Art, Psychotherapy and Psychosis: The Nature and the Politics of Art Therapy   by Chris Wood

Volume I

For Bosch or Bruegel, these forms are generated by the world itself; through the fissures of a strange poetry, they rise from stones and plants, they well out of an animal howl; the whole complicity of nature is not too much for their dance (Foucault, 1967, p. 280).

Acknowledgements

I think it would be very difficult to undertake a piece of work like this without a lot of collective support. There are many people who have offered their support in lots of different ways. Firstly I need to thank all of the people who have been patient enough to be my clients over the years, they have taught me a great deal. Then I need to thank both Professor R. M. Young (my internal university supervisor) and Associate Professor J. Schaverien (an external supervisor) for the kind yet challenging supervision both have given. Many of my colleagues in the health service, in the university and in the art therapy profession have given me both practical and moral support. My family and my friends have been great all of them have been rooting for me, particularly Dr R. A. Pitt who simply could not have given me more support and encouragement. Finally I need to thank my mum who patiently helped me cut back on what was rightly described as 'a proliferation of commas'.

With reference to the *Code of Ethics and Principles of Professional Practice* (1994, The British Association of Art Therapists) and the *Guidebook for Research Students And Supervisors* (1999-2000, The University of Sheffield) I have observed the following arrangements.

Confidentiality

In this document I have concealed the identity of any clients that I have written about by providing pseudonyms and removing identifying features such as dates, place names or identifiable relationships.

I have had the necessary written permission from all of the clients whose images I have photographed for inclusion. Some of the people involved wrote specific letters to me giving their permission and some simply signed the form below.

Permission To Use Artwork: December, 1999

I give my permission for the art therapist Chris Wood to photograph my artwork for inclusion in her thesis. I understand that she will do what is necessary to conceal my identity.

Signature

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Outline Introduction:

<u>Combining Art, Psychotherapy and Social and Political Awareness:</u>

This study is a form of star gazing in that it locates the art therapy profession within the firmament of psychological methods aimed at liberating people with serious mental disorders. It considers the nature and the politics of art psychotherapeutic practice with clients with a history of psychosis. My thesis can be summarised in the following way.

There is international evidence to suggest that there is a relationship between poverty, social deprivation and psychosis and that mental disturbance is not divorced from the societal context.

Similarly, the art therapy profession's development reflects societal trends. During the second part of the twentieth century, the emergence of social and political awareness in art therapy occurred in relation to the treatment philosophies of social psychiatry and during the optimistic, economically prosperous decades of the 1960s and 1970s. This contributed to the development of large sections of the profession's practice being with people with serious mental disorders in the public sector.

The proportion of work by art therapists with the seriously mentally disordered during the 1980s and the 1990s was maintained. However, the profession together with others working in public sector mental health, looked inwards during this harsh political and economic time in Britain and the focus of attention turned to the development of psychotherapeutic rigour at the expense of other aspects of its practice.

Despite the historical estrangement between public psychiatry and private psychotherapy, art therapists have found that an understanding of psychotherapeutic theory is important to the development of their practice. It is particularly important for work in the public sector with people with a history of psychosis, but psychotherapy alone is not sufficient.

It is also necessary to theorise what making art might mean to the people involved in psychotherapeutic relationships. Nevertheless, it is not sufficient to view what happens in art therapy solely in the light of this art making and the cultural issues provoked by it, because the development of theory and practice also depends upon an awareness of the social political context and the ramifications this has for practitioners and clients.

Repeatedly throughout the history of relations between psychiatry and psychoanalysis there has been a failure to mention the different locations of their practice. Psychiatry takes place in public sector institutions and psychoanalysis is mainly practised

with fee-paying clients in the private sector. Confusions of practice are a consequence of the widespread failure to notice the difference. Adaptations of the therapeutic frame are necessary for work within the public sector. People working in public sector institutions wishing to apply the tenets of psychoanalytic theory regularly fail to translate the knowledge gleaned from it into forms of practice that are appropriate to the public sector. This is compounded by the fact the very few actual psychoanalysts involve themselves in the public sector, and by the estrangement between the psychoanalytic community and that of psychiatry. An additional influence is the tendency in both communities to be alienated from the political sphere.

Art psychotherapeutic relationships with people with serious mental disorders and the conditions of the public sector indicate that there is a searing need for a synthesis of art, psychotherapy and political awareness. In the present political climate this is underlined by the ideological push for evidence of effectiveness and by the continuing estrangement between psychiatry and psychotherapy. Using the history of art therapy practice and contemporary ideas about work with people with serious mental disorders, I show that a synthesis of the three elements is possible and necessary. This synthesis could make a potent improvement to the ability of art therapists to claim the distinctiveness and effectiveness of their contribution.

History, Context and Scepticism about Treatment

The political circumstances in which psychotherapeutic practice is situated create a dynamic that is rarely explored in the literature. In part this may explain why psychotherapy is not currently in a strong ideological position within the public sector. In Britain within the world of art therapy it is acknowledged and demonstrable that art therapists in the public sector have regular experience of working with clients either who are in the midst of psychosis or who have a history of it. Art therapists working in Sheffield in the 1980s made a census of their caseloads showing that some 58% of their clients had a serious mental disorder (Hill, 1983). Another more wide-ranging census made in Sheffield in 1996, showed that 49% of the clients of art therapists had an enduring mental illness (Wood, 1996, see chapter 13). This is set against the history of considerable scepticism in mental health practice about the feasibility of therapeutic work with the most disturbed when it aims at helping the client make sense of their experience. In psychoanalysis and psychotherapy there have been parallel but different reservations.

Since the Second World War art therapists have continued their practice with clients who are seriously mentally disordered, either ignoring or being unaware of this scepticism.

During the last five years there have been a number of factors which have lowered the level of resistance in general mental health about therapeutic work with people with a history of psychosis, but funding during this period has not been easily accessible. Where funding has been available, it has only occasionally been used for forms of treatment that aim to enable the client to find an understanding of their experience. One initiative has been in the various forms of Psycho-social Intervention (PSI) (Birchwood and Tarrier, 1994). These are derivatives of cognitive behaviourism and they do not include a notion of the unconscious, although a recent development is their attempt to address meaning with the client. These approaches have filled a vacuum created by the estrangement between psychiatry and psychoanalysis. They have been well received because they attempt to respond to what are pressing needs of people with serious mental disorders and because they espouse evidence-based practice.

The quest for meaning is the essence of art therapy. However, unlike cognitive approaches or many other approaches associated with general psychiatry, an understanding of unconscious processes is part of the quest for meaning within the discipline. This makes it particularly suited to work with the effects of psychosis, but if art therapists are to be able to justify this, systematic studies will have to be made. Methods are needed that can repeatedly enable art therapists to examine and clarify their practice. Essentially it is important to use methods that give dual attention to the intimacy of a therapeutic relationship and to the dynamic links in therapeutic work with socio-political circumstances. This last point is the context in which the provision of evidence of effectiveness becomes manageable in ways that do not damage the ethos of art therapy.

Poverty, Moral Treatment and Mind-Body Dualism in the Historical Relations Between Psychiatry and Psychosis

The thesis opens with a brief general psychiatric history of 'therapeutic' work with people with serious mental disorders, i.e., those conditions that have been variously described as dementia praecox, the schizophrenias, manic-depressive disorders and psychosis. In offering this history I hope to show that the historical rises and falls in therapeutic hopefulness about this group of clients are linked to the political circumstances of a period.

As with physical health, mental health is intimately linked to social and economic factors. Three themes span several centuries and influence treatment for people with a history of psychosis. These are poverty and class, moral management and mind-body dualism, each has a general historical significance and a particular pertinence to art therapy.

An indication of the history of diagnosis is given. The closely associated issue of finding appropriate language with which to describe these conditions remains problematic throughout.

Situating Theory and Practice

The links between art psychotherapeutic practices, the condition of psychosis and the political circumstances of the time continue to be examined in the light of the history of art therapy practice with these clients in Britain. The ideas implicitly contained in the literature of art therapy about how to practice with clients with a history of psychosis are considered in relation to three periods in the history of art therapy and psychosis. This is followed by a consideration of the historical estrangement of psychoanalysis from the practice of psychiatry throughout the twentieth century. In many ways, the smaller discipline of art therapy is caught on the cusp of this estrangement between these two larger disciplines. Like psychiatry, art therapy is largely practised in the public sector and is subject to the same constraints of the ideology of welfare, but like private sector psychotherapy, it is at its best when concerned with the quest by clients for meanings and metaphor that enable them to choose how to live.

The history of general psychoanalytic and psychotherapeutic theories concerning the nature of health and notions about psychosis is introduced. An examination of central themes that arise from the relationship of theory, practice and technique for work with disturbed people is made. This centrally considers the role of transference in the psychoanalytic ideas about such practice.

Questions about therapeutic technique appropriate for work with people with serious mental disorders were not resolved and they remained controversial throughout the twentieth century. These questions were heightened and confused because of the different locations of psychoanalytic and psychiatric practice and because the class issues provoked by these differences are rarely acknowledged.

The fact that psychotherapeutic theory rarely mentions class confirms the idea that the failure to comment upon the difference in location of psychiatry and psychoanalysis is widespread. It also suggests that philosophically there is a tendency to consider the psychological aspects of human existence as though they are divorced from the socio-political context. Facing class issues (as a result of its main location in the public sector) is a groundbreaking aspect of art therapy as a form of psychotherapy. Some of the ramifications of this are discussed in chapter four.

Adapting the Therapeutic Frame: Using Art and Psychotherapy in the Public Sector

The assertion of liberation made in my first sentence is easy to make and it could, if taken too glibly, conceal the painstaking nature of art therapy practice with people in the midst of psychosis. It could also conceal my awareness of the ambitious nature of this project.

A number of forms of art therapy practice for clients with a history of psychosis have been reported with individuals and groups. These forms have been described variously as art therapy, art psychotherapy and analytical art psychotherapy therapy (Schaverien, 1994). Schaverien offers a consideration of technical factors in different forms of art therapy; the distinctions she makes are largely concerned with the different use of transference. Distinctions such as these are useful in thinking about the appropriate forms of therapy for clients with differing needs; however, it would not be helpful to ascribe the terms to different practitioners. It would be better to use them as ways of distinguishing a range of possible technical approaches. Any one art therapy practitioner may use several. The consideration of therapy technique appropriate to particular client need fits into the current evidence-based practice tendency in the public sector. This is the attempt to estimate *what* form of therapy *works for whom* (Roth and Fonagy, 1996).

In addition to considering aspects of technique for particular client need it is also important to consider the impact of varying institutional circumstances upon practice. Technical adjustments made to better accommodate the contextual circumstances are a particular feature of public sector practice for art therapists. Section three contains four chapters that consider aspects of art therapy practice with the seriously mentally disordered and discusses the need to adapt the therapeutic frame in public sector institutions. These chapters also continue to examine what the philosophical differences and estrangement between psychiatry and psychoanalysis mean in practice.

Contemporary art therapy practice in relation to psychosis operates on many levels. The chapters in section three are concerned with some of the central issues. Vignettes are offered to show how, when working in the public sector with individuals and groups of clients who have a history of serious mental disorder, there is an attempt to understand something of their detailed identity, the quality of their relationship with the therapist, as well as the influence upon their lives of the social and political context. There is a need for theory and practice that pays attention to the dynamic interplay between relationship and context; psychotherapeutic practice in the public sector cannot exist in isolation. Related to this is the fact that people with serious mental disorders often live in extraordinary isolation and consequently an understanding of therapeutic containment is fundamental to the work. Containment like liberation is easy to assert, but it is not straightforward to construct the

therapeutic frame in some public sector circumstances. All of the chapters in section three consider the ways in which the therapeutic frame often needs to be adapted to the circumstances of the institution, whether it is based in the hospital or in the community.

Acknowledgement is made of the fear associated with the condition and the symbolic containment represented in the person of the therapist, other group members and by the physical nature of the studio. The fear associated with psychosis is not mentioned in the diagnostic criteria of psychiatry. However, terror and disrupted states of mind are central to psychoanalytic theory about psychosis. This is one of many examples of the philosophical differences between psychiatry and psychoanalysis. For the art therapist there is a resulting tension about how to acknowledge terror in a psychiatric setting and a repeated question about how to translate between what they know of psychoanalysis and psychiatry.

Ideally, at the level of the therapeutic relationship containment is coupled in the person of the therapist and in the possibilities for containment that can be part of art making. In group practice, the group may also provide containment. However, for therapeutic work to be possible with serious mentally disturbed clients, the institution itself needs to acknowledge and hold the practice.

The form of the relationship with the art therapist is always significant, and as with other forms of psychotherapeutic practice, there is a clinical decision to be made about whether or not it is wise to acknowledge transference in relationships with very disturbed clients. The use of art making is considered as a way of mediating some of the difficulties. It is also considered in terms of its potential for *quiet* excitement and absorption. Although reverie is a notion referred to in both the literature of art and psychoanalysis, the need of human beings to have periods when they are not alienated from themselves but able to be absorbed in what ever they are engaged in doing is not. I have suggested in chapter eight that the potential for absorption that exists in art making in the presence of another is a unique part of what art therapy can offer. This seems particularly pertinent to work with people who, in the midst of psychosis and in its aftermath, sometimes seem to lose their capacity to be absorbed.

Group practice when it is working provides a useful stepping-stone for clients between the strangeness of their inner world and meetings with others in the outer world. In groups the relationships with other group members can defy some aspects of the diagnostic criteria for the condition of psychosis, which suggest that sufferers are unable to relate. Also facets of the process of making and sharing art can undermine the toxicity of psychotic experiences. Sometimes the tension between art and relationship provides a peculiarly helpful

dissolution of aspects of the alienation that haunt the seriously mentally disordered in contemporary society.

The part played by having a studio in which to base practice in enhancing the capaciousness of the art therapy process is the subject of chapter eight. I have suggested that the difficult political period of the 1990s meant that art therapists tended like others to look for inner world solutions. This meant that they often neglected both the political basis of their practice and the need for the provision of a studio in which to make art, as they necessarily focussed upon the development of psychotherapeutic rigour. The fate of studios in the British public sector in the 1990s is one example among many of the difficulty for art therapists of negotiating and translating between the public sector psychiatry and psychoanalysis.

<u>The Politics of the Aesthetic: Some Anachronisms in the Use of Art</u>

There are three distinct histories of art made by people in the midst of psychosis; one is concerned with its status as art and the others are concerned with its uses as diagnostic and therapeutic tools.

The scholarly industry of the 'art of the insane' was (during the middle years of the twentieth century) overly romantic. It treated the art created by mental patients between 1880 and 1930 as part of a 'golden age of psychotic art', and it seemed concerned to preserve and set apart examples of work from this period. In its wish to avoid 'contamination' by the contemporary mainstream culture it is similar to proponents of *Art Brut*.

The vexed question of whether or not the products of art therapy constitute art is briefly considered in relation to the art associated with psychosis. The example of Ernst Kris is germane. MacGregor suggest that in his study of his patient 'F.W.', Kris was unable to recognise the sheer quality of this patient's artwork during his breakdown. MacGregor suggests this is because although Kris had detailed knowledge of Renaissance and Baroque, this 'failed to provide him with a basis for understanding or responding to these images which only the art of the twentieth century has made visible' (MacGregor, 1989, p. 264).

This example begins to indicate the complexities involved in an examination of the nature of the art associated with psychosis. Another complication is that the proponents of the 'art of the insane' and 'art brut' have totally evaded psychoanalytic concepts that attempt to explain the attack upon thinking inherent in psychosis. This is in contrast to the dangers of pathologising through the overuse of such concepts.

Art therapists have tended implicitly to adopt romantic traditions of art for their clinical practice. It certainly seems to me that significant aspects of the art therapy profession's practice throughout the twentieth century are interwoven with the romantic ethos of much nineteenth century art. This might be seen as an anachronism. In some respects the

ways in which the art of art therapy is theorised is similar to the romantic nostalgia of the early 'art of the insane' scholars and the proponents of 'art brut'. The contributions of romanticism are contemplated and not dismissed, but, in addition, the possibilities for the useful inclusion of influences from popular culture and contemporary art are considered. I propose that an adequate theoretical framework for the element of art in art therapy would be enhanced by the inclusion of aesthetic criticism with a dynamic sense of mainstream culture and politic. The element of art shapes the nature of art therapy practice, supervision and research, and its value and vitality is enhanced if it can include and acknowledge contemporary influence. The thoughtful use of a wide range of art can help art therapy practice with the clients of the public sector retain its identity and integrity. This section provides another example, of my central argument that theory and practice will be enhanced by repeatedly moving backwards and forwards between the intimate details of practice and the wider cultural and political context.

The Politics of Evidence Based Practice

The Evidence Based Practice (EBP) movement powerfully affects mental health research in the current period. This is a politically motivated movement and not a straightforwardly scientific impulse and it could become, if not handled with political acumen, a further wedge in the estrangement between psychiatry and psychoanalysis. As a result, in matters concerning research for art therapy there is another sense in which a consciousness of politics is necessary. The research strategy for the profession needs to develop a dynamic between theory and systematic, quantitative evidence of effectiveness. However, in the midst of the struggle to demonstrate its effectiveness of practice it is important not to lose sight of the two inspirational fires, art and relationship, which first draw people to the profession. There are general tensions inherent in demonstrating effectiveness within the discourse of EBP for a profession like art therapy. The particularities of a way forward for demonstrating the evidence for work with the most disturbed are considered.

There are three chapters in this section including an example of census. 'Gathering Evidence: Expansion of Art Therapy Research Strategy' is general, stressing the need for a research strategy that locates itself in relation to the health policies of the day. Chapter twelve is concerned with the surprisingly small amount of evidence for art therapy with this client group in the form required by governments and the EBP movement in healthcare. The possibilities and the particularities of a way forward are considered. Fortunately art therapy is not alone; all the health professions are currently involved in a scramble to address the vexed question of evidence. The two evidence based practice conferences for mental health

therapists (1996 and 1999) both contained papers that anticipate the development of appropriate evidence over a ten to twenty year period.

The census study in chapter thirteen shows the nature and numbers of clients with serious disorders on the caseloads of art therapists working in adult mental health services of one city. This is a relatively simple example of what can be contributed to the accumulation of the kind of evidence required.

The Narrative and its Method

Throughout I have adopted study methods appropriate to an understanding of history. I provide a number of examples that demonstrate that there is need to move backwards and forwards between the details of art psychotherapeutic work and the socio-political context in which the work is situated. This process is similar to those methods usefully employed in many disciplines, notably for history and sociology and for aesthetic and literary criticism. It is possible to speculate about the recent appeal of post-modern methods in the terrain of psychotherapy because of the generally focused (often de-contextualized) forms of attention required by its practice, but there are beginning to be significant challenges made to post-modern methods. By contrast, the use of a method in academic work that has pluralistic aspects and that enables a historical overview is not fashionable. The thrust of my position is that the discipline of art therapy, which exists at the intersection of many others, needs repeated reference to cultural, historical and social political context.

Art therapy depending upon your point of view is positioned in a glorious hinterland of theoretical languages or in a ghetto full of colourful creole or pidgin. The image I have often conjured for myself in order to represent the extent of overlap and intersection in art therapy is that of a geographical hinterland with its overlapping peoples, cultures and languages. When I was younger I had to study linguistics, and I was always fascinated by what happened to languages at the borders of countries. There can be sophistication in creole or pidgin although prejudice often means that its sophistication remains hidden. It is in this sense that I think that the value of art therapy has often been hidden.

Another image, that of a games room, was suggested to me by my colleague Therese Richardson in a personal communication. It also conveys something of the nature of art therapy. The games room I had in mind when she first proposed it was a heady mixture of the pool hall (walls lined with games machines) and a sci-fi space ship full of computer wizardry. If I had to construct this image on a computer screen I would use a photograph of a turn-of-the century pool hall upon which I would superimpose the space ship seen in *Lexx* and some of the gadgetry seen in Dennis Potter's TV play *Cold Lazarus*. These images conjure up and offer playful attention to the number of disciplines that overlap in that of art

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therapy. It is my strong conviction that these disciplines connect and conflict in a manner that can produce a synthesis and a useful form of practice.

Conclusion

In this study I have often taken a historical perspective as a tool in the process of clarification, while at the same time searching out and making use of competing tensions in the field. This approach has grown out of the history of my own development and the many different experiences of theory and practice in my working life. A historical perspective has repeatedly helped me make sense of my experiences within the profession; it provides a tool with which to begin to understand the many factors (aesthetic, historical, social, psychological and political) influencing the nature of practice with people in the midst of psychosis. I am member of a middle generation in my profession. This means that my experience, together with that of my generation, has in part been a conduit of what has been practice and what will become practice. I begin by suggesting that there is a searing need for synthesis of art, psychotherapy and social and political awareness. This thesis provokes a number of implications for the training of art therapists that have been raised throughout and some of these are woven together in the conclusion.

Not surprisingly, my overall conclusion for the study is that it is helpful for art therapists to work with people with serious mental disorders. However, there is a need to develop greater clarity in matters of theory, practice and politics if there is to be a good outcome for the way of working and if it is to be sustainable by practitioners and useful to the clients of the public sector who experience psychosis.

Art, Psychotherapy and Psychosis: The Nature and the Politics of Art Therapy

I see, in this thoroughfare,
A natural, followed by children.
...Consider this unhappy wretch;
Poor mad fool, what will he do
With so many rags and tatters?
I have seen such wild lunatics
Shouting insults in the streets

(François Colletet, early seventeenth century
writer quoted in Foucault, 1967, p. 36).

First Section: Historical Context and Scepticism about the Treatment of Madness

Introduction to First Section:

The social realities of poverty, the philosophical underpinnings of mind-body dualism and moral treatment are part of a history that clearly predates the emergence of the discipline of art therapy, which began in Britain just before the Second World War. This chapter briefly retells the history of ideas about madness and its treatment, beginning at the end of the eighteenth century. It highlights three themes as having general historical relevance to the scepticism about the possibilities for 'treating' madness and particular pertinence to the heritage of the discipline of art therapy.

The chapter helps locate the practice of art therapy within the firmament of other approaches to the treatment of madness. Although my version of the general history is not original its particular emphasis on the themes of poverty, mind-body dualism and moral treatment philosophy is important. I indicate how these contextual forces have shaped the treatment of madness in general and the use of art therapy in particular.

The majority of art therapists practice in the public sector, and consequently they have been able to work with significant numbers of people with serious mental disorders. Treatment philosophies for serious mental disorders are part of a continuum that moves between systems that focus on the body and those that focus on the mind and meaning.

The relative emphasis of treatment in the public sector fluctuates in response to changes in the historical period and these changes have influenced the development of art therapy. At the end of the twentieth century psychotherapeutic clarity was strengthened, and yet interestingly the profession manages to uphold and combine this greater clarity with aspects of eighteenth century moral treatment and twentieth century social psychiatry. Although neither of these philosophies is currently widely used, they have shaped the form that art therapy has assumed. The discipline of art therapy together with pockets of other disciplines in the field of mental health, holds and maintains the memory of these two effective strategies for therapeutic work with the seriously mentally disordered. The history suggests we can wait or perhaps push for better times.

Chapter One:

Poverty, Moral Management and Mind-Body Dualism in the History of Relations between Psychiatry and Psychosis:

This is a brief general psychiatric history of 'therapeutic' work with people with serious mental disorders, i.e., those conditions that have been variously described as dementia praecox, the schizophrenias, manic-depressive disorders and psychosis. In opening with this account I hope to show that the rises and falls in therapeutic hopefulness about particular clients are linked to the political circumstances of the time. As with physical health, mental health is intimately linked to social and economic factors. In addition three themes span several centuries in their influence upon treatment: poverty and class, moral management and mind-body dualism.

An indication of the history of diagnosis is given. The closely associated issue of finding appropriate language with which to describe these conditions remains problematic throughout. A recent attempt to deal with this was proposed by Murray Jackson. He suggests that the two phrases 'psychotic conditions' and 'serious mental disorders' do not carry the 'powerful implications of a disease of exclusively biological nature, poor prognosis, chronicity, unsuitability for psychotherapy, and of the necessity of exclusively biomedical attention' (Jackson, 1994 & 1995, p. 11) that are the connotations of 'schizophrenia'. Many different terms have been used historically, and it remains a problem today to find language that does not dehumanise the person. I have found myself making various attempts to describe the conditions of psychosis, including those proposed by Jackson, in ways that avoid equating the person with the condition. The much criticised tendency in general medicine of describing a patient as 'the liver in bed 13' is little different from describing a person as 'the schizophrenic in the street'. However, I am not convinced by overly reductive philosophical accounts that wish to suggest that experience is fundamentally shaped by language. This is because such accounts do not allow for social and political factors. The inadequacy of the language with which to describe mental disorder is not at the root of the difficulties of the experience of psychosis, although it may be a small indication of the extent to which our society has difficulty with it.

Comparisons between unemployment and psychosis

It may seem strange to begin with a comparison between the history and effects of unemployment and those of psychosis, yet a comparison between the psychological consequences of unemployment and psychosis help to demonstrate the socio-political underpinnings of mental life. This is also a helpful way to introduce more general history of therapeutic work with people with serious mental disorders.

During the time of my work as an art therapist many of my clients have been unemployed. Consequently I have thought a lot about the psychological consequences of their unemployment. I have explored the literature (Kelvin & Jarrett, 1985; Coyle, 1984; Townsend, Davidson & Whitehead, 1988; Young & Schuller, 1991) and spoken to people with different perspectives. The psychological consequences of unemployment are deeply embedded in history and culture.

Initially I was surprised to notice the convergence between matters affecting people who are unemployed and those with a history of psychosis. Foucault claims that historically those people who occupy the mental hospitals are those who will not work.

> From the very start, one thing is clear: the Hôpital Général is not a medical establishment. It is rather a sort of semi-judicial structure, an administrative entity which along with already constituted powers, and outside of the courts decides judgement and executes (Foucault, 1967, p. 40).

Foucault clearly links confinement in a mental hospital with a process of moral correction. He writes of the 'great confinement' as a way of describing the process of institutionalisation, which began in France the middle of the seventeenth century (p.38).

> Before having the medical meaning we give it, or that at least we like to suppose it has, confinement was required by something quite different from any concern with curing the sick. What made it necessary was an imperative of labour. Our philosophy prefers to recognise the signs of a benevolence towards sickness where there is only condemnation of idleness (Foucault, 1967, p. 46).

Hearing personal accounts make it strikingly clear that the long-term effects of unemployment have much in common with the long-term effects of psychosis. Indeed Warner asserts that: 'Many of the negative features of chronic schizophrenia are identical with the psychological sequelae of long-term unemployment' (Warner, 1985, p. 148). Also a chart taken from his work (Table 3.2, p. 72: see my Table 1 which follows) suggests that the rate of recovery in schizophrenia is linked to the economy and levels of unemployment.

Table 1: Correlation of recovery rates in schizophrenia with average unemployment rates in the USA and UK during four periods of the twentieth century (Warner, 1985, p. 72).

ADMISSION PERIOD	COMPLETE RECOVERY %	SOCIAL RECOVERY %	US UNEMPLOYMENT %	UK UNEMPLOYMENT %
1901-20	20	41	4.7	3.5
1921-40	12	29	11.9	14.0
1941-55	23	44	4.1	1.5
1956-1985	22	45	5.4	2.7

The psychological consequences of succumbing to a period of psychosis are also deeply embedded in the history and politics of our culture. By choosing the phrase 'deeply embedded' I want to indicate the length of social and political history from which come the experiences of people facing unemployment or psychosis now.

In Britain the *Ordinance of Labourers* of 1349 distinguished between 'sturdy beggars' who were considered as fit for work and the 'deserving poor' who were not considered fit because they were either ill or too young or old. After 1349 anyone found helping a sturdy beggar 'avoid' work by providing food or charity risked imprisonment. The central distinction survived and was repeated in the Poor Law of 1834 when the deterrent to erstwhile sturdy beggars, of the workhouse, was introduced. It is possible to uncover the basic distinction between the 'deserving' and the 'undeserving' in all subsequent attitudes and policies concerning 'provision' for the poor or the unemployed.

It is possible to uncover similar distinctions in legislation and other matters affecting the insane. During the 1730s Bedlam was still using its charges as a freak show, whereby it was possible for visitors to pay to see the iniquitous den. Hogarth's cartoon of such a visit being made to Bedlam is undoubtedly a caricature, but it catches the flavour of the divide *(see figure one)*.

In 1744 a revision of the law of 1714 was passed which required each parish to restrain 'pauper lunatics' and while restraining them 'effect' a cure. A little later the Head of Bethlem Hospital, Thomas Monro, made the famous quip that restraining chains were 'fit only for the pauper lunatic: if a gentleman was put in irons he would not like it' (Hunter and Macalpine, 1964, p. 703). Gregory, a medic writing during the second half of the eighteenth century, realised that psychiatric medicine such as it was in the eighteenth century was distinguishing from the outset between socio-economic conditions of 'pauper lunatics' and the 'nervous disorders of the bourgeois'.

> It is not unusual to find physicians treating these complaints with the most barbarous neglect, or mortifying ridicule when the patient can ill afford to fee them; while at the same time, among patients of higher rank, they foster them with the utmost care and apparent sympathy; there being no disease in the stile of the trade, so lucrative as these of the nervous kind' (Gregory, 1765, in Hunter & Macalpine, 1964, p.703).

Evidence of differences in treatment offered to people from different economic backgrounds appears in the story from 1787, when 'hysteria' amongst women textile workers halted production in their factory. It is recorded that a 'cure' is produced and production resumed as a result of the ministrations of a Dr. W. St. Clare who was called to the factory with an electric shock machine (*The Gentleman's Magazine*, 1787).

The influence of the Industrial Revolution during the second part of the eighteenth century produced profound social changes. Large parts of the population moved from small rural workshops towards urban industry. The workhouses were gradually to become

figure one
William Hogarth's engraving of Bedlam in which two-well to-do women make a tour. The engraving is part of the series' The Rake's Progress' (1735)..

an undesirable economic threat to the new factory owners and eventually a number were to be converted to asylums. Also possibly as a result of the need for labour, there was greater attention given to 'pauper lunatics'. Doerner suggests that psychiatry was established in order to take a surrogate role for the community in relation to the insane (1969, p. 1). It is possible to make a direct comparison between the surrogacy of the community provided for the insane in the person of the psychiatrist and that provided by the workhouse for those not eligible for 'outdoor' relief. In the workhouse the health of the business cycle (Warner, 1985, p. 56) influences the relative harshness of the treatment. When able-bodied labour was plentiful and easily available, life became more difficult for people in the workhouse. In the asylum the same business cycle influences the strenuousness or otherwise of the rehabilitative efforts. The labour shortage in early nineteenth century America was associated with more intense rehabilitative efforts and higher cure rates in public asylums. 'Whereas the high levels of unemployment in Britain throughout the nineteenth century may well have limited rehabilitative efforts for the insane poor' (Warner, 1985, p. 126 see *figure two*).

Three themes

I have mainly considered the ways in which Doerner (1969) Porter (1987, 1997) and Warner (1985) have interpreted the history. Early efforts at helping and understanding the 'insane' were recorded in the seventeenth century. During the eighteenth century: 'The "pauper lunatics" were literally the embodiment of the ills and incipient crisis of the mid-eighteenth century' (Doerner, 1969, p. 69). It was only during the nineteenth century that psychiatry gradually became identified as a specialised branch of medicine. From its inception to the present time, three themes of poverty and class, the possibilities for moral management and the mind-body issue have been present in relation to the seriously mentally disturbed.

The influence of poverty and class

Doerner sees the history of medicine as tied to social and political issues. He suggests that that the bourgeois classes established psychiatry specifically for the poor insane. He thinks that many themes related to the development of psychiatry 'were one aspect of the class struggle, as well as an early solution to the incipient *social question*' (Doerner, 1969, p. 1).

He points to the failure of sociological accounts to distinguish sufficiently between psychiatric history and that of psychoanalysis. He suggests that the failure to produce theoretical accounts of the development of psychiatry (compared with the sociological enthusiasm to theorise about psychoanalysis) is as a result of the harsh and complex political realities that face psychiatry. I tend to agree that some of the issues that face people working in psychiatry can be painful to witness and seemingly insoluble.

figure two
A Scene in a London Workhouse,
c.1900.

Consequently it is understandable that throughout the history of psychiatry it seems that: 'Praxis is limited to hard to verify success in individual cases, or becomes purely administrative' (Doerner, 1969, p.4).

This impression is relevant to contemporary debates about evidence-based practice, certainly in psychiatry and more modestly in art therapy. Also this impression suggests the extent to which the poverty and high number of clients can pervade the development of a discipline.

'Before the nineteenth century the treatment of the mad hardly constituted a specialised branch of medicine' (Porter, 1997, p. 493). When in the eighteenth century there began a 'trade in lunacy' it was only very slightly in the hands of doctors and it was focussed on private mad houses. These were to be subject to much criticism, famously by Defoe in 1707 and 1728, who saw them as sources of exploitation and abuse of their paying guests. He criticised the practice of citizens 'among the better sort' who used these houses to rid themselves of wives they had tired of.

Doerner proposes that insanity during the early part of the eighteenth century is a political matter in a broad general sense (1969, p. 24). He describes the ways in which approaches to treatment were strongly influenced by ideas from the emergent bourgeoisie. Towards the end of the previous century in 1682 Thomas Sydenham had published an account of hysteria that was 'a sort of underhanded moral description of England's bourgeoisie' (Doerner, 1969, p. 26). He identifies hysteria found in women as hypochondria and its equivalent in men as melancholia. He asserted that only women who work and only men who do not lead a sedentary life are free of hysteria. Very little is mentioned about insanity. 'Thus the disorder manifested by the bourgeoisie – hysteria – became the medical model for nervous or mental diseases' (Doerner, 1969, p. 27). The poor insane at this time remained outside the public domain and outside the focus of medical attention. Until the close of the eighteenth century 'madhouses' tended not to be medical institutions, and most were supported by religious or charitable organisations.

Then at the beginning of his madness in 1788, King George III in a sense puts psychiatry on the map, by accepting the successful treatment of Francis Willis who was both a clergyman and a medic. After this the idea of doctors for the mad, know as 'mad-doctors', gradually became more acceptable. Then a further step towards the credibility of these mad-doctors was also associated with George III. When in 1799 James Hadfield tried to assassinate the King, the trial was stopped when the defence lawyer convinced the Judge that Hadfield was mad. During the early decades of the nineteenth century the plea of insanity became increasingly reliant on the medical testimony of the early psychiatrists.

However, it is the development of Industrial Capitalism at the end of the eighteenth and beginning of the nineteenth century that sees the birth of psychiatry. The

many overlapping developments that accompanied industrialisation destroyed the subsistence base of small workshop workers, creating poverty and insecurity for many. Large sections of the population moved to the towns and the factories and became the first members of the urban working classes; members of their ranks made up the majority of those admitted to the newly institutionalised asylums.

Statistics collected at the time by Dr John Thurnam (Warner, 1985, Table 5. 2, p. 112: see Table 2 below) show the difference in recovery rates between private and pauper madhouses. The figures below show that houses receiving paupers consistently had lower recovery rates and higher rates of death.

Table 2: Recovery and mortality rates for British mental institutions, comparing private and pauper establishments before 1845 (Warner, 1985, p. 112).

	RECOVERY AS % OF ADMISSIONS	MORTALITY AS % OF NUMBER RESIDENT
County Asylums Receiving both private and pauper patients (average of 6 asylums ,1812-44) Receiving paupers only (average of 9 asylums, 1812-44)	46.87 36.95	10.46 13.88
Metropolitan licensed houses Receiving principally private patients (average of 27 houses, 1839-43) Receiving principally pauper patients (average of 3 houses, 1839-43)	30.87 23.74	6.80 18.10
Provincial licensed houses Receiving principally private patients (average of 41 houses, 1839-43) Receiving principally pauper patients (average of 44 houses, 1839-43)	43.50 41.50	6.57 10.56

The table above repeatedly indicates that those institutions (of all varieties, county, metropolitan and provincial) that received pauper patients had worse recovery and mortality rates.

Warner also gathers strong contemporary evidence showing that in industrialised society lower class people die younger. It is also clear that because the stressors of lower class life are greater there is more likelihood of greater physical and mental illness. Schizophrenia and other mental disorders are more common in the lower classes (Warner, 1985, p. 33-56). There is, however, a difference in the concentration of mental disorders in the industrial world compared with the Third World. The changing social circumstances and fortunes of upper caste members of Third World cultures tend to mean that they have high rates of mental disorder. Theories of social causation as opposed to social drift are the best explanation for this. However, it is likely that although for the majority the strains of lower class life contribute to the higher levels of serious mental disorders, downward social drift after the onset of mental illness can account for a proportion of the social class gradient.

It is clear from Warner's powerful international work that social economic factors influence the course and appearance of schizophrenia. To substantiate this he points to a meta-analysis of 68 follow-up studies conducted in Europe and North America since the beginning of the 1900s. One clear example of the influence of poverty and class is the finding that recovery rates were significantly lower during the Great Depression of the 1920s and the 1930s in America, Europe and Scandinavia (Warner, 1985, pp. 73, 77, 79).

Moral management

Dr Thurnam did not think that the statistics he produced in 1845 about worse rates of recovery and higher mortality rates for paupers (see Table 2, p. 8) were entirely conclusive. He thought they might in part be explained by differences in style of management and not only by the condition of the patients on admission (Thurnam, 1845, p. 36).

Warner asks a series of pertinent questions concerning the historical emergence of the treatment philosophy known as moral management. His main question concerns the fading away of the movement for moral management. He asks why this humane method of treatment for psychiatric patients which was adopted widely in numerous countries, fell into decline after some 50 or 60 years. The use of these methods had been accompanied by claims of excellent recovery rates. He also points to the way in which many psychiatrists have compared the common features of moral management to the movement for social psychiatry after the Second World War. His table makes a good tool for comparison (5.1, p. 109: see my copy of it, table 3 which follows).

Table 3: Moral treatment and the post-Second World War social psychiatry revolution compared (Warner, 1985, p. 109).

MORAL TREATMENT	POST-SECOND WORLD WAR SOCIAL-PSYCHIATRY REVOLUTION
Non Restraint	Non Restraint
Non-confinement	Open door
Self-control emphasized	Therapeutic Community
Privileges - not punishment	Positive reinforcement
Small treatment settings	Small units
Homelike environment	Less barren wards
Warm baths and generous diet	Patient comforts improved
Work therapy	Vocational rehabilitation
Patients are human	Patients are to be respected
Patients seen as child	Patient seen as adult
Social activities	Social retraining
Drugs seldom used	Drug treatment valued
Early discharge	Early discharge
Community involvement	Community involvement
Legitimised institutional expansion	Legitimised institutional decline
Supposed cost savings	Supposed cost savings

Warner asks whether similar social and economic conditions contributed to the creation of these two approaches to treatment. If claims that these two approaches were remarkably successful are correct, then a number of other questions need to be posed about the development of psychiatry, its treatment philosophy and its relationship to social and economic factors. It is more ordinary to present development in psychiatry as progress to higher levels of technological achievement. The idea of progress through technology is itself an ideology. The notion that it may also be one that is particularly potent during certain historical periods will be considered again in section five, in relation to the movement for evidence-based practice in medicine and mental health.

The philosophy of moral management emerged at the time of the French revolution and the Industrial revolution in England. The revolutionary nature of the treatment philosophy is striking when it is compared to what existed prior to it.

A visitor to the York Asylum in 1814 (not the York Retreat) discovered a series of small cells: 'In a very horrid and filthy condition...the walls were daubed with excrement;

the air-holes, of which there was one in each cell were partly filled with it' (Warner, 1985, p. 102). Dickens recorded that the old asylums provided:

> Coercion for the outward man, and rabid physicking for the inward man. Chains, straw, filthy solitude, darkness and starvation: jalap. syrup of buckthorn, tartarised antimony and ipecacuanha administered every spring and fall in fabulous doses to every patient, whether well or ill; spinning in whirligigs, corporal punishment, gagging 'continued intoxication'; nothing was too wildly extravagant to be prescribed by mad-doctors (Dickens, 1850-9, in Stone, ed., 1968, pp. 381-91).

Suddenly it seems that Hogarth's cartoon gives only a sanitised impression. Similarly the painting by Robert Fleury in 1876 seems to offer a domesticated version of the conditions which led Pinel, a century before, to loosen the chains for the insane held at Salpêtrière *(see figure three).*

Parry-Jones (1972, p. 289) has argued that it is not satisfactory to explain the level of neglect in asylums at the end of the eighteenth century as being solely the result of abuse. At that time lunacy, insanity or madness was equated with bestiality. People in the madhouses were left naked in the cold and damp because they were believed to possess the 'natural' resistance of animals.

Andrew Scull (1981, p. 107) and Michel Foucault (1967) have both written that moral treatment was part of the general process of enlightenment and it involved a redefinition of madness. It gradually became possible to acknowledge that mad people could retain a degree of rationality. A Swiss Doctor made the following comment in the visitor's book at the Retreat at York (the most celebrated home of the approach in Britain).

> In moral treatment, one does not consider the insane to be completely deprived of reason, out of reach of the influence of fear, hope affection and honour. Rather one regards them, it seems like children who have too much energy, and who put it to dangerous uses (quoted by Kathleen Jones, 1972).

There was interest in using the methods for moral treatment throughout Europe. In 1789 in Florence, Vincenzo Chiarugi, the doctor in charge of the Hospital Bonifacio, published regulations that eliminated the use of physical force. He announced: 'It is a supreme moral duty and medical obligation to respect the insane individual as a person' (1793). This is cited in Warner (1985, p. 104); it is taken from the work of the psychiatric historian George Mora. In France a number of treatises were made advocating humane care. Also at the Manchester Lunatic Hospital, John Ferriar suggested that the primary goal of treatment was in 'creating a habit of self restraint' (1795, pp. 111-12) without coercion.

This notion of self-restraint was epitomised in the methods used by the York Retreat. William Tuke's daughter-in-law gave one of the descriptions of the Retreat that does most to convey the quality of its work. It was she who suggested the name 'Retreat' as opposed to a 'Hospital' or 'Asylum'. She wanted to describe 'a quiet haven in which

figure three

French physician Philippe Pinel supervises the unchaining of mentally ill patients in 1794 at La Salpêtrière, a large hospital in Paris. Pinel believed in treating mentally ill people with compassion and patience, rather than with cruelty and violence. This painting, Pinel Frees the Insane from Their Chains, was completed by French artist Tony Robert-Fleury in 1876.

the shattered bark might find the means of reparation' (quoted by Kathleen Jones, 1972). However, it was her husband Samuel Tuke who committed to print the abiding principles of the way this Quaker family responded to the 'insane persons' committed to their care (Tuke, 1813).

Founded in the dales close to York, the Retreat had the appearance of a farm sitting in a large walled garden. The Quaker Society of Friends founded it after one of their congregation Hannah Mills died through neglect at the York Asylum. It was initially under the guidance of William Tuke whose family system provided non-medical care, in the belief that even very disturbed people would respond to kindness and respect. Patients were gently encouraged into an ordered life and into finding self-control and self esteem. Samuel Tuke's simple but powerful *Description of the Retreat: An Institution Near York for Insane Persons* (1813) was secretly dedicated to his father William. I return to Tuke's *Description* in my summary and conclusion.

In reading a number of accounts of moral treatment I am mindful of some aspects of the theory and practice of art therapy. The art therapist Terry Molloy wrote a paper concerning the place of art therapy within the rehabilitation of people with a history of psychosis. He suggested that art therapy:

> offers an opportunity to exercise self-discipline, an attribute that will be of great value to a patient who is attempting to adjust to the pressures of a changing life. Anyone who has struggled with the demands of creative artwork will know that it is insufficient to produce a simple cathartic flood (Molloy, 1984, p5).

The emergence of the moral treatment philosophy was characterised by the removal of restraints. Clearly, the practice of art therapy does not involve the use of any actual physical restraints that can be removed, and yet I think that there is a connection between it and an erstwhile moral treatment philosophy. This seems pertinent to work with hallucinated patients. Unlike some of the strategies used in general mental health work intended to divert the client away from their fears, art therapists have a long tradition of offering to meet the terrors of a client's inner world. They make efforts not to artificially restrict (or restrain) the emotional territory that it is possible for the client to explore in therapy.

Greenwood and Layton saw that one of the main things that someone might gain from art therapy is to learn better how to the ride the tide of the unconscious and achieve changes in self-mastery (1987). This idea of enabling some sense of greater self-mastery over the tides of the unconscious has often been in my mind's eye while working with clients who seem flooded with unconscious material. This is different in aim from an approach that might attempt to stem the flow of unconscious material, or one that physically restrained the patient.

Much art therapy literature refers repeatedly to the need to treat people with care and respect; respect for the patient or the client is a strong tradition within the discipline. Also the human need for retreat is one that art therapists have embraced, and most try to provide it (in part) in the form of a studio. The avoidance of suppression, genuine respect and the provision of sanctuary or retreat are three 'connections' in art therapy with aspects of the moral treatment philosophy and the social psychiatry movement. They strongly suggest the traditions from which art therapy has emerged and they help situate contemporary practice. However, as with most 'family' connections, the lineage here is not straightforward, and these are matters to which I necessarily return.

It is interesting that repeatedly in Warner's account he provides evidence that the humane methods of moral treatment were attempted in the public asylums of Europe and America (Warner, 1985, pp. 110-111, & 119). They tended to be adopted more whole-heartedly in the private asylums in Europe (where patients were fee paying). In the wealthier America where the demand for labour was higher there were many successful examples of the rehabilitative success of moral treatment, even for the poor, although in some large cities, in New York for example, Pauper Asylums remained as dire as gothic examples in Europe.

Warner pursues the idea that the high success of moral treatment for rehabilitation and cure (where it was whole-heartedly implemented) was a fact that was obscured in the rewriting of psychiatric history. He describes the tricky statistical manoeuvrings of one Dr Earl and the general tendency to deride statistics gathered at the time, which seemed to demonstrate that rates of cure for moral treatment had been high. In fact, Isaac Ray subsequently challenged Earl's work. He totally rebutted Earl's mathematical data and demonstrated that statistical reports of high cure rates for moral treatment that had been collected at the time were reasonably sound and that treatment results had deteriorated since the moral period (Warner, 1985, p.125).

However latter day psychiatrists have tended to uphold Earl's account and overlook the rebuttal by Ray. In doing so, they have buried the important information that 'the course of functional psychoses in patients admitted to early nineteenth-century American hospitals was more benign than in the hundred years which followed' (Warner, 1985, p. 125).

Doerner's perspective on moral treatment is jaundiced and it seems to me to obscure its humane qualities. He proposes that external restraints were simply replaced by internal ones. Of course it would be possible to argue that the qualities of discipline and self-restraint upon which the moral philosophy was based would be useful attributes for the new production lines of the new factories. However, as we have seen it is not clear that the new urban working classes were the beneficiaries of the moral treatment methods.

The philosopher Habermas and the historian Hobsbawm both suggest ways for understanding these developments. Habermas writing in the 1960s saw the development of much wider political thinking being connected to the growth of industry and capital. He includes the discussion of many matters (including madness) in his notion of an emergent political public during the period 1694-5.

Hobsbawm also sees the ideas of enlightenment as being central to the capitalist transformation of production that occurred with the industrial revolution. He writes that it is significant that:

> The two chief centres of the [Enlightenment] ideology were also those of the dual revolution, France and England...A secular, rationalist and progressive individualism dominated "enlightened" thought. To set the individual free from the shackles which fettered him was its chief object. ...Liberty, equality and (it followed) the fraternity of all men were its slogans (Hobsbawm, 1962, p. 38).

The philosophy of moral treatment then was born at a specific political and economic point in history. It was argued for by Tuke in England with his *Description of the Retreat* (1813) and by Pinel with *Traité* (1801) in France. Both recommended it on grounds of humanity and efficacy. It faded away as a result of equally specific social, economic factors some 50 to 60 years later. Understanding this is powerfully important in considering the development of treatment approaches today.

Mind-body matters

Edward Shorter's latest book *A History of Psychiatry* asserts that at the end of the twentieth century there is no longer any question about the exclusively physical origin and treatment for schizophrenia. 'If there is one central intellectual reality at the end of the twentieth century it is that the biological approach to psychiatry —treating mental illness as a genetically influenced disorder has been a smashing success' (Shorter, 1997, p. vii). This together with his assertion that Freud's ideas are 'vanishing...like the snow of winter' (1997, p. vii), provide an example of one side of an argument that has been taking place over several centuries. Before the middle of the eighteenth century and the periods known in the Europe and America as the Enlightenment, madness was associated with the epitome of physicality — bestiality.

As early as 1697 the Whig Defoe and the Tory Swift had crossed swords about the origins of madness and its cure. Defoe argued vehemently against the abuses of private asylums. He insisted that there should be clear distinctions made between sanity and madness, in order that it would be harder to wrongly incarcerate people. On the other hand Swift mocked the very idea of madness but pragmatically got himself elected as governor of Bethlem Hospital in 1714. Defoe and Swift represent two sides of enlightenment thinking both of which were necessary to the development of psychiatry, one filled with optimism for reform and the other pessimism. Or as Doerner puts it:

The optimist Robinson Crusoe (1719), who, appropriating nature, made the most out of nothing, confronted the pessimistic world of Gulliver (1726), who sarcastically exposed the reverse side of the Enlightenment (Doerner, 1969, p. 23).

One of the Yahoos in Swift's *Gulliver's Travels* suffers a kind of madness (of the humours) and he is cured by hard physical work and not by pleasant distractions normally prescribed (according to Swift) for the well to do at the time (e.g., travel, swimming or riding).

Locke in his *Essay Concerning Human Understanding* (1690) ignored the role of the physical aspect of human life (animal spirits) in favour of the life of ideas. He suggested that,

> Madmen, having joined together some ideas very wrongly...mistake them for the Truth. [And] the difference between Idiots and mad Men [is] the mad Men put wrong Ideas together, and so make wrong Propositions, but argue and reason right from them. But Idiots make very few or no Propositions, but argue and reason scarce at all (Locke, 1690, p. vol. II, ch.11, par.12-13).

With the moral movement and the removal of restraint, a number of further distinctions about the origins of madness and its relationship to the mind and body began to emerge. The idea that physical restraints could be dispensed with had seen Pinel removing the chains of patients in France and the Tuke family establishing the Retreat in England. These actions augur the end of the end of viewing mad people in bestial terms.

Esquirol, Pinel's pupil dominated French psychiatry for many years; he firmly upheld and promoted physical disease notions of classification for mental disorders. Porter suggests that, during the ensuing period of treatment moral treatment in Europe and America, many psychiatrists acknowledged the propriety of moral treatment but actually believed in the physical origins of madness (Porter, 1997, p. 498). John Connolly, the reformer who worked to make the removal of restraints general, is one of those he suggests typifies the period in this. 'Whilst stressing moral therapy, Connolly upholds the physical basis of insanity, drawing in the controversial phrenological doctrines developed by the Austrian Franz Joseph Gall (1758-1828) and J.C. Spurzheim (1776-1832)' (Porter, 1997, p. 449).

In America Benjamin Rush was another successful psychiatric moral reformer who at base believed in bodily remedies. His advice for mania was to let blood. 'It should be copious on the first attack...From 20 to 40 ounces of blood may be taken at once...The effects of this early and copious bleeding are wonderful in calming mad people' (Rush, 1812, quoted in Porter, 1997, p. 500).

The philosophy of René Descartes concerning mind-body dualism (1641) was influential during this period when Connolly and Rush were writing. Descartes had proposed that human beings were composed of two separate parts and they, mind and body, are totally different substances, which enable thought and the movements of the

body. Although the conundrum did not prove helpful to early nineteenth century psychiatrists, it seems that some today still wish to operate with a mind-body split. Ryle caricatures this as being 'the dogma of the ghost in the machine' (1949).

By the middle of the nineteenth century the controversies over the preponderance of mind or body had appeared in Court. The 1844 M'Naghten Rules established the defence of insanity as one whereby the defendant could not distinguish right from wrong. This undermined the more psychological explanations of disorders of emotion and volition or 'irresistible impulse'. Jurists saw notions of partial insanity as a threat to free will and the idea of associated guilt and punishment.

Today the legal and psychiatric systems still contest the difference between the bad and the mad. This continues to echo the basic conflict between treatment philosophies that mainly approach the mind and those that seek to influence the body. Psychiatry by the mid-nineteenth century was increasingly presenting itself as a science. Medical science tends to need a body to investigate. The moral treatment philosophies had provided justification for orderly institutions for the insane.

> Progressive alienists pinned therapeutic faith on the architecture and atmosphere of their asylums, trusting to order and organisation, discipline and design, and their leadership qualities. Asylums were prized as scientific, cost effective, curative institutions (Porter, 1997, p. 502).

The resulting institutions were to grow too large. Interestingly Warner (1985, p. 109-110) points to the way the moral movement in the eighteenth century enabled the push towards large asylums and he compares this to the way the social psychiatry movement (with open-door policies) in the twentieth century enabled the closure of the asylums. Both of these reforming movements enabled the development of policies that gradually became spectacularly corrupted.

In both periods, the late nineteenth century and the late twentieth century, psychiatry is faced with extraordinarily complex social and political neglect of psychiatric patients. Earlier I suggested that this could explain the trend towards descriptive, categorising, case-by-case praxis (page 15 above). It could also explain the tendency to fall back upon physical explanations alone. Psychiatry is uneasily poised in society on a precarious fulcrum as a result of being ' from its very beginnings... a science of both emancipation and integration' (Doerner, 1969, p. 304). When I consider some of the dilemmas faced by the members of multidisciplinary teams in which I have worked in psychiatry, the precarious balance seems characteristic. A part of his precarious balance is seen in contemporary versions of the 'deserving' and 'undeserving' distinction; for example, in relation to public discussions about people given a diagnosis of personality disorder, erstwhile patients begging, drinking or using drugs on the street, the need for

supervision orders and the misrepresentation of the amount of violence perpetuated by mental patients.

For art therapists this precarious balance manifests itself in the way their work is viewed: either as a discipline with the capacity to offer a full and mature form of therapy or as merely a method that provides calming distraction and maintenance of the status quo. It is generally those proponents of the exclusively physical origin and treatment of psychosis that maintain the latter as a suitable role for art therapy.

Philosophers have suggested that in the twentieth century Wittgenstein and to a lesser extent Ryle have resolved the divorce of mind and body proposed by Descartes. Using examples from language both demonstrated that a separation between mind and body and between inner and outer is incoherent and untenable. However, Warnock suggests that the same issues concerning mind and body are resurfacing in problems thrown up by the study of genetics. 'It is no longer Newtonian physics that threatens the concept of human freedom but our increasing knowledge of the human genome' (Warnock, 1993, p. 2). I have already indicated that some in psychiatry continue to propose a form of mind-body dualism and would be likely to approve of Warnock's enlisting of genetic study. However, it may prove to be the case that Warnock overstates the case for the proficiency of genetic knowledge. It seems probable that discussions in this area will continue and that resolutions are likely to be complex with few simple divisions between matters of mind and body.

Many complicated issues continue to be influenced by the relative significance placed upon mind and body in psychiatry. This is seen in the difficulties and complexities of diagnosis, the power of international drug company monopolies and in the impact of economics upon health and welfare.

Diagnosis

Questions related to diagnosis are a part of the precarious nature of psychiatry. They also clearly demonstrate the continuing discussions about the relative place of mind and body in the origins and treatment of madness.

Emil Kraepelin the German psychiatrist formulated the concept of schizophrenia. He studied patients admitted to insane asylums in the last years of the nineteenth century. He observed and categorised types of insanity. He used the term dementia praecox (dementia of early life) to describe the conditions that he considered had their onset in early life and then developed into a variety of symptoms before the general degeneration of mental functioning and personality. In 1887 he linked three conditions, which had previously been considered separate. These were hebephrenia, characterised by aimless and incongruous behaviour; catatonia, which might be characterised either by extreme

passivity or extreme agitation; and dementia paranoids, where delusions of persecution and grandeur were predominant.

Kraepelin's purpose was to demonstrate how the condition differed from other forms of insanity and from idiocy. Dementia praecox did not seem to stem from a specific source whether physical or stress related. Also Kraepelin distinguished it from manic-depressive psychosis, by suggesting that dementia praecox had a progressively deteriorating course.

With a few exceptions Kraepelin's outline of characteristic features continue to be used as a description of the contemporary features of schizophrenia. The chart of Kraepelin's features in Warner's chart (Table1.1, p. 10-12) is interesting to read (see my table 4 copy of it, below).

Features of dementia praecox identified by Emil Kraepelin (Warner, 1985, p. 10-11). Table 4.

FEATURE	DESCRIPTION
Hallucinations:	
Auditory	At the beginning these are usually simple noises, rustling, buzzing ringing in the ears (p. 7) Then there develops ...the *hearing of voices.* Sometimes it is only whispering (p. 7). What the voices say is, as a rule, *unpleasant* and *disturbing* (p.9). Many of the voices make remarks about the thoughts and doings of the patient (p. 10). It is quite specially peculiar to dementia praecox that the patient's own *thoughts appear to them to be spoken aloud* (p. 12).
Visual	Everything looks awry and wrong (p. 14) People appear who are not there (p. 14)
Delusion:	
Paranoia	The patient notices that he is looked at in a peculiar way, laughed at, scoffed at...People spy on him, persecute him. poison the atmosphere (p. 27).
Guilt	The patient has by a sinful life he believes destroyed his health of body and mind (p. 27).
Grandiosity	The patient is 'something better', born to a higher place,...and inventor, a great singer, can do what he will (p. 29).
Ideas of Influence	Characteristic of the disease...is the feeling of one's thoughts being influenced (p. 12).
Thought transference	The patient sometimes *knows the thoughts of other people (p. 13).*
Ideas of reference	Indifferent remarks and chance looks, the whispering of other people, appear suspicious to the patient (p. 31).
Thought disorder Poverty of thought	There is invariably at first a *loss of mental activity* and therewith a certain poverty of thought (p. 19).
Loose associations	The patients lose in a most striking way the faculty of *logical ordering* of their trains of thought...The most self-evident and familiar associations with the given ideas are absent (p. 19).
Incoherence	By these disorders, which ...remind one of thinking in a dream, the patients' mental associations often have that peculiarly bewildering incomprehensibility ...It constitutes the essential foundation of *incoherence of (p. 20).*

Thought block	There can be a sudden 'blocking' of their thought, producing a painful interruption in a series of ideas (p. 22).
Affect (emotional expression): Blunting	Singular indifference ...towards their former emotional relations, the extinction of affectation for relatives and friends...'no grief and no joy' (p. 33).
Inappropriateness	One of the most characteristic features of the disease is a frequent causeless, sudden outburst of laughter (p. 53).
Lability	*Sudden oscillations of emotional equilibrium* of extraordinary violence may be developed (p. 35).
Speech: Abnormal flow	The patients become monosyllabic, sparing of their words, speak hesitatingly, suddenly become mute...let all answers be laboriously pressed out of them (p. 56). In states of excitement...a prodigious *flow of talk* may appear (p. 56).
Neologisms	They may be produced...quite senseless collections of a sound reminiscent of real words (p. 68).
Autism:	Patients with dementia praecox are often more or less inaccessible, ...they shut themselves off from the outside world (p. 49).
Stupor:	The rigid, impenetrable shutting up of themselves from all outer influences (p. 50).
Negativism:	Stubborn opposition of all sorts (p. 47).
Lack of drive:	The patients have lost every independent inclination for work or action (p. 37).
Automatic obedience: Waxy flexibility	The preservation of whatever positions the patient may be put in, even although they may be very uncomfortable (p. 38).
Echolalia	The involuntary repetition of words said to them (p. 39)
Echopraxia	The imitation of movements made in front of them (p. 39)
Mannerisms:	They assume flourishes by which the movements become unnatural, affected and manneristic (p. 45).
Stereotypy:	Continuance in the same position as well as...the reception of the *same movements* or *actions (p. 43).*
Intellectual deterioration:	The patients are distracted, inattentive, tired, dull, ...their mind wanders, they have no perseverance (p. 23).
Deterioration of judgement;	The faculty of judgement in the patient suffers without exception severe injury (p. 25).
Personality deterioration:	Their thinking, feeling, and acting have lost the unity...of the psychic personality, which provides the healthy human being with the feeling of inner freedom (p. 53).

Original Source: Kraepelin, E. (1919) *Dementia Praecox and Paraphrenia.* **Edingburgh: Livingstone.**

In reading these descriptions of characteristic features, I am reminded of many matters that have been spoken about with me by clients who have had a history of psychosis. They have mainly had a diagnosis of one of the schizophrenias or a manic depressive disorder. Although contemporary categories and definitions change with each new diagnostic manual, the traces of the features identified by Kraepelin are still much in evidence. With old diagnostic categories, as with new ones, there are some distinctions that give cause for pause because the sense of an individual person is lost in the process of generalisation.

The strange and extraordinary conclusions made as a result of over-generalisation are also implicit in the pictures of patients (*see figures seven that follow*) used by psychiatrists throughout the nineteenth century and later, to suggest a visual demonstration of the features of madness. In Morrison's *The Physiognomy of Insanity* (1824) he writes, 'The appearance of the face, it is well known, is intimately connected with, and dependent upon, the state of mind' (Morrison, 1824; extract cited in Skultan, 1975, p. 71). This is not too much to claim, but he continues at a pace that becomes crazy. Of the drawing meant to show *Monomania with Pride* (that could suggest a multitude of interpretations and scenarios) he writes:

> This plate represents a Female, in whom, although a Pauper, ideas of wealth and grandeur are predominant. She is liable to violent fits of fury, when her delusions are called in question, but talks rationally enough on subjects unconnected with them (Morrison, 1824; cited in Skultan, 1975, p. 72).

Many of the pictures which emerged out of this attempt to link physiognomy with diagnosis are compelling to look at, but they are also uncomfortable to see in conjunction with the diagnostic label attached to them because then they imply the bizarre and powerful relationships that psychiatrists (and indeed all mental health disciplines) can hold with their patients. Yet all of the pictures are interesting because they are human faces reminiscent of people we might have known and faces do seem to invite us to ascribe emotions to them.

The sculptor Franz Xaver Messerschmidt made a series of heads that have been an enigma for two centuries. These *Character Heads (1770-1793)* were for a time enlisted in the excitement about the possibilities for a science of physiognomy, but with the passage of time they defied categorisation (Lingwood and Schlieker, 1977; Macgregor, 1989). The twentieth century artist Arnulf Rainer used the heads to extraordinary effect in his overdrawings of them (*see the final picture included with figures seven*). His work plays with Messerschmidt's enigma and shows the face as an expressive *mask*.

From another perspective Julian Leff, the social psychiatrist famous for his systematic work with families, proposed that catatonic symptoms might be a 'somatic expression of delusions of influence, symbolic thinking and pathological fear, as much as a

figures seven
Dr Hugh Diamond's photographic presentation of religious mania, c.1856
Royal Society of Medicine.

figures seven
'Inmates of Surrey County Asylum (1852),
photographs by Dr Hugh Welch Diamond
presented in conjunction with theories about the
physiognomy of insanity.

figures seven: Images cited in Vieda Skultan's (1975) 'Madness and Morals: Ideas on Insanity in the Nineteenth Century'. London and Boston: Routledge & Kegan Paul, pp. 71-8. Skulton refers to Alexander Morison's 'Outlines of Mental Diseases' (1824).

figures seven
Arnold Rainer 'Untitled Photograph of Messerschmidt's Yawner' (1975).

bodily symptoms of hysteria are a conversion of anxiety' (Warner, 1985, P. 13). His proposal provides another challenge to mind-body dualism.

Catatonia and hysteria could still be seen shortly after the Second World War but they rarely now appear in the West, although catatonic schizophrenia is still one of the commonest forms of the disorder in the Third World. Leff suggests that this can be explained by the idea that in the West the population has developed the capacity to articulate emotions rather than express them as somatic symptoms (Leff, 1981). The implication is that catatonia will also gradually fade in the Third World and other forms of culturally determined symptoms will emerge. Warner also suggests that it is probable that the 'harsh and regressive' condition of asylums around the turn of the century tended to provoke and worsen catatonic symptoms that 'persisted as a physical expression of the patient's dependent status and barren existence' (Warner, 1985, p. 13).

These poor conditions are also probably a better explanation for the degeneration of patients at this time, rather than the idea held by Kraepelin that degeneration was inherent in the condition.

> Therapeutic nihilism, extended hospital stays and coercive management within the asylum walls, and poverty and unemployment beyond them, during these years of the late nineteenth-century Great Depression combined to limit the chances of recovery from dementia praecox. Few psychiatrists since Kraepelin...found the course of schizophrenia to be so malignant as originally portrayed. As Kraepelin's classification was adopted around the world, nevertheless, so was the impression that the illness was inevitably progressive and incurable. To varying degrees the same view holds sway today — that without treatment the outlook is hopeless — despite considerable evidence to the contrary (Warner, 1985, p. 13-14).

The work of father and son Eugene and Manfred Bleuler in their 20-year study of the lives of their schizophrenic patients has been much referred to, but it has not had the prominence given to Kraepelin's work. I will return to the optimistic evidence from the Bleulers long-term study (in chapter twelve). Here it is important to indicate the way in which evidence in these matters and the way it is promoted is not dependent on a rational meritocracy. Many influences, social, economic, political and personalities can have an impact.

This is also shown in the account Warner offers of the different range of diagnoses (some restricted and some broad) that are operated in different countries. In Scandinavia, most of Europe and after the 1970s in America, psychiatrists used a restricted diagnosis. In Russia before westernisation, almost certainly in China and in some areas of Japan a broad system of diagnosis has been more common (Warner, 1985, p. 17). These differences lead to wide variations of diagnosis, despite internationally used manuals.

A study made in the late 1960s and published in the early 1970s indicated that American psychiatrists were twice as likely to diagnose schizophrenia as their English counterparts (Cooper, Kendell, Gurland et al., 1973).

The possible variations in diagnosis illustrate the reasons why the prescription of psychotropic drugs have not been the powerful cure that was anticipated:

William Sargant (1907-88) saw in the new drugs a release from the shadow land of the asylum and the folly of Freudianism. Drugs he said, would enable doctors to "cut the cackle" predicting that the new psychotropic drugs would eliminate the problem of mental illness by the 1990s (Porter, 1997, p. 521).

Clearly, when judiciously prescribed the drugs can alleviate some suffering, but many of my clients testify to the fact that despite what is often their addiction to them, they are not the panacea hoped for.

The economics of contemporary history

Many studies (e.g., Priest, 1979; Lamb, 1984; Warner, 1985 & 1995; Morchen, G. et al., 1992; Cohen, 1993; Thompson, 1993; Commission for Social Justice, 1994; Pearson, 1995, DOH, 1999) show that poverty increases the incidence of psychosis.

Although health cuts in mental health became apparent during the 1980s under the Conservative government, the first cuts in health spending were initiated in the previous decade by the then Labour Government. The oil crisis in the early 1970s meant that OPEC increased the price of oil fivefold. The Labour Government asked the International Monetary Fund (IMF) for help with the economic problems that arose as a result of the oil situation. The IMF provided a rescue package for Britain, but one of the strings attached was a commitment to reduce public spending and consequently it was a Labour Government that instigated the first major cuts in health spending. In relation to mental health the consequences of the cuts became apparent in the 1980s.

Within the economic constraints of the time, pressures and aspirations were still evident about improving services. Hostility towards the old hospitals in many quarters was real, as were aspirations to give "the mentally ill" a better deal. Nonetheless, if we put together the bias towards the funding of hospitals at the expense of community facilities alongside a wider constraint on public spending, then community care was a vulnerable policy. Whilst the prospect of closing the old asylum and re-siting acute psychiatric care in new District General Hospitals was good, the prospect of a well-resourced community service for the person with long term mental health problems was not (Pilgrim and Rogers, 1996, p.75).

The figures for the reduction in hospital beds, and the rate of increase in hospital admission and 'throughput' during this period of change, give the most tangible evidence of the cuts that had an impact on mental health provision.

- The overall number of psychiatric beds decreased by about one-third, from 193,000 in 1959 to 108,000in 1985 (DHSS, 1987). Bed occupancy has also decreased dramatically – between 1980 and 1990 alone it was [correctly predicted] to drop by almost a quarter (HMSO Mental Health Enquiry, 1986).

- The number of admissions to hospital and patient "throughput" have increased. In 1982 there were 183,593 admissions to hospital compared with 192,000in 1992 (DH, 1994a). The number of daily "mental illness" beds were 84 per thousand population in 1982 compared with 47 in 1993 (DH, 1994a). Differences in patient activity and throughput has also been noted between the old asylums and general-based provision. Patients are discharged more slowly from Districts with a large mental hospital and a greater proportion of patients are still resident one year after admission (Glover et al., 1990). In Britain in 1992, 133,410 psychiatric patients left hospital after less than a month – representing 63.2 per cent of all patients leaving hospital that year. The increase in the number of short-stay admissions has led to the notion of 'revolving door' patients, who are admitted for a short period and then discharged only to be readmitted a short time later (Pilgrim and Rogers, 1996, p.31).

During the same period there has been only a modest increase in hospital outpatient activity.

- In 1982, 188,000 "new patients" were seen on an out-patient basis compared with 238[000] in the years 1992-3 (DH, 1994a). However, it interesting to note that over the same period the number of attendances increased only marginally, suggesting that contact for each patient is currently *lower* than a decade ago (Pilgrim and Rogers, 1996, p.31).

It is not an accident that the three countries whose cities come closest to a comprehensive community psychiatric service in relation to the seriously mentally disordered are Italy, the USA and Australia. These three spend more that 8% of the GDP (Gross National Product) on health and they spend more on health per capita than Britain. The edited monograph by Goldberg and Thornicroft (1998) shows how real are the differences in level of service that is provided between countries that spend 6% and 8% of GDP. Britain spends 6%. The following graph from their edited book provides a crude comparison of the amount spent on health by 10 different countries.
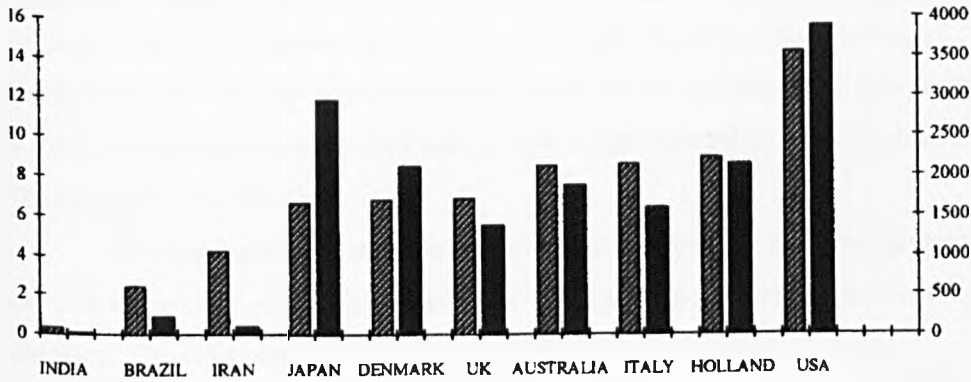
Percentage of gross domestic product spent on health, with countries arranged in rank order with the lowest to the left, and the highest to the right. The black histograms show the value of the health spend, per head of population, in US dollars (Goldberg and Thornicroft, 1998). Table/Graph 5.

Another graph from the collection provides an international comparison of the provision of psychiatric beds. Beds are of particular interest because the extent to which the old mental hospitals have been replaced is a powerful determinant of the total mental health funding available for work in the community. This is something many governments are currently discovering.
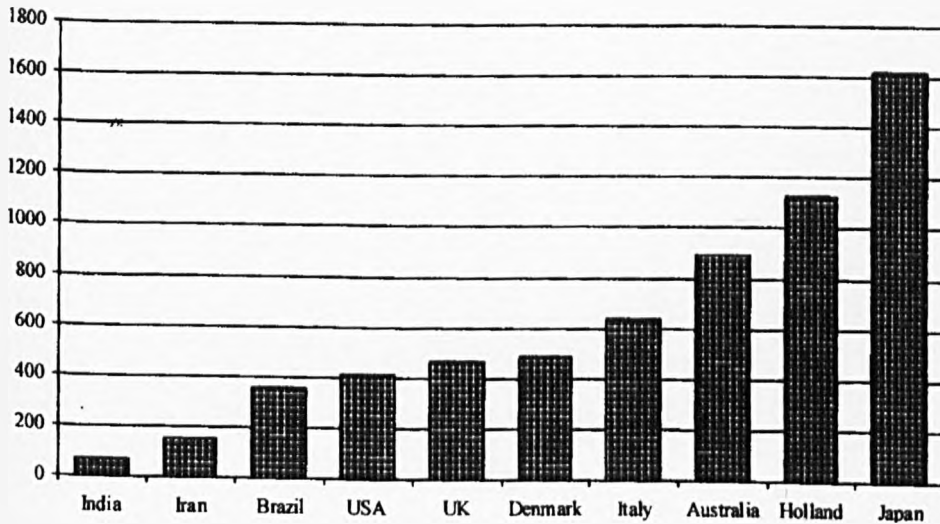
Total hospital beds per 100,000 at risk: 10 countries in ascending rank order (Goldberg and Thornicroft, 1998). Table/Graph 6.

This all tends to demonstrate that art therapists, and indeed other mental health disciplines working in the in the public sector, are well advised to be mindful of the prevailing social economic conditions in estimating the possibilities for treatment.

Conclusion

The estrangement between the philosophical practice of psychiatry and that of psychoanalysis has its roots in this history. The estrangement has endured throughout the twentieth century. With Doerner, I consider that the harsh political and economic realities

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faced by psychiatry make an analysis of its practice complex (page 14 above). Doerner contrasts this to the apparent interest of sociologists concerning the position of psychoanalysis. He suggests that the range of difficulties psychiatry is charged with by society tends to mean that justification of its practice is based on individual cases or upon the needs of administration.

I have indicated some of the central themes underlying the estrangement in relation to psychosis as being concerned with poverty, moral management and mind-body dualism. The emergence of the moral treatment method is shown to be the consequence of particular social and economic conditions at the beginning of the nineteenth century. Its demise some fifty to sixty years later is a result not of its lack of benefit, but because of the massive social, economic upheaval brought about by the industrial revolution. A similar example is that of the post Second World War social psychiatry movement. Developments in theory and practice are less often linked to a rational meritocracy of ideas and more often linked to political economic circumstances of a historical period. This last idea is one I examine in the next chapter in relation to three periods of art therapy history.

Art, Psychotherapy and Psychosis: The Nature and the Politics of Art Therapy

Section Two: Situating Theory and Practice

Chapter Two:

Three Periods in the History of Art Therapy and Psychosis (1938-1999):

> Both the concept and management of psychosis appear to have been influenced by political and economic factors. Ideology and practice in psychiatry, to a significant extent are at the mercy of material conditions (Warner, 1985, p. 127).

The period of post war economic recovery and the boom times of the late 1960s and early 1970s coincided with real strides forward in psychiatric practice. The difficult economic climate of the late 1980s and early 1990s coincided with what were reactionary backward moves in psychiatric practice. It has been widely reported by psychiatric staff and recorded in some of the literature that cuts in resources during this period led to a greater reliance on physical treatments, often because there were fewer staff to talk with patients (e.g., Jackson and Williams, 1994; Pilgrim and Rogers, 1996). The tenets of community care, which include visionary aspects and could lead to inspired development, were not in this economic climate able to achieve much that resembles either community or care.

Unusual amongst those professionals offering forms of psychotherapy, art therapists have attempted to create the circumstances for their practice within public sector services. They have a consistent history since the end of the Second World War of offering therapy to people who experience psychotic episodes. The history of art therapy and psychosis is not well documented, but it is possible to see what has been recorded in order to think about and plan for development in the future. This chapter will describe aspects of the theory, practice and technique developed by art therapists for this particular client group during three periods of the profession's history. It will also begin to briefly consider possibilities for the future against a background of Community Care legislation in Britain.

An overview of the period that sees the gradual move towards work in the community (1938-1995)

Given the history of the art therapy profession, it could have a part to play in developing and providing future services for people with a history of psychosis. I view the recent history of art therapy in Britain as having three main periods of development. I consider these periods to be firstly the time between the late 1930s and the end of the 1950s when the first ideas about using art as a therapy in hospital settings began to emerge. Secondly, the period between the early 1960s and the late 1970s when in the wake of the creation of British Association of Art Therapists many art therapists found themselves allied to the anti-psychiatry movement and to humanistic schools of therapeutic thought. Finally, the third period which had its beginnings in the early 1980s and continues throughout the 1990s, is a period when art therapists have lived through many changes in public sector legislation, the

increasing professionalisation of their work and a more obvious linking of it to models from psychoanalysis, psychotherapy and group process.

My understanding of the profession's history has been greatly helped by the historical analysis made by Diane Waller (1991). Although there are many areas of overlap, essentially the clinical practice of the three historical periods can be seen in the first as upholding the power of expression, as taking an anti-psychiatric stance in the second and as strengthening a psychotherapeutic base in the third. However, where clients have a history of psychosis it is sometimes particularly difficult to find evidence of just how the therapist behaves.

It is interesting to consider that the development of psychotherapeutic work in public sector services in Britain coincided with the more modest developments of art therapy from the time just before the Second World War. Both psychotherapy and art therapy were employed in the movements to rehabilitate people (mainly armed service personnel) traumatised by war.

A number of historical accounts of the modern history of psychiatry describe the decade after the Second World War as being a crucible for the production of many powerful new ideas for psychiatric practice. The economic confidence of the period provided the firm foundations upon which new practice could be based. Equally powerful impulses in the world of art were felt at this time, in the push towards Expressionism and in the Surrealist and Dada movements.

The trauma and stress of war had a wide reaching impact for most people, and psychiatrists in post war Britain and Europe were necessarily affected. Two World Wars and the Great Depression had provided the economic need to find immediate understanding of the nature and treatment of mental distress. A number of rehabilitative initiatives that had prophetic power were developed as a result of this wartime experience, not least of these were the initiatives, 'to site psychiatric care in the community, at least in general hospitals, providing outpatient facilities' (Newton, 1988, p. 11). With hindsight, Warner's comparison (1985, p. 109) of the moral treatment in the nineteenth century and the open door policies of this period in the twentieth century shows that both of these optimistic reform movements enabled the development of mental health policies that later led to stagnation.

The actual process of de-institutionalisation and its origins are extremely interesting. The 'open door' policies in mental hospitals and community care strategies followed the advent and use of neuroleptic medication for the treatment of psychotic disorders. However, a number of historical accounts of psychiatry do intimate that numbers of patients in the large mental hospitals began declining before the advent and use of neuroleptic medication. Richard Warner (1985) makes a coherent analysis (with adequate statistical support) of the

cluster of factors that may have influenced this decline in the asylum population. It is not historically accurate to suggest that the decline is due to the advent of psychotropic medication. In making this argument, Warner convincingly demonstrates the need for much more careful consideration of community care strategies.

He points to the difference between studies of mental hospital population decline made in Northern Europe and those made in America. He points to work in Norway by Örnulv Ödegard (1964) who studied the figures for patients first admitted to all Norwegian psychiatric hospitals before and after the introduction of the anti-psychotic medication. Ödegard found a small increase in discharge rates during 1955 -1959 compared with those admitted during 1948-1952, prior to the use of drugs. But, he found a much bigger increase in the discharge rate when he compared the 1948-1952 group with patients admitted in the late 1930's. Warner also points to similar patterns observed in Britain at Bexley Hospital in Kent; and to findings by Michael Shepherd and colleagues after studying discharge rates at St John's Hospital, Buckinghamshire. There was no significant change because of the introduction of the drugs. Warner also records that similar findings were recorded at Mapperly Hospital in Nottingham.

The evidence in the United States however suggests that the steady decline in the psychiatric hospital population did coincide with the introduction of neuroleptic medication. However, even in America, the famous study made by Henry Brill and Robert Patton could not lay claim to conclusive evidence. They concluded that 'the abrupt population fall was in nature and degree due to the introduction of the new drugs', because 'no other explanation could be found' (Brill and Patton, 1959, 116, pp. 495-509).

The differences between psychiatric provision in America and those in Britain were quite marked. In 1958 when the new drug treatments were firmly established, St Lawrence Hospital in New York became fully 'open door'. However as early as 1946 in Britain a small but influential number of psychiatrists were involved in trying to develop different patterns of institutional life through the establishment of therapeutic communities and the use of psychotherapeutic groups. A small number of art therapists were involved with these early therapeutic communities. Initially the ideas of the therapeutic community were not applied to work with people with a history of psychosis, the elderly or to people with long term problems, but the new ways of working did have an influence on institutional practice and the general climate of treatment. The different standards of care and attention in Britain and America directly influenced the way community provision is viewed.

> Antipsychotic drugs, then appear to be more effective for the psychotic patient who is living in an inadequate setting and to be less valuable where the environment is designed for his or her well-being (Warner, 1985, p. 86).

This is a claim worth considering very seriously because of the implication that the elements of care and respect in this particular work are centrally important (Wood, 1992). The elements of care and respect are important in humanitarian terms and in terms of the outcome of the therapy; as already indicated the results for moral treatment were good. Outcome can be a cluster of effects that include the rehabilitative influence on the client's life, staff morale and the effects of both of these on the general level of therapeutic hopefulness.

Art therapists have been unusually hopeful both because they make efforts to offer psychotherapy to people with a history of psychosis and because they attempt to create the circumstances for this work within public sector services. The attempt by art therapists to maintain this work in the public sector is not exclusive, though it is long lived.

The gradual introduction and development of therapeutic community ideas did not at first encompass work with people with a history of psychosis. Similarly, the psychotherapeutic group work developed by Wilfred Bion at Northfield Hospital in 1942 was not aimed at people in the midst of psychosis. In general, the army did not appreciate his methods. However, his influential work has enabled strands of psychotherapeutic understanding to be woven into public sector services. Foulkes succeeded Bion at Northfield, and he worked there with Harold Bridger, Joshua Bierer and Tom Main. They have all become very well known in the history of innovative psychiatry and the use of group psychotherapy. Diane Waller's (1993) comment about their work is telling, 'They too make use of group psychotherapy but took care to integrate their approach into the overall treatment philosophy and hence were able to stay on with much success (Waller, 1993, p. 5).

The question of how to integrate a therapeutic approach into the overall treatment philosophy must necessarily tax the mind of anyone working in public sector services. This is particularly complex when working with a group of clients whose needs are potentially so widespread as those with a history of psychosis. For art therapists this has been a thorny question throughout the history of the profession. During the period 1991-95, art therapists, in common with others working in the public sector, found themselves facing an extraordinary lengthy bout of service reorganisations. The policy changes that until recently had the aim of taking the main point of contact with clients into the community had an impact that as yet is only partly understood. However, policy statements at the end of the 1990s (*Framework for Mental Health*, September, 1999) suggest that yet further changes will occur and that there will be a return to mixed provision for clients with serious mental disorders.

In the period shortly after the Second World War, the development of therapeutic communities and their particular philosophy of care anticipated the later development of some aspects of community care. Within the framework of the therapeutic community, staff and

patients worked together to establish a community environment in which the traditional methods of the institution and its power relations were challenged. Patients were encouraged to take and share responsibility for the therapeutic work of the community. Staff and patient roles were blurred and open honest communication was encouraged. As already stated, this form of community was not, in the first decade, directed towards work with people with a history of psychosis. Initially Maxwell Jones and Tom Main worked with people described as having personality disorders. At the Henderson, a Therapeutic Community in South London, Jones worked with many people who had experienced long term unemployment. Peter Cole, an art therapist based at the Henderson, described in an early edition of *Inscape* (1976) the gradual inclusion and acceptance of art therapy within the therapeutic community. Cole's account confirms quite clearly that ideas about the range of clients amenable to psychotherapeutic work was widening within certain sectors of the public services. Throughout the 1960s and 1970s, these ideas were introduced into many psychiatric wards in the N.H.S. and were used in the attempt to help a whole range of patients hitherto not involved in psychotherapeutic approaches. This included people with a history of psychosis and even those in the midst of a psychosis.

In some hospitals in Britain, the ideas were introduced with much more conviction than in others. A number of hospitals gained a reputation for their innovatory work in the use of the therapeutic community, for example, Littlemore in Oxford, Fulbourn in Cambridge, Dingleton in Scotland. Dr Ben Pomryn who had worked with Maxwell Jones at the Henderson set up therapeutic community wards for the elderly, for brain-damaged patients and for adult psychiatric patients at Littlemore Hospital during the sixties. I include mention of his work to show how wide the net of the criteria of suitability for psychotherapeutic work had become in some sectors of the N.H.S.

The therapeutic community movement coincided with relative economic prosperity. I agree with Warner that the explanation for the sharp twists and turns in the treatment philosophy of the public sector are fundamentally influenced by the political and economic circumstances of the day.

The mid 1990s were a difficult period in which to work in psychiatry. Nevertheless, many psychiatric workers in all disciplines struggled bravely to generate ways of working that have meaning and value. However, the tensions inherent in the attempt are evident in what Peter Barham wrote in 1992, first quoting S. Shah and later the Seebohm Report:

Community Care in Britain at the present time, it has been recently said, is "an unknown quantity with an unknown distribution around the country". Depending on the good or bad fortune of his location, "a young man with severely disabling schizophrenia might block an acute psychiatric bed for a year, enter a slow-stream rehabilitation ward, move

to a hostel in the centre of town, return to his parents' home, stay in bed and breakfast accommodation or sleep in a cardboard box". As has been widely remarked, the hopes that have been entertained for resettling the disadvantaged into integrated communities in which they will benefit from a "network of reciprocal social relationships" have paid scant regard to the realities of late twentieth century Britain (Barham, 1992, p. 104).

I find it interesting that the range of interest described by Barham's first two publications *Schizophrenia and Human Value* (1984) and *Closing the Asylums* (1992) moves from the careful consideration of the details of therapeutic work in his first book, to a shrewd analysis of the political realities of mental health legislation in the second book. In public sector settings, people working therapeutically need to give attention to the intimacies of their therapeutic relationships and at the same time have an understanding of the political and economic circumstances of the work. Art therapists (because of most of their work is in the public sector) have had to develop a similarly oscillating consciousness.

It is interesting to follow the development of the different forms, into which art therapy has crystallised for work with people with a history of psychosis. It is perhaps in work with these clients that the tension between the inner process and the outer political world is most striking. People in the midst of psychosis (or with a history) find it difficult to defend themselves in the face of difficult social and economic circumstances and a great deal of institutional change. Similarly, it is becoming increasingly difficult for therapists and people in other disciplines to offer therapeutic work, which provides a container for the most disturbed clients, because in the midst of so much organisational change few staff feels themselves to be contained by their respective institutions. Consequently, a combination of pragmatic survival tactics and the desperate need of clients, mean that it is advisable to take an interest in the political circumstances of the work, at least at the level of policy and legislation. Perhaps this is particularly relevant to small professions such as art therapy, but it is relevant to all.

In relation to the legislation in the last twenty years, the White Paper, *Care for People*: in *Community Care the Next Decade and Beyond* (1989) and *Working for Patients* (1989) both built on the Griffiths Report (1983) and prefigured *The National Health Service and Community Care Act* (1990). That act asserted that the promotion of choice and independence were underneath all the Government's proposals and that services should be the responsive. Services were to allow a range of choices for consumers and provide services that intervene no more than is necessary in order to foster independence. It is not hard to detect the laissez-faire philosophy of conservatism here. However, even at this stage the particularities of how all this legislation and recommendations will affect mental health work practice are complex and difficult to estimate.

Scull (1977) along with Warner (1985) and others reject explanations that propose that the effectiveness of psychotropic drugs is central to the shift towards the community. To Scull the motives for change are more negative; he uses the phrase 'decarceration' as a shorthand to describe a state sponsored policy of closing down the institutions which had enabled the earlier policies of segregation and control. He sees the State as moving towards a more laissez-faire position as a direct result of the increased costs of segregation and the fiscal crisis of the State. He warns of the dangers of hiding a lack of provision for the mentally ill under the apparently humane mask of community care. Joan Busfield (1986) (citing Sedgewick as support) suggests that the analysis by Scull actually misses a very significant shift in mental health care practice that requires more than an economic explanation. She asserts that the move towards community care has been associated with a significant reorientation of the attention of the mental health services. This reorientation has seen resources being allocated to services for acute mental disorders and not into services for chronic long-term mental illness. Community Services for the former group of clients have been enlarged during the post war period, whereas services for the people with long-term mental illnesses have not. Resources for these latter services have always been meagre. It now seems highly probable (DOH, 1999) that some attempt to influence this distribution of resources will be made. Therapeutic work may be reserved for people with enduring mental health problems. This may have the effect that the largest group of potential clients (those who do not have a history of psychosis) are increasingly to be encouraged euphemistically towards 'independent' living.

The art therapist Joan Woddis (1992) has suggested that white papers like *The Griffiths Report* have done little to clarify the situation in practice.

> The notion of day units, possibly conducted on therapeutic community lines for the use of both acute and long-stay patients, remains largely a matter of precept not practice... and the issue of the difference in approaches between practice in the community and hospital settings remains a crucial factor (Woddis, 1992, p. 32).

These are the powerful issues of modern history for all disciplines working in the field of mental health, but what follows is a result of my looking specifically through the literature written by previous generations of art therapists. Although this literature is well worth exploring, it is generally not very specific about the theory, practice and techniques of work being used. Using the writings of previous generations of art therapists, I have tried to glean the implication of what was done for people with a history of psychosis.

The first period, the time between the late 1930s and the end of the 1950s

Possibly the impulse for much psychotherapeutic work with people with a history of psychosis comes from the wish to understand more in order to be helpful. Tracing the origins

for this particular work in the world of art therapy is not straightforward. It is very clear that Adrian Hill, a much-heralded pioneer in Britain, did not encounter people with a history of psychosis. An image from his book *Art Versus Illness* (1945) implies something about the psychological innocence of his approach *(see figure four)*.

His work developed from an art education approach, to one that gradually became more psychologically minded. The same might also be said of Arthur Segal, in his wish to forge links between medics and artists something for which, Waller (1991) records, Freud commended him.

In the art world since the end of the nineteenth century, there had been steadily more concern with the outreaches of human experience. Klinger's etching *The Plague* (1903) *(see figure five)* graphically portrays the frightening dreamlike preoccupations of the turn of the century. Then two world wars compound what seems to have been a general sense that an innocent understanding of the surface of human experience is not enough. It was into this reeling world that what has become known as art therapy emerged in Europe. Gradually it became apparent that the art work made by people in the midst of psychosis often resonated with a more general need to understand those matters which lie below the surface.

Some of the art therapists working during the first period, between the late 1930's and the end of the 1950's clearly did work with people in the midst of psychosis. There is evidence in their writings that both Edward Adamson (1984) and E. M. Lyddiatt (1972) did such work. I personally began work as an art therapist at Netherne Hospital in Surrey in the late 1970s. Netherne Hospital had been the psychiatric hospital in which one of these pioneer art therapists Edward Adamson had worked for many years after the Second World War. I was very interested to meet at Netherne some of the long-term patients who remembered 'Mr Adamson'. The studio and the gallery he had established were still in existence. The studio was a long, white wooden building with windows on three sides. The equipment for each person included an easel, a white wooden chair and a white wooden frame with two shelves for art materials; each person was able to have a small self-contained area in which to work. It was possible given the size of the room to work in a way that did not feel overlooked *(see figure thirty nine in chapter eight)*. I was interested to discover from Waller's book (1991) that Edward Adamson was involved in work when he was first at Netherne in 1946, which was part of a controlled study by the two psychiatrists Dax and Reitman. The study was concerned with the effects of leucotomy. Adamson was given a clear brief by the medical staff: 'He was not to attempt to "interpret" pictures, nor to show any interest in the patient's life history or psychological problems in case he may have influenced the work produced' (Waller, 1991, p. 54).

figure four
'Continuing his painting, the patient after many months in bed is promoted to "tea in a chair", and finds a new subject for his pencil and brush in the wider view now obtained from his window' (Hill, 1945, p. ix).

figure five
Max Klinger 'The Plague' 1903

In my conversations with some of the people who remembered working with Adamson all of them mentioned the quietness of the studio and Edward Adamson's equally quiet presence. They also remembered the respect with which they felt themselves to be treated by him. It may be that partly as a result of the medical brief he was given and partly because of his personality Adamson was able to provide powerfully receptive containment for many of the patients who worked with him. His way of inviting people to do some painting was very simple; he would sit down next to them and ask them if they would like to do some painting. One artist, Rolanda Polansky, was still living as a patient at Netherne when I was working there between 1978 and 1981. By her account she had been very disturbed when she first met Adamson. She spoke movingly to me of his having really understood her needs. Of her he writes:

> During this time, she worked intermittently in the studio. When she was very ill, she was unable to produce anything, but as her spirit slowly gathered strength, her creative ability was renewed and she succeeded in composing some exceptional works... Her work transcends natural self-pity, to portray elements of universal suffering (Adamson, 1984:53), *(see figures six).*

Whereas Rolanda Polansky (who has achieved a degree of public recognition which is the reason I can offer her name) was unable to produce artwork while she was very disturbed, Adamson encountered other people who apparently had the impulse to make artwork throughout even very difficult periods. One man presented him with a picture entitled *Graffiti on Lavatory Paper*:

> These drawings were presented to me by a very ill man who had been on a locked ward in the hospital for years. He was incontinent and unable to speak clearly. He had drawn vigorously on the only paper he could find. The top strip is filled with strange shapes and words which had a special meaning for him. The second strip depicts a lion and its mate, which he loved to draw repeatedly when he later came to the studio... (Adamson, 1984, p. 9).

Of the work in general Adamson writes:

> The hospital residents who came to the studio were accorded the dignity of helping to cure themselves. The very fact that they came to the studio each day placed a responsibility on their shoulders, rather than allowing them to become the passive recipients of authoritarian care. We were all working very much in the dark in those early days. I must confess that within a few weeks of starting my new job, I was in two minds whether I would have sufficient courage to continue. On looking back I realise that I stayed mainly in response to the overwhelming need of those who queued up everyday outside the studio, eager to begin (Adamson, 1984, p. 2).

The comments about working in the dark and having the courage to continue must be recognised by all therapists when they are trying to contend with the sorts of feelings evoked by working with psychotic processes. However, it does seem that Adamson's methods were
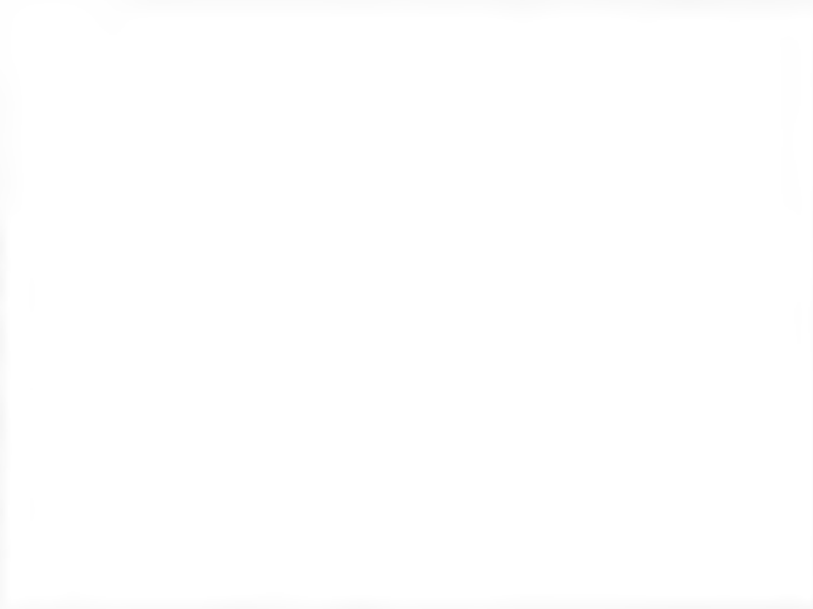
figures six
'Dejection' Rolanda Polansky

figures six

' *'The Stations of the Cross' Rolanda Polansky*

broadly similar with all of his clients. There seems to be very little mention of special or different work with people with psychotic disorders:

> When a person comes to the studio, I never suggest what he should draw; it is essential that the idea should be entirely his own. This particular approach demands a considerable amount of patience, sometimes it is often weeks, months, or even years, that we are both obliged to wait for someone's creativity. All I can do is try and create a permissive atmosphere and have the necessary paint and paper on hand. If the person is prepared to come and spend the time with me, then I must be prepared to join in the vigil (Adamson, 1984, p. 7).

Occasionally there is an indication of how disturbed some of his patients must have been, but little to distinguish what he did with them, from what he did with less disturbed people. I glimpse something of his steady work of therapeutic containment in occasional sentences here and there, for example, 'Rich veins of surrealism are discovered in the studio. When, sometimes they are fearful and persecuting, painting ventilates them within the safety of the studio' (Adamson, 1984, p. 6).

It would have been very interesting to know whether the people involved in the group murals that Adamson describes had a history of psychosis. From what he says of them it suggests they might have, 'Many of them had regressed and would not communicate, or if they did, it was in a private language, unintelligible to me ' (Adamson, 1984, p. 44). He goes on to describe how over a period of eight hours this same group of twelve people went on to paint an: 'unusually integrated picture of a fishing scene'. I myself have seen groups of very disturbed people get involved with group pictures. The ways in which they are able to co-operate and plan the work is impressive.

He also established small individual studios for particular patients (some famous, some not) in the round summerhouses dotted around the grounds of Netherne or in small cupboard-like rooms off its large main corridors. The physical effort involved in helping Rolanda Polansky to cast her large clay made sculptures in plaster-of-paris (*figures six*) suggests that the quality of Adamson's involvement was not as passive as some of his writing might imply. He was no mere pawn in the outcome of controlled experiments. He was very much engaged with people who had serious disorders.

Martina Thomson (1989) gives a very moving account of her apprenticeship to the art therapist E.M. Lyddiatt. The account made me seek out Lyddiatt's book *Spontaneous Painting and Modelling* (1972). I was impressed to find in her introduction the following assertion.

> Diagnosis and other medical procedures are not the concern of an art department. A person may be suffering from a disease that is labelled schizophrenia, but he remains a human being - his mind still works as do other minds, although certain notions may have

become exaggerated. In essence he is unaltered and frequently he can be restored to health (Lyddiatt, 1972, p. 5-6).

Repeatedly I find evidence in the early writings of art therapists of the insistence on being with people, no matter how disturbed in as ordinary a way as possible. John MacGregor (1989) suggests that there is something about the artwork and the writings of real men and women offered partly in the attempt to explain their condition, which does invoke respect. Respectfulness seems implicit in much of what is written, and given the damage that people feel as a result of stigma, respectfulness can be a real balm and a very good place to begin for a therapist. I have come across many people working in the psychiatric services who understand this. The understanding often seems to have less to do with their professional training than with what comes from themselves. I also think that the lineage of the moral treatment philosophy is strong and that this has an influence in a wide range of psychiatric practice.

In the introduction to Lyddiatt's book the Jungian E. A. Bennett writes:

Although the range of Miss Lyddiatt's experience has been wide, her methods remain much the same with all who use the art room. That they are patients is forgotten; they work in an informal group. Yet by the nature of the treatment they must do so as individuals. Some prefer to paint unobserved, and there is nothing against this (Bennett in Lyddiatt, 1972, p. xiv).

Thomson (1989) describes the chaotic, rich muddle found in Lyddiatt's art rooms. This is in sharp contrast to the cool order of Adamson's rooms. References that Lyddiatt makes to the studios in which she worked throughout her book suggest a very homely rambling collection of small rooms full of art work in progress. Thomson remembers Lyddiatt saying with a smile: 'my house is a mess but my dreams are in order' and suggests that this was somehow expressive of her approach to art therapy. Lyddiatt writes:

Even if it is an over-simplification it may sometimes be a useful plan to describe spontaneous painting in three stages: firstly, imaginative material is given form; secondly, it "works back" on the maker and is experienced; and thirdly, one feels more alive. Often these stages blend (Lyddiatt, 1972, p. 6).

Later in the book she describe how she considers that understanding the content of pictures that are made is a problem that is 'exceedingly complex'. She does not see intellectual understanding as being the key; she quotes Jung: 'the important thing is not to interpret and understand fantasies but primarily to experience them' (Jung quoted in Lydiatt 1953). This does resonate with my own experience when clients have presented me with images and ideas I have found difficult to understand. Lyddiatt's book gives the impression of clear beliefs and a certain confidence about her work. However, in some of the examples of work with particular individuals it seems that her confidence is not altogether sustained in

the face of some of her more disturbed clients. What is refreshing is her honesty and humour about her doubts:

> He was deeply involved in the idea of the journey from hell to heaven. I believe he wanted me to take the part of the Holy Virgin Mary and to act with him, but, afraid, I pleaded that I was busy. Then, quiet and meditative, he asked to work in the side room which was full of odds and ends, wooden boxes, rope, a table and chairs - and these he deliberately re-arranged about the room.
>
> After a period of silence he declared, "Now I am ready for you", and then insisted on a further silence before he led me round the room, climbing, jumping, scrambling on the pilgrimage from hell to heaven. The Communion was half-way; subsequently he fell to the floor from a "hill" back to the first corner, where he said, "Now we do it again and that will be on a higher level". At each change of direction he genuflected, and at the climax walked backwards. Seeing the reflection of sunlight on lavatory windows of the distant hospital building, this was shown to me as "holiness", and I was told, "You must start and assimilate the lowest".
>
> At one point he gripped my shoulders fiercely and declared that I was the victim, and I stupidly produced orange juice to drink in the hope of providing a diversion. This, however, became part of the play—and holding up the glass to see the light through it, he told me,
>
> "When you see the spirit you must hold it fast - then it swings and moves".
>
> Later that same morning he painted his "holy" picture; it was of the pilgrimage. In it, dragons and animals, as well as men, make this journey which is finally accomplished when man is carried to Christ by an animal from a mountain-top high on the right side. The figure of Christ, "He Himself", is portrayed in pencil in a dull yellow circle in the top left corner.
>
> Incidents of the moment were made one with this picture - a fly flying out of the window was going to Christ, and dust, and paint happening to drip - all were incorporated in the experience and all were real.
>
> The picture has a strange quality which bewilders and fascinates me. At first sight it appears confused and messy - yet this man knew exactly what each fragment was intended to be. Looking at the picture one finds more and more. The colour is mainly Indian red and dark grey. A dull green hill is at the bottom left and a grey-blue building with tiny people higher up. To achieve this, I imagine paint was put on and then the pictures he saw in the accidentals were established by drawing in pencil on top of the paint. There is much detail that cannot be understood without explanation and I have often regretted that I did not spend more time with the painter that day.
>
> A member of the staff from whom I asked advice, wondering what the afternoon would bring, shocked me by declaring that the patient was "playing up"; but I have since reproached myself that I let him down through my fear and lack of understanding (Lyddiatt, 1972, p. 63-64).

A number of the people with whom she worked had had leucotomies. Lyddiatt writes of how the sensitivity of their image making deteriorates after these operations. In reading these descriptions it becomes clear how hard it must have been at that time, in such a context, to maintain some sense of clarity and confidence about work with people with a history of psychosis. Yet it does seem that her basic approach of treating people with respect and of

trying not to evade the 'ever-present phenomenon' of the unconscious in everyone are the cornerstones of a method of work which, if it can be adhered to, has much relevance for practice today.

Some of the underlying Jungian inspiration for Lyddiatt's work does resonate with what was developed at Withymead. This was a therapeutic community in Devon that made the use of art into a fundamental part of its therapeutic work. It was established, by Gilbert and Irene Champernowne towards the end of the Second World War. Irene Champernowne had been analysed by both C G Jung and Toni Wolff in Zurich. Her vision and energy provided the original inspiration for the community. Anthony Stevens (1986) gives an account of Withymead that might have been written in the 1940s. The community does appear to have been a remarkable place in its attempts to run along democratic lines. There was a prodigious amount of contact between the clients and the staff (particularly the Champernownes). It provided many studios and access to different forms of art and music. People with a history of psychosis certainly did stay at Withymead although the majority of the community members did not have such a history. However, Champernowne did herself acknowledge that the community did not work easily in the service of some if its more disturbed members. Stevens writes: 'Irene's rather condescending attitude to the use of drugs may seem naive...unlike many Jungians, Irene was not against the use of drugs on principle', and ' Schizophrenics were clearly better off taking their Largactil at Withymead than in a conventional mental hospital ward' (Stevens, 1986, p. 49-50).

When she was giving a lecture in 1970 in Britain (published in 1971 in both America and Britain), Champernowne gave a more substantial glimpse of how she thought about the question of psychosis:

> It is true that in therapeutic practice many of the creative forms arise from the depths of the psyche - a place where the universal experience of all mankind also originates. This is true particularly of the psychotic patient whose ego has already been flooded with images and experiences; overwhelmed quite often by archetypal patterns, and thus deprived of the simple human ways of living and loving. Creative expression which is recognised and called Art is often the result. A psychotic patient may sometimes paint out a very great deal of his archetypal involvement through his paintings or even crystallise out and freeze some of the unacceptable elements in his psyche in aggression or perversions in art form. But my experience of many series of paintings of this archetypal nature often displayed in exhibitions is that they have had little effect upon the individual painter's total way of living. The creator is often unable to observe and learn from what the unconscious has expressed. The ego is already too drowned in the unconscious experiences itself to be illuminated by that which has been created. In any case it is such a highly skilled job deciphering the mysterious messages of these statements that it is rare for the painter already swallowed up by the flood of images to come through to a conscious grasp of his own creation, though people like C G Jung and Godwin Baynes and others have struggled and in many cases wonderfully succeeded in effecting healing through their understanding of them (Champernowne, 1971).

Her comments seem dated now and perhaps a little patronising. It is worth noting that both Michael Edwards and Patsy Nowell-Hall were amongst those art therapists who developed the work of art therapy during the following second period. They were both prominent amongst the number of art therapists who lived and worked at Withymead during this early first period.

The second period between the early 1960s and the late 1970s

The period between the early 1960s and the late 1970s was not surprisingly, given the historical context, a time of many rich influences in the development of art therapy. The emerging humanistic schools of therapy were prevalent at the time, as were existential ideas and the anti-psychiatry movement. The influence of psychoanalysis became more publicly and popularly acknowledged. All of these developments informed ways in which art therapists felt able to work. During the first period between the late 1930s and the late 1950s, it has been suggested (Jones, 1987; Waller 1992) that the class origins of most pioneer art therapists were such that they could easily appeal to the sympathies, and thereby gain the patronage of, psychiatrists and medical superintendents. In the sixties the social origins of many art therapists were equally middle class but the tenor of the times were different. The first period had been characterised by a 'wholesome' approach to the plight of the mentally ill; with the 1960s came challenges to accepted ideas about what constituted madness.

Although the influences acting upon art therapists in this second period were rich ones it is still difficult to find substantial descriptions from that time of what art therapists actually did when working with people in the midst of a psychosis. Again, I feel the need to add that I think actual accounts of this work have not commonly been made by any profession in any period. However, it is possible to identify a cluster of attitudes to the work from what the writings of art therapists during this time implied. Also, I trained at the end of the seventies and so I think elements of my training embodied the main preoccupations of the period.

MacGregor (1989) suggests that a new sensibility towards the art of the insane developed during the first quarter of the twentieth century. MacGregor considers that the origins of this new sensibility, largely amongst a few cultured psychiatrists, are to be found in the development of philosophical, literary and aesthetic Romanticism. It is possible to trace aspects of this earlier Romanticism amongst some of the art therapists writing during the 1960s and 1970s. This is in keeping with more general characteristics of that time. Art therapy literature at that time regularly refers to the notion of a creative illness. Michael Edwards wrote: 'There were some uncomfortable paradoxes - one person's work was drawn

with extraordinary refinement and conviction at times when he was most ill, turning to pleasant but very ordinary little flower paintings in recovery' (Edwards, 1978, p. 12).

An idea related to that of the creative illness is that of the mad genius, it re-occurs at different points in the history of western culture and it provided a cultural image that in part suited the ethos of the sixties. This image might make the idea of a cure into something barbaric, or the idea of treatment as being beside the point. Concerns which seemed connected to these are seen in the discussion in the art therapy world at that time about whether or not the products of the insane were to be considered as art or not. Philosophically, in settings adjacent to art therapy practice, the questions are of interest, but they do seem to have been posed in a defensive way. This is perhaps not surprising given that the mainstream art world was at that time regularly dismissive of the concerns of art therapy. Possibly the defensiveness amongst art therapists of the period is comparable to defensiveness during the early days of the psychology profession when it was anxious to be considered as a serious science in relation to medicine.

Although not publishing his PhD thesis until nearly a decade later MacGregor was almost certainly writing during this time, in the late 1970s. He would have us resolve the issue by defining the 'art of the insane' as only consisting of those rare works, worked on during lifetimes of incarceration by artists such as Wolfli, Aloise and Emile Nolde. MacGregor would no longer include all works by 'madmen' in the category 'the art of the insane'. He describes the ultimate conclusion of his position as being a moral obligation upon physicians to anticipate the rare emergence of a 'schizophrenic master'. These physicians should then, 'attempt to create an environment in which creativity and independent growth exists, whatever form it may take' (MacGregor, 1989, p. 103).

MacGregor clearly considers that the production of art by severely mentally ill will soon cease almost entirely. He saw the conditions for the creation of such art as prolonged hospitalisation, prolonged psychosis (i.e., before the use of medication) and the absence of therapy. Although MacGregor's writing is replete and scholarly, his focus of attention and actual conclusions do seem perversely romantic. It is the myopic tenets of such romanticism that led to the tragic and cruel incarceration of the poet John Clare between 1837 and the end of his life in 1864 (see Porter, 1987, p. 76-81).

In the Catalogue *The Inner Eye* for the exhibition held in Oxford in 1978, of art made in psychiatric hospitals and clinics, the art therapists Peter Byrne, Michael Edwards, Diana Halliday and John Henzell wrote about some of the concerns of the art therapy world. Byrne, Edwards and Henzell address the issue of whether or not the work resulting from psychiatric patients is art or not. Edwards quotes Jung:

Although from time to time my patients produce artistically beautiful creations which might very well be shown in modern art exhibitions. I nevertheless treat them as wholly worthless according to the tests of serious art. It is essential that no such value be allowed them, for otherwise my patients might imagine themselves to be artists, and this would spoil the effects of the exercise. It is not a question of art – or rather it should not be a question of art – but of something more, something other than mere art, namely the living effect upon the patient himself (Jung, 1933).

Edwards writes about how his assumptions about art itself were severely shaken by his first visit to an art department in a psychiatric hospital in the 1950s. Byrne too grapples with how when aestheticians refuse 'the art of the insane' they provoke questions about the function of art in society and a potential critique of the art world and its values. The excitement which all four art therapists who wrote articles in the catalogue felt in relation to the art works on view in the exhibition and the aesthetic questions they provoked is evident and is entirely characteristic of the period. I suggest that it is this excitement about the art that enabled the art therapists of both the first and second periods to respond to their 'schizophrenic' patients with such sustained respect and interest. The influence of such genuine interest must have been for many patients a real relief from the effects of stigma.

The main indication of Byrne's approach to his work with his more disturbed clients seems implicitly to characterise the tenor of the second period when he writes, 'These are not images of illogical worlds, but their logic is obscure. In unravelling the meaning of these pictures, some of which seem only too obvious, others of which seem to defy analysis, we will certainly gain new insights into *man's* creative capacities' (Byrne, 1978, p. 11; my italics). The idea of unravelling the meaning of pictures made by people in the midst of psychosis in order to achieve some form of universal understanding does seem to be the quest of most periods. In the first period of British art therapy history this is characterised by benign interest and in the second by a sense of indignant solidarity.

The push for understanding grew large during the second period as a result of the work of R. D. Laing. His central proposal was that the communications of people in the midst of psychosis are meaningful, even though they might initially seem to be a nonsensical 'word salad'. He wrote prolifically throughout his life about the question of psychosis in a manner that provoked a strong, lasting and wide ranging impact (Wood, 1991).

Edwards writes about the private quality of much of the work on view in *The Inner Eye* exhibition (1978), suggesting it was made originally as part of a process of private contemplation. He names such art 'inner' art and describes three sets of circumstances in which such art might emerge. Firstly such work may be a spontaneous occurrence; secondly it may arise because of being invited to paint dreams and fantasies by a psychotherapist. Thirdly he suggests that inner work may develop out of 'a planned therapeutic environment

where art materials are freely available and an art therapist is providing encouragement, support or sympathetic non-interference' (Edwards 1978, p. 14). It is interesting to compare this idea of an 'inner' art with the earlier description made of Lyddiatt's 'spontaneous' art. Edwards' early training had been as a result of his living with his family at Withymead. Although his thoughts about the process of art therapy might be generally applied, they are not intended as particular precepts for work with people in the midst of psychosis.

The influence of Irene Champernowne must have been in the roots of his work, just as Jung was in the roots of hers. Edwards is at pains to point to an aspect of Champernowne's belief which might be central to work with any client but would be particularly sensitive in therapeutic work with someone in the midst of psychosis:

> Central to her thinking was the belief that "illness" was not to be projected onto the "patient", creating a "them" and "us" situation between patients and staff, but that any individual engaged in therapeutic work must be prepared to face up to and be conscious of his or her own "ill" or less integrated aspects — throughout life (Edwards, 1978, p. 18).

Perhaps Edwards comes closest to writing something about work with people in the midst of psychosis, when he describes the work of Adamson with this client group as being dependent on 'intuition and sensitivity, rather than on preconceived theoretical considerations' (Edwards, 1978, p. 17).

Halliday (1978) in her paper in *The Inner Eye* catalogue rather tantalisingly refers to some work with a twelve-year-old boy who had been deemed autistic. She describes his work as 'typical of many autistic children' in its repetitiveness. She says very little about the process involved, other than indicating that she felt the relationship was fundamentally reparative of early relationships, in the mirroring work she felt she was able to provide. This way of gliding over the process and technique of the work is characteristic of much art therapy writing of the period.

Henzell's paper (1978) in the same catalogue is a brief but interesting account of the ways in which he views the very human history of various attempts to understand the expressions of insanity. In trying to glean an impression of what this might have meant for his practice as an art therapist at the time, I am struck by a number of comments which imply a strong valuing of the actual process of image making. Of the Romanian refugee Arthur Segal, Henzell writes:

> Segal was a painter who, through his association with the Blaue Reiter group. had known Prinzhorn. He left Germany in 1936 and set up his school of painting in London where he taught artists as well as psychiatrists and their patients. He believed art possessed therapeutic properties; the laws of psychological functioning and art were linked and therefore a valid art experience, that is one in conformity with the laws of art, was highly integrative (Henzell, 1978, p. 32).

Waller (1992) records that framed on the wall of Segal's studio was a letter to him from Freud which warmly applauded the way in which Segal aimed to bring together doctors, patients and artists in the one studio (this seems to me to record a not often seen democratic side of Freud). The practical focus of the work of some art therapists during this period are seen in Henzell's comments about the distance between the focus of art therapy and those of the artists involved in Dubuffet's *Compagnie de l' Art Brut*:

> Leo Navratil has drawn attention to the creativity of schizophrenia while Arnulf Rainer and Ernst Fuchs have argued that, far from treating madness, we should consider it an ultimate form of sanity and set up institutes of insane culture where forms of psychotic expression could be encouraged (Henzell, 1978, p. 32).

Henzell also almost prophetically describes what he sees as an emerging 'transformation of psychoanalytic approaches to art and to aesthetics' through the work of Anna Freud and Melanie Klein. He highlights Anna Freud's ideas about creative activity providing a form of ego defence against potential psychotic upheaval.

Finally, he was able to summarise a particular tension with which the decade of the 1970s had begun, a tension that had been first expressed by Irene Champernowne (1971):

> Hence, the first art therapists were caught in the same dilemma that had faced analysts and psychotherapists in attempting to reach a *modus vivendi* with institutional psychiatry. As a result they tended to adopt one of two courses of action: they stressed the clinical side of their work, adapting current theory to this end, and here there is a connection between pragmatism and a certain theoretical conservatism; or they minimised their therapeutic responsibility and concentrated on the art ingredient of their practice so as not to conflict with their psychiatric patrons (Henzell, 1978, p. 33-34).

This tension still exists, however; it does depend on how it is expressed as to whether it is experienced as enlivening or deadening within the art therapy world. Certainly, work with people in psychotic states does require the therapist to have made some very urgent, if only temporary, synthesis of these polarities. One strong thread in my thesis suggests that the whole dilemma of the estrangement between psychoanalysis and psychiatry is easier to understand if viewed in its social and political context.

It is interesting that at the end of the century Greenwood (1997) follows from Henzell's prophetic comments about the development of ego defences through creative activity, with her paper 'Psychosis and the Maturing Ego'.

Towards the end of *The Inner Eye* catalogue, some twenty-one-art therapists who were practising (mainly in psychiatric hospitals) at that time give brief accounts of their approaches. It is interesting to find that none of the accounts makes any specific reference to work with people in the midst of psychosis. However again, it is possible to find written comments that seem to imply such work. Included in these twenty-one, Robin Holtom, the art therapist then at Springfield Hospital in London writes:

The art therapy department in a psychiatric hospital is often an asylum within an asylum. That is to say, it is a refuge from the depersonalising manoeuvres of a large institution and its agents. It also provides people with space to express inconvenient or unspeakable feelings. The relationship between an art therapist and the hospital that employs him is often abrasive. It can scarcely be otherwise since it often happens that people paint their best pictures when they are most "ill" and the pictures often get worse as a person gets 'better'. This paradox is central to art therapy (Holtom, 1978, p. 40).

My own training as an art therapist ended in 1978, and I think this account by Robin Holtom epitomises much that was prevalent in the ethos of my training. Holtom at this time introduced the phrase 'asylum within the asylum' in art therapy as a way of trying to indicate the treatment ethos of the period.

Art therapists (together with other workers in psychiatry) need access to ideas that help them understand and work within the prevailing climate of established psychiatry. During this second period, the works of Erving Goffman and those of R. D. Laing were centrally important in this respect. Goffman's work reversed the focus of attention from the concerns of staff in institutions to those of the patients or, as he put it other 'inmates'. This reversal was in keeping with the ethos of the 1960s. In his book *Asylums* (1961) he considers the assault on the person's sense of self upon admission to a mental hospital. He discusses what he sees as the institution's mortification processes acting upon patients and the possible responses they might make. This includes a sort of under life that can develop in large hospitals. In one sense, Laing's project was also concerned with how the structures of self are influenced by the social network of relationships in which a person lives. Laing himself did not confine his attention to the family, although the focus of his attention was concerned with intimate familial relationships and their influence upon a person's sense of security in the world. Goffman's project was more widely sociological.

The work of both Laing and Goffman still has relevance. At the end of the 1970s when I was training the effects of what they were proposing were potent; it often seemed that the response to their writing was as powerful as the content. Indeed sometimes, the response bore little relation to the content. My response, when I first began working in a psychiatric hospital, was to adopt a mental-set that caricatured and stereotyped all those people who had not been diagnosed as mad (i.e., the staff). It would have been easy to caricature my position as a pompous exaggeration of Laing's dictum to treat patients as people and not as things. I related to many staff as inanimate objects and reserved the status of people for patients. I discovered the craziness of my stance in relation to staff quickly and painfully, greatly helped by the good-natured banter of staff with whom I worked.

The art therapy practice of the period is sometimes attributed to being part of the profession's adolescence (Waller 1987). Yet an explanation with more explanatory power is

one that acknowledges the ferment that was characteristic of the period. There was a powerful sense of the need for change.

Every so often, there is a year which casts a spell on a generation. Afterwards simply to mention it brings innumerable images to the minds of many people who lived through it.

...1968 was a year in which revolt shook at least three major governments and produced a wave of hope among young people living under many others. It was the year peasant guerrillas of one of the world's smaller nations stood up to the mightiest power in human history. It was the year the black ghettos of the US rose in revolt to protest at the murder of the leader of non-violence, Martin Luther King. It was the year tear gas and billy clubs were used to make sure the US Democratic party convention would select a presidential candidate who had been rejected by voters in every primary, and Russian tanks rolled into Prague to displace a 'Communist' government that had made concessions to popular pressure. It was the year the Mexican government massacred more than a hundred demonstrators in order to ensure that the Olympic Games could take place under 'peaceful' conditions. It was the year protests against discrimination in Derry and Belfast lit the fuse on the sectarian powderkeg of Northern Ireland. It was, above all, the year that the biggest general strike ever paralysed France and caused its government to panic (Harman, 1988, p. vii).

It is hardly surprising that people from a wide spectrum were caught up in the atmosphere of the period. In Italy the psychiatrist Franco Basaglia began to argue for radical reform of the psychiatric system, culminating ten years later in the radical Law No. 180. In psychiatry in Britain, many were receptive to what Laing was writing about the plight of the 'schizophrenic' left alone on a back hospital ward in a world no one would share. Many art therapists (along with many in other professions) read Laing's work — particularly *The Divided Self* (1959) and *The Self and Others* (1961). It is remarkable therefore that although many art therapists did use the ideas, none at that time that I can discover wrote in any detail about how the ideas influenced their practice.

Laing wrote in his introduction to *The Divided Self*:

no attempt is made to present a comprehensive theory of schizophrenia. No attempt is made to explore constitutional and organic aspects. No attempt is made to describe my own relationship with these patients or my own method of therapy (Laing 1959, p. 9).

He did nevertheless describe his ideas about psychotic experiences that offer valuable insights. For example his description of the forms which can be assumed by psychotic despair ('engulfment', 'implosion' and 'petrification') have helped me move a little closer towards some of the people I have been working with.

The psychiatric establishment behaved as though Laing was proposing the non-existence of madness. I think this has been a very persistent misconception, which goes some way to explain the force of the reaction against him. Laing himself I think made only the modest claim that it is: 'far more possible than is generally supposed to understand people diagnosed as psychotic' (Laing 1959, p. 11).

The account given by Mary Barnes and Joseph Berke (1973) shows the very human lengths to which Laing, his followers and the clients were prepared to go in order to achieve this understanding. Of course, the way in which Barnes became a painter and her use of her art is interesting for art therapists. Berke, her main therapist, made few attempts to unravel the details of her art work, although he was clearly involved in encouraging Barnes to paint and in providing a continuing response to the work. It seems as though she did use her artwork, particularly her wallpaper picture stories to explore her own life story. Of painting she says:

> Paint I did. Gradually it seemed to me perfectly right again, to paint. Painting when I wasn't too 'bad' to do it, got me together, in my body and soul. All my insides came out through my hands and my eyes and all the colour (Barnes & Berke, 1973, p. 145).

Later when her engulfment of Kingsley Hall with her paintings created real conflict in the community, one angry resident took all of them down from the walls. Barnes writes:' Soon after the paintings had come down, I had a period of intense loneliness' (Barnes& Berke, 1973, p. 176).

The art therapy world at the end of the 1970s, myself included, took much sustenance from all of this. It seemed to confirm and deepen what art therapists had been proposing in the twenty years immediately after the War. We may not have understood all that was brought to us, but we could respect the people who shared their artwork with us and we could really pay attention to it and to them. The effects of this care and respect enabled many of the clients deemed psychotic to develop helpful relationships with art therapists, in the context of mainly public sector settings.

<u>The third period, beginning in the early 1980's and continuing through the mid-1990s</u>
During the second period of the profession's history, the effects of paying such careful attention to the patients themselves and to the nature of their artwork began to lead to a plethora of quite difficult questions. The emergence of another phase of development often contains much of what has gone before. This is true of the early stages of what I have called the third period, which begins in the early 1980s and continues to the present in the second half of the 1990s. Art Therapists have now begun to give a much clearer account of psychosis and of the particular styles of therapy that have developed out of work with clients experiencing it. The first two periods have left art therapists with a legacy of using the same careful approach to therapeutic work, an approach that does not single out any particular client group. Clients in the midst of psychosis are regularly offered art therapy. There is now a quest for a greater clarity of understanding for this particular client work. It was in 1960 that Enoch Powell made his famous water-tower speech sounding the death knell for the large Victorian asylums: 'brooded over by the gigantic water-tower and chimneys combined, rising

unmistakable and dauntingly out of the country side — the asylums which our forefathers built with such immense solidity' (Powell, 1961). Yet, at the beginning of the 1980s, not a single hospital had yet closed and it was not until the beginning of the 1990s that the commitment to closing the old asylums had been embraced by government policy. Nevertheless, throughout the 1980s art therapists were aware of the impending shift into the community (Wood, 1985).

It seems that this awareness of policy coupled with the effects of many years of work with clients with a history of psychosis has resulted in a shift in the approach of art therapists. This shift could be partly explained by the economic strictures of the 1980s and the 1990s: these tended to provoke the impulse to focus upon inner world processes. In addition, work in the public sector became increasingly difficult, and a number of art therapists responded by training in psychoanalysis and psychotherapy and moving towards private practice.

The series of questions asked by Terry Molloy in his article (1984) about the role of art therapy in psychiatric rehabilitation were pertinent to the experiences of many art therapists at the time. He discusses the difficulties of establishing basic conditions and boundaries for psychotherapeutic work within many psychiatric rehabilitation services in the health service. He wryly suggests the need for art therapists to be able to perform George Orwell's 'Doublethink' if they are to make the attempt. He refers to a survey made by the Salford Project in 1975, which was a research project considering the possibilities for establishing a 'Continuous Care Register' for those discharged into the community yet deemed to be in need of continuous care. Molloy refers to many accounts given in the Salford Project publication by people who had received some form of psychiatric treatment. He highlights areas that seem to have been of particular concern. These include a sense of not belonging, of being different, feelings of emptiness, inability to prevent feelings overwhelming aspects of everyday life, difficulties in rehabilitation, difficulties with medication with some people wanting to get off all medication and others being grateful to it. Molloy carefully explores the ways in which an art therapist might respond to and work with these feelings. His account is impressive in the way that he demonstrates the range of psychotherapeutic work that is possible with clients who are rarely offered it. He is very clearly arguing for art therapists to challenge standard approaches to work with this client population and to try to use their work as a balance to other rehabilitation programmes. He sees this being most effectively achieved through close teamwork, when this is possible. He writes of:

> ...inner emptiness...a psychic paralysis resulting from the terrifying confrontation of two worlds, inner and outer. In such cases no amount of practical training in coping with work and the realities of life is likely to be of much use. Art therapy can help break

through the emptiness and as rehabilitation progresses, can support a patient's return to reality (Molloy, 1984, p. 4).

Molloy does not underestimate the terrifying nature of some feelings with which clients have to contend but he did not at that time identify any particular approach to art therapy as appropriate for this client group.

In my own review of work with long-term psychiatric patients, written in 1992, I stressed the possibility of using art therapy as a form of psychotherapy with this particular client population, which at the beginning of the 1990's was largely to be found in the community. Like Molloy, I understand (together with many other art therapists) the need to continually propose a case for the use of art therapy with clients with serious mental disorders in the public sector. Many of the services have been preoccupied with what has seemed interminable change over the last few years, so that it has not always been easy to maintain the basic conditions needed for the frame of therapy. It is understandable that what some art therapists have spent their energy upon is the repeated need to discuss and argue for very basic work.

The climate of the period meant that focus has been upon individual survival, deregulation in all areas of public life, and constant change in the public sector as it struggled to express itself as a marketable commodity. Reaction to this climate has, when not confused, been varied. David Smail's work (1987) powerfully and usefully challenges the position and function of therapy in society. Other less considered challenges to the role of therapy and psychoanalysis have tended to focus on the nature of therapy and not the wider political context as the source of difficulty (e.g., Malcolm, 1982; Masson, 1989).

Nevertheless the experience of working increasingly in the community with very disturbed clients has driven the need for more clarity about the work. I think this need is reflected in the literature of many of the helping professions. For example, the work of Bentall (1992), Barham (1984, 1992, 1995), Boyle (1992) and Lefevre (1994) is exciting and encouraging. All of these have made persistent and dogged attempts to establish the basis for therapeutic work within the public sector with those most in need. Also as I have already indicated, the use of psychosocial cognitive approaches flourished during this period. In addition, many art therapists have persisted, although from a less powerful position, to continue such work. Increasingly with the developing maturity of the profession, they are not shy of making allegiances with whoever will support the work.

Some of the most innovative ideas about art therapy and psychosis to date have been proposed by Helen Greenwood and Geoff Layton (1987, 1988) and Katherine Killick (1991, 1993) and in a jointly written chapter Killick and Greenwood (1995). Between the end of the

1980s and the present time Greenwood, Layton and Killick have been putting forward the idea that very particular approaches are needed in art therapy with people who experience psychosis. These approaches depend upon whether or not the client is in the midst of psychosis or whether they come to the therapist with a history of psychosis. In many ways in their writing, Killick addresses the former scenario, and Greenwood the latter, but much of what both write lends a helpful clarity to practice and holds the promise of further development. The clarity comes from a careful application of psychoanalytic ideas in the Kleinian tradition, particularly those of Bion (1967) and Hanna Segal (1986) and from the object relations and independent school of psychoanalysis.

Historically there have been and there remain deep philosophical conflicts between the way in which the Kleinians characterise psychosis and the approaches of other psychoanalytical schools (Jackson, 1995, p. 12). I discuss this in chapter three.

What is clear is that these conflicts will be reflected in the differing approaches to the work of different art therapists. However, it is not yet apparent where the conflict in philosophy will emerge in practice. What is different in the current third period, compared with the first two, is the clarity about aspects of theory, practice and technique. Both Killick and Greenwood insist that in the early stages of the work there is a need to suspend questions about the content of the artwork that clients make. Killick argues: 'Images produced by psychotic patients do not serve a symbolic purpose until a containing relationship is formed' (Killick, 1991, p. 6).

It is no accident that Killick, Greenwood and another art therapist, Anna Goldsmith, refer in detail to the nature of the rooms in which they meet with clients who are either in the midst of, or have a history of psychosis (Killick, 1991; Goldsmith, 1992; Greenwood, 1987). The very details of the rooms, and the manner in which they are used, all contribute to the work of containment. Goldsmith's account of the room previously used by Killick (*see figure thirty eight in chapter eight*) describes the therapist's sensitive attention to the use of the room when working with someone in the midst of psychosis who is an inpatient.

> The programme for this kind of functioning state may be designed so that the table is kept entirely for that person's use and the work and other objects put on or near the table are left totally undisturbed. The table and its environs (including any images) may be experienced as an extension of the psychotic person's self structure. To interfere with, or make unsafe, that safe area of experiencing is to risk gross intrusion into fragile "self" defining structures... To support it can enable the psychotic person to relax some of the defensive strategies and experiment with others that later may be more viable in the world of relationships and symbolic structures (Goldsmith, 1992, p. 45, in Case and Dalley, 1992).

It is interesting to note both the similarities and the differences between this last description and that of Greenwood and Layton when describing work with people (no longer in the midst of psychosis) in a community setting:

> When we came to develop a psychological model we started by considering how in psychotic states the boundary, space or structure between inner and outer reality, or between conscious and unconscious aspects of the self, are frail or flawed. It is useful to understand that reconstruction and strengthening of psychological boundaries can be facilitated by the social and physical setting of the group. Both staff and patients need to feel secure about the setting. A regular time and place for the session is important. The therapists reserve a time in the timetable and a space in the building which corresponds to a time and place in their minds. Therapists have to take responsibility for this setting and ensure that the session is not interrupted, or threatened by others who might want the room for other purposes.
>
> ...At the outset the group was offered the following facilities: a large room with an area of comfortable chairs, tables that need to be erected, art materials and time of 1.5 hours and two therapists (Greenwood & Layton, p. 1987).

The differences between in-patient and outpatient settings (even to the tables that need to be erected) are quite markedly connected with the relative transience of the setting and the 'container' it is possible to offer and the extent to which the therapists themselves feel contained by their work setting. The ways in which studios can contribute to the processes of containment are considered again in chapter eight.

Both Killick and Greenwood (1995) are clearly inspired by the client group and are involved in the process of thoroughly exploring those psychoanalytic concepts that might lend clarity and understanding to the process of art therapy. A jointly written chapter produced a series of specific recommendations. These five recommendations (1995, p. 114) include methods that enable the therapists to foster ways of mediating between concrete and symbolic thinking. They propose that therapists pay very careful attention to 'dynamically structured and maintained boundaries' in ways that enable projected material to be contained within the relationship. This requires a time scale, which enables clients to develop sufficient ego strength 'to assimilate what has been projected'. They describe different places upon the possible continuum of the range of therapeutic work it might be possible to offer people with serious mental disorders. Their joint chapter contains much that is helpful, but I personally would be interested to see what would have emerged in terms of the theoretical differences and the nuance of practice, had they written individual chapters. Possibly the editors of the book missed an opportunity when they commissioned only one chapter. The needs of practice in this third period demand further elaboration.

Killick (1993) describes the way in which her thinking has developed during many years of working with people with serious disorders in a psychiatric setting. She, along with many other art therapists during the 1980s, found that she was in a position to be able to offer

long-term therapeutic relationships in a sufficiently containing psychiatric setting. Killick's ability to offer well-contained long-term work in the NHS was normal in the 1980s, but it would now be rare. During the second half of the1990s with the advent of community care and the relentless pace of change in public sector settings, it is no longer clear that work of such length and depth could take place.

The community ethos within which Greenwood finds herself employed does not make work at the depth that Killick describes feasible. Greenwood's work is usefully informed by knowledge of psychoanalytic theory. Knowledge of theory can be useful to the work, although it is not always be appropriate to apply it in public sector settings; this is something that repeatedly affects contemporary art therapy practice. Many art therapists, like Greenwood, are currently engaged with other colleagues in trying to make an appropriate transition from more contained institutional settings to the community services. In the community, the therapeutic frame is not always well supported and quite complicated questions about where it is appropriate to conduct therapy arise. For example, there may be quite strong expectations (generally problematic) within community teams that some client work is done in the client's home. Woddis is correct in suggesting that the technical questions provoked by the move into community settings have still to be addressed. Questions of technique are ever present during this period.

There has been a gradual theoretical shift and the profession became much more influenced by psychotherapeutic practice. Indeed there is now a debate within the profession about a variety of possible titles (see pages five and 314) the different titles indicating the use of different technique in different forms of practice. However, during the 1990s the debate about the profession's title was fierce. The fierceness seems to be a symptom of a failure to situate the practice historically. Art therapists have adopted no one model of psychotherapy during this period (although strong influences have come from different psychoanalytic traditions). The increasing claim by art therapists to the psychotherapeutic nature of their work has been reflected in the content of the recognised training courses. It seems to me that what characterises art therapy in the current period, as distinct from art therapy in the two earlier periods, are questions of theory and technique, a general quest for more clarity of practice and a clear framing of practice in relation to the institutional context in which it is situated.

Some art therapists who became established during earlier periods warn of dangers of too uncritical an adoption of psychotherapeutic methods. In the present period, David Maclagan in an article in *Inscape* during 1994 and in a book to be published at the end of

2000 continues to highlight these issues and the understandable concerns to which they give rise. There is a continuing need to attend to the synthesis of art and psychotherapy.

The confusion in the debate about the title of the profession seems related to a failure to see the developing practice from a historical vantage point. The quest for clarity of technique seems to me to be driven by the very wide range of client needs that art therapists have encountered in their work and by the changing circumstances of practice in the public sector. Perhaps the range of need is most apparent in work with clients who have a history of psychosis. Also, increasing numbers of art therapists work in the community away from the close support of a team.

By indicating that there is a quest for clarity of technique, I intend to suggest something about the full range of skills that contribute to what I would like to name' the philosophical craft' of a profession. It appears that what characterises the contemporary period in the development of art therapy is the greater exposition of its theory, technique and 'philosophical craft'.

It is not until this third period that significant numbers of art therapists have written or edited books about the nature of art therapy practice. These art therapists include Dalley (1984), Dalley et al (1987), Case and Dalley (1990, 1992), Dalley, Rifkind and Terry (1993), Gilroy and Dalley (1989), Gilroy and Lee (1995), Killick and Schaverien (1997), Liebmann (1986, 1990, 1994; et. al., 1999)), Schaverien (1991, 1995), Skaife and Huet (1998), Simon (1992 and 1997), Thomson (1989), Waller (1991, 1993), Waller and Gilroy (1992) and (Wood and Pratt, 1998). The subject matter in these books indicates something of the wide range of practice. In their pages it is possible to find evidence of art therapists using widely differing models of practice; art as healing (Hill, 1945; Adamson, 1984; McNiff, 1992), person centred art therapy (Silverstone, 1993), brief art therapy (McClelland 1992; Skailes, 1990), supportive art psychotherapy (a good deal of the art therapy offered to people with a history of psychosis has been this, Molloy, 1984; Charlton, 1984; Lewis, 1990; Wood, 1992; Greenwood and Layton, 1987, 1988; Greenwood, 1994). Another example is art psychotherapy (much writing during this period might be described in this way, e. g., Killick, 1993; Case, 1994; Dalley, Rifkind and Terry, 1993), and then there is group analytic art therapy (McNeilly, 1983); group interactive art therapy (Waller, 1993); art psychotherapy groups (Skaife and Huet, 1998) and analytical art psychotherapy (Schaverien, 1991, 1994, 1995). The clarity of explanation beginning to be available in such books and in journal articles (particularly in *Inscape*, the journal of the British Association of Art Therapists) will undoubtedly contribute to the development of increasingly substantial accounts of the theory, practice and techniques of art therapy. However, my thesis is that all of this development will

be made more potent if adequate acknowledgement is made of the social and economic circumstances in which art therapists practice and the lives of their clients are situated.

Much that has been written so far by art therapists about this client group has taken the form of occasional papers or chapters in books. An increasing number of people in the art therapy world are writing about their work with people with serious mental disorders (e.g., Thornton, 1990; Mann, 1991, 1995). Their work is varied in its theory and technique but it does share a broadly supportive art psychotherapy approach. A great deal of work has not yet been subject to much scrutiny; for example many art therapists have worked in groups with people who have a history of psychosis but so far only a small number of papers exists about such group work. The first of these was by Greenwood and Layton in 1987 and all of the others are included as chapters in the edited book by Skaife and Huet (1998).

The theoretical conflict within the world of art and that of psychoanalysis in relation to psychosis have not yet found exposition within the writings of art therapy. The demands of the work will increasingly involve art therapists in taking different positions in relation to conflicts about the nature of psychosis and responses to it. The book edited by Killick and Schaverien in 1997 *Art Psychotherapy And Psychosis,* strongly suggests that art therapists will continue to have much to contribute to work with seriously disturbed clients. Some of the contributions to this book are indicated in section three.

Conclusion

The majority of art therapy practice in relation to people with a history of psychosis has taken place within the public sector. A small number of analytically trained therapists work privately with people with such a disturbed history (this is not work held within a team structure). This private art therapy work with a small number of disturbed clients has undoubtedly contributed to theory and practice. However, clearly for the most part it is not feasible for art therapists to single-handedly provide an adequate container for people who have serious disorders. In the public sector, poverty and class have necessarily influenced the course of work with people with serious disorders. The material impact of these issues has been considerable, but there has still been development. In public sector art therapy practice, the traces of the lineage of moral management and social psychiatry are everywhere implied: in periods of better economic fortunes it is likely that these genealogical lines will again become more visible.

Actual physical genealogy is regularly proposed (with some substance) in relation to the origins and treatment appropriate to people with a history of psychosis. However, art therapy is sometimes characterised as being limited to providing a calming tool for diversion by those who would propose an *exclusively* physical origin and treatment. The work of

clarifying and making the case for a more far-reaching art therapy practice needs continually to be made. This is in keeping with the general need to continually propose that a treatment strategy for working with people with a history of psychosis must acknowledge that their experiences have meaning.

I hope that this chapter has demonstrated how the methods of work employed by art therapists with people who experience psychotic processes, have gradually become much more explicit. During the first period art therapists focused on the powerful means of expression that they might offer to people with serious disorders and on the provision of respectful containment. During the second period art therapists tried to counter some of the alienating effects of psychiatric institutions by providing an 'asylum within an asylum'. In the third contemporary period the work of art therapists has become more influenced by psychotherapeutic practice and by the problematic transition from asylum to an unknown community; during this time questions of theory, practice and technique have become paramount. Each of the three periods has had drive and development. They have all contributed in powerful ways to a belief in the possibility of such work. One thread that has run throughout the three periods is the fundamental need for care and respect, which is heightened when working with very disturbed people.

That art therapists have sustained and developed ways of working with people with serious mental disorders is inspiring, but the continual change of circumstances in which many public sector art therapists currently find themselves working can be seriously undermining of them and of the clients they are endeavouring to help.

People working in the public sector at the end of 1990s and at the beginning of the new century felt themselves (along with the patients) to have been flung out of the old asylums or big houses. They were often trying to work with people in the midst of deep distress, without having a reliable setting or a sense of container for themselves and their work. There are not enough services for this client group and this is distressing for clients and workers alike. This shortage of resources in psychiatry meant that what could have been a progressive transition to community care did not happen. Indeed many psychiatric workers are convinced that successive British governments adopted the policy cynically to reduce spending. This kind of suspicion can be demoralising and I think that the courage on the part of psychiatric workers required to maintain good work practices in the face of many changes and cuts in services is not always recognised. In addition, it has been hard to detect an overall government vision for the mental health services during the last part of the twentieth century, whereas it has not been difficult to suspect the rationalisation of resources as the motive behind a number of policies.

MIND the mental health charity and campaigning organisation, and various campaigning bodies argued throughout the 1990s about the absurdity of trying to replace services with supervision orders. One client asked a government minister at a National MIND Conference, 'Why do you imagine that for me, someone diagnosed as paranoid, that a supervision order will make me feel better?' The government proposal in the late 1990s to use Compulsory Treatment Orders for people with serious mental disorders was suspended because it aroused considerable controversy. However, the policy has not been abandoned, and it may still be included in mental health legislation to be introduced during late 2000 or 2001. It seems clear that such a compulsory policy would influence the power relations and trust between people with serious mental disorders and health or social service workers. It is not likely to alleviate what have become the major difficulties of mental health provision in large inner cities and it is likely to have a detrimental effect. It seems this proposal was a result of government anxiety about a number of incidents involving community mental health patients. MIND continues with a well-conducted campaign (1998 ongoing).

A part of MIND's campaign involves constantly arguing against a media led response to the anxiety created by the placement of people with serious mental disorders in the community. They produce statistics that impressively demonstrate the level of media over-reaction. 'From 1957 to 1995, during the period of deinstitutionalisation, the proportion of homicides committed by people with a mental disorder actually fell steadily from 35% to 11.5% according to home office figures' (Sayce, 2000, p. 33). An overview of the research by MIND suggests that there is a very limited link between active psychosis and violence and that it is not possible to explain an increase in violence by recourse to fears about patients in the community. People who are not mentally ill commit the vast majority of violent crime in Britain; this is the case for 95% of such crime (Sayce, 2,000, p. 33). MIND regularly campaigns for a considered approach to service planning and suggests that what is needed is a combination of services: crisis intervention, continuing care, day care, work and occupation, accommodation and a place in the community. More recently mental health strategies for people with enduring mental health problems, even those coming from government central offices have been impressive and even visionary, but the funding is not and without funding much effort becomes meaningless.

The user movement is growing despite this grim backdrop. Their demands are that professionals and government alike really consider the rights and the perspective of users. This has wide implications for therapeutic approaches in general and the way they are linked to the social and economic circumstances in which people live and work. An organisation originating in the early 1990s in the Netherlands known as the *Voices Movement* is a force for

change. It challenges explanations of the phenomena of 'hearing voices' and it works in a number of countries to establish networks of users who can support voice hearers through self-help groups. *Voices* looks set to survive. Its demands are clear. It is not 'anti-psychiatry', but it does ask for more judicious prescription of medication, psychological intervention and professional support in establishing self-help groups. It also makes a clear proposition that psychotic experiences have meaning, although it allows that possibilities for finding meaning may be reduced on occasion. The user movement in general is beginning to make it much more difficult to forget the millions throughout the world who succumb to psychosis.

Art Therapy became a State Registered Profession during 1997. This meant that the qualification to practice became one that is regulated by the State. State regulation is the primary legislative method by which members of the public can be protected from malpractice by one of the professions. The Health Act of 1999 changed the designation of the health related professions from 'Professions supplementary to Medicine' to simply ' Health Professionals'. A number of health legislative matters have been tending towards the position indicated by this change of designation. It will become more difficult for members of the health professions to hide behind the gowns of the medics. This new state of affairs heralds a level of independence that will hold some benefits and some dangers because there are tensions between servicing society and serving the interests of clients (both might be included in the notion of the 'public' as designated by the tenets of state registration). The precarious balance inherent in the practice of psychiatry and professions related to it is likely to continue. In addition, the changes in legislation may involve a greater distribution between the professions of the weight of responsibility within in the public sector. It remains to be seen what the impact of this will be in relation to work with people with serious mental disorders. Surprisingly it is not straightforward to trace the impact of different historical periods upon practice. This is true of much clinical literature about therapy with this client group; the failure to locate practice is by no means confined to the writings of art therapists. The failure to locate and articulate practice suggests something about the difficulty in describing this particular work. It is also related to the estrangement between public sector psychiatry and private sector psychoanalysis that is the subject of the next chapter.

Chapter Three:

The Historical Estrangement of Psychoanalysis from the Practice of Psychiatry in the Treatment of Psychosis (1900-1999)

The estrangement between psychoanalysis and psychiatry has had implications for the vast majority of people who succumb to psychosis. This estrangement has been an international feature of the relations between public sector psychiatry and private sector psychoanalysis throughout the twentieth century. However, it is possible to make a case to suggest that the estrangement has been at its height in Britain during the difficult economic period of the 1980s and the 1990s. Many aspects of psychiatric provision during this period seemed to stop developing as mental health workers increasingly complained that they had little time to think or dialogue.

Judging the practice of many busy psychiatric teams working with people in the midst of psychotic episodes, it would be difficult to tell what is the evidence for an effective approach to the work. From the perspective of inner city psychiatry it is startling to be reminded that contemporary evidence from the American Psychiatric Association suggests that the optimal treatment for psychosis is a combination of psychotherapy and pharmacology (American Psychiatric Association, 1993, p. 6; American Psychiatric Association, 1994, p. 15).

I think the interdisciplinary estrangement that means that this evidence is not apparent is part of the 'ideological force field' (Barham, 1995, p. 27) within which all disciplines in the public sector (including art therapy) have to find ways to develop coherent theory and practice for their work with the most disturbed. This force field is a political one, it depends upon the material circumstances of a period and it determines what it is possible to offer people who succumb to psychosis. It also tends to determine which ideas about treatment predominate.

The ideological vacuum left by the decline of interest in R. D. Laing's ideas about psychosis, coincided with difficult economic times at the beginning of the 1980s. Laing's rise to fame was meteoric during a passionate period of modern history in the 1960s and 1970s. The height of his fame was at the time of May 1968 in Paris (the largest general strike in history); world wide protests against America's war in Vietnam; the crushing of the Prague spring in Czechoslovakia and amongst other struggles, those by black and white Americans for the Civil Rights Movement. Laing's ideas about psychosis had a massive impact at that time, his books were translated into many languages and they sold a million and a half copies. The sheer scale of this success is evidence of a kind that Laing understood and shaped a popular sense of change being needed. His ideas influenced change in many aspects of psychiatric practice (in some ways that endure) in areas where psychoanalysis has

failed in relation to psychosis. Yet many details of his thinking were as a result of the psychoanalytic training that he had received.

Psychoanalytic ways of understanding psychotic communications question why a mind in the grip of psychosis apparently tries desperately to destroy a sense of meaning. I discuss first some of Laing's ideas before considering a range of psychoanalytic theories that have relevance to this question.

R. D. Laing

Although Peter Sedgewick was critical of Laing in his book *Psycho Politics* (1982), he did allow that Laing was one of the first writers in 50 years to question and reframe Kraepelin's presentation of Schizophrenia as a disease process. Included in an obituary about Laing (Clare, August 25th, 1989, The Guardian) were a series of photographs of Laing. In these photographs Laing seems to me to have allowed his image to be used as a parody of basing diagnosis on physiognomy (*see figure eight*). These images convey the quality of provocation he caused throughout his life, this seems to have ranged between inspiration, irritation and confusion.

Essentially Laing asked his fellow psychiatrists to consider treating patients diagnosed with schizophrenia as 'persons', as opposed to them being examples of a disease process. He makes no claim himself in his preface to the original edition of *Divided Self* (1959) to present a comprehensive theory of Schizophrenia in either organic or interpersonal therapeutic terms. As already mentioned his proposal is more modest, in the preface to the Pelican reprint (1965) he writes, 'I wanted to convey above all that it was far more possible than is generally supposed to understand people diagnosed as psychotic'. In keeping with a reflection of the times during which he was writing, he asserted that an understanding of people diagnosed as psychotic entailed an understanding of the social context of their lives. For Laing and his colleagues (Esterson and Cooper) the focus on context was largely concerned with a consideration of family and close relations.

This curtailment of the focus of their attention to the boundaries of family and friends is a source of some legitimate criticism of the anti-psychiatry movement's work (e.g., Sedgewick, 1982; Mitchell, 1975). I am only aware of the work of the social psychiatrists, Warner's work (1985) in particular, as having considered context more widely and these accounts tend not to take a psychotherapeutic approach in relation to psychosis.

I was a first year degree student when I first heard of Laing through seeing the film *Family Life*. The film seemed powerful at that first viewing of it, because of its clear statement that what we communicate cannot really be understood outside the context in which we speak and act. When I saw the film some ten years later I was working as an art therapist and I remember thinking that the film was badly made, clumsy and even embarrassing. The family members portrayed by the film seemed on second viewing to be

figure eight
R. D. Laing (Photograph taken from the obituary 'A Divided View of Madness' by Anthony Clare in The Guardian on August 25th 1989).

little more than caricatures. The roles given to the mother and father of the patient were cruelly unsubtle in their implications. There was seemingly no compassion for the plight of a parent. My two very different responses to this film could in themselves provide a neat synopsis of the way in which many people responded to Laing's work: after an initial enthusiasm there was a tendency to deny or rephrase the wide impact of his ideas. I think this was particularly because of the possibilities for vilifying the family of patients that *seemed* inherent in the work.

A fundamental flaw seems to have been that Laing stopped short at the edge of the family context, he did not move on to consider the social and political context in which the family was trying to exist. Given that many of the people diagnosed as schizophrenic are likely to experience difficult social economic circumstance, this is a blind spot in the work of Laing. Within the psychiatric profession itself some of the negative reactions to his work were extreme; however, these reactions tended not to be on the basis of his failure to make a socio-economic analysis of the position of the family. Aspects of Laing's position were flamboyantly counter-culture and this caused fear and offence in some places.

I found it difficult to find an adequate reference for the film *Family Life.* Interestingly I did find a passage about it in a book of conversations with Laing, but it seemed from what Laing said a couple of years before he died, that he himself had not liked the film. Laing had thought it to be too clear-cut in its portrayal of the family members (Mullan, 1995, p. 299).

There is much that remains powerful about Laing's writing, particularly in the early work *Divided Self* (1959) and *Self and Others* (1961). Mitchell points to developments in psychoanalytic ideas that had provided a background to his ideas about psychosis. The records of work with children by the analysts Klein, Riviere and Winnicott had formed a background to some of his ideas about psychosis. This is because they 'were all concerned with studying psychosis and with locating its fixation points in the first mother-child dual relationships, as Freud had located the fixation point of neuroses in the triadic relationship of the Oedipus complex' (Mitchell, 1975, p. 230).

Laing's ideas about ontological insecurity were very helpful to many people attempting to work with clients in the midst of psychosis. Although made from a different philosophical position, Bion's work concerning 'nameless dread' (which I consider briefly in chapter five) is attempting to address similar experiences concerning the terror of psychosis.

Laing's account of the features of ontological insecurity includes ideas about the 'embodied self' and the 'unembodied self' (1959, pp.65-8). His description of the form terror can assume in terms of 'engulfment', 'implosion' and 'petrification' (1959, pp. 43-47) provide descriptive details of states of mind, which serve as helpful metaphors to a

practitioner. Laing suggests that his intent is descriptive and not prescriptive of a form to be assumed by therapeutic relationships.

He acknowledges his indebtedness to the philosophical tradition of existentialism. However, possibly of more interest to those art therapists who were practising at the time, he makes a lot of reference to the work of artists and writers in the attempt to describe and understand altered states of mind. He regularly quotes Blake and he sees forms of the psychotic terror he is describing in the paintings of Francis Bacon. In *Self and Others* (1961), he uses Dostoyevsky's tortured character Raskolnikov (*Crime and Punishment*) to demonstrate the confusions of mind that can arise from the tangle of human relationships. Raskolnikov features twice, firstly to show the possibilities for muddling of fantasy, imagination and waking perception (Laing, 1961, p. 61-7). Then he is shown being placed by his mother and sister in an untenable position (Laing, 1961, p. 165-173). I have written elsewhere (Wood, 1991, p. 15-18), that possibly Laing found a combination of enthusiasm and explanation in works of art and that this explains his historical appeal to art therapists. His work seems to have been one source of the courage that has enabled many art therapists to sustain work with seriously disturbed people.

Laing's capacity to move backwards and forwards between inner and outer is helpful. 'The term schizoid is split in two main ways: in the first place there is a rent in his relation with his world and, in the second, there is a disruption of his relation with himself (Laing, 1959, p. 17).

However, Laing's ambivalent relation to the ideas of psychoanalysis meant that although he recorded his patients' dreams and phantasies, his existential perspective meant he was sceptical about notions of the unconscious. This may explain why, despite the centrality of the relationship in his therapeutic work, he did not address issues connected with relationships in terms of transference or in terms of the symbolic qualities of the relationships between doctor and patient or therapist and client. I think this, together with the establishment disparagement that followed the decline in the use of his ideas, has meant that his work has been sidestepped by later developments in psychoanalytically inclined psychotherapeutic work with psychosis. The neglect of Laing's ideas could also be partly as a result of declining resources for mental health and conservative features in the worlds of both psychiatry and psychotherapy. For different reasons neither would be likely to appreciate Laing's thought that:

> Psychiatrists and patients were, and are, too often ranged on opposite sides...The psychiatrist-patient rift across the sane-mad line seemed to play a part in some of the misery and disorder occurring within the field of psychiatry. Maybe this loss of human camaraderie was the most important thing. Maybe its restoration was the *sine qua non* of "Treatment" (Laing, 1985, p.145).

Nevertheless, there is much sensitively written psychoanalytical and psychotherapeutic literature that is able to clarify many of the issues provoked by psychosis. A powerful and abiding theme throughout this literature is the idea that primitive and irrational processes are central to the human condition. That the potential for such processes to become activated is in everyone and the attempt to outlaw them or confine them to the provinces of the mentally ill is not helpful. Within psychiatry there are many people in all disciplines who work respectfully with people with serious difficulties; their task is enormous because they are charged with working with everyone with mental health difficulties. I think they often feel that they and their work are not seen, because there is something about madness that is still outlawed. Jane Ellwood introduces the book entitled *Psychosis* with the following.

> This volume springs from a conviction that psychosis should be central to our understanding of mental illness in all its shapes and should not be pushed to the remoter shores of our history, society and work; in other words: as far from our own lives as possible (Ellwood, 1995, p. 1).

The collection of papers from which this comes, is a timely and thoughtful contribution to psychotherapeutic work with people who have serious mental disorders. All of the papers have relevance to the public sector, yet the theoretical basis for such work has not received the public attention given to community care.

Hard times

The material pressures brought to bear upon the health, social and voluntary services during the late 1980s and the 1990s meant that all disciplines working in these sectors have reported that it had been hard to sustain meaningful work with their most disturbed clients. There has been a rise in the number of people reporting (in published accounts and conference papers), that practice (of any brand) in the mental health services involves feeling increasingly unsupported in workplace settings. Murray Jackson and Paul Williams have designated the characteristic policies of this period with their cost cutting and quick cure approach as 'Fast-food psychiatry' (1994, p. 177). They also cite a newspaper report that describes inner-city psychiatric hospitals as 'crumbling mad-houses' (*The Times*, 11.12.93). I certainly noticed the increasing dilapidation of mental hospital buildings during the mid 1990s. When I saw some of the poverty-stricken squalor that became a characteristic of the hospital buildings during this period, I found myself thinking that the function of the institution was returning to that of the poor house. At the end of the 1990s a small number of mental hospitals are being refurbished; but it will take more than this to enable patients and psychiatric workers to feel that they are again working in an area concerned with human value.

In a paper by Richard Marshall (1995) I hear the sometimes-railing voice of myself and other health service colleagues. Marshall at the time of writing was clearly disillusioned with psychiatric practice in the harsh market place that the NHS had become.

Exclusively physical explanations of mental illness tend to predominate during difficult economic periods. Much of Marshall's paper suggests that in his frustration he would have wanted to ridicule 'physicalist' explanations of schizophrenia and remove himself from public sector psychiatry, but my overall impression is that, sadly, he felt defeated. During the difficult political, economic period of the 1980s and the 1990s, many people working in the public sector reported feeling that it was difficult to influence policy and practice.

Estrangement between psychoanalysis and psychiatry

Paul Williams (1999) suggests that what has given rise at the end of the 1990s to the efforts of cognitive therapists in this area, is the historical failure of psychiatry and psychoanalysis to combine and together influence the wider treatment of people with serious mental disorders (see chapter eleven). This is against a background of widespread thirst amongst public sector mental health workers to find a meaningful practice in relation to psychosis. The great majority of people who have psychotic experiences are offered medication and banal forms of distraction. The distractions rarely work and this is not satisfying for anyone and painful for everyone.

Peter Barham's account (1995) of the work of the psychiatrists, father and son, Eugen (1857-1939) and Manfred Bleuler (1903-) is empathic. Barham understands the particular need in work concerned with seriously disturbed patients for linking between psychoanalytic thinking and psychiatric practice. He shows that Eugen Bleuler laid the foundations for psychotherapeutic and psychosocial approaches and that he never gave up the struggle to reconcile the two psychiatric traditions (the organic and the psychotherapeutic). Although he reports that this struggle 'overwhelmed' him towards the end.

It is on the life of Manfred that Barham mainly focuses, he considers that Manfred Bleuler's major work (1972) gives the most incisive and critical account to date, of the history of schizophrenia. Barham describes Bleuler's work as showing that the characteristic dialogue of psychiatry is between a professional class and a pauper class. Implicit and powerful in his description of Bleuler's work is the contemporary relevance of the 'gripping account of the ideological force field in which the whole problem of schizophrenia is entrapped' (Barham, 1995, p. 27). Manfred Bleuler's work is full of moving accounts of working with and listening to his schizophrenic patients over a twenty-year period.

In describing the evidence from the work of the Bleulers, father and son, Barham is clearly proposing that clinical hope in this area is well grounded, but he is also indicating that what is less secure is political support for such work. He considers that there is the potential for making scapegoats of those staff who work psychotherapeutically with disturbed clients. I suspect that a number of art therapists become team scapegoats, as a

direct result of working with clients who are stigmatised. Certainly clients with a history of psychosis often report feelings of alienation, stigma and a sense of being a scapegoat. This is something to which I return in chapter four.

<u>The potential benefits for health service workers of psychoanalytically informed supervision</u>

I sympathise with the frustrations of contemporary practice and I recognise the ideological factors at play that mean that cognitive approaches fit in well. People trained in psychosocial intervention methods(PSI) are making genuine attempts to work with the meaning of psychotic experiences. However, PSI does not acknowledge the weight of unconscious phenomena with which clients in the middle of psychosis have to deal. For this reason, I tend to agree with Murray Jackson who is both a psychiatrist and a psychoanalyst that a lack of communication between psychiatry and psychoanalysis is to the client's detriment. The lack of communication also means that there is very little psychoanalytically inclined supervision available in the NHS.

Jackson writes movingly of the failure of communication between both psychiatry and psychoanalysis and of the loss this entails for the person who experiences psychosis. He describes work he was able to do in London at the Maudsley (1994) and in Scandinavia (1995) that enabled psychiatric staff at all levels to learn to think about psychotic processes. He clearly acted upon his democratic belief that staff doing the face-to-face work with clients, can be helped by acquiring knowledge. He thinks that appropriate, psychoanalytically informed theoretical concepts are essential to the work of psychiatry and consequently he makes careful use of staff supervision groups. Jackson's close colleague Paul Williams, has made an interesting addition to this proposition by advocating more co-operation in the examination of the links between psychosocial intervention and psychoanalytic methods (1999).

Joseph Berke also indicates the need for good supervision by showing how therapeutic staff can find themselves making disturbed interventions during the course of their work with disturbed clients. He makes the case for clearheaded, outside supervision during his chapter about psychotic interventions in the book *Sanctuary* (1995). Resident therapists and Berke himself found their thinking processes embroiled and attacked by the level of disturbance they encountered at the Arbours Crisis Centre.

It is interesting that Jackson, Berke and Barham all suggest that there is a serious need for fraternization between psychiatry and psychotherapy. They propose fraternization to be in the interests of clients and staff alike. In the contemporary climate I think fraternisation would involve making links and more co-operation between different brands of therapy. This can be difficult in the face of the comparisons being made by empirical trials. Attempts towards genuinely collaborative research are constrained by market

pressures in health care. Political economic forces often mean that it is hard to evade such constraint.

Sustenance for keeping going with the work

Although I advocate the benefits of psychoanalytically informed clinical supervision. I think that without the possibility of making meaningful links between the physical, psychological and social economic factors, people working in psychiatry can begin to feel an uncomfortable sense of stagnation and poverty of practice. Robert Young proposes a parallel idea to that of scapegoat. 'The official healers in society do their jobs humanely but get turned into minders' (Young, 1995, p. 49). Here I am reiterating the idea that psychotherapy alone is not sufficient.

Nevertheless, although it does not influence the immediate material circumstances in which psychotherapeutic work in the public sector might have to take place, psychoanalytic and psychotherapeutic literature and supervision can offer sustenance of a kind. The quality of thinking provided by a psychotherapeutic perspective is often welcome to people who have continued to work in difficult times and circumstances with people with serious mental disorders. I think the sustenance it provides is largely gained by focussing upon the detail of theory and practice. It is also to some extent political in that it democratically offers theoretical grounding in some psychoanalytical concepts, and it contributes to a public debate about the feasibility of such work. This is in stark contrast to the internecine warfare that is currently being waged between the different psychoanalytic groupings at the turn of these two centuries (the twentieth and the twenty-first).

Although not received entirely without criticism such literature has held the attention of art therapists, particularly during what I have described as the third contemporary period of art therapy history. This is because of the involvement of so many art therapists, in psychotherapeutically informed work in psychiatry with people with a history of psychosis. Art therapists have also been receptive to the PSI initiatives in this area, though not to the same extent. I think this is because of the failure by PSI to acknowledge the unconscious.

Understanding psychosis

Ellwood offers a vivid account of her work with a young boy, and in doing so she demonstrates that when we understand what it is that is disturbing to a child we can also understand something about the form that fears might take, in an adult psychosis.

> The person suffering from psychosis relates not to the real world but — like a baby needing desperately to hold onto good experiences, good memories (the good objects), and succeeding in so doing only by getting rid of (projecting) the bad and the frightening feelings into the outside world — he or she constructs his or her own world by omni potently imposing his or her own inner structure on the real outside world which has, perforce, to contain all the terrifying thoughts and objects which had never previously been contained and assimilated. Considered in this way, psychosis

is part of our very early developmental process, most of us know it is still there and keep in touch with it through dreams, and others — the poets, artists, musicians — have access to it in the painful process of creation (Ellwood, 1995, p3-4).

The last comment in this quotation is particularly thought provoking for art therapists, although it is only deceptively straightforward. This is something to which I return in chapter six in a discussion of the concept of symbolic equation.

A paper by Young (1995) following a Kleinian tradition, describes the ways in which psychotic processes can be seen as ubiquitous. It suggests that we can all find examples and understanding of these processes within ourselves, and this can help our understanding of clients who are flooded by them. This idea neatly turns on its head, the tendency to suggest that explanations for schizophrenia can be exclusively physical, for example, World Health Organisation (WHO) reports have sometimes been used to demonstrate from a ten country study that 'schizophrenia is ubiquitous' and can be understood exclusively as a disease process (e.g., Jablensky, et. al., 1992).

Peter Buckley (this is not unlike Laing's position) neatly summarises a possible starting point for the consideration of psychoanalytic theory in relation to psychiatry and psychosis. 'A psychoanalytic theory of the phenomenology of the psychoses can be constructed without simultaneously advancing a general theory of aetiology...' (1988, p. 1).

It is likely that Schizophrenia will eventually be shown to be a group of discrete disorders some of which are characterized by considerable genetically determined biological predisposition in which precipitating and sustaining environmental factors are necessary to give rise to the syndrome while others may be found to be primarily a consequence of intrapsychic and interpersonal stress without prominent biological loading. Our current inability to predict outcome will undoubtedly yield eventually to a greater understanding of the relative importance of these factors in different subtypes of the syndrome. This in turn will lead to a clearer therapeutic approach to the patient (Buckley, 1988, p. xv).

Thomas Freeman (analyst and psychiatrist) makes a related point.

Over the past two or more decades descriptive studies of psychoses have suffered from the impact of chemotherapy, particularly from the long-acting medications. Chemotherapy has tended to obscure the clinical manifestations and interfere with the natural course of the illness, and it has therefore been less easy to decide whether or not the disappearance of a delusion or catatonic sign is in fact indicative of a remission of the attack. Equally it is difficult in long-standing, chronic cases to determine whether the potential for further improvement is being hampered or assisted by the drug treatment. However, chemotherapy need not have these effects. In modest doses and in the context of an understanding relationship with psychiatrist or nurse, it is possible, through the patient's utterances to, to observe the great variation within and between types of psychosis that exists and to follow the different courses of illnesses (Freeman, p. 2, 1988).

The administration of medication varies greatly. Similarly there are wide variations in the way psychoanalytic ideas are applied to the question of psychosis and they provoke a range of controversies. Some practitioners suggest the specific needs of people in the midst of psychosis require a radically different therapeutic approach; others insist that no change

in a classical psychoanalytic technique is needed. There have been a variety of explanations for these controversies, some of which are centrally theoretical and some seem attached to clashes between personalities and styles of practice. I think that work in this area can bring practitioners and clients into contact with painful and frightening material, and that there is something about the nature of the material that can add a fierce charge to controversy.

Although Freud's early proposal, that there is no possibility of using the transference when working with disturbed clients has been superseded, the extent to which the transference is acknowledged remains controversial. Similarly, the possibility for symbolic functioning in the midst of psychosis remains an area of debate, as does the wisdom of confronting psychic defences.

Many aspects of theory and practice are extremely pertinent to the work of art therapists, because they help them clarify the nature of their psychotherapeutic work with the most disturbed and the need for greater clarity is often pressing. 'Many psychoanalysts hold the view that in psychosis the unconscious becomes conscious' (Buckely, 1989, p. xii). I understand this to mean that the unconscious becomes more visible. This is powerfully reminiscent of what one client (a research scientist) shared with me about her psychotic episodes. She said that in the midst of acute episodes it was as though she was dreaming while she was awake. Her accounts of these states were vivid; she lived in constant fear of them returning. In part this was because of the attack they made upon her thinking processes and in part because of her subsequent humiliation about people having seen her in an altered state. The weight of this did eventually mean that she killed herself. Sadness about her death still haunts me, and I think it provides a significant part of my motive for trying to clarify the theory and practice of the work.

The history of psychoanalytic theory in relation to psychosis

From the very beginnings of his career Jung had powerful interests in both imagery and madness. He describes his perceptions of the nature of unconscious material for people diagnosed schizophrenic.

> While with neurotics the complexes consist of split-off contents, which are systematically arranged, and for this reason are easily understandable, with schizophrenics the unconscious proves to be not only unmanageable and autonomous, but highly unsystematic, disordered and even chaotic. Moreover, it has a peculiar dreamlike quality, with associations and bizarre ideas such as are found in dreams. In my attempts to understand the contents of schizophrenic psychoses, I was considerably helped by Freud's book on dream interpretations (Jung's Foreword to J. W. Perry in 1953, p. 353 in the Collected Works, 1953-1966).

From what he writes it seems as though Freud's book on dreams had only just been published which dates this passage by Jung, as being written just after 1900. In a letter to Freud in 1909 Jung wrote, 'it has become quite clear to me that that we shall not solve the ultimate secrets of neurosis and psychosis without mythology and the history of civilisation'

(McGuire and McGlashan, 1979, p. 169). This foretells his lifelong interest in the place of imagery and symbol and in the historical archaeology of their place in psychological matters. His methods in relation to imagery have been judged by art therapists to be methods of amplification, as opposed to the more convergent methods prescribed by Freud in relation to imagery. It is possible to find evidence of both methods in the approaches used by art therapists.

Aniela Jaffé in her section of Jung's *Man and His Symbols* discusses the idea that modern art sometimes demonstrates a retreat from reality a 'lack of reflection, and the predominance of the unconscious over consciousness' (1964, p. 260). Later in the same passage she describes the consternation created by Jung's suggestion in 1932, that Picasso's work was sometimes flooded with unconscious material. She also writes that 'it is now realized that schizophrenia and the artistic vision are not mutually exclusive' (1964, p. 260). This statement begs a number of questions to which I return in chapter nine.

What is important about Jung's work is his affirmation of the place of imagery and symbol in working with people who are disturbed; indeed, he shows that the connection between madness and images has an ancient lineage. As early as 1900, during the time of his early days of work with schizophrenic patients at the Burghölzli Hospital Clinic in Zürich, Jung was asked by Eugene Bleuler to give a report on the interpretation of dream images. Also, his PhD thesis in 1906 was entitled *The Psychology of Dementia Praecox*. Jung's close association with the work of Eugene Bleuler in relation to schizophrenia is not widely known. However, at some point there was a disagreement between them concerning the use of psychoanalytic methods with disturbed patients. This rift appears to have been permanent; it is referred to in correspondence between Jung and Freud in 1911 (McGuire and McGlashan, 1979, pp. 238, and 248-9).

Bleuler, who was Kraepelin's contemporary, had a more optimistic idea of the outcome of the psychoses. It was he who used the word schizophrenia for the condition described more pessimistically by Kraepelin as dementia praecox. Freud considered both terms to be unsatisfactory. He proposed the term paraphrenia (Freud, 1911, p. 463) on the grounds that this word would evoke fewer preconceptions. The term did not achieve common usage.

For Freud the cardinal distinction between psychotic and non-psychotic states, was the leaving hold of 'reality'. He described psychotic states in the same language he used for the unconscious and firmly distinguishes them for secondary processes. In the midst of psychosis he suggests that primary processes function; instinctual energy is free, wishes pursue a pleasure principle and the rules of reason and logic no longer prevail. In addition there may be a different sense of time.

Freud's main examination of the nature of psychosis is included in his study of Schreber's autobiography. Schreber's autobiography *is* extraordinary; it demonstrates some of the characteristics of thinking under attack. Of his visionary and hallucinated experience in the midst of psychosis Schreber writes:

> Each time they approached me they lost part of their nerves in favour of my body through the power of attraction; finally they consisted only of one single nerve, which for some mysterious reason not further explicable, assumed the form of a "little man" (Schreber, 1903, p. 83-5).

These little men were said by Schreber to live briefly in the hair on his head.

figure nine

I do not know whether Steadman's cartoon in his book *Sigmund Freud* (1979) was intended to illustrate what Schreber describes, it seems pertinent to show it here. Later in the same passage Schreber continues his account:

> in recurrent nightly visions the notion of an approaching end of the world, as a consequence of the dissoluble connection between God and myself. Bad news came in from all sides that even this of that group of stars had to be "given up"; at one time it was said that even Venus had been flooded...

> ...the impression gained hold of me that period in question, which, according to human calculation, stretched over only three to four months, had covered an

immensely long period; it was as if single nights had the duration of centuries…(Schreber, 1903, p. 83-5).

Freud's interest in Schreber (1911) is often indicated as marking the beginning of his interest psychosis. He did however, have some seriously disturbed patients before the time he was writing about Schreber. His discussion of Schreber is not straightforward, but in it he does make some helpful remarks about the way he views the nature of psychosis.

At the time he was writing about Schreber, he suggests that the main difference between neurotic and psychotic defences is that a neurotic defence might make someone go into flight, whereas psychosis would be more likely to involve a desperate attempt to 'remodel' reality.

A fundamental point by Freud

Freud also makes a fundamental point that describes a reality that has influenced the course of work with seriously disturbed patients throughout this century.

> The analytic investigation of paranoia presents difficulties of a peculiar nature to physicians who, like myself, are not attached to public institutions. We cannot accept patients suffering from this complaint, or, at all events, we cannot keep them for long…It is only in exceptional circumstances, therefore, that I succeed in getting more than a superficial view of the structure of paranoia … (Freud, 1911, p. 387).

At the end of the 1900s the great majority of patients with serious mental disorders were still treated in public institutions, and, as yet, this means that the majority do not receive help with finding a sense of meaning for their experiences.

Freud's discussion of Schreber involves his thinking about the material in the autobiography as though it were the manifest content of a dream. His formulation about the origins of Schreber's breakdown being associated with the fact that he and his wife had not been successful in having children are convincing. In addition the part of the account discussing the appearance for Schreber of homosexual feelings seems plausible. Unfortunately though this may be the origin of a strain of biological determinism within psychoanalysis, which long maintained an association between homosexuality and pathology.

Freud's theoretical formulations about psychosis were to undergo a number of fluctuations. In 1916 he wrote: 'These patients, paranoics, melancholics, sufferers from dementia praecox, remain on the whole unaffected and proof against psychoanalytic therapy' (1916, p. 438-439). This conclusion was largely due to Freud's idea at this time, that in the midst of psychosis the patient would not form a transference relationship with the analyst. 'Observation shows that sufferers from narcissistic neuroses have no capacity for transference or only insufficient residues of it. They reject the doctor, not with hostility but indifference' (1916, p. 447).

Freud's pessimism, about psychoanalysis for people with psychotic conditions appears to increase during the period between two series of *Introductory Lectures* in 1916 and 1933. His pessimism may have been connected with his work at that time relating to his theory of a death instinct. In 1940 he returns to a discussion of the treatment of psychosis in *An Outline of Psychoanalysis*. Here he suggests the need to make an ally of some part of the patient's ego and that this is not feasible for the psychotic patient, but he does begin a discussion of the process of splitting which seems to occur in the midst of psychosis. Klein, Rosenfeld and Bion later took up this idea.

It seems likely that a personal antipathy was also involved for Freud. A quotation from a letter sent by him to a colleague in 1928 is interesting.

> Ultimately I had to confess to myself...that I do not care for these patients [psychotics], that they annoy me, and that I find them alien to me and to everything human. A peculiar kind of intolerance which undoubtedly disqualifies me as a psychiatrist (McGlasham, T. M., 1983, p. 21).

Freud's honesty here is disarming.

Juliet Mitchell proposes that whereas, 'Freud always thought of himself as a poor therapist, Klein was a superb clinician' (1986, p. 30). In the early stages of her career Klein was a careful follower of Freud. Then as her work developed differences between her approach and his began to appear. Abraham encouraged her to pursue her interest in the possibilities for child analysis. The play technique developed from 1955 is remarkable and has had wide-ranging impact. Klein developed it as a result of working with clients who had very little language, i.e., with very young children or with children who were autistic. She claimed that the play technique was the equivalent of the free association used in Freud's methods to gain access to the unconscious. Her main diagnostic method was to find a way of understanding the nature of the client's anxiety.

> It has already been pointed out in the introduction to this paper that my attention from the beginning focused on the child's anxieties and that it was by means of interpreting their contents that I found myself able to diminish anxiety. In order to do this, full use had to be made of the symbolic language of play which I recognized to be an essential part of the child's mode of expression. As we have seen, the bricks the little figure, the car not only represent things which interest the child in themselves, but in his play with them they always have a variety of symbolical meanings as well which are bound up with his phantasies, wishes, and experiences. This archaic mode of expression is also the language with which we are familiar in dreams, and it was by approaching the play of the child in a way similar to Freud's interpretation of dreams that I found I could get access to the child's unconscious. But we have to consider each child's use of symbols in connection with his particular emotions and anxieties and in relation to the whole situation which is presented in the analysis; mere generalized translations of symbols are meaningless (Klein, 1955, p. 51, in Mitchell's selection).

There are clear parallels and possibilities here for art therapy. Indeed, many possibilities opened up as a result of Klein's work. Although she focussed her work upon

child analysis, she paved the way for others to begin analytically informed work with people with a history of psychosis.

Mitchell identifies four mechanisms that are essential to an understanding of Klein. These are *splitting, projection, introjection and projective identification.* Klein describes the normal process of infant development as containing all of these elements but 'excessive use of these defences is psychotic' (Mitchell, 1986, p. 20-1). It is interesting in relation to symbol formation that, 'in some psychotic conditions, no anxiety is expressed, then there is stasis and no, or severely reduced, symbol formation including language' (Mitchell, 1986, p. 22).

It is helpful to read Mitchell's thoughts, situating the work of Klein in broad philosophical terms. She suggests that it is not helpful to think of Klein in the same terms as one of the scientific theorists of the nineteenth and early twentieth centuries as, for example, Darwin, Marx or Freud who all explain the present through an analysis of the past. She suggests that Klein is part of a later twentieth century tradition that espouses sociological phenomenology and tends to study 'lateral, horizontal, not vertical, relationships' (Mitchell, 1986, p. 29). I'm not convinced that history can be apportioned so neatly but I realise that Mitchell wants her reader to understand something fundamental about Klein. This is that Klein's method of theorising perceives the past as existing in the present.

> It is always recognized that Klein's theory itself can be somewhat confused. It is held that the confusion arises because theory is really more a descriptive phenomenology that sticks close to the complexity of her clinical material. Without doubt such an explanation is correct...Being a good clinician is not the same as being a good theoretician, but being good at identifying with what one observes in order to follow what is going on in something other than oneself and then describing it constitutes an intermediary level of conceptualisation. This is Klein's achievement — but it is more than just that. Just as Freud theorizes the construction of what scientific theory is about, so too, Klein identifies and describes what intuitive, identification and clinical observation are about: areas of confusion, fusion, lack of boundaries, of communicating without the differential structure of speech (Mitchell, 1986, pp. 30-1).

These matters are the substance of Klein's approach and they make clear the reasons her work has been taken up by so many who wish to understand psychotic experiences.

Contemporary psychoanalytically informed practice

There exist many interpretations of those psychoanalytic concepts that can be used as a way of understanding the nature of psychosis. A number of perspectives have relevance to work in the public sector and some are particularly significant for art therapy. For art therapists the list would include Klein's play technique and Hannah Segal's concept of symbolic equation which both have radical consequences for work with people in the midst of psychosis. It would certainly include Jung's particular interest in psychosis and the ways in which he understood the archaeology of imagery. Also much used by art therapists have

been Winnicott's ideas about the process of containment and the significance of play. The vexed question of whether there is a need to modify practice in relation to psychosis is complicated for art therapists (and others) by the similarly vexed question about the need to modify practice in relation to the circumstances for it in the public sector.

Many people working with psychosis refer to work in the Kleinian tradition; a smaller number take guidance from a more general approach to Object Relations ideas from the work of the middle school. A paper by Armstrong-Perlman makes particular references to the work of Fairbairn. She posits psychosis as a loss of self in her paper, 'Psychosis: The Sacrifice that Fails? (1995).

Jackson's work regularly provides an outline of the conflict between the Ego Psychologists, who offer supportive work in the face of what they see as boundary impairment (Federn 1952), and the Kleinians who tend to view psychosis as evidence of powerful defensive strategies. This is because his work often provides a helpful overview of the contemporary theoretical field. He suggests that the ideas of Klein and Bion are particularly useful, while readily acknowledging that psychotic communication can be viewed through very different frames of reference. His long experience in the Health Service tends to mean that he does not take a catholic approach to any one school of thought. I think it is reassuring for public sector psychiatric workers to have examples of revered figures working to integrate various psychoanalytic approaches with the realities of psychiatric practice.

In his later work Winnicott became such a figure for many in the health service. He seems to have started out by adopting a Kleinian approach and not altering classical technique when meeting with disturbed patients. Then later in his career he began to propose that in the first instance, in therapeutic work with disturbed clients management is all (Winnicott, 1954, p. 279). His work with Margaret Little when she was his client illustrates this. The ways in which his work concerning containment and play, has had such a wide appeal to art therapists are returned to at several points in section three.

In many accounts the contribution of the Kleinian analysts are remarked upon as being amongst the first to work with clients in the midst of psychosis, they include Rosenfeld, Segal, Bion, Joseph, Money-Kryle, Meltzer and Rey. Robert Young (1995) offers a way of philosophically situating Kleinian and post Kleinian practice.

Harold Searles is also mentioned in much of the literature because he provides vividly portrayed accounts of his relationships with his most disturbed clients. I think his work appeals to many people because it captures the sense of extraordinary commitment that practitioners (from all disciplines) sometimes demonstrate in relation to their work with the most disturbed. However, Rosenfeld makes technical criticisms of the level of involvement by Searles with his patients. These criticisms make sobering reading.

Searles examined the schizophrenic transference in admirable detail and has become aware of the importance of projection and projective identification in the transference. I think, however, he is seriously mistaken in his belief that the analyst should enter into the symbiotic transference as a state of mutual dependence, in which the analyst feels as dependent on the patient as the patient on him and often expresses his feelings of love and hate quite freely to the patient. I feel that Searles, who has trained himself to elaborate use of his countertransference feelings, is sometimes carried away by them and does not sufficiently acknowledge or recognize the patient's projected desires for a mutual relationship with the analyst which eliminates the differences between child and adult (1988, Rosenfeld, p. 164).

Rosenfeld goes on to describe Searles technique as 'acting in' (p.165) and he suggests that this leads to an increase in the ego weakness of the psychotic patient. Although I can see the last point that Rosenfeld is making here, it seems to me that it is problematic to generalise to the extent he does about either Searles or psychotic patients.

Searles (Langs and Searles, 1980) does a good deal to justify his approach in what Young has described as 'gladiatorial dialogues' (Young, 1995, p.41) with Robert Langs. Langs is known for his strictures concerning the therapeutic frame, but as far as I know he is not known for his work with clients in the midst of psychosis. Criticisms made by Langs of Searles have a flavour of those made generally about R. D. Laing. The criticisms do not anywhere acknowledge the circumstances of Searles work were those of public sector psychiatry in America.

Projective identification

The concept of narcissism has long been associated with psychoanalytic explanations of psychosis. The narcissistic patient is said to withdraw so completely that they are not contactable by the analyst. However, recent theorists tend to use the use the concept in relation to 'borderline states'. Fakhry Davids makes use of the concept in this way in his paper, 'The Management of Projective Identification in the Treatment of a Borderline Psychotic Patient' (1995). The concept of projective identification is not straightforwardly associated with psychosis, although it is referred to frequently in many accounts of clinical work. In connection with psychosis I think that the question of projective identification is complicated because of different theoretical positions about the question of whether to use the transference or alter the technique in relation to psychosis.

Bell makes some of Bion's theories in relation to psychosis more accessible (1995). It is interesting the way in which he traces the history of Freudian ideas. Mental disturbances were first posed as the result of damned up libido, before a theory developed which considered the trouble to be caused by moral conflict that originated in an excess of love or hate. In a manner that is of relevance to art therapists, Bell suggests that Klein's play technique enriched the concept of transference and that this enabled some of the first analytic work in the area of psychosis. Bell also gives a clear exposition of Bion's ideas about work groups and basic assumption groups: the latter sometimes providing terrifying

breeding ground for psychotic processes. Psychotic processes are to be distinguished from a full-blown psychosis.

Young also indicates the ways in which psychotic processes have powerful effects upon groups and institutions, citing the work of Bion, Jaques, Menzies-Lyth and Meltzer. He cautions us to remember.

> Having objects into which to project is the *sine qua non* of mental well-being. But we do so in a vulnerable space, on one side of which are nameless dread and a black hole and on the other the intense projections of outgrouping, racism and virulent nationalism (Young, 1995, p. 48).

Young's exposition makes a clear case for allowing that human distress and he includes psychotic anxieties, must be a part of what it is to be human. He considers and contrasts Freudian and Kleinian ideas in relation to psychotic processes and *repositions* these ideas within a philosophical, cultural and political framework. I think such repositioning is helpful; it enables a perspective that has a wide view. This enables thinking to take place at some remove from either, the cloisters of psychoanalysis or the strictures of psychiatry (Young, 1995, pp. 34-53). In particular the repositioning has helped me reassess the contemporary significance being placed upon the concept of symbolic equation in art therapy literature. I discuss this in chapter six.

Is there a need for a classical analytic attitude and technique, or for a technique that accommodates psychosis?

It is interesting that the art therapist and analyst Killick felt that the nature of her engagement with psychotic processes 'differed from that which I had been trained to understand' (Killick, 1993, p. 108). She is at this point referring to her art therapy training (during the late 1970's) and suggesting that it did not take sufficient account of the specific nature of psychosis.

I suspect that here she is referring to Laing's ideas that would have been much used by art therapists and in art therapy training during the late 1970s. Specifically she is almost certainly questioning Laing's idea in the light of 'symbolic equation' that, 'it was far more possible than is generally supposed to understand people diagnosed as psychotic' (1959, p. 11). Yet Laing's ideas concerning 'implosion', 'engulfment' and 'petrification' are not so different from those by Bion that propose 'attacks on linking'.

Killick's paper (1993) about working with psychotic processes is of particular interest to art therapists, but it also has a wide relevance. Her work raises the controversial issue for theory and practice about whether or not there is a necessity to change technique of practice in the face of psychosis. It also raises a question about the duration of symbolic equation associated with psychotic states (I return to this in chapter six).

Much psychoanalytic literature contains clear examples of theory, technique and therapeutic strategy in relation to work with patients with psychotic experiences. Rosenfeld

suggests (1988) that there have been two main groupings in psychoanalysis in relation to the question about whether or not to modify technique in the face of psychosis. In fact it is sometimes difficult to see clear lines of distinction between them.

The first tendency

The first tendency or group (I stress that these are loose associations) see narcissism/psychosis as a complete obstacle to psychoanalysis unless the analytic technique is changed. The perspective of this group of analysts suggests that the disorder is caused by some early trauma in the facilitating environment and what is needed is the provision of new and better 'parenting'. Included among this group are L. P. Clark, the early work of Fromm-Reichman and the later work of Winnicott (1958). Also Searles might be included, although his position changes and adopts the position of the different groupings during different periods of his practice. As practitioners grappled with different therapeutic relationships fluctuation in the position they assumed regarding technique was quite common.

Clark in 1933 identified some problems of over idealisation by patients when working from the perspective of the first group. Fromm-Reichmann, worked for 20 years at the American Chesnut Lodge Sanatoruim that is famous for its psychotherapeutic work in relation to psychosis. In her first paper in 1939 (cited in Rosenfeld, 1988) she echoed Clark's idea of narcissistic injury and recommends an atmosphere of complete acceptance for disturbed patients. She changes her position and moves towards the second grouping in later work.

However, the later work of Winnicott (1958) seems to change to the approach loosely associated with the first grouping. It is interesting that he began by being influenced by Klein and seeming to have views which accorded with analysts in the second grouping. However his position changed after his paper of 1945, 'Primitive Emotional Development,' when he had seen no dramatic changes from the classical approach as being necessary. In *The Maturational Process and the Facilitating Environment* (1958, published as a collection in 1963) he adopts Clark's position of the necessity of repair to early environmental failure. Searles position fluctuates, but for a time his technical approach fitted with the first group and 'environmental repair'. Earlier, Walder in 1925 (cited in Rosenfeld, 1988) and later Edith Jacobson in 1967, also alter their psychoanalytic technique in the face of psychosis. (Jacobson mainly worked with people with manic-depressive psychosis). They decided against analysing the transference with clients in the midst of psychosis and worked instead to maintain a positive transference.

The second tendency

The second historical tendency is represented by groups of psychoanalysts who deal with narcissism and other psychotic manifestations using a classical approach with only minor alterations, i.e., the same analytic attitude with only minor differences of technique.

Abraham's collected papers (1927) show that as early as 1907 he was writing about the problems of psychosis, but his particular contribution came a little later with his work on manic-depressive disorders. Then in 1908 he was writing of the, 'the negativism of dementia praecox as the most complete antithesis to transference'. Then in 1912 he made reports about work with six manic-depressive patients in which he gave clear accounts of transference phenomena. Stern (1938) Cohn (1940) Bullard and Stone (1940) all describe both positive and negative transference and work in the classical method using classical interpretations.

Federn made very detailed contributions from 1943 beginning with 'Ego Psychology and the Psychoses', which introduced the notion of transference psychosis. He believed that it is possible to work psychoanalytically with psychosis, but he modified his approach quite considerably. Federn (although his work with psychotic patients was at the turn of the nineteenth century) seems to represent the pragmatic merging of different strategies. This merging of the two tendencies now seems characteristic of contemporary psychoanalytic practice in relation to psychosis. Rosenfeld quotes various sections of Federn's 1943 work as an illustration of this modified method:

> First abandon free association, second abandon analysis of the positive transference, third abandon provocation of transference neurosis, because it quickly develops into a transference psychosis in which the analyst becomes the persecutor. Fourth, abandon the analysis of resistances which maintain repression. Phobias are left undisturbed because they protect against deeper fears and conflict...In analysing the psychotic regression must not be increased (Rosenfeld, 1988, p158, quoting Federn).

> ...The psychoanalyst shares the acceptance of the psychotic's falsification as realities. He shares his grief and fears and on this basis reasons with the patient. When convinced that by this procedure the patient feels himself understood the analyst presents the true reality as opposed to falsification. He then connects this with the patient's deeper fears and conflicts and frustrations (Rosenfeld, 1988, p.159, quoting Federn).

Interestingly in contrast to Freud, Federn thought that loss of reality is a consequence of and not the cause of basic psychotic experience. However, it was Federn's idea concerning the splitting of the patient in relation to their healthy and psychotic parts that was taken up by Freud in his, 'Outline of Psychoanalysis' (1940).

After 1935 there was a marked increase in studies of psychoses. For example, Sullivan a public sector psychiatrist in Australia wrote many papers (published as a collection in 1947). His developmental theory was based on that of Frieda Fromm-Reichmann whose early work was based on the notion of narcissistic injury. In later papers

1955, 1952 and 1954 (the last two cited in Rosenfeld, 1988) Fromm-Reichmann revised and criticised her earlier approach. Then the later work of Searles seemed to straddle both tendencies. Whereas, the work of Segal, Bion and Rosenfeld was much more catholic in its relationship to the issue of psychosis and they maintained an analytic attitude with only minor adjustments of technique.

All of these matters have a potent relevance to what takes place now. However, a translation of this dialogue within psychoanalysis in order that the thinking it represents can be used within the public sector, is not straightforward. In fact although the psychoanalytic community continues to contribute widely to thinking about practice with people with serious mental disorders, it is internationally acknowledged by this community (1997, ISPS Conference) that their actual contact with clients with serious disorders is small.

There are some notable exceptions of psychoanalytically inclined practitioners who are based within the public sector and as a result they have caseloads in which there are significant numbers of disturbed clients. The work of Valerie Sinason (1992) is a clear example of this. She offers numerous descriptions (that are very moving) of psychoanalytic psychotherapy with severely and profoundly handicapped patients, who also have serious mental health problems. I think it is clear that she adapts her practice both in order to reach her clients and to acknowledge the circumstances of their lives in relation to the public sector. Her adaptations and her work in general have produced controversy. The adaptations of the therapeutic frame by art therapists working in the public sector are considered throughout section three.

Adaptations made to the therapeutic frame when working in the public sector are as a result of the day-to-day impact upon staff of seeing large numbers of people with serious disorders. I think that the numbers of patients and the circumstances of public sector work mean that even when a psychoanalytically informed perspective is adopted (not much supported in the NHS) some pragmatic modification of technique is necessary in order to respond to the impact of psychosis. For example, one way in which some art therapists working in the community have responded to the changing circumstances of their work is to offer a supportive psychotherapeutic approach in some instances.

However, a modification of technique by any discipline provokes questions about the psychotherapeutic nature of the work and the level of coherence it is possible to maintain for it. These are questions that might be legitimately posed by evidence-based researchers. Modifications in technique certainly provoke specific questions in relation to the practice of art therapy. Rosenfeld's suggestion has wide applicability:

> The therapist should ask himself whether he is inclined to change his psychoanalytic approach because he does not understand the psychotic patient or because he believes he has arrived at a better understanding of psychotic psychopathology, and that

alterations in technique are the outcome of his understanding (Rosenfeld, 1988, p. 147).

Conclusion

I hope it is clear that I find the theoretical tradition of psychoanalysis helpful. It has enabled me to think about therapeutic work I continue to do in an area that is notorious for its 'attacks' upon 'linking' or thinking. Ideas taken from the wide field of psychoanalysis have helped me become more aware of the dangers of generalising about psychosis and the people who succumb to it. In the midst of psychosis people do not all paint the same picture.

Questions about therapeutic technique appropriate for work with people with serious mental disorders were not resolved and they remained controversial throughout the twentieth century. Although continuing questions about the nature of practice are related to the difficulties inherent in the condition of psychosis: they are also connected to the continued political estrangement between psychoanalysis and psychiatry. This also endured throughout the twentieth century and is in no small measure related to the surprisingly fundamental effects of the economy upon the political will and its inclination to provide for people with serious mental disorders, the majority of whom are connected to public institutions. The next chapter considers this in relation to class issues in therapy.

The fourth section, which follows chapter four, keeps Rosenfeld's cautionary note in mind but it returns to adaptations of technique necessitated by the public sector.

Chapter Four:

Class Issues in Therapy:

> Events...especially the defeat of the great miners' strike of 1984-5, and Labour's successive reverses in the general elections of 1983 and 1987, *(and 1993, my brackets)* have lent apparent credibility to the idea that the working class is finished as a social and political force (Callinicos & Harman, 1987, p.1).

Despite the widely spread pronouncements by multimedia and academics that we have either seen the end of class divisions or that they are no longer significant most people still have an idea of the class from which they originated and this shapes their sense of identity.

I am often intensely aware of the influence of class upon different aspects of my work as an art therapist in the health service. However, my impressions of the part that class plays in relation to a person's mental health are not easily articulated; indeed, class issues in therapy are not widely discussed.

I hope in this chapter to be able to show some of the connections between health and class that I am aware of during my work as an art therapist with the mental health services. I focus upon matters which are likely to affect people who are either lower middle or working-class because my experience of working in the public sector has largely been with people from these origins. I also hope to indicate some of the areas that seem to me to deserve the attention of art therapists in relation to practice; issues of class provoke some questions about therapeutic technique and philosophy. They also provide a framework with which to understand the alienating consequences of the experience of psychosis.

Sometimes it takes an outsider to help us see what are the elements of our identity. The Finnish photographer Sirkka-Lissa Konttinen came as a young woman to live in Byker, the working class district of Newcastle. She lived with people there and took their photographs over a ten-year period.

> I came from a small papermill town in Finland via a short stay at Helsinki University, and a film school in London. Out to acquire skills on a meagre bank loan, and to learn about life...I arrived from one set of conventions to another; a stranger in more than one sense (Konttinen, 1988, p. 5).

She records her memories of the way people in Bykker thought about her during her early days there:

> 'She's left home' (neglecting her duty towards her parents). 'She comes from Finland, such a beautiful place, nice and clean, and she *chooses* to live in Byker' (what's the matter with her?). And a year later. 'She hasn't got her nets up *yet*. She plays the *piano*; she drives a *van* (thundering scrapheap, never seen a bucket of water), *and* rides a rusty bicycle (she rides anything!). She goes round taking photographs, and *gives* them away

for nowt (she working for the S.S., or just a mug?). And she doesn't cotton on to half the cracks, poor soul — mind, A cannot understand a word of what she says either. But she's alright— canny, aye. Poor little bairn, so far from home, and is she even married to that man?' (Konttinen, 1988, p. 5).

Many aspects of class identity and the puzzlement caused by independent womanhood are in this account. The photographs she took show connection contrasted with loneliness; people living, people dying and the elements of family life. It is possible to see the echo of ancient myth and tragedy in these pictures, but they all come from a different set of conventions to those normally encountered by psychotherapists because the people depicted in the photographs come from a different class *(see figures ten, eleven and twelve)*.

Class and difference

'Difference' is the word currently used for describing the huge gaps that exist between people in terms of wealth, health and opportunity. Meiksins Wood (1986, p. *xii*) suggests that the use of the word has been part of a tendency to depoliticise issues and assign them to forms of the post-modern 'discourse' that became prevalent in the late 1980s and 1990s. Difference is attributed to race, gender and disability. Discussions about difference that are prescribed by an institution run the risk of becoming sanitised. Whereas when such issues are analysed within the broad framework of class it is difficult to remove and sanitise the societal conflict that these matters represent. An understanding of class can add clarity to some aspects of the therapeutic relationship in ways that may help to improve practice.

Discussions about the significance of race and culture in the shaping of a person's experience regularly overlook the place of class. Something similar happens within discussions about gender. Differences of gender are not are not experienced in similar ways universally. The differences of power between women in government or women with great wealth compared with those women trying to support several dependants on a minimal wage are enormous. Their experiences of the world are extremely different because of their class position. On the surface this seems obvious but it can be the origin of quite passionate arguments.

Race, gender and disability shape experience and can have a profound impact. Cultural issues are more general, and, although they do provoke passionate feelings, they tend not to be experienced quite so personally or as partisan. This cannot be said of class.

Political movements which intend to raise awareness about (for example) racism; sexism, sexual preference and disability have done much to raise the general level of understanding. More tolerance of difference does seem to have been born of the different

figure ten
Byker photographs by Konttinen
(1988).

figure eleven
Byker Photographs by Kontinnen (1988)

figure twelve
Byker Photographs by Konttinen (1988)

struggles made by people arguing for change in political movements throughout the world. This is dramatically illustrated by the cultural time lapse that exists in the former eastern bloc countries; with the possible exception of Czechoslovakia, people in the eastern European countries were not easily able during the time of the old regime, to form political movements and struggle for change. The results are uncomfortably plain to see: despite the false socialist rhetoric of their former governments, many ordinary people who grew up under the old regime express opinions which might have been common in the west some three generations ago. There are high levels of sexism (even amongst women against themselves) extreme homophobia and racism, and now there are politicians with fascist programs prepared to exploit the fear and hatred which is further fuelled by the desperate economic situation. This terrible exploitation of fear, hatred and economic difficulty has resulted in many wars in the last decade of this century. The devastation visited by war has been experienced directly in a number of the former eastern-bloc countries and in the third world. Although Britain participated in many of these wars, they have not directly affected the general population.

However, this political backdrop means that all areas of difference continue to be matters over which people need to struggle, the level of struggle necessary being determined by the political landscape. In the first year of this century both the major political parties in Britain tried to manipulate and encourage racist sentiments against refugees and asylum seekers. This was in the wake of much government rhetoric about the racist murder of Stephen Lawrence and government led calls against 'institutional racism'. This does seem to demonstrate that political movements resulting from widespread opposition are more influential than those that attempt to impose 'corrective' attitudes about difference from above. Another example is shown by the need for renewed efforts against homophobia at the time of the Clause 28 Legislation; also the infamous Community Charge (poll tax) was clearly seen as an attack on the class of people with lower incomes and this provoked widespread resistance.

Human differences all over the world create strange hinterlands of overlapping experience, for example, a woman who sees herself being treated as a second class citizen in terms of wages or childcare provision will share on some level the experience of a black man turned away from too many jobs with no good reason. Of course, the shared experience will not always be recognised. One thing it seems important to stress is the idea that there is no inherent moral superiority in the difference itself. This is true of race, class, gender, sexual preference and disability. The contemporary impulse in our society to acknowledge and work

with difference takes many guises. Some social movements have produced a popularised push for understanding of difference, while in other developments the impulse has been incorporated into institutions and professional training and legislation. Of course this has not simply resulted in the steady improvement in our understanding of difference: many concerns about class, race and gender can provoke feelings of chauvinism; an arched-back moral high ground where most of us might sometimes find ourselves standing with hand on hip. Chauvinism and moralism are rarely productive, they can lead to relationships corrupted by guilt, or worse, they can contribute to the process of scape goating. This can even lead to actual physical attacks; this is clearly seen in the case of racism. Violent racist attacks are almost without exception generated by right-wing bigotry. However, chauvinism and moralism forge a particularly pernicious double-edged sword on both right and left sides of the political spectrum.

It is not surprising in the face of serious provocation that people develop a sense of outrage. This is a proper response. Nevertheless, sometimes-justifiable reactions are confused with strategies for change. A high-handed moralistic position is not a strategy for change; a moralistic attack upon someone's lack of awareness or upon his or her lack of a shared difference is not helpful in any area where there is a question of difference. These ideas are particularly pertinent to the world of therapy. Therapists need to be able to make relationships with clients that are not corrupted by their own guilt. Clients need to feel that their differences will be acknowledged and that the therapist will make an honest attempt to understand their experience. Any understanding that develops as a result of effective therapeutic work may contribute to the general pool of understanding of the part difference plays in our lives. However, it seems important not to confuse this work with the need for broader political movements for change.

Mental health provision and class

The history of mental health legislation in this country has developed out of legal welfare provision. Kelvin and Jarrett, in an interesting and helpful book concerned with the social psychological effects of unemployment, trace the history of contradictory attitudes to unemployment back to the 1349 parliamentary Ordinance of Labourers. It was this Ordinance which distinguished between 'sturdy beggars' and the 'deserving poor'; a distinction which has lasted until the present time, emerging at one point in the infamous Poor Law of 1834, which introduced the workhouse as the ultimate deterrent to those 'less eligible' for 'outdoor relief.' Kelvin and Jarrett suggest that that many tenets of this age-old 'work ethic' are in fact a

'wealth ethic' (Kelvin and Jarrett, 1985, p.104). It was out of the much-feared workhouses that the first mental hospitals developed in this country.

As I have indicated in chapter one, it does seem that the opposition of 'deserving' and 'undeserving' prejudice was incorporated into mental health legislation and practice. I also indicated there that Foucault (1967) made a case to show that throughout Europe mental illness was associated with idleness and it was widely thought that those who inhabited the mental hospitals or 'houses of correction' were those who *would* not work.

All of these moralistic associations of 'deserving' and 'undeserving' persist in relation to the present day treatment of people with a history of psychosis. There was some research in the 1970s (Brown and Harris, 1978) that tended to indicate a class bias (if not a moralistic bias) to diagnosis and treatment. I am not aware of contemporary research in this area. It seems unlikely due to the political climate that research concerning the influence of class will have been conducted during the 1980s and 1990s; although towards the end of the 1970s and the 1980s there was some research that considered race bias in diagnosis (Harrison, 1975; McGovern and Cope, 1987).

The difficulties and stigma experienced by people with mental health problems are widely acknowledged. Theories about the poor social and economic circumstances in which people with enduring mental health problems find themselves hinge on two kinds of account. Those which poses the origin of such circumstances in the mental illness itself which leads to downward social drift: or those that suggests that poor living circumstances contribute to the higher incidence of mental illness as a result of social and economic stress. There is strong evidence from different parts of the world that the difficulties of life for people in the lower classes contribute to their higher incidence of physical and mental ill health (Whitehead, 1987; Blaxter, 1988{cited in *The Black Report and Inequalities in Health*}; and Warner, 1985; WHO, 1985; Commission for Social Justice, 1994).

Mind uses figures from the Office for National Statistics (Meltzer, et al. 1995) to produce the following table that shows the incidence of severe mental illness in relation to social class.

Adults with significant mental health problems — by social class

Social Class	Female	Male	All-
I (professional)	16%	6%	10%
II (managerial)	14%	11%	13%
III NM (non-manual)	18%	13%	6%
III M (skilled manual)	19%	11%	14%
IV (semi-skilled manual)	22%	11%	16%
V (unskilled manual)	24%	13%	18%

Table 7: Cited by MIND and taken from (Meltzer, et al. 1995)

It is clear from Warner's powerful international studies (1985, discussed in chapter one) that social economic factors influence the course and appearance of the schizophrenias. Warner also points to the similarities in the psychological effects of unemployment and those of long-term mental illness. Work problems, economic stress and unemployment influence the incidence of suicide throughout the world and periods of economic boom and slump affect the use of mental hospitals. This probably confirms what most people suspect, namely that social and economic stresses are a fundamental contributor to mental illness. Jarret and Kelvin quote research made by Zawadski and Lazarsfeld in 1935 that led them to postulate six stages in the emotional response to unemployment:

> (1) reactions to the dismissal itself, with a sense of injury, fear, sometimes hatred, fury, desire for revenge; then (2) numbness and apathy, replaced by (3) calming down, some adaptation to circumstances, a trust in God, fate, or one's own ability and a belief that things will soon get better; however (4), this hope fades as one finds that one's own efforts are futile and when (5) the situation worsens, *savings* and *resources run out,* there is hopelessness and fear, of winter, of hopelessness; and after that comes (6) acquiescence or dumb apathy and the alternation between hope and hopelessness, activity and passivity, *according to momentary changes in the material situation* (Kelvin and Jarrett, 1985, p. 20).

Kelvin and Jarrett are largely quoting the words of Zawadski and Lazarsfeld here but they include their own italics in order to indicate what is often the material basis for the fluctuations in mood. This is also something of which I am keenly aware in working with people with long-term psychiatric histories — yet the material influences upon their lives are rarely commented upon in psychological research.

In Britain two reports commissioned by Conservative governments in the 1980s collected substantial evidence of the effects of poverty upon health. The first was the 1980 report of the Working Group on inequalities in health (known as the *Black Report* after its Chairman and edited by Townsend and Davidson, 1988). The second was a review published by the Health Education Council (1987, edited by Whitehead) of the studies made on the same

subject which had been made subsequent to the publication of the *Black Report* and is known as *The Health Divide: Inequalities in Health in the 1980s*. Some relatively ineffectual attempts to suppress the findings of the two reports were made by government officials. Both reports were judged to be political dynamite for the Conservatives, especially the second report which appeared during an election year. In the event the government's attempt to suppress reports they had in fact commissioned produced an uproar that echoed throughout the national media. This meant that a much wider audience than such a report might have been expected to reach, read *The Health Divide*.

The *Black Report* drew attention to the fact that, whereas three decades of a Welfare System and a Health Service had played a small part in reducing inequalities in health, it would be measures aimed at reducing 'differences in *material* standards of living at work, in the home and in everyday social and community life' (Townsend and Davidson, 1980, p. 165) which would be of even greater importance (the italics are mine). Three main recommendations of the *Black Report* were:

- To give children a better start in life
- To encourage good health among a larger proportion of the population by preventative and educational action
- For disabled people , to reduce the risks of early death, to improve the quality of life whether in the community or in institutions, and as far as possible to reduce the need for the latter

As the report's authors also commented:

> Thirty years of the Welfare State and of the National Health Service have achieved little in reducing social inequalities in health. But we now believe that if these three objectives are pursued vigorously inequalities in health can now be reduced (Townsend and Davidson, 1980, p.201-202).

It is striking that a major report upon the health of a nation focused in its recommendations not upon health reforms but upon the social and economic conditions (indeed the class conditions) of a person's life. Following the format of the original *Black Report,* the review made by *The Health Divide* considered the influence on health of occupational class, employment status, gender, area of residence, ethnic origin and housing tenure. The evidence contained in *The Health Divide* suggested that serious inequalities in health persisted into the 1980s and in many instances had worsened: 'Those at the bottom of the social scale have much

higher death rates than those at the top. This applies at every stage of life from birth through to adulthood and well into old age' (Whitehead, 1987, p. 351).

Direct evidence that unemployment creates much worse physical and mental health became available at this time and was reported by *The Health Divide*. The health of working class women is shown to be particularly poor. There is evidence of striking regional variations in health (the north-south divide). There is a lot of circumstantial evidence to suggest that the health of ethnic minorities is poor, many of whom suffer bad housing, poor working conditions and a high risk of unemployment. It was also indicated that successive Conservative governments had reduced the collection of pertinent data: 'For example, in the past many have relied on the Registrar General's occupational mortality Decennial Supplements for authoritative information, but the latest supplement (1986) scarcely addresses the issue' (Whitehead, 1987, p. 354-5).

Interestingly the review also suggests that more 'sensitive ways of measuring social class' (Whitehead, 1987, p. 355) are needed in understanding the impact upon health of certain factors in a person's daily life. The Commission for Social Justice published the results of its eighteen months research in 1994. This report *Social Justice* was dedicated to the late Labour leader John Smith. The strategies for the future outlined in the report foreshadowed what has become government policy under Tory Blair. What is useful about the report is its information about poverty in Britain (cited above; & 1994, pp. 27-52).

> No one is satisfied with the state of the UK today — and with good reason. In economic and social terms, the gap between this country and our foreign neighbours is shaming. More important the gap between what we are and what we could be is a source of frustration and depression. But this report is not just a chronicle of decay; it also addressed to the causes of and remedies for national malaise (Commission for Social Justice, 1994, p. 52).

Some aspects of the report indicate what is needed to address poverty, but some of the strategies proposed, with hindsight, seem naïve because of subsequent world events. For example, countries whose economies have either subsequently collapsed or suffered economic crisis are held up as economic models:

> But economic and social modernisation are not easy: the countries that have managed it in the last 100 years — Germany, Japan, and now the countries of the Pacific Rim have all combined simultaneous reform of the financial system, investment in education and training, and reform or the state machine to produce as credible strategy for national renewal (Commission for Social justice, 1994, p. 114).

The idea of a 'gap between what we are and what we could be' (p. 52) is often a poignant one for lower class people whose opportunities have been limited. In addition, the chasm between levels of wealth and general issues concerning class markedly influences the health and welfare of people. The *National Service Framework: Mental Health* (1999) indicates a number of areas related to class, mental health and social exclusion. They appear throughout the report, but are most concentrated in the section concerned with mental health promotion (1999, pp. 27). A few examples that clearly relate class to poor mental health are:

- Unemployed people are twice as likely to have depression as people in work
- Children in the poorest households are three times more likely to have mental health problems than children in well off households
- Between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to a half may be alcohol dependent

(National Service Framework: Mental Health, 1999, p. 14).

It remains to be seen what in practice the recommendations of *The NHS Plan* will be upon 'a national inequalities target' (DH, 2000, p.9). It may also be the cause of some alarm if the plan's avowed intention to ensure that :

- hundreds of mental health teams to provide and immediate response to crises (DH, 2000, p.8).

This is because resources needed for the long-term support needed by people with serious mental disorders may be diverted in crisis work.

Low levels of awareness about either poverty or class in psychotherapy

It is possible to explain the absence of class-consciousness from discussions in the world of psychotherapy. The explanations might well be unsatisfactory in that they would be likely to invoke the inner world as the only rightful concern of therapy. It is more puzzling, in the face of the great divide opening between those with work and those without it, that class is not something that is more widely spoken about at a societal level. An HMSO publication *Social Trend* (21,1991, p. 25) indicated that the wealthiest 1 per cent of the population own 27 per cent of the wealth and the wealthiest 5 per cent own half of all wealth. Then the wealthiest quarter of the population own 80 per cent of all wealth and the bottom 50 per cent in society own only 7 per cent of the wealth.

More recent figures from the report chaired by Sir Gordon Borrie (1994) do not suggest that matters are improving.

For nearly forty years after the Second World War, the income gap between the richest and the poorest in the UK gradually narrowed. That progress has now been reversed. Today, the gap between the earnings of the highest-paid and those of the lowest paid workers is greater than at any time since records were first kept in 1886. While the best-off have increased their share of total income, the proportion going to the poorest is shrinking...The bottom half of the population who receive a third of our national income in 1979, now only receive a quarter. Nearly two-thirds of people live in house-holds whose income is below the average (Commission for Social Justice, 1994, p.28-9).

Great differences in wealth clearly exist but these differences are not manifest or obvious in the lives of the vast majority of people. Nevertheless it is clear that in the public sector poverty is likely to be a part of what a client needs to speak about to a therapist. I imagine that many art therapists like myself have often been aware of its stunting effects in their clients' lives.

The history of therapy in all its many forms provokes class issues that are rarely spoken about within the context of most psychotherapeutic training; although references are regularly made to these issues by 'user-groups' in the media and by popular culture. It is starkly obvious that access to a form of psychological dialogue intended to help a client make sense of his or her life is in general determined by economic means. Psychoanalysis commonly requires attendance on five days a week. The cost of an individual session for one hour might (at a modest estimate) be the equivalent of twice the daily earnings of someone on a minimum wage. It is inevitably the preserve of the few. Other forms of psychotherapeutic help which do not require such frequent attendance are accessible to people in a wider economic bracket but access is still limited and unlikely to contain many who are working-class or even lower middle-class, except perhaps from amongst those who are obliged to have therapy while training to become therapists.

Access to psychotherapeutic forms of help within the public sector services (where people do not have to pay) is small and of variable quality. Some psychotherapeutically orientated counselling is being made available through a small number of GP practices, but David Widgery's account of his GP work in the East End of London gives graphic illustration of the constraints being experienced in the most deprived areas. Counsellors are not even on the agenda for GPs in areas where economic resources are hard pressed. Other forms of psychotherapeutic help that have an established history within the health service, for example, child psychotherapy and art therapy do not have a high profile. Some areas of the country do have newly established psychotherapy services; they tend to be led by consultant psychiatrists with psychotherapy training but they seem to have difficulty conveying the relevance of the

contribution they might make to beleaguered services. Often what they provide is perceived as a luxury.

Members of many different disciplines in the health service do now have counselling or psychotherapy skills, including nurses, social workers, occupational therapists, psychologists and art therapists, but the circumstances in which many of them work often make it difficult for them to provide properly contained and well supervised work. All of these matters contribute to what is very limited access to psychotherapeutic work. In addition I suspect that because of the difficulties of access the range of people considered suitable for such therapy is not much tested and is artificially constrained along class lines.

Nina Coltart lists nine qualities that she considers constitute the assessment of psychological-mindedness. I think it is useful to quote her thoughts in full, because, although the list is thought provoking, it makes the possibility of defining psychological-mindedness along lines which favour middle-class and omit working-class people very clear.

- An acknowledgement, tacit or explicit, by the patient that he has an unconscious mental life, and that it affects his thought and behaviour.
- The capacity to give a self-aware history, not necessarily in chronological order.
- The capacity to give this history without prompting from the assessor, and with some sense of the patient's emotional relatedness to the events of his own life and their meaning for him.
- The capacity to recall memories, with their appropriate affects.
- Some capacity to take the occasional step back from himself and his own story and reflect upon it, often with the help of a brief discussion with the assessor.
- Signs of a willingness to take responsibility for himself and his own personal evolution.
- Imagination, as expressed in imagery, metaphors, dreams, identifications with other people, empathy and so on.
- Some signs of hope and realistic self-esteem. This may be faint, especially if the patient is depressed, but it is nevertheless important.
- The overall impression of the development of the relationship with the assessor (Coltart, 1988, p. 819-20).

Although it is clear to me that the majority of my clients have these qualities (even if latently) I have heard (recently) some middle-class professions assume that most clients in the

figure thirteen
The Daily Mirror's announcement of the death of
Marge Proops who was the paper's agony aunt for many years...

public sector do not have them. I can see how the assumptions arise; either because of very different class experiences, or because when meeting people in the midst of psychosis their lucidity and their ability to relate to a therapist is disrupted. However, I would propose that even for people who experience psychotic episodes their inability to demonstrate psychological-mindedness according to these criteria is only temporary. Assumptions about the capabilities of public sector clients are often fundamentally mistaken.

There is widespread derision amongst staff working for the mental health services (in one city at least) about the public sector psychotherapeutic services; most of the jokes mischievously mock the psychotherapy criteria of 'psychological-mindedness' implying that it excludes all but the smallest percentage of the population of people using the psychiatric services. Another implication of these jibes is that psychotherapists can only help those who do not need help. It is not difficult to imagine how such hostility and the criteria themselves can be understood in terms of differences of class. There does tend to be a sociological map in which mainly upper middle-class people have access to psychoanalysis, a range of well-enough heeled individuals have access to various forms of private psychotherapy or counselling, and a broad range of middle and working-class people have whatever is available to them in the public sector. In the public sector treatment concerned with mental health is largely governed, in the current economic climate, by pharmaceutically led psychiatry. For the many legions of people outside any of these categories what has remained available to them are the agony aunt columns or letters sent to the problem pages of newspapers and women's magazines; the late Marge Proops being one famous example *(see figure thirteen)*. A person's understanding of therapy is often largely dependent upon their class vantage point.

The need for demystification

I know from my own profession, that art therapists working in the public sector regularly find themselves meeting prospective clients who are working-class and have very little knowledge of therapy. Also when a client has a history of psychosis their ability to understand is likely to be disrupted for a time. Therapy is not generally offered to working-class people; consequently, what they know about it will come more from popularised accounts in films and the media than from people they know and have been able to talk to. The prefix *art* means that art therapists have more to explain when introducing themselves to prospective clients from any class, but the extent to which it is necessary to demystify the process of therapy will often be determined by the class of the client.

The demystification of therapy is an idea that has been advocated by the Women's Therapy Centre since the late 1970s in North London and since the early 1980s in New York. The work of these centres took a feminist psychoanalytic perspective and there was some reference to class. In general though a class perspective is rarely adopted in the training of therapists. This is no less the case in art therapy training, and in this it is comparable to most other forms of psychotherapeutic training, but given the class composition of the client population using art therapy within the public sector it seems important to begin to articulate some of the issues which arise as a result of class.

The need to articulate these issues is general given the increasing recognition of the socio-economic determinants of health. To find a definition and to describe the significance of class is problematic within both political and sociological frames of reference and it is no less so in a therapeutic framework. The definitions which I have found helpful are those which avoid confused ideas about life-style; or as Lindsey German puts it those which make comments about whether or not there is a sauce bottle on the table.

> None of these subjective approaches really help in defining class, because they start with distributions and consumption, with the out come of an unequal class society, rather than with what creates class society in the first place...If we want to understand how and why groups of people form classes at different points in history the we have to turn to the economic and social factors underpinning society. We have to see class as a relationship which is social as opposed to individual. It does not depend in the first instance on how people feel about what class they are in, but on their objective relationship to what Karl Marx called the means of production (factories, machinery and so on) (German, 1996, p. 14).

Definitions of class that have explanatory power are essentially social and collective and this is probably the main reason why so little attention has been given to matters of class in the world of therapy. The theoretical world of psychotherapy is strained when it attempts to widen its frame of reference beyond the individual and the family; although of course, work with groups does touch upon societal issues.

Translating awareness of poverty and class into principles of practice

It is no easy task thinking about how to translate a consciousness of class difference, or indeed any difference, into what needs to take place in therapeutic practice. I find it hard to imagine that even the strictest psychoanalytic format would fail to acknowledge some aspects of difference. It would be interesting to explore such matters further in terms of what would be psychoanalytic practice if it could be more located in the public sector than is currently the case. The majority of people in the helping professions in the public sector do not adopt a

psychoanalytic perspective. They work in areas where questions of difference between client and therapist are a regular occurrence. Differences of class, race, gender and disability are often immediately apparent (at a visual level). Although some public sector professionals may draw on the tenets of psychoanalysis, few are likely to claim a psychoanalytic practice. The lack of the requisite training is one clear explanation for this; however, other explanations are necessary. It is clear that a significant (though small) proportion of the psychoanalytic community is concerned about this and prepared to engage with such issues. The Tavistock Clinic and the Cassell Hospital are the only sizeable parts of the public sector that have official sanction in Britain to apply the tenets of psychoanalysis. Some of the complicated issues of translating psychoanalytic ideas into forms appropriate for the public sector are implied the Tavistock's television series *Talking Cure* and the accompanying book (Taylor, 1999). Many psychotherapeutically inclined professionals working in the public sector find that they cannot ignore or confine to the transference the socio-economic aspects of a client's life. It is generally necessary to make some acknowledgement of differences between therapist and client, of for example, class, race or disability. Without such acknowledgement the client may not feel inclined to work with, or be able to trust the therapist. These issues are nowhere directly addressed by psychoanalysis.

The fact that matters concerning 'difference' are now a necessary part of nationally recognised training courses in art therapy, some counselling and psychotherapy courses does not necessarily mean that clear ideas of how to proceed in practice have been worked out. There is little concerning questions of difference written about face-to-face meetings between therapist and client. The Sri Lankan psychiatrist, Suman Fernando in his book *Mental Health Race & Culture*, discusses the mistaken therapeutic practice of being 'colour-blind, culture-blind' (Fernando, 1991, p. 137). Also even within the world of counselling it seems that the issues about class are not much addressed; a small literature search of the counselling literature procured only one book. Nevertheless this book by Anne Kearney (1996) provides some interesting suggestions for training exercises.

The recent book *Art Therapy Race and Culture* (Campbell and Liebmann et al., 1999) was a compilation of differently authored chapters. It included a token chapter on class, but in general, it did not suggest a theoretical response for therapists trying to grapple with obvious differences in the experience of client and therapist. Some of the chapters in the book used issues of difference to advocate a person-centred approach. However, these chapters did not

address the lack of a notion of the unconscious in person-centred work. This is a serious omission because much of the history and development of art therapy implies the need for a theoretical response to the phenomena of the unconscious.

Before therapy begins, it is necessary to address those matters that might tend to mystify the nature of therapy for a prospective client. This could involve sending preparatory information in advance of a first meeting. It means doing exploring and becoming aware of a client's preconceptions about therapy.

Although very little is written about what a therapist might do in practice, a number of things have helped me navigate the waters. It seems important to acknowledge any differences of which I am aware during the assessment process of therapy (hopefully this process contains some aspects of mutual assessment). I tentatively raise any questions of difference during the first meeting in the hope of being able to acknowledge that clients may wish to voice their feelings about the conditions of their particular experience. I also try to indicate that if I misunderstand something about their different experience I would wish them to tell me in order that I might be able to understand more. However, I also say that I understand that this may be difficult for them to do. In these simple ways, I hope to agree a way forward with the client during the assessment process, in the event that we should work together. I continue to ask hopefully appropriate questions about matters of difference that I do not understand throughout the therapeutic relationship. A false attempt to convey understanding is generally perceived as that and it seems to me much better to ask questions than to alienate someone by pretending to understand.

With regard to class in particular, there are a number of issues it would be useful for a therapist to be aware of (forgive me if the following two examples seem obvious). Poverty or economic strain causes anxiety; people who have grown up believing themselves to be a designated member of the lower classes are likely to have low self esteem and a sense of limited personal mastery over events, particularly at times of stress. Various international studies since Marie Jahoda's famous work in the 1930s have indicated that these psychological factors are consequences of working-class life.

The prejudices or assumptions that tend to be made about working-class people are varied. Low intelligence is one such assumption — one client of mine had even been mistakenly diagnosed as educationally subnormal. This client had a broad Yorkshire accent and she lived within the massive concrete complex of a council estate, with her husband and her

two children. It is frustrating when people like her (see chapter ten) miss the opportunity to make sense of psychotherapeutic help because of prejudice.

An elitist frame of reference is occasionally adopted in relation to art therapy by some psychotherapists who refuse to acknowledge the modifications of technique (the adaptation of the therapeutic frame) that may have to be applied in the difficult circumstances of many public sector settings. Admittedly these settings do not have drive-by shootings in the way that many American inner-city areas do (reported by an American colleague), but the circumstances in which many British art therapists find themselves working and in which their clients find themselves living are grim. Possibly because of what are often poor conditions for the work, the psychotherapeutic nature of art therapy is regularly questioned. The solution for the profession is not (as some recent commentators have intimated) to abandon the public sector in the attempt to find more pure circumstances for the work, but nor is it to abandon the tenets of good psychotherapeutic practice.

There is a great deal of collective experience housed in the art therapy profession for work in difficult and deprived circumstances. This means that there is practice with people who might otherwise not experience anything resembling psychotherapy. These people, the clients of art therapy, include the elderly, those with a history of psychosis, people with learning disabilities, the terminally ill, children and young people. They necessarily include many people from lower middle and working-class origins and they deserve boundaries and clear techniques.

A census I made in 1996 (see chapter thirteen) of the caseloads of the art therapists working for the mental health services of one industrial city showed the extent of deprivation amongst art therapy clients:

> 32% of art therapy clients live alone, 72% of art therapy clients are either separated, single or widowed. Only 8% are in full time employment, 6% in part time employment, 4% are students. 46% live in rented accommodation and an additional 23% live either in hostel or hospital accommodation make a total of **69%** in disadvantaged living circumstances (1996, p. 284, chapter thirteen).

Public sector, trade unions and training

It seems clear that despite the challenges posed by public sector practice it is in the interests of public sector clients that art therapists stay in and help make the public sector more amenable to psychotherapeutic work. Art therapists are not alone in recognising the need to make public services more amenable. Members of all the other disciplines have experienced similar struggles in recent years. Undoubtedly if the art therapy profession is to maintain its foothold

in the public sector and provide access to a wide range of clients; then some of the effort to maintain viable services will have to demonstrate evidence of effectiveness, and other efforts will need to take the more traditional guise of the general struggle against cutbacks. The thought of both the struggle to produce evidence of effective practice and the politics of fighting cutbacks might cause many therapists to groan, but the clients of the public sector will loose access to therapy if we do not engage with these difficulties.

The history of the profession is full of examples of people struggling to maintain and develop this way of working. In general, I think it is the case that art therapists learn quite quickly that political naiveté is not in the interests of their clients. This is not because they are essentially different creatures from their psychotherapeutic counterparts but because of the educational impact of the public sector contexts in which they work.

Although David Pilgrim's book *Psychotherapy and Society* is a cursory attempt to situate the practice of psychotherapy within a political framework, it makes a number of powerful observations that have been rarely articulated elsewhere. In reviewing the literature concerning class distinctions he confirms that there are numerous conceptual and methodological problems in the scant literature that exists linking class and psychotherapy. He quotes the review made by Bromeley (1994) which demonstrates that the selection criteria are elitist in the way they favour middle class patients and he suggests that the literature essentially shows that:

> biological treatments and coercion increased in probability as the class of patients became lower and, to complement and confirm this, voluntary talking treatments increased in probability with increased social class (Pilgrim, 1997, p. 49).

He continues that it is in a:

> ...historical context that the selection bias...needs to be understood. The inertia of individual psychotherapists is part of a wider cultural inertia within psychotherapy about lower-class patients. The latter were rejected from the outset or were treated reluctantly or paternalistically as an addendum to the 'proper' work of engaging with fee-paying middle-class neurotic clients and (later) special soldier patients (Pilgrim, 1997, p. 51).

The reasons that have enabled the art therapy profession to avoid this class bias against either lower class or more disturbed clients are not actually to be found in the class status of its early pioneers who were middle-class (Jones, 1987; and Waller, 1991). However, it is important that the practice was at first almost entirely in the public sector and the majority of the clients who art therapists found themselves paying attention to and taking seriously were from working-class backgrounds. There is long tradition within the profession of respect for

the client. In earlier chapters I have written about the different ways in which this notion of respect have been interpreted in three periods of the profession's history; but I think that there are common threads throughout its history which confirmed both the need and the possibilities for therapy with a wide range of people. The public service context in which the practice of art therapy still largely takes place does much to shape its fundamental principles and in the following section I indicate the extent to which it is important to acknowledge this.

However, it is also the case that from the sixties onwards there were a substantial number of art therapy practitioners who were not afraid to link the needs of professionalism with those of trade unionism. These include many people indicated in Diane Waller's book *Becoming a Profession,* 1991, for example, Edward Adamson; Frank Breakwell; Graham Cable; Michael Edwards and John Henzell. Also there is Diane Waller herself, who has undoubtedly been a potent influence in this aspect of the profession's development. It is clear throughout the historical development of the profession that there has been an absence of a certain middle-class coyness associated with many professions about linking the protection of its members through trade union activity, with the 'learned society' function of a professional association and principled idealism about the interests of its clients. This is despite the fact that many members of the profession have middle-class origins. It seems to me that art therapists have had to struggle with changing societal forces a little in advance of their contemporaries in the other professions; the early blue-collar concerns of the profession is one example of this and it seems to foreshadow the proletarianisation and casualisation of large sections of the erstwhile middle-classes at the end of the twentieth and the beginning of the twenty-first century.

Much in the historical development of the art therapy profession has distinguished it from other forms of psychotherapeutic practice. For example, whereas people generally train in another profession before training as a psychotherapist, most people who train as art therapists do so as their first professional training. This alone could explain the tight professional organisation which has characterised the organisation of art therapists since the late 1960s; also much of the professional association's (BAAT) attention focused on the public sector: whether in the health service, education, social services or the prison service. All of these public services now recognise the state-registered qualification to practice art therapy. No one would claim that the profession has a high profile in any of these areas, but it has a broader base than any of the other psychotherapies. I have no doubt that the context of the work has influenced the status of the profession, just as the need for trade union membership

has influenced the particular sense of professional identity which art therapists have of themselves. In some ways art therapists have necessarily had to become more street-wise than their professional counterparts who practice psychotherapy privately. The state registration of the Arts Therapies in 1997 (Hansard indicated them as the first of the psychotherapies to be registered) is another indication of their different professional and political history compared with other psychotherapy professions. This difference of history and development probably means that the class composition of the people who train as art therapists is more mixed. However, this is not something that has been surveyed, and as I indicated at the beginning of the chapter, class status of whatever kind confers no moral prerogative. Occasionally when there is less difference between client and therapist it may facilitate greater understanding, but this is not certain. The example is not entirely fair but working-class prison officers do not necessarily have an understanding of their working-class prisoners.

The class then of the individual practitioner is not central. However, there is an interesting account that offers a very human understanding of the difference that class makes. It is included in a small book entitled *The Weary Sons of Freud* by Catherine Clements (1987). It concerns the 'The Story of Mme Victoire'.

> One fine day Mme Victoire turned up at a clinic in a working-class district in the outskirts of Paris where Mme Z, a psychoanalyst was practicing...Enter mother and daughter, pushing and shoving each other. They keep interrupting one another, so much so that Mme Z asks Mme Victoire to leave so she can hear the daughter. Now at last Janine becomes quiet, nice and calm, not in the least like the agitated, impossible monster her mother had depicted. When she talks to her daughter. Mme Victoire can only yell, in a very loud voice; yet her voice gradually drops when, she talks about herself and her own history. The same scenario is repeated several times: Mme Victoire barges into the room and keeps her daughter from talking. From this, the analyst concludes that the one who really needs to be listened to is Mme Victoire, and she offers her a deal: Janine will have her own sessions and Mme Victoire will have hers. But Janine misses *her* sessions and under the pretext of making excuses for her daughter the mother is the one who comes. She comes and she talks: she is in analysis.

> To be fair, because one should never forget the absent 'third party', the psychoanalyst asks to see the father. He's a truck driver, seems out of it, annoyed with the whole business; he mainly talks about his wife. Little by little, through a lot of yelling and screaming and trouble, one gets to know the history of that woman. She is pregnant and arrives one day with the baby. A girl, and like the first one, she too is screaming. Like their mother, that is...And while the baby is screaming, at the top of its voice, the two women, who can't hear each other at this point, start to laugh, and together, they get out of Mme Victoire's misery. The psychoanalyst grabs the child, puts her on the couch — what do you know! — and the baby calms down. Janine is playing in one corner of the room and Mme Victoire talks in a soft voice so she won't wake up the child.

> It is in this unorthodox situation — but what is essential in the setting has remained intact

— that the analysis of Mme Victoire, a cleaning lady, takes place. For four years, it went on —in secret, since the clinic dealt only with children. We will learn nothing of the details in this story for the person who tells it is not interested in Mme Victoire as a 'case'.

Mme Victoire reaches the end of her analysis one fine day: she has gone as far as she can possibly go in the understanding of her history, up to the point where a stumbling block appears; 'I cant understand any further than that', a statement echoed by the psychoanalyst, who cant go beyond this point either.

But at the same time something funny has teen happening to Mme Victoire. 'Before, nobody talked to me; now, everywhere I go, they talk to me, everywhere I go to clean, they used to treat me like a bird-brain; now it seems like people are always asking me for advice. You can't believe what people can say without realizing it, it's really embarrassing. Just like in here...but I cant say any of it, they'd think I'm crazy...I'm no analyst...Maybe I help them after all because I listen to them, and no one else really does. It makes me laugh sometimes, I feet like telling them, 'I'm only your cleaning lady, you know.' But sometimes, I don't feel too good. Not like before when nobody would talk to me, in fact it's much worse, They talk to me and I can't answer. So I'm even more lonely than I was before.

...Mme Victoire has truly become a psychoanalyst. She has even got herself a brain, when she had none before, a sure sign that people have implicitly recognized some unofficial power in her: the power of listening. She even has the secret sign very few analysts talk about, except in private: the tenacious fear of being alone because she hears too much. The loneliness of the shamanistic frontier where Mme Victoire now stands. She has become a psychoanalyst.

No, she hasn't. She *should* have become a psychoanalyst, she should open a space, furnished with a couch, and an armchair, but that did not happen, to the great chagrin of her psychoanalyst, faced with the social contradiction of psychoanalysis and with Mme Victoire's class origins. She couldn't go any farther, she couldn't lend Mme Victoire a hand in closing the social gap that set her apart from the profession.

Now let's listen to the psychoanalyst, in the home stretch and short of answers: 'What prevented Mme Victoire from having access to analytic practice? I think it's simply that she was a cleaning woman. Although we somehow got to meet *in* the knowledge of desire, sex and death, her academic knowledge remained nil and that was the only difference between her and any other analysand who has reacted the point where it is agreed that the analysis his become a training analysis. I don't think I'm the only analyst to have 'sacrificed' an analysis (an analyst) in this way, by driving an analysand — deprived of 'education' but an analyst nonetheless — to loneliness and social silence. Another way out is to say 'But this is wonderful, she is the true analyst, she will do a great job precisely because she doesn't know'. So does she know or doesn't she? Well she does know the unconscious but she does not know how to become literate. And so Mme Victoire stopped her analysis, doomed as she was to listen to her bosses between the vacuum cleaner and the kitchen sink.

Yet in a true discourse that proves — as if proof were needed — that one can talk about the unconscious and about therapeutic listening without using one single word of the psychoanalyst's language, she clearly *shows* what motivates the analyst to become an analyst: the ability to listen, a suppressed desire to give advice, the relativity of an act in which the analyst serves as an intermediary between the patient and himself, in which he is

only the ferryman. And all this makes her laugh: 'Don't you forget it — I'm only your cleaning lady.' Nevertheless, she displays a desire to heal, or a will to heal, which will never be realized. Because she is not part of that privileged class which long ago gained access to the psychoanalytic profession peripherally, sideways, through social codes which have nothing to do with therapeutic practice: culture, literature, writing, talking in public — the intelligentsia (Clements, 1987, pp. 87-90).

This is a nub of tension at the heart of any form of psychotherapy practice. The relative ease of access to training in a profession indicates a great deal. The recent advent of fees for higher education and the abolition of maintenance grants mean that it is increasingly difficult for people to gain access to any form of higher education. The payment of fees at post-graduate level and the lack of maintenance grants has long been a difficulty for those wishing to enter the art therapy profession, although it is still just possible for people from a wide range of backgrounds, but the training can be a struggle economically for many students.

Although the class origin of a practitioner need not make a difference to the possibility of engagement with a client, in some circumstances it may have relevance. However, what makes a difference to the lives of art therapy clients is the collective memory and history of the struggles which have kept the art therapy profession alive. Diane Waller expresses the hope that:

> Given the challenges ahead...we, as art therapists, will continue to do what we seem always to have done, that is to subject ourselves and our profession to self-scrutiny in the interests of providing a genuinely effective alternative treatment to people from all classes and backgrounds (not just those who can afford it) and especially to those who in the past have been considered "unsuitable" for psychotherapy or "insight provoking" treatment (Waller, 1991, p. 266).

The nature of alienation in psychosis

Certainly people who experience psychosis are regularly deemed unsuitable and so alienated from treatments that involve the quest for meaning. This is central to the many aspects of alienation that touch their lives.

The consequences of alienation influence the lives of most people, they seem particularly powerful for people with a history of psychosis. Many times clients speak to me individually and in groups about societal matters that tend to alienate them from themselves. It is not straightforward to make a list of the ways in which mental health patients are alienated because often the processes of alienation seem elusive and sometimes it is difficult to make a distinction between what comes from the individual and what comes from society. This last point applies equally to everyone. I do not want to imply here that people are mistaken about the sources of alienation because of their mental condition. Repeatedly themes that clients speak

about are concerned with the sense of being disconnected from society. They speak about not being taken seriously, feelings of isolation and loneliness, stigma and the difficulties of paying bills and of sorting out their social security benefits. The introduction (1999-2000) of the verification framework to judge the validity of a housing benefit claim has been particularly worrying for people with serious mental disorders.

Many writers in different contexts have used theories of alienation and estrangement taken from Marx. To relate Marxist theories of alienation to the experience of the mental patient may be helpful but it requires careful thought. Many mental patients are unemployed and on the surface this seems to exclude them from consideration within a theory of labour and production. A definition of alienation offered by Marx in relation to a person's labour is:

> All these consequences are contained in the definition that the worker is related to the product of his labour as to an alien object. For on this premise it is clear that the more the worker spends himself, the more powerful the alien objective world becomes which he creates over against himself, the poorer he himself — his inner world — becomes, the less belongs to him as his own (Marx, 1844, p.70).

However, Marx does not confine himself to definitions of alienation directly related to labour but he suggests that this is the fundamental basis of the way all human relations and activities are estranged by the capitalist organisation of society. The pupil of Georg Lukács, Dr István Mészáros writes about the ways in which Marx's theory touches all aspects of life.

> For the concept of alienation, as grasped by Marx in 1844, with all its complex ramifications is not a concept which could be dropped, or one-sidedly "translated"...the concept of alienation is a vitally important pillar of the Marxian system as a whole, and not merely one brick of it. To drop it or to translate it one-sidedly, would therefore, amount to nothing short of the complete demolition of the building itself and the re-erection, perhaps, of its chimney only (Mészáros, 1970, p. 227).

In discussing the power of money in the processes of alienation, he quotes Lenin:

> ...money is thus the object of eminent possession. The universality of its property is the omnipotence of its being. It therefore functions as the almighty being. Money is the pimp between man's needs and the object, between his life and his means of life...The extent of the power of money is the extent of my power. Money's properties are my properties and essential powers — the properties and powers of its possessor. Thus, what I am and am capable of is by no means determined by my individuality (Lenin, cited in Mészáros, 1970, p. 179).

I hear the voices of many of the people who have attended my groups in this lament, 'what I am and am capable of is by no means determined by my individuality'. It seems particularly pertinent to those with a history of psychosis who as a consequence of their condition find themselves trapped with little money and no prospect of employment. These are material realities, although they do have symbolic consequences, and these tend to make people feel

disconnected, excluded and worthless. Often it is very hard to distinguish which of these feelings originate in material circumstances and which in the nature of the condition. When people with a serious history of mental illness find themselves living alone and in poverty, they can be strongly affected by the material forces of alienation. These can compound and deepen the feelings that are associated with their mental condition.

Many of the people whom I meet with a history of psychosis live in extraordinary isolation. If they did not get out of their beds for a week, very few other people, if any, would know. Interestingly Mészáros suggests that ideas about loneliness are modern phenomena of the twentieth century. The dislocation and isolation of many mental patients can be seen as the historical result of life in modern societies.

> Expressions like "the lonely crowd" and "enforced privatisation" have become catchphrases in...sociological literature. We must read them, however, in proper perspectives: against the historical background of this century. In fact "loneliness", for the past fifty years, has been a central theme in artistic works, as well as in many theoretical discussions (Mészáros, 1970, p. 255).

Mészáros also suggests that much artistic work accompanies sociological texts in describing the huge possibilities for loneliness in modern society. He points to the words of Max Jacob 'Le monde dans un homme; tel est le poète moderne'. (The world within the confines of one human being; this is the nature of the modern poet). He also quotes Pierre Reverdy, 'Le poète est poussé à créer par le besoin constant et obsédant de sonder le mystère son être intérieur' (1970, p. 338, n. 227). (The poet is driven to create by the constant, obsessional need to make sounds out of the mystery of their inner world).

For Mészáros these matters are to be understood historically. 'By the time we reach the twentieth century... political and social references disappear, and the socio-historically conditioned circumstances of the individual's atomized, privatised life are characterised, ahistorically, as the "human condition"' (1970, p.255).

Some treatment policies seem to follow from this with the oft-repeated injunction given to long-term patients living in the community that they must find their independence. I understand after some twenty years of practice why many kindly staff in the psychiatric services issue these injunctions (which are often experienced cruelly). They are more to do with treatment philosophies, staffing shortages and economics than intentional cruelty, but they really do have a devastating effect on many patients who live in isolation. I have many times heard clients berate themselves because they cannot manage to feel content with meagre rations of human contact and comfort. They tend to think that because they cannot manage with such

little human contact, this is evidence of their own internal inadequacy. Again, ideas about the many forms alienation can take seem relevant,

> ...alienation and reification, by producing the deceiving appearance of the individual's independence, self-sufficiency and autonomy, confers a value *per se* on the world of the individual, in abstraction from its relationships with society, with the "outside world". Now the fictitious " individual autonomy" represents the positive pole of morality and social relations count only as "interference", as mere negativity (Mészáros, 1970, p. 258).

Shortly before her demise Thatcher's pronouncement: 'There is no such thing as society, there are only individuals' (cited in Jones, 1993, p. 17) seemed to corroborate this impression of a late twentieth century zeitgeist.

A book by the psychiatrist Arthur Kleinman *The Illnes Narratives* (1988) is one that I have found helpful in my attempt to understand the impact of a 'chronic' condition upon a person's sense of self. Kleinman convincingly suggests how it is such conditions can confuse a person's sense of identity. He also shows it is futile to attempt to understand chronic illness in ways that do not allow for the impact of the social world. 'Acting like a sponge, illness soaks up personal and social significance from the world of the sick person. Unlike cultural meanings of illness that carry significance *to* the sick person, this... transfers vital significance from the person's life to the illness experience' (Kleinman, 1988, p. 31).

What Kleinman writes is intended as an exploration of the psychological consequences of physical illness but it has acute relevance to the situation of the long-term mental patient. Kleinman addresses the vexed mind–body issues without being reductive (1988, p. 42) and he writes subtly about the therapeutic implications of trying to help the patient find their own sense of meaning for their condition. 'The detailed empirical and symbolic particularities of this life trajectory, like those of every other, create a unique texture of meaning — external layers written over internal ones to form a palimpsest — for each person's experience of chronic illness' (Kleinman, 1988, p. 32).

He describes the centrality of feelings of loss for many patients, the courage they need and how they want to have the peculiar personal significance of their condition acknowledged. His therapeutic strategy is to enable the client to construct their own illness narrative, while offering them as much knowledge as possible about their condition. He discusses the alienation of existing at the margins and living with the fear of a recurrence.

> The undercurrent of chronic illness is like the volcano: it does not go away. It menaces. It erupts. It is out of control. One damned thing follows another. Confronting crises is only one part of the total picture (Kleinman, 1988, p. 44).

Often therapeutic work with people with a history of psychosis would be well advised to follow Kleinman's therapeutic strategy; essentially it is to enable the patient to identify the many layers of meaning in their illness narrative and to return and forge links again with their culture. However, given the massive assumptions portrayed in the media about people with long-term mental health problems, it is not surprising that forging links with culture and society is not straightforward for them. One of the clients about whom I write in the following chapter (with the pseudonym Elizabeth) made the painting shown as figure fourteen. It seems to me that in this image she powerfully portrays her personal sense of alienation (*see figure fourteen*).

Conclusion

The essential part played by the relationship in therapy means that the therapist must do all they can to communicate despite differences of experience between them and their client. Issues of gender, race, disability and class are likely to be only a part of the gap that needs to be crossed. The effort to communicate will involve continuing to think about the power inherent in professions in general and in therapeutic relationships in particular. It will also be necessary to continue to scrutinise the frame through which the art that is made by clients is viewed. However, the allegiance of art therapists as a professional group to the wide range of clients in the public sector means that there is considerable experience of the challenges this poses for practice. It also means that there is some reason for optimism that increasingly helpful methods for working with the effects of poverty and deprivation in therapy will emerge from the challenges of practice. The fundamental challenge to practice is the question of how to manage and adapt the psychotherapeutic frame to the circumstances of the public sector. The four chapters in the following section are concerned with some of the issues relating to this.

figure fourteen