has led some commentators to point out that many who have been diagnosed with DID "would probably have received different diagnoses in other places and other times" (Paris, 2012, p.1077).

Despite diverging opinion as to the efficacy of therapeutic interventions in cases of DID (Dimidjian & Hollon, 2010), some researchers maintain that the condition is amenable to psychotherapeutic intervention (Brand, Loewenstein, & Spiegel, 2014; Dorahy et al., 2014) not least because of a strong relationship between dissociative disorders and childhood abuse (Kisiel & Lyons, 2001) which remains a core element of psychological distress explored through psychotherapeutic intervention. Recent trauma research in psychobiology (Schore, 2001, 2002, 2003) and interpersonal neurobiology, which seeks to integrate the findings of neuroscience, biology, psychology, developmental theories and psychodynamic understandings (Siegal, 2006), has led to a renewed interest in the role of a range of expressive therapies[i] posited as offering an important, nonverbal approach that may foster integration between the emotional nonverbal brain and the rational verbal brain (Prendiville & Howard, 2017). This work may hold out promise for the addressing of childhood trauma and its possible consequences in adult pathology. A corollary to this is the interest in how

engagement in expressive activities may offer a means of therapy in cases where talking therapies have been limited in their impact.

Dissociative Identity Disorder and Art-Making

The role of the expressive visual arts therapies in helping people with trauma and complex disorders has increased in recent years (Cox & Cohen 2000; Gonzales-Dolginko, 2003; Pierce, 2014), offering a means by which the individual "can look at a trauma without being it" (Thompson, 2016, p.342). One reason for the interest is the difficult to quantify benefit of offering a therapeutic practice not based in verbal exchange, but instead in imagery and the making of imagery to people for whom a relationship with words and verbal exchange are fraught. Language, as Stern identified in his now classic 1985 work is "a double-edged sword" and can be a key challenge within the therapeutic setting, driving "a wedge between two simultaneous forms of interpersonal experience: as it is lived and as it is verbally represented." (Stern, 1985, p. 162). Fosha (2003) also reminds us that "emotional experience is not processed through language and logic; as the right hemisphere speaks a language of images, sensations, and impressions … therapeutic discourse must be conducted in a language that the right hemisphere speaks" (p.229). Wilkinson (2010) too acknowledges that "from a therapeutic viewpoint, words have limitations" (p.89).

It has been noted that expressive visual arts therapies can help individuals who have internalized warnings not to talk about childhood abuse (Braun, 1987). Studies point to promising developments in the area of these therapies with clients experiencing a core characteristic of DID, dissociation, with Engle (1997) maintaining that "Artwork is one of the best ways to access the dissociated material" (p.247). Cox and Cohen (2000) suggest that visual art-making offers a "safe way for DID clients to communicate, as they have often been threatened into silence by their abusers during early childhood" (p.195). Creative arts therapies more broadly may also support or enhance cognitive restructuring strategies with

potential effects that appear to be especially helpful with clients with dissociative tendencies (Altman, 2000).

Not confined to the DID diagnosis, dissociative phenomena, frequently attributed to experiences of childhood abuse, are largely understood both as a failure in the normal development of the self (Liotti, 2009) and a defensive mechanism against pain (Ross et al., 2008). They can be seen as a creative defence maximizing survival, yet they become a hindrance in later life. Expressive arts therapies, aligned to psychotherapeutic principles, aim, amongst other things, at an integration of polarized affect states and representations of self and other into a more coherent whole. Dissociative Identity Disorder, associated with persistent problems in forming a coherent and consistent identity (Ross & Ness, 2010), thus offers a unique challenge for the expressive arts therapies. Art-making as sole or as ancillary therapy for people with DID may therefore be of unique benefit (Cox & Cohen, 1995, 2005).

There is much written about the disorder of Dissociative Identity from the point of view of the clinician. There is also, as indicated, an increasing amount written about the disorder in relation to expressive arts therapy, written largely from the perspective of the therapist. Less work however, is available that penetrates the personal experience of living with DID; and even less that seeks to capture the interface of visual art-making *outside* of the clinical context and DID from the art maker's perspective. This paper is located at precisely that juncture and hopes to give insight into clients with complex conditions who have come to reject formal talking and clinically based art therapies but who nevertheless engage in visual art-making.

Methodology

Since the 1980s, psychology, along with other disciplines which were part of the "narrative turn" in social science, has been sharpening its tools in narrative research and understanding. In offering an alternative conceptual framework to that provided by

mainstream positivist psychology, narrative inquiry in its various forms[ii] has enabled a penetration of complex psychological experience. The phenomenological approach to narrative research has, in particular, demonstrated a germane and lively currency amongst those working with the very intense and intangible experiences of mental ill-health, who, in questioning the biomedical model of mental ill-health, seek a more in-depth and, as first coined by Sass in 1988, 'experience-near' description of the phenomenon (Hollway, 2009).

Phenomenology emphasizes attending to descriptions of human experience rather than explanations in terms of causes and is increasingly recognized as an important theoretical paradigm in understanding illness (Carel, 2006). This is but one of the reasons researchers working in a collaborative, person-centred approach to qualitative research with mentally ill individuals favor its comparatively bottom-up, non-expert ethos. Such an approach is particularly important today as healthcare systems continue to take fiscal knocks under the so-called austerity regimes ushered in as an inherent facet of neoliberal economies. As a part of this move and a commodification of mental health (Esposito & Perez, 2014), there is a drive towards positivist metrics of outcome, which marginalize the quieter relativist metrics of experience. A phenomenological perspective highlights the importance of language in these descriptions and the words that are used, along with intonation, gesture, tempo and "the way of speaking" (Heidegger, 1927/1990, pp. 204–206). The meanings made by the individual, of their experience are crucial.

The rallying cry of phenomenology, the philosophy developed by Edmund Husserl (1859–1939), was "to the things themselves" (*zu den Sachen selbst*) and the aim of describing direct experience of the world involved a process of "bracketing off" assumptions (the law of *époché*), to avoid the distorting effects of theories and presuppositions. The validity of the concept of "*époché* " is now challenged through post-structuralism and the claim that it is possible for assumptions to be "bracketed off" is largely rejected in this paper. It is a

phenomenological sensibility (Finaly, 2014) that is being striven for in the methodology of this work, nevertheless employing Ricoeur's (1970) hermeneutics of suspicion in narrative to problematize "the participants' narrative" (Josselson, 2004, p.11) and offer some decoding beyond the text. Within health psychology, researchers have long emphasized the value of narrative research as a means of making sense of the disruption of illness (Crossley, 2000; Murray & Sools, 2014) with illness narratives offering up rich depictions of the unique experience of illness.

For this case study, Thematic Analysis (TA) (Braun & Clarke, 2006) was employed for its flexibility and accessibility. Unlike methods which require the adherence to firmer templates, there is "room" within TA to remain committed to the individual, to the experience, and to the related exploratory research question rather than be governed by the method (Holloway & Todres, 2003). The approach and method are informed by Bradfield's (2012) synthesis of phenomenological hermeneutics and psychoanalytic case study research, which has been important in bringing to the fore an understanding of intersubjective processes through an openness, sensitivity, and flexibility (Dahlberg, Dahlberg, & Nystrom, 2008).

Data was analyzed by coding dominant categories which emerged in the uninterrupted flow of the individual's descriptions. These were then reanalyzed to identify the sub-themes contained therein. Sub-themes were then further interrogated, relating these to the inquiry's main focus, that of the "is-ness" (Giorgi, 2009) of things; in this case, the experience of making art as a person with DID.

Participants

Participants of the original study were recruited through calls made through mental health on-line networks for adults with a diagnosis of mental ill-health willing to talk about experiences of art-making (Sagan, 2014). Consent was given both verbally and in writing,

and each participant was reminded of the right to withdraw at any time during the interview or research process. The ethical process of the host university was strictly adhered to.

The narrative case study presented here is of Henrietta (Henri) who was one of seven of the 10 people originally interviewed with a diagnosis of either Borderline Personality Disorder or Dissociative Identity Disorder. Following the completion of the original study Henri was interviewed again to explore her experiences further. It is on the collected interview data of Henri that this case study is based.

Interviews

Interviews with Henri took place by telephone. Each was an unrushed opportunity for further explanation of the research, and for Henri to ask questions. At the end of each there was a debrief. Maximum attention was given to enable rapport to be built and for the participant not to feel rushed, judged, probed, or interrupted. At times the interview was literally an "*inter-view*, an interchange of views between two persons conversing about a theme of mutual interest" (Kvale, 1999, p.101). A manner of "co-participatory creativity" (Bradfield 2012, p.267) was aspired to with Henri later saying she felt that the interviews had been a positive process with the free-associative element being useful (Hollway & Jefferson, 2000).

Case Study Findings

Henri is a woman, in her words, in *"*her middle years*"* and identifies as being White British. I interviewed her three times by telephone as she is guarded about her privacy and preferred not to meet in person. Diagnosed with Dissociative Identity Disorder nearly five years ago, she says that, "Before then, things hadn't been right for a long time - forever." She'd been "in and out of hospital since about 17 years of age." Henri has been diagnosed at different points in her life with schizophrenia, anorexia, depression, borderline personality disorder, acute anxiety, and post-traumatic stress. She describes her life, prior to her middle

age, as chaotic, a series of diagnoses, medications, opinions, experts, inconclusive interventions, confusion and despair. She says, "something was very, very wrong, I was wrong."

At the time of interviewing Henri, she was living in a social housing estate on the outskirts of a middle-sized English town. She lived in a small flat and was in loose contact with a number of community and medical support professionals. When I spoke to her, she had opted out of both talking therapy and art therapy. Henri left school at 16, has no post-compulsory education, and laments the fact that "there didn't seem to be any art at school, I think that is a shame, I reckon [pause] it might have helped, might have given me a way in [chuckles] or a way out…" While interviewing Henri, I noticed frequent changes in her voice, timbre and intonation, as well as subtle accent changes, most notably at times sounding much younger than her years and other times older. It is not suggested this was indicative of the presentation of "alters" or other personalities, but an observation that added to the challenge of the interviews. For although Henri was personable, she also reacted quickly to any indication on my part of over-prying or of "going too far" in a direction with which she was not happy, and her voice would change as a result. I regularly stopped the interview to check that she was willing to continue, and to remind her that she was in control of the process, able to stop or retract whenever she needed to. This seemed to reassure Henri signaled by another slight change of pitch in voice.

In approximately four and a half hours of interview data, three dominant themes emerge, that of the experience of dissociative states, the participant's early childhood and her journey towards diagnosis and the role of therapy as part of becoming diagnosed. In each theme a sub theme is present, that of "Making Visual Art." Henri describes how, in relation to each dominant theme, her art-making helped her in a process of integration, and it is this experience of integration that is explored in this paper.

(Fig. 1 here)

The theme of integration is chosen for more in-depth inquiry here not only because it emerged in all dominant themes in the study with regards to making art, but also because a central aim in therapy with those diagnosed with DID (Biswas, Chu, Perez, & Gutheil, 2013) and in art therapy (King-West & Hass-Cohen, 2008) is an integration of so called "alters," parts or different personalities of the individual with DID. The first-person narrative of the experience of integration is therefore deemed to have both practical and theoretical importance.

Integration: Getting to Know Dissociative States and Childhood Events Through art-making

For Henri, the experience of having dissociative states is distressing. She says:

> When I disassociate, although I don't usually use that term, it is a bit like sleepwalking. I can easily get up, walk all around the flat, have something to eat and get back into bed… then somebody tells you, they say this is what you did, and you just, you think, "No, I don't believe that, not me, I, I [pause] I didn't do any of that…because I've got no memory of it."

Yet Henri acknowledges that someone did these things and explains how painting has helped with this disturbing aspect of the experience:

> I know one of the others has been out and about, doing this. And yes, it freaks me out a bit…used to anyway. Painting has helped with that. One of the good things that has happened…. whereas before I had no real idea who it was that was about, I just kind of I knew it wasn't me, so I would be thinking "who was it?" and I don't know. Now, though, they do painting…and I can tell by the difference in the style of painting, the materials used, the colors….so [pause] somebody has been painting, maybe for an

> hour, longer or shorter, but I can see what's been done… they were… are there, painting and I at least know the person, they call them alters, by the way, has been out there painting.

Henri, who expresses relief at this step forward of at least now knowing "who the others are" rather than living in fear of them, then speaks quietly about how frightening the experience of alters can be. This is especially the case when one or more seem to remember events not only in the present, but way back to childhood, that Henri could not otherwise remember:

> There are younger parts that don't talk. Have never talked. Now, they paint, so then that is their voice. And they remember [pause] they remember stuff… all that I can tell you is that it's a bad place that they've been to. Painting… it is like their voice. I suppose in a way it set us free because otherwise they, the alters, would still not be expressing themselves. I didn't know how many alters there were, either, but now, well, since I started there has been…there's a difference in the paintings, even how the room looks after it has been painted [chuckles]…some are really, really, really messy! So, where I didn't know before, how many parts there was, we now feel sure, through the paintings, there are seven. 'Til now.

Each alter not only paints in a different way, but uses different materials and is present in the studio (Henri's small kitchen) differently:

> One of them leans the board against the wall, one flat on the table, a couple work from the floor. One'll use sponges and palette knives but no brush, one just fingers…one or two clear up afterwards, others leave a mess everywhere, like there was a load of 'em working at the same time…

Most poignantly, Henri talks about coming to know about early years experiences of abuse through the paintings of two alters:

> Before, before painting, my therapist asked about [pause] stuff in my childhood…I used to get like a knot? In my chest? Like there was something stuck there, right there but I couldn't remember or say anything, it was just caught. When the painting started…there was in one, she used a lot of really bright colors, big, big color. And you could see in them, a figure, and, like another figure…[pause]The color, it was like you've got to take notice of this picture because…you see the bright color and it is hard not to see it. So, I've found out a lot about the personalities; I wouldn't have known that. I wouldn't have known why she had done bright colors; I learned about the abuse, the stuff that had gone on. So, I think she had been told not to talk about it; well, BIG COLOR… she's painting about it.

Henri says that art-making has given her "some peace" that she cannot describe. She feels; however, it is related to her getting to know the alters, which she regards as a good thing, using the phrase "coming together" frequently in her narrative of painting and her alters:

> I didn't know who they were, how many, what...and they never used to do anything together and, but now…this main alter communicates with the rest of them and sometimes, I think, they come together to do the art, which is good because that means that we are coming together as one.

Integration: the Role of Diagnosis and Therapy

In the past fifteen years Henri has had psychotherapy, dialectical behavior therapy (DBT), some "mentalizing stuff" as she recalls it, and art therapy with more than six different therapists. Her journey to diagnosis has been turbulent:

> Oh, lots, lots, and lots of comings and goings, changing opinions, different people with different views….each time I'd be told I had something else and each time I'd feel less like anyone or anything.

She acknowledges that some discontinuity with therapists during and following diagnosis was down to her, with a reluctance at times to engage:

> It was really hard, at the beginning…and now, really…[to engage with therapy] that was about the parts being let down by people and so we just have to do everything on our own and we don't ask people to help us out and things like that. We've…this has got to be us doing it…

Yet Henri also describes a series of damaging and sudden cessations of services; frequent changes of practitioner, especially in the art therapies and more recently cuts made in her support network, with the loss of at least one person who "just really got me, you know, kind of knew me?" Ironically it was this person, a community support worker, who encouraged Henri to paint at home, and helped her get set up with materials: "since then I haven't stopped painting."

Henri does not speak negatively about her experiences of therapy yet claims her decision to withdraw from it as "important for me, a turning point." It was at this point too that Henri begins to retreat from thinking about her diagnosis and what she might "have." This meaningful decision was described thus:

> I know I've got to get to know what's going on… [with the others]. I can't be…I want this to be my journey, and I don't want to be led down paths, ideas, suggestions…[pause] I've got some tools now, and with the painting, I can get to some better place…it's not about what I have. [meaning diagnosis]

When asked about these tools, a dialectic process, important for the movement towards integration, was described between her therapies and her paintings, whereby each:

> …speaks to the other… if you know what I mean? The paintings, colors and images, they give me ideas, so…when I speak about things, and those ideas find their way back onto the art work…and back [laughs…pause]

It seemed Henri learned from different sources and these learnings resonated with her, sometimes much later. For example, when remembering her first art therapy sessions:

> Ages later, I remembered that… I used to get a lot of headaches in the sessions, didn't think about that 'til I started painting at home, and they came back, so I thought, blimey! … the feelings and emotions and memories would come out of each part. Like it was their voice, but until something could come out, I'd be stuck with this banging head.

But then, the wariness of the spoken word as part of her therapy sessions is raised. She says, "the explaining bothered me…it missed the mark, got in the way, twisted stuff…" Henri's experiences of talking therapies were mixed. On the one hand she found the process helpful, and feels that at least to begin with it added to her learning:

> …with talking therapy, the therapist…she can put in really helpful techniques, like…. Techniques…and talk to the parts to help them see that the things that happened to them in the past, they are… are not happening now.

But as time went on, she Henri began to feel there was some confusion:

> Look - some stuff I would have known anyway…but the therapist there then tells me what has been said. And I worry, I worried that some of the things that were said [pause] I then somehow thought had happened and that became part of the story, in the therapy, and I started getting really...I couldn't trust what was going on?

Henri feels that ideally, you'd have "the two [talking and art therapy] because they both do different things to help the disorder." Yet she maintains that, having picked up some workable tools:

> …through me painting alone…that's where, look, that's where I started trusting what I saw in the paintings….and knowing it was coming from me, no ideas from anywhere else…no words that didn't fit. Not all of the personalities paint, there are some that don't paint. Can't paint, but my therapist, the art therapist he'd encourage them to paint…he thought this would be very helpful. It wasn't. They weren't ready, and I think they burrowed away further and further.

Henri is clear about her aim, to work towards a point when:

> I won't split off into different alters, parts, whatever… and hopefully I can become one person. One personality. They'll still be there, but, how, how can I put it, we can all, work together… because it is really hard to explain. And it might be something others can do, by other means, but for us, it's more achievable by producing the art, painting, looking, watching. Learning more. Here, alone at my kitchen table [laughs].

She also envisages a time when "I can go back, to psychotherapy. With all this…and move from there, maybe. Slowly."

Amidst the turbulent journey of changes and cessation of services and support, changes in therapists and Henri's withdrawal from talking therapy, an ad hoc discovery of her own art-making occurred. It appears from these extracts of narrative which at first hearing seem to describe disparate elements, a journey of "coming together" and a sense of integration is described, one which is centered around the solitudinous activity at Henri's kitchen table.

Discussion

At clear risk of falling through holes in the net of mental health support, Henri is not atypical in having a record of patchy engagement with a pattern of rejection and withdrawal,

clear difficulty in gelling with therapists, and a reluctance to engage with a clinician associated with authoritative figures from the past (Brand, Armstrong, and Loewenstein, 2006). That's one portrait, and certainly one to be heeded, particularly at a time of increased cuts within mental health support (King's Fund, 2015) and with fragmentation of support not likely to improve. Another portrait, however, is glimpsed in this case study; that of a motivated woman, determined to learn more about herself and to *'get well'* - and perhaps too little credit is still given to the resilience and strategies home-grown by individuals outside of the mental health system, such as the art practice described in this case study.

Despite a decades' long struggle with a complex and serious condition, Henri feels she has been given a lease of life and hope through an activity that has become part of her daily existence in her middle age. So, it is worth considering further why this activity has been experienced as helping where other interventions have failed to engage Henri and what implications there are for professionals working in both the expressive and talking therapies.

Firstly, for Henri, as with many others with personality disorders, dissociative tendencies and a history of trauma, words are a difficult currency, described by Chong (2015), as a "powerfully manipulative tool to dissociate and foster the 'false self'" (p.120). This "false self" as described by Winnicott (1965) develops as the compliant verbal self, speaking in the words of another. Therapeutic (verbal) engagement may be thus destined to be limited, if engaged with at all, offering little or no means by which the preverbal self can articulate. A recurrent theme of Henri's narrative was the difficulty inherent in using language to communicate nonverbal or preverbal experience, but also a perennial wariness of the dangers of the "colonization" of words.

In suggesting that the therapist allow patients to use pictorial methods within talking therapy, in Henri's words, "the therapist…maybe if she had let me draw too, at the same time, maybe…" Henri is alluding to creative methods in talking therapy. She thus endorses the

point for practitioners and counselors made by Cox and Cohen (2000); the value of using drawing, mandalas, photo-elicitation and other visual materials "as a method of bringing their circumstances to the therapist's attention or to share information that they are unable to discuss" (p.195). The International Society for the Study of Dissociation (2005) also concurs that within psychotherapy nonverbal processes and products can "serve as a visual or written record of the experiences of the internal system of alternate identities and may be examined at any point in treatment." (p.161). The inclusion of the skills needed to work with imagery in counselor education would also assist in giving new trainees further means through which to explore the inner worlds of clients for whom verbal engagement is difficult.

A corollary of the mistrust of words is a deeply embedded mistrust of *relationship*, again, a legacy of trauma - and Henri's own account described a record of problematic engagement with professionals, exacerbated when those relationships were also the collateral damage of services curtailed or eroded through welfare cuts. The DID personality, wary of words and struggling with the building blocks of relationship, is often locked in a hermetic relationship with the self, and one of the recommendations for the treatment of dissociative disorders issued by the ISSD (2005) emphasizes a nuanced and phase-oriented approach requiring long-term therapy, with the recommendation that "Clinicians should never underestimate the difficulties that DID patients have with establishing and maintaining a therapeutic alliance" (p.141).

Henri was fortunate in having a long-term support worker, who, showing continuity, patience, care, and a non-judgmental stance encouraged Henri to "just start painting stuff, there! At my kitchen table!" This non-clinical, yet heartfelt suggestion nudged Henri into a new chapter of self-understanding which felt at first acceptable, then empowering as an agentic and deliberate move away from the clinical "world of words that just go round and round, experts, and that…" (Henri).

Art making was described by Henri with a vocal liveliness absent from the cautious, sometimes haltering narrative of other life experience. It is a narrative that visual artists will recognize; one bordering on exuberance with a relish for the color, dynamism, mess, and discovery of painting. Art-making was predominantly talked about as "giving" and "a way in;". lso described was "a sense of calm;" and how art making was "a way to understand [the alters]" one that offered "a window into …what happened to her [sic]". In this giving, as suggested in this paper, was a profound sense of integration. For Henri, this was articulated as an integration of her alters and an integration of events from her past that were "essential for the formation of a coherent identity" (Huntjens et al., 2016, p.216).

Another way of thinking about this is in a phenomenological sense, as an existential integration of one's narrative coherence (Ricoeur, 1984), with the possibility too that a neural integration (Schore, 2003) was being nurtured through the narrative coherence offered through the art-making. In cases of trauma, such as that experienced by Henri, memory of such remains stored in a nonverbal realm beyond the reach of verbal probes and without temporal narrative organization (Schore, 2002) yet potentially offered through non-verbal means. Future studies in this area should, however, bear in mind that the shibboleth of narrative coherence for those with DID has been provocatively questioned by Molloy (2015) and its role more generally by Mcadams (2006).

Psychoanalytic understandings of integration as attained, or worked towards through art, demonstrate a reading of the psyche as dynamically engaged in moving towards integration and cohesion. The art object, in this schema has an "**integrative** capacity, an ability to draw together disparate elements of the self into more complex wholes" (Wright, 2009, p.152, emphasis in the original). Inherent in art-making, too, is a search for a resolution and the addressing of old woundedness experienced through "deficiencies of response" (Wright, 2009, p.49) in the early environment. Fascinating to researchers within the

psychoanalytic canon is that similar claims are being made in the emerging field of interpersonal neurobiology. Siegal (2006), for example, describes no fewer than nine forms of integration pertaining to the cultivation of wellbeing.

Conclusion

There is much work being done gathering expertise from the combined insights of developmental psychology, psychoanalysis, biology, and neuroscience (Schimmenti & Caretti, 2016; Schore, 2000) and vital work urging preventative, creative work with children suffering trauma (Desmond, Kindsvatter, Stahl, and Smith, 2015). This case study points to the need too, for non-clinical arts in health provision for adults with complex histories of trauma. This provision should not be underestimated for its unique capability for engaging with those who for whatever reason, fall through the clinical therapeutic net, and for those who find empowerment in developing a more autonomous art practice through which to engage in a journey of self-reflection and even discovery. It may be that this provision brings them to a point where, as Henri stated, "I could try again now, that I feel I 'get it'" and they return to art therapy or talking therapy, bringing the lessons learned and imagery produced. Or, it may mean moving on to other things, like Henri, who is now developing art workshops for women victims of violence. A high capacity for creativity in people suffering DID has been mentioned in previous studies (Gerity, 1999) and it may be that more people like Henri find this compensation (Nettle, 2001) outside a clinical domain. Their voicesof experience have much to teach us.

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[i] This article encourages researchers to differentiate between
1) Expressive arts therapies (including drama and music therapy; visual art therapy; creative writing)
2) Visual art therapy (painting/drawing/sculpting and a range of other activities where a *visual* object is created, which may include, for example, quilt-making)
3) Non-clinical visual art making that does not encompass a therapist / psychotherapeutic interpretation by a clinician (the focus of this paper).

[ii] See Murray, 2000, for a useful and concise overview.