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Collaborative drawings

Blue-prints of conversation dynamics

The role of images and image-making processes to improve communication and the well-being of pain patients and clinicians in a series of art workshops at the National Portrait Gallery.

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Well-being

Despite periodic calls for its revision, and many networks and conferences, the World Health Organization's definition of health and well-being has remained the standard since 1946, 'Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity' ([Clift and Camic 2016](#)).

Many experts, including within this volume, have put forward alternative notions of well-being ([Stickley et al. 2017](#); White and Blackmore 2015; [Atkinson and Scott 2015](#); [Chatterjee and Noble 2014](#); [Galvin and Todres 2013](#); [Carr 2004](#)). This chapter does not attempt to repeat what has already been said but aims to build on the notion of well-being not confined to the absence of disease or illness.

With an ageing population and a rise in chronic health-related conditions, well-being can and must exist within a range of conditions. There are dangers in making an equivalence between health and well-being as Sarah [Atkinson \(2013\)](#) and others have highlighted. Framing discussions of well-being solely within that of healthcare focuses on individual experience at the expense of the relational. Creativity however, is one means of exploring improving well-being as both an individual and relational experience. Images and image-making processes have a role to play within healthcare, in promoting improved trust and rapport between those with long-term health conditions and their healthcare providers – more urgent than ever before and of equal value to both. This chapter will focus on ways in which collaborative drawing and image-making processes can trigger discussion of significant experience and personal narrative often felt to be ‘not medical’ or ‘not relevant’ by both clinicians and patients and thus frequently omitted from medical discussions, when their very omission is detrimental to well-being.

In the words of facial pain specialist Joanna [Zakrzewska \(2011\)](#):

Too often have we divided the mind from the body. The two go together and it is about fusing them back together again. The functional imaging [fMRI] . . . is showing more and more how these psychological factors are influencing pain; our perception of pain, our readiness to accept pain, and I think having some physiological basis to be able to explain to patients that these things are important and do have an impact opens up the discussion a lot more. I would consider it medical but a lot of people wouldn't as they have shut the door on the psychological aspect. I think every illness, particularly chronic illness has a psychological component. Often . . . clinicians don't want to go there.

[Khetarpal and Singh \(2016\)](#) identify the power inherent within concepts of health, illness and disability and the contribution language makes to continuing divisive constructs. The same

divisive power could be ascribed to the ways in which well-being is described and conceived.

They describe language as:

A powerful instrument that can mould our thoughts even about ourselves, our near ones and the world in which we dwell. Phrases, clichés and anecdotes are used to describe identities. . . . The phrases and anecdotes work towards objectifying disabled persons, and converting them into lessons, learning experiences and something that carries hidden messages, rather than viewing them as human beings with their own desires, needs, aims and goals.

(p. 162)

When we discuss well-being, whose definition are we accepting? Embracing the power of language itself raises questions around how we conceive and frame well-being as much as around how we view disability. It is an apposite moment to review the role images can play in advancing nuanced concepts of health and well-being, learning from those whose well-being is challenged, encouraging toleration of ambiguity, of living and finding well-being within the way we adapt and embrace challenge and difference – ways in which we accept that which we cannot change and build on and flourish through that which we can and that which we are.

There is a physicality, a livingness, an unpredictability to which we have to respond, within the creative process. Artist Jenny Saville describes this as follows:

When I'm in the process of working an area of the painting, in my head I have an idea of a sequence of marks I'd like to try. Usually it doesn't work out like I planned – sometimes it's better and more suggestive than I'd imagined, but often it feels like a potential disaster and I panic. Adrenaline sets in, as a kind of rush where you're pulling all these paint strings to articulate something and you have to hold your nerve. Just one mark can start to pull together something that has no structure. It's a weird game of control – trying to get to it – to suck it out of

yourself and out of the painting. There is a moment when the painting starts to breathe, it gets a kind of presence.

(Saville 2012, p. 318)

Artist and psychoanalyst Patricia Townsend highlights the ways in which Saville is speaking of the developing artwork

as a living, breathing being as if it has become another person. She is engaged in a 'game of control' in which there is an attempt to coerce it into the shape she has (consciously) imagined whilst at the same time she is responsive to its own suggestions, learning from her medium as well as imposing her will on it.

(Townsend 2015, pp. 121–122)

The process of art making can be seen as similar to the process of building on and responding to the physiology one has been dealt, embracing and changing with its inner and changing dynamics rather than resisting it. Evolving with ill health or pain, breathing through and with it – can be seen as a process of resilience and growth contributing to the evolution of self.

There are many projects where images have been generated by those living with illness or pain in order to process, understand and communicate the most distressing aspects of their condition (Closs et al. 2015; Oliveira and Oliveira 2013 cited in Christenson 2013, also Main 2012; Henriksen 2011; Geller 2011; Collen 2005) to others as well as themselves, and descriptions of the many benefits of phototherapy and photo-elicitation techniques in a range of contexts (Dennett 2011; Radley, Hodgetts and Cullen 2005; Radley and Taylor 2003; Martin and Spence 1987; Spence 1986) alongside renewed interest in the value of creativity for well-being through social prescribing with cinema on prescription, arts on prescription and museums on

prescription gaining current traction. However it is the potential for photographic images and collaborative drawing processes to act as stimuli to mutually beneficial two-way conversation between patients and healthcare providers that this chapter will focus on, drawing on a series of art workshops offered to pain patients and clinicians to attend together at the National Portrait Gallery and University College London Hospital (UCLH)'s artificial hospital in London in 2009 as part of the *face2face* **1** project. The aim of these workshops was to stimulate a type of discussion between those living with facial pain and those who treat facial pain using images and image-making processes to minimize traditional hierarchies and expand dialogue and interaction beyond what is normally possible in the clinic. It could be argued that the well-being and resilience of individuals increased in parallel with the collective well-being of both cohorts.

Face2face

The *face2face* project explored how photographic images co-created with pain patients could expand pain dialogue in the consulting room to include aspects of experience frequently omitted using traditional measures such as rate your pain on a scale of one to ten. The project had many strands: art workshops for clinicians and patients to attend together; the co-creation of photographs with facial pain patients reflecting their experience at different points in their treatment journey; the creation of an image resource developed as an innovative communication tool for clinical use and piloted in the clinics of ten pain experts and an artist's film, *Duet for Pain*, focusing on doctor-patient dialogue and the role of narrative.

Developing on from this the *Pain: Speaking the Threshold* **2** project was launched at University college London (UCL) to bring together a multidisciplinary team to analyse the

material produced during *face2face*. The project aimed to evidence ways in which photographs of pain placed between patient and clinician could trigger more negotiated dialogue in the consulting room, democratising the encounter and improving the quality of medical dialogue – arguably improving well-being for both those in pain and those treating it. Accessing Prof. Zakrzewska's clinics, I co-created with patients over 1,000 photographic images that reflected and symbolised their pain. From this material we developed a pilot pack of 54 pain cards trialed as a communication tool in clinical consultations at University College London Hospitals NHS Foundation Trust (UCLH). Video recordings were made of 20 baseline/control consultations, without images, and 20 study consultations with images. Many strands of the project have been covered in other publications ([Padfield et al. 2017](#); [Semino et al. 2017](#); [Padfield et al. 2015](#); [Padfield 2013](#); [Padfield 2011](#)) so this chapter will focus on the National Portrait Gallery workshops and ways in which collaborative drawing and photographic processes acted as catalysts for improved understanding and communication between patients and clinicians.

The National Portrait Gallery was a particularly apposite venue as most of those attending the workshops, whether patient or clinician were from the facial pain management teams and so for many of them the face was a charged arena. Facial pain has all the difficulties associated with musculo-skeletal pain as well as additional ones specific to the face. The canvas most of us use to express pain is the face, so when that canvas is itself in pain, it is difficult to express in a way which others can read accurately. This impact of pain on identity and interaction was strongly reflected in the discussions during the workshops and the need for it to be heard and acknowledged by clinicians was a major factor in improving a sense of well-being amongst the patient group.

Art workshops at **the National Portrait Gallery for clinicians and patients**

Four two-hour workshops were held, two at the National Portrait Gallery (NPG) and two at the Education Centre, University College London Hospitals NHS Foundation Trust (UCLH) during October and November 2009 for clinicians and patients to attend together. Fifty people attended the workshops made up of patients, carers/relatives, clinicians and other NHS Staff. Some of the participants had not visited the National Portrait Gallery before. Each workshop was complete in itself but built on the previous one to form a series. Sessions were facilitated by myself with artist Mark Woodhead from the NPG and art-psychoanalyst and film maker Helen Omand. Activities involved looking at, discussing and drawing from work in the NPG collection, creating photographic portraits in pairs using objects along with discussion of contemporary photographic practice, quick mark-making exercises, collaborative drawing and an introduction to the portrait and to the work of Henry Tonks by art historian Dr Emma Chambers (previous Leverhulme Fellow, NPG). In the quick drawing and photographic exercises an attempt was made to pair healthcare providers with patients by asking participants to work with someone they didn't know. This was another way of facilitating a two-way flow of ideas and knowledge between healthcare providers and service users. All sessions involved a mix of discussing contemporary portraiture either through examples in PowerPoint slides or those in the National Portrait Gallery collection to stimulate discussion, practical creative activities and a review at the end of each session on emerging themes from the process and outcomes of the workshop. The sessions were audio recorded and transcribed, evaluation forms were completed by all participants (n = 50) and the work produced was photographed and documented. The qualitative data was analysed

thematically (for a discussion of the challenges and advantages of qualitative analysis see Mason 2007).

Results

The main themes emerging from the free comments in the evaluation forms and workshop transcripts were: the necessity of negotiation, the importance of the group and the value of exchange and interaction. In answer to the question, ‘what did you enjoy?’ participants wrote:

The below content treated as ExAS

‘The interchange between the participants’

(respondent 50)

‘Sharing ideas and doing artwork together and being in a studio. . . . I don’t feel so alone about all of this now’

(respondent 40)

‘The exchange with a totally unknown person. It was amazing!’

(respondent 46)

‘Working in a group discussing art’

(respondent 9)

Increased mutual understanding and two-way discussion were core aims for the workshops. This was re-enforced by the comments from pain sufferers on how they valued clinicians attending

these sessions. For example to the question ‘What would you like to see included in future workshops?’ respondent 16 answered: ‘More time and more clinicians’.

The strong desire for clinicians to participate (on an equal footing) correlates with the sentiments repeated by so many patients attending pain clinics that doctors do not hear or understand them, ‘what do I need to do to make them understand?’ (Padfield 2003, p. 86).

Academic and psychologist Dianna Kenny in her review of doctor-patient interaction in pain clinics identifies the challenge to communication when healthcare providers and patients have different expectations and different agendas (Kenny 2004). Articulating these and providing a space where they can be explored and shared contributes to the consultation satisfaction and thus the well-being of both patient and clinician.

In the National Portrait Gallery workshops being outside the hospital setting neutralized the institutional hierarchy, but there was still a strong need expressed by pain patients for doctors to hear their perspective and to appreciate the impact of pain on their lives.

The individual words which appeared most frequently in the workshop transcripts and evaluation forms also reflect the importance of effective communication and the dangers of miscommunication. These were: reflections, mirror, sharing, identity, communicate and express.

Examples are:

‘Share perceptions’

(respondent 5)

‘A reflection of the soul, the essence of the person’

(respondent 9)

‘In rare moments a mirror of the soul’

(respondent 30)

‘An object? Of expression of self mirror reflection . . . image personality’

(respondent 31)

‘Communication, expression, identity’

(respondent 39)

‘Crucial in identity, expression of emotions and needs of patients’

(respondent 10)

‘To show expression/emotions’

(respondent 12)

Mirroring

Mirroring in the sense of looking and being looked at, of projecting onto/receiving from another became focal in the discussions and when there were disconnects and misunderstanding within these processes, suffering and isolation were described as the result. Miscommunication with others emerged during the *face2face* project as a whole as a key factor increasing intensity of suffering and the sense of isolation for facial pain patients.

Several individuals commented on the experience of being given permission to really look at someone’s face for a long time, ‘Permission to study another person’ (respondent 24).

Perhaps the power of art workshops to address disconnects in communication is due to the fact that when we are drawing or photographing, we look in a different way to how we do in the rest of life, usually, though not always, without judgment. We get absorbed into the forms, the tones, the colours rather than into a series of moral or personal judgments. ‘The intimate and *unmediated* sensation that occurs between body, gesture and material is particular to drawing, and is what continues to make drawing a radical and potent method of thinking, feeling and enquiry’ (McCausland 2016).

The hope is that this approach to looking and accepting can be paralleled in the consulting room. This could be one of the ways in which the legacy of the *face2face* project could work to increase well-being amongst patients and clinicians more widely. Luce Irigaray identifies respect for and confidence in both each other and the self as essential qualities for shared dialogue.

It is necessary to listen to the saying of the other, and to discover a saying that could be fitting for the two. This saying cannot already be foreseen by a previous discourse: it arises from mutual listening, from the sense that is discovered thanks to the confidence of two subjects in one another, from the search for words that correspond to this reciprocal abandon.

(Irigary 2008, p. 6)

The process of looking together and drawing together cements this.

Revealing, perceiving, exposing, concealing

The importance of the schism between self and other, the complex relationships between revealing, perceiving, exposing and concealing and how these are negotiated within communication was evidenced by the discussions triggered when participants were shown a slide of the logo image from *face2face*, [Figure 25.1](#).

If you've got a broken limb you can show that you've got pain through the face, you don't show it through your broken limb necessarily, whereas here you've got to try and show your emotion and pain through the same medium and perhaps you're trying to layer it or not show it sometimes and that's why you've got different faces which you are trying to peel away to try and get to the bottom of it. Perhaps you don't want to show some people part of it and want to hide it from people.

(workshop participant with pain)

Whether or not what they felt was their 'authentic' self was expressed through the face, (whether or not such a thing exists is a different question) and whether this was accurately or inaccurately understood by other people was uppermost in the minds of facial pain sufferers. The words 'broken limb' is repeated twice in a short phrase, reminding us of the metaphors of injury equating invisible pain with physical injury, correlating with one of the three main categories, X-Ray/Anatomy, Mirror, Weapon, David Biro identifies as core pain metaphor categories (Biro, 2010 and 2014) and the category of injury metaphors identified by Semino (2013). Emotion and pain appear in the same sentence, very close to each other, posited as discreet and separate layers, 'emotion and pain', which it is suggested are in turn peeled to reveal or layered to conceal. There is a distinction made between depth and surface paralleling a distinction between the mask and the inner or 'authentic' self, but you could also turn this on its head within the framework of 'different faces' which 'hide' or 'show'.

In the short extract above the word show appears five times within two sentences, suggesting notions of ‘showing’ and ‘hiding’ are pivotal to the statement, and ability and/or inability to express, a locus of significant suffering. It might also suggest the need to evidence experience, sensation and pain. Whichever way these are interpreted, there is a tension between emotion and pain felt, and emotion and pain understood by/communicated to others, which increases suffering and by inference increases pain. The image, ([Figure 25.1](#)) which literally layers a negative print onto a positive print, re-photographing them to become one, acted as a trigger for these discussions of sensation. I believe it was a trigger only because it resonated with an already existent and deeply rooted element of pain experience, bringing this to the surface of consciousness via language. This ability to permeate below the surface, to bring back material from memory to be discussed via language is a key characteristic of photography and one on which much has been written, from Benjamin to Berger ([Benjamin 1936](#); [Berger 1972](#), [1980](#), [1982](#)). See also [Seremetakis 1994](#)).

Looking

Many of the comments in the discussion on facial pain resonated with those voiced during the previous project *perceptions of pain* on musculo-skeletal pain, for example:

I have a feeling that it's another face looking into the face. Two perspectives of the same person. One is looking inward towards himself, trying to see.

(participant with pain in response to [Figure 25.1](#))

This idea of looking/being looked at, of performing/witnessing, of splitting has resonance not only for pain dialogue, but for portraiture.

The original sufferer with whom I made the image in [Figure 25.1](#) described how she: didn't realise until [she] saw the photograph but it is about having the inner and the outer experience at the same time. It is because you have inserted the collage between my face and my hand. It is about touch. It is about having two sensations at the same time, normal and abnormal, It is almost as if my face were in positive and negative. It is about presence and absence.

([Keddie 2001](#), shortened version in [Padfield 2003](#), p. 113)

The processes of revealing/hiding and showing/masking through discourse catalysed by other images were evidenced as important issues with which pain sufferers struggled; for example one participant said of a self portrait made by another participant during the third workshop:

Perhaps it shows a way, of coming to terms with this pain, and finding ways to cope with it, because, not showing the eyes to me is like hiding, and hiding is a place of refuge, finding a place of refuge, finding this refuge place in childhood, in the happy times, and be able to recover perhaps, a little bit of that carefree-ness. . . . As children, when we are hurt, we stop what we are doing, and be with the hurt, and that in itself is part of the remedy.

(W3, Transcript of Workshop 3 NPG)

It appears that although there are issues specific to facial pain many of them also thread their way through all pain experience, and through discourses on photographic portraiture for example: the process of visibility – looking/being looked at; of pain behaviour – performing/witnessing, revealing/masking, the construction of identity of another, the loss of identity to the gaze of another, loss of identity from the self. Portraiture and facial pain both raise

questions around the representation and/or communication of a cohesive or 'authentic' self and notions of identity as continually evolving rather than as fixed or stable. Aldersley-Williams writes 'We are not only our skin, colour, sex, our professional reputation, the sum of our possessions. We are simultaneously and quite possibly contradictorily, many other things as well' (2009, p. 15). He asserts that identity is always formed partly in response to social surroundings, not by the individual in isolation, which suggests that improvements in individual well-being might only be achieved through improvements in the well-being of the group. He expands: 'The question "who are you?" invites the riposte "Who wants to know?" long before it leads onto the more reflective question, well yes, who actually am I?' (p. 15). This strengthens the argument that creative workshops and any interventions aimed at improving the well-being of patients should also involve those who care for them and that the well-being of both cohorts is relational and mutually interdependent.

Identity

The aim of the third workshop was to explore notions of identity specifically and the impact pain has on sense of self. Participants were asked to represent their identity not through the face but through objects, in the hope of capturing identity and individual experience at the intersect between language and object. This would remove the face as the locus of identity and contestation. Clinicians and patients were asked to bring in objects with which to create photographic self-portraits and work in pairs to photograph them during the session. The resulting conversations happening around the process revealed many aspects of facial pain experience, the most significant of which was that pain, like identity, has a longitudinal arc,

resonating not only with the present but with what has come before and what will come after.

This correlates with part of the IASP definition of pain: 'Each individual learns the application of the word through experiences relating to injury in early life' (Merskey and Bogduk 1994). Pain is given significance by earlier experiences and colours the anticipation of future experience.

Referencing her photograph of two dissimilar stones, workshop participant (study code W2) stated:

This would be in the background, it's shrunk, there is not much of me left. But this one is me, this is all pervading, because I feel like I've lost part of my face, I feel like I've lost part of my soul and that there is a massive great big cleft going down me and it's destroying me. . . . But that's me, that symbolises everything about my identity now, and my identity in the past, which I crave, because I'd love not to feel so fractured and in pain. . . . I used to be a geologist.

(*face2face* participant, Study Code W2)

Her words not only highlight the fracturing effect pain has on identity, but through reference to stones and geology, reference time – the longitudinal nature of identity and pain. They also reference her own identity as a geologist. The way in which she moves between describing the stones and herself is reminiscent of some of the dialogue in *perceptions of pain* (see the extract below; Padfield 2003, p. 100). It suggests that for some people with facial pain the complex layers of identity can be reflected and represented more fully or more freely via objects and discussion of objects than via their face or a traditional self portrait. For example, looking at the images we had made together, one pain sufferer from INPUT (pain management unit, St Thomas Hospital) taking part in the *perceptions of pain* project and who had found it very difficult

initially to describe her pain in words, described herself through description of the sunflower in the photographs we had made together:

It is just in agony by the look of it. I caught it on a bad day. I didn't have a very good day that day. The head is down, it just seems as though it has ended its life, but what it will do this year is it will shoot back up again. The roots are strong. It varies with me. This one will come up again.

(Harding 2001, quoted in [Padfield 2003](#), p. 100)

Another significant aspect of pain referenced in W2's description quoted above, is the equation of pain with loss. In the *face2face* project this is emerging as a critical feature of pain experience. It is an element re-occurring in almost every strand of the project.

The shadow metaphor alluded to by W2 integrates both loss and identity.

That will be massive, and that will be shrunk into the background, and this will cast a massive shadow, and that sounds really horrible, but that's how I feel.

(*face2face* participant, Study Code W2)

It is an image which did not occur so often within *perceptions of pain*, suggesting that it has more resonance for those with facial than with musculo-skeletal pain.

It was not only pain sufferers but clinicians who made photographic self-portraits using objects. This allowed the perspective of those witnessing pain to be discussed alongside those living with pain and thus for two-way exchange and learning. Noticing unexpectedly a small image of a face reflected in the silver foil within her 'self portrait', [Figure 25.2](#), one pain specialist observed:

there is a little face there. It's me looking at faces, and faces looking at me and observing, which fits in with me liking art and liking looking at things . . .

and my job as a doctor . . . looking at people. . . . But there's something else hidden underneath, . . . that people discover when they look a bit deeper. That's why I loved finding that face in the middle, because suddenly you find something extra in there that you didn't think was there to begin with. We didn't see it until we looked at the photograph, . . . until we photographed it.

(face2face workshop participant, Study Code A)

Once again the process of looking/being looked at and witnessing/disclosing were central to the discussion and once again stimulated by photography. It could be argued that the distance the photograph provides allows us to recognise and share experiences which are difficult to articulate, just as clinical detachment might allow professionals to listen to what is difficult to hear. [Sontag \(1978, 2003\)](#) reminds us of the dangers of the distance the photograph creates between the original experience and the viewer but in this context it worked for us. Are there occasions when this distance and clinical detachment can complement each other supporting the central hypothesis of this work – that images can enhance dialogue and mutual well-being?

Collaborative drawings – conversations through drawing

The aim of the fourth and final workshop was to untangle some of this further confronting and addressing the inherent in-balance of power within clinical dialogue. Like pain, the communication process is largely invisible. Through treating collaborative drawing as conversations the exercises aimed to construct a process through which we could learn about its

dynamics and patterning. Could we observe how and where dialogue gets blocked, and how and where it moves freely between agents in a shared manner?

Participants were asked to find a partner by sitting opposite someone they didn't know. They were given a sheet of transparent acetate, a black pen and were asked to create collaborative portraits (two per pair). They were asked to draw one line of a portrait of their partner and then to exchange sheets before adding another line to the drawing they had been passed, this time as a self portrait (as the image they had been given by their partner would now be of them). Then they swapped back again and drew a third line in what was beginning to be a portrait of their partner, and so on and so forth until they had two portraits they felt finished. Participants were not given a specified time or number of lines to complete the drawings in, but asked to negotiate when they thought each portrait was finished. Treated as conversations through drawing, the process could be seen as a process of dialogue broken down into visible sections. Issues of manipulation, compliance, resistance, control and negotiation were revealed and exposed, all of which have relevance to doctor-patient exchanges.

The type of negotiation enacted within each pair differed wildly, varying levels of awareness, relationships and dynamics evolving. Not only did these parallel relationships found in the clinic but the characteristics of the resultant images – demonstrating a direct fit between outcome and process. Are there implications in this for medical dialogue and the well-being of interaction in the clinic? Does the quality of the process of dialogue parallel the success of the outcome of that dialogue? If so it is crucial to understand its dynamics and explore ways in which it can become more mutually satisfying.

After the workshops the acetate drawings were used to make photograms in the darkroom which were exhibited in the exhibition at the Menier Gallery in 2011 **3**.

Some examples

W/W5: Figure 25.3

The drawing process for partnership W and W5 was slow, each retaining control of their own part of the drawing without entering into much dialogue with that of their partner; the final drawing having the appearance of being unfinished. There was a sense they had not found any resolution to their exchange by the time the exercise was finished. It was notable that W (pain clinician) partnering W5 (pain patient) said he ‘went for symmetry and imposed it within the development of the thing’. Both W and W5 drew few and simple lines, neither engaging with nor looking at the other. W said he realised he was looking at the page rather than at W5 and noticed he was doing so. Most significant of all, he confessed with the drawing he drew what he expected rather than what he saw. W5 said very little. This is a fascinating expose of some doctor-patient dynamics, (to which pain consultations are particularly susceptible) where both participants come bringing their own agendas and language, in the form of standardised questions and crystallised stories, which are then imposed onto the consultation. If dialogue has a tendency to go along anticipated patterns, it is arguable that images inserted into it can shift it into the present, encouraging the unexpected and encouraging speakers to engage with what is actually being said in the present, rather than what they expect to be said.

X/Y: Figure 25.4

Partnership X/Y revealed levels of manipulation possible in dialogue, highlighting another common characteristic of medical dialogue. X (medical student) was partnered with Y (relative

of person with pain). Y ended up feeling unsatisfied with the portraits produced describing how he felt he was being compelled to fill in between the lines he was given, and that it made him feel he was being controlled – which he didn't like, but acquiesced in. X, a medical student, acknowledged she had consciously laid down lines which she had been hoping Y would follow, and admitted being glad when he did. X seemed surprised that Y had noticed he was being manipulated as she hadn't thought he would! Is it important that patients do not feel they are being manipulated, and that when they feel they are, they can voice this recognition? Equally how many times do clinicians feel manipulated by patients, and is there space for them to articulate this without fear of destroying doctor-patient trust? It is a common occurrence in pain consultations for both doctor and patient to enter the arena with different agendas. It is the task of effective and shared communication to shift these, reconciling conflicting aims. Manipulation is an obstacle to mutually acceptable solutions emerging, but recognition of its limiting effect can help avoid it.

W4/W3: Figure 25.5

W4 and W3 were both people living with pain. The sudden destructive turn in their exchange was a stark reminder of the potency of images and image-making processes, and the importance of keeping these safe for all participants. It was also a reminder that this cannot always be within anyone's control; the same may be true of the consulting room. Images, though able to catalyse emotional disclosure are, by the same token, able to trigger unexpected and spontaneous emotional reactions. They work at a deep level sometimes revealing what needs to be brought to the surface and into the consulting room to be discussed as part of the pain experience. They also need to be accompanied by recognition of the depth of emotion they can evoke.

The exchange between W4 and W3 became heated when W4 said she was getting impatient as she felt she was ‘more lenient’ on W3 than W3 was on her.

Look at those frown lines! They must’ve taken three goes to do.

(W4)

W4 continued her assault on W3 by saying she thought that W3 had deliberately brought out the weakness in her face whereas she herself had tried to depict and stay with the lightness of W3.

W3 replied very quietly that she was only trying to convey the determination and concentration she saw in W4. W3 then tentatively observed that ‘to create we destroy . . . in order to create something new’.

This had a placatory effect on W4 – it was very gently asserted – and W4 went on to admit to the group that at first she ‘felt very sad and unbearable’ while drawing and then described how she ‘started to have fun’. As W4 smiled, W3 said she was seeing W4’s teeth for the first time. A smile arose spontaneously from W4 and W3 said how courageous she felt W4 was. The tension eased between them, there was laughter – the moment of conflict had been smoothed over. It could quite easily not have resolved anywhere near as quickly. W3 had responded spontaneously to what was being thrown at her by W4 and rather than remaining fixed in a position of conflict had used adaptability and sensitivity to facilitate a resolution. W3’s comment on destroying ‘to create something new’ was also a reminder of the proximity between destruction and creation, which resonates with discourses around pain. With pain, the self has been assaulted and identity impaired or destroyed; conversely images and image-making processes can offer opportunities for new ways of relating to the world and the self to be created, new ways of being well within the world.

G/V: Figure 25.6

This pair identified ‘negotiation’ as central to their process. They evidenced awareness of the inbuilt frustrations of not being able to control the whole image simultaneous with a fluid and straightforward negotiation. The resultant image reflects this simplicity and clarity. G/V demonstrated the benefit of negotiated dialogue, arriving at images both were happy with through a process both were equally engaged in. Is it significant that neither of these participants were pain sufferers? Is there something intrinsic to the experience of pain that can skew democratised dialogue as much as the difficulties of inherently unequal power relations within a medical setting?

Concluding thoughts

In her workshop on sensational drawing at the Encountering Pain Conference (2016), artist Onya McCausland described *drawing as* ‘engaging collaboration and dialogue to exploit verbal language and interaction’ and ‘as a vehicle to explore how gaps between words, meanings and marks on paper can open cracks into new experiential insights’. She focused on the interaction ‘between subtle tangible sensations through a combination of shared communications and imagination’ rather than seeing drawing as purely optical. The collaborative drawing exercises at the NPG, part of the *face2face* project, engaged participants from different cohorts in a shared process involving sensation and the physical body as much as perception or language.

The different processes of negotiation visible within these pairs of collaborative portraits/drawings could be seen as paralleling those that happen within communication in the consulting room. The drawn ‘conversations’ provide a visual mapping illuminating the dynamics

of both spoken conversation and non-verbal exchange. These findings have direct relevance to the consulting room and to the ability to enhance well-being outside of what is normally conceived of as good health.

Giovanni [Rosti \(2017\)](#) states that ‘Improving patient-physician communication is an area of medicine that deserves greater attention’. He describes how

current medical practice is dominated by evidence-based medicine, [which] dictates what therapies the clinician will offer in a given circumstance, ideally supported by (evidence-based) guidelines. However, when taken alone it tends to decentralize the patient. There are many different approaches that can be used to understand the patient and what he or she is experiencing as a result of their illness.

One way in which I believe images and the image-making process can aid clinicians’ understanding of what their patients are experiencing and be transformative to patient clinician interaction and well-being is in effect a shared space in which to reflect together, a space which encourages negotiated dialogue to come into being. Images can expand a space to accommodate the unknown, or the not yet consciously known – which might be fundamental to an individual’s pain and fundamental to their well-being – but neither voiced nor heard yet in a clinical space. Voicing difficult sensation and embarking on a shared communication process where deeply personal insights are heard, engaged with and valued are key to participation in recovery and well-being.

In an interview for a new film *Pain under the Microscope* (Padfield and Omand 2016) screened at the Encountering Pain Conference 2016, [4](#) psychologist Dr Amanda Williams said

It is hard to think about what people need to communicate without saying that to do so there must be someone who listens, and not just one person who listens but a listening world . . . and I don't think that listening understanding world is there.

This throws the emphasis back on all of us to help create a listening environment, erode disbelief and improve understanding. There are many components of health and well-being but feeling understood and acknowledged by others is one. Creative exchange is one step towards building that listening understanding world and increasing well-being whether or not it is accompanied by 'health'.

[Place Figure 25.7 here.]

Notes

References

- Aldersey-Williams. in: Aldersey-Williams H., Arnold K., Gordon M., Kotsopoulos N., Peto J. and Wilkinson C. (eds) *Identity & Identification*. 2009. London, Black Dog Publishing.
- Atkinson S.J. Beyond components of wellbeing: the effects of relational and situated assemblage. *Topoi*. 2013;32:137–144.
- Atkinson S.J. & Scott K.E. Stable and destabilised states of subjective wellbeing: dance and movement as catalysts of transition. *Social and Cultural Geography*. 2015;16:75–94.
- Benjamin W. 'L'œuvre d'art à l'époque de sa reproduction mécanisée' in: Alcan, F. (ed) *Zeitschrift für Sozialforschung*. 1936. Jahrgang V, Paris, pp. 40–68.
- Berger J. *Ways of Seeing*. 1972. London: Penguin.
- Berger J. *About Looking*. 1980. London: Writers and Readers Publishing Cooperative Ltd.

Berger J., Mohr J. *Another Way of Telling (on Photography)*. 1982. New York: Pantheon.

Carr A. *Positive Psychology*. 2004. Hove: Brunner-Routledge.

[Chatterjee H.](#), Noble G. *Museums, Health and Wellbeing*. 2013. London: Ashgate Publishing.

Clift S., Camic P. (eds) *Oxford Textbook of Creative Arts, Health and Wellbeing*. 2016. Oxford: Oxford University Press (check this last bit of ref).

[Closs S.J.](#), [Knapp P.](#), [Morely S.](#), et al. Can pictorial images communicate the quality of pain successfully? *British Journal of Pain* 2015;1–8.

Collen M. Life of pain, life of pleasure: pain from the patients' perspective – the evolution of the PAIN exhibit. *Journal of Pain & Palliative Care Pharmacotherapy* 2005;19(4):45–52.

[Dennett T.](#) Jo Spence's auto-therapeutic survival strategies, in: [Bell S.](#) and [Radley, A.](#) (eds) 'Representations of illness and disease'. *Health*, 2011;15(3):223–239.

[Galvin K.](#), [Todres L.](#) (2013) *Caring and Well-Being: A Life-World Approach*. Abingdon & New York: Routledge.

[Geller B.](#) The PainT project. *Pain News* 2011;Winter:42–43.
www.britishpainsociety.org/bps_nl_winter_2011.pdf

[Henriksen N.](#), [Tjornhoj-Thomsen T.](#), [Ploug Hansen H.](#) Illness, everyday life and narrative montage: the visual aesthetics of cancer in Sara Bro's Diary, in: [Bell S.](#) and [Radley A.](#) (eds) 'Representations of illness and disease' *Health*, 2011;15(3):277–297.

[Keddie N.](#) Interview 2001 as part of the *perceptions of pain* project. 2001.

[Kenny D.T.](#) Constructions of chronic pain in doctor-patient relationships: bridging the communication chasm. *Patient Education and Counseling*, 2004;52(3):297–305.

[Khetarpal A.](#), [Singh S.](#) Reintroducing differences linguistically! *Indian Journal of Medical Ethics*, 2016;1(3):162–166.

Main S. Picturing Pain: Using creative methods to communicate the experience of chronic pain, *Pain News*, 2012;1:32–35. www.britishpainsociety.org/bps_nl_vol12_issue1.pdf

Martin R., Spence J. New portraits for old: the use of camera in therapy, in: Betterton R. (ed).

Looking on: Images of Femininity in the Visual Arts and Media. 1987. London: Pandora.

McCausland O. Encountering Pain Conference Programme abstract. 2016.

Merskey, H., Bogduk, N. (eds) (1994) *Classification of Chronic Pain*, Second Edition, IASP Task Force on Taxonomy. Seattle: IASP Press. pp. 209–214.

[Oliveira J.](#), Oliveira M. Depicting depersonalization disorder. *American Journal of Psychiatry*, 2013;170(3):263–264.

Padfield D. *MASK: MIRROR: MEMBRANE: The Photograph as a Mediating Space in Clinical and Creative Pain Encounters*. University of London Thesis. 2013.

[Padfield D.](#) Mask:Mirror:Membrane, *PAIN NEWS*, 2012;10(2):104–109.

[Padfield D.](#) *Perceptions of Pain* (Monograph). 2003. Stockport: Dewi Lewis Publishing

[Padfield D.](#) Representing the ‘pain of others’, in: Bell S. & Radley A. (eds) Another way of knowing; Art, disease and illness: *Health*, May 2011;15(3):241–258.

Padfield D., Chadwick T., Omand H. The body as image: image as body. *Lancet*, 2017; 389(10076):1290–1291.

Padfield D., Zakrzewska J.M., Williams A.C. de C. Do photographic images of pain improve communication during pain consultations? *Pain Research & Management*, 2015;20(3):123–128.

Radley, A. What people do with pictures. *Visual Studies* 2010;25(3):268–279.

[Radley A.](#) *Works of Illness: Narrative, Picturing and the Social Response to Serious Disease*. 2009. Ashby – de-la-Zouch, UK: InkerMen Press.

Radley A., Hodgetts D., Cullen A. Visualising homelessness: a study of photography and estrangement. *Journal of Community and Applied Social Psychology*, 2005;15:273–295.

Radley A, Taylor D. Images of recovery: A photoelicitation study on the hospital ward. *Qualitative Health Research*, 2003;13:77–99.

Rosti G. Role of narrative-based medicine in proper patient assessment. *Support Cancer Care*, 2017; DOI 10.1007/s00520-017-3637-4

[Saville, J.](#) Interview with Simon Schama, 2005, in: Stiles, K. & Selz, P. (eds), *Theories and Documents of Contemporary Art*, pp. 316–318. 2012. Berkeley, Los Angeles, London: University of California Press – check this ref

Saville. Check in Patricia’s refs? 2012.

Semino, E., Zakrzewska J.M., Williams A.C. de C. Images and the dynamics of pain consultations. *The Lancet* 2017;389:1186–1187.

[Seremetakis, C.N.](#) *The Senses Still, Perception and Memory as Material Culture in Modernity*. 1996. Chicago: University of Chicago Press.

Sontag, S. *On Photography*. 1978. London: Penguin.

Sontag, S. *Regarding the Pain of Others*. 2003. London: Hamish Hamilton Ltd.

Spence J. *Putting Myself in the Picture*. 1986. London: Camden Press.

Stickley, T., Parr H., Atkinson S., Daykin N., Clift S., de Nora T., Hacking S., Camic P.M., Joss T., White M., Hogan S.J. Arts, health & wellbeing: reflections on a national seminar series and building a UK research network. *Arts & Health*, 2017;9:14–25.

Townsend P. *British Journal of Psychotherapy*, 2015;31(1):120–131.

Willenfelt J. Documenting bodies: pain surfaces, in: Boddice R. (ed) *Pain and Emotion in Modern History*. Basingstoke and New York: Palgrave Macmillan 2014:260–276.

Zakrzewska, J.M. Interview in the film *Duet for Pain*. Padfield. 2011.

Legends for figures

Figure 25.1 Deborah Padfield with Nell Keddie from the series *perceptions of pain 2001–2006*, Silver Gelatin Print

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Figure 25.2 Photograph by participant A (clinician) from NPG workshop, digital print, 2009

Figure 25.3 Photogram from collaborative drawings on acetate by NPG workshop participants W and W5

Figure 25.4 Photogram from collaborative drawings on acetate by NPG workshop participants X and Y

Figure 25.5 Photogram from collaborative drawings on acetate by NPG workshop participants W3 and W4

Figure 25.6 Photogram from collaborative drawings on acetate by NPG workshop participants G and V

Figure 25.7 Deborah Padfield with Linda Williams from the series *face2face*, 2008–2013, Digital Archival Print

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Notes

1 For further information on *face2face* please see: www.ucl.ac.uk/encountering-pain/past-projects and www.ucl.ac.uk/slade/research/mphil-phd/deborah-padfield

2 For further information on *Pain: Speaking the Threshold* please see:

www.ucl.ac.uk/encountering-pain/past-projects and

www.ucl.ac.uk/slade/research/projects/pain-speaking-the-threshold

3 For further information on the *Mask: Mirror: Membrane* Exhibition at the UCH Street Gallery and the Menier Gallery, London, please see [Padfield \(2012\)](#).

4 For further information on the *Encountering Pain* conference held at UCL in 2016, please see www.ucl.ac.uk/encountering-pain