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

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Volume II

This thesis is bound in 3 volumes although it has been written with 5 sections and a conclusion.

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Introduction to Section Three:

I think there is a thirst in public sector workers for ideas that enable them to make sense of their clients' experience of psychosis. A number of international examples (Scandinavian psychiatric literature; Jackson, 1995; Lefevre, 1994; Kanas, 1986 and 1999; Pines, 1999) suggest that much understanding and sustenance can be gained from psychoanalytically informed supervision. However, I have asserted that such supervision even if widely provided (which it is not) would not be sufficient to sustain workers in the field of psychiatry. This is because the nature of psychosis means that those who succumb to it and those who work with them are situated at the intersection between intimate relationships and socio-political circumstances in what Barham has described as an 'ideological forcefield' (Barham, 1995, p. 27). Efforts to understand psychosis need to be both personal and socio-political and when this is not grasped by practitioners, it seems that it is extremely difficult for them not to succumb to a sense of stagnation in relation to it.

Art therapists are generally public sector employees and they repeatedly find themselves having to adapt their construction of a therapeutic frame in order to accommodate the circumstances of the public sector. When they combine art and psychotherapy in long-term relationships without an understanding of the need to adapt the therapeutic frame to the socio-political context, they can similarly find themselves following a path towards stagnation and frustration.

Chapter Five:

Facing Fear with People who have a History of Psychosis...Psychiatric Fear and Psychoanalytic Terror

Introduction to chapter five

In the previous chapter I discussed the nature of alienation associated with psychosis. I suggested that therapeutic strategies could usefully adopt Kleinman's (1985) approach of enabling the client to elaborate their own narrative before helping them turn around and engage again with the culture and society of their time. To consider the forces of alienation is to consider the dynamic tension between the inner and the outer world. Here I consider the ways in which some aspects of the work need to enable the client to grapple with primitive inner world anxieties and also find ways of understanding these fears in terms of the influence of society upon their lives.

The criteria for psychiatric diagnosis do not generally include the 'fear' associated with psychosis. My historical explorations do not lead me to conclude that this is because psychiatry can only view the schizophrenias as a disease process. The complicated challenges faced by psychiatry have meant that attempts are made by many psychiatric practitioners to offer a multifaceted response at the level of mind, body and social circumstance. However, in general the client is not encouraged to explore the source of their terror in any depth. There is a sense in which the ethos of psychiatric practice is to appeal to the client's rationality. For psychoanalysis, on the other hand, terror and disrupted states of mind are central to a theoretical understanding of psychosis. Sometimes then for art therapists there is a resulting tension about how to acknowledge terror in a psychiatric setting. The resolution of this tension is never complete but its acknowledgement can enable the therapist to think about the provision of a psychotherapeutic frame.

Terror

In this chapter I wish to focus upon the sense of terror that seems to underlie the experience of psychosis. I think that it is often the intense desire to avoid such feelings that makes people with a history of psychosis believe that they are somehow hollow or that they do not have inside themselves whatever it is that is necessary for life. Bion wrote: 'At the beginning of life the absent object is not experienced but is replaced by an hallucination. When this fails the infant does not experience an absence but something bad' (Bion, 1967a, p.112). I find myself remembering some of the phrases that Bion uses to describe the experience of psychosis when I am working with people who are in the midst of it. These phrases, 'attacks on linking', 'bizarre objects' and, in particular, 'nameless dread' have the quality of metaphor in the way they help elaborate understanding even though they clearly belong to a very

particular Kleinian theoretical framework. There are passages in the work of Bion that dislodge the safety of language and make the reader understand something about the quality of experience in psychosis. His ideas help in thinking about the nature of dread in psychosis.

For people who have a history of psychosis, as with us all, making sense of experience is crucial, but the possibilities for them being able to make sense of what they experience are fraught with difficulties and often a presentiment of danger. Sometimes they are able to use making art and forming a relationship with a therapist, in order to move away from a sense of hollowness (looking into the abyss) and towards an understanding of their experience. I provide some examples of this with vignettes from an art therapy group.

The profession of art therapy and its practice of art psychotherapy can be ideally suited to the process of containing over time many of the difficult, chaotic feelings and experiences that might be involved in psychosis. However, it is not a simple matter to explain or justify this belief. The need for evidence of effectiveness is important and I begin to address this in section five. However, I think a full justification of the practice requires dialectical explanation. This means thinking about the connections between matters of theory, practice and technique and asking questions about what remains of the creative process in the face of psychosis. Also as I have been repeatedly indicating it means situating the explanation at a point in history by considering the ways political circumstances influence the experience of psychosis in our society.

The difference between fear and anxiety

The philosophical differences between psychiatry and psychoanalysis have direct and sobering consequences for clients and practitioners alike. Too often in the Health Service, I have witnessed the pain of both, as practitioners from all disciplines skate around and fail to acknowledge the experience of terror when expressed by people in the midst of psychosis. Clients need to know that we hear the terror. Or when they make images about it, they need to know that we see it. It is helpful not to do or say anything else, until efforts have been made to acknowledge the client's feelings: although it is understandable that sometimes practitioners find themselves trying to persuade clients that their fears are not well founded. Such persuasions are made for a variety of reasons, not least of which are the practitioner's difficulties in hearing the extent of the terror.

In addition there is also a strong pharmaceutical ideology behind many of the methods employed in psychiatry and this influences the way people in the health service are educated about psychosis. Often the training practitioners receive does not help them know how to talk with disturbed clients. A lot of what happens that is humane depends upon the

wit of health workers and upon what they bring with them, despite their training. This may also be true in the case of art therapy training.

During my time as an art therapist a great many clients with whom I have worked have had a history of psychosis. Many of them have alluded to their fear. In everyday language the word *fear* is used to describe feelings generally thought to be more powerful than those described by the everyday use of the word anxiety. In contrast to this in psychoanalytical technical language, the word *anxiety* is used to describe feelings that do not have a clear object, whereas the word *fear* is used when feelings have clearly been provoked by an object. Once this is understood it becomes clear why so much psychoanalytical writing refers to *anxiety* and not to *fear*. When a feeling is without a clear object it can be experienced as being more difficult than those feelings that are clearly provoked by something or somebody. This is the nature of much anxiety in psychosis. This also helps to explain the power of Bion's phrase 'nameless dread'. Psychoanalytic explanations move deeper into the terrain of subjective experience than those of psychiatry. Kleinian explanations of psychosis are particularly concerned with aspects of anxiety and terror.

Kleinian proposals about psychosis

The tenor of much Kleinian writing and the distilled quality with which it describes emotions would seem completely alien to many people working in psychiatric services and indeed the majority will not have encountered it.

The reasons behind this lack of knowledge relate again to the philosophical estrangement between psychiatry and psychoanalysis. It is unfortunate because it is possible to see how the work of Bion offers an understanding of the different layers on which work with people with a history of psychosis might operate. Different layers link inner and outer world concerns; for example, the feelings and the life circumstances of the client interact with the feelings and experiences of the practitioner and these in turn interact with the institutional and political context in which both find themselves. Bion's work in relation to attacks on linking implies (although not in a direct political sense) something of the multi-dimensional or dialectical nature of the processes at work. The inner world of clients can have a strong impact upon the inner world of psychiatric workers. They in turn influence both clients and institutional structures and much of this influence is at a less than conscious level. Isabel Menzies Lyth's famous study (1959) showed how primitive feelings and anxieties could powerfully affect human relationships in a general hospital; it seems reasonable to assert that the primitive processes at play in psychiatric services are equally potent.

The Kleinian proposal in relation to terror in psychosis is that it is related to an aspect of early infantile experience. The notion of 'maternal reverie' is a term adopted by

Bion (1962) to describe the state of mind in which the person caring for an infant is able to provide what I envisage as a digestive process for the infant's feelings. The examples generally given are of the infant projecting anxiety and terror in an inchoate form into the mother. Thus the mother's *emotional stomach*, metaphorically speaking, semi-digests the feelings on behalf of the infant who is then able to recognise that the feelings are partly tolerable, and this process enables the infant to have back what might otherwise be intolerable. Hinshelwood's Kleinian dictionary describes what happens in the following way:

> Nameless dread was ...given a specific meaning by Bion to describe a state of meaningless fear that comes about in the context of an infant with a mother incapable of 'reverie', a concept that derives from Bion's theory of containing. When the mother fails to contain the infant's terrors and make them meaningful, this...is felt to strip the meaning from the experience and the baby. [This]...leaves the subject in a mysterious meaningless world (Hinshelwood, 1989, p. 363).

In Bion's words, the infant 'therefore reintrojects not a fear of dying made tolerable but a *nameless dread*' [my italics] (Bion, 1962, reprinted 1992, p. 116).

It is problematic to use the parent/infant analogy too literally in the world of therapy, although analogies between ideas about the container and the contained in therapy and parenting can be helpful. This seems to be true both in the relationship between client and therapist and between therapist and institution. There does appear to be a primitive quality in the anxieties experienced by people with a history of psychosis and comparing these anxieties to early infant fears of death and annihilation gives an indication of the extent of the terror that may be present in an adult in the midst of psychosis. An understanding of these primitive feelings can also help in understanding how much people working with these processes in the public sector have to contain. Young suggests that practitioners need to be able to 'take things in; hold, ruminate and detoxify...'(Young, 1994, p. 34). This is not of course a simple prospect and close clinical supervision is needed to enable the practitioner to work with whatever it is they find themselves trying to contain.

Other psychoanalytic proposals

In contrast to a Kleinian approach of containment with its unmodified analytic attitude being used for people with a history of psychosis: another analytic school of thought (of the first tendency discussed in chapter three) would propose the idea that psychosis represents a form of narcissistic injury and they would view the psychotherapeutic task as being one of re-parenting. This would entail the provision of a reparative environment and this would clearly be problematic for practice in the public sector (even though aspects of psychiatric ideology are parental). It would be equally problematic to adopt an uncompromising Kleinian approach. I suspect there would even be problems in using either approach exclusively in the private sector. This difficulty tends to lend weight to the idea that both the nature of the

condition and the institutional and social context in which work takes place, need to be considered when thinking about a therapeutic strategy. However, this weighing of inner and outer world influences is rarely straightforward. In addition the characteristics of many institutional settings can mean that it is too easy without good supervision and a supportive working team, to misappropriate psychoanalytic thinking and use it in a half digested manner.

Klein's 1930 description of her work with a small boy in the midst of psychosis is regularly described as revolutionary, because she shows how she was able to make real contact with him in a manner that had hitherto been considered impossible within the psychoanalytic tradition. My understanding of the shift that this enabled in analytic technique is that Klein was able to use her awareness of psychoanalytic theory to understand the deep conflicts precipitated by psychosis. This enabled her to contain and detoxify some of the destructive aspects of the patient's mind while working along side the life-supporting aspects. A number of different psychoanalytic accounts suggest that the therapist's attention to the processes of therapeutic containment make work with disturbed processes possible.

Hinshelwood points out how Bion's concept of *reverie* is comparable to Winnicott's idea of *holding* (Hinshelwood, 1989, p. 420) despite the different theoretical origins of the two concepts. I think the overlap in these two divergent theories is of particular relevance to art therapy because many of the concepts used by art therapists have their roots in ideas concerning the quality of the therapeutic milieu provided by both the therapist and the art studio. Art therapists have drawn on the work of both Klein and Winnicott in efforts to explain their practice. Winnicott's idea of holding of the potential space seems playful and benign and in sharp contrast to the metaphorical digestive acids needed by the Kleinian to detoxify the provision of mental space. The way in which the therapeutic container is conceptualised can be vital in work with seriously deprived clients. This is because when working with difficult emotional material the therapist needs a metaphor or an image with which to help themselves provide a container for the client.

Therapeutic strategies and the ways in which they are influenced by both the condition and the context

The client may experience serious obstacles in their ability to think and to make sense of their experience. Some of these obstacles may be largely internal, whereas others may be a potent compound of internal and outer world difficulties. Consequently in relation to psychosis some of the theoretical concepts employed for more general psychotherapeutic work may need to be modified. An example of this is that although transference and projective identification are clearly present in my art therapy groups they appear to be spread thinly between the group members, the artwork, the studio and myself. Wherever possible, I would wish to

acknowledge and use the transference but I would not necessarily draw it out in the way I might do in other work. There are examples within psychotherapeutic and psychoanalytic literature of theory being used to inform therapeutic management but not directly in therapeutic practice. It is possible to think of some aspects of supportive psychotherapy in this way. Winnicott wrote that therapeutic work with disturbed clients:

> must deal with the early stages of emotional development before and up to the establishment of the personality as an entity...The personal structure is not yet securely founded...The accent is more surely on management and sometimes over long periods with these patients ordinary analytic work has to be in abeyance, management being the whole thing (Winnicott, 1954, p. 279).

This shows how much Winnicott's position had changed, moving away from the strict Kleinian stance of his early work to this position about management in his later work (see p. 81 above, Chapter 3). Another example of the modification of a strict psychotherapeutic stance is the way in which it is sometimes appropriate to acknowledge the real world concerns of clients.

Supportive psychotherapy?

The wide range of clients with whom art therapists in the public sector work means that the nature of the work provided for the most disturbed clients is best described as supportive art psychotherapy. This is **not** to suggest that supportive work is the only form of help offered by art therapists, but that there are theoretically coherent reasons for adopting the approach with the most disturbed clients in the settings in which most art therapists in the public sector find themselves working.

The beleaguered nature of public sector services during the difficult economic period of the 1980s and the 1990s has meant that the organisations in which therapists work are often unable to provide an adequate container for any of the disciplines attempting to provide something for people with serious mental disorders. Many of the people attempting to do such work barely have time to think, yet they have pressing needs for exploration and consideration of a wide range of theoretical approaches that are able to acknowledge the context in which their work is done. It is not feasible to ignore the societal context of therapeutic work in the public sector, particularly in work with the most disturbed clients: ironically they are often the clients who most repeatedly remind practitioners of the material world in references to bills and social security.

The art therapist Helen Greenwood discusses the supportive form the work can take when working with people with a history of psychosis (Greenwood, 1997, p. 107). She cites the work of Hartland in this area. The aims of such work are said to be 'a long term psychotherapy aimed at maximising the patient's strengths, restoring his psychological

equilibrium, acknowledging but attempting to minimise, his dependence on the therapist' (Hartland, 1991, p. 214).

Greenwood (1997) discusses some of the features of supportive work outlined by Hartland by suggesting that it is less clearly defined than dynamic psychotherapy and it is at the opposite end of the continuum of therapeutic practice. Therapists are said to need inexhaustible levels of patience, skill and commitment because change is likely to be slow. Roth and Fonagy's report 'Research on the Efficacy and Effectiveness of the Psychotherapies' concerned in part the importance of maintenance treatment: '...the long term outcome of (even effective) short-term treatments for such disorders may be poor unless the treatment is maintained, perhaps at low intensity, over prolonged periods' (Roth and Fonagy, 1995, p. 238).

There are clear links between the possibilities for supportive psychotherapy and the discussion in chapter three about whether there is a need to adopt a different psychotherapeutic attitude and technique in relation to psychosis. This question may be something that is particularly pertinent to work in the context of the public sector but it is also germane to the condition.

An art therapy group

I offer ongoing weekly art therapy groups for people with a history of psychosis who are referred from the mental health services. They come to work with me in a studio at one of my workplaces. It is not usual in the current NHS economic climate to offer long-term groups. However, there exists considerable pragmatic acceptance amongst my managers that some clients are so disturbed that they need long term work and that there are economically sensible reasons for offering it.

With clients who have history of psychosis I have found my work being particularly shaped by their influence. The shaping has sometimes felt muddled; in response partly to the needs of the client group and partly to the constraints upon work in the public sector. I am clear, nevertheless, that what the group offers to members is the possibility for finding sufficient mental space each week to achieve a greater sense of self-mastery, meaning and safety in the world.

I received referrals from a wide inner city area for the group that I am about to discuss. All the referrals concerned people with a history of psychosis. With this client group it seemed necessary to allow people the time they needed to find a sufficient sense of structure within themselves to enable them to attend a group regularly and on time. This involves being more tolerant of irregularities in relation to boundaries than with other groups. Therapists themselves need to remain scrupulous about matters concerning boundaries but the

comments they make to clients about any transgressions are probably best made gently. Nevertheless, clear boundaries are highly significant to any work with people whose psychotic processes are heightened, so it is important that the therapist does not evade commenting upon them. A fundamental reason for this is that clients need to gain a clear sense over time that their inner fear will be contained within the boundary of the group.

During one of the group sessions, just three group members were present with me. Other group members had a variety of reasons for their absence. I will refer to the people present as Elizabeth, George and Peter. Elizabeth was a young married woman who had a realistic self-perception of herself as being bohemian and cultured. She had had a series of major psychotic upheavals in her life since being a teenager spanning a fifteen-year period. She had a keen sense of wit but she struggled daily to maintain the fabric of her existence, always finding it difficult to get out of bed and sometimes not managing for several days. On occasions I could be the object of very witty barbs. At the time of the group being described she was living alone.

George was approaching what would be retirement age, but he looked much younger than that. He grew up in the north of England but I knew very little about his relationship with his parents. I also knew that he had worked for many years on different building sites and I think he found it painful trying to conceal the nature of his illness from former workmates. He had a virulent sense of shame. The encyclopaedic range of his knowledge often stunned me and other group members. At some point in his life he must have been very well read. At the time of this group he described his reading as something in the distant past. He was living with a couple that acted as his carers.

Peter had a diagnosis of autism. He had spent many years in sheltered employment as a gardener; unfortunately in his late 30s he was made redundant. His level of communication was limited but he chose to attend the group and made his own way to it. Much of his time was spent walking, in the city or in the country (always alone). He was living in a mental health hostel with regular home visits to his elderly parents. In the early days of the group his parents had made unsolicited visits to the group venue and they had been a little surprised that they could not join. That they made the journey to the group and quickly grasped the idea that they could not join Peter in it, is a testimony to both their genuine concern and their understanding. I regularly see examples like this of family members trying to understand and contribute what they can.

During this particular group a discussion about anxiety took place, principally between Elizabeth, George and myself. Peter continued to paint during the discussion; he was

figure fifteen

facing away from us. The tolerant manner in which other group members related to his limited interaction with them is interesting.

Elizabeth began speaking about a pastel drawing that she had made (*see figure fifteen*) it seemed unusually faint in its colours. It had a similar form to many previous images it represented the top part of her face and head. The eyes are shown in the process of opening. The whole form of this picture takes the shape of a well-rounded arch. It seems to me almost like a proscenium arch with the tip of a huge head filling it. Elizabeth put the image on the floor in order to show it and invite discussion, and I was aware of it seeming to be part of a related cluster of images made previously in the group (*see figures sixteen*). Most of these images show her head as large and central and all of them have a quality that suggests the vastness of the sky and space. When looking at the pictures in the presence of Elizabeth I had the impression of a celestial archway. There is also a sense of being observed from a vantage point somewhere in space. It is as though Elizabeth imagined her mental space to be within a proscenium arch and sometimes it seemed that she could not believe in the ability of this arch to protect her from the vastness beyond.

In relation to *figures sixteen* she had spoken on occasions about a series of several outer arches surrounding the crown of her head. She said the darker outer arches represented a black hole of everything that was frightening outside of her. At this point, George interrupted Elizabeth in a manner that jarred; possibly he could not bear to listen to her account of experiences that were frighteningly familiar to him. He seemed to urgently want to reassure her, to stop her speaking and yet to also pursue the thing she was describing. Although I knew that I risked wounding George, I interrupted him and asked him to let Elizabeth continue.

She had taken out several of her previously made pictures and she continued although not referring to any specific picture by saying that the more faintly coloured arches inside the black arch represented the everyday parts of her life. She felt that there was nothing much to protect her everyday experience from the black hole. She spoke about feeling that this dark hole had been in her life since she was very young and that she had spent a great deal of her life trying to look away from the hole. She felt that it was too late for her and that the hole 'will always be there'. I think that the process of making these images had enabled her to find some words with which to describe this intangible but frightening feeling. I thought that what Elizabeth was describing was a kind of dread and I said this. She nodded vigorously. For me Bion's thoughts seemed to underline her nodding: 'The patient feels imprisoned... by the menacing presence of expelled fragments within whose planetary movements he is contained'

figures sixteen (cluster of related images)

figures sixteen (cluster of related images)

figures sixteen (cluster of related images)

figures sixteen (cluster of related images)

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figures sixteen (cluster of related images)

figures sixteen (cluster of related images)

(Bion, 1967, p.39). I went onto to say that there seemed to be something similar in what she was describing to matters spoken about by George.

George had repeatedly spoken about experiences, which gave him a sense of 'unreality' (his word). A dreamer always has the sense, no matter how slight, of being an observer and on the outside of their dream. I think something like this describes the quality of George's waking experiences that had troubled him for much of his adult life. They were once named as 'depersonalisation' by a psychiatrist and the memory of the naming of his experiences had given George considerable solace over the years: an instance of how important it is to acknowledge and if possible name, what the client is sharing.

George joined in with the discussion at once, although he kept a wary eye on me, maybe because I had just interrupted him. I apologised for my interruption and explained that I had thought it was important to let Elizabeth finish.

I do find myself offering different forms of reassurance with this client group; it would be counter-therapeutic on occasions not to do so. The technical side of psychotherapeutic work with this kind of client group, within the constraints of the public sector, has not yet been greatly explored or discussed. This is despite the long history of debate within the tradition of psychoanalysis concerning theory and technique appropriate to the work with people who are psychotic. Criticisms might be made about the practice of reassurance; however my current thinking and practice coincides with notions of supportive psychotherapy and psychoanalytically informed management of the most disturbed clients. I think it would be absurd in the circumstances of the public sector, to attempt to adopt a rigorous analytic attitude, let alone the strictures of Kleinian technique that do not provide for any forms of reassurance. This is not wishing to deny that public service practice is on occasion very usefully analytically informed.

George had by this time stood up; he was holding his brush still charged with paint and using it to emphasize the points he was making. His gestures were assertive, not aggressive, with the manner of an orchestral conductor who is passionate about a particular phrase in the music. He was nearly twenty years older than Elizabeth, and it was clear that he wished to help and reassure her. He knew that she was experiencing some terrible pangs of guilt and grief as a result of her relationship breaking up. He began by proffering straight advice:

George: You need to set up a new base, with some security. Have you got much emotional support? You need some, outside of here. What about friends?

Elizabeth shook her head sadly. George addressed me:

figures seventeen

figures seventeen

George: What happens to her after this? They just don't want to know, the professionals, they don't like you to talk about these feelings and yet these are what its about...

I knew that this statement was in part addressed to me. I nodded; I wanted to make it clear that it was all right to talk and that he needed to work out some of these feelings about professionals with me.

He looked at me fixedly with the kind of stare I had seen recently in previous sessions, when he had been upset and very unsettled as a result of having to move into new accommodation. Then he suddenly seemed calmer; he walked towards me still talking and then past me to the door, saying:

George: Yes, I do feel calmer it is partly to do with coming here.

He opened and shut the door:

George: It's like this...

He opened and shut the door repeatedly saying:

George: It's like this in my mind. When we come here its possible to open things, to talk about them, but then we have to go and the door shuts.

On one level, this was an account of limited mental space. I acknowledged his disappointment in having to go. He had repeatedly spoken about the problem of limited time for the group each week. He often seemed to have to rush his art work and bitterly regretted having to wait a week before continuing with a piece, and I regularly had a sense of the intensity of his fear about leaving at the end of a group. Using Bion again: 'The intervals between sessions are admitted and feared. He complains that he is insane, expresses his fear of hallucination and delusion and is extremely cautious... lest he should become insane' (Bion, 1967, p.32).

It may be that the meditative nature of George's art making *(see figures seventeen)*, often being concerned as it was with carefully made compositions helped detoxify some of his terror, but it was difficult for him to pursue much of his art work outside the frame of the group. I think these difficulties were internal ones and not due to his living circumstances. I think that his experiences often attack his capacity to think and it is in this sense that he experiences limited mental space. The container provided by the group and by me enables him to pursue his artwork.

Repeatedly, George had asked in quite an aggressive way about what happened after the group. He was asking whether I could do anything about the feelings he was experiencing outside the group, also whether any of the sustenance he felt in the group could last into the rest of the week.

The relationship between George and myself was changing. He was moving away from a position of absolute deference to me, towards a relationship that felt increasingly like sitting on a wobbly seesaw. I did not altogether understand the transference and it was clear that the group and myself did not manage to 'detoxify' the most difficult parts of his mental experiences. However, his relationship with his own artwork seemed to be gaining in strength and relevance for him and I think this was an indication that the group was providing a boundary and frame, with positive internal consequences for him.

When George returned to his seat after opening and shutting the door I said I hoped it would be possible for us to continue to explore these very difficult feelings in the group, whether through the conversations or through the artwork. I also acknowledged that it was less safe to refer to such feelings in more public situations.

Elizabeth moved to look at George's painting (the second picture of *figures seventeen*). His work had changed from previously laboured drawings to a fluid painting style. She told George that she thought the painting was beautiful. This painting and the one he did the previous week showed idyllic country cottages in contrast to his far from idyllic council estate. Perhaps the very contrast showed he was more able to calmly savour his appreciation of the natural world. Prior to these pictures of cottages during earlier group sessions he had made some paintings that seemed to be satisfying meditations upon a particular tree (*see figures twenty five and twenty six in chapter six*) that he regularly passed in a park on the way to the group.

Earlier Elizabeth had described how she had bought a music video, discovering when she arrived home that the box did not contain the video shown on the label. This experience had heightened her sense of confusion. She had had to ask her mother to help her sort it out. In the intervening period she had tried to comfort herself by trying to collect some messages from the radio but had been unable to hear any messages aimed particularly at her and this had left her feeling desolate. She said, "Even my messages have deserted me". The desolate feeling made her feel more conscious of the sense of the black hole.

I imagine that Elizabeth, after the dependent intimacy of her relationship (which was at that time about to end in divorce), dreaded the impending sense of loss. Indeed, she tried desperately to hold it at bay. She did break down seriously at one point, shortly after the split with her husband. She had terrifying and strange experiences while hospitalised concerning murderous thoughts directed at her. On her return to the group she was unnaturally calm. However, what came were a series of pictures that appear to be looking some ancient dread in the face.

Some time after she made the proscenium arch picture of her head (*figure fifteen*) she made a painting of the outline of a head without features *(the first of figures eighteen)*. Other heads she had made in the past (also shown as *figures eighteen*) had been more grotesque but maybe the mask-like qualities in them suggest that she was able to stand back from the experience they describe and even play with it. On this occasion she spoke about the feeling that the black hole had come right inside her and of it having the quality of mucky plastic and rubbish. The other group members listened attentively and I think with compassion; I had a strong sense that they wanted me to do something. One person listening to her began to speak about the remembered death of her mother. I think that this was the only way in which she knew how to voice something that might acknowledge Elizabeth's pain. The linking of 'nameless horror', a horrible presentiment of death found in Melville's *Moby Dick* and Bion's 'nameless dread', seems appropriate in thinking about what emerges in therapeutic work with people who have periods of disintegration. This linking of 'nameless dread' with 'nameless horror' was something I first saw in the work of the art therapist David Hardy when he was a student. Margaret Little (1958 and 1960) also powerfully suggests that the client needs to face the fear of annihilation and death in order to move forward differently.

The following week Elizabeth's picture was a faint coloured pencil drawing of several lions snapping and tearing at her. Although the image was faint in colour, it was powerfully formed *(see figure nineteen)*. She spoke about feelings of extreme panic when she is on her own. She had wondered during these panic feelings about taking a taxi to her soon to be ex-husband or to the Casualty Department. She had stopped herself with the thought that neither her husband nor the Accident and Emergency Department would be able to do anything about the terror. I think she was beginning to realise that she could face the fear without disintegrating and in the picture of the lions she was experimenting with this hard won knowledge. She also wanted to show and have me understand something about this experience.

After this time Elizabeth came to a full stop. There were no more pictures in the series. For two weeks she came to the group but sat quietly while other people continued with their artwork. She told me that she needed to do nothing. She needed to stop looking at the dread because the artwork she had been involved in was, in her words, "too close to the bone!" I accepted what she was saying. She seemed quite resigned but I wonder if perhaps I sensed ambivalence towards me. She was maybe wondering if I could do anything to help.

The interruption of Elizabeth's art work after that brief but intense period of art making made me think a lot about what is needed by people when they are particularly fragile: if they are to be able to continue to engage in their own forms of creative work and

figures eighteen

figures eighteen

figures eighteen

figure nineteen (drawn faintly in coloured pencils)

living. The very process of trying to create or introduce something new into the world involves for most people their diving into subterranean parts of themselves. All manner of things can be provoked and stirred. It is like putting a hand in clear water and causing a mud cloud by touching the bottom. After her two week vigil Elizabeth did resume art making. The first images she made at this time involved her in intricate pattern making with little obvious emotional content.

The impact of the material world upon art making and psychotherapy

Even in good material circumstances, by which I mean having heat, food and friends, the creative process involves a struggle with the self and the realities of the world. All of the people in the groups in which I work worry about the cost of heat; all have diets with dubious nutritional content; and the majority go to sleep and wake in extraordinary isolation. These hard material circumstances do curtail the possibilities for improvements in their mental condition. At the same time their sense of themselves in relation to the world has been seriously traumatised both by unhappy events and by the effects of stigma.

Nevertheless, most that I meet do manage to engage in their own creative work. Of course sometimes they feel empty and stuck and what they produce is not satisfying to them. Although this is familiar ground for us all, there seems little doubt that the experience of psychosis at its most intense causes damages for a time. This is in part due to the 'attacks on linking' within the condition (Bion, 1962) but also in part due to the way in which the political world impacts upon the experience of psychosis. It is this dynamic between the inner world of the patient and the impact upon their life of the political world, that is increasingly difficult for public sector mental health workers to overlook.

When I write about the impact of the political world I mean to encompass the change in the power status of patients and — their economic position and cultural representations of their condition and changes in psychiatric policy including the legislative controls that might be imposed upon them. All of the members of my groups would be included in categories used in health censuses to define serious disturbance and disadvantaged socio-economic circumstances. It is not surprising that the effects of their internal difficulties and the circumstances of their lives combine on occasions to damage motivation and creativity.

However, in my experience the damage is not total or even permanent. I am encouraged in thinking this by the 20-year research conducted by the Bleulers, father and son, published in 1972. Their work represents one of the longest studies so far about the lives of people who succumb to psychosis and the likelihood of their rehabilitation. Their findings are hopeful that people can reclaim former faculties. This is something to which I return in chapter twelve.

However, in the midst of psychosis Bion suggests that the condition undermines a person's sense of his or her own inner reality. The person's ability to make links between their different mental processes become chaotic and this can disrupt their ability to symbolise. This disruption can be of vital significance to the techniques of art therapy that it remains possible to use (Killick, 1993, 1995 and 1997; Killick and Greenwood, 1995).

Although the capacity to function symbolically does not appear to be permanently damaged for someone with a history of psychosis, it can take a great deal of puzzling therapeutic work with someone in the very midst of psychosis before they can return to what seem to be less concrete ways of using images and language.

The work of the art therapist Katherine Killick (1993 and 1995) indicates some of the obstacles to therapy inherent in the condition of psychosis. She shows how she understands what she thinks needs to happen before more usual art psychotherapeutic work can take place with seriously disturbed clients. Her writing describes with clarity her way of working when the client's ability to symbolise has been disrupted. In reading her work I am reminded that it is possible to modify psychotherapeutic technique when trying to help clients face the obstinacy of psychosis. However, her work poses some questions about strategies for practice in art therapy to which I return in the following chapter.

Sometimes the form and content of art works being made by people in the midst of psychosis do not appear to be vital or to have life (Schaverien, 1997, p. 21), and yet at other times the cumulative effect of the patient's body of artwork can be very powerful. It seems important to assert that the making of one image or artefact is not enough to enable the person to begin a dialogue within them self and within the therapeutic setting. I think that for disturbed clients the making of art is most fruitful when made within a containing relationship and familiar place provided over a long enough period of time.

The time of each single therapeutic session has to allow time for both art making and sharing thoughts. The number of sessions available over time needs to be adequate. Decisions about these matters need to form a part of the therapist's formulation for the work, especially in contemporary health service settings. I know a number of art therapists who offer individual sessions that are one and quarter hours in length in order to allow time for art making. Groups offered by art therapists are also often a little longer than those offered by other psychotherapeutic practitioners, being in the region of two to two and half hours. When clients use the sessions to make artwork this additional time presents no difficulty, but if clients decide not to make artwork it can make the sessions seem long for everyone concerned. The nature of the art making process and the level of the client's disturbance can both influence the time frame offered for therapy.

In more ordinary circumstances the process of making artwork that satisfies its maker requires sufficient time to digest and rework. This is comparable to other human matters that take time to work through and understand. It is also directly analogous to the way artists might develop and struggle with their artwork over time. The difference for the client with a history of psychosis is that their fears of annihilation may be heightened, and so their struggle to make art may be most feasible when undertaken within a containing relationship. This is not to deny that there are many famous historical examples of people making art in the midst of psychosis with minimum assistance from anyone. I return to this in chapter nine in a discussion of the art associated with psychosis.

I remain convinced, however, that the offer of a container in the person of the therapist and a familiar physical environment can provide the opportunity to find lost mental space. The client may begin to 'split' in the early stages of the work and so they may project their anxieties into other people (the relative fragility of the client seems to determine whether or not this is the therapist). However, if the therapeutic work is sufficiently containing (if the adaptation of the frame to the public sector has been successful), it can enable people to face some of the most frightening aspects of psychosis.

Peter Barham's first book (1984) was a compassionate exploration of his work with a group of long-term patients with diagnosis of schizophrenia. The following section seems concerned with the terror. It is taken from an account of two sessions with a group of 'troubled agents, all of them chronic, working-class schizophrenics and – with the exception of one day patient – inmates of several years service in a psychiatric hospital' (Barham, 1984, p.100).

Joseph:	It's impossible to live there now. It's just solid rock you know. You couldn't live there. It's just dust you know. You see, you can't live anywhere you know, you've got to have the weather conditions to live in...
Me:	Why?
Joseph:	Why, because if you go outside you get dust up your nose and down your throat.
Me:	In F.?
Joseph:	Why anywhere, don't you. (with some irritation).
Me:	So we are not just talking about F.?
Joseph:	No, even here. What they do is they get a pressure suit when you take seriously ill and you have to live on tablets. And when you take seriously ill they put you on a crash course in a pressure suit and you go crazy altogether, crackers altogether for about three weeks. There's one on M15s. That's psychiatry that. You see the whole world is, you see there's so much dust and dirt and things like that, you can't live. Most people live in communities under big domes. Now you don't know the dome is there. They build a whole village, and then they build the dome and you see aeroplanes flying about inside.

Me:	Inside the dome? And what is there outside the dome?
Joseph:	Certain death. There's domes under the sea.
Me:	Is there a dome over this hospital, or does the dome exist over the whole of England?
Joseph:	No, just over this area, for about five miles around. You see aeroplanes only that big (demonstrates with his hands) they put hypnotic gas in and there's little bits of aeroplanes flying about.
Me:	Inside the dome?
Joseph:	*Inside* the dome. Some of it's possibly inside me. It's the only way to exist on a world like this.

(Barham, 1984, pp. 115-6).

This is potent because it shows the extent to which these group members' ability to symbolise flickers (like an optical illusion) on the edge of symbolic equation and powerful metaphor. Symbolic equation if present would mean that the dome and the pressure suits are experienced as real and tangible, whereas the possibilities for metaphor are intensely concerned with the terror of the outside world and the imminence of its collapse into the inner world. The dynamic between the inner world and the political has remained Barham's theme and fragments of dialogue from his work with clients show why this is necessary. I continue to propose that this is a general necessity for work of this nature.

The containing metaphors of popular culture

Many aspects of the outer world echo the inner world fear of annihilation. I hear a great deal about popular culture in accounts given to me by individual and group clients. I can often see its significance in images that they make (the impact of popular culture upon therapeutic relationships is fascinating for art therapists, and I return to this in later chapters). For people with a history of psychosis working with the symbols and the metaphors from popular culture can be a useful part of their finding their way back to their own ability to symbolise and it is sometimes useful that the images they bring contain terror. Popular culture in all of its myriad forms can be a rich source of raw material, be they epic, archetypal or even dull monotonous images. There have been occasions when the images from films described, have been so grotesque that other group members respond with wincing humour and this does seem to help in the general process of emotional digestion! Young's paper, 'Primitive Anxieties in the Cinema' (1996) touches on the withering containment that is provided even in forms of contemporary gothic found in films. He describes the endless toying in such films of those things that might give rise to a sense of 'nameless dread'.

He offers the image 'of children being engulfed, disappearing with covers down a hole in the middle of the bed with a concluding belch of blood on the ceiling (Young, 1996, p 3). This example has the quality of many archetypal B movies that are often rerun on satellite television and it is the kind of thing my art therapy group members tell one another about with

extraordinary humour. B movies may well produce B graded archetypes, but this one does seem graphically to illustrate a very particular anxiety of being sucked down into some unseen underworld to face annihilation. This is late twentieth century hell with a seat in purgatory at the cinema. Although I see intense forms of the same anxiety in people with a history of psychosis, I also see them use the same humour as the rest of us in the attempt to digest the terror. This is discussed in a paper by the art therapist Helen Greenwood and the medic Geoff Layton 'Taking the Piss' (1988).

The artwork made by clients often incorporates the symbols and metaphors of popular culture. This suggests (even for those who have a history of psychosis) that it is possible to work with experience and develop a sense of self-agency. Much art therapy offers the possibility for clients to develop their own sense of agency by making art and this can make a vital addition to the spoken aspects of the psychotherapeutic work.

The work of Barry Richards is interesting in relation to this sense of agency and power because he challenges the high-art concerns of psychoanalysis without eschewing the attempt to harness some of its knowledge, in order to gain an understanding of popular culture. I think art therapists can make use of a similar approach to psychoanalysis. I return to this in chapter ten.

Some of Robert Young's work (1994, 1995 and 1996) is concerned to demonstrate the psychoanalytic proposition that psychotic processes are ubiquitous. As a result of my experience in psychiatric work I recognise and support this proposition that the potential for such processes to occur is in everyone. I think it helps me work with people in the midst of psychosis, because it confirms the reference points that exist within myself. It also makes me seek out other containing metaphors and stigma-reducing reference points in different cultural and societal forms.

Conclusion

I do not think it is exaggerating to suggest that most workers in public mental health have had to learn about-facing their own fears. Institutional and community settings have been increasingly disturbed during the 1980s and the 1990s. Given adequate supervisory help (Jackson, 1995) most psychiatric workers would recognise that they already know, through reference points inside themselves, about 'attacks on linking' and 'nameless dread' (Bion, 1962). The absurd pace of change in the public sector organisations does mean that healthcare workers have on occasion found it difficult to think, and that they have felt afraid, both for their clients and for themselves. The title of this chapter suggests that the clients are not alone in having to face these feelings. The fears of clients and workers alike have real objects in the social economic circumstances of the times in which we live, whereas our anxieties have objects that are less clear but none the less powerful.

In public sector psychiatry opinion remains divided as to what is the most helpful therapeutic strategy with people with serious disorders, whether to 'repress' or to uncover disturbed states of mind. Sometimes questions about what works for whom can only be resolved within the carefully considered details of a therapeutic relationship. Opinions about appropriate strategies are also influenced by the availability or scarcity of resources. For art therapy intimate acknowledgement of primitive anxieties requires understanding and action on three levels: art, psychotherapy and socio-political awareness. There is also a need for courage against the tendency to stigmatise and anaesthetise the frightening feelings provoked by therapeutic work with the most disturbed.

I hope this chapter has managed to indicate some of the different facets of how I understand the acknowledgement by art therapists of the primitive anxieties of their clients, when working in the public sector. In the chapter that follows I continue to consider the different facets of being able to offer therapeutic containment in these potent relationships with people in disturbed states of mind.

Chapter Six:

Art as Mediator and Engagement for Containment and Transference

Here I consider the need for therapeutic containment and the possibilities for containment that are found within the art making and the relationship. In particular I consider the strange holograms that can emerge in the meeting space as a result of the transference relationship. As with the previous chapter this one focuses upon qualities of the work that result from close contact with the client. The focus here tends to be concerned with the inner world of psychosis.

Containment, transference and artwork are all three linked in this work. For example, the acknowledgement of transference in any psychotherapeutic relationship implies that the process of containment is understood symbolically and deciphered by considering the qualities of the therapeutic relationship. The actual artwork made can often be a platform for transference and it acts as a mediator in the general process of containment. An understanding of these matters and their sensitive use in practice can influence a good outcome.

I like the subtitle of the book about groups edited by Skaife and Huet in 1998. This is because the phrase 'between pictures and words' suggests the weft and warp of art therapy. The tension that exists between pictures and words are essential elements of practice, as are the horizontal and lengthways threads in a piece of woven cloth. Taking the metaphor a little further the relationship between client and therapist is the loom that holds the threads together.

Containment

The term 'containment' is used widely and loosely in a number of different contexts. In psychiatric settings it is used to indicate the actions needed to ensure that a disturbed patient does not harm himself or others. This generally means admission to an acute psychiatric unit in the first instance. In a benign setting this form of containment need not be unrelated to the concept of containment indicated in much psychoanalytically oriented literature. Containment in this second sense is intended to indicate the provision of circumstances (in the form of a particular therapeutic relationship) that enable the client to weather, survive and develop through their emotional difficulties. Bion is credited with the mature form of the concept with his 'container/contained' (1962) ideas. However, Segal famously provided a vivid summary:

> The infant's perception is that he has projected something intolerable into his object, but the object was capable of containing it and dealing with it. He can then reintroject not only his original anxiety but an anxiety modified by having been contained. He also introjects objects an object capable of containing and dealing with anxiety. The containment of anxiety by an external object capable of understanding is a beginning of mental stability (Segal, 1975, p. 94-7).

The anxious engagement of me by a man in one of the groups for people with a history of psychosis suggests that the process of containment needs to happen on a number of levels. He will often stand and face me with very persistent accounts of military campaigns. It seems important that I do not turn away and that I think quickly enough in order to find something to say that shows that I can digest the intense emotional stuff that he is pushing my way.

Robert Young suggests that: 'Bearing projections is the whole basis of containment' (1994, p. 72). I have found his notion of capaciousness helpful in thinking about what I need to provide, 'the issue is not one of content but of capacity, not what is contained but that there should be a suitable container' (Young, 1994. p.34). This has pertinence to any client group. Later Young describes the particular form that this capaciousness might take in relation to psychotic processes.

> ...to find a way of treating mental space as available for containment, a place where one can bear experience, hold it and be able to ruminate it, metabolise it reflect upon it, savour it. The meaningfulness of experience is always under threat. It may be batted away or used to locate, amplify and feed madness and then be reprojected or reduced to cliché or collapsed into despair. The point of capaciousness is that it should serve as a container for thought, and the point of thought is to keep emotion alive. Without living emotion there are no viable relationships, and without relationships there is no world. The greater the pressure of primitive anxieties on the dimensionality of mind, the less able we are to symbolise and to participate in culture (Young, 1994, p. 52).

There seems to be a paramount need for sanctuary for people in disturbed mental states. This is addressed directly in the conclusion of Katherine Killick's chapter, 'Unintegration and Containment in Acute Psychosis' (Killick, 1997, p. 50). She examines the details of the studio environment, the materials, the portfolio and the niche in a cupboard. They all contribute to the creation of a secure-enough environment. When Killick moved away from the hospital studio and into a multi-purpose setting, a move characteristic of the move being made nationally into the 'community', it seemed to her that much that had made work with the most disturbed processes possible in the hospital was lost in the community. One of her patients spoke with her about his impression that because he had been so ill when he had started his art psychotherapy sessions, he would have been unable to feel safe-enough for therapy in the multi- purpose setting (Killick, 1997, p. 50). I remember myself the extraordinary and terrible agitation created for some of my seriously disturbed clients by a change of venue. Killick uses the work of Bick to real effect in her explanation of the significance of the boundaries created by room, portfolio and the person of the therapist (Killick, 1997, p. 39). Bick suggests that in the midst of psychosis 'the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary' (Bick, 1968). Later in her chapter Killick shows that as the more containing

aspects of the relationship and the setting are experienced by the client, then the experience of emotion becomes bearable (Killick, 1997, p.47). She considers that it is at these points that the non-psychotic parts of the personality (as described by Bion, 1976) become more apparent and available to therapy.

I have offered a number of weekly art therapy groups specifically intended for people with a history of psychosis, and since the early 1980s these groups have all been held in community settings. The venue for the first of these groups was a room booked by the health authority in a Methodist Church Hall; this setting was not ideal for making art but it did have a safe atmosphere and it was easily located because it was in the city centre. Subsequent settings in which I have hosted these groups have each had their own character. Those that have been sustainable have tended to combine a number of significant features. These are the potential for uninterrupted meetings, more space than is usual for other groups and reasonable arrangements for making art. These practical provisions help convey a good deal that is important. They respectively convey a sense of safety, the chance to feel uninvaded (or at least to feel that skin and body boundaries are not permeable) and the impression that art making is taken seriously, is meaningful and need not be rushed. Clearly significant parts of these messages are conveyed through the demeanour of the therapist.

I have written in chapter two and elsewhere about the differences between community settings and the old hospital studios (chapter two, p. 58-9). These differences have been commented on repeatedly (Goldsmith, 1992; Greenwood and Layton 1987; Killick, 1997). The opportunity to leave artwork out over the period of time during which it is being made (which may be several weeks) and the sense of having a personal place which will not be taken by someone else, are some of the aspects of containment provided by old-style studios. They are often lost in multi-purpose community settings, yet they are sensitively important in relation to the people and the art associated with psychosis.

However, Greenwood's paper, 'Psychosis and the Maturing Ego' (1997) contains three powerful clinical vignettes, two of which demonstrate how much it is possible to contain in the community. It is important to record that Greenwood's clinical experience is considerable. It is interesting that although one base in which she saw one of the patients described is much better than the average facilities that are available in NHS community settings, she did also see another patient with good results in a small multi-purpose room without windows. I do not think this last example undermines the general need for stable circumstances in which to do such therapeutic work. Nevertheless, her paper seems to me to address some of the real possibilities for transition into the community and the cause for therapeutic hopefulness that still exists.

There are some particular problems posed by the removal to a distance away from institutional boundaries. Many people who have been moved into the community feel

uncontained because they now live in isolation in their own accommodation. For example, Paul the faithful partner of the client I name Angie worried himself sick about her potential for promiscuousness and her addiction to various over-the-counter pharmaceutical preparations. I think he found some comfort himself in discovering that Angie would come willingly to art therapy sessions because, although he was often in desperate need of help for her from the services, it was not easy to get her to attend other parts of the psychiatric service.

He delivered Angie to the sessions, I showed him where to make himself a drink and found a place for him to wait. It took some time to negotiate the beginning of sessions, because often Paul would wait for Angie to find a seat in the studio. He would then stand over her and proceed to give me a list of her misdemeanours during the preceding week. He did this almost in the manner of a child telling an adult about the bad behaviour of another child in the hope that the adult will tell off the 'bad' one. Often clients and their carers are desperate to reconnect with the containment previously provided by an institution.

I tried to resolve the tension created at the beginning of Angie's sessions when I acted on my realisation that after the individual session it would be useful to spend a little time with both Angie and her partner Paul. I realise that this is unusual and that it altered the boundaries of what I was doing. I have no illusions about being able to offer family work on my own, although I have participated in successful teamwork of this kind. I think that there have only been about three such attempts at including 'family' members in separate parts of my individual work with clients with serious mental disorders. For Angie and Paul, I think my meetings with them helped ensure that the therapy could continue, and they provided a safer container for difficulties and misunderstandings within the relationship. However, Paul was containing a great deal that enabled Angie to function and he needed some 'appreciation' of this from the service. I could understand Paul's frustrations with his wayward partner, but equally I could understand how misunderstood Angie often felt. Earlier in her life Angie had had a child who had been removed because of her illness. This was a source of grief for her and for him, although it had not been his child. Nevertheless, it was clear that they both loved one another in straightforward ways and, although sometimes I felt like a referee, I was often moved by the extent to which Paul understood Angie's psychotic episodes and the way she understood what she provided for him. I offer the example as an indication of some of the contemporary complications about the provision of containment within the public sector. I am aware that this adaptation of the therapeutic frame for my work with Angie was not ideal. Some of the issues about containment are difficult to resolve in public sector work, especially with clients who have to face both serious deprivation and serious mental disorder.

Various attempts in the Therapeutic Community movement have been made to extend the range of what is included in the frame. Joseph Berke (1995) suggests that the history of therapeutic communities and their all-encompassing therapeutic frames of reference developed out of the wide-eyed enthusiasm of people wanting to be helpers. Yet even within the zeitgeist of the late 1960s and the 1970s there was clarity about the need for frame and containment.

> This is a point the importance of which we did not quite appreciate at the time. Really, the Arbours was established for helpers seeking a new framework, a new home, just as much as for everyone else (Berke, Masoliver and Ryan, 1995, p. 173).

People working in psychiatry need a sense of institutions providing them with containment for themselves, and then they are to be able to contain their clients. The therapeutic community movement flourished during the late 1970s, which was a period of optimism. That the 'helpers' at that time had a clear sense of a frame for their work in part explains why much that was innovative and positive was possible during that time.

In contrast to this is what has taken place during the 1980s and the 1990s, the title and subject of Claire Baron's book *Asylum to Anarchy* (1987) sometimes seems to be a fitting description for the move towards community settings. Baron is at pains to point out the dangers of losing a sense of containment for the work when a clear frame of reference even an institutional frame is abandoned. In addition Steiner's comment about containment and dependency suggests the extent of the conundrum posed by the provision of a containing relationship in any setting. What he describes of the dependency needs that can be awakened by therapy are often either resisted or seen as detrimental in public sector settings.

> It always seemed to me that Bion condenses his theoretical account of the stages that have to follow containment if permanent change is to result. In my view, containment is necessary but not sufficient, and while the immediate result is a lowering of anxiety, it is accompanied by a reliance on the containing object which is necessary for the relief. This is one of the reasons for the intensely dependent transference that develops between the psychotic patient and those who have to cope with the disturbing and often unbearable mental contents that the patient has projected into them. Separations are then poorly tolerated and often lead to a recurrence of the anxiety and to relapse to a dependence on omnipotent psychotic mechanisms (Steiner, in Jackson and Williams, 1994, p. xvi).

This notion of dependency does not fit with some aspects of the market culture ideologies being pressed upon psychiatry. Perhaps this is relevant to the fact that it took nearly a decade for ideas about transference to become integrated into art therapy practice within the public sector. In 1993 the book entitled *Three Voices of Art Therapy* was published (Dalley, Rifkind and Terry); it describes a transference relationship, and it demonstrates what has now become mainstream practice of art psychotherapy by using the account and the experiences of the client Kim Terry. The book is unusual in the way it

enables the reader to see the perspectives on therapy taken by client, therapist and supervisor. The account suggests that transference was acknowledged and worked with. The therapy took place at a time in the client's life when he felt depressed and suicidal. It is interesting that Rifkind felt that the art making had mediated in the intensity of the transference (if not throughout the relationship, certainly at its beginning).

> The image making seems to have reduced some of the intensity of the initial relationship, which might have been an important developmental stage for Kim. He was able to turn his back to me in the session and then talk when he felt ready. Making the image provided him with thinking time and allowed him to prepare what he was going to share with me. This enabled him to feel more in control, which initially contributed to his feeling of safety as the image became the transitional space in the dialogue we would have together...The opportunity of making pictures allowed the transference to be communicated by the image. This was to diminish its intensity and allowed the possibility of it being understood and integrated. Transferred directly on to me, Kim might have felt the need to defend against it. The transitional space of the making of the image allowed the possibility of recognising some of his earlier patterns of relating (Dalley, Rifkind and Terry, 1993, p. 134-135).

There is also a helpful discussion of idealised transference in response to the client having made an idealised portrait of the therapist from memory. There had been some concern that he had not been able to acknowledge his more negative feelings. The therapist Gabrielle Rifkind comments on this.

> What I hoped for in our relationship was that Kim would find a way of taking in the relationship, so that it would exist inside him as a template for future relationships once therapy had ended. The experience for Kim would not be one of imitation but introjection. . . If Kim has remained stuck in an idealised transference this would have not allowed him to go through the process of separation and finding a separate sense of self. It would have left him feeling strengthened but an empty vessel when the therapy ended (Dalley, Rifkind and Terry, 1993, p. 135-6).

Later Dalley comments upon something I have occasionally experienced in relation to clients with a history of psychosis.

> Kim's description of his experience highlights the process of idealisation: the therapist for a time was his 'guardian angel', which led to dependency and a sense of deepening despair. In the one session he brought no picture, the emptiness prompted such anxiety that he perceived Gabrielle in a different role in his request for medication. The art therapist moves to 'doctor' in his confusion but Gabrielle responds and holds this anxiety and does not react to it by doing something for him. By staying with his difficulties, she did not collude with his anxiety to be given something. She offered reliable, predictable space that was a containing experience for him to feel safe. This was sufficient to hold him until the following week. As he describes, this was ultimately a strengthening experience. He was able to work through his difficulties for himself and survive (Dalley, Rifkind and Terry, 1993, p. 139).

It is sometimes not possible to respond to a client with a history of psychosis in the same containing way. It may on occasion be advisable to seek the help of an actual doctor. If this goes well the whole experience can continue to be experienced as containing but sometimes things do not go well when people outside the frame of therapy are invoked. Yet social and medical issues may be genuinely pressing and it may not be feasible for a

therapist to contain these on their own. This can make therapeutic boundaries confusing and hard to determine. There may also tend to be a number of factors with very vulnerable clients when the therapist tends not to draw out and make manifest latent examples of negative transference.

Considerations provoked by context and the network of services are discussed by Greenwood and Layton (1987). It is one of the complicating factors of working psychotherapeutically in a public sector team, one that is particularly heightened when clients have a serious mental disorder. Similarly complicated boundary issues are movingly reported by Schaverien (1998) in an account of her work with a client who had a terminal illness. Her maintenance of boundaries (although they became more flexible as the client approached death) enabled her to be clear that what she continued to provide was analysis. This is pertinent to the impression that I have sometimes had that I am no longer providing therapy when it becomes long-term in ways that make it seem more like offering a rut than an anchor.

Transference

Questions about the dependency of clients upon a therapist have meant that the issue of whether it is possible or wise to work with the transference when psychosis is present has been central. It is interesting that the history of development and training in art therapy has also had a central theme concerning the use of transference.

During the late 1980s and the early 1990s it became increasingly apparent that art therapists were acknowledging the transference in their relationships with clients. In 1992 the training criteria were reformulated in order to allow for this development. The criteria became overtly psychotherapeutic and included the requirement for training-therapy.

In chapter three I offered a history of psychoanalytic ideas about work with people with serious mental disorders. Freud confessed his discomfiture about working with people with psychotic disorders and he tended to presume that it is not possible for these clients to engage in transference relationships. His writings on this influenced the development of psychoanalytically inclined work with people with such a history.

Throughout the twentieth century the question of whether to work with the transference in the province of psychosis remained as a powerful source of debate. Contemporary psychoanalytic practice has arrived at a pragmatic conclusion. This involves using careful clinical judgement to determine whether to maintain a strict analytic attitude or whether to modify technique and acknowledge transference only when it is judged that it will not threaten the client's ego strength too severely.

In the first two stages of the art therapy profession's historical development (the 1940s-1950s and then the 1960s-1970s) it seems that little comment was made about transference issues. Frames of reference involving art and social awareness took precedence

over a psychotherapeutic one. During the third period (1980s-1990s) this changed quite markedly, but only later in this third period did the particularities of work with people with serious mental disorders begin to be addressed. Even then there were few specific ideas about using the transference for these patients. The work of Schaverien was an exception; she published the first paper in Britain concerning art therapy and transference in 1982.

Schaverien and transference

Schaverien is a Jungian analyst, although she was formerly an art therapist practising in the NHS. Her work concerning the nature of transference in art therapy practice (1982, 1987, 1989, 1991, 1994, 1995, 1997 and 1998) continues to refine and echo historical developments towards greater psychotherapeutic proficiency within the profession. Repeatedly she provides examples of how we might use and understand transference phenomena in ways that are specifically related to the place of art in various forms of arts therapy practice. One of the issues addressed by this is the manner in which some psychoanalytic perspectives might view the artwork as a distraction from the relationship — a form of 'acting out'. Also unusually, her work contains a number of examples of transference work with clients who have a history of psychosis particularly in the books published in 1991, 1995 and 1997.

Much of what Schaverien has done to conceptualise the particular ways in which the process of art making influences transference in art therapy is related to a broad psychotherapeutic approach with clients who have wide-ranging difficulties. This has general relevance to work with people with a history of psychosis but Schaverien also considers particular aspects of transference in relation to psychosis. However, the question of whether to acknowledge transference in work when a client is particularly fragile is always a matter for clinical judgement in the particular circumstances concerned. Close clinical supervision is important. Supervision might adopt an exploratory approach or it may be more didactic. What is important is that the therapist provides themselves with a place to think. This is obviously important in psychotherapeutic relationships where thinking may be under attack and embroiled.

Schaverien has created and introduced a number of concepts with which to think about the transference in art therapy. These include the 'scapegoat transference' and the 'talisman transference' (1991). She also proposes the idea of the 'transactional object' (1995) a concept that might be used to understand the particular object relating that might characterise the way someone in the midst of psychosis uses his or her artwork.

Her propositions are radical and they mark the beginning of greater conceptual confidence in relation to psychotherapy for the art therapy profession. She proposes that the artwork mediates the psychotherapeutic relationship and becomes:

> an object of a scapegoat transference. Through the mobilisation of the natural propensity for splitting and projection, the picture becomes an object into which a transference of attributes and states is made. Thus the picture comes to be experienced as holding, in substantial form, attributes which are usually considered to be intangible. This is a new approach to understanding the role the picture plays within a therapeutic relationship. I have suggested that this offers an opportunity for resolution and reintegration of the transference without it necessarily being enacted through the transference to the art therapist (Schaverien, 1991, 61).

The notion of the 'talisman transference' seems like the scapegoat, to come from ancient cultural practices of myth making and magic. In this it is fitting description for the equally ancient and world-wide processes of art making and their use in therapy.

> The attachment to, and so the investment in a token may be intense, but it is less so than that in a talisman. It is a conscious attachment which creates a token, whereas the motivation for the attachment to a talisman is likely to be, in part unconscious. There is a sympathetic connection to a talisman; it is magically empowered. This difference is important in clarifying the different ways in which pictures in therapy may become empowered. Sometimes they are invested as talismans with magical power, and at others they may be merely tokens, keepsakes and memorials of friendship (Schaverien, 1991, p. 139).

The 'transactional object' (Schaverien, 1995) owes a theoretical debt to the concept of 'transitional object' proposed by Winnicott (1971) and that of the 'transformational object' in Bollas (1987). However, Schaverien writes that its heritage has a different root.

> The idea is based on anthropological explorations of the use of art in different cultures throughout the world. The word transaction implies a category where the object is used in exchange for something else. It is an object through which negotiation takes place. This may be thought to imply a conscious transaction but the process to which I refer is primarily unconscious and may be magically invested (Schaverien, 1995, p. 127).

In proposing this idea Schaverien is not denying that the artwork may on some occasions act as a 'transitional object' but in putting forward the idea of 'transactional object', she is putting forward a specific idea about the function of artwork. Her ideas about the ways artwork mediates in psychotherapeutic relationships in general have potential for understanding work with clients with serious mental disorders. In particular, the ideas of the 'fetish object' and the 'talisman object', 'both of which are magically invested transactional objects' (1997, p. 13), can explain aspects of what their art making might represent for someone in the midst of psychosis.

Since the advent of psychoanalysis the notion of fetish has commonly been associated with forms of sexual perversion. However, Schaverien prefers a more general, early psychoanalytic account to explain something of its function. 'The transformation of the object into a fetish is a way of dealing with desire and it might be understood to be a substitute for relating' (1997, p. 20). She wishes to maintain an older definition that has been lost in later psychoanalytic work. 'The origins of the term "fetish" are derived from sorcery. A fetish is a doll or an object made with the intention of conveying some desired effect. It may be experienced as "live" with influence for good or ill' (Schaverien, 1997, p.

19). This last point echoes one made by Bléandonu in his account of Bion's work in this area.

> The psychotic does not always behave as if he were incapable of forming symbols–in fact, some psychotics seem to find symbolic meaning where none is apparent to the analyst. These actions, symbols or events seem to them to have the meaning of a message that is personally addressed to them. The "symbol" of the psychotic is less a symbolic equivalent of something than a message to the patient that he is intimately connected to a deity or a demon. It represents a conjunction between the patient and a divinity which the patient regards as constant. A symbol usually represents a conjunction which a group or society regards as constant (Bléandonu, 1990, p. 224).

The fetish and the talisman

I wish I had had Schaverien's notion of fetish available to me when I was working with the client I have called Angie, because she invested a great deal in a series of elaborate images. These images seemed to populate her inner world and emerge spontaneously. She had both an innocence which was child-like and few ego boundaries, this meant that she was often in trouble about what was regarded as promiscuous behaviour. She had a long history of psychosis dating from her teenage years to her late twenties (the time when I made a relationship with her).

Angie came very consistently to the art therapy sessions in a manner that was not characteristic of her relationship with other parts of the psychiatric services. She began to make a series of images in the session and these spilled into her life at home with Paul her faithful sexual partner. He was much older than her and managed to provide real care and some boundaries (it was he who always delivered her to the art therapy sessions).

The images made by Angie became prolific. I think they served a powerful function for her, which was sometimes benign and sometimes frightening. They contained many of her unexpressed desires and they seemed magically invested for her. When with me, while she was making them Angie kept up a running dialogue with her images. Paul said that it was the same at home; she talked with the images before bringing them to visit me.

Her talk while making the images was characteristic of the absorption of a child, although much of the talk was not childish. I did have the impression that Angie was engaged in weaving spells. There was no 'as if' quality about the images they had the quality of 'symbolic equation'. Some of the spells they were weaving were intended to protect her; benign pictures like this were carefully guarded and carried backwards and forwards between sessions. Other images frightened her and these she left in her portfolio with me. She wanted to look at them occasionally, but she always opened the portfolio with caution when she did and I had to be present and attentive.

During sessions when the frightening pictures were seen she would be argumentative with me and ask many questions designed to find out whether or not I understood. Although I think I often failed in these tests of hers, somehow there was

enough in the sessions to provide her with some sense of containment. It was very important to her that I looked at her growing collection of artwork and that I made efforts to understand the narrative about her life that they described and enacted. She had strongly held ideas about the point when her illness had begun.

She felt that she had had a visitation when she had put her head out of a window when she was a teenager. There were some significant characters in the history, some of these were quite frightening and played tricks on her memory. Her narrative was not easy to follow it was described in minutiae and sometimes I felt lost in it. She had a sense of when this was happening and when it did, she became very upset with me accusing me of not believing her.

I provided some containment over a two-year period and I managed to understand parts of the content of her narrative. She stayed out of the hospital during this period. The pictures and the relationship were 'alive' to her, but it was not straightforward trying to fathom their content. With hindsight, I think that seeing the artwork in part as having the function of a fetish helps to explain its mediating function in our relationship. She seemed to be making the artwork in the attempt to control her world. It was 'made with the intention of conveying some desired effect' (Schaverien, 1997, p. 19). My presence was necessary to her as a way of legitimising the 'spell' she was weaving. If I had had this concept available to me at the time it might have enabled me to be more conscious of what was taking place between us. Her pictures like her conversation involved elaborate details and meticulous meanings. In looking at the pictures with her it was as though I was drawn through a zoom lens in order to understand the extraordinary plethora of meanings she ascribed to individual details (*see figures twenty and twenty-one*). Her language while making art was both child like and poetic. At one point she described the coloured pencil she was using, that had become blunt through great use, as 'downtrodden'.

There are a number of other clients whose artwork comes to mind as having for them the qualities of 'fetish object'. One of these —I will call her Mary— seemed to make one art object as a way of warding off evil. She had had a strict catholic upbringing and her family relationships had been very disturbed from her being a teenager. She became withdrawn and existed on the edge of psychosis for a number of years with occasional episodes of several weeks duration. She made a lot of artwork that had strong echoes of the mainstream art world. It was possible to recognise the atmosphere of the darker side of German Expressionism in her pictures *(see figures twenty two and twenty three).*

Her work described her fear and alienation and in this sense it had a direct symbolic function. Sometimes members of the team to whom she showed her work wondered if it were 'alive' to her because of these echoes of the art world. They saw these references to the outer art world this as copying, because they did not have an idea of the way art often

figure twenty

figure twenty one

figure twenty two

figure twenty three

develops through shared influences. However, I am convinced that the artwork was 'alive' to her. My conviction was aided by a frightening sculpture she made of a head that was given to her psychiatrist for safekeeping.

I cannot show the head she made. I can describe its atmosphere, which made it seem like the preserved head of a Bog body like the one shown below.

figure twenty-four

It was clearly magically invested and frightening for her. She had only told her very fatherly psychiatrist about it, but when an artist was giving an illustrated talk on her ward he showed some slides that contained images very like her sculpture. This terrified her, not because she thought her psychiatrist had told anyone about her sculpted-head, but because she was convinced it had malignant power and that this appearance of similar images was evidence of it reaching out to her magically. Thus her terror was voiced in ways that she had hitherto not found possible. Her experiences were to some extent mediated through this strange enactment with her own imagery. Terrible split off feelings were placed in the scapegoated object.

I distinguish the notion of a 'fetish object' from that of a 'talisman object' by the intent (whether conscious or not) with which it seems to be made. If I have understood this correctly, it seems that the talisman has a more straightforwardly benign and protective function than that of a fetish. A fetish need not be frightening, but it is seemingly made with some purpose in mind, whereas those images or artworks which become talisman seem to 'acquire' their special qualities. The qualities of both fetish and talisman are ones that are especially 'alive' in the mind of their maker. Also there seems to be no 'as if' quality in the way they function, as though they were 'symbolic equation', a concept I discuss later in this chapter starting on page 149.

One client, about whom I have written in the past (Wood, 1992, p.86) I named as Ruth. She made a series of pictures portraying her 'imaginary' lover; these pictures of 'Jeremiah' protected her in a magical way from full realisation of her sexual isolation and loneliness. They also mediated her extraordinarily paranoid belief system and made it

possible for her to consider it in a way that did not threaten her. Occasionally I certainly became one of the *dramatis personae* within the paranoia but I think the image making made it possible for our relationship to contain this.

The man I referred to as George in chapter five made several images of a tree that he regularly walks past when he makes his way to the art therapy group (*see figures twenty five and twenty six)*. Another of his images that seems connected to these is the picture of the gateposts leading to the house in which the group is held (*figure twenty seven)*. I think these images are alive for George The tree pictures represents his occasional sense that the natural world is benign and the special magically invested qualities of that particular tree. The gatepost picture suggests the magical qualities with which he invests the group and the protective function it holds for him. I am reminded of Rifkind's discussion of idealised transference (above, p. 138). Unfortunately, it seems too painful for him to address the isolated 'unreal' feelings that are the contrasting feelings he experiences when he is on his own.

Other images that seem to hold the properties of a talisman and to be alive for their maker were made by a man I named Peter in chapter four. He paints prolifically (sometimes as many as fifty images of the same kind). These series of images are very repetitive, and yet the very act of painting seems to absorb him in a magical thrall. Occasionally something happens and the images become more alive and not simply repetitive, and then other group members respond genuinely to them as well as to him. There is something ritualistic and protective about the way Peter paints *(see figures twenty eight)*.

However, the artwork made by people with very disturbed histories can have the more straightforward function of an emotionally invested token. They might include images of a fondly remembered parent or a beloved child.

Mann in an article written in 1989, before the publication of Schaverien's book *The Revealing Image* (1991), argued that it is not necessary to introduce new terms into the theoretical repertoire of art therapy. He proposes that theoretical terms already existing in psychotherapy suffice. Consequently, he suggests that Schaverien substitutes the use of the 'scapegoat transference' and its subsidiary concepts with the concept of projective identification. He seems to miss the point, which is to begin to theorise the role of the art, rather than leave it always as an unexplained adjunct to the psychotherapeutic relationship. I'm not convinced that his position was adequate for the development of the art therapy profession at the end of the 1980s, it was still less adequate at the end of the 1990s. In 1988, Rust and Skaife wrote:

> As a profession which has, over the years, borrowed so much theory from the whole range of verbal psychotherapies it seems crucial that at this stage we should set out to examine the relationship of art therapy to psychotherapy.

figure twenty five

figure twenty six

figure twenty seven

figure twenty eight

We can then begin to formulate a cohesive theoretical framework of our own (Rust and Skaife, 1988, p. 23).

A strategy such as the one Mann implicitly proposes could leave psychoanalytically inclined perspectives prone to characterising artwork made by clients as a form of acting out. Certainly to generalise and describe all the art made by clients as a surface for projective identification does not help me differentiate the ways in which my clients use art.

The mediation of the transference by the art

Many images (made by people with a history of psychosis) suggest themselves to me as having enabled potential transference issues to be delt with less intensively. Schaverien points to Greenson the Freudian analyst and his suggested division of a psychoanalytic relationship into three elements. These are the real relationship, the therapeutic alliance, and the transference (Greenson, 1967). In the case of analytic art therapy practice Schaverien adds a fourth element, the scapegoat transference. The scapegoat transference is the main concept; the transactional objects, the talisman and the fetish are aspects within it.

> ...my argument is that analytic art psychotherapy offers a distinct way of developing a conscious attitude and so owning the split-off elements of the psyche through their disposal in the picture...
>
> the therapeutic alliance is a centrally important aspect of the work: and at times it is the main relationship between patient and therapist. The "real relationship" and the "therapeutic alliance" may be activated, but without interpretation of any transference between patient and therapist. Instead the transference is observed as it manifests in the pictures. Thus the regression, and irrational or unconscious images, emerge *within* the relationship, but *in* the pictures. In some cases this continues to be the stance, and the interpretations which are made later are always directed through the pictures. This is a common form of working with patients who would otherwise be considered unsuitable or unready for psychotherapy. For example with certain psychotic or borderline patients, with children or with patients who are in an environment which is not conducive to transference in interpretation, due to unclear therapeutic boundaries, such as a general psychiatric ward. The work here is possible because the transference is contained in the picture which is an intermediary object which is under the patient's control (Schaverien, 1991, 33-37).

The image *(figure twenty nine)* was made by the client I have named Ruth. She had been speaking vehemently about how she constantly felt on the verge of thumping someone. She had actually threatened to 'glass' a family relative by whom she felt threatened. I should mention that Ruth's family was not given to 'glassing' one another. The person concerned had almost certainly not done anything to provoke the threat.

I did not think that I was a target for this angry impulse, although I was not sure, because in the session preceding this she had been screamingly angry with me, and I had been rudely awoken to grapple with many aspects of our relationship, including the transferential ones.

However, in this session I felt Ruth simply needed me to listen and understand the reported rage. She described it as relentless. In the past the periods of paranoid fury had

figure twenty nine
The Mouth

either been a precursor to a psychotic episode or to acts of violence that caused serious alarm in the service and for her family. I felt enormous compassion for her as she tried to face the reality of the implications of her potential violence. She knew she risked the loss of even her limited life at home with her parents.

She feared, as did I, that she could not contain the angry feelings without acting on them. It was almost half-heartedly that I asked her if she felt able to use the art materials to show me something more about how the anger felt. Straightaway, she began the painting that is shown *(figure twenty nine)*. It is a huge black mouth, inspired by her memory of an old Mediterranean woman (who had been wearing traditional black) as she fell asleep in the sun with her mouth open. She worked intensely on the mouth, showing the decaying teeth in a lot of detail before transforming the picture by enclosing it in a frame that represented a metal cage. She was explaining the significance of the different elements of the picture as she went along. She was angry while painting it. Then she stopped painting, looked at what she had done and told me that the anger had passed. She clearly felt relief that the anger had been in her without catastrophe. I think this is an example of the mediation of the angry transference by the art making. Over time this sort of work can enable the client to feel more certain of their ability to contain their feelings.

Another image of the torment of one male client in relation to memories and dreams of his late father seems to me have a similar potential for mediation (*see figure thirty)*. The image is of a repeated dream of being strangled in his sleep by his father. This client who I will call Frank had an angry, disappointing relationship with his violent father and he hears his dad's voice taunting him during stressful times when he is not asleep. Frank lost contact with his children partly because of his own violence. This loss remains a profound grief to him. Understandably he is wary of his anger and he tries to hold himself in strict check but sometimes the anxiety that seems to be the result of this holding himself in check is paralysing. His picture on one level might represent an image of him throttling himself. It might have been very difficult for him to deal with some of these feelings within the transference in the group or directly with me. The image was a helpful part of mediation. It provided a scapegoat that made it possible for him, members of the group and me to consider his complicated undercurrent of feelings.

Another example of this mediation was the expression of sexual anxieties within a group. Using a graphic image that included written explanatory thought bubbles, one very thoughtful young man was able to share his anxiety that if people really knew much about him they would reject him in disgust. Despite the explicit nature of the imagery, his image was accepted by other group members with equanimity and they reassured him that they did not feel he was 'spilling out' his thoughts. They simply and I think rightly considered that he was trying to understand and deal with his feelings. Although he did not speak much

figure thirty

about this I think he was relieved by the experience and used images as a way of mediating his relationships in the group again at a later stage.

The image *(figure thirty one)* shows him with two heads. The image seems to function on a number of levels. It is a wry comment on the way he feels himself to be perceived because of his diagnosis of schizophrenia. On another level he is grappling with feeling he has about himself and on another it is concerned with anxiety he has about group members perceiving him as two-faced. The formal qualities of the faintness of the image is something that it would have been interesting to have explored further with him. I think it provides an example of the use of image making in the move towards mature defences. I realise that this might not be the first impression gained of this image, because it is such an ironic caricature of the popular misconception of schizophrenia as being like the Hollywood Jekyll and Hyde.

There are other more straightforward examples of transference in verbal exchanges. Occasionally clients describe feelings of envy they feel about my health and position. Whereas there are real factors in the relationship that tend understandably to provoke these feelings, it is often also possible to discover other connections with these feelings and other aspects of their lives that trouble them.

When it is possible to work openly with the transference at least on some level, the client concerned is likely to have a stronger sense of the therapeutic alliance. This might be particularly valuable to a client who feels them self to be beyond the human pale because of their diagnosis. I think examples of the value of this happening can be seen in the collaborative work of Murray Cox with Shakespearian actors at Broadmoor. Although witnessing performances by the Shakespearian actors cannot be directly compared to working with the transference, the same intense processes of acknowledging on some level, shared humanity (even in murderous feelings) are present in both (Cox, 1992).

The long historical nervousness about working with clients with serious mental disorders (in both psychiatry and psychoanalysis) has resulted in many clients feeling alienated. The idea of using the relationship as the basis for treatment was offered to relatively few clients during the twentieth century. Sometimes it seems to me that the diagnostic criteria that describe people affected by psychosis as unable to relate have had the paradoxical power of a self-fulfilling prophecy.

I have looked through the literature concerning the use of cognitive psycho-social intervention (PSI) methods with this group of clients because as I have indicated (pages 3 and 248) I think that use of the approach has resulted in a historical shift in attitudes to the work. However, the nearest comparison to the concept of transference and the use of relationship directly in that treatment is something described as a 'collaborative

figure thirty one

empiricism'that is cultivated in the relationship between therapist and client by staff using the PSI approach (Birchwood and Tarrier, 1994).

However, clients of mine who offer favourable accounts of the help they receive from staff using PSI methods, seem also to report (from my perspective) that unacknowledged transference issues regularly create some confusion for both staff and client alike.

Symbolic Equation

Hinshelwood (1989) points to the work of Jones (1916), Ferenczi (1912) and Milner (1952) as having discerned a particular form of symbolism; but it is with Hannah Segal devoted follower of Klein, that the concept is most often associated. Hinshelwood describes her contribution as vivid. Of symbolic equation she writes, it

> is a part of a disturbance in the relation between the ego and the object. Parts of the ego and internal objects are projected into an [external] object and identified with it. The differentiation between the self and object is obscured. Since a part of the ego is then confused with the object, the symbol — which is a creation and a function of the ego — becomes, in turn, confused with the object which is symbolised (Segal, 1957, p. 53).

The phrase 'the symbol which is a creation and a function of the ego' (from the quotation above) has general interest for an art therapist, but the whole concept of symbolic equation poses a number of questions for the practice of art therapy with people in the midst of psychosis.

Jackson, Hyatt-Williams and Killick, in the collection of papers edited by Ellwood (1995), all explore and use ideas related to the concept of symbolic equation. They offer sensitively drawn images of those occasions when their clients have, in the very midst of psychosis, been unable to distinguish between concrete and symbolic aspects of the world. One vivid example of this describes: 'A psychotic patient, attending for twice-weekly psychotherapy, enters the room, and remarks that when he comes in a bird lands on his head and when he leaves it flies away' (Jackson, 1995, p.10).

As the therapy proceeded with this patient it seemed that gradually the meaning of the bird became clear. The bird was no longer mentioned but a 'heavy feeling' took its place. A little later the same patient brought a cartoon of a patient with a cloud over his head and his psychiatrist was unravelling the cloud by a thread, putting the unravelled thread in his pocket as the cloud grew smaller. Jackson suggests that the psychotherapy patient was acknowledging that his work with the therapist brought him relief. He had become able to recognise the symbolic significance of the bird, the same bird that had originally had a concrete and near-delusional quality.

Katherine Killick describes the evolution of her approach to this work in her paper 'Working with Psychotic Processes in Art Therapy' (1993). She shows that the journey

from concrete to symbolic thinking for someone in the midst of psychosis is often painstakingly slow. Nevertheless, her proposal is that art therapy relationships 'can offer opportunities for experiences which foster evolution of these symbolising ego functions' (Killick, p. 106). Quoting Searles work of 1962: 'Awareness of emotion is father to metaphorical thought' (Killick, 1993, p. 118) she suggests that it is only when the symbolising function has been *restored* that more usual therapeutic relations can begin.

In art therapy the work of Killick (1993, 1995 and 1997) and (Killick and Greenwood, 1995) suggests that the first focus of the therapeutic work with a client who is experiencing 'attacks on linking' is containment.

Fiona Foster (1997) considers fear of three-dimensionality that seems to her to be a characteristic of the way in which people in the *midst* of psychosis relate to the production of artwork. She also ponders on what can be a lifeless and repetitive aspect of some of the art work made at these times; and contrasts this with times when,

> production of more complex and "powerful" imagery often evoked a lot of feelings and symbolic associations in' *her* 'but seemingly not in the patients (Foster, 1997, p.52).

This reflects the relatively new sense in the art therapy profession that there exist times in the life of a seriously disturbed patient's artwork, when it is preferable to disengage from too close a scrutiny of its content. This is intended to avoid the dangers of wild projection at times when artwork is likely to contain evidence of thinking processes under attack. This is in keeping with the concept of symbolic equation introduced by Hanna Segal.

> The difficulty of forming or using symbols is, I think, one of the basic elements in schizophrenic thinking. This is certainly at the root of the concrete thinking described in schizophrenics. It accounts, probably, for much of the difficulty in understanding schizophrenic speech (Segal, 1950, p.104).

Klein's notions of the infant's early development can help in understanding the infant-like qualities of symbolic equation. Early projections and identifications are described as the beginning of the process of symbol formation. In discussing Klein's work, Segal writes the following about symbolic equation.

> The early symbols, however are not felt by the ego to be symbols or substitutes, but to be the original object itself. They are so different from symbols formed later that I think they deserve a name of their own. In my paper of 1950, I suggested the term "equation". This word, however, differentiates them too much from the word "symbol" and I would like to alter it here to "symbolic equation".
>
> The symbolic equation between the original object and the symbol in the internal and the external world is, I think, the basis of the schizophrenic's concrete thinking where substitutes for the original objects, or parts of the self, can be used quite freely, but...they are hardly different from the original object: they are felt and treated as though they were identical with it (Segal, 1955/1986, p. 53).

Segal continues a little later on this page, with:

> The differentiation between the self and object is obscured. Then, since a part of the ego is confused with the object, the symbol – which is a creation and function of the ego – becomes, in turn, confused with the object which is symbolised.
>
> Where such symbolic equations are formed in relation to bad objects, an attempt is made to deal with them...by total annihilation and scotomisation. In Melanie Klien's paper (1930), it seemed as though Dick had formed no symbolic relations to the external world. The paper was written very early on in Dick's analysis, and I wonder, if on the basis of my own experience with schizophrenics, whether it did not, perhaps, subsequently transpire that Dick formed numerous symbolic equations in the external world (Segal, 1955/1986 p. 53).

In the same paper Segal proposes that the problem in the midst of schizophrenia is not only that the patients cannot communicate with others but also that they cannot communicate with themselves. However, before the end of the paper she discusses the possibility of people moving from concreteness of thought towards the depressive position where anxieties can gradually be dealt with through the returning processes of symbolisation (Segal, 1955, p. 54).

Gérard Bléandonu's book concerning the life and works of Bion (1994) suggests that Bion modified the psychoanalytic approach to psychosis in two respects. The first concerned what he considered (in contrast to Klein) the pathological structure of projective identification and the second concerned his proposal that the non-psychotic part of the personality is never completely relinquished.

> ...the ego never completely withdraws from reality at least not in those patients who come for psychoanalysis. The patient's contact with reality is overridden by the predominance, in thought and behaviour, of an omnipotent phantasy which "aims to bring about a state which is neither life not death". Since contact with reality is never completely lost, the so-called neurotic phenomena are never completely absent; they can be found within psychotic material when the patient has made some progress (Bléandonu, 1994, p. 123).

It is interesting that the use of the concept of symbolic equation by art therapists developed during the 1990s, becoming more prevalent in its use towards the end of the 1990s. I have repeatedly indicated that the 1990s were a difficult economic period in general for the public sector in Britain. Many art therapists were affected by these hard times and it seems unsurprising to me that at that time the focus of attention in this work became that of containment and close attention to inner processes.

It now seems to be an accepted tenet of art therapy theory and practice that at the time when the patient is in the very midst of psychosis the therapist needs to work upon matters of containment and wait with the patient until they are able once again to participate in symbolic processes. As symbol formation returns it can be seen that the process of making art within the context of the relationship contributes to the building of a bridge upon which the patient could cross from one state to another (away from psychosis). If this happens the patient may become available to more ordinary psychotherapeutic relations.

I think the work elaborating an understanding of symbolic equation in art therapy has been important. Killick's exposition of the concept (1995) through clinical examples has been powerful and helpful for art therapists. However, I think it is important that in the flush of enthusiasm for Killick's work, art therapists do not present the use of this concept as the whole of their practice in relation to psychosis.

I noticed in the reported speech of one of Barham's clients that he had an idea of how long an 'acute' episode of psychosis might endure. I imagine Joseph can make as good an estimate as most.

> Joseph: ...What they do is they get a pressure suit when you take seriously ill and you have to live on tablets. And when you take seriously ill they put you on a crash course in a pressure suit and you go crazy altogether, crackers altogether, for about three weeks. There's one on M15s. That's psychiatry that (Barham, 1984, p. 115).

The point I wish to make here is that the acute states of psychosis do not endure for long periods, although the general condition may be long-term. Once an episode subsides a client may be thirsty to make sense of what has happened to them and then require more than containment. They will also need a more considered response to the content of their art.

Nevertheless, it seems clear that in the midst of disturbed processes art may be made in a defensive way. This is something about which the art therapist and psychotherapist David Mann has written (1997). However, he urges against the implication that that this is 'an either/or process: either painting is creative or defensive' (Mann, 1997, p.73). He also suggests that the notion of fetish may help in understanding some of the more defensive uses of art making (Mann, 1997, p. 81). He is similar in this to Schaverien. However, I think it is important to assert that there are some aspects of art making for people with serious mental disorders that are not well described by only pointing to the detail of their defensiveness.

The jointly written chapter by Killick and Greenwood (1995) is a powerful crystallisation of the psychotherapeutic rigour that has developed within art therapy during its third period. They assert that it is fundamental to provide containment before attempting to work with the content of a client's image. However, their clarity of understanding about matters of technique needs to be applied very carefully. They are both experienced practitioners and it is clear that both work towards meaning in relationships with disturbed clients. However, ironically, there is a danger implicit in the way this particular aspect of technique might be misused (over concretely) in relation to psychotic processes. In my experience the extent to which a client's thinking processes are disrupted in the midst of psychosis fluctuates. Their ability to communicate in a symbolic way waxes and wanes, sometimes the period when their thinking is of a kind described by the concept of symbolic equation is brief. Whereas I recognise that even though a person's thinking may not be consistently disrupted or inwardly attacked, relationships with them require careful and even

painstaking work. The experience of psychosis is complex, for any one person it can fluctuate and assume different forms. There is a danger in assuming that the whole of psychosis involves symbolic equating because this might involve an age-old tendency to fix and generalise the nature of insanity and this may mean that chances to communicate could be lost. This could undermine the benefits of the Laing's insight that it is easier than is generally supposed to understand the communications of people in the midst of psychosis. It could also tend to deny the understandable urge expressed by user movements to discover some meaning in the experience.

The artwork as engagement

The ideas of the psychiatrist Sullivan are held to have sparked analytic interest in working with psychosis in the public sector. His notion of containment seems itself like careful creation.

> It occurred to me some time since that if in receiving these patients we regarded them as persons, we attempted to discover what continued to be of interest to them, and we attempted to adjust the environment to which they are exposed in a fashion in harmony with these particular findings, we might then discover a rather remarkable recovery rate (Sullivan, 1947, p.222).

I like this because it suggests that the project of working with people with schizophrenia is one of engagement. This is counter to Freud's pessimism about the possibilities for engagement. Also Sullivan's arguments remind me of the possibilities for engagement inherent in working with the transference. However, whether a therapist adopts a gently supportive approach or a more challenging one, the task of therapy is to enable clients to become absorbed in their lives. Making artwork can remind a person what it is to become absorbed even absent-mindedly.

With clients who do not have a history of psychosis there are often uncomfortable periods at the beginning of therapy when they do not know how or why to begin making art. I am conscious at such times of Winnicott's notion that that if the client is unable to play the therapist must attend to this before anything else (Winnicott, 1971, p. 55).

With clients who do have a history of psychosis, it often seems that this sort of self-consciousness about making art does not occur. I am not sure why this seems to be the case; it may be something to do with the proximity (or at least the recent proximity of unconscious phenomena). It may also be connected with what seems a child-like focus of attention that seems to accompany the condition or people may just feel too fragile to challenge the therapist's suggestion about using art materials. The characteristics of a person's play and thinking can be much altered by psychosis. Recent experience of a psychotic episode may be a strong stimulus for making art and indeed something connected with this facility may be what is being described when scholars of the insane write about spontaneous art making.

However, spontaneity does not always entail thoughtful engagement. It is interesting that Schaverien's ideas about art making seem to pursue philosophies of art that imply engagement. In particular, she considers the part of the philosophy of Ernst Cassirer (1955, 1957), which proposes that:

> ...consciousness is mediated and transformed through symbolic forms. Like myth and language, art is one of the means through which the 'I "comes to grips" with the world' (Cassirer, 1955b, p.204). I propose that art objects made within the therapeutic context are similarly means through which the 'I' of the client 'comes to grips' with his or her world. Thus the relationship of the client to the art object may be considered to be 'formative' (Schaverien, 1991, p. 4).

Schaverien also looks at Kant's schema in which there is the idea of the essential unity of *concept* and *intuition*. She takes Cassirer's use of Kant and his application of it to substantial objects and suggests that the client mediates consciousness through their artwork. In this process of mediation, it is important that pictures '... are concrete... material objects and... self-made' (Schaverien, 1991, p. 11). This notion of art making is active and engaged.

Two ideas from the student and translator of Cassirer, Susanne Langer (1957) are particularly important to Schaverien's proposals about artwork. These are 'significant form' and 'significant motif', pictures that either are 'imbued with life' or 'remain cold'. Langer suggests that psychoanalysis fails to make this distinction and consequently tends to treat all art as unshaped expression, quite like dreams (1967). However, Schaverien's concepts of the 'embodied' and the 'diagrammatic' image (1991) were developed in part by stressing the distinction. Langer proposes that 'In good art the expression is true, in bad art false and in poor art unsuccessful' (Langer, 1967, p. 380). Schaverien follows. 'The embodied image, coupled with the therapeutic relationship, may well be 'good art' by this definition. Such a work would be true in the sense of adequately conveying the authentic, current meaning in therapy' (Schaverien, 1991, p. 93). She continues by suggesting that 'bad art' within the context of the therapeutic relationship might be that which is produced to conform to what the client imagines the therapist requires and that this is comparable to psychoanalytic notions of the 'false self' (e.g., Winnicott, 1958). However, the usefulness of this phrase 'bad art' in therapy is limited it seems more helpful to consider the art made in terms of the client's own level of engagement with it.

Through a series of interesting clinical vignettes Greenwood shows that making artwork can contribute to a patient being able to move towards mature defences (Greenwood, 1997, p. 110). She uses the work of the American psychiatrist Vaillant as support for an understanding of mature defences and the way they sometimes 'commingle' in the art associated with psychosis. Vaillant touches on the paradox of this kind of process

when he writes that the 'wonder is that creativity and psychosis can become, on occasion commingled' (Vaillant, 1993, p. 246). Greenwood quotes *The Wisdom of the Ego*:

> ...threat of madness can sometimes drive one to art. Great art can stave off insanity. Art is not dangerous; it is the circumstances that bring it forth that are perilous; and it is failure to harness the passions with mature defences that may be fatal (Vaillant, 1993, p. 246).

Greenwood's continued practice in the NHS has meant that she has had to arrive at a synthesis of theory and practice, which allows for the possibility of the development of mature defences in people with serious mental disorders. Aspects of her practice suggest that she is an inspired pragmatist in the way she manages to 'commingle' a synthesis of aspects of psychiatry and an analytic perspective in relation to clients with serious mental disorders.

One final clinical example illustrates the extent to which I consider this commingling necessary. The collage picture *(see figure thirty two)* has always stuck in my mind as evidence of the importance of paying serious attention to the client's words and actions. I will call the young client who made it, Diana. She had a diagnosis of manic-depressive psychosis and she was in the midst of an episode when working on the collage. She made a collection of bits of things she found all over the hospital and used them as the raw material for her picture. During its construction she was often humorous, although it was clear that the image concerned painful feelings. At times the work spread all over the floor of the art studio. Hospital staff became aware of its construction during Diana's rummaging for collage material. They simply thought the collage was evidence of her inner mental state. When a concerned doctor visited her parent's home because he had inkling that there was something more, the connections between her inner world and the realities of her outer world became apparent. To write more of the details of this would maybe run risk of identifying her, although the experience of her family is common enough. Even when made in the midst of psychosis art can make references that point to the material realities of the outer world.

In the following chapter I begin to consider the functions of group practice in the mediation of the outer world for seriously mentally disturbed clients.

figure thirty two
Diane's collage

Chapter Seven:

Using Groups as a Stepping Stone between the Inner World and the Outer

> Singular indifference ...towards their former emotional relations, the extinction of affectation for relatives and friends... "no grief and no joy" (Kraepelin, 1919, p. 33).

Since Kraepelin's proposal of these diagnostic criteria known as 'blunting of affect', a variety of forms of diagnostic methods have used the idea that people with serious mental disorders have extreme difficulty in relating. This would seem to mean that use of groups is contra-indicated. However, in my experience groups of clients with a history of psychosis have regularly been able to work together with a highly sensitive and empathic appreciation of the difficulties of fellow group members. Only on one occasion did I judge that a client was too actively and extremely paranoid to be able to make use of group work.

However, the task of establishing a group that employs some of the dynamic principles of group work in the public sector is not straightforward. For example, although there is a clear need for group work for many sections of the population of clients using the psychiatric services, it can take a great deal of time establishing a group for people who have needs in common.

It regularly takes me between two and four months (and sometimes more) to gather enough appropriate referrals in order to begin a group for people with a history of psychosis. The levels of disorganisation, disturbance and deprivation that can accompany the condition, means that a lot of preparatory work is needed in order to find a sufficient number of people who are able and willing to attend a group. The same difficulties also influence the ability of practitioners to formulate a clear approach to group practice, just as with individual psychotherapeutic practice there is often a need to adapt the frame in order to accommodate the circumstances of the clients and those of the public sector. For example, it may take some time for individual group members to grasp the time boundaries of the group. The point at which some people join a group may differ because of the vagaries of the referral system. Clients may see one another in other parts of the service outside the group and other health service staff may hear of events in the group from accounts by individual group members.

Many technical adjustments may relate to the circumstances of the public sector setting. A consideration of such matters and not just those involved in face-to-face work with clients constitute the establishment of an adequate therapeutic frame.

The art therapy profession's attention to group process has been steadily evolving and developing a sharper focus. This is a parallel development to the strengthening of psychotherapeutic theory in individual work. Here again, the increasing isolation of art therapists offering groups in the community, away from a team base, has driven the need for a greater understanding of group process theory. There is a constant quest for development;

because therapists in the course of their practice encounter many issues they wish they knew more about, in order to offer more help to their clients. There is still a great deal of rich uncharted terrain in relation to using art and psychotherapy together in such groups. There is a constant challenge within art therapy to arrive at a synthesis of the psychodynamic elements of the relationship, art and context.

This chapter explores the general use of groups in British art therapy and their impact on work undertaken with seriously mentally disturbed people. It is suggested that groups can provide a useful mediation (or astepping stone) to the outer world for people who have been isolated with serious mental disorders.

A brief history

In the contemporary period the closure of the old asylums and the basing of many groups in the 'community' have driven group practice along psychotherapeutic pathways and we are yet to see what the impact of evidence-based practice will be. In the years following the Second World War and those leading up to the present time there was a gradual development of knowledge of group process in art therapy and this has influenced practice greatly. The development this knowledge in the profession was partly stimulated by the numbers of art therapists working in the public-sector therapeutic communities during the 1970s. However, as with other progressive impulses in psychiatric practice the demise of therapeutic communities in the public sector coincided with the third period of art therapy history and the harsh political economic conditions in Britain. During this period there was a stasis in developments in psychiatric practice and this affected developments in art therapy with the seriously mentally ill. Only during the late 1980s and the mid 1990s did references return in art therapy literature to an interest in group process. It is not yet clear what this will mean for art therapy groups with the seriously mentally disordered.

The development of group process awareness in art therapy has been gradual but it is not possible to characterise it as a steady chronological progression. Accounts by art therapists of open-studio groups throughout the period from the 1940s to the end of the 1970s demonstrated aspects of group-process awareness. However, sometimes the only common features in the literature are that art therapy clients certainly share the studio spaces and the art therapist. During the late 1980s and the 1990s the earlier lack of a theoretical structure changed as more art therapists adopted a group analytic perspective after Foulkes.

Then there was a lively debate amongst art therapists towards the end of the 1980s concerning technical issues about groups. These issues were described as the debate between 'directional and non-directional styles of group work' (McNeilly, 1984). This involved a comparison between those art therapists who offered their clients a theme for exploration in their artwork and those who simply responded to whatever the clients made.

When Gerry McNeilly's and Jeff Robert's papers on group processes in art therapy appeared in *Inscape* in 1984, 1985 and 1987, they created an indignant response from those art therapists who wished to defend the use of themes, this side of the debate was represented by the Bristol group. Those involved in the Bristol Group who wished to defend the use of themes (Thornton, Liebmann, Ford, Buddery, Lowes, Curtis, Holst, and Drucker, 1985, p. 23-25) were clearly working with clients who were not normally served by the psychotherapeutic community and may well have included those with a serious history of mental illness. Their main protagonist, Gerry McNeilly, has subsequently (1987) suggested, that it would be good to get away from characterising all the complications and technical matters in a crude polarity. This had placed 'directional' and 'non-directional' styles of group work in opposition. However, although people on both sides of the debate made some interesting and cogent points about the nature of group practice in art therapy, the questions about group processes when working for clients with a serious mental illness were not specifically addressed.

The tension in the 'directional' versus 'non-directional' debate in art therapy may relate once again to the estrangement between public-sector psychiatric practice and private sector analytic practice. All those who challenged McNeilly's stance as being too uncompromising, did so from a public sector perspective, whereas McNeilly was writing during the first flush of enthusiasm for his private sector group-analytic training at the IGA. It was later in 1987 that McNeilly was able to modify his position, possibly after he had the time to integrate his private sector training with his considerable public sector experience.

In addition the changing circumstances of group work as psychiatric practice moved into the community was not indicated by this group debate. This may be because in 1985 most art therapists offering groups were still able to host these groups in hospital studios.

Certainly the move of psychiatry into the community at a time of economic restraint in Britain posed many challenges for practitioners. There was a need for many practitioners to quickly acquire more understanding and skills as they found themselves having to work more on their own. Deco (1998) also suggests that as art therapists left the institutional containment of the old hospital studios, the focus of the work necessarily had to shift. In many places the containment previously found in the environment of the studio was lost; more reliance was upon psychotherapeutic understanding, the containment offered in the person of the therapist and other group members. In addition I think that in some respects this meant that the focus of attention turned inwards into the development of technical and theoretical rigour in order to 'escape' the hard political climate that it was difficult for public sector employees to feel they could influence.

Art therapists are making serious efforts (Killick and Schaverien, 1997) to describe what they hope to provide for people with a history of psychosis. Yet until 1998 very few

papers addressed the practice of *groups* with this client group, the exceptions were two papers by Greenwood and Layton in 1987 and 1991. Indeed, as with the provision of individual psychotherapy for people with a history of psychosis, there is considerable scepticism in the psychiatric and the psychotherapeutic community about the wisdom of creating groups for these clients. Again although the art therapy profession has had a long history of group work for clients with a serious mental illness, it has not always addressed or been aware of the theoretical scepticism about such work. This apparent lack of awareness may be due to the difficulty of thinking about the estrangement between the two different philosophies and the complications of translating the precepts of one into an appropriate form for the context of another.

The book entitled *Art Therapy for Groups* and subtitled *A Handbook of Themes Games and Exercises* edited by Marion Liebmann expressly states that it provides no guidance for those embarking upon long-term therapeutic work or for work with specific client groups (Liebmann, 1986, p.3). Throughout the 1980s and the 1990s, numerous art therapists (notably a number of the staff in the Goldsmiths Training) pursued a group analytic training in the Foulksian tradition. Indeed a special edition of *Group Analysis: The Journal of Group Analytic Psychotherapy* (1990) was devoted to group work in the arts therapies. Subsequently Goldsmiths staff established a group analytic training course. This is a separate course offered alongside the art therapy training.

Art psychotherapy groups in the public sector

Then in 1998, the excellent book entitled *Art Psychotherapy Groups: Between Pictures and Words* was produced; again this was an initiative of staff from Goldsmiths (Skaife and Huet). Since the publication of this book I have recommended it to most of the students and art therapists I meet. It is absorbing to read because repeatedly in each of the chapters experienced art therapists explain how they are thinking about the relationship between their own group practice and theory. Each of the contributors gives a clear description of their practice and from this show the reader how they have arrived at their theoretical conclusions. No one is dogmatic about theory or practice and this gives the reader the overall impression of the maturity of group practice in the profession.

I began by indicating that art psychotherapy group practice within different public sector settings is not straightforward. This is not surprising given the wide-ranging nature of these settings. In the book edited by Skaife and Huet (1998) Frances Prokofiev describes working with young children in an inner-city mainstream school. Nicolas Sarra gives a powerful account of working with people in psychotic states on a forensic ward. Sarah Deco, Jane Saotome, Angela Byers and Neil Springham all describe group work in different sections of public sector psychiatry. They discuss the nature of group work in relation to

acute psychiatric patients, long-term and rehabilitation patients, the elderly and people with drug and alcohol addictions.

In particular, Frances Prokofiev discusses the adaptation of the setting and the dynamic administration of a group within a mainstream school (Prokofiev, 1998, p, 53). The chapters by Sarah Deco and Jane Saotome describe group work with people with serious mental disorders. The practice they describe demonstrates the quality of their thinking and their reasons for therapeutic hopefulness.

However, despite this developing integration of group analytic knowledge within art therapy, a number of issues about groups for very disturbed clients have not been addressed. This is understandable given the general psychotherapeutic wariness about working with these clients (there are legitimate technical problems) and because social and political factors influence the range of possibilities for therapeutic practice with them. For example, clients may be disorganised and chaotic at some points. They might find it hard to remember to attend the group at the right time or they might find it difficult to travel to a group on their own. They may simply not have the bus fare.

Knowledge of group process theory in the profession and its development in relation to the art making

In some discussions there tends to be a presumption that the use of open-studio groups in art therapy has had more to do with a mirroring of the studio approach in art schools than with group work. Yet the focus by art therapists on the group process means that art therapy practice varies considerably from that used in art schools. Attention to the nature of these variations could lead over time to a rich source of technical development in group practice.

It might also be said that what happened in open-studio groups often mirrored an early 'classicist' approach to groups (the American Slavson 1943, is said to have been one proponent). Using this approach group leaders tended to work with material shared by individual clients in the presence of others, the group leader offered attention on an individual-by-individual basis with a lot of power residing in the hands of the therapist. This was not altogether without benefit to the group in general, but the style of work probably did not do enough to harness the power of the group process.

Knowledge of group process theory has had an interesting and eventful history within art therapy (McNeilly, 1984 & 1987; Roberts, 85; Thornton, 1985; Liebmann, 1986; Greenwood and Layton, 1987 and 1991; Waller, 1990 & 1993). The book just mentioned, edited by Skaife and Huet (1998), reflects the impact of the history. Importantly it takes the examination of the tensions between group processes and art making to a very interesting new level. The two introductory chapters (Huet and Skaife, 1998) discuss the sense in which there is both dissonance and harmony at the juncture deftly indicated by their subtitle:

between pictures and words. I found their theoretical exploration to have explanatory power.

One comment and a number of questions posed by Skaife and Huet in their introductory chapters do a great deal to situate group practice in art therapy today. The comment is a powerful one and it asserts that a central problem in art psychotherapy groups is that '*there is too much material*' (Skaife and Huet, 1998, p, 17). They discuss the ways in which they attempt to work with this abundance of material, and acknowledge the dilemma created by the combining of group dynamics *and* matters arising from individually made artwork. They pose three questions about the practice of art psychotherapy groups:

> ...the first is, does the use of art effect the working through of dependency and authority issues in the group? The second is does the symbolic/metaphorical meaning of the image take precedence over art making? The third is, does the verbal interaction tend to predominate over art making? (Skaife and Huet, 1998, p, 11).

All three of these questions have particular pertinence to therapeutic work with groups of people who a have a history of serious mental disorder.

Skaife and Huet also propose two factors that they see as enabling. These are: the ways in which some images or artefacts made in the group can come to symbolise the group process and the ways in which the use of materials and studio room can provide many additional elements to the expression of those processes.

These factors are pertinent to all art psychotherapy group work. However, their significance moves in and out of focus depending on the nature of the difficulties faced by clients and the atmosphere in a group. Also in a similar way the focus of attention moves backwards and forwards between the individual, their art making and the group dynamic. It is hard to imagine how else the tension between individual art work and group process might be resolved, other than by adopting this integrative or Foulkesian approach. The different chapters explore many different facets of this potential for changing emphasis in art psychotherapy groups. Many art therapists have sought additional training in group analysis within the frame of reference indicated by Foulkes.

<u>Art psychotherapy group theories and the needs of the seriously mentally disordered</u>

A review of Diane Waller's book *Group Interactive Art Therapy* made by the Group Analyst Anne Harrow (1993) provokes some interesting questions. In one of her comments that particularly caught my attention, Harrow is discussing the possible meanings of the 'container'.

> Bion's concept of container as an active space in which it was possible to think, is different from the idea of emotions being "contained" in an artefact. The artefact is a valuable means of communication, but therapeutically there has to be movement from that, to conversation which necessarily involves an other (Harrow, 1993, p. 27).

I think this comment betrays that its author has little experience of the process of making art and little if any experience of making art in the company of others. I suggest this

because I believe the process of making art can provide a *different* way of thinking. McNeilly writes.

> It is more demanding for the group-analytic art therapist to sit watching and remain alert for the first forty-five to sixty minutes (the image making period) while many simultaneous expressions occur. Perhaps it was at this seminar that I began to develop my view that this part of the art therapy group is like 'classical free association', whereas in conventional group analysis 'group associations' occur throughout the session. This is because in the group's beginning the members are creating their own image in concurrent unison. If people spoke concurrently in group analysis this would be chaotic or nonsensical. The verbal group analyst therefore has a linear technique to work with through consecutive verbal input. There was surprise that so much resonance and cohesion could be reached when people have the freedom to create their separate imagery, to emerge in the verbal section united or fighting, like the best of groups. There was a prior view that the opposite would occur — that people would become more isolated from one another (McNeilly, 1990, p. 217).

Winnicott suggests that it is useful to be involved alone in a task, while in the company of others (Winnicott, 1971, p. 56). It seems undoubtedly to be the case that those group-client's of mine who quietly make art in the company of other group members are sharing on a number of different levels. Admittedly, the conversation during the quiet industry of making art, may only be termed 'conversation' at the level of resonance as proposed by Jeff Roberts in his *Inscape* article in 1985. Musical terms are commonly and helpfully used in discussion of groups. Roberts uses the term 'resonance phenomenon' to indicate something of the way in which artwork made in a group can have connections with other pieces made in the same group by different people. These connections are seemingly unconsciously made (Roberts, 1985, p. 19).

Anne Harrow is correct to indicate that the container provided by the group and the particular qualities of thinking space created by groups are not the same as those held within the image. The qualities of containment gained through the process of making art can nevertheless be active and varied. I see evidence of these various forms of containment in watching clients of mine make art. For one man his absorption in painting is total (he almost uses his tongue to lick the paint onto the paper). Such absorption seems to occur in few other areas of his life. For others their involvement and excitement waxes and wanes, and there are clearly times when engagement in art making is a struggle. The cyclical nature of art making can be accommodated in a therapeutic frame shaped by the different elements of group, art and therapist. It would not be wise to suggest that it is the process of making art alone that provides the sense of containment and the resulting space for thinking; but there are interesting differences between art therapeutic work with people with a history of psychosis and art therapeutic work for those without such a history.

David Maclagan comments upon the contribution made by art therapy groups to the group programme in the therapeutic community. He felt that they provided a different way (and sometimes the only way) of holding 'toxic' emotional material. He discusses the

individualistic appearance of some aspects of these groups, acknowledging that whereas it is true that group members make their own artwork, what is made is quite likely to reflect the group process and the surrounding community (Maclagan, 1985, p.7). He acknowledges the tension that can be provoked by reductive or over literal translations between group process and artwork and the reverse, but feels that it is all too easy to mistake the 'visible and superficial aspects' (Maclagan, 1985, p.8) for the total effect.

I think that this mistake is often made in relation to long-term art psychotherapy groups with clients who have a history of serious mental illness: an observer might on the basis of a superficial impression imagine that not much is happening. Yet as Maclagan points out:

> The mere existence of a group in which irrational material is regularly tapped, and in which feelings, even if profoundly negatively ones, are given a formal anchor, must have a considerable, if invisible effect in preventing unconscious images from being confined within the individual, where they may fester in poisonous privacy (Maclagan, 1985, p.8).

This notion of 'poisonous privacy' is particularly helpful in relation to thinking about the potential benefits for people with a history of psychosis, of making art in a group. Although art might be made in semi-privacy on an individual basis, there exists the potential of gradually coming to the point where it is possible to share with other group members and the therapist. That the art therapy group holds within its structures the possibilities for some concealment can be a considerable comfort to someone who feels them self too close to the edge of their last psychotic episode. In the group they may then have the chance to discover over time that some aspects of privacy in the company of others can be benign.

A good deal of recent work by art therapists concerning the nature of the art made by people in the midst of psychosis (Killick, 1991; Killick, 1993; Killick & Greenwood, 1995; Killick and Schaverien, 1997; Wood, 1997) has pointed to difficulties in thinking experienced by people with serious mental disorders. Earlier I discussed the form this might assume in 'symbolic equation' (chapter six). Thinking processes under attack need first to be contained before they can be worked with (Killick and Greenwood, 1995). I suggested in chapter five that this need for therapeutic containment explains why the nature of much therapeutic work offered by art therapists to people with a history of psychosis needs to be in the style of supportive psychotherapy. However, as groups have moved away from institutional settings the possibilities for containment have shifted from the institution and the environment of the studio onto the person of the therapist and the dynamic of the group, it is no longer effective or appropriate to be unclear about the kind of group approach being used.

Although many of the people with a history of psychosis who find their way to art therapy groups in the community are not actually in the midst of psychosis, they can at

times be very fragile. They can experience difficulty in thinking and find it difficult to work symbolically. Consequently the therapist does need to be aware of the problems of technique that can be provoked by psychosis. However, I tend to think that the worst attacks upon a client's capacity to think are short-lived and it would not be appropriate for the therapist to act as though this were not the case.

I agree with Schaverien's idea that for the psychotic client:

> the mediating function of the art object is especially significant. Relating directly to another human being may be experienced as far too threatening to a fragile personality, but to relate through a mediating object may be possible (Schaverien, 1997, p. 34-5).

I am of the opinion that the more disturbed group members are, the more they need to firstly establish a central relationship with their artwork, almost as prerequisite before they might begin to engage in the life of a group. Greenwood and Layton (1987, p. 18) describe their impression that sometimes clients use decorative work as a way of finding a way of being in the group. One group client of mine made an elaborate copy over many weeks, I suspect that this enabled him to remain partially concealed and so gradually find out whether he could feel safe within himself in a group *(see figure thirty three)*.

These matters lend a specific ordering to the attention of the group therapist. Also they show the relevance of an approach that permits the therapist's attention moving between individual concerns and group concerns. Although there is always the possibility of commenting upon anything relevant to the group dynamic, it seems likely that with disturbed group members the therapist will be drawn first into focusing upon individuals and their individual ways of using art before they venture into making comments about the group dynamic. The differing needs of different client groups will determine the emphasis of the therapist and the focus of their attention.

Long term groups

Long-term groups with the seriously mentally ill are not an easy undertaking. Supportive psychotherapeutic work is often underestimated in terms of the range of skill and endurance needed by the therapist (Hartland, 1991, p. 214). Yet it seems abundantly clear that there are many clients who have real needs for long-term work. It would be short sighted for services not to make some provision for these needs. Indeed it does seem that in some areas of the country, for example, Tameside Health Authority in Manchester, such needs are beginning to be recognised. Psychosocial Intervention (PSI) teams are now working with a system known as 'case-loads-for-life', which acknowledge that health economics justify long-term maintenance work, by consistent professionals with needy clients. Also standards four and five of the *National Service Framework: Mental Health* (Department of Health, 1999, p. 41-68) suggest that health policy is beginning to move in the direction of providing long-term maintenance support for clients with severe mental illnesses. My own experience

figure thirty three

of offering long-term groups convinces me that they can contribute quite considerably to the maintenance of the sense of equilibrium and personal containment felt by each group member. The majority of people in groups that I provide seem to need only limited contact with other parts of the psychiatric services, unless they are in the midst of an episode.

The art therapist Helen Greenwood and her colleague the community psychiatrist Geoff Layton have shown the feasibility of using long-term community groups with people with a history of psychosis (1987 and 1991). The two papers they wrote together describe aspects of their co-work in running a long- term group. The first paper provides an interesting discussion of a number of things that are often features of such groups. It opens with a preface by the Consultant Psychiatrist Michael Radford who appears to have been a clinical supervisor for the group. He laments the fact that attempts to enable people themselves to 'contain their psychoses' have overlooked the uses of arts therapies and humour, in enabling the strengthening of social defences. The paper opens with its own lament that is about the heavy over prescription of depot neuroleptics under the threat of compulsory re-admission. It points to the way in which some people will 'actively escape contact with services that enforce their use, to join the ranks of modern "pauper lunatics"' (1987, p. 12). It is painful to know the extent to which this has been prophetic. There has been an increase in the number of ex-mental patients on the streets. In addition, the Mental Health Service Executive is still toying with the idea of Supervision Orders that will administer medication compulsorily. For at least a decade the period that followed the publication of Greenwood and Layton's paper in 1987 was hard economically and as a consequence it does appear that a 'physicalist' philosophy has predominated in psychiatry. This tends not to allow that a patient does need some help with making sense of their experiences. The administration of medication has generally been judged as both sufficient and appropriate during this difficult period. This tends to support the thread throughout the thesis that a progression in health care (as in other social movements) is unfortunately halted or even reversed during difficult political economic periods.

The room in which Greenwood and Layton's group was held was a part of a community day-centre that is housed in two large terraced houses in Birmingham. The ways, in which its features were gradually changed to accommodate the use of art materials in the group and art therapy in the centre, are interesting.

> When Helen first came to work at the Day Centre, eight years ago, one of the rooms was filled with tables and used as an O.T. /craft room. The other room was used for psychotherapy. Demolition of the wall between these activities and its reconstruction psychically by dividing the session into discussion in one part and artwork in the other, all seem to symbolise the growth of intrapsychic structures. The absences of a separate art room in the Day Centre has meant that art therapy has to be separated and integrated at a psychic level rather than a physical one.

> This is therapeutically important as it represents compartmentalisation and integration within individuals (Greenwood and Layton, 1987, p.13).

Although there was not a dedicated studio there was clearly a place made and held for art therapy within the structures (both psychic and physical) of the daycentre. This makes the task of containing delicate and disturbing work a great deal more feasible. In addition there is the suggestion throughout this paper that it helps to enable clients themselves to 'contain their psychoses' (Radford, as above, p. 12). This is because boundaries are everywhere being symbolised and demonstrated within the structures of the day centre and inside the frame of the actual group. All the normal boundary-setting devices were used concerning time, prohibition of telephones (this has a contemporary pertinence given the advent of mobile phones) and arrangements concerning absences and holidays.

Appropriately, it seems that the group therapists did not shrink from the inevitability of clients needing to refer to their use of medication. Indeed the group purposely coincided with the time other day centre staff held clinics for the administration and monitoring of medication. As with all other aspects of their experience, it is helpful to acknowledge the feelings of group members about medication (positive or negative). This acknowledgement might be very simple and straightforward initially, or it may involve helping the client to make some sense of their use of medication at a symbolic level. This does not necessarily involve acquiescence to the use of medication. Indeed, it may involve the acknowledgment of the difficulties of addiction to major tranquillisers. It is very helpful that the Department of Health has indicated: 'The incidence of adverse reactions tends to increase with dosage and there is not evidence that the standard dose of anti-psychotic medication is less effective than a higher dose in preventing relapse' (DOH, 1999, p. 45). Many clients over the years have reported to me their distress at having medication greatly increased. Of course some clients have felt distressed because their medication was not increased. There are understandably a range of powerful feelings that are with having to take major tranquillisers. These feelings can be a recurrent discussion in groups.

The group conducted by Layton and Greenwood was one in which themes were used as a way of helping patients begin to make art. The reluctance of the art therapist Helen Greenwood, to offer a theme is discussed in the light of her allegiance to Gerry McNeilly's propositions about themes. However, it was felt that the use of themes (certainly those which seemed to emerge out of early conversation at the beginning of groups) might be an appropriate way of allaying anxieties with this particular client group.

> The theme gives focus for the projection of anxieties. We find now that group members suggest difficult and threatening themes, and the non-threatening themes previously suggested by the therapist are now scorned. By personal choice we would not work with themes, preferring a more spontaneous approach, but it is recognised that

> this might increase anxiety and confusion and leads to further disintegration in this group of potentially psychotic patients. Whenever it is suggested that we have no theme the group are quick to respond with an appropriate idea. Although they recognise that the theme is needed so that they can commence artwork, it is often very quickly abandoned or responded to only obliquely (Greenwood and Layton, 1987, p. 14).

The description is given of the way in which even the proffering of themes becomes part of the process of containment and a description of the art therapist's feelings about the themes suggested by clients to her, is very interesting.

> When she hears the suggested theme there is a feeling of fear within her, together with protectiveness towards the group or particular individuals that they should have to face the anxieties associated with the theme. She struggles with this and when asked for the theme gives it back. It seems important that the theme is not avoided (Greenwood and Layton, 1987, p. 14).

Later the paper continues:

> Group members suggest a theme out of conversation but is interesting that they do not seem ready to move until they have turned to Helen to agree or restate the theme. Helen experiences the stated theme as difficult and then inwardly panics wondering how the group will cope with exploring such sensitive areas. She sits with this uncomfortable feeling dealing with it by her own internal process of mental digestion until she feels able to give back a slightly modified theme, or if the theme is not modified, the anxiety associated with it has been. Sometimes even the group member suggesting the theme turns to Helen to be reminded of it (Greenwood and Layton, 1987, p. 15).

This suggests to me the high level at which thinking is taking place about the synthesis between artwork and the psychotherapeutic relationship. In similar ways the use of portfolios for each patient provides containers at a practical and at a psychic level. I recognise this use of portfolio and the similar use of client sketchbooks and notebooks. Personally I have not found it necessary to suggest themes for use by the whole group. Occasionally with this client group however, I have suggested a theme to an individual to work on in their art making. I draw such individual themes from the material the client seems preoccupied with, for example, I might suggest that someone explore a particular feeling that they have been describing in his or her artwork.

On another level, there is the real possibility of having to contain aspects of work with these clients on behalf of society. Greenwood and Layton describe an example of how easily relations between different parts of public services can become confused when communicating about disturbed clients. Quite a lot of work may need to take place in relation to these clients to try to ensure that societal reactions from such agencies as the police, social services and hospital-based psychiatry do not make matters worse. This supports the relevance of sufficiently long-term therapeutic work as a way of ensuring that therapists have sufficient knowledge of the client to enable an appropriate containing response, based on understanding. This might then mean that the therapist's communication

on behalf of the client can reduce the likelihood of a non-comprehending reaction from other services in ways that can make matters worse for everyone. Such confusions can be costly in emotional terms for the client and in economic terms for services.

All this implies meticulous attention to consistency on the part of group therapists. Clear notice in relation to holidays and departures by staff and other group patients is important in work with any group of clients. When clients have a history of psychosis these matters can be particularly significant. When information about them is not clearly conveyed the client can experience breaks in therapy as internally catastrophic. I have noticed an increase in the level of breakdown at such junctures. This is a potential subject for empirical investigation.

Greenwood and Layton (1987, p. 18) suggest that,

> ...changes in self-mastery are no mean achievement and learning to ride the surf of the unconscious better may be taken as our principal object in therapy...We start from a general theoretical position that we are looking for control and acceptance of the unconscious energies by development of the ways of making them conscious. This can transform intolerable experience into creative adaptive qualities by virtue of the relationships of each individual in therapy, which are real and immediate, but on another level simultaneously symbolic. Every detail is invested with meaning. The "container" or "image of tolerability" by which growth of the ego occurs is both a boundary and a space between self and other. We see the process of therapy as a growth of each person's ability to deal with and utilize his or her internal psychic energies. These are "contained" by processes of thought and feelings that are developed in the space offered by a therapeutic relationship. The physical space and setting of therapy is offered to the patient...as a model by which growth can occur (Greenwood and Layton, 1987, p. 19).

The use in such group work of a style of work they designate as 'side by side work' (Greenwood and Layton, 1987, p. 14) is advocated, they cite Kohut (1966) and Lachman-Chapin (1979) as support for their approach. However, it seems to me that essentially they are invoking ideas from the first psychoanalytic tendency described in the work of Rosenfeld and discussed in chapter three. Their notions of a 'side by side stance in therapy', whereby they try to create a sense of equality and sharing and actually engage in the art making process themselves is evocative of the position taken by Searles and of some aspects of the work of Laing, also discussed earlier in chapter three. Their subsequent paper (1991) about the function of humour in long-term groups seems to adopt a similar stance.

Although Huet does not mention the use of group work in her paper (1997) she strongly implies that in rehabilitation work in the public sector it is necessary to 'adapt' art therapy practice. Her small-scale survey amongst a number of art therapists involved in rehabilitation work suggests that this is a common approach. Also the warm description made by Barham (1984) for the human value of such work, seems to imply something about adapting technique when he describes as 'discussions' his work with small a group of 'chronic schizophrenics':

> These were not intended to be 'therapy groups' in any formal sense. Whatever else might be said about them, the sequences are perhaps best approached as a record of discussions between a group of troubled agents within a historical located social world who met together to discus various features of their respective situation, their ideas and beliefs about the social world, their hopes, griefs, prospects, discontents and so on' (Barham, 1984, p.107).

In relation to such long-term group work I have been quoted as asking, 'What are we doing? Is this therapy?' (Huet, 1997, p. 15). I know that this anxious question of mine relates to the constant need to adapt the frame. It is important, however, that practitioners do not abandon the attempt to adapt the therapeutic frame in the public sector and thereby abandon public sector clients. Too often people with a serious mental-illness diagnosis are asked to be satisfied with approaches which **do not** construct clear boundaries around the work and so they do not allow for the frightening nature of psychotic experiences and the client's need for a sense of meaning. Clearly framed psychotherapeutic work with this client group requires careful attention to ensure that it is gently supportive. It is no longer feasible to dismiss such work as dangerous, although such dismissals are understandably the result of the many challenges faced by psychiatric practice. I have encountered dismissal from some psychiatric colleagues at various points during my career. However, the majority of psychiatric practitioners are similarly concerned to find ways of working with disturbed clients in ways that encompass meaning.

There are genuine and pressing needs from clients for art therapists to continue to develop in this area of work. However, it is important not to underestimate the strenuous nature of such work for any practitioner. It is important in this particular work to make careful assessment before inviting someone to join a group. In addition, regular supervision is in the interests of both clients and therapists. Attention to these aspects of practice is fundamental in what can be delicate and difficult work. In part I sympathise with some aspects of the contemporary plea to guard against over-clinification (Allen, 1992) but I counter this with a determination to assert that the clients themselves deserve the most thoughtful and effective approach available. Of course it would be difficult, alienating and probably not helpful to follow an overly formulae approach to painful and poignant stories shared in groups by clients.

People who have to contend with the worst of what our society has to offer populate long-term groups. They face alienation, isolation, long-term unemployment, addiction (often to psychotropic drugs) and poverty. It is not surprising that therapists sometimes report that they are no longer sure whether what they are providing is indeed therapy. A long-term group with seriously mentally ill clients can reach a point where it is hard to gauge whether what is being provided is a rut or an anchor. Certainly there are many aspects of long-term illness that can make a person feel strangely disconnected from society.

This is why the potential for finding ways of sharing their experiences that are available in a group is potent and it is how groups provide a stepping-stone towards re-engagement with a wider society. It is not possible to escape the need in this work to have some political and contextual understanding. This is an important matter for everyone's heath, client and therapist.

Proposals for practice and areas for further investigation

Art therapists offer groups to a wide range of clients with disparate needs and this means that they need to be aware of a number of technical resolutions to dilemmas that can be provoked by group practice. Group work in the art therapy profession is developing all the time. There are many possible approaches for work with people who have serious mental disturbances, but there seem to me to be a number of common elements that are important to good practice. I enumerate these elements because I think they represent areas suitable for further investigation. The profession can use both theoretical accounts and case studies in these investigations, however, there will also be a need to make separate studies of the effectiveness of art therapy groups.

The important common elements of groups seem to me to be as follows.

1. The need for attention to *boundaries of time, place and appropriate confidentiality.* By appropriate confidentiality I mean that I think it is important for art therapists to be conscious of their position when working in multi-disciplinary teams in the public sector and observe the conventions of the team in which they are working. Clients need to be made aware of these conventions at the outset of any therapeutic work.
2. In all groups, the therapist needs to *gauge the way the way in which their attention shifts between group members' words and images.*
3. There is a need to *be aware of the potential disruption of the client's ability to function symbolically.* Although I am not of the opinion that people with a history of psychosis are permanently unable to function symbolically. I think therapists need to be able to recognise the times when their clients seem to lapse into a state where they seem to be mainly functioning through the use of symbolic equation (Killick, 1991, 1993, 1997; Killick and Greenwood, 1995; Wood, 1997).
4. The therapist always needs to *pay attention to the group process* although there are occasions particularly with disturbed clients when the relative emphasis between attention to the group process and the attention given to an individual group member will need to fluctuate. The relative emphasis which is predominately adopted will determine the approach of the group practice; whether it is an open-studio approach or another approach at any point along the continuum to a more closed group. I think it is probably fair to suggest that a strict adherence to a group

analytic approach is not appropriate with people with a very disturbed history, although such a group *may* be able to contain one disturbed individual at any one time, it is a possibility which would need careful evaluation (Pines, 1983, p. 98). In general the group analytic approach would be likely to raise too much anxiety for a group consisting entirely of group members with histories of serious mental disturbances.

5. When working with clients who have a disturbed history it is wise for the therapist to *adopt a supportive psychotherapeutic style*. Supportive psychotherapeutic work is less clearly defined than dynamic psychotherapy, and is at the opposite end of a continuum of therapeutic practice.
6. It is worth considering the possibility of introducing a combined approach, something which does arise out of a group analytic method and has apparently been a way of working that a number of art therapist have adopted. This method basically involves the clients also having regular individual contact with the group leader. It would be necessary to asses how effective this approach might be in terms of resources.
7. It is an important matter for all client groups but it seems to me to be paramount for groups where the clients have a history of serious mental disturbance *that the art therapist needs to resist any institutional incursions which damage their ability to adapt the frame and provide an adequate container for group work.* At the very least this involves the provision of a room that is safe from interruption during the life of the group. However, it seems to me that the work of ensuring adequate containment for the group work needs to take place on a number of human levels within the setting where the therapist is working. In the following chapter I liken this political work of ensuring the adequacy of the container to the constant attention needed by a garden if it is to thrive. I have also asserted that we should as art therapists repeatedly make the case for the provision of good studio spaces, especially when work is moved into the community.

<u>An assertion of the benefits of group practice with people with a history of psychosis will need to be supported by evidence of effectiveness</u>

In art therapy literature Waller also offers a list, this is of the potential benefits and some of the problems that might occur as a result of introducing art materials into the processes of groups (Waller, 1993, p. 37-40). It is clear that the time is upon us when we will have to do more than assert benefits of practice because of the growing demand for evidence of effectiveness. I begin to address some of these issues in section five. However, it is useful here to simply outline the benefits as I have understood them because they provide an

indication of the kinds of areas to investigate in terms of evidence of effectiveness, a theme I pursue in section five.

1. Art therapy groups if we can get them to gel, are particularly appropriate for people with a history of serious mental disturbance. This is because the very existence of the group runs counter to the terrible isolation and alienation in which many with such a history tend to live. This point seems to be supported by a suggestion in the *National Framework for Mental Health,* concerning the engagement of those clients (between 14 and 200 per 100,000) with severe mental illnesses who are particularly difficult to engage (1999, p.46).
2. The art making part of the group can serve the purpose of the group's existence in a number of ways.
    a) Art making can give people a way of *being alone in the company of others.*
    b) It can provide *a reprieve from the intimacy of the relationships* that might otherwise be experienced as too threatening; paradoxically this way of art making provides a shield that can enable people to stay in a group when they might not otherwise be able to.
    c) The art-making can provide a place for emotional material which might have *'festered in poisonous privacy'* and this material can either be shared verbally at the artist's own pace or it can be simply shared visually.
    d) The artwork can sometimes give *an indication of clients' feelings about the group* and *the therapist* that can be used both dynamically and where appropriate supportively.
    e) Making art in such a group may be one of the few ways in which it is possible to have *a tangible sense of what is needed to enable someone to survive a period of symbolic equation or disruption.*
    f) The making of art in the context of the gradual development of relationships with other group members and with the therapist can contribute to the client's sense of meaning. It can also add to their sense of their own ability to master the powerful forces of their less conscious aspects. This can act against the forces of alienation.

Some evidence about the effectiveness of general groups for people with serious mental disorders has been produced, particularly in work by Kanas that I discuss in chapter twelve. There is also international general evidence about the benefits of combining medication and psychotherapy for these clients that I introduced on page 66 in chapter three (American Psychiatric Association, 1993 and 1994). Art therapists will almost certainly be able to make use of such evidence in defending the effectiveness of their group practice. There is an interesting tension between the apparent usefulness of group practice with

seriously mentally disordered clients and the knowledge that the propensity of individuals to produce psychotic phenomena can be heightened once they join a group.

The poem at the beginning and the general tenor of Terry Malloy's paper 'Art Therapy and Psychiatric Rehabilitation: Harmonious Partnership or Philosophical Collision?' (1984) is concerned with helping people to live. It is interesting to me that this poem was one much appreciated by one of my first clients with a manic-depressive psychosis.

Days
What are days for?
Days are where we live.
They come they wake us
Time and time over.
They are to be happy in;
Where can we live but in days?
Ah, solving that question
Brings the priest and the doctor
In their long coats
Running over the fields.

(Philip Larkin, 1965).

The groups offered by art therapists for people with a history of psychosis clearly provide a space where it is possible to ask the question posed at the beginning of the poem. The physical and symbolic nature of the spaces provided by the environment of the studio is the subject of the next chapter.

Chapter Eight

The Use of a Studio Facilitates the Absorption of the Client in their Art Making and it can Expand the Capaciousness of the Art Therapist.

Recent history has demonstrated that it is not straightforward for art therapists to advocate the use of studios for their work with clients in the public sector. The 1980s and the 1990s were difficult periods in which to work in health and education in Britain. The economic love affair between Thatcher and Reagan during this period meant that much public spending was diverted into warfare. The frames of reference about what might legitimately be offered by health and welfare systems were dramatically challenged and many cuts in services were made on both sides of the Atlantic. On a smaller scale, but not unrelated to this economic climate, the use of studios by art therapists was also challenged. In Britain some studio spaces were lost and not replaced as a result of economic strictures and the move of psychiatric services into the community.

Studio rooms offer the implicit message of there being time for play, exploration, reverie and absorption. They enable the therapist to provide an additional dimension and a greater capaciousness for their relationships with clients. Given the high levels of alienation and the complexity of difficulties faced by the clients of public sector services, having a studio in which to practice might make the difference between being able to offer therapy and it not being appropriate to do so.

I am clear that the development of the art therapy profession has moved beyond a polarisation of approaches that tended to suggest that there is an either/or emphasis on art or psychotherapy in the approach to practice. The debate in the profession is now concerned with the vitality that comes from the integration of art and psychotherapy in its theory and practice. It seems to me that continued integration between the elements of art and psychotherapy is more likely if the practice is able to take place in a studio. Of course the arguments and the diplomatic campaigning necessary to secure a studio require engagement with the outer socio-political world, another element that is a strong part of the art therapy profession. This is a challenge worth undertaking because if we are successful in establishing more studio they can importantly add to an environment in which public sector clients who may have little knowledge of the culture of therapy might begin to understand its uses.

It seems timely for art therapists to resist further loss of studio spaces and to gradually make a case for a range of studios to be developed in the public sector. In keeping with the ethos of the Roth and Fonagy, 'What Works for Whom?'(1996) this chapter suggests that different kinds of studios are appropriate for different kinds of client need and that it could be a good time to

challenge the lament over studios and start a song about their current place in the provision of good practice.

Background

I have indicated that in the period after the 1988, 1989 and 1990 publication of the policies concerning community care (Rogers and Pilgrim, 1996, p. 90) art therapists found that their work moved towards a greater focus upon the elements of the psychotherapeutic relationship. My explanation for this interesting and necessary historical shift does not include a sudden evangelical conversion to the tenets of psychoanalytic psychotherapy on the part of art therapists at the expense of their art. I do not subscribe to polarised accounts (art vs. psychotherapy) in the theory and practice of art therapy. I think rather that the move of health and social services into the community meant that art therapists found themselves assuming increasing responsibility for complex relationships with their clients. The potential support of a multi-disciplinary team was often not so close at hand and this meant that there were material reasons for greater clarity about psychotherapeutic theory, practice and supervision. In addition, the fact that in many places 'community care' policies were undertaken as a way of reducing expenditure often meant that there was not provision for a studio in the community. There has been confusion about the relationship of these matters and it has sometimes been assumed that an increasing emphasis upon psychotherapeutic clarity means that there is less need for a studio, but there is no reason why greater theoretical clarity cannot encompass a studio-based practice. When health care cuts are made studios may well be lost but the loss has been economically driven. It is not helpful to make a theoretical virtue out of what seem to me to be these false economies. It is more useful to see cuts in health care spending for what they are and then it becomes more straightforward to make the case for adequate provision.

Although art therapy literature has contained rich references to the use of hospital studios, the case for studios in which to work has increasingly been made retrospectively, as a lament for what has passed. During the 1990s art therapists necessarily focused upon the development of methods of practice for use outside the old asylums. The fate of the old hospital studios and in some places their lack of replacement in the community is just one example of the difficulties art therapists have to negotiate as they attempt to communicate across the divide between the requirements of public-sector psychiatry and the tenets of what is largely private-sector psychotherapy.

The need for a studio becomes stronger after the move into the community

Community care policies were planned during the 1980s and enacted during the 1990s. During the 1990s art therapists fared differently in different locations. Some did maintain studio space

although this is a fact not often recorded in the literature. Others were caught up in the late twentieth century phenomenon of being asked to share interchangeable space in the workplace. A number of newly built workplaces and some public buildings (including some of the mental health community daycentres) seemed designed to restrict the possibilities for private space. Many aspects of contemporary culture do not readily distinguish between public and private place.

Foucault's account (1979) of Jeremy Bentham's Panopticon was prophetic; it is a powerful metaphor for the maintenance of power in liberal bourgeois societies. Basically the Panoptican was a design for a prison based on a circular watchtower. From the tower prison warders were able to look into each of the cells and although prisoners knew that they could be seen in their cells at any time, they did not know when they were being observed (Crossley, 1997, p. 41). Although this prison was never built, its architectural notion of constraint without full physical restraint influenced subsequent nineteenth century design for public institutions.

What is permissibly private has become more complex in our culture. It is no longer straightforward to claim that at times of stress there may be a greater need for privacy and the sense of safety that it can generate. In the workplace climate that produces the automated production line, the hot desk and the open-plan office, I acknowledge that it can be difficult to make a case for studio space. However, together with the other art therapists mentioned in this chapter, I argue that for an art therapist this is part of setting the therapeutic frame. My argument is different in that it links the demise of some studios to the political circumstances of the period and does not suggest that psychotherapeutic theory alone can enable the therapist to provide what is needed.

My general proposition is that whereas psychotherapeutic understanding is essential to art therapy practice, in itself it is not sufficient. I think that the mental health of the therapist is more likely if their theory and practice includes an understanding about how art, psychotherapy and socio-political awareness influence one another. Also proposals for the development of the theory, practice and technique are more potent if they originate in political and cultural understanding. This is the case even in relation to the ways in which we ensure that the employing authorities understand the provision of studios, because there are many levels upon which they can represent containment *sufficient for therapy* for both client and therapist.

In relation to the provision of studios practitioners often have to gauge the political circumstances influencing the work as they establish a case for their provision. Michelle Gunn (2000) has shown how the political context during the 1990s included time-limited grants given for the arts and health. Hard-pressed health authorities sometimes acted divisively in relation to these grants and the relationship between hospital artists and art therapists. This almost certainly had an impact on the employment of art therapists and on the provision of studio space.

Art therapy literature like this by Michelle Gunn has tended to demonstrate an understanding of the institutional framework in which practice takes place and the social and political influences upon the lives of clients and practitioners. The influence of political matters upon the lives of the most disturbed clients can be profound. Clients in the public sector often have little knowledge of therapy and in order to work effectively the therapist will need to understand the context of the client's life. Studios can help in this by providing the client with some actual space during the time they probably need in order to understand some of the basic tenets of psychotherapy. I think that this physical space can augment the return of mental space that is the aim of the therapeutic relationship. In art psychotherapeutic relationships a significant part of the recovery of mental space is thought to develop through the opportunity for reverie and absorption.

The public sector and the multiplicity of policy changes

To an unprecedented extent, the British health services during the 1980s and 1990s were repeatedly subject to cuts, policy change and the euphemistic review. All this has meant that there has been a hard-won understanding among some art therapists of the inter-connected nature of many aspects of public sector working. It is increasingly understood that even though there may be many aspects of them with which we are philosophically at odds, we depend upon the institutional structures of the public sector, for our ability to work safely with clients with complex needs. The provision of studio spaces is part of what we must ask the public sector to provide if we wish to develop the most effective employment of art therapy skills.

The paper by Nadija Corcos, 'Trust' (1995), is an excellent illustration of some of the issues provoked as a result of policy changes. One aspect of her paper, the nightmarish description of her locking the door to the studio to minimise interruptions in a busy day hospital setting, powerfully suggests how much work is needed to ensure that the setting and the teams in which art therapists work provide an adequate framework for the work. Corcos seems to me from the evidence of her article to be an effective political proponent for the needs of the work to be bounded within a framework understood by the institution. Her article makes it clear that achieving good enough circumstances for practice in relation to multiple policy changes can be strenuous.

It is possible, when we acknowledge the support we need and the support that is available for our work, to establish boundaries for it that are much less likely to create fear and suspicion for those disciplines alongside whom we work. Ironically (in the light of our anti-psychiatry roots) the move into the community and changing service constellations have often been troubling for art therapists, because they have meant that it is not always so straightforward to reach institutional backup for the work. In many places it has been difficult to retain the use of a studio; in some

places it has even been hard to find book-able space. Therapists often have to establish their own boundaries for practice, often in relation to much smaller sections of the health service (individual GP practices or day hospital services, for example). It is understandable that making the case for clear spaces in which to practice have not seemed to be a priority in a period that has involved so many policy changes. There has been though a growing acknowledgement of the need for more bounded practice and this has been seen as pressing as work settings move away from the institution. This is partly why the establishment of a therapeutic frame increasingly seems to find its locus within the therapeutic relationship and less within the fabric and infrastructure of the institution. However, it seems important not to underestimate the extent to which art therapists working with needy clients have the need themselves of an institutional frame. What is needed from the institution is a team of colleagues with whom it is possible to share client work and also many aspects of the institutional infrastructure are necessary to work with clients who have many faceted needs relating to their inner and outer world experience.

Changing policy and funding arrangements are being addressed with art therapists offering more individual work and some brief focused work. Art therapists are working in ways that are more coherent and more psychotherapeutically informed. For example, appropriate clinical supervision became one of the *Principles of Professional Practice* in 1994 and it is no accident that in 1992, training-therapy became a national requirement. However, in making efforts to respond to the changes by developing greater psychotherapeutic rigour, art therapists have not highlighted the idea that the contribution of the studio remains current. Later I discuss how I think that studio-based practice adds to the quality of the therapeutic frame an art therapist is able to provide.

The paper by Paola Luzzatto in 1997 seems to epitomise some of the confusions in the profession about what kind of work we designate as art psychotherapeutic work. Admittedly Luzzatto names the work she describes as *open session* work and distinguishes it from studio based open *groups*, but whereas I can understand many of the difficulties faced in acute ward settings, I think what she describes needs to be very firmly distinguished from psychotherapeutic practice. A canteen with an ever-open door in the middle of a ward setting is not adequate. It does not afford basic respect for the client's privacy. A fundamental aspect of individual or group art psychotherapy involves the creation of boundaries. Although Luzzatto freely acknowledges the strenuous nature (for the practitioner) of what she names 'open door self-expression sessions' (Luzzatto, 1997, p.3) and although she clearly has a specific client group in mind, I think her paper begs more questions than it answers. If left unchallenged, such exploratory papers fudge the continued and real need for our practice to be bounded by the therapist for the client and by the institution for the therapist.

It is a hard reality that art therapists are responsible for the efforts needed to maintain therapeutic frames that are good enough. This involves boundaries of time and place and it could regularly involve arguing for the use of a studio where none exists. It also often involves the development of political understanding and the continuing struggle for funding which this understanding implies. All these matters can determine the success of therapeutic practice: and in time they might be suitable areas for research concerning evidence of effectiveness.

The need for adequate therapeutic frame is nowhere more powerful than in work with the seriously mentally ill, and possibly this is why such work has been quite badly influenced by the multiplicity of policy changes and in particular by aspects of community care. That the influence upon work with seriously mentally disturbed people has often been bad has been witnessed by many newspaper reports. The organisation MIND has repeatedly reported in its journal *Openmind* that much media coverage has given a disproportionate, unfair focus to violent incidents involving homeless people with a history of psychosis. Also there has been some evidence (DOH, 1999; Sainsbury Centre, 1998; Ritcie et al. 1994) that more of those patients with serious mental disorders who are difficult to engage end up in prisons, inadequate hostel accommodation or homeless.

> Some of the 15,000 people in England with severe and enduring mental illness, between 14 and 200 per 100,000 are difficult to engage. They are a diverse group, more likely to live in inner city areas, to be homeless, and to be over-represented in suicide, violence and homicide (DOH, 1999).

Permanent studio spaces in the community could be a positive way of offering engagement with these clients. Yet, sometimes it has seemed that mental health workers (including art therapists) who have been working during this period with people with a history of psychosis have been trying to shore-up inadequate social and political provision for them. It is remarkable that some of the theoretical and technical questions concerning practice with these clients continue to be developed. Of course many of the questions are not resolved and thinking about such work needs continued attention. It seems most likely that possibilities for development will emerge in the context of studio practice and within the institutional framing and support that the studio represents.

The studio tradition and absorption

Human beings seem to have a basic need for periods of absorption. Absorption seems to be the opposite of alienation. When alienated it is as though we stand beside and watch ourselves with uncomfortable self-consciousness. In contrast to this when we are absorbed we are engaged in the moment, absorbed in our lives and in what we are doing. Perhaps what we call play as children with its characteristic lack of self-consciousness, is simply absorption. It sometimes seems to me

that my capacity to be absorbed is an indication of the current level of my mental health. In some circumstances I have trouble enabling myself to reach the point when I can become immersed in what I am doing. At those times I have to consciously do something with what I think of as my own mental debris, and I almost certainly need to give some attention to the environmental circumstances in which I find myself.

It can then be a strangely ethereal process thinking about how to enable someone else find his or her own sense of absorption and creative reverie. It is particularly strange to think about this when with someone who is in the midst of a psychotic episode and flooded with unconscious material. One individual client of mine needed to pace around and around the room for several sessions. It was good that the studio was large enough for her agitated, desperate circuit. Thinking about what specifically might enable a particular person to make art may help them begin to engage (it may not be necessary to speak about this). When I am able to work in a studio this seems to help me work with both art and psychotherapy and not be overly seduced by a client's words. Central to my psychotherapeutic relationship with clients is a concern with what might enable them to make art — whatever that means to them. Art making involves reverie and this can be totally absorbing, studios throughout the centuries have contributed to the environmental circumstances that make absorption possible.

The French 'realist' painter Gustave Courbet made a painting that has the making of art as its subject. *The Artist's Studio* painted in 1855 *(figure thirty four)* shows the intellectual and inspirational history of his studio. The creation of a physical or mental place in which it is possible for someone to work creatively holds such a history. I am always interested to discover accounts of different studios, because these accounts help me think about what is needed to enable art to be made.

The studios of artists have stories to tell. Accounts I have read of the working processes of numerous artists suggest that most studios are used to provide the circumstances for absolute concentration. A place where absorption is possible seems to be what many artists provide themselves with. This seems true of Bonnard, Turner, Monet, Auerbach, Matisse, Howard Hodgkin and many others. Rodin is described here:

> He had forgotten me completely in that hour of extreme concentration. He no longer knew that a young man whom he himself had led into the studio to show him his work had stood behind him with bated breath...In that hour I had seen the Eternal secret of all great art, eyes, of every moral achievement, made manifest: concentration, the collection of all forces, all senses, that *ecstasis,* that being-out of-the-world of every artist. I had learned something for my entire life (Zweig, 1943, in Gayford and Wright, 1998,17).

The quotation is dated and it could be read now as amusingly camp, but it does catch something important about absorption. With such levels of concentration can come energetic work and

figure thirty four
'The Artist's Studio' painted in 1855 by Gustave Courbet is held by the Musée d'Orsay in Paris. It is intended to depict the intellectual and physical history of his studio, including people who had helped or inspired him.

engagement, Bonnard and Matisse are reported as working on several canvases in one session. Studios also seem to provide a form of containment for the artist. Robert Hughes describes Auerbach as being inured to his own domestic irritants.

> They are part of the solemn game of stasis. The essence of this place is that things do not change in it, except that dust accumulates, waste pigment slowly builds its reef on the floor, the light fluctuates...The studio is the antitype of the Matissean ideal. But it offers the painter a certain stability, a guarantee of changelessness...So with Auerbach and his studio. It is a troglodyte's den of internalisation, the refuge...(Hughes, 1990, in Gayford and Wright, 1998, p. 13).

Auerbach, Degas and Bacon all had studios that were encrusted with the debris of making art. Gayford and Wright use the phrase 'dingy midden' (1998, p. 15) to describe this mess of studio. There is something about continuing to focus and pulling something out of the mess, which is potent.

The history of studios is long. It contains the tradition of apprenticeship. Evidence of the models of practice of particular schools is a part of art history. The need for guidance and for a place to work is accepted in the annals of art education. The studio or atelier tradition exists in many areas of art including painting, sculpture, architecture, dance, music, film and photography.

Most disciplines have frameworks and rituals in which the insights are held and repeated. This is true of psychotherapy and many aspects of the studio provide this function for art. It is interesting to speculate about the ways art therapy needs to combine both of these frameworks and sets of rituals.

The differences and similarities between studios made by artists and those provided for clients

The historical tradition of apprenticeship and the collective use of studios has changed and acquired a more individualistic tenor, but aspects of it still exist in art schools. It seems mistaken to use an apprenticeship model to explain art therapy practice with clients, but the provision of a collectively used studio can provide a variety of models of ways of being.

In thinking about the needs of art students the art commentator and lecturer Andrea Duncan developed with her colleague Geoff Brunell an 'atelier' approach to studio work *with* students. Her accounts provide some cameos of the significance of studio practice. For example:

> ...They felt uncertain and inarticulate in all kinds of ways. They wanted to learn through a dialogue where being able to articulate themselves verbally and vocally actually helped them begin to express themselves better in the studio... (Duncan, 1997, p. 27).

> ...working with material becomes embodied — and there is a sense of proportion in practice —and limits. Sometimes, literally the force of gravity or the limits of paint — the reality principle also operates in the studio (Duncan, 1997, p. 28).

The studios of famous artists develop out of the needs of their particular personalities and their forms of art making. It is difficult to provide a client with their own inviolate sense of

physical place in public sector studios. Although the art therapy literature describing some of the old hospitals suggests that it was possible for a lucky few clients to have their own place in a studio (Case and Dalley, 1992; Wood, 1992; Killick, 1995, 1997). The ability to create a space for oneself in which it is possible to become absorbed is valuable because it enables the discovery of those personal rituals and accompaniments that produce the possibility of mental space. A studio space, to which it is possible to return and find it as it was left, holds the possibility of development.

One of my-long term clients (who had had twenty five years of psychiatric 'treatment' including insulin comas, multiple ECT and much multiple medication) had such a place in the large studio I worked in for a number of years. He had his own table, easel, bookshelf and easy chair. He stuck up his work in progress, on the walls and windows around this area. His work in the studio would sometimes enable him to draw himself up out of the armchair, out of the river Lethe and out of the lethargy of depression that too many years in a psychiatric hospital had given him *(see figure thirty five)*.

A particular scholarship of the 'art of the insane' focuses upon the period 1890-1930 in Europe and provides some fascinating accounts of how some famous 'patient-artists' made corners of the asylums into their studios (MacGregor, 1978). It seems likely (although it is not known how much) that earlier examples from such scholarship influenced the studio-based practice of British pioneers of art therapy.

For the majority of clients this consistency of a personal place in a studio is not possible. They quickly realise that other clients use the studios in between their sessions. This can potentially disrupt their sense of absorption and provoke a range of thoughts and feelings. Nevertheless, shared studio rooms can begin over time to feel comfortably familiar to them and this familiarity together with the relationship the therapist can contribute to a strong sense of 'containment'.

Containment

I return to the notion of containment (already introduced in chapter six) because it is something I think about on at least two distinct levels. When I was thinking about how to explain this an image from a *Superman* movie repeatedly came into my mind. Lois Lane, Superman's paramour falls from an American skyscraper. In the midst of her rapid and apparently fatal descent, Superman flies to her rescue. He catches hold of her and guides her safely to the ground. However, when he first gets hold of Lois saying something like, 'Don't worry, I've got you'. She yells back in some alarm, 'Who's got you?'

figure thirty five

While being aware of the undesirable potential for a therapist to practice from the basis of a hero or heroine mythology, I think this clip with Lois Lane and Superman provides a kind of simile. Therapists in a sense get hold of their clients' material, but they themselves need someone to help them get hold of their own.

Getting hold of the client's material when working as a therapist in an acute psychiatric setting can involve the attempt to understand a range of complicated emotions and the acknowledgement of some seriously deprived aspects of a person's life. The client may be enduring high levels of anxiety and distress and this may temporarily curtail the mental space they have for thinking. The therapist's role in those circumstances is to attempt to establish a relationship that the client might use to regain some mental space. The first distinct way I have for thinking about containment involves psychoanalytic explanations of this process in the close relationship between therapist and client. It is not that the therapist attempts to do the client's thinking for them but that they create the space where thinking will be possible. R. M. Young explains this by writing that it is not an issue of content but one of capacity (1994, p. 34). He uses Meltzer's ideas about the two dimensionality of thinking under stress. Meltzer offers the following description of how he understands the availability of mental space to an autistic child.

> For months he had drawn doors and gates, usually with complex wrought-iron grills. Then gradually rather Victorian gothic houses took shape. One day he painstakingly drew an ornate house seen from the front on one side of the page, a house in Norwood, while on the other side he drew a back view of a pub in Southend. Thus the child demonstrated his experience of a two-dimensional object; when you enter by the front door you simultaneously exit by the rear door of a different object (Meltzer *et al.*, 1975, p. 18).

In this way the child shows that he has:

> ...a paper-thin object without a delineated inside. This produces a primal failure of the containing function of the external object, and thus of the formation of the concept of self as container...This deficiency of containment related to internal spacelessness of the self...(pp. 19-20).

My experience of establishing relationships with clients whose thinking seems dominated two-dimensionality is that it is an extremely slow process. I have many two-dimensional images made by one man over several years *(e.g., figures thirty six and thirty seven).* Occasionally something happens, the image changes and there is a push on the part of the client to engage before he slips into another cycle of two-dimensional thought. However, Meltzer's explanation helps me remember what I am doing. I am trying to enable a greater capaciousness of thought. Interestingly this client who usually sits painting with his back to the room and to the other clients in the group, will occasionally turn around and seem to engage with a larger space. This extreme example reminds me of the more ordinary needs for three and four-dimensional space of other clients. However, in the majority of therapeutic relationships I am on some level trying to enable clients to

figure thirty six

figure thirty seven

rediscover (as opposed to *discovering*) their inner capaciousness for thought. 'The point of capaciousness is that it should serve as a container for thought and the point of thought is to keep emotion alive' (Young. 1994, p. 52). A large part of a therapist's work is to bear and 'contain' projections in close relationships with clients until the client discovers or rediscovers their own capacity to take them back. Given the extreme nature of the life difficulties faced by many clients in the public sector, it seems to me that the existence of a studio adds an additional dimension to the capaciousness of thought for both client and therapist, because it greatly contributes to the possibilities for mental absorption. The process of becoming absorbed in art making is uniquely part of what art therapy can provide.

The studio exists on the border between the therapist and the institution. It stands at the edge of what I think of as the second distinct level of containment, that of the therapist by the institution and the socio-political context. It is still a level of containment that has been helpfully described (though not exhaustively) by psychoanalytic thinking.

Isabel Menzies-Lyth published her seminal research *The Functioning of Social Systems As A Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital* in 1959. It has been subsequently republished many times. In the research she carefully examines the psychic effects upon nurses of the institutional practices. She shows how many institutional mores are institutional defences that originate for historical reasons long forgotten, but they still impede the capacity of nurses to have the mental space to think about what are often painful life and death events that they have to work with and witness. It is clearly possible to generalize from the work of Menzies-Lyth that institutions have profound psychic consequences upon the people who work in them, they might provide clear frameworks in which to work or they might over defensively hinder the capacity of workers to think.

> The enforced introjection and use of such defences also interferes with the capacity for symbol formation (see also p. 49 above *in Menzies-Lyth's text*). The defences inhibit the capacity for creative, symbolic thought, and for conceptualisation. They inhibit the full development of the individual's understanding, knowledge and skills that enable reality to be handled effectively and pathological anxiety to be mastered. Thus the individual feels helpless in the face of new or strange tasks or problems. The development of such capacities presupposes considerable psychic integration, which the social defence system inhibits...The social defences prevent the individual from realizing to the full her capacity for concern, compassion and sympathy, for action based on these feelings which would strengthen her belief in the good aspects of herself and her capacity to use them (Menzies-Lyth, 1959, 1988 reprint, p. 75).

It seems to me that not only the nurse can be pushed out of the symbolic and cultural realm by institutional defences, so too can any health service worker including the art therapist. However, the provision of a studio by the institution can help an art therapist to maintain a

therapeutic frame that is at least partly understood by the institution and this can contribute to the preservation of the therapist's capacity to think.

This does not deny that matters at an institutional and political level can be fraught and during the last two decades in Britain, large numbers of people in different health care disciplines have described themselves as feeling 'not held' or let down in their work by the institution and by the political demise of the health service. I have already mentioned that this was the period when some studios were lost. An alarming contemporary example of a failure to provide thoughtful institutional containment is that Forensic Unit staffs have recently been subject to increased security measures in ways that might be viewed in the light of Menzies-Lyth's ideas about institutional social defences.

Unintegration and containment in acute psychosis

Katherine Killick did a good deal towards offering her clients in the psychiatric services an inviolate sense of space in the hospital studio. She has written a number of powerful papers (Killick, 1991, 1993, 1995 and 1997). They describe the ways that a studio and a relationship can provide a pathway for someone in the midst of psychosis to move out of the state described by Searles as 'desymbolised' (1962). Using the work of Bick, Bion and Meltzer she shows how it is that the analytical art therapy setting can come to represent a containing object for even those in the midst of frighteningly unintegrated psychotic experiences.

She suggests that the states of mind experienced in the midst of acute psychosis represent a failure of containment on many levels and that the work enabling the client to follow a path that returns them to sense of containment can be slow. In all of these papers she refers to her experience of using a large studio room that was part of a large psychiatric hospital *(figure thirty eight)*. The room was large enough to accommodate twelve people, each with sizable areas in which to work. Effectively it was possible for some clients to have designated areas that they could use and return to over long periods of time.

I remember the gasp of an audience who saw an image of the use made by one client of his table in the room.

> As I went about my business, trying to contain my curiosity, he proceeded to fill the coffee tins with water, and place the legs of his table in them. He then unpacked his bags on the table, placing a selection of fruit, vegetables and a small collection of objects in a careful arrangement. He later told me that he had to ensure that the space would be safe from invasion by ants before he could place valuable objects within it (Killick, 1995, p. 114).

Acquiring a lasting form of understanding about the distinction between internal and external realities is painfully slow for some clients who have psychotic experiences. Killick's work repeatedly shows the tangible part played in this internal work by the existence of a capacious

figure thirty eight
The Studio at Hill End Hospital

hospital studio. It enabled work to be left out over sufficient time (weeks or even months), and this could give repeated experiences of making art which might help the client see that there is a distinction between inner and outer. Killick's finely observed work suggests that her approach to studio practice enabled clients to move away from the catastrophic 'desymbolised' states of mind. However, repeatedly Killick questions the viability of such work in those current psychiatric settings that do not have such studio spaces. She was clearly inventive in process of transition to a community psychiatric setting, initially symbolic reference was made by her and a number of clients who had known it, to that studio space in the old hospital. The quality of Killick's work in a desperate area of client need suggests the importance of refusing to leave her work as a potent lament for studio based practice. One of her clients (who had had a serious mental disorder) is quoted as saying: 'People like me need places like that art room. Places which allow the mind to heal' (Killick, 1997, p. 50).

The rationale for the use of studios in art therapy

The story of the different use of studios by the art therapy profession helps reaffirm fundamental aspects of its practice. The provision of a studio makes the nature of practice clearer on a number of levels. In showing a prospective client a studio we are able to give them a tangible indication of what they might be letting themselves in for. Straight away they are likely to gain a sense that their own agency will be involved in therapy. Prospective clients of any psychological treatment might imagine that the practitioner will be able to work some magic upon them (this includes the clients of art therapists). However, it is unlikely that a prospective client of art therapy could anticipate that the therapist will paint their picture or build their sculpture for them, although of course it is true that clients still ask art therapists what they should do.

Most psychotherapists that I have encountered have paid close attention to the provision of a consistent room in which therapy takes place. This is basic to all psychotherapy. However, the predictability and protected nature of the meeting room is particularly important for people with a history of psychosis. The art therapist working with seriously mentally disordered clients is likely to have to hold in mind even more material than the abundance generally associated with art therapy groups (Skaife and Huet, 1998, p. 17). This is because sometimes these clients are themselves flooded with unconscious material, and this can make them prolific in terms of their art making and their verbal and non-verbal communication. This helps to explain why the significance of the studio room in which therapy is held, is heightened for some clients. Ordinary spaces not equipped for art making generally do not have enough space or the facility for mess.

There have been a number of different approaches to the use of the studio in art therapy. The community care policies that led to the loss of some hospital studio spaces tended to be known

about in the 1980s but not enacted substantially until the 1990s. It is a strange quirk of history (though probably no accident) that as community care began in the late 1980s and the early 1990s most of the art therapy literature appeared that mentions the places used for practice (Greenwood and Layton, 1987; Schaverien, 1989; Case and Dalley, 1992; Wood, 1992; Waller, 1993). It is a rich literature, because it tries to describe how the substantial qualities of physical space and art materials can enable clients to have a place apart in which to locate their emotional distress.

There are also a number of inspiring accounts of art therapists using studios in work with children (Case, 1987 and 1994; Arguile, 1994). Studio rooms are often used graphically and symbolically by children with them climbing and crawling all around the rooms. Then towards the end of the 1990s some further accounts of studio-based practice appeared but most of these gave a retrospective account of it from a time before the moves into the community (Killick, 1997; Huet and Skaife, 1998; Pratt and Wood, 1998). Despite the high quality of the accounts by art therapists of linking studio spaces to their psychotherapeutic endeavours, there seems in this later literature to be a sense of resignation about the loss of studios.

I suspect this sense of resignation has been greatly influenced by the 1990s having been such a harsh political economic period. A lot of people working in the caring professions felt it was increasingly difficult to affect policies or have an influence. It was certainly a difficult period in which to argue for studio provision. However, aspects of the *Mental Health Framework* (1999) suggest that there are now a number of the ways in which the case for studios could be made in relation to particular client need.

It is interesting that Case and Dalley made a suggestion in 1992 that has not yet been taken up. It may be the time to develop such suggestions.

> One way of solving the problem of space for art therapists working peripatetically would be to set up art therapy centres in each geographical area for use by all services – health, education and social. Organisation would be needed to 'bus' clients, but it should be possible. In the meantime, art therapists working for the different services struggle with accommodation difficulties (Case and Dalley, 1992, p. 38).

With the advent of community care and the closure of the large old asylums, we have heard during the 1990s of the loss of some venerable hospital studios. Art therapy commentators have remarked upon this as a significant loss (Macgregor, 1989; Killick, 1993; Maclagan, 1997; Killick, 1997; Deco, 1998). However, it seems important to guard against a sense of finality that is an aspect of these pronouncements because that may defeat the sense that it is possible to argue for studios.

> It is to be noted that, although an approach inspired by the studio model is still in use, the disappearance of large institutions has meant a loss of permanent studio space where art was to the forefront of the art therapy process. The consequences of this loss have not yet

> been fully realised by the care system, although one suspects they have been heartily felt by clients and art therapists alike (Skaife and Huet, 1998, p. 10).

I would stress the part of this quotation that indicates that we do not yet know what the effects will be, because I think we could in arguing for studio provision influence the outcome.

Quite a number of art therapists have managed to swim against the tide in the public sector. They have evaded the workplace push for the availability of *only* book-able or multi-occupancy rooms. Later, I briefly describe the experience of the Coventry based art therapist Chris Lyle to illustrate this.

Art therapists regularly work with individuals in studios. Also a variety of ways of using studios for group practices are possible and as they are increasingly described in the literature. It is becoming possible to differentiate the ways in which different techniques are appropriate for different clients.

The origins of the studio in British art therapy

It was the studio tradition that the first art therapists in Britain espoused after the Second World War. Their studios began to appear under the aegis of the largest public institution, the health service. What constitutes public space seems to change with each new generation and for this post-war generation placing studios in hospitals and connecting them to health provision did not seem unusual. These studios flourished from the mid 1940s until the late 1970s and then a quick succession of changes in health policy saw either their demise or their removal to the community.

That the origins of art therapy are in a studio approach is something that can be clearly seen in many aspects of the profession's British history. It is clear to me from listening to the accounts of his former patients at Netherne that the pioneer Adamson was centrally involved in enhancing the making of art. He provided his patients with a range of group and individual studios in the hospital and grounds that were Netherne. My conversations with some of his former patients gave me a picture of the cool and ordered place that was his main studio, providing a haven for them in the grounds of the Hospital (*see figure thirty nine*). The substantial nature of the art work of some of his clients (Rolanda Polansky's sculptures for example) make it clear to me that he was not simply a slave to the attempts made by the psychiatrist Cunningham Dax to conduct controlled experiments (Waller, 1992; Wood, 1997).

The art therapist E. M. Lydiatt's studios were different. It seems that there was a rich muddle of art materials and art work in progress in those studios (Thompson, 1989). I remember something similar in the studio created by the art therapist Robin Holtom at Springfield Hospital in south London in the late 1970s and also in the studios kept by Britta Warsi at Warmington Park Hospital. A visit to these places left the visitor in no doubt as to the purposes of those rooms.

figure thirty nine
Adamson's studio at Netherne Hospital in Surrey, the be-suited gentleman is Adamson.

Undoubtedly the studios had the imprint of the personality of the art therapist concerned somewhere in their atmosphere and furniture (something which might be problematic for contemporary practice), but the centrality of the art making and the studio to the practice of all these therapists was clear.

Withymead the therapeutic community with a Jungian orientation established by the Champernownes shortly after the Second World War upheld the value of the process of making art as an integral part of the analytic journey. The outward manifestation of this being that a range of different studios was available to residents during their stay at Withymead. It would be interesting to know if these studios were used in different ways.

Open-studio approach

Although much art therapy literature refers to the 'open-studio approach' this is only one model for work in a studio and it may be the case that the 'catch-all' nature of the phrase is confusing to art therapy thinking about studio practice. It may even be the case that a failure to define what is meant by the 'open-studio approach' is preventing the development of new ideas in relation to studio-based practice. Andrea Gilroy's suggestion that the origins of art therapy were in the open-studio approach (Gilroy, 1996, p. 54) produced the spark that was the inspiration for my exploration of the use of studios.

The phrase 'open-studio' might on a first encounter mistakenly suggest free access and few boundaries. Although most art therapists would have a notion of what is meant by the phrase it is not a straightforward one to define. In fact, what has been offered as an open-studio group seems to have varied greatly between different practitioners. My impression of the essential ingredients of these groups is that they involve offering sessions where a number of clients share the studio facilities at the same time. Clients work upon their own individual artwork. There are often long periods of silence as people become immersed in the process. There is generally no prohibition on dialogue. An exception to this was found in the work of Adamson who asked his clients to work silently. The art therapist offering such a group acts as the keeper of boundaries and host. She or he will generally tend to wander around the studio working with individual clients at different times. The others can overhear conversations whether between clients or between clients and the art therapist. The therapist sets the time boundaries and other basic boundaries such as safety and non-interference with the work of other clients. Depending upon their style of work they may ask clients to gather towards the end of the time in order to share thoughts about artwork made in the session. The focus of attention in open studio groups has tended to be on individuals and the individually made artwork as opposed to the group processes.

There are quite a number of idiosyncratic accounts of what is meant by the open-studio approach to the work. One of the clearest contemporary accounts that I have seen is by Sarah Deco (1998). Her account is an excellent justification of the use of open-studio work. Yet she suggests that,

> the studio space often no longer exists and therefore cannot be the primary focus for attachment and therapeutic change. There has been a change in therapeutic emphasis from the setting being the primary focus for attachment and therapeutic change (Deco, 1988, p. 88).

This provides a satisfactory explanation for only a part of the historical trend in relation to studio work. It does not explain why the trend towards more exclusive focus upon the psychotherapeutic relationship occurred during particular historical circumstances. The title of Decco's chapter is 'Return to the Open Studio Group', but she does not acknowledge the need to argue for a studio room where none exists. She focuses upon psychotherapeutic considerations. This is not unusual, very little psychiatric or psychotherapeutic literature attempts combine the perspectives of the individual, institutional constraints and society. However, for the development of work within the public sector art therapists have to develop the capacity to *locate* their practice quite early in their student days. This sense of political location can be a strong aspect of their work, because it can enhance the capaciousness of their practice.

Working in studios

My own experience of working at Netherne in my second art therapy post in the late 1970s was in an excellent studio-room, ideally situated at the end of the acute admission unit of Netherne Hospital, called at that time John Reid House. The room had three bay windows overlooking the Surrey countryside, a lot of space and a lot of individual tables that could be made into drawing desk easels. This was before the advent of community care, at a time when a central ethos of art therapy was to provide through studio work an 'asylum within an asylum'. However, there was beginning a shift towards more focussed therapeutic work, and my practice in studios developed on the cusp of this period of change.

It took quite some time to establish a referral system and to try to establish an appropriate combination of clients sharing the room at any one time. There had been a long and venerable tradition of open-studio work at Netherne dating back to days of Edward Adamson's time at the hospital, which had been shortly after the Second World War. The patients living at Netherne had long experience of being able to drop into the various studios scattered around the grounds. Long-stay patients would make regular appearances at the studio in which I worked with acute patients. Sometimes they would stand at the door and shout of their inalienable right to free access. The grand manner of these communications was sometimes hard to resist. I did nevertheless manage to establish some boundaries around some parts of my work, and it was then possible to hold some

small dynamic groups and arrange some individual sessions. I was able to do this, because I had managed to introduce the basic elements of the therapeutic frame. At other times however, I provided open-studio groups for a series of individuals who shared the room with other patients while continuing with their own artwork. I would then move around the room working with and talking to different people at different times. One clear advantage of this open studio approach that remains in my mind is the amount of time some of the patients were able to have working in the art room. This leisurely approach to time enabled clients to become absorbed.

For example, the senior art therapist Julia Gudjonson turned the exhibition space in the long-stay part of the main Netherne hospital into another art therapy studio. The room was large, long and situated half way down a curved main corridor in the hospital. It was large enough to allow each of those patients who wanted to work with Julia to have their own space. It was genuinely amazing to see how people who had been living for many years in that custodial though relatively benign institution began to create series of their own art work.

I particularly remember one woman as she created small sculpted and painted animals. They populated a new world that she became completely absorbed in creating. That studio became a vibrant absorbing place to visit and the artwork was often wonderful to see, and it was always evidence of the individuality of the people who had made it. Of course, because the studio was intended for the use of long stay patients, the way in which boundaries were created and referrals received had to be delicately negotiated. The patients were used to sharing space with one another and they did discuss between themselves, but I generally had a strong impression that their main relationship in the studio was with Julia and their artwork. Gudjonson was clearly an excellent mistress of the open-studio approach, but what she offered was not a free-for-all, even though her approach was liberal and facilitating.

The sessions were open in the sense that groups are said to be open when they have a gradually changing population, although a great deal of thought was involved in considering who would be able to usefully join the particular combination of personalities in an existing group. When such an approach is well managed it can be a valuable way of providing *supportive psychotherapeutic work* for clients with long-term needs.

<u>For the client and from the institution: the need for boundary and containment at all levels</u>

My experience at Netherne was formative, because it enabled me begin to explore the ways in which different forms of practice are useful for clients with differing needs. When I took up a new post in Sheffield I was aware of the need to introduce my practice as having clear boundaries and that I needed to defeat quite quickly the idea that I would provide open-access activity sessions without even a clear referral system.

In fact I was fortunate to encounter a number of colleagues in Sheffield who were receptive and enabling to my work. I was able to establish a range of different forms of practice with individuals and groups in two different studios. I quickly received a number of individual referrals, but it took some time to establish a group, because I was clear about my boundaries but also because some of the issues that makes group practice in the public sector less than straightforward. I ceased offering open-studio sessions, because it was too difficult at that time to establish boundaries in the face of some aspects of the old asylum ideology.

My own consciousness of the need for boundaries coincided with developments in working patterns in the profession. My training had been towards the end of the 1970s during the period when many art therapists were drawn to the anti-psychiatry movement. I have written of the ways in which I applaud the contributions made to mental health and indeed to psychiatry by the anti-psychiatry movement (Wood, 1985, 1991). I do nevertheless think that some aspects of the way in which ideas emerging from this period *were used* was profoundly reactionary, because the anti-psychiatry mantle was used to vilify family members and psychiatric staff without an understanding of the constraints operating upon them of the political context.

The way in which this is relevant to ideas about therapeutic containment concerns the way in which ideas emanating from the anti-psychiatry movement tended to localise the source of a patient's distress as being in other family members or hospital staff, although much understanding was gained it was not generally recognised how hard it can be for the family members of people who are mentally ill. Nor were the difficulties faced by mental health staff considered. In many ways there was during this period a lack of understanding of the interconnectedness of the many social, economic and political experiences that can contribute to mental disturbance. Consequently, art therapists who were working at the end of the 1970s spoke about the hospital art studio as being a refuge from the ravages of psychiatry. This was what was meant by the phrase 'providing an asylum within an asylum'. They often set themselves up as being at least covertly against the other staff, yet in effect it was probably only possible for these art therapists to work with so much mental patient distress because the institution *held* them and their work and it provided a studio.

At the time of anti-psychiatry the therapeutic community movement developed, and it gradually became an accepted form of practice in the public sector during the 1970s. At the same time (not unrelated to the development of therapeutic communities) was the development of group work practice. Both of these developments were to influence the use of shared space in treatment philosophies, and possibly this had an early effect on how art therapists thought about the use of studio.

Jane Saotome addresses straight away the function of the studio room in her *dynamic group* work with long-term clients in the old asylum system.

> The role of the containing art room space and the flexibility of art therapy in institutions to engage a diversity of sometimes anxious, disturbed and confused patients within a group setting, have been vital characteristics of practice. The slow run-down of to closure of the hospital where I work has resulted in reduction, to some extent, of this dynamic containing function. It has been replaced by what I think of as the imperative of the ending (Saotome, 1998, p. 156).

She continues by describing a small research project in which she tried to ascertain whether such practice could be transferred to the community. What she found implies that many features of this work can be transferred, although it is not clear whether those art therapists she questioned managed to retain the use of a studio. It seems important to make the case for studio space for such group work, whether it takes place in the hospital or the community because its existence can make sustained work with clients with complex needs more feasible.

Studios in the older style that seem to facilitate exploratory practice

I was particularly heartened by my conversations with the art therapist Chris Lyle in the spring of 1997, because from her I learnt that art therapists in Coventry have managed not only to keep hold of their old studio space; they have also been successful in acquiring additional purpose-built studio space. I was excited by the implications of this, because it seemed to me that Chris Lyle's experience provided a case example of attention having been successfully paid to the requirements of containment, both at the level of the individual and that of the institution.

In the summer of 1997 I went to visit Chris Lyle and to see the studios for myself. Firstly I went with her to the older studio, which is situated, in the psychiatric wing of a large general hospital. I found her thinking about the work needed to both preserve and create new studio space to be helpful. As we spent time together in the older studio she described some of the ways in which she had acquired it. Then how, having acquired it, she ensured that it was given a place and a meaning in the institution.

I quote from the letter to her manager in which Chris Lyle made her case for another room:

> *'For Art Therapy to be effective as a treatment the client needs to become 'absorbed' in their artwork as it is being created. This absorption allows unconscious material (i.e. previously blocked off memories and emotions) to emerge and be worked with in the sessions. Absorption needs quiet — it can be damaging and frightening for a client to be jerked out of their absorption by noise intrusion'.*

It seems important that she was not coy about the needs of absorption even in a letter to an administrator, because there is something fundamental about these needs that can be recognised by most administrators.

In the same letter a number other points were made about the basic needs of an effective art therapy service and about the overall benefits for the service in making provision of a good studio room in which the art therapist might work. The firm but friendly tone of the letter and also, of course, its success impresses me. Two pictures of the studio room that was provided as a result of her diplomacy are included *(figures forty and forty one).*

Chris Lyle feels that the studio always has an initial impact on clients and in her words, '*the room communicates its purpose'* often with the message, *'here you can feel.'* There are a lot of different places where it is possible to work, whether seated or standing, at a shared table, at an individual table or in a slightly concealed place. There is a wealth of materials with which to work. It is a richly filled place that is clearly owned by a community of clients and staff.

The studio room is big enough to enable large works to be made, if that is what is needed. It accommodates the work of more that one art therapist and their clients and this has meant negotiations over the sharing of the space. Negotiations between art therapists about sharing space are new phenomena for art therapists that have arisen in places where several art therapists are employed. In a number of places art therapists have reported that territorialism has shifted to other art therapy colleagues, as opposed to the erstwhile tendency to see other disciplines as saboteurs. This is unfortunate because there are strengths to be gained in solidarity. However, it is clear that the studio space plays a great part in providing even a team of art therapists with a sense of their work being contained within the institutional framework (which may now extend into the community).

Chris Lyle went on to describe the way in which once the studio had been created there needed to be work done to establish respect for its boundaries within the institution. This involved a radical change to the practice by ward staff of sending all the people on their ward to open sessions. It meant offering workshops for staff in order that they could understand the therapeutic practice being offered, and then be in a better position to make appropriate referrals.

The studio gradually became more established within the frame of the institution, as its boundaries were made clearer. The work of keeping a studio as a safe place needs repeated attention; it is like the work of gardening. The work of keeping boundaries can make it necessary to deal with what can be at times a lack of understanding, at times fear and at other times frank hostility.

However, when an institution is able to uphold and support studio work by an art therapist this seems to be an indication that there is good enough containment for the difficulties of therapeutic work and that therapist can be reasonably sure of safe practice. In acute psychiatric settings the need for boundaries around therapeutic work is important. Acute units house some

figure forty

figures forty one

figures forty one

very disturbed individuals, and it seems counter-intuitive and inappropriate to operate a laissez-faire open access system. Chris Lyle is very clear about the need to use referral and assessment before accepting clients, even for so-called 'open' sessions. These older style studios can facilitate the provision of an experimental, exploratory practice but there is still a need for clear therapeutic boundaries.

Cooler studios: the equivalent of the blank screen in art therapy?

The blank screen is a caricature of poor psychotherapeutic practice. What is being caricatured are the technical devices used in psychotherapy to enable a focus upon the therapeutic relationship to develop. The second studio shown to me by Chris Lyle is in keeping with more focused practice. Some pictures of this purpose built studio follow *(see figures forty two and forty three and forty four).*

To reach this second studio we had to travel to another hospital that had outpatient facilities in a department of psychological services. That we had to pass under a giant concrete underpass indicates something of the inner-city nature of the location and the work. This is in dramatic contrast to the countryside settings of many of the old hospital studios.

This second studio is sparse by choice. There is a cool uncluttered ambience to the room. It has been thoughtfully put together. There are a lot of windows and a lot of light that is filtered only by muslin blinds. Chris Lyle spoke about the transition this room represents in working practices for the therapist and she also acknowledged the transition it might represent for clients. Some clients had initially made comments about the room not being big enough and for the need for something from the old studio (some pots were brought from the other studio). However, many clients who come here have not seen the other studio. Interestingly this tends to be used mainly for individual work.

It offers the possibility of much more focussed work than is possible in the older studio. Even the way in which the clients are brought to the room is different. They go first to the receptionist who asks them to take a seat in the waiting room, from where they are collected by the therapist. Therapist and client then make the small journey to the room. Chris Lyle has noticed in herself that this walk to collect and return to the studio with the client helps to put her into role. Few words are exchanged until the room is reached.

Although images might be pinned on the boards during sessions and although one client had needed to leave an image on the wall very few images are left on display here. Chris Lyle's feels that the work done here seems more focused and more intimate. It is tightly bounded work, possibly more 'shut down' with the use of materials seeming more limited, although greater focus and attention is possible.

figure forty two

figure forty three

figures forty four

figures forty four

Chris Lyle commented that whereas Katherine Killick (1991, 1993) has written about the benefits for disturbed clients of work in progress being left out, it would not be appropriate in studios such as this second one. The opening and closing of sessions in this studio are very definite compared with the less clearly defined aspects of some closing rituals in the older studio (where some work in progress might be evident). She wonders if it would be an appropriate room in which to work with clients in acute states, thinking that the amount of focus might be intimidating for them.

She thinks that clients who are able to make use of this second studio tend to know that they are coming for therapy, and consequently they often have some idea of what to expect. This might be in contrast to other parts of the mental health care systems that operate in what can be a necessary framework of dependency, because of the very real needs of their clients. The difference in ideology and the extent of client needs can mean the difference between a clients who comes initially in order to be understood; as opposed to someone who comes to find their own understanding. I think Chris Lyle was suggesting that the second studio might be better suited to work with the latter.

What works for whom: different kinds of studio practice for different client need

I recall a conversation I had with an art therapy colleague during a time when quite a number of art therapists had recently completed group-analytic training. She was simply wondering out loud with me, whether in the light of her group practice, studio rooms like the one I remember visiting at Warmington Park Hospital (in the late seventies) helped or hindered psychotherapeutic practice. I remember the room because it was encrusted with the artwork and the debris of 'generations' of clients.

Some aspects of the room would have made Francis Bacon's studio look orderly (below). His Studio was legendary, because he was faithful to its mess for thirty years.

figure forty-five
Francis Bacon's Studio

In one sense the discussion with my colleague made me wonder whether the 'midden' type studio interfered with the possibilities for free association. It is possible to speculate about whether these kind of studios like the old style studio shown to me by Chris Lyle; the one I have visited at Manchester General Hospital and the one I had worked in at Netherne, are too cluttered with the evidence of *other* clients. Such encrusted rooms may make the possibility for projections too abundant and this may make psychotherapeutic work too complex. It is this kind of exploration that could usefully be developed in order to think about different kinds of studios for different kinds of client need. It is a similar exploration to that taking place in writings about various forms of psychoanalytic psychotherapy.

> There are those who advocate occasional suspension of what can be seen as rigid or strict maintenance of the boundaries of the frame – what Christopher Bollas has called 'Expressive Uses Of The Countertransference' (Bollas, 1987, ch.12). related views have been expressed by Symington (1986), Little (*1949*) and – perhaps more notoriously – by Nina Coltart, in a lovely essay entitled 'Slouching Towards Bethlehem...Or Thinking The Unthinkable in Psychoanalysis' (1986)...'(Young, 1994, p. 67).

The art therapists Kalmanowitz and Lloyd have written about their experiences in former Yugoslavia and in South Africa. Their book title *The Portable Studio: Art Therapy and Political Conflict* makes the subject matter of the book plain. They describe the range of practice that might be possible in extreme circumstances, they show situations when it is really not possible to have any thing other that a studio 'en plein air' *(see figure forty six)*.

I applaud their endeavours and see them as entirely appropriate for such conflict-ridden territory. It is possible for art therapists to work with such 'portable' studios, but it is important to resist the idea that studios might be portable in areas of practice were it is not appropriate. Art therapists for the sake of their clients and themselves are well advised to not accept post-war-zone conditions for their practice in the British public sector. It is not necessary for them to do so, and indeed arguing for good studio spaces may help engender a wider vision of what art therapy could provide.

When I first spoke about these matters at a conference in Birmingham one art therapist in the audience made an eloquent plea for the use of his art material trolley. He felt that trundling around with his trolley and setting up his practice in whichever location he landed enabled him to reach all parts of the institution. I think he felt that my defence of the studio is too 'precious' in some sense. It was clear from some uncomfortable laughter in the audience that a number of the art therapists had struggled with these issues themselves in the public sector. I simply wish to suggest that it is important for us to respect our clients enough to have the courage to argue for consistent studio rooms in which to work with them. I do not underestimate how much campaigning and negotiating this might involve, nor do I pretend that for periods of time art

figure forty six
Children make a home with found objects in the town dump near Hrastnik (Slovenia) refugee Camp. The symbolic home was made with found objects and when it was knocked down twice by town children, the refugee children made drawings of it (Kalmanowitz and Lloyd, 1997, p. 42 and plate 3)

therapists might find themselves either carrying their art materials on their backs or pushing them on a trolley. However, I think too long a period of working without adequate provision and without a sense of containment for the therapist of which the studio is only the outward manifestation) in delicate work with disturbed people could damage the mental health of the therapist and tip them off their own trolleys.

Contemporary examples of the use of studios include *Studio Upstairs* the brainchild of Douglas Gill and Claire Manson, who met during their art psychotherapy training. *Studio Upstairs* is a working art studio with therapeutic concern *(see figure forty seven)*. It is a registered charity which:

> assists people in London who have mental health problems... to develop their artistic expression while at the same time providing support. It is, however, first and foremost a working art studio and performance space... Studio upstairs works within the traditions of the Philadelphia Association, founded in the 1960s by R.D. Laing, which put into practice Dr Laing's idea of therapeutic households. The work of Studio Upstairs is also influenced by the founders' ideas and beliefs that art only exists in a public place in the sense that it needs a social context in order to come alive (Gill, 1998, p.1).

I am reminded by this of the way in which the psychiatric reform movement Psychiatrica Democratica in Italy established studios in the old hospitals during the late 1970s for use by ex patients and by people who had had nothing to do with the psychiatric services. It was a genuine attempt at rehabilitation that did for a time create a real integration of former psychiatric patients with members of their community (Wood, 1985).

Another contemporary example is the studio on stilts in Devon, this is the inspired use of community housing by the art therapist and psychotherapist Jenny Hackett. She and Joe Hackett her partner built the studio according to the architect Walter Segal's Self-build design. Segal successfully made the design (that is purposefully easy to construct) as a way of enabling council tenants to build their own affordable and yet desirable accommodation. It also can be used as excellent studio accommodation. Being on stilts ensure that the buildings can be erected on any kind of building site, even hillsides and this means that relatively cheap land can be used. The stilts also ensure that the views from the windows have an interesting perspective and it means that a lot of windows can be included (giving good light) without the danger of being overlooked. The Segal Self-Build Trust may be something we could persuade public sector employers to consider in relation to studio provision. It may be exactly the kind of architectural inspiration that art therapy needs now *(see figures forty eight and forty nine)*.

Deco's (1989, p. 88) comment that the focus of attention for art therapy has shifted from the studio room to the relationship has some explanatory power for what happened to art therapy practice during the 1980s and the 1990s. In increasingly demanding practice settings where those

figure forty seven

figure forty eight

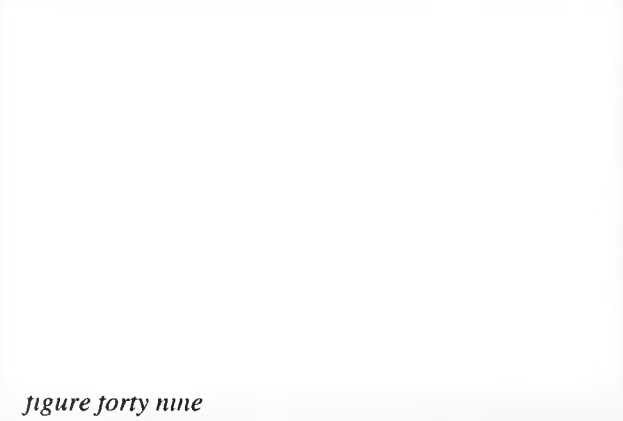

figure forty nine

clients who reach the public sector are often the most disturbed, the shift in attention has been necessary. However, what I propose in this chapter is the need to redress the balance of attention and to again highlight the nature and significance of place for meeting with clients.

I suspect that we will see a number of studios being developed. It is likely that some studios will have cooler less cluttered features and so provide the setting for more focussed psychotherapeutic work. Some forms of studio may be developed in relation to work with a particular client groups and this might be something that could be examined in terms of 'effectiveness'. That would seem to fit in with the ethos of Roth and Fonagy (1996) *What Works for Whom*. For example, some studios are more appropriate for individual work and some can accommodate a group. Some clients might fare better in an older studio and some might be helped by more focussed work offered in a cooler studio.

It is not possible at this stage in the profession's development, to make clear-cut pronouncements about what kinds of studios rooms are appropriate for particular therapeutic approaches. The facility to make appropriate and differing use of the spaces available is an indication of the developing capacity of the profession to face and articulate technical issues in relation to work with different client groups. A paper by Joy Schaverien in 1994 has initiated a consideration of some of these technical issues.

Whether for individuals or groups, studios have a long and venerable history in the process of gaining understanding and making art. Studio spaces remind us as art therapists that our psychotherapeutic practice is coupled with what are often the awkward ingredients of art making.

Gaston Bachelard describes the importance of place for human beings in ways that sometimes seem particularly pertinent to people with a history of psychosis, but these things have relevance to us all:

> Our soul is an abode. And by remembering "houses" and "rooms" we learn to abide within ourselves (Bachelard, 1964, p. xxxvii).

In effect when we remember places where we have felt at home, we remember ourselves and reclaim the *capacity* to be *absorbed.* This was a precept evident in the extraordinarily well cared for environment that Bruno Bettleheim created for the children in his Orthonogenic School in Chicago. In a public lecture he gave in Newcastle (1984) he spoke of his efforts to show clients that they are worth caring for through the provision of a good environment. He used gold leaf on the doors, elaborate mosaics on the walls and provided ample possibility for private space. I will accept that the British public sector cannot run to gold leaf, but I think we should keep arguing for the rest.

In this chapter I show that it is not a romantic lament to once again make a clear case for a studio in which to practice art therapy. It is simply to make a case for the most appropriate (and possibly the most effective) circumstances in which to work with public sector clients.

In contrast to this in the following chapter, I have questioned the anachronistic and romantic tenor of the way some commentators have considered the art objects that have been made in hospital studios, throughout the twentieth century.