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

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Volume III

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 Four:

The previous section considered some of the matters that need attention in order to enable art to be made within a therapeutic fame. The fourth section continues to look within the frame to examine the nature of the art associated with psychosis. The history and politics of aesthetic systems used to understand the artwork made by the people associated with psychosis tells the story of the ways in which they and their artwork have been separated and set apart from the rest of humanity.

At the beginning of the twentieth century the scholarship connected with the study of the 'art of the insane' seemed interested in preserved specimens of artwork made by mental patients during the period between 1890 and 1930. Its aesthetic assumed a formalistic approach and did not seem concerned with the healing potential of the art being studied. However, there are hopeful signs at the beginning of the twenty first century that such scholarship is changing to allow that the artwork made by mental patients has wide relevance. The change in this form of scholarship confirms a central theme in the thesis about the subtle impact of the political and economic changes upon theory and practice.

Chapter ten expands on this by making a case for the inclusion within art therapy of influences found within contemporary art and popular culture.

Chapter Nine:

The Nature of the Art Made by People Associated with Psychosis

David Maclagan suggests that there has been no convincing explanation of the way in which psychotic conditions (and I would add the associated art) have acquired a modern identity, 'a history not just of psychiatric techniques or diagnostic categories, but of the tacit assumptions and cultural motives at work beneath their surface' (Maclagan, 1997, p. 7). I find this statement provocative in a manner characteristic of Maclagan's work. It points to a missing dynamic because much academic work about the history of psychosis has not attempted a synthesis of the diagnostic, therapeutic and cultural dimensions of the condition. There are three distinct histories of art made by people in the midst of psychosis. One is concerned with its status as art and the others are concerned with its uses as diagnostic and therapeutic tools. In this chapter I am mainly concerned with the first two of these histories (its status as art and its chequered use in systems of diagnosis), and then in the following chapter I return to the possibilities for healing in the province of art.

Throughout this chapter I use the clumsy phrase 'the nature of the art made by people associated with psychosis', because it is problematic to use the description 'psychotic art'.

A scholarly industry of a formalist persuasion

There is a scholarly industry that addresses the status of the art made by mental patients and by people on the margins of society. Some fascinating accounts of famous 'patient artists' have emerged from this scholarship. The 'art of the insane' that tends to be included in these studies was made by mental patients largely during the period 1880 to 1930 but fascination with the work has endured throughout the whole of the twentieth century. One example of the longevity of interest in 'the art of the insane' from this period is that works from the collection of Prinzhorn's famous study published in 1900 were given an exhibition held at the Hayward Gallery in 1997. It is interesting these studies have not extended their remit to include the art associated with psychosis from later periods. It may be that this focus on the work of the past enables the scholarly industry to maintain its aesthetic formalism. Whereas the connections between arts associated with psychosis made today and the contemporary cultural context would be hard to discount.

From as early as the eighteenth century many of these celebrated patient artists were given a remarkably receptive response by the various hospital staff with whom they made relationships. A number were provided with their own studio spaces within the hospital. Wölfli

turned his single room into a studio at the Waldau Asylum in Switzerland, as did Richard Dadd at the Bethlem during the 1800s. Both of these artists were amply provided with materials and thoughtful companionship. Some of the basic requirements of space and absorption were simply accepted and provided for a number of fortunate patients. Others scrounged materials and worked, as they were able in appalling conditions. Most art made in asylums would be dubbed the 'art of the insane' although some of it may have also been included in the category 'art brut'.

The artist Jean Dubuffet named the art made by those at the margins *Art Brut* in 1949. Later in 1972 the art critic and linguist Roger Cardinal offered the translation *Outsider Art.* There are interesting connections between the two areas of inquiry, i.e., the 'art of the insane' and 'art brut'. Both offer nostalgic views of the works and both eschew contemporary influence and seem concerned to study preserved specimens. Then there is a tension between them and what is seen as the potential contamination from contemporary art or popular culture.

The period 1880-1930 has been described using another problematic phrase as 'the golden age of psychotic art'. What this phrase is intended to convey is a time when the art made by people who had experience of psychosis was unadulterated by either therapy or drugs. Some of the most celebrated examples of 'psychotic art' were made by people who spent long periods incarcerated in the mental asylums of Europe around the turn of the century. Implicit in many of the studies of 'the golden age of psychotic art' is the idea that incarceration with minimal psychiatric 'interference' is preferable to another more considered or 'therapeutic' approach.

During the middle years of the twentieth century the critical ideologies of *Outsider Art* and the *Art of the Insane* (Dubuffet, 1967; Cardinal, 1972; MacGregor, 1978 and 1989) contributed for a time to an anxious suspension of theory in relation to art therapeutic work with the seriously mentally disordered. Many aspects of these scholarly accounts were ideologically blinkered. Nevertheless MacGregor's book *The Discovery of the Art of the Insane* (1989) is fascinating to read. I recommend it but some challenge needs to be made to aspects of such scholarship which touch the parameters of art therapy. John MacGregor displays ignorance about the theory and practice of art therapy but does not refrain from commenting upon it. It is MacGregor's belief that 'much of what is done in the name of art therapy has little to do with either therapy or art' (MacGregor, 1989, p. 189).

Both Roger Cardinal and John MacGregor regularly convey (together with Dubuffet) the idea that there was a time, now past, when people in mental hospitals were able to produce art which was unadulterated by either drugs or therapy. The art they assert was neither sanitised nor

watered-down. The tenets of similar romanticism saw the incarceration of the poet John Clare in Northampton Asylum between 1837 and 1864. Those well wishers and patrons of the arts who secured Clare's compulsory detention, judged that the hospital would provide less troubled circumstances in which to write poetry than would the circumstances of his life outside the hospital (Porter, 1987, p.76-81). In effect they judged his poetry more important than his life.

Many moral issues are provoked when contemplating the nature of the art associated with psychosis. I do not wish to pretend that any of them can be easily resolved. I recognise, for example, the need for safe circumstances in which to make art and explore the inner world, and I consider this need is heightened in relation to psychosis. Nevertheless, John Clare's incarceration, in order to provide him with an untroubled place for writing poetry was a travesty. The therapeutic and moral issues concerning the production of art by mental patients are more complex in human terms than some scholars of 'the art of the insane' would allow. The complexity is even more confusing when little attempt is made at understanding the connections between art and the culture from which it emerges.

An art set-apart and preserved

Repeatedly in the studies of the 'art of the insane' and writings of 'art brut' there is a naked hankering for the past, for a time not contaminated by contemporary culture. In what are replete and scholarly accounts there is the suggestion that the springs of creativity are diminished by incorporation into the mainstream. Consequently the passing of the circumstances in which some mental patients at the turn of the nineteenth century, produced spontaneous work because they were incarcerated for long periods and because they were without medication are regretted. Although it is laudable to resent the over-prescription of psychotropic drugs, much scholarly writing in the idiom of 'the golden age of psychotic art' takes a frankly elitist position. MacGregor offers his own recommendation of distinctions he thinks should be made as though they were a description of actual historical processes.

> The meaning of the phrase "art of the insane" evolved over a long period. In its early usage it implied all drawings, paintings and sculptures made by madmen. Towards the end of the twentieth century, the phrase began to be used in referring to only those rare works perceived as being of unusually high artistic quality or meaning (MacGregor, 1989, p. 6).

He recommends that psychiatrists need only ensure provision is made for those rare patients with remarkable talent (MacGregor, 1989, p. 103). This pronouncement is breathtakingly elitist in its dismissal of the talent and creativity of the majority.

Then Dubuffet in his gloriously antagonistic style insists that any contact by *Art Brut*

artists with mainstream art or culture amounts to contamination and diminution. In a similar vein scholars of the art of the insane lament the way in which avant-garde artists assimilated and used some of the stylistic features of art associated with psychosis.

figure fifty: Klee 'Ancient Fable

figure fifty one: Aloïse Sphinx Marie Stuart

There are many possible examples of this process. One example, of this seeming to have happened might be the painting *Ancient Fable* by Paul Klee made in 1923. His painting was made just one year after the book by Prinzhorn was published and it is known that the Bauhaus artists had copies of it. Klee's style in this image is reminiscent of much art associated with psychosis. There is an echo of it in the coloured drawing by Aloïse, the artist and mental patient. Her images began to be preserved by kindly psychiatrists from 1933 onwards. The vivid *Sphinx Marie Stuart* by Aloïse is hard to date, but a comparison between it and Klee's *Ancient Fable* indicates clear possibilities for cross-fertilisation between contemporary art and art associated with psychosis. Indeed in later life Klee openly discussed the impact of patient art upon his work. In *figure fifty-two* the power of this impact is evident.

The preference amongst scholars of the 'art of the insane' and the advocates of 'art brut', to remain out of reach of mainstream cultural influences has a number of implications. Firstly there is the implication that an art genre is entirely able to survive upon its own formal qualities.

figure fifty two
Paul Klee 'Threatening Head' 1905 etching held in San Francisco Museum of Modern Art

Such a view wrenches art from its social context and will tend to claim that the circumstances in which it is made have no relevance. In the case of the 'art of the insane' the network of relationships within which the art is produced is not considered. This means that the experience of psychosis is not considered as a question of humanity; only the art associated with psychosis is valued. This approach to the art bypasses its meaning because it divorces it from its context. From their position of nostalgia for the kind of artwork associated with psychosis that was produced in the old asylums of Europe and America at the turn of the nineteenth century, it is asserted that psychiatric intervention and 'therapy' have spoilt the source of these creative artefacts.

Art Brut is similarly hostile to such 'interference'. Dubuffet's statements about the high quality of inspiration found in the collections of 'outsider art' have a provocative appeal.

> Any works which, out of ignorance or obstinacy, depart for the accepted codes are given no more that a passing or condescending glance; or, at best, they are granted the status of a marginal art. Yet, it may be that this is a misguided view. It may be that artistic creation, with all that it calls for in the way of free inventiveness, takes place at a higher pitch of tension in the nameless crowd of ordinary people than in the circles that think they have the monopoly of it. It may even be that art thrives in its healthiest form among these ordinary people, because practised without applause or profit, for the maker's own delight: and the over-publicized activity of the professionals produces merely a specious form of art, all too often watered down and doctored (Dubuffet, 1995, p. 5).

Some of Dubuffet's statements about *Art Brut* read like parts of a manifesto although they are often contradictory. It was common for art movements of this revolutionary period: Activism, Surrealism, Dada, Futurism, Formism, Constructivism and Suprematism to have strong rhetoric and manifestos. Dubuffet upholds the power of work by ordinary people as 'art brut' and yet implies that unless this artwork remain untouched by mainstream influences it will cease to qualify for inclusion. This seems reminiscent of the kind of chauvinism that accompanies notions of working-class culture or 'Proletkult' one of the art movements that emerged in the revolutionary period shortly after 1917 in Russia. Although there might be something appealing in claims made for 'clean' new forms of culture that can reach a wide audience, the exclusiveness that accompanies ideologies like 'art brut' is confusing and reductive. It attempts to be ahistorical and divorce itself from the cultural context. Consequently it does not have the explanatory power with which to understand the mechanisms that enable the development of art.

Dubuffet may have been aware of the passionate philosophical debates taking place in Russia concerning the development of art in the period shortly after 1917. However, it seems

unlikely that he was aware of some of the arguments that were used against Proletkult and the relevance they might have to his ideological position concerning *Art Brut*. Briefly these arguments concluded that art may or may not be political. There is no obligation for art to be political. Some universal themes seem to persist in all cultures and the kind of political correctness seen in the ideological statements of the *Art Brut* movement is irrelevant to its art. The idea that workers or ordinary people produce better art simply because of their identity as workers is chauvinistic and erroneous. In addition the notion that it is better to avoid contact with previous cultural forms is something that Trotsky argued passionately would abort the development of art. He offered numerous examples including those of Dante and Pushkin.

> How is it thinkable that there should be not a historical but a directly aesthetic relationship between us and a medieval Italian book? This is explained by the fact that in class society, in spite of all its changeability, there are certain common features. Works of art developed in a medieval Italian city can, we find, affect us too. What does this require? A small thing: it requires that these feelings and moods shall have received such broad, intense, powerful expression as to have raised them above the limitations of the life of those days. Dante was, of course, the product of a certain social milieu. But Dante was a genius (Trotsky, 1924, p. 67-8)...
>
> Shall we say to the worker; read Pushkin in order to understand how a nobleman, a serf owner and gentleman of the bedchamber, encountered spring and experienced autumn? This element is, of course, present in Pushkin, for Pushkin grew up on a particular social basis. But the expression that Pushkin gave his feelings is so saturated with the artistic, and generally with the psychological, experience of centuries, is so crystallized, that it has lasted...(Trotsky, 1924, p. 69).

I am conscious here of a comparison between the cultural precept to divorce art from context and history and the oft-quoted psychoanalytic one, 'a psycho-analysis should be conducted — without memory or desire' (Bion, 1967, p. 163). Bion's near-Hindu precept probably should not in fairness be taken out of context but it does powerfully suggest similarly ahistorical tendencies that are at play within psychoanalysis as those espoused by the formalist movements of art for art's sake.

Comparison between the 'Art of the Insane' and 'Art Brut'

The comparison of what is written about the features of the 'art of the insane' and those of 'art brut' is interesting and it helps describe the historical pattern of the way issues about the art associated with psychosis have emerged. All of these discussions seem concerned to preserve these art forms in isolation from mainstream culture. It seems appropriate to begin with MacGregor's definition of what he sees as 'essential to a truly psychotic art' (1989, p.10).

> The drawings and paintings that form the focus of events described in this study were without exception created in response to a spontaneous impulse arising from within the

individual personality. The tremendous fascination that they exerted on artists and physicians in the nineteenth and twentieth centuries derived from this purity of impulse and content (MacGregor, 1989, p.10).

Then Michel Thévoz, one of Jean Dubuffet's closest allies identifies three essential characteristics of 'art brut'.

> First, the makers of art brut are outsiders, mentally and/or socially. Second, their work is conceived and produced outside the field of "fine arts" in its usual sense as referring to the network of schools, galleries, museums, etc., it is also conceived without any regard for the usual recipients of works of art, or indeed without regard for any recipient at all. Third, the subjects, techniques and systems of figuration have little connection with those handed down by tradition or current in the fashionable art of the day; they stem rather from personal invention (Thévoz, 1995, p. 11-12).

Other than his fundamental requirement for the art to be made spontaneously, MacGregor seems loath to make generalisations about the details of the 'art of the insane'. Of Dadd's work he writes,

> These so-called schizophrenic characteristics are reserved for the small group of pictures: *The Flight out of Egypt, The Fairy Feller, and Contradiction. Oberon and Titania, The Bacchanalian Scene,* and the *Portrait of a Young Man.* These works, the masterpieces of Dadd's oeuvre in terms of twentieth-century critics, were never commented upon in any reference to Dadd's work at Bethlem. Here, we discover the bizarre association of subjects and ideas, the shifting and flattening of the spatial plan, the use of extremely minute forms built up with almost microscopic dots of the brush, and strange distortions of the human form, which verge on the grotesque (MacGregor, 1989, p. 140).

I remember that a print of the *Fairy Fellar* was hung on a long set of stairs in my secondary school. It held endless fascination for me as I filed with my school friends up and down the stairs. However, it was hard then as it is now to articulate the reasons for my fascination. There is a precocious reality about the figures and the forms in the painting even though they belong to a dream world *(see figure fifty three).*

Dubuffet too comments on the difficulty of 'diagnosis' or definition,

> Though some have tried to find one, no common definition will fit these works, for they answer to endlessly different mental positions and keys of transcription, each of these being invented by the maker for his own purposes of the moment...The standards and the references of cultural art fail to apply. Each of these works has its own standards, its own system of reference to which one has to adjust (Dubuffet, 1995, p. 6).

Maclagan is unusual in that he has written extensively about *both* the 'art of the insane' and 'art brut' (just a few examples are 1983, 1989, 1997). The specific features of the art that he mentions include:

> crowded composition, the "nesting" of figures one within another, a tendency to treat figures in an abstract or diagrammatic way, a complex liaison between text and texture — could be

figure fifty three
Richard Dadd, 'The Fairy Fellar's Master Stroke' (1855-1864)

called "psychotic" in the same way as art historians use the term "baroque" (Maclagan, 1997, p. 132).

Margaret Naumberg the psychoanalytically inclined American pioneer of art therapy also identified a number of possible features in her book *Schizophrenic Art: Its Meaning in Psychotherapy.* She, like Schaverien (1997) notices the tendency for clients in the midst of psychosis to 'intermingle' words with their images. She discusses the uninhibited sexual energy and bawdiness often seen in the artwork. Also she suggests that there is often a disorganisation between figure and ground in much work. This point highlights the dangers of not being aware of historical and cultural location, because many styles of modern art flatten the plane of perspective. However, fundamentally Naumberg wishes to point to what she sees as the archaic qualities of much of the work produced — that much of the work is dreamlike and seems to be linked to unconscious material. In addition many commentators have perceived fragmented qualities in the artwork and although this might be anticipated as an identifiable feature of art associated with psychosis, it is not difficult to imagine its clichéd over-use.

David Maclagan concludes:

> Psychotic art, as I mentioned earlier, is not an absolute or constant category: it is a cultural construct, marked by specific agendas. Whatever it may have meant to its creators, it has cultural, as well as clinical, functions. Like its first cousin Outsider Art, psychotic art functions as an extreme image of creativity: instinctually driven, totally possessional, strikingly original yet strangely impersonal: it acts like a magnified and exaggerated reflection of the post-Renaissance myth of the heroic artist. The triumph of the artistic power of invention over cultural restraints, the inherent power of the image to exceed rational explanation, and the anti-social inclination of the individual expression, are all features that find an echo in the profile of psychotic art (Maclagan, 1997, p. 139).

He sees an 'anti-social inclination' as a feature of the individual expression of such work, whereas I would assert that this is more a characteristic of those involved in the scholarly industry and not so clearly a feature of the art itself.

Contemporary attitudes about whether the art associated with psychosis has the status of art

The catalogues of art collections of work made by the mentally ill have provided an indication of the many ways in which the nature of the art associated with psychosis has been viewed at different historical moments. Towards the end of the twentieth century a more historical approach emerges in critical assessments and there is less of a desire to hark back to a golden age.

Three essays introduce the catalogue of the exhibition, *Beyond Reason: Art and Psychosis: Works from the Prinzhorn Collection* held at the Haywood Gallery at the end of 1996

and the beginning of 1997. These essays give a finely drawn outline of many significant *late twentieth century themes* in the quest for understanding of the nature of such art.

In the first essay Bettina Brand-Claussen describes the difficult history of the Prinzhorn collection, and in doing so she illustrates the way in which even this art of the inner-world cannot escape the influence of the historical period in which it is made. It is possible to detect in the art many subtle contemporary influences upon the patients who made the work. Brand Claussen suggests,

> Prinzhorn's psychology of artistic creation was successful in bringing about a shift in values. It is true that he erected autonomous, natural expression into an absolute, ignored social factors, disregarded all reactive, processual or interactive mechanisms, and, by adopting empathetic "essential insight" (*Wessenchau)* as his epistemological method, laid the way open to projections of every kind. And yet it was his achievement to rescue previously despised works from the psychopathological and diagnostic clutches of his colleagues and — by virtue of their psychological origins in "the deepest strata" of the mind — to place them on an equal footing with 'professional' art (Brand-Claussen, 1996, p. 13-14).

Gruhle, the psychiatrist who wrote the first introduction to the collection was like Prinzhorn, a follower of the theory of empathy espoused by Theodor Lipps. He was very clear about his wish to use the collection to help demolish the prejudice which places the mentally ill outside any system of social values and which places no value on anything they produce. It is tragic that a little later the psychiatrist Schneider, as part of the Nazi propaganda machine, crudely manipulated the collection. The Nazi exhibition of degenerate art was a part of this propaganda.

Inge Jadi takes issue with the idea that it might be possible to classify some examples of art in the Prinzhorn collection within the frame of reference designated as *Art Brut*. Throughout the twentieth century there have been attempts to link the ideological interests of the scholars of the 'art of the insane' and those of 'art brut'.

Jadi uses the work in the collection by Weiser as an example. She asserts that his artwork was that of 'a highly educated man whose knowledge and artistic experience were an integral part of his thinking within psychosis' (Jadi, 1996, p. 25). It interesting that she clearly thinks that a portion of Weiser's thinking remained intact. She describes him as constantly,

> inventing and selecting, even on the brink of his own mental dissolution, he escapes into a magical space in which things are reassembled: his unruly, uncontrollable thought processes; his ravaged body robbed of its unity; the sounds, words and images that oppress him. First these things are stretched and intertwined between magical points with a highly sensitive line, like an exposed tissue of nerves, then condensed into simple curves and signs that proclaim the final silence. Weiser's works are the evidence of this process, which is close to

> the existential core of the artistic experience, and *belong* within the context of twentieth-century art (Jadi, 1996,p.25).

Jadi suggests that *Art Brut* artists do not develop like this because they 'follow an inner necessity and are absolutely uncompromising' (Jadi, 1996, p.25). She thinks that some of the patient-artists whose work is included in the collection can rightly be understood within the frame of *Art Brut* because their works are exploratory and apparently driven; but that most of the collection might be considered to be of mixed genre. This notion of a mixed genre is helpful. In addition, it is interesting that one of the recurring features that she identifies across the range of these different genres is the devotion to magic.

In the third essay of the collection-catalogue Caroline Douglas takes her apposite title *Precious and Splendid Fossils*, from the subtle description made by the eighteenth century American psychiatrist Benjamin Rush. Douglas explores the strange hinterland in which the art associated with psychosis exists. She draws a picture of a point in the road, 'where anthropological study and the emergent science of psychopathology converge with the most avant-garde enquiry into the origins of artistic expression' (Douglas, 1996, p.36). She considers it unsurprising that those psychiatrists who worked most respectfully with their patients were amongst those who were the first to observe the spontaneous artistic productions of their charges. She cites Pinel as one of these. MacGregor cites Benjamin Rush as one of the first in America (1989, p.31). This directly contradicts numerous assertions made by proponents of *Art Brut* for example; a close collaborator with Jean Dubuffet described the typical sentiment.

> Formerly, in psychiatric hospitals, the creative individual had to cope with bullying and repression. His works owed their vivacity and virulence precisely to the climate of opposition and clandestinely in which they arose...One can understand why the work of psychiatric inmates has now taken a different turn, why it is no longer genuine. Therapeutic encouragement and paternalistic benevolence act as a conductor towards "normalisation"; they are in effect a much more subtle and efficient means of repression (Thévoz, 1995, p. 16-17).

Although this caricature is not without the appeal of a provocative posture it does not aid understanding.

Whereas for someone like me who was originally wary of catalogue collections of the 'art of the insane', Douglas makes me understand that the 'invisibility of the insane through confinement' is like ' the invisibility of the poor and working classes through impermeable class structure' (Douglas, 1996, p.38). Such collections have done much to make the insane visible.

This visibility is worthy of applause although it is received ambivalently by the *Art Brut* movement.

Douglas also draws my attention again, as did Brand-Claussen, to the startling observation that much content of the art associated with psychosis has powerful references to the outer social and political world. She indicates the repeated appearance of what Tausk has called the '*influencing machine*' (Tausk, 1918) in the images in the collection, and points to the actual emergence of the machine age at the time when the work was being made *(see figures fifty four)*.

The acknowledgement that there is evidence within the pictures of the influence of the outside world is a recent modern phenomenon in scholarship concerning the 'art of the insane'. In spite of many visual references to the machine age in artwork made by patients at the end of the nineteenth century, early 'art of the insane scholarship' did not acknowledge them. The idea of outside influence is one that has always been anathema to *Art Brut*.

Louis A. Sass has made another contemporary examination of the nature of the art associated with psychosis in his book *Madness and Modernism* (1992). The basic thesis of his book is that madness can be understood in some cases as a particular form of heightened awareness that is excruciatingly painful. He proposes that this form of awareness alienates the person 'not from reason but from the emotions, instincts and the body' (Sass, 1994, p. 4). He thinks that close attention to what is said, written or by implication painted, by people in the midst of psychosis reveals a strangeness 'of a noonday rather than a midnight world... where... solitude is broken not by bestial cries so much as by the incessant murmur of inner witnesses' (Sass, 1994, p. 5). Sass suggests that this is 'hyperreflexivity' (Sass, 1994, p. 8) and that it contains many useful parallels with aspects of a modernist culture.

He thinks that a modernist (and he seems to include a post-modernist) sensibility, might consider the alienation and self-consciousness of the modern mind as the inevitable signs of increasing degrees of complexity of contemporary life. He asks whether it is necessary to see the ramifications of modern life in a less benign light, as evidence of disease at the heart of our society or whether parallels in the expressions of late twentieth century society and those of the art associated with psychosis might lead us to re-evaluate our ideas of the nature of psychosis. This reversal might mean that we use what we know of healing through making art, rather than making diagnosis through it.

The recognition of awareness of the external world in art associated with psychosis is not what might be expected given the theoretical concepts being used by contemporary

figure fifty four
James Tilly Mathews 'DIAGRAM, or Plan of the Cellar or Place, where the Assassins Rendevous and Work (John Haslam's Illustrations of Madness', 1810).

figures fifty four
Drop brake wind up wheel/ Seat/ t Chain of wind vane sprockets (two) / R. space between seats / to insert a wheel / hole/ then et (4 cogwheels) / Drop brake cord anchor drum side slots (Alfred Frenkl, recorded Neufriedenenheim Asylum 1906).

figures fifty four
'The Scaffolding of Water: Automobile on Water, on Land 1913'
Friedrich Bedürftig

psychoanalysts and therapists. These concepts are concerned with the way the condition of psychosis attacks the ability to think (e.g., Bion, 1962).

It seems to me that there are echoes in the thesis made by Sass concerning the relationship between madness and cultural modernism of the historical development of art therapy. Sass attempts to offer a political context to an understanding of these phenomena. His work stood alone in the early 1990s in making this attempt. Most actual practitioners in the public sector were struggling with basic issues because of health cuts but despite this there were very few attempts to think about the political context of practice. Some practitioners facing too many cuts in service found that psychoanalytic ideas provided an alternative path upon which to retreat into the concerns of the inner world, Young (1987) has suggested that possibly this provided a defence against the pressures of the outer world.

Sass's work is a *tour de force*, but he does not address the psychoanalytic proposition that psychosis disrupts the ability to symbolise. Symbolic equation is a powerful concept that is applicable in the midst of florid psychosis. However, patients are rarely permanently in the midst of psychosis. This has an impact on the generalisations that might be made about the nature of art associated with psychosis. It also means that clinicians have to try to be clear about when a person's psychotic processes are waxing and when they are waning, because there will be the need for radically different therapeutic technique at the change-over point.

This potential disruption must be of vital concern for the clinician. However, in psychiatry many practitioners are often without support and or, at a loss about how to respond. Perhaps in part this is because psychoanalytic ideas about this have not been widely disseminated or tested. It is only in the most recent period that art therapy literature has begun to address the matter (Killick and Schavrien, 1997).

The book published in 1997 *Art, Psychotherapy and Psychosis* is a collection of papers, edited by Katherine Killick and Joy Schaverien, written by people who in their work as art therapists are addressing the nature of the art associated with psychosis from a clinical perspective. The first section of the book contains a number of papers describing the development of current theoretical approaches to clinical practice. It contains much that is helpful to psychotherapeutically inclined practitioners of all disciplines, but the use of art by people with a history of psychosis is central. The book is the first attempt to address the influence of psychoanalytic ideas upon contemporary art therapy practice in the area of psychosis.

Joy Schaverien discusses the ways in which she considers that the picture mediates for a person in the midst of psychosis as a fetish and as a talisman, both of which she describes as 'magically invested transactional objects' (Schaverien, 1997, p. 13). She also draws our attention to the use of words embedded in images made by people associated with psychosis and considers how the words might relate to a magical attempt to fix experience and to communicate. These thoughts seem pertinent both to what Brand-Claussen described as the devotion to magic in much of the work collected in the Prinzhorn collection and to the quality of experience which I often witness when working in the groups I offer for people with a history of psychosis.

Schaverien introduces the idea (often repeated in the book) that in the midst of psychosis direct relating to 'another human being may be experienced as too threatening to a fragile personality, but to relate through a mediating object may be possible' (Schaverien, 1997, p. 34). She proposes that it may be when transference occurs that a symbolic attitude is returning (Schaverien, 1997, p. 24).

The paramount need for sanctuary is addressed directly in the conclusion of Katherine Killick's chapter 'Unintegration and Containment in Acute Psychosis' (Killick, 1997, p. 50). She examines the ways in which the details of the studio environment, the materials, the portfolio and the niche in a cupboard. All contribute to the creation of a secure-enough environment.

Art associated with psychosis may be made in a defensive way. However, David Mann urges against the implication that that this is 'an either/or process: either painting is creative or defensive' (Mann, 1997, p. 73). He discusses the ways in which projective identification might be understood in relation to the art product. He dislikes Schaverien's attempts (Schaverien, 1987; 1991; 1997) to produce a specific theoretical model to explain the patient's particular investment in the image. Schaverien proposes the concepts of scapegoat, talisman and fetish in a manner specific to the art object. Mann also suggests that the notion of fetish may help in understanding some of the more defensive uses of art making in the midst of the disturbed processes (Mann, 1997, p. 81). However, he accuses Schaverien of reinventing the wheel of 'projective identification' through the new use of terms and through the concepts she proposes. I tend, rather, to see her work as helping to design wheels for a very particular vehicle. She is trying to provide art therapy with some theoretical concepts that are able to encompass art and psychotherapy.

Fiona Seth-Smith proposes four views of the image which seem to her particularly pertinent to her understanding of work with her seriously disturbed patients (Seth-Smith, 1997,

p.95). These are concerned with the formal qualities, narrative aspects, the degree of symbolic functioning and the shadow of infantile experience in the artwork made by an adult. She also comments on the effects of the absence of stable rooms in which to work — feeling that with the advent of multi-purpose rooms 'much of the sense of continuity and of therapeutic process is sustained within the pictures themselves and in the development of a particular relationship a patient builds with a therapist' (Seth-Smith, 1997, p. 86). The absence of designated rooms she shrewdly suggests means that for 'the psychotic patient who creates a symbol, a certain act of bravery - of trust in the surrounding environment - is necessary' (Seth-Smith, 1997, p.93). This runs counter to much 'art of the insane' and 'art brut' ideology that tends to propose the need for isolation. Finally, Greenwood upholds the idea that what is vital is the making of artwork. Her chapter illustrates a number of ways in which the process of making can contribute to the development of mature defences (Greenwood, 1997, p. 110). Greenwood's chapter continues within the historical tradition from Pinel via Prinzhorn and Jung. A strand of this tradition straightforwardly espouses the healing potential of making art.

The theoretical propositions in the book, *Art, Psychotherapy and Psychosis,* are mainly based upon the work needed to help in the very midst of psychosis and because of this most papers in the first section are centrally concerned with therapeutic technique aimed at helping a person move out of a period of symbolic disruption. I have found the ideas explored useful. They help my thinking about work with disturbed clients. The therapist's thinking about such work is notoriously subject to attack (Bion, 1962). However, it is important to stress that most of the people participating in the groups that I offer 'in the community' are not floridly psychotic at the time. Their thinking processes are only occasionally affected by their history. It is as though there is an optical-illusion-flicker at play in the way their thinking moves in and out of the characteristics of psychotic thinking. This is an area where contemporary art therapy theory requires a wider theoretical framework than that of psychoanalysis.

<u>The art associated with psychosis in relation to the estrangement between psychiatric diagnosis and psychoanalytic accounts of the inner world</u>

Although it may be possible to make some comments about the general features of art made in the midst of psychosis it would be foolish to claim that such generalizations had diagnostic potential. Art therapists believe that their clients can gain insight through making artwork and most think this is a different matter from taking their client's work and using it as a diagnostic tool.

In a number of papers Robert Young discusses some of the ways in which diagnostic classification systems develop historically (1988, 1999). He offers numerous examples to support the idea that such systems are of their times, both culturally and historically. I would wish to emphasise the inclusion of the political and the economic within the historical. Young offers one example he describes as the coup that occurred between the production of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) numbers two and three. DSM-I was published in 1952, DSM-II in 1968 and DSM-III in 1980 and revised in 1987. The latest edition appeared in 1994. Melvin Sabshin took over the chair for the group that was to revise the DSM-III. He stipulated that he would only undertake the work if he could take a free hand in purging the manual of all psychodynamic and psychoanalytic concepts. 'All descriptions of diseases were to be about behaviour, not about the inner worlds of patients. It was a palace revolution, a coup' (Young, 1999, p. 3). He continues with a general point

> ...leading ideas of an epoch are the ideas of its ruling elites, and ideology becomes a material force in theory and practice by virtue of which individuals get the posts and who gets to write the textbooks and manuals and edit the journals which define the norms in a given field...the ideological determination of ways of thinking in human sciences does not always militate towards conservatism. DSM-III was, as I have shown, dominated by a biological, objective approach at the expense of psychodynamic concepts concerned with the inner world. But there was a significant omission. Homosexuality, which features as a mental diseases in DSM-II, simply did not feature in DSM-III...it was de-pathologised as a result of the rise of the gay and lesbian movement for the rights of the homosexual. This is a striking example of how social and political forces change our concepts of who is ill and who is just different (Young, 1999, p. 4).

This is helpful, but it is not a sufficient explanation of how the estrangement between psychiatry and psychoanalysis became worse during this political economic period. It was the time when Reagan's economics made radical incursions into welfare spending as billions were diverted into warfare. The ideological love affair between Reagan and Thatcher affected welfare and health provision on both sides of the Atlantic. Against this backdrop the estrangement between psychiatry and psychoanalysis is put in perspective. Psychiatric services during this period were experiencing massive cuts and a return to minimal provision of a physicalist nature was often the result. However, it is important to mention that it took most psychoanalytic institutes longer than psychiatry to cease the pathologising of homosexuality. Neither philosophy made progressive moves during that period. The real coup was in terms of economic ideology on the world stage with massive cuts in welfare spending being presented as essential. In this drama

the estrangement between the ideologies of psychiatry and psychoanalysis were minor skirmishes in remote regions.

In 1996 an HMSO publication *The Primary Care of Schizophrenia* contained a chapter by Julian Leff that offered some sobering information about the stage knowledge had reached as the twentieth century ended.

> Schizophrenia has to be defined by symptomatology because there is currently no laboratory test for the condition. It may well cover a diversity of conditions with differing aetiologies. However, heredity plays a substantial part in its transmission. Narrowly defined schizophrenia has a relatively constant incidence across the world affecting about 1 in 100 people. Brain imaging studies suggest a structural abnormality in a proportion of patients. Whatever the biological basis for the condition, patients are very sensitive to environmental stress, both acute (in the form of sudden events), and long-term (in the form of a tense atmosphere in the home). While maintenance anti-psychotic drugs reduce the relapse rate, they give only partial protection against stress. Helping patient and family to cope better with everyday problems of living with schizophrenia confers additional benefit over and above drug treatment (Leff, 1996, p. 5).

I think Leff's description indicates that a consequence of the estrangement between psychiatry and psychoanalysis was the failure to progress in terms of 'treatment'. Given that the description of symptoms is still contemporary practice in relation to the diagnosis of schizophrenia, it is not surprising that approaches based on symptomatology have dominated the way the art associated with psychosis has been viewed during the previous three centuries. Intense curiosity about the nature of madness seems to transcend history and the attention given to the artistic products of people designated mad has long been a part of that curiosity. However, the understanding of the nature of the art associated with psychosis is situated historically and culturally, just as is diagnosis.

MacGregor points to the work of the little known French psychiatrist Paul-Max Simon as one of the first to make a study of the art of the mental patients in his care. He applauds Simon's work because of its almost literary descriptions that pay close dispassionate attention to detail. Also because as an 'artist himself, Dr Simon was less inclined to associate creativity with pathology' (MacGregor, 1989, p. 106). Simon's interests included an investigation of the links between handwriting and the personality, an approach he wished to transfer to artistic productions in order to link the features of artwork to the diagnostic nosology of his day. However, MacGregor feels that within the confines of his time, Simon made efforts to observe accurately and to draw relatively objective conclusions. He was not prone to pathologising pronouncements about the wide evidence he found of the imagination of his patients. He tended

rather to see everything they did, their choice of dress, their imaginative descriptions and their artwork as attempts to communicate. He felt that it is 'the imagination of the patient which forms the subject of our investigation' (cited in MacGregor, 1989, p. 110). He also had the humility to acknowledge that he recognised aspects of his own reality in some parts of his patients' artwork. This was highly unusual for the period during the second half of the nineteenth century; it was more usual to make clear distinction between sanity and insanity.

Making clear distinctions between the sane and the insane is the approach that was adopted by the anthropologist, criminologist and psychiatrist Cesare Lombroso (1835–1909). He promoted the infamous use of physiognomy. It was Lombroso and not Simon who caught the imagination of his time: he was enormously influential. In keeping with beliefs during the second half of the nineteenth century he was pessimistic about mental illness, he used theories of degeneracy and he believed that mental patients and criminals were born and not formed by social conditions. It is MacGregor's view that psychiatry still struggles against this late nineteenth century pessimism (1989, p. 94). I tend to think that twentieth century cuts in health and welfare spending have been more significant.

Two areas of interest dominated Lombroso's work. These were the nature of genius and the classification of mental diseases. In studying the art associated with psychosis he clearly felt he was able to serve both interests. Genius he described as a form of moral degeneracy and he closely linked evidence of creativity with evidence of insanity. Nevertheless, MacGregor considers that the thirteen features of the 'art of the insane' that Lombroso outlined are interesting. Although, he does caution that these features need to be carefully used because:

> ...it is now understood that artists can safely regress in the context of their work to very primitive mental states without bringing their sanity into question. As a means of identifying a special class of "insane art" these characteristics have ceased to have any value. His conviction that insanity necessarily influences the creative process led him to ignore the fact that seriously disturbed patients can, and often do, produce perfectly conventional representations (MacGregor, 1989, p. 101).

The nineteenth century contained a number of examples of medics who felt that artwork could make 'the patient's insanity, visible and concrete' (MacGregor, 1989, p. 33). John Haslam 'Apothecary of Bethlem Hospital' published his *Illustrations of Madness* in 1810 (cited in MacGregor, 1989). His title explained his purpose, which was to use the art and writing produced by patients to demonstrate their insanity. This is a similar aspiration to that hoped for in using the evidence of a patient's physiognomy in the same period. Ironically the psychiatric

patron Dr Georget who commissioned portraits of the insane was not convinced that they looked any different from people in good health.

It was apparently contrarily that Georget commissioned the artist Géricault to make ten portraits of the insane. Géricault was already famous for his *The Raft of Medusa* 1818-1819. In medical circles this fame was based on his having had a studio containing many actual body parts during the painting of the raft. The carnage shown so graphically in the raft painting was later used by Delacroix as the basis of his painting *Liberty Leading the People* in 1830. Géricault had pushed against the boundaries of what might be looked at and seen. Five of his portraits of the 'insane' remain and they have been wonderfully executed. MacGregor includes them as amongst the most significant masterpieces of the first quarter of the nineteenth century. They situate Géricault as having uniquely contributed to the development of a psychologically penetrating French Realism; although they did nothing for diagnosis based on physiognomy. Nevertheless, the shared humanity of those patients who sat for Géricault's portraits is caught for all time, see *figure fifty-five.* There is something interesting here that seems to characterise the historical development of ideas about madness: the dawn of consciousness about the nature of psychosis and a realistic view of its ubiquitous aspects seems to take some steps forward and then some backwards.

Dr Fritz Mohr (1874–1966) the German psychiatrist made encyclopedic studies of the 'art of the insane'. MacGregor suggests that he initiated an experimental approach by introducing a series of drawing tests that were amongst the first examples of psychological testing. He moved his attention away from spontaneously made artwork to the use of copied drawings. MacGregor suggests he was concerned to use these copies to answer the following kinds of questions 'the effect of perceptual disturbances on the patient's ability to see and represent the world. Do schizophrenics see the world differently? Is altered perception the basis for the characteristic forms observed in certain groups of drawings?' (MacGregor, 1989, p. 190).

One predominant theme in studies made of the 'art of the insane 'is this focus of attention upon the formal aspects of the artwork. 'The more fragmentary the thought processes, the more fragmentary the picture' (Mohr, 1906, p. 106). This tendency persists and it can be used in ways that under the guise of objectivity detract from the patient or artist's account and from an attempt to consider the meaning of content. This is not to deny that an understanding of the artist's meaning might be helped by a thoughtful consideration of both form and content.

figure fifty five
'La folle ou monomanie de l'envie',
Théodore Géricault (1822-1833).

The late nineteenth and early twentieth centuries saw the development in the art world of Late Romanticism in Britain, Symbolism in France and Expressionism in Germany. This undoubtedly contributed, as seen in the following chapter, to a more receptive response to the art associated with psychosis. Although the development of awareness about psychosis was not even, it gradually became more acceptable to consider the meaning of the art associated with it. Increasingly the artwork made by patients was less likely to be used in poor attempts at diagnosis although of course some contemporary attempts to use patient artwork like so many tealeaves are still made.

Towards Healing

Prinzhorn published his *Bildernerei der Geisteskranken* in 1922. The title can be translated roughly as, 'the creative imagery of the mentally ill'. As his title suggests, the psychiatrist Prinzhorn was interested in the imaginative life of mental patients. He is widely reported not to have ever used their artwork for diagnostic purposes. An excerpt from his book included in translation in Ferrier and Pichon (1998) is Prinzhorn's explanation for the fascination of healthy people with the art associated with psychosis. 'Clandestinely or by absurd means, they express a capacity that lives in everyone but which usually remains latent or atrophies' (Ferrier and Pinchon, 1998,p. 220). Also from the same excerpt:

> It is a surprising fact that the relationship between the sensations of schizophrenia and the sensations that are manifest in contemporary art has to be evoked in the same terms. But when making this observation, we also must establish the difference between the two, which is not a difficult task. With the schizophrenic, the experience is like destiny. He becomes detached from the world of the senses and is torn apart as if he were the victim of a cruel and unavoidable fate against which he often wages a long struggle, before surrendering and gradually feeling at home in his autistic world, enriched by delirium. With the contemporary artist, the detachment from reality, familiar and even courted as of late, is also the result of an experience, but this detachment is more or less the effect of the sorrowful awaking of an individual for whom traditional ties with the world have become unbearable (Prinzhorn, 1922: cited in Ferrier et al., 1998, p. 221).

Here Prinzhorn is proposing that some of the startling impact of German Expressionist art must arise from the alienation of the artist. With the advantage of hindsight, this seems a reductive account of that exuberant movement. However, in other matters he shows considerable sensitivity:

> However little attention we may pay to contemporary forms of expression, we discover everywhere, in the plastic arts as in the various literary genres, a series of tendencies that would reach their highest pitch only in a true schizophrenic. Our intention, however, is not to find signs of mental illness in these forms of expression. We simply sense throughout these forms an affinity for particularities we recognise as distinctive characteristics of

schizophrenics. This explains the kinship among the works of our collection, and the fascination they evoke.

This affinity for the "schizophrenic" world is essentially the same affinity that twenty years ago explored forms of expression and experiences from the worlds of the child and the primitive — in protest against the tentacular rationalisation of past generations, in which the best saw themselves as suffocating (Prinzhorn, 1922: cited in Ferrier et al., 1998, p. 221).

Just over ten years later Jung published his *Modern Man in Search of a Soul* (1933) that addressed issues close to Prinzhorn's notion of a suffocating culture and the healing nature of artistic production.

...the human psyche is the womb of all the science and arts. We may expect psychological research, on the one hand, to explain the formation of a work of art, and on the other to reveal the factors that make a person artistically creative. The psychologist is thus faced with two separate and distinct tasks, and must approach them in radically different ways.

In the case of the work of art we have to deal with a product of complicated psychic activities — but a product that is apparently intentional and consciously shaped. In the case of the artist we must deal with the psychic apparatus itself. In the first instance we must attempt the psychological analysis of a definitely circumscribed and concrete artistic achievement, while in the second we must analyse the living and creative human being as unique personality. Although these two undertakings are closely related and even interdependent, neither of them can yield the explanations that are sought by the other. It is of course possible to draw inferences about the artist from the work of art, and *vice versa,* but these inferences are never conclusive (Jung, 1933, p. 175).

Although the Jung's Archive's in Zurich contains hundreds of artworks made by his patients, there is almost nothing to suggest that he followed a diagnostic approach in relation to these images. The analyst and art therapist Michael Edwards spent some years ordering and making available examples of the artwork belonging to the archives, but he has been careful in the management of this work not to provoke crude diagnostic enquiries. In a paper entitled, 'Learning from the Image' (Edwards, 1999) he takes a clear position against the more gothic examples from the history of using artworks as diagnostic tools. Indeed the absence of notes by Jung directly concerning details of the huge store seems to be a clear indication that his concern with the artwork was that of the patient's own process of individuation and not that of diagnosis.

In contrast to this crude attempts at diagnosis of patient artwork are included in the writing of the otherwise revered psychiatrist Silvano Arieti. His book *The Interpretation of Schizophrenia* was first published in 1955 and later revised in 1974. The twenty years intervening between publication and revision had done nothing to invoke a reconsideration of his crude interpretations of patient artwork. *Figures 56 and 57* are taken from Arieti (1974, p.356-7).

figure fifty six

figure fifty seven

What he writes about them suggests the convoluted mess he gets himself into in the attempt to use them for diagnostic purposes.

> But the most characteristic feature of schizophrenic art is a partial application of Von Domarus's principle. Some partial identity among the subjects is based upon partial or total identity of a predicate or a part. In these cases, we have no total identity but fusion or condensation or two or more subjects. Figures *[56]* and *[57]* are drawings made by a female patient with unresolved homosexual conflicts. She sees herself as a devil. The tail and the snake are phallic symbols (Arieti, 1974, p. 362).

This seems to me to illustrate the difficulty of making adequate translation between psychoanalytic and psychiatric accounts.

It is possible to see some theoretical tenets in what he writes. The idea of condensation comes from Freud's *The Interpretation of Dreams* (1900) and the Von Domarus principle seems to be a version of Symbolic Equation developed later by Segal. However, it is difficult to follow the reasoning of Arieti in this because he does not provide sufficient information about either the images or their maker. The images themselves suggest an ironic posture on the part of the artist, but it is not possible to judge this with certainty on the basis of the little information Arieti provides.

Many people imagine that diagnosis based on scant information is the practice of art therapy, I have come across various forms of this assumption since the end of the 1970s. It is one of the consequences of being a member of a small profession on the cusp of two that are more powerful. Wild diagnosis is of course a danger for all disciplines (including art therapy).

Conclusion: what does a contemporary consciousness allow in relation to both art and psychosis?

It seems that a contemporary consciousness is likely to allow that psychotic processes are ubiquitous. In this there is agreement between psychiatry and psychoanalysis. Differences between the sane and the insane exist but they are not enormous and they are probably not permanent, although it is a serious matter to be mad. This is in contrast to an older consciousness, which uses many ruses to preserve and enable strict distinctions between the sane and the insane. The history of the art associated with psychosis has not been one of even development. A contemporary approach might wish to assimilate and integrate the art associated with psychosis into a wider social world of art. An older formalist approach might wish to maintain a separation between this art and that of the mainstream. Something similar emerges in relation to diagnosis. A contemporary approach is wary of reading a diagnosis from an image made by a psychiatric patient, whereas an older view wishes to find the traces of madness in its aspects.

The three main periods of art therapy history all contain elements that have contributed to the theoretical coherence of the psychotherapeutic practice of art therapy. Interestingly much of the development of practice has been in parallel to scholarly attention given to the art associated with psychosis in neighbouring disciplines of art, psychopathology and art history. However, developments have seen the over-use of some theoretical concepts and generalisations. For example, it is not always the case that the art associated with psychosis is a defence mechanism or the product of difficulties in symbol formation, but for a clinician it is essential to know when this is the case. Nor is it always the case that clinicians pathologise the meaning of art associated with psychosis, but it will be important for artists, scholars of art history and scholars of the very particular 'art of the insane' to point out when clinicians are in danger of doing so. Clinicians in their turn might wish to challenge some of those scholars who would paint an overly romantic portrait of psychosis.

Discussions and speculations about the nature of art made by people associated with psychosis have a long history. Some of the contemporary discussions relating it to the world of art as opposed to that of psychopathology have usefully been made by Cardinal in 1972; MacGregor in 1989, Hall & Metcalf in 1994 and repeatedly by Maclagan. However, the discussions have reached beyond the borders of the art world and take place at the intersections between disciplines, for example, between psychiatry, psychotherapy and art history. Contemporary discussions need to include contemporary art practice, the state of psychiatry and the form that art psychotherapeutic work might feasibly take within the public sector.

Perhaps it is not surprising that people from different clinical backgrounds who are attempting to do this work seem to be building bridges of theory and practice between psychiatry and psychoanalysis with very complex structures. Nevertheless there is a need for bridges to be built upon which clients might cross from one state to another and understanding between disciplines might be gained. This is fundamental to the interests of the *people* associated with psychosis.

In one sense David Maclagan's paper 'Has "Psychotic" Art Become Extinct?' (1997) asks a useful question. I hope this chapter has indicated that a reasonable conclusion at the beginning of the twentieth-first century is that modern consciousness may increasingly not allow for the use of the diagnostic category 'psychotic art'. There is still a need, however, to understand more about the impulse to produce artwork in the states of mind associated with psychosis.

It is important not to isolate the mentally ill either by incarcerating them in large asylums at the edge of the giant conurbations or by confining their artwork to the margins of culture. The incorporation of the art associated with psychosis into wider culture would be valuable to the host culture and knowledge of the wider culture can provide the raw material, inspiration and emotional sustenance to people with a history of psychosis. In the next chapter I explore further this notion of inclusion through the examples of contemporary art and popular culture.

Chapter Ten:

Towards Inclusion: Popular Culture and Contemporary Art

I hope in this chapter to elaborate a theme started in the previous one. I make the case for the greater inclusion of mainstream influences in thinking about how art therapists work with the art made by clients. Examples from my casework suggest that inclusion of references from contemporary art and popular culture, even at a symbolic level, can be of value to all clients but of particular value to those with serious mental disorders living at the margins or our society.

However, the inclusion of art in psychotherapeutic relationships is a messy business. It tends to challenge the traditional psychotherapeutic frame. The inclusion of a wider notion of art is potentially even more challenging to traditional psychotherapeutic approaches, but it could contribute to the empowerment of our clients.

The social class of public sector clients has been important and class has influenced the manner in which the profession has thought about its use of art. I hope to show here that this can be fruitfully explored and that more cultural influences could be opened to art therapy practice.

It would be possible to forgive an observer of the profession who thought that whereas many aspects of its theory and practice are appropriately connected to the contemporary period. Its use of art seems mainly linked to the turn of the eighteenth and the nineteenth century. Greater clarity about psychotherapy, the social awareness of practitioners and their efforts to produce evidence of effectiveness are examples of the ways in which art therapy does meet contemporary concerns. However, in relation to its use of art, I think the romantic tradition of nineteenth century art epitomises much of what happens now in art therapy. In some respects the ways in which the art of art therapy is theorised is similar to the romantic nostalgia of the early 'art of the insane' scholars and the proponents of 'art brut'.

Many aspects of the romantic tradition are appropriate to the practice of art therapy. Romanticism in art was characterised by a belief in the primacy of artistic freedom, originality and self-expression. It upheld the power of imagination, subjectivity and an affinity with nature, in opposition to the principles of Classical art. The materials used reflected nature, oil, pigment, clay, earth and stone. Many artists are associated in the popular imagination with Romanticism. They include amongst the many Blake, Turner, Constable, Goya, Fuseli and Freidrich.

It is surprising to realise that Goya's justly famous *The Sleep of Reason Produces Monsters* (1797-1799) was painted one hundred years before Freud's *The Interpretation of Dreams.* It comes from *Los Caprichos* (Caprices) one of a series of etchings. *Los Caprichos* satirized social customs and the Church but they clearly contain elements of

inner terror. Goya was able to portray the links between inner terrors and the state of the world. Although a number of popular accounts of Goya's life evade the idea that after he became deaf in the later part of his life, he was seriously mentally disturbed for a time. Many of the pictures of the later period are imbued with his knowledge of depression and mental disturbance and his horror at butchery of innocent Spanish civilians by the French army.

figure fifty-eight

Goya: The Sleep of Reason Produces Monsters (1788-9)

The Romantic Tradition accommodates the psychoanalytic notion that all art can be viewed as unshaped expression similar to dreams. This seems linked to notions of 'spontaneous' production that are a characteristic aspect of scholarship concerned with the 'art of the insane'. It also seems linked to psychoanalytic premises of free association and to run counter to the idea of making suggestions to a client. Nevertheless, it is interesting to see what happens if art therapists begin to make suggestions to clients about making art that uses forms and feelings from popular culture and contemporary art.

I use the term popular culture very widely to encompass the many forms of mass entertainment, media and news. What is found in television, film, theatre, computers, literature and art; all of these influence the artwork made by clients. Perhaps it is possible to do more to help clients make the influence of these forms upon their imagination explicit. The world is awash with rich multicultural influences; the international nature of contemporary culture makes worldwide cultural influences accessible to ordinary people. Yet despite this bounty, many feel alienated.

Art therapists often have to work with a client's sense of alienation when thinking about how to enable them to make artwork. The purpose of making artwork in therapy seems in one sense to be for the client to regain a sense of meaning and possibly inclusion. It may also enable them to gain a sense of the history of their imagination as opposed to their history as a patient.

Is the artist a subject or an object?

The Hegelian aesthetic assumes that art proceeds not 'from external conditions but rather from personal volition and character...' (Hegel, 1920, p. 251). In keeping with the rest of my argument this not a sufficient framework with which to consider the art made by clients. Augusto Boal suggests this kind of romantic aesthetic came originally from the desire of medieval nobility to create a world were it was possible to operate clear moral values. That Romanticism 're-edits' feudal themes and is ' the swan-song of feudal nobility' (Boal, 1979, p. 75). He asserts that the aims of feudal art coincided with those of the feudal clergy and nobility in their wish to immobilise society and to perpetuate the existing system. Even the Romantic revival seen in the late nineteenth century Pre-Raphaelite movement, demonstrates this wish to immobilise society at a pre-industrial stage. Earlier the Renaissance and the Machiavellian project (which can still be included within the remit of Hegelian aesthetics) had wished to 'liberate' human beings from all moral values and proposed that the artist alone is the subject who creates the history of art.

The aesthetic theories of Brecht are in conflict with those of Hegel. Hegel's poetics suggest that all exterior actions of art have their origins in the artist's free spirit. Brecht asserts on the other hand that the artist is not free but an object-subject of history.

> The marxist poetics of Bertolt Brecht does not stand opposed to one or another formal aspect of the Hegelian idealist poetics but rather denies its very essence, asserting that the character is not the absolute subject but the object of economic and social forces to which he responds and in virtue of which he acts...The character is not free at all. He is an object-subject (Boal, 1979, p. 92).

This also has relevance to ways in which it is possible to think about the quality of alienation experienced by people with a history of psychosis. It is not feasible to think that people are troubled in isolation from the societal forces that act upon them. In addition it is helpful to consider how these same societal forces can alienate the nature of imagination.

One aspect of an art therapist's project in relation to their clients is to enable the production of art. Augusto Boal's thinking in relation to the production of theatre is germane. His very brief history of theatre shows how in Aristotelian tragedy the spectator delegates power to the dramatic characters. Then in the theatre of Brecht the spectator delegates power to the dramatic character so he may act in the spectator's place but the spectator reserves the right to think for himself. Boal describes the participatory theatre of revolutionary periods in Latin America. He proposes that in this *Poetics of the Oppressed*, the spectator 'focuses on the action itself... delegates no power to the character (or actor) either to act or think in his place; on the contrary, he himself tries out solutions, discusses plans for change — in short trains himself for real action' (Boal, 1979, p. 122).

Similarly it is the art therapist's project to enable the client to try out solutions, discuss plans for change and find ways of acting and thinking. The vehicle for this in art

therapy is found in the relationship and in the process of making art. However, as discussed in chapter four it is important for the art therapist to be aware of the processes of alienation that interfere with the ability of people to either make artwork or form therapeutic relationships.

Arthur Kleinman in *The Illness Narratives* (1988) shows that there is also the potential for alienation within the condition of 'illness'. His ideas about enabling the client to tell their own narrative of their condition, and its impact upon their sense of social significance suggest the possibilities for building bridges between medicine and psychoanalysis. Kleinman does not directly refer to the unconscious but the unconscious is implicit in much of what he describes.

Mistaken assumptions

A client of mine that I mentioned briefly in chapter four, lived within the massive concrete complex of a council estate with her husband and her two children. Possibly because of her broad Yorkshire accent and her general unconfident demeanor, she was diagnosed as educationally sub-normal. At first the artwork she made during the time she spent with me was tortured but it began to go through playful phases. There came a time when she began to illustrate a series of Greek and Roman myths in ways that were acutely appropriate to her position. I can smile wryly now with hindsight at memories of my surprise when I first saw these apparently archetypal illustrations. She had started to work on her art at home, and these were some of the first products from home.

She laughingly told me pictures in her children's library books had inspired the Greek/Roman series. The fact that the series had not been 'hot-wired' from archetypal sources did not remove their pertinence to her life, or their unconscious connections. Indeed the combination of thought and playfulness that was evident in her work invalidated the diagnosis made of her as educationally subnormal *(see figures fifty nine and sixty)*. I suspect that the medic who had coined her original diagnosis had not initially been able to get beyond his difficulty with her broad accent. To his credit after seeing some of her pictures he changed the diagnosis.

Dialects and accents, types of clothing and general demeanour can convey a great deal of information about a person's origins. All of these matters though are notoriously subject to mistaken assumptions. It is perhaps the knowledge of such assumptions, which means that youth culture has played constantly for many generations with appearance. Teddy boys, swingers, mods, rockers, sixties gear, punks, new age and post-moderns all flaunt their appearance and manipulate assumptions.

However, the assumptions about working class stupidity are not generally so dramatic as the diagnosis 'educationally subnormal', although they are commonly made. Valerie Sinason has written powerfully concerning the assumptions made about stupidity.

figure fifty nine

figure sixty

She has written from a psychoanalytic perspective about her work with people with learning disabilities. It seems to me that her ideas about stupidity have relevance to a wide range of practice (including matters of class although strictly speaking class is not a minority matter). 'Being made the recipient of hostile, patronising or demeaning projections is an experience all minorities experience' (Sinason, 1992, p. 27). This is why she suggests that many people will have a tendency to try sometimes to pretend that they have knowledge of something when they do not. She compares herself with Thomas a teenager with a 'severe mental handicap'.

> Both Thomas and I were in the same predicament of finding it intolerable that the precious small resource of specific knowledge we had was not adequate for the particular task needed. In the circumstances...we both managed to deal with that hurt and admit we needed help. We were able to demonstrate what Confucius considers true knowledge, an understanding of what we did and did not know (Sinason, 1992, p. 19).

I personally think this kind of mechanism may operate in some working-class slang used to describe mental illness and mental disability. Phrases are commonly used such as barmpot, crackpot, from the funny farm, off their trolley, they've got a screw loose, they are sixpence short of a shilling and so on. These expressions are often used to describe people who are not behaving ordinarily but they are also used humorously to the face of people who are not actually disturbed. When this happens I do not think it is romantic to think that sometimes there is affection contained in such remarks. Although of course when such calling is aimed at people who have a history of serious mental illness it will be experienced very differently and painfully as stigma. Lack of knowledge about mental illness and mental disability is painful for everyone, those who look on and those who experience it. The possibilities for misunderstanding and failure to communicate are rife.

Making art

This is why it seems to me that the possibilities for extending the range of communication inherent in art therapy are so valuable; the possibilities for extension clearly exist in the art. However, there is a tension between the use of psychoanalytic ideas and the artwork made by the clients of art therapists in the public sector. This tension has the potential to be creative but we need to examine it. I think it arises in part from the different class location and origins of these two different forms of clinical practice.

Some strict psychoanalytic practitioners might see the artwork made by the clients of art therapy as a distraction to the psychotherapeutic relationship or even as a form of acting-out. Psychoanalytic psychotherapy is a form of practice that focuses upon the enactment of the inner world of the client within the relationship between the analyst and client. The notion of the art being a distraction or a form of acting out comes from the very different set of presumptions to those operating within art therapy. Psychoanalytic

perspectives have tended historically to be quite narrow in relation to art and would not necessarily acknowledge, or perhaps include the experience of making art with which to understand, what I suggest in chapter six that struggle and engagement are necessary.

On the other hand in,

> many cases the decision to enter psychoanalytic therapy, as opposed to seeking some other form of therapy or eschewing all expert help, is determined by a pre-established familiarity with and sympathy for psychoanalytic discourse (Richards, 1989, p. 122).

For clients of the public sector who generally have little prior knowledge of psychoanalysis the intensity of psychoanalytic psychotherapy could initially be mystifying. I have repeatedly made the important point that although the art making process in art therapy contains its own mysteries, the time involved may enable art therapy clients to digest an understanding of the psychotherapeutic process. Also the art making process physically demonstrates to the client the fact of his or her own agency in the world. This can be powerful and it can act against a sense of alienation.

Popular culture

In his book *Disciplines of Delight,* Barry Richards considers the way in which psychoanalytic study views the products of popular culture. The issues he addresses seem to have real relevance to the ways in which we might think about what clients produce in art therapy sessions. Richards wishes to view popular culture in a positive light.

> A consideration of the psychic dimensions of cultural participation suggests that — both in the present and the foreseeable future — popular culture will continue in at least some sectors to be a "mass" culture, because it can provide helpful ways of managing internal anxieties and conflicts from which we all suffer (Richards, 1994, p.5).

The complex and often contradictory nature of the satisfactions to be obtained from popular culture makes Richards consider that the techniques of psychoanalysis can be a powerful tool for understanding them. However, he shows that popular culture has been described by psychoanalytic writers as 'the enemy of psychic truth, in its preferences for simplicity, entertainment and evasion over the complex and the painful (Richards, 1994, p. 9). He suggests that such views are consistent with the class experience of the educated 'cultured' upper and middle classes,

> for whom the high culture of literature, the visual arts and classical music is the primary mode of aesthetic experience, and a major expression of moral value. This kind of class-based orientation is the "default" position of psychoanalysis (Richards, 1994, p. 9).

He continues with the idea that:

> For those legions of us born into working and lower middle class cultures the stuff of aesthetic is more likely to be found in things like television, both in its content and in its form as a medium, in other forms of mass entertainment and leisure, in the urban and suburban landscapes we inhabit, in the objects we buy or covert, in advertising and commercial design, and in popular music (Richards, 1994, p. 10).

In these ways the work of Barry Richards challenges the high art concerns of psychoanalysis, yet his project also attempts to harness some of the knowledge provided by it in relation to popular culture. I think that art therapists can make use of such a project because there is reason to explore widely in seeking further understanding of the many artworks made by our clients.

John Fiske is another writer on the nature of popular culture. He does not take a psychoanalytic perspective but he does point to the 'high' and 'low' concerns of the art world. 'Artistic complexity is a class distinction: difficulty is a cultural turnstile — it admits only those with the right tickets and excludes the masses' (Fiske, 1989a, p. 121). Fiske makes interesting comparisons between the ways in which popular culture is perceived and used in Britain, America and Australia. He has direct experience of living in all three. I find his international perspective useful in countering the idea that notions of class are outmoded and remain of interest only in the history of industrialised Europe.

However, the most interesting idea that I take from Fiske runs throughout his work and it proposes an idea about the location of meaning in the products of popular culture. 'Popular culture is always in process; its meanings can never be identified in a text, for texts are activated, or made meaningful, only in social relations and in intertextual relations. This activation of the meaning potential of a text can occur only in the social and cultural relations into which it enters' (Fiske, 1989b, p. 3).

This has strong echoes of art therapy literature that is concerned with the art products made by the clients in a *relationship* with an art therapist. Thoughts about the art made in therapy have found lively expression in the pages of *Inscape* in recent years. There has been particular vigour in those papers concerned with the naming of the profession (art therapy or art psychotherapy). I think this is because they centrally address the dynamic tension between the art making and the psychotherapeutic nature of the relationship with the therapist. For me many of the issues were invigorated in papers by Schaverien (1994; 1995), Skaife (1995), Tipple (1995) and Bryne (1996) all of them concern themselves (in different ways) with the relative emphasis placed in different therapeutic circumstances upon the art and the relationship. The debate inherent in these papers is no longer concerned with a simplistic and overly romantic opposition between the art and the psychotherapy. There is a wide spectrum of thought about the nature of the art made in therapy. A comparison between some of these ideas and the ways in which the products of popular culture have been theorised could produce some interesting new vantage points.

One of the comparisons that can be made is found in the subversive elements of both popular culture and art therapy, although of course these are not automatic in either.

> Popular culture is the culture of the subordinate who resent their subordination; it is not concerned with finding consensual meanings or with producing social rituals that

> harmonize social difference, as the liberal pluralists would have it. Equally, however, it is not the culture of subordination that massifies or commodifies people into dupes of capitalism...neither argument allows popular culture to work as an agent of destabilization or as a redistributer of the balance of social power toward the disempowered. They are therefore inadequate (Fiske, 1989b, p. 7-8).

Fiske is interested in locating the power of popular culture at the point where its consumers manage to turn it to their own creative, ironic and even subversive uses. There is something similar in the concerns of the art therapist Sally Skaife when she writes:

> Art therapy is by its nature radical. It is about empowering people. By making art, people discover their own ability to act and create originally. Art provides a mirror or comment on society, it reaches beyond the conventions of daily life. Art therapy is thus nearly always a subversive activity (Skaife, 1995, p. 2).

A comparison with the way in which Fiske writes about the uses made of popular culture is pertinent here.

> A pair of jeans in a museum of fashion is not totally meaningless — depending on their relationships to other garments in the display they could carry a number of generalized meanings about twentieth-century America — but they are still an impoverished text. Their meanings can be brought to fruition only intertextually, by including the ways they are promoted commercially, the ways they are worn and talked/thought about by their users, and the meanings that the press and other social commentators make of them. In other words the study of popular culture is the study of the circulation of meanings — treating a text as a privileged object artificially freezes that circulation at a particular (if convenient) point and overemphasizes the role of the text within it. The popular text is an agent and a resource, not an object (Fiske, 1989a, p. 124).

A great deal of art therapy literature is concerned with the circulation of meaning between the art studio, the art object and the persons of the therapist and client. It is a mistake to treat the art as a 'privileged object' and 'artificially freeze' efforts to locate understanding within the art object alone. Much of the art made within art therapy relationships is powerful but some of its richness and quality might be overlooked if taken out of the context of the relationship in which it is made. This is not to deny that some of the work made in art therapy is impoverished. However, it is irritating when commentators such as MacGregor (1989) Cardinal (1997) and Dubuffet suggest variations on the theme that the art produced by people in the midst of mental distress is generally less interesting when it is made in the context of an art therapy relationship. It does sometimes seem that such commentators wish to take art out of any context and preserve it even unto its passing.

Fiske on the other hand, gives a warm and ample account of a number meanings that can be taken from the *use* of popular artefacts, mass entertainments and icons in ways which I think illustrate the contextual nature of the meaning of much contemporary culture. One example he offers is that of Madonna, who was a major phenomenon of popular culture in the late 1980s.

> Her success has been due at least as much to her videos and her personality as to her music — about which most critics are disparaging. It is also significant that her fans and her publicity materials, along with journalistic reports and critiques, pay far more

> attention to what she looks like, who she is, and what she stands for than to what she sounds like (Fiske, 1989b, p. 95).

Her significance in the culture is wide and sometimes ironic and contradictory. She is:

> circulated among some feminists as a reinscription of patriarchal values, among some men as an object of voyeuristic pleasure, and among many girl fans as an agent of empowerment and liberation. Madonna as a text, or even as a series of texts, is incomplete until she is put into social circulation (Fiske, 1989a, p. 124).

The same issues apply in relation to the many contemporary phenomena, for example, the various forms of Girl Power, the Spice Girls and numerous young female bands. There are also an increasing number of TV series that invert traditional female roles (often with humorously tongue-in-cheek style) e.g., *Zena: Warrior Princess* and *Buffy: Vampire Slayer.*

I have taken some time to discuss these matters because I think the analogy between the arts made in therapy with the artefacts of popular culture can provide a useful vantage point that has some pertinence to the position of many clients. Art Therapy is a form of psychotherapeutic practice which is applied widely often in difficult circumstances. The Appendix D of *NHS Psychotherapy Services in England: Review of Strategic Policy* suggests that 'Art therapists work with some patients other psychotherapists would not consider taking on' (Parry and Richardson, 1996a, p. 107). I think this statement is true, but I can see how it might be taken by some as an indication that the practice of art therapy is not sufficiently rigorous and that its criteria for accepting clients is simplistic and not comparable with the criteria for psychotherapy. I hope I have already shown how particular class vantage points might lead to this mistaken conclusion. It is worth pointing out a comparison, the charge of over simplicity is one also levelled at popular culture.

In thinking about the way in which popular culture is viewed a number of issues emerge. Popular culture is often portrayed as simplistic and Bordieu suggests that it arouses what he calls the 'disgust of the facile' (Bordieu, 1984, p. 486-8). By this he means to indicate that assumptions are made about the worth of much popular culture. He contrasts this with assumptions made about the quality of 'high' art and suggests that a critical industry has been developed around such art, which highlights complexity and so makes it possible to draw distinctions between those who can appreciate and those who cannot. He mischievously suggests that such distinctions are in themselves a source of satisfaction to those with the education able to make them.

I have already indicated evidence of this kind of elitist prescription being aimed at the world of art therapy. There are numerous examples in the writings of the early 'art of the insane' scholars and in those of 'art brut'. I have suggested that one example of the logical conclusion of this kind of thinking is the experience of John Clare who was effectively kept a prisoner in Northampton Asylum between 1841 and 1867, until the end of his life, in order to ensure he would continue to produce poetry.

Lord hear my prayer when trouble gloom:

I bear my enemies reproach
All silently I mourn
They on my private peace encroach
Against me thy are sworn
Ashes as bread my trouble shares
And mix my food with weeping cares

John Clare: (Robinson, 1984, p.328).

Commentators such as MacGregor, Cardinal and Dubuffet have regularly taken a high church position in relation to the art produced in art therapy. Their methods of aesthetic criticism can seem befuddling and elitist, 'artificially freezing', as Fiske would have it, the art object within a frame that excludes relationship and context. In other respects the work of MacGregor and Cardinal contains many insights but not in this undervaluing of much that occurs under the guise of art therapy.

A similar condescension toward art therapy is evident in the mainstream art world and in the psychotherapeutic communities. It has long been apparent to me that art therapists, along with other disciplines who choose to work with disadvantaged groups of clients are regularly stigmatised along with the clients with whom they work. In some areas this stigma has inhibited the profession and it may be that in conjunction with the difficult economic period of the 1980s and the 1990s it has slowed down the exploration of many rich seams in contemporary culture.

Contemporary gothic?

Peter Ackroyd in his biography of William Blake writes humorously about some of the gothic exaggerations at play in Blake's work. He shows the interesting way in which it is possible to take cultural influences from the past and combine them with contemporary preoccupations:

> "Hopeless! abhorred! a death shadow, /Unseen, unbodied, unknown" — we are close to the overwrought language of contemporary fantasy with its death stars and dark forces. Of course it would be unwise to press the comparison too far, since there is a qualitative difference between Blake's illuminated books and the comics of the late twentieth century. But there is a resemblance, at least, which springs in part from the sense of alienation or exclusion from the conventional literary establishment that many writers of fantasy experience; modern writers of fantasy tend also to be political radicals with an urban sensibility not untouched by an interest in the occult. They might be seen, then as sharing part of Blake's consciousness. But before we ask what is so twentieth-century about Blake, we might consider what remains eighteenth century about ourselves (Ackroyd, 1995, p. 181).

Blake's visionary experiences and his social status put him throughout his life on the edge of the establishment:

> Fuelsi says, Blake has something of madness about him. If Blake were ever canvassed as a possible member of the Royal Academy, then such conversations would have ruined his chance. He was singular, probably a little mad. He had even married a

servant. When he spoke of his angels, also, he was attaching himself to an urban and decidedly 'lower-class' vocabulary of religious millenarianism; even if he was sane, he was certainly not well bred (Ackroyd, 1995, p. 196).

Blake's angels, his lifelong struggle against poverty and for recognition, strongly put me in mind of many of the art therapy clients with whom I work. They share stories of experiences that are couched in the language and images of popular culture or in the gothic equivalents for our times *(see figures sixty one, sixty two, sixty three, and sixty four).*

I am sometimes astounded by the creative use they can make of even the most banal episode in a soap opera. One example involved the macabre but humorous play they made with an episode of *Brookside* that a number of group members had seen. Interestingly and perhaps fortunately, it was an episode I had seen myself. It involved the discovery of a body in a suburban back garden. The black burlesque humour with which my clients in their own post-mortem of the episode addressed matters of life and death was edifying.

Dennis Potter's writing for television tends to damage the argument that popular culture only panders to the lowest common denominator of demand. Apparently the viewing figures for many of his television scripts have been extraordinarily high; this was particularly the case for *The Singing Detective.* This serial was a searching exploration of the life of Marlowe (hospital patient, gumshoe and crooner) *(see figure sixty five).* It was well crafted and written. It contained many references to the ways in which unconscious processes are woven into the fabric of life, and yet it attracted a mass audience week after week. The viewing figures were reported as being greater than those for *Match of the Day.* This suggests there is widespread interest in the patterns of life and the ways in which they can make themselves manifest. An interview with Potter shows his attitude to autobiography.

Graham Fuller: You denied in interviews at the time of 'The Singing Detective' that Malowe was in any sense autobiographical, but subsequently you've said you were less certain about that.

Dennis Potter: There's overt autobiography, which is first-person narrative...There is also another kind of autobiography, which is fictive and uses the experiences and the geography and the memories of how one felt about certain kind of things, like illness and geographic dislocations in childhood — in my case, moving from the Forest of Dean to London, briefly, and then back. There are *real* memories that are invoked millions of times even if you are writing about Julius Caesar. The *form* of autobiography is very powerful because it appears to be authentic. As I've said before, autobiography is one of the most venal and lying of all the sub-art forms in prose (Fuller, 1993, p. 95).

This account of Potter's ideas about the venality of autobiography make thought provoking stuff for any therapist. What he and his work made clear is that there is a mass audience for such ideas and a thirst for knowledge about the processes at play in biography. Two television plays *Karaoke* and *Cold Lazarus* were written by Potter shortly before he died. They were screened posthumously on both Channel Four and BBC-1 in May and June of

figure sixty one
William Blake (1757-1827) 'Count Ugolinl and His Sons in Prison'.

figure sixty two
Cover of Cook's book 'Dennis Potter: A Life on Screen' (1995),
The image shows the main character in 'Cold Lazarus' one of Potter's posthumously screened TV plays (1994).

figure sixty three
Lexx: Gothic Equivalents In Space

figure sixty four
Teal'c is a member of the Jaffa race and formerly of the elite Serpent Guard of the Goa'uld Apoplis, but after saving the Stargate team he returns to earth with them as a volunteer.

figure sixty five
The 'Singing Detective': Michael Gambon as Philip Marlow (hospital patient, crooner and gumshoe)...

1996 and both made powerful use of science fiction and fantasy genres. Ackroyd highlights these genres as often being the vehicle of the alienated radical to explore and play with many political themes of power and class. Certainly the description 'alienated radical' seems an appropriate one for Potter, difference in class background being one of his abiding themes. His interest in working class experience explains something of his widespread appeal.

The art therapist Dave Edwards has considered the mass appeal of football. He writes very interestingly about many aspects of football: the significance of the play, the artistry and the sublimated sexuality and aggression. He quotes Hopcraft, 'What happens on the football field matters, not in the way that food matters but as poetry does to some people and alcohol to others; it engages the personality' (Hopcraft, 1968, p. 12). Edwards also comments on the sad lack of linking between the areas of knowledge represented by the disciplines of sociology and psychoanalysis (1995, p. 65). This observation seems to me to be one that is commonly made by art therapists because their experience in the public sector means that they are aware of the lack of linking between ideas about the psyche and the social. I mention Edward's football study because it seems to me that there are many cultural pursuits that deserve the attention of art therapists and that there is reason to be wary of defining our range of attention too narrowly as we attempt to attract the imagination of our clients. 'At this level of discourse the symbolic meaning of football is "up for grabs" and what we may read into it is limited only by the imagination' (Edwards, 1995, p. 40).

One story that caught my imagination and is highly relevant to the potential of art therapy is that of a young black Chicago photographer, fifteen year old Ennis Beley. It is important to mention that Beley was no one's art therapy client. He grew up in south central Los Angeles being cared for by an elderly friend of his young mother. Everyone had wrongly assumed that this person Howard Glen was Ennis's father because he had cared for him since he was a baby *figures sixty six* and *sixty seven* are both photographs taken by Ennis).

Ennis grew up at the back of Howard's barricaded dry cleaning store. Howard was in his seventies when members of a rival street gang gunned down Ennis. I heard an American family therapist talk recently about having to ask families she was seeing in inner-city areas to sit on the floor because of the danger of stray bullets from the outside. In some ways this indicates that it is remarkable that the death of Ennis made it into the *Independent* newspaper because deaths like his are all too common for young Americans.

Ennis drew attention to himself and his life because he participated in a BBC programme *LA Stories: From the Eye of The Storm.* His self-made videos and his photographs are potent. He began working with photographs when he was twelve. Interest in his photography created interest in him. A number of people from more privileged

figure sixty six

figure sixty seven

circumstances tried to help him escape from his neighbourhood, the gangs and the drive-by shootings.

Ennis was given the chance of an education because his photography drew widespread approval. When asked how he had changed since he picked up a camera he said, 'Now I have something to do when I ain't doing nothing and it can keep me away from gangs and joining and drive-by shootings and everything' (Heller, 1996, p. 7). He felt his photography changed him. It was the circumstances of his life that clung to him and eventually killed him. A memorial exhibition was made of his photographs. People speaking at his funeral felt that what they had been able to do for him had been depressingly inadequate. Howard Glen said, 'I never knew anything like that would hurt so bad' (*see figure sixty eight*). He blamed himself for not making Ennis take off his gang's colours before he went out on the day he was shot by a member of a rival gang.

People had a powerful glimpse of his life from his photographs, because he had an acute eye for his world, but his attempt to escape the deadly side of that same world failed. It is hard, but in many circumstances like this we would be deluded to imagine that therapy alone could do enough.

Contemporary art:

It seems to me that there is some defensiveness (understandable enough) felt by art therapists because of the misunderstanding and undervaluing of their work from a number of sources. There is evidence of this in psychiatry, psychotherapy and mainstream art. Perhaps it is this defensiveness has meant that there has not been much development in the way art therapists relate to the art world.

Art therapy relations with the art world have been written about only briefly, and it would be difficult to clearly point to their inclusion and influence in matters of practice. This may be germane to Gilroy's thesis concerning what happens to a therapist's individual artwork once they become a therapist (1989). Michael Edwards (1989) wrote about the relationship of the art making in art therapy to the art movements of both Neo-classicism and Romanticism. David Maclagan has regularly commented (1983, 1989, 1994) on the influence of Surrealism and Modernism. As yet only Peter Bryne (1994) in published form has intimated that the practice of art therapy needs to consider its response to contemporary art practice.

Much of what has occurred in art movements since the turn of the nineteenth and twentieth centuries can be seen as enlivening and as a part of the democratisation of art practice. This might suggest that access to art and therapy has been enhanced but this would not be a straightforward matter to demonstrate. For the vast majority of people understanding and access to the art world is subject to many variables and contradictions.

figure sixty eight

The art of the twentieth century has encountered many twists and turns in its public fortunes. Descendents of the Romantics include Impressionism, the Symbolists, the Expressionists and Surrealism. Exhibitions of Impressionist work held at the end of the twentieth century in Britain were massively popular and yet the same works had been greeted with scandal and satire when first exhibited in Paris in 1874. 'It is a commonplace that works of art in the modern period often appear strange and difficult. As a result of this they have frequently been subject to scepticism and ridicule' (Meecham and Wood, 1996, p. 1). Throughout the period from the turn of the eighteenth century to the end of the twentieth, there has been much in art able to touch the popular imagination and it is possible to see that art has been both celebrated and reviled.

The twentieth century saw an explosion in the range of materials used by artists, paint and clay remain but there are many others. Artists regularly used collage and assembly and incorporated materials from every aspect of life, including even bodily products towards the end of the century. Found objects and consumer objects all could be included. Performance art was filmed and photographed as artists began to use themselves as a central form in representation. Land art could be on an intimate or an epic scale and film (for photographs and video) was everywhere. In a sense the materials for making art were within everyone's reach, and although this could represent a form of democracy, lack of knowledge and confidence often means that it does not.

It is hard to know how widespread or curtailed knowledge about art has become. It seems that some artists from pre-twentieth century are individually famous although the movements of which they formed a part are not, whereas many celebrated and influential artists during this century are not known widely. Three that come to mind are Willem de Kooning (1904-97) Robert Rauschenberg (b. 1925) and Joseph Beuys (1924-86).

The thick texture of de Kooning's abstract expressionist paintings seem to merge into that of his later sculptures. Much of his work was centred on the human figure *(see figure sixty nine)*. Rauschenberg was often said to be a model of joy in art, an enfant terrible of American modernism because of the way he moved between different genres; collage, assemblage sculpture and painting and drawing. His mixed media *Bed* (1955) was said to be 'half art, half life' *(see figure seventy)*.

Beuys was a sculptor but it seems miserly to confine a description of him to one genre. In some ways he anticipated the German concern with ecology and the use of natural materials. He was a wonderful propagandist espousing the fundamental need for creativity. In *Une Intervention de Joseph Beuys* a video he made in 1984, he said 'to be creative means...creating self awareness for the freedom of every member of the human race'. His legendary status in the art world if not in the popular imagination is almost certainly due to the story of his rescue by Tatars after he survived a plane crash. They had kept him alive in

figure sixty nine
De Kooning
'Head' (1973).

figure seventy
Rauschenberg's 'Bed' (1955).

hostile circumstances through the ministrations of felt and tar: the materials that subsequently became the raw materials of many of his pieces *(see figures seventy one and seventy two)*.

Formal changes and a dislocation from the social political context characterise art in the early part of the twentieth century. A sense of context gradually returns throughout the century. Political issues emerge and then fade from art. Sometimes they are directly part of its fabric and sometimes only tangential. Concentration on self-expression is present throughout the century. The movements of Modernism and its ambivalent relative Post-Modernism reflect in uneven ways the political economic periods in which they exist. Confident exuberance followed by something more subdued, pluralist and passive.

Many themes from the art world seem to be a part of a therapeutic repertoire: self-disclosure, confession, bodily functions, sex, life and food, family and death; all of these figure largely. Yet for large parts of the twentieth century the suggestion that a piece of work is therapy remained an insult. During its last twenty years many of those artists celebrated and collected in Britain have originated more generally from lower class backgrounds than has been the case in the past. However, this does not make wider access and understanding any more straightforward.

The group of artists who exhibited in 1988 with Damien Hirst in the *Freeze* exhibition did not at that stage seem destined for the kind of success they achieved. The work shown had a wide range of forms, some was conceptual and much was not easily accessible. Many of the same group continued to exhibit together and a large number were included in the Saatchi Collection exhibition *Sensation* 1997. By 1997 a number of the artists had become famous often as a result of media interest in the non-comprehension that regularly greeted the artwork.

This is true of both Turner prizewinners Hirst and Whiteread. Whiteread's house opened up domestic space for inclusion in art. Billingham's uncompromising photographs of his family in their flat on a Sunderland estate have been exhibited in major galleries internationally *(see figures seventy three and seventy four)*.

> Billingham's photographs have been hailed as a mass of contradictions. They are naïve, humane and beautiful, as they are artificial, raw and disconcerting. They lie somewhere between documentary and fiction. As an obvious insider, Billingham is as much a spectator as actor in this tragicomedy of domestic life.
>
> Against the grain of traditional British propriety, the photographs are a warts-and-all depiction of a disconsolate working class family. Billingham's parents, Ray and Liz, are the primary focus of the pictures. Seen through the camera's lens they are at once heroic and lamentable. In one image we see Liz handing Ray a plate of food; his arms are extended and a thankful smile lights up his face. In another, Ray, a chronic alcoholic, is witnessed passed out on the bathroom floor, his vomit covering the toilet seat. Still another shot shows Liz nursing a puppy with a syringe, supported by her tattooed arm. Whether, violent, miserable, or endearing, Billingham's photographs

figure seventy one
Joseph Beuys 'Plight' (1985),
Installation at Centre Pompidou

figure seventy two
Joseph Beuys
'La Revoluzionesiamo noi' (1971),
Guave, photography, text and stamp,
Musée de la Roche sur Yon

figure seventy three
Richard Billingham
'Untitled' Colour Photographs on Aluminium, Varied Measurements (1993 –5).

figure seventy four
Richard Billingham
'Untitled' Colour Photographs on Aluminium, Varied Measurements (1993 –5).

evince the artist's understanding of his subject's spiritness in their ineluctable situation (Bussel, 1997, p. 193).

These pictures provoke many feelings and sense of contradiction in the spectator: the possibility of Ray and Liz presenting themselves for psychoanalytic treatment would provoke a similar sense of contradiction. The material context of their lives would make the level of psychological inquiry represented by psychoanalysis seem superfluous to their material needs. Whereas although the same contradictions would exist I think it is possible to imagine their possible engagement in art therapy.

The art historian and philosopher Professor Donald Kuspit is ferocious in his attacks on what he describes as the cult of the avant-garde, which he associates with the financial corruption and comodification of art and society during the late part of the twentieth century. He suggests that post-modern work, the avant-garde of this period, denies the possibility for human development, therapy or change. He makes use of the psychoanalytic concept of narcissism to establish the basis of his critique (Kuspit, 1993). However, although his invective is powerful and convincing in many respects, an aspect of the work of the young British artists associated with Hirst and exhibiting in the *Sensation* exhibition is their propensity to work and exhibit in groups. I think this throws some questions against the criticisms of crude commercialism. In addition much of the work is clearly powerfully referential, although disturbing, e.g., Chapmans' child manikins and Harvey's *Myra (see figures seventy five and seventy six).*

Kuspit is equally acerbic in his thoughts about psychoanalysis. He proposes the idea of the 'application' of psychoanalysis to another discipline, 'The Use and Abuse of Applied Psychoanalysis' (1993b, p. 313-330). His notion of the abuse places psychoanalysis in the role of parasite to the host discipline.

The vexed question of suggestion within the therapeutic relationship points to an area where I think that art therapists might consider modifying a too direct application of psychoanalytic precepts. This is because it is sometimes useful to make suggestions to clients about the culture we inhabit and the possibilities for making art. Such suggestions would be aimed at enabling people to try out a wider range of media in the hope that they might stumble upon a form that enables them to engage with their artwork. It might also mean that they begin to feel the connections between their own concerns and those of the culture. This would not provide a panacea against alienation but it could contribute to the realisation of the extent to which such experiences are shared.

One example of making a suggestion in this way involves a client (I will call her Mary) in one of my groups who was still mourning her mother's death. It had been a number of years (possibly three) since her mother's death. By this time her mourning was undoubtedly mixed with melancholia. She had lived all of her adult life with her mother

figure seventy five
Jake & Dinos Chapman (1995)
'Zygotic acceleration, biogenetic, de-sublimated libidinal model (enlarged by 1000)'

figure seventy six
Marcus Harvey
''Myra' (1995)
acrylic on canvas made up of the handprints of children

and had nursed her in their council flat for several years of a terminal illness. On a number of occasions she had visited the grave in great distress and had at times spent most of the night in an alienated lonely vigil. At the first group she attended after she had had a long break she spoke about having resumed her graveside vigils and about having discovered that one of her relative's gravestones had been vandalised. She spoke about the high financial cost it was going to be to her to have the stone repaired but her feelings seemed to touch something terrible and deep *(see figures seventy seven and seventy-eight). Figure seventy-eight* is entitled *Figure Study* (1975), a painting by Francis Bacon, that seems to evoke the atmosphere of conversations with Mary.

I began to think about the video poem *V* by Tony Harrison and I said this. Another group member voiced that he had been thinking about this poem and added that it was his favourite.

The ones we choose to love become our anchor
When the hawser of the blood-tie's hacked, or frays.
But a voice that scorns chorales is yelling: ***Wanker!***
It's the aerosolling skin I met today's.
(Harrison, 1985, p. 21).

He spoke a bit about the poem and explained that it contained quite a bit of swearing (he is from a younger generation to her). I laughed (I think because I had the same worries about the swearing). I thought about the lines from the poem.

I don't fancy an encounter with mi mam
Playing Hamlet with me for this swearing
(Harrison, 1985, p. 15).

My counter-transference feelings were clearly to do with Mary being of an older generation and with not wanting the prodigious amount of swearing in the poem to offend her.

I asked Mary if she might be interested in seeing the video of the poem and when she nodded I agreed to bring her a copy to watch. I also said a few things about the swearing. Mary began to laugh, she told the group member who had also being warning her and me that she had heard quite a bit of swearing in her day.

On another occasion I mentioned to a client who is very skilled in using clay that Gormley's *Field for the British Isles (see figure seventy nine)* would soon be put up in the local gallery. As a result of this suggestion all of the group members made their way to the exhibition independently. There were numerous references to the exhibition subsequently in the group.

I have a number of examples like these of responding to clients with suggestions about where they might look in the world of art. In addition clients in groups often do this

figure seventy seven
Cover picture to Tony Harrison's poem 'V' (1985) Boodaxe Books.

figure seventy eight

for one another. They bring in images to show from art books. There was a time when a number of monographs about Freda Kahlo were shared these produced genuine excitement at the range of possibilities for self-portraiture that they introduced *(see figures eighty and eighty one)*.

Newspapers are often discussed and occasionally a photograph. Recently there has been a tendency to bring things from the net. All of this seems to me to part of the tradition and process of making art. Art thrives on influence and borrowing. I realise that this alters some aspects of the container that I provide but I suspect that this acknowledgement of the world in which we meet and the way it is shaped by contemporary art and popular culture tends towards their sense of inclusion. My client who visits her mother's stone in the middle of the night often imagines she does this because she is mad. Harrison's poem suggested something different to her, which is that her experiences need not be thought of as mad. That the emotions they represent can be partly contained within the frame of a poem and that they can be understood within notions of modern citizenship.

This chapter has involved a plea for the inclusion within art therapy of mainstream art and popular culture. This seems important for the life of the discipline and a more wide ranging acknowledgement of the imagination of clients. However, there is another sense in which the contemporary clients might be excluded from the mainstream if art therapists do not manage to enter the contemporary race for evidence of effectiveness. Mainstream evidence for art therapy is the concern of the next section.

figure seventy nine
Antony Gormley
'Field for the British Isles' (1993-1994).

figure eighty
Freida Kahlo
'Broken Spinal Column' (1944).

figure eighty one
Freida Kahlo
'The Suicide of Dorothy Hale' (1938-9).

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

Section Five: The Politics of Evidence Based Practice

ChapterEleven:

Gathering Evidence: Expansion of Art Therapy Research Strategy

This chapter contributes to the political discussion about a research strategy for the art therapy profession and the kind of evidence that will be gathered in order to demonstrate the effectiveness of its clinical practice. A sharp distinction is made between the ideological movement for Evidence Based Practice (EBP) and a more wide-ranging approach to research. Whilst I am strongly of the opinion that we need to avoid falling into doctrinaire aspects of the EBP movement, I advocate the importance of evidence of effectiveness couched in the language of a particular evidence-based discourse. Systematic studies of the effectiveness of our work can be produced, but these can only form a part of a much wider research strategy — one that does not eclipse discursive theory. Contemporary Health Policy is examined both in relation to its content and its political agenda.

Introduction

Some, although not all, art therapists might feel that entering into evidence-based practice is like accepting an invitation to dance with Dracula. I understand the reluctance; my own ambivalence about gathering evidence has had many twists and turns. The cartoon (*figure eighty two*) below was drawn in 1981 by a colleague Kevin Jones when I was working with him and Julia Gudjonson at Netherne Hospital in Surrey.

figure eighty-two

It was drawn after we had all been fooling around and mocking one of the psychiatrists who kept asking me about evidence for art therapy. Kevin Jones is now employed doing art therapy research using a randomised control trial (RCT), and I have begun the struggle to write *some* chapters like this one…

The word *gathering* has many meanings including a person summoning up their strength, harvesting crops from the land or an assembly of people who meet politically. All three meanings seem poetically pertinent to the sense in which arts therapists need to *gather* themselves.

It cannot have escaped the notice of many art therapists that the time for an expansion of evidence is upon us. The political pressures for systematic evidence that our therapeutic practice is effective is no longer something that it is possible to ignore. The tenets of Westminster, the market culture in health care and users rights movements have all driven the demand for clearer public evidence of effective practice and this trend is an international one.

The profession needs to both preserve and develop its traditionally descriptive and theoretical research, but its research strategy needs to *expand* to include the forms of empirical evidence of effectiveness currently being required of health care. *Gathering* systems are required by arts therapists for the national co-ordination of research and the collection of outcome results (where they exist). It would not be feasible or desirable for the professions to attempt a simple merging of the two main research strategies of qualitative and quantitative approaches (despite undoubted areas of overlap). A research strategy that gives attention to political direction will keep a weather eye on government health policies. It also involves co-operative efforts throughout the profession, the training organisations and research groups and liaison with other disciplines with wider experience of outcome research. However, it is important not to condense and confuse real economic pressures and moral arguments into false, apolitical ideas about what constitutes 'scientific' evidence. There is much skill and vision within the art therapy world, and I think we can undertake what needs to be done without quenching the fires of what first draws us to the work – our belief in the power of art and of relationship. However, I suspect that the attempt to invoke and maintain all of the elements for a successful research strategy will require acuteness and a sense of humour.

<u>The legislative politics behind some aspects of 'evidence-based policy'</u>

Aneurin Bevan, the Labour minister who was the architect of the nationalisation of health, is reputed to have gained the support of the Consultants and the Royal College of Medicine for a public system, against their GP colleagues, by 'choking their mouths with gold' (Widgery, 1988, p. 23). In fact Bevan was so generous in his concession to the medical hierarchy, the power of the medical profession within the NHS has remained almost unscathed until very recent times. Hence the scandal during June 1998 which greeted the revelations of very high infant mortality under the knives of three surgeons in Bristol and the news that the whistle blower anaesthetist had

had to flee to Australia. This case seems destined to focus the increasing public demands for more than professional self-regulation in medicine and other health care professions.

In a conference paper Eve Pringle (1996) gave an account of the legislative history of measures that have aimed in part at curbing this power of the medics. She describes how, in the 1970s, the Cochrane and Rothschild reports respectively set in motion questions about lack of evidence for many common treatments and questioned the political ability of the medical profession to determine the health needs of the nation. In 1983 the Griffiths report introduced the idea of general management for the NHS. In 1987 the Lords Select Committee on Science and Technology and the 1990 NHS Community Care Act focused the Conservative government's desire to resolve long-standing issues in NHS research and development. Thus notions of effectiveness and efficiency were firmly put on the agenda. It is important to note that efficiency generally implies 'cost efficiency' and this is different from 'efficacy'. The research emphasis upon effectiveness and efficiency was continued in the document *Research for Health* (Department of Health, 1993b). The Nursing organisations generally welcomed this research strategy (1993a) and they invited the Therapy organisations to join the discussion. Three therapy professions (speech and language, occupational therapy and physiotherapy) made a position statement in 1994.

Pringle shows that the motives behind many aspects of government policy in health care have been ideological. She points to the ways in which the former Conservative government was trying to take the initiative and alter the balance of power between professionals, managers and policy makers and suggests that many of the policy initiatives in research and development have followed a 'good housekeeping' philosophy. This last point for me, perhaps a bit wickedly, conjures up images of Margaret Thatcher and the economics of the corner shop; it helps me understand more clearly at least one strand of the push for evidence-based practice. However Pringle also indicates that there are motives for the research policies that appear to have a more pragmatic and a less ideological motive; these are escalating health care costs, limited budgets and the large-scale use of the NHS. The publication in 1996 of the *NHS Psychotherapy Services in England: Review of Strategic Policy* seems to fit into this last category.

The White Paper *The New NHS: Modern, Dependable* (1997) and the report *A First Class Service: Quality in the NHS* (1998) do not suggest a radical departure from what has been before but it seems that there are to be subtle shifts in emphasis. The proposal to introduce the policy of Clinical Governance is made in the second of these documents. Both propose an idea of

needs' assessment together with attempts to tackle unmet needs. The drive towards effectiveness is continuing but policy statements suggest that it will be coupled more carefully with notions of quality as opposed to economy alone. Research strategies are being linked to Health Improvement Programmes (HIP) and the National Institute for Clinical Excellence (NICE) is producing guidelines on clinical effectiveness and cost effectiveness for all parts of the NHS. It is impossible not to look at this list of abbreviations without a wry smile. It is clear that if art therapy is to develop it cannot evade the political implications that are heralded by these policies, nor in *some* respects would it wish to do so. An evidence-based National Service Framework for all major health care areas is being introduced. The *National Service Framework for Mental Health* was long awaited and it made national headlines on more than one occasion before it was published in September 1999. It pursues many previous agendas, setting standards for mental health promotion; access to services through primary care, effective services for those with severe mental illness, for carers and action intended to reduce suicides. There is a lot in the document to which art therapists can relate in socio-political terms (certainly at the level of the rhetoric). What is clear is that there continues to be a demand for standards based upon evidence and knowledge. What is new is the idea that health workers should have a level of cultural competence. This seems to mean that they are now institutionally obliged to be aware of the influence on health of those matters I discussed in chapter four that are often given the sanitised description of 'difference'. In fact the report was published in the wake of the Stephen Lawrence enquiry at a time when government minds were necessarily focussed upon what was described as 'institutional racism'.

The 1996 NHS Executive strategic policy document on psychotherapy indicates much of the political context in which we as art therapists find ourselves in relation to research in mental health. It defines effectiveness as 'clinical results in terms of reducing levels of mental ill health and improving people's functioning' (Parry and Richardson, 1996a, p.61). Although the definition is not daunting and is not beyond the scope of a well-established profession, it does indicate a very different framework for justification than that wide-ranging research perspective previously encompassed by the Arts Therapies Professions (Payne, 1993, Gilroy & Lee, 1995, Mcniff, 1998).

Definitions of research and science

Gilroy (1996, p. 57) usefully points to the ideological and narrow nature of what Goldner and Blisker (1995) insist are the 'rules' of evidence based practice (EBP) in psychiatry. Goldner and

Blisker were the first proponents of EBP in mental health. The 'rules' they outline are exclusively taken from quantitative methods; the need for explicit hypothesis, reliable and valid measures, randomly chosen subjects, statistical evaluation and blind experiments. On the surface these might appear to be straightforwardly scientific rules, but if applied too literally they would exclude the use of many fruitful scientific theories. Darwin's theory of evolution, for example, would appear to satisfy only the first rule. Science contains a huge spectrum of different philosophies and methods ranging from the strictly empirical to those that are strictly theoretical. Goldner and Blisker's rules, despite their token additional rule of specific and sensitive measures, would exclude many areas of knowledge from scientific enquiry, for example, the study of evolution, cosmology, anthropology, archaeology and surprisingly large areas of mathematics and physics. Significantly Goldner and Blisker's method does not allow for the testimony of clients. Although it would be problematic to have client opinion as the only measure of effectiveness, it would be unsatisfactory to have a method which did not have the capacity to consider them. The first documents about health care produced by the 1997 Labour Government highlighted the importance of investigating patient experience (1998, p. 67, paragraph, 4.5.7).

Scientific methods necessarily include the study of what happens through close observation and the proposal and testing of theories. It is not possible to remove the element of theory in favour of quantifiable data, although of course it is legitimate to show that theories involve assumptions. The history of science shows that different areas of human enquiry develop methods of investigation, which are appropriate to the subject matter. The discipline of physics has evolved from a system of experimentation. Mathematics derives new theorems from theoretical axioms and laws of deduction. The 'hard' sciences of physics and chemistry rely on repeatability as a way of testing proposals. The 'human' sciences cannot rely on this kind of replication for their development, yet in all disciplines there is a relationship between theory and practice and it is simply not possible to produce evidence that is divorced from theory and practice. The knowledge contained within disciplines such as psychotherapy and art therapy can be both protected and challenged when operating this liberal view of science. I would certainly echo Gilroy in saying that we are able to produce our own kind of evidence for art therapy, including the addition of systematic outcome measures without adopting the stricter ideology of some proponents of EBP. We do nevertheless need to expand our own evidence base and agree concepts by which we judge what constitutes good practice and then begin to *gather* information on a national scale.

Evidence-based practice?

Gilroy's article (1996) is useful because it describes the contemporary context in which we will be representing ourselves. I appreciate the humour of the article, because I think the humour wryly acknowledges the very human and irrational side of research and for me this makes it less daunting! Her example of Drs Green and Ross of ER fame plugging into their computer *Medline* (even mid-surgery) to check that their practice is indeed evidence-based touches quizzical anxieties about what on earth might be the art therapy equivalent. What do we plug *ourselves* into? Gilroy is unequivocal about the need to be plugged in.

It is important to distinguish between efficacy studies, studies of effectiveness and cost effectiveness measures. Efficacy studies commonly involve participation in randomised control trials (RCTs) and whereas these are seen by many as the gold standard of research methodology (Wessely, 1998) they pose many thorny problems for a discipline like ours. Seligman (December, 1995, p. 965-974), commenting on the American *Consumer Reports* (November 1995), makes a helpful distinction between efficacy studies and studies of effectiveness. Efficacy studies are linked to RCTs – they rarely reproduce the actual conditions of practice but they can provide sophisticated empirical validation that will be widely respected. Seligman points to the difficulties inherent in using RCTs for psychotherapy disciplines. In practice psychotherapy is not of *fixed duration,* it is *self correcting,* patients *actively seek it,* patients have *multiple problems* and it is concerned with *improvement in general functioning:* all five of these distinctions are actively evaded in designing an RCT. Studies of effectiveness on the other hand can provide large-scale empirical surveys but they do not have the same methodological rigour as RCTs. The *Consumer Reports* provides a study of the effectiveness of psychotherapy. 180,000 people completed the survey, 3,000of these answered multiple questions which seemed to determine the effectiveness of their psychotherapy experiences. However, the respondents are self-selecting and this is a methodological flaw. Seligman suggests that this study provides strong evidence that RCTs are not the right method for psychotherapy; he suggests on the basis of the report that a combination of efficacy and effectiveness studies would be more potent.

There are a small number of efficacy studies in art therapy involving the use of randomised control trials (RCTs); two in particular concern art therapy groups with people with serious mental disorders and art therapy work with people with dementia. The art therapist Kevin Jones was employed specifically to conduct the first of these with his colleagues at Lewisham and Guys Trust in London, and Diane Waller is conducting the second with colleagues

in Brighton (1999). However, the influence of the results from these two RCTs will be skewed unless they have the company of other art therapy control trials. A number would need to be performed before they could be seen as helpful to the profession's overall research strategy. There are also other pioneering initiatives about evidence for effectiveness in for example Birmingham, London, Norfolk and Wales. It will be interesting to see the results.

Psychosocial Intervention: an example of good evidence-based practice

This example of good practice is included as a cautionary tale against the profession glibly dismissing evidence-based work. I have been encouraged by my knowledge and experience of the psychosocial intervention work (PSI) that has been established (largely though not exclusively within an EBP framework) with people with a history of psychosis. This work has been established in the North West Tameside Mental Health Services (Manchester) with revolutionary consequences for the lives of seriously disturbed people. Examples of these revolutionary changes include the introduction a system of 'case loads for life' for those disciplines involved with people with serious mental disorders and the reversal of the focus of the mental health services in this part of Manchester. People there with a history of psychosis now receive the lion's share of mental health resources. This is very different from the short-term partial interventions that many mental health services have had to provide in the recent period and it gives an example of one of the positive motives Gilroy sees in EBP. 'Egalitarian, research-based debate versus received, authoritarian wisdom' (Gilroy, 1996 p. 56). It also gives a clear example of how good research can influence the lives of real people to good effect. Although it is unlikely that art therapists will attract the kind of large-scale funding and managerial control that has enabled the work in Tameside to happen, it would be folly not to applaud the very positive nature of such work as a result of philosophical differences. The creativity of the art therapy profession can meet the challenge posed by such developments, especially as many art therapists work with a similar range of clients to those being offered psychosocial intervention work. Co-operation in practice and research with initiatives like psychosocial intervention could be fruitful.

The '*Review*' and '*Our own kind of Evidence*'

The *NHS Psychotherapy Services in England: Review of Strategic Policy* (1996a) [from now referred to as the *Review* (Parry and Richardson, 1996a)] and the article by Andrea Gilroy *Our Own Kind of Evidence* (1996) both gave me initial reservations. I think that in part my reservations were based on the initial strangeness of thinking about art therapy within a

systematic research framework. I now think that they both suggest useful ideas about what is to be done.

Both documents take the form of a critical review of what currently exists; this is surprisingly helpful. They offer a political outline of existing policies and this is useful to the profession in making preparations to link with the evidence-based National Framework for Mental Health and the National Institute for Clinical Excellence (NICE).

The *NHS Psychotherapy Services in England: Summary of Strategic Policy* (1996b) [from now referred to as the *Summary* (Parry and Richardson, 1996b)] outlines the framework it uses in order to distinguish three different approaches to psychotherapeutic work, Types A, B and C. This is a method of trying to limit the confusion surrounding the use and proliferation of the term psychotherapy. Type A includes work which is not stand alone but integral to the work of a team. Type B includes eclectic approaches to psychotherapy and counselling and is stand alone work. Type C includes formal theoretically coherent approaches to psychotherapy and is always stand alone work (Parry and Richardson, 1996b, p. 3).

In the *Summary* (Parry and Richardson, 1996b, p. 6) it is stated that art therapists along with many other mental health service professionals increasingly provide all three forms of psychotherapy. Although it is stated that no hierarchy is intended between these types of psychotherapeutic work, I think it is cause for concern that on occasion in the *Review* (Parry and Richardson, 1996a, p. 74, paragraph, 5.3.7) (unlike their *Summary,* 1996b*)* the commentary could be read as implying that art therapists only provide Type A interventions. A letter replying to me (1997) from Anne Richardson, co-author of the report, confirmed that this implication about art therapists had not been the intention. However, it is clear that as a profession we have a lot of work to do in order to introduce more clarity to our therapeutic protocols and research work if we are to be in a position to rightfully claim the breadth of our work.

A reading of the *Review* (Parry and Richardson, 1996a) makes it abundantly clear that any research strategy for the demonstration of effectiveness needs to be embedded in the policy framework of the day. It is apparent that this document will influence policy and research in psychotherapy in the public sector for years to come.

Importance of co-operation

To develop concepts of good practice and to collate evidence of effectiveness requires wide co-operation between the professional association, the arts therapies board of the Council for Professions Supplementary to Medicine (CPSM) that is shortly to become the Health Professions

Council (HPC) and the training organisations and research groups. Parry and Richardson in the *Review* (1996a) stress that this kind of co-operation is central *(see figure eighty three, which is taken from their page 44).*

A group within BAAT with a specific brief of gathering and disseminating research would be excellent. This research group could benefit the profession in a number of ways: keeping up to date with policy initiatives and possibly identifying sources of funding. Funding can make the difference between research taking place or not.

The *Code of Ethics & Principles of Professional Practice* (CE &PPP) (BAAT, 1994) already indicates some of the ways the profession views good practice. It seems timely to expand the definitions given of these principles in order to develop a clearer framework for the *qualitative* aspects of our work. An expanded PPP could provide a guide to standards for clients, practitioners and employers. These standards could provide a fruitful basis for qualitative research.

It is a much more difficult proposition to provide a *quantitative* framework by which the profession can gather nationally co-ordinated audit and research measures. Criteria for measuring mental ill health and improvement through therapy are likely to be problematic to achieve and we will necessarily have to research as widely as possible into methods being tried by other psychological therapies if we are to gradually develop systems sensitive to art therapy.

Repeating research work produced by the wider psychological community that can already be used in some instances to demonstrate the effectiveness of what we do would be a bit like reinventing the wheel. The potential tensions in this 'borrowing' approach are well indicated by Jones in his discussion of the work of Roth and Fonagy:

> The authors argue that there is evidence for the importance of non-specific, pan-theoretical factors in causing change and improvement. They consider that the difference in effectiveness of therapies may lie in the differential way they allow common curative factors to come into operation rather that the extent to which specific factors are brought to bear. Indeed they argue the logical case for convergence of the various therapies. This might seem alarming to a profession that had recently achieved recognition of its autonomy and professionalisation through state registration (Jones, 1998, p. 76).

Jones continues quite provocatively in this vein suggesting that the logical outcome of the Roth and Fonagy approach might be to conclude that the specific factor of the art in art therapy could be deemed the 'common curative factor' as opposed to the adoption of any theoretical orientation. If this happened it could undermine a good deal of the therapeutic clarity that has been developing in the profession. It seems politically and professionally wise to develop

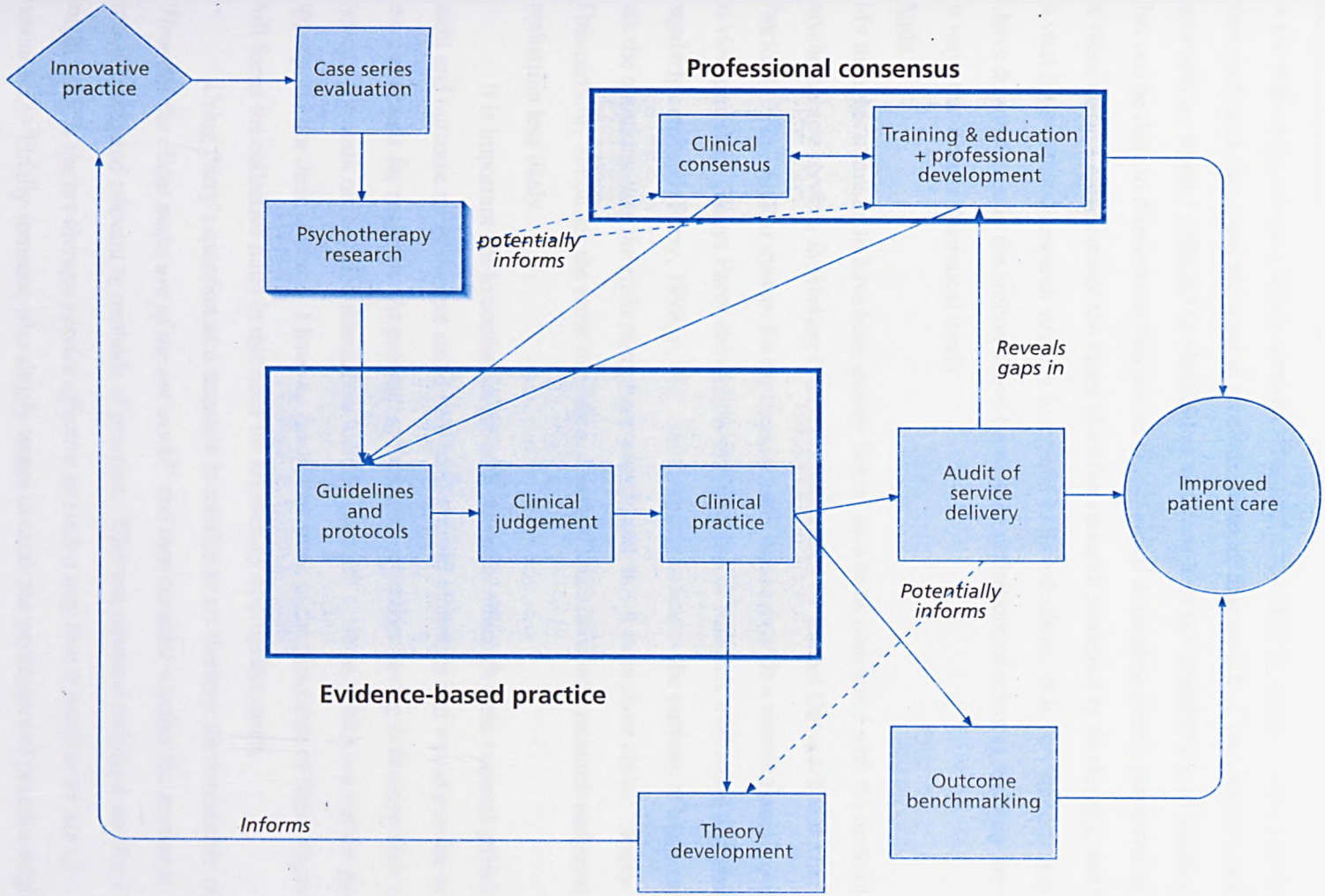


figure eighty three

methods over time that enable us to gather our own constellation of evidence that is art therapy specific.

How do we proceed?

In the following sections I briefly consider what might be meant by *audit, service evaluation, case study* and *client specific work* in an evidence-based framework. I also present some *census information*, which I collected in Sheffield as an example of the straightforward nature of work that can be done to demonstrate that our service is aimed at meeting clearly perceived needs. All of these matters move outside the range of earlier research strategies in art therapy, and I think it is vital for a national research strategy to expand to include them. It is very important (as I hope I have demonstrated in the section above concerning definitions of science) that they are not used in ways that eclipse theoretical work.

Audit

My thoughts about audit have been greatly helped by a book concerned with the audit of psychotherapy services *Rethinking Clinical Audit,* edited by Rachel Davenhill and Matthew Patrick (1998). A clear system for art therapy audit would provide a simple visor through which to view practice. Glenys Parry shows how the functions of research, evaluation and audit are regularly confused (Parry, 1998, p. 16). She famously indicates the purpose of audit as being to ask the questions *'has the right thing been done?'* and *'has it been done right?'* (Parry, 1996). This certainly simplifies the remit of audit and makes confusions with research and service evaluation less likely.

It is important not to confuse audit with research, although clear national guidelines for audit and outcome measurement could help hard-pressed clinicians and would provide an excellent *basis* for research. At present art therapists are either having to develop their own systems for audit or they find themselves included in audit systems, which are not the most appropriate for their practice. I have no doubt that some of the processes of State Registration will focus the collective mind in this need for art therapy appropriate audit.

Using Parry's question as a template in relation to art therapy: the *researcher* might ask: *'How did the client make use of the art work?'* and then consider whether the answer is generalisable and relevant to methods of practice. Whereas someone making a *service evaluation* might ask: *'Is the art therapy service effective in such a way that it justifies its use of resources?'* Finally someone who simply wants to *audit* the particulars of practice might ask questions of the following kind: *'Has art been introduced in the context of a therapeutic*

relationship [has the right thing been done]?' and *'Has this introduction of art in therapy been done appropriately [done right]?'* A complete audit of client work would involve a series of questions about each therapeutic relationship. Two examples might be:

- Has discrimination (on the grounds of race, class, sexual preference, gender, disability etc.) been avoided at the point of referral? [CE 3 & PPP 2] (British Association of Art Therapists, 1994).
- Has adequate preparation of the client been made before therapy began? [CE6, CE7, CE9] (British Association of Art Therapists, 1994).

Hopefully these examples make clear the way in which well conducted audit could provide a space for thinking about practice. In some instances it might produce the raw material of research although it is not research in and of itself. Audit can have a relatively straightforward purpose:

1. Defining standards for clinical care.
2. Comparing actual practice with these standards.
3. Implementing change to bring practice up to standard.
4. Repeating the cycle at appropriate intervals.

(Healy, 1998, p. 32).

How audit is introduced greatly determines its usefulness and the way it is perceived. Successfully introduced it can be a benign and useful tool, but on the other hand when it is not introduced well practitioners can experience it as a constant source of managerial criticism. Nevertheless a clear theme from the consultation process in the *Review* (Parry and Richardson, 1996a) is that: 'All psychotherapists should audit their work' (p.100).

The art therapist and trainer Niel Springham speaking at the BAAT AGM (1998) suggested that art therapists nationally joined the CORE audit and research initiative (CORE, 1997). Unusually this is a system, which actually does combine some of the audit functions with those of research. It is clear to use and it has economy of effort implied. The Leeds Research Unit where CORE is based, reported in a public lecture (1998) that art therapists are one of the largest professional groups outside psychology to respond to the initiative. This is encouraging because it suggests the extent to which art therapists nationally understand the need for such work. It is necessary to sound just one cautionary note; such initiatives require the delivery of our audit results to researchers outside the profession and this cannot be a full solution to our research profile.

Service evaluation and clinical governance

Service evaluation, in the light of clinical governance, is set to become much more common place. It involves considering the overall provision of a service in relation to perceived needs, effectiveness and current government policy. Audit procedures at the level of service evaluation are used generally in order to gauge a pattern of service delivery (as opposed to the details of therapeutic relationships and their individual outcomes). Such matters as relevance to geographical area, population and client group are considered, together with matters of equity, accessibility, acceptability, efficiency and effectiveness (Parry, 1996a, p.61, paragraph, 4.5).

Clinical governance is defined in the Government's document *A First Class Service: Quality in the new NHS* (1998):

> Clinical governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Department of Health, 1998).

The main elements of the implementation of clinical governance involve clear lines of accountability, quality improvement (as opposed to cost effectiveness alone) management of risk and remedies for poor performance. Although bland phrases describe each of these elements, it is not difficult to imagine their potential if mishandled, for creating persecutory anxiety in both NHS managers and their clinicians.

Certainly the dictum that 'the NHS Trust Chief Executive carries ultimate responsibility for assuring the quality of services provided by the Trust' (Department of Health, 1998, p. 36) will focus managerial minds upon monitoring structures that exist. It may not be easy to keep a sense of humour in the face of all this monitoring.

The functions of research, service evaluation and audit can become confused because their functions are connected. Yet within existing health policies, all three are matters to which we cannot fail to give attention. The government's chapter on clinical governance (Department of Health, 1998, p. 32) underlines this last point in showing the way the connections between research, professional regulation and quality standards are perceived in Department of Health 'circles'. Rhodri Huws a Consultant Psychiatrist in Sheffield has suggested (2000) that it will not be possible to even implement clinical governance policies without understanding the political agenda that they imply.

Case studies

Many aspects of case study can provide evidence of both a qualitative and a quantitative kind. For example, if it is the case that most art therapy clients have a high rate of continuing with their therapy sessions, this could be useful information to collect in order to demonstrate the quality of alliance made by an art therapist. A high rate of clients engaging in therapy would be particularly significant because the wide socio-economic range of clients using art therapy means that many have little if any prior knowledge of therapy (and to some extent the therapist will need to demystify the process of therapy for them). Also the developing literature of case study in edited compendiums by different practitioners can provide powerful qualitative evidence that demonstrates the differing use of theory and technique with different client groups. I think the recent book *Art Psychotherapy Groups: Between Pictures and Words* edited by Skaife and Huet (1998) falls into this category. Similarly the chapter by Killick and Greenwood (Gilroy & Lee, 1995, pp. 101-116) demonstrates the quality of theoretical work that can emerge from the case study method.

An interesting challenge to the widespread use of the narrative case study in both British and American Art Therapy training is made by Marcia L. Rosal writing in *The Arts in Psychotherapy* (1989). She would wish to propose the alternative use of a single case experimental design for training purposes. An example of a single case experimental design is one that would help the therapist demonstrate the outcome of therapeutic work. This would involve measures being made before and after therapy.

Rosal's paper poses serious questions and her comments might help all of us avoid some of the pitfalls of the narrative. On the other hand, narrative case studies can be of value to practitioners and trainees in developing their own styles of practice, something that single case study designs might circumnavigate. However, when I read some art therapy case studies (including my own) I am aware of the possibilities for greater clarity about theory and technique. This is echoed by a report written for the Mental Health Foundation:

> Mental health services for children and young people do not require high technology; they depend upon the capacity and capabilities of the people who look after and work with children. In reviewing services, it is most important to be able to describe accurately the work that is carried out by staff and the extent of their skills, experience and training (Kurtz, 1996, p. 49).

Greater clarity can develop from a number of different approaches to case study, including single case experimental research designs. Certainly Parry suggests that single case

studies can indicate whether innovative work is sufficiently promising to continue with more formal research (Parry, 1998, p.14).

Some of the expanded evidence for art therapy will develop as a result of asking different questions. For example, Robin Higgins, a medic who has considerable experience of contributing to the training of arts therapists writes, 'We need our intuitions of case study to set up hypotheses about which we can then be sceptical' (Higgins, 1993,p. 86). He shows very clearly how the use of case study in research is open to a range of methodological approaches (Higgins, 1996, pp. 58-68). He also demonstrate the elegance and the usefulness of the single-case research to case lore (Higgins, 1993, p. 98).

Specific client work

The idea of considering varying approaches in relation to the needs of specific client groups is in keeping with the contemporary push in psychotherapy research literature proposed in the book *What works for Whom? : A Critical Review of Psychotherapy Research* (1996) edited by Anthony Roth and Peter Fonagy. This book was commissioned by the Department of Health at the same time as the *Review* (Parry and Richardson, 1996a). It is a straightforward book to read, the two editors are respectively a research psychologist and a psychoanalyst, and this gives it an interesting perspective. It adopts an even-handed method for a consideration of the evidence *so far* about which particular psychological approaches have been shown to have a good effect with people with particular mental health difficulties. It tends to examine the evidence on a chapter-by-chapter basis of particular difficulties that have succumbed to particular therapeutic approaches. Examples include depression, bi-polar disorders, anxiety disorders, eating disorders, schizophrenia, personality disorders and alcohol dependency.

The evidence has been largely gathered according to the results of randomised control trials and the sobering truth is that as yet there is not any mention of the arts therapies as being an approach with a demonstrated effect for any of the difficulties. This is a bit worrying despite reassurances from the *Review* (Parry and Richardson, 1996a) which repeatedly points out that no evidence does not mean that an approach is not effective, it simply means that as yet an approach has not been investigated in a systematic way. It is hard to remain entirely cool about these reassurances, because we have seen in a small number of locations the political consequences of some managers being premature in their application of outcome research. This has resulted in a number of art therapy redundancies, hence my sense of urgent pragmatism in relation to gathering evidence.

The grouping of mental health difficulties in the manner of Roth and Fonagy makes me realise the use we can make of the groupings that have already taken place in art therapy for people with particular difficulties (e.g., work with people with eating disorders, in hospices, in prisons, with children and with people with a history of psychosis, etc.). However, I am mindful of the political dangers of competitive comparisons between disciplines (comparisons implied if not explicitly stated by *What works for Whom?).* Instead of a crude competitive stance we require 'research which seeks to distinguish between the suitability of varying approaches...to different situations and client groups' (Gilroy and Lee, 1995, p. 8). An economic policy wishing to cut public health and welfare spending might want the different professions placed in a competitive stance in relation to one another. Such a strategy would not serve the rhetoric of clinical governance that in large measure depends upon multidisciplinary co-operation. I think Jones is essentially correct in his assertion that because they are writing from 'the ahistorical framework of the empirical approach, Roth and Fonagy fundamentally accept current political assumptions about public spending' (Jones, 1998, p. 76). His review (Jones, 1998, p. 75-7) of their book is a helpful guide to the way in which it will almost certainly shape the political landscape of outcome research for psychotherapeutic disciplines for the foreseeable future. This is ironic given their apparently apolitical stance.

We will be well advised to keep the government policy initiatives in mind in relation to particular client groups when we are thinking about making a case for the work or designing outcome research. Our clients regularly give testimony to the help they have found in art therapy relationships and these could be recorded. In Wales the art therapist Richard Manners and his colleagues have introduced a system of triangulation into questionnaires that are intended to provide an indicator of the effectiveness of work with disabled people. This triangular system of questionnaire collects and compares information from clients, therapists, other members of the health care team and carers (Manners & Chatham, 1998). This approach fits well with policy statements made in *A First Class Service*: *Quality in the NHS* (Department of Health, 1998).

The wide socio-economic range of our clients

The art therapy profession has wide experience housed in its collective history of providing therapy for a range of clients, including sections of the population not ordinarily offered psychotherapeutic forms of help. There is a wealth of case studies that demonstrate that art therapists are not strangers to work with people who have been either seriously mentally disturbed or who face extreme poverty. Socio-economic circumstances are recognised as being

fundamental to health in industrial countries worldwide. It is extremely valuable to general efforts to improve health across the social spectrum that art therapists have so much experience of working with the psychological effects of deprivation

The range of client work encountered by the art therapy profession means that members of the profession have to have a wider social and political awareness than is commonly associated with psychotherapy. Government health policies (no matter of what persuasion) tend to give more priority to the very clients with whom art therapists work in the public sector. However, we need evidence that we work with the clients who have been prioritised, hence the importance of gathering the kind of information gleaned from census studies (Wood, 1996, see my chapter thirteen).

Census information is cited as useful in the *Review* (Parry and Richardson, 1996a, p. 59, paragraph 4.4.8) and it certainly fits in with the political agenda to address unmet need. Such census work would manifestly increase in its potency if it were part of a nationally co-ordinated strategy. Census information can provide evidence that arts therapists are addressing the political agenda to work with those most in need: it would manifestly increase in its potency if it were part of a nationally coordinated strategy.

Irrationality of some research motivation

Despite the potential benefits to art therapy clients that might result from well-conducted research it is important to remember that the world is not a rational place. It would be naive to assume that funding for additional posts will automatically follow favourable research findings. Funding tends to reflect existing power relations and ideologies. Well-researched socially useful projects do not automatically receive funding and political support.

The fear generated by market pressures in health care means that the motive for much health research is not well grounded. Indeed, in spite of the growth of the market culture in health care, it is remarkable that little research manages to show much that is relevant to cost efficiency (Krupnick and Pincus, 1992, Parry, 1992, Pringle 1996). This is really surprising and begs some interesting questions about what actually motivates such research. I am increasingly aware that there are some strangely irrational impulses involved.

Resistance to research and the difficulties facing practitioners who wish to engage it

I suspect that some of the resistance to evidence based research arises from the fear that it could mean that the approach to the work will become homogenised and lose its more vital connections with the art making process. A powerful paper by Patricia B. Allen was published in the *Art*

Therapy: Journal of the American Association in 1992. It espouses these fears and makes a good case against the over-clinification of art therapy. I personally acknowledge such fears but try not be ruled by them. In this country the art therapists Dave Edwards and Andrea Gilroy have written helpfully about different aspects of resistance to research (Edwards, 1993, Gilroy 1992).

The position statement issued jointly by three Therapy Professions on the research and development needs for their work is almost certainly one that the Art Therapy Profession would endorse. This is because it recommends the development of *career structures* and *funding systems* that recognise and support the development of research by clinicians themselves (College of Speech and Language Therapists, College of Occupational Therapists, College of Physiotherapists, 1994). Without such structures many professions (not only our own) will be seriously disadvantaged in comparison to those professions that have research as an integral part of the work (e.g. medicine and psychology). There is not, as many people have pointed out, a level playing field.

A cautionary tale is provided by the Bristol Cancer Centre where clinicians themselves were not involved in its research. The research reported, with much national publicity, that women with breast cancer who went to the Bristol Cancer Centre were twice as likely to die as women who did not. Even though the findings were later retracted (the data had been analysed inappropriately) the damage had been done. In retrospect the people who had invited in the medical researchers realised that because they had so little research experience themselves they had been forced to trust the researchers blindly (Fitter, 1997, p. 614).

Finally one difficulty created by resistance to research is that repeatedly referred to in the outcome literature and that is the conundrum of how to ensure that the results of research are appropriately disseminated and applied to practice. It is generally not enough apparently to publish the results! This is another reason for suggesting our development of systems for gathering and disseminating research.

<u>The art of practice</u>

I think that fears about what may be lost in the process of research work are concerned with the knowledge that clinical work depends upon the art of practice. Therapy in all its many forms depends upon the capacity to bring to life the relationship between therapist and client. There is much evidence to suggest that the particular qualities of the individual therapist and the quality of the therapeutic alliance, no matter what form or 'brand' of therapy they employ, are amongst the most influential elements in ensuring the positive outcome of a therapeutic relationship. Reviews

of more than 100 studies concerned with the significance of alliance completed in the last two decades have been made by Gaston (1990) Horvarth and Symonds (1991) and Horvarth et al (1993). That so much in psychotherapy depends upon human qualities does not mean; however, that it should not be subject to scrutiny of a certain 'scientific' kind.

Conclusion

The profession has always ensured that art therapy remains within the provisions of the public sector through a combination of establishing clinical credibility amongst colleagues, espousing the benefits of art making, wider public relations and political lobbying. All of these strategies will continue to be necessary, whether or not the profession's co-ordinated efforts to *gather* itself, and its research demonstrate that this old and even ancient way of working is indeed miraculous. I suspect it will because we have a rich crop to gather.

Chapter Twelve:

Existing Evidence for the Work of Art Therapists with People with Serious Mental Disorders

This chapter continues the discussion about the kind of evidence needed by the art therapy profession to demonstrate the effectiveness of its clinical practice. In the previous chapter I indicated that the development of a research strategy for the profession will require good art, good science, political acumen and humour.

Understandably there is some reluctance in the profession to engage with evidence of effectiveness but the development of a political position in relation to research (no less than in other areas) is in the interests of art therapy clients. It may also be in the interests of the creation of more posts in the longer term.

I have already suggested that it would not be feasible or desirable to attempt a *simple* merging of the two main research strategies of qualitative and quantitative approaches. However, it is important to tolerate differences of research approach. There is a rich diversity of possible strategies. Here I consider existing research concerning evidence for art therapy work with disturbed clients. At this stage in common with most other health care professions, evidence of effectiveness is slender. This is something commented upon by numerous papers at the two evidence based practice Norfolk conferences for therapists working in mental health (1997 and 1999). It is pertinent to reiterate the point that a lack of evidence does not mean that it is not possible to produce it. At this stage it simply means that research has not been undertaken. One keynote speaker in Norfolk Dr Marie Donaghy (1999) suggested that it is likely to take some ten to twenty years to produce a level of evidence-based practice in the whole range of health care professions working in mental health. However, it would be dishonest to imply that it is a simple matter to produce research. This is not only because of the political and economic reasons that I have been discussing but also because there are a number of tensions that are inherent in the attempt to produce systematic accounts of clinical effectiveness in a profession like art therapy.

Art therapy practice with seriously mentally disordered clients

Art therapists have a consistent history since the end of the Second World War of offering therapy to people who experience psychotic episodes. They have been unusual amongst those professionals offering psychotherapy in attempting to create the circumstances for this work within public sector services. The history of art therapy and psychosis is not well documented

but it is possible to see what has been recorded in order to think about and plan for development in the future. There has been a range of approaches developed by art therapists for this particular client group during the three periods of the profession's history. These approaches have adopted differing approaches to transference in ways described by Schaverien (1994). The table offered by Schaverien to illustrate these differences is as follows.

Transference in Different Forms of Art Therapy

	Art Therapy	Art Psychotherapy	Analytic Art Psychotherapy
The Real Relationship			
The Therapeutic Relationship			
Transference Interpretations			
Scapegoat Transference			

Table 8: Depicting 'Applications of the therapeutic relationship in different forms of Art therapy' (Schaverien, 1994, p. 43).

Schaverien explains the table.

> In art therapy this is transference to the picture and it may, or may not be linked to traditional psychoanalytic transference. It is an engagement, in the picture, by the patient/artist. Movement and insight may be generated through a relation to the art object. The... diagram may help to clarify the distinctions I am attempting to make. I am suggesting that these aspects of the therapeutic relationship play different roles in various forms of therapy. As with all linear representations the boundaries are, in practice, not as clearly defined as a diagram might suggest. In fact these categories may blend into each other and overlap.
>
> In the diagram... we see that in Art Therapy, in the first column, and Art Psychotherapy, in the second column, one of the categories is missing. In the third column, all the elements come together in Analytic Art Psychotherapy (Schaverien, 1994, p. 43).

Table 8 outlines Schaverien's schema. Here it is seen that there is less likelihood of acknowledging transference in the approach of art therapy as she defines it. Similarly, with the approach of art psychotherapy the possibility of scapegoat transference to the image is absorbed into the transference relationship. This is very interesting because much of the history of psychoanalytically inclined work with people with a history of psychosis involved and continues to involve debate concerning the question of whether or not to acknowledge transference (see chapter three).

On different occasions any of the approaches in Schaverien's schema might be adopted for work with individuals or groups of people who are seriously mentally disturbed. However,

in most public sector circumstances some long-term supportive version of art therapy or art psychotherapy would be the most appropriate. I can assert this from the length of my clinical experience and this has some validity but it is not sufficient. It is necessary to do more to demonstrate the validity of this opinion in order to serve the rules of evidence currently being required by systems for evidence of effectiveness.

In chapter two I described the history of art therapy in relation to this client group as having three main periods of development. Firstly, there is the time between the late 1930s and the end of the 1950s when the first ideas about using art as a therapy in hospital settings began to emerge. Secondly, the period between the early 1960s and the late 1970s when in the wake of the creation of British Association of Art Therapists (BAAT) many art therapists found themselves allied to the anti-psychiatry movement and to humanistic schools of therapeutic thought. Finally, the third period which had its beginnings in the early 1980s and continued through the 1990s, is a period when art therapists lived through many changes in public sector legislation, the increasing professionalism of their work and a more obvious linking of it to models from psychoanalysis, psychotherapy and group process.

In chapter two I propose that although there are many areas of overlap, essentially the clinical practice of the three historical periods can be seen in the first as upholding the power of expression, as taking an anti-psychiatric stance in the second and as strengthening a psychotherapeutic base in the third. I also indicate that when clients have a history of psychosis it is sometimes particularly difficult to find evidence of just how the therapist behaves and that this is true of a good deal of general clinical literature about therapy by all disciplines with this client group. I think that there are a number of reasons for this omission; previous generations used much less defined ways of describing practice, they had a more generic approach and they were not being pressed by government's worldwide for demonstrations of effectiveness. I also think that there is a difficulty in describing this particular work because it involves thinking about strange qualities of mental life. Nevertheless in the contemporary period more clarity about the nature of such work is emerging.

During the last twenty years of the twentieth century the number of British books about the practice of art therapy increased dramatically. Throughout the 1990s publications became more numerous and quite a number contained material that addressed art therapy practice with seriously mentally disordered clients.

In 1990 Marion Liebmann edited *Art Therapy in Practice*. This is a collection of chapters. It includes a section on working with people who have manic-depressive disorders by Thornton and another on the use of art therapy in community based rehabilitation by Lewis. In 1991 *The Revealing Image* by Joy Schaverien used the whole text to explore a theoretical account of art therapy practice and some parts of this account concern practice with disturbed processes. Two handbooks of art therapy (Case and Dalley) and (Waller and Gilroy) appeared in 1992. They were both jointly written books with particular sections dedicated to referenced art therapy work with the most disturbed clients. In 1995 *Art and Music Therapy and Research* jointly edited by the art therapist Gilroy and the music therapist Lee. One of the chapters of this book focussed upon research about art therapy for people with a history of psychosis (Killick and Greenwood).

In 1997 a full book was dedicated to situating theory and practice with disturbed clients. This was *Art, Psychotherapy and Psychosis* a collection of papers edited by Joy Schaverien and Katherine Killick. The following year in 1998 Sally Skaife and Val Huet edited *Art Psychotherapy Groups: Between Pictures and Words.* This is also a collection of papers including four concerning groups for the mentally disordered clients by Nicholas Sarra, Sarah Decco, Angela Byers and Jane Saotome.

The Journal of the British Association of Art Therapists *Inscape* began to referee its articles during the 1990s. However, in the 1980s three seminal papers concerning practice with clients with disturbed processes appeared. These three are often cited. Firstly, Molloy's paper in 1984 concerned the philosophical collision between the psychiatric rehabilitative practices of the period and art therapy. In 1987 and 1988 there were two jointly written papers by the art therapist Helen Greenwood and the community psychiatrist Geoff Layton. These papers 'An Out-patient Art Therapy Group' (1987) and 'Taking the Piss' (1988) were of a very high standard in their attempt to marry the concerns of psychoanalytically orientated art psychotherapy with the challenges of community psychiatry.

More papers concerning work with this client group appeared in the 1990s. Greenwood's paper 'Cracked Pots: Art Therapy and Psychosis' (1994) continued to meet the challenges of art psychotherapeutic practice within the context of psychiatry. In addition a small number of papers began to find their way into journals with a wider audience than the one made up of the art therapy profession. Katherine Killick's paper 'Working with Psychotic Processes in Art Therapy' published in *Psychoanalytic Psychotherapy* (1993) is the most

celebrated of these. In the pages of *Inscape* papers dedicated to work with psychotic processes continued throughout the 1990s. These were by Killick in (1991) Wood (1991) Crane (1996) Huet (1997) Wood (1997) and Evans (1998).

A number of features of theory, practice and philosophy are emerging in these publications as being common (or at least appropriate) to art therapy work with seriously mentally disordered clients. My impression is that these features include the following:

a) a belief in the feasibility of a therapeutic relationship even with disturbed clients

b) a ***supportive*** psychotherapeutic approach regularly being seen as appropriate for work with this client group in the public sector

c) a respect for the human value of people in the midst of psychosis

d) recognition of the alienating consequences (personal and social) of such conditions

e) the need for someone in the midst of psychosis to be able to make sense of what is happening to them ***while acknowledging the serious possibility for disruption in the person's capacity for symbolic functioning (including for example, the theoretical concept of symbolic equation and the notion of attacks on linking)***

f) the ***containing*** nature of the art making process and its inherent potential for making meaning even in the face of serious disturbance

g) the need for clear boundaries and a stable environment (within the relationship and the physical environment)

h) a repertoire of possible group approaches

These features strongly suggest the history from which art therapy has emerged. They indicate that the practice has lines of lineage in both the moral treatment philosophies of the early nineteenth century and the social psychiatry movement following the Second World War in the twentieth century. They also suggest the extent to which art therapy practitioners have pushed against the mainstream psychiatric tide which tended in the later part of the twentieth century to negate the possibility or usefulness of helping seriously mentally disordered clients make sense of their condition. The position of mainstream practice is complicated, both progress, and backward tendencies in treatment are due in part to advances in neuroleptic medication but also due in part to clusters of socio-economic factors.

In their article concerning research about art therapy with people in the midst of psychotic episodes, Killick and Greenwood summarise the technical elements of their work in the following way:

- The therapist aims to foster the evolution of a language for the patient, within the art process, of structures which initially mediate between concrete and symbolic ways of thinking, and which can serve increasingly symbolic purposes in the relationship.
- Clear, dynamically structured and maintained boundaries establish and maintain the fact of relationship between therapist and patient/group. These facilitate strengthening of psychological boundaries and the growth of intrapsychic structures. Negotiation of rules and boundaries offer significant points of therapeutic contact in the relationship.
- The therapist responds to formal aspects of the patient's relating, suspending references to content and meaning, until symbolising functions enable the patient to experience interpretation *as* interpretation. At times, the focus may need to be entirely on the concrete aspects of the relationship, the art materials, and the physical environment.
- Projected material is contained within the relationship, in the art process and the counter transference, and held until the patient has developed sufficient ego strength to assimilate that, which has been projected.
- Within the boundaries of the relationship, ego-strengthening opportunities for experimentation, exploration and creative play with the experiences offered are maximised.

(Killick and Greenwood, 1995, p. 114).

The particular nature of art therapy work with disturbed processes is certainly being clarified by such texts, **but** there remains a need to show more precisely the extent and hopefully the effectiveness of the art therapy contribution to this area of mental health practice.

The forensic psychiatrist and analyst Christopher Cordess spells out the *zeitgeist* in healthcare when he reviews the book *Art, Psychotherapy and Psychosis* (Killick and Schaverien, 1997).

> This is a well edited-volume containing a range of diverse riches. To quote the authors: "It seemed to us that this book was waiting to be written". I recommend it to libraries, but even more for personal acquisition since it is a book to which one will return.
>
> Is it too much to hope that in a few years time along with the practice of other psychodynamic psychotherapies in the treatment and management of psychosis, a book with a title like *Compelling Evidence for the Effective Art Therapy Treatment of Psychosis* will also be waiting to be written (Cordess, 1998, p. 75).

Census studies

We might begin by simply demonstrating that we do indeed work with some of the most disturbed clients, because there are a number of historical examples of diagnosis being challenged when clinicians claim that they are working with people with a history of psychosis. This seemed to happen to R. D. Laing whenever he made claims for a good outcome, but it also happens to less famous practitioners. It should be possible to demonstrate irrefutably that art

therapists are involved in this area of practice. I became aware of the need for this at the 1997 *International Conference for the Psychotherapy of Psychosis* (ISPS) when I heard significant numbers of analysts and psychoanalytically inclined psychotherapists acknowledge that they have very little face-to-face experience of working with those in the midst of psychosis, although they regularly write and discuss the work. In contrast to this the majority of art therapists working with adults, do a significant amount of work with people who experience psychosis, but this pattern of work is still something the profession needs to demonstrate empirically.

With this in mind and with the agreement and help of two health service managers and those art therapists with whom I work in adult psychiatry in Sheffield, I used a nationally determined set of criteria in order to conduct a census of the caseloads of the art therapists (Wood, 1996). The results were very interesting because they provided information about the social, economic circumstances and diagnosis of all the clients on the caseloads of five part time art therapists.

Clearly, the sample for this census was small (99 clients) and, whereas I am confident that regional and national surveys would show a similar picture, I think it would be useful for the art therapy profession to demonstrate this. National and regional census studies would greatly increase the potency of the information provided. The census results are included in chapter thirteen. The government organisation NICE is currently considering (2000) the possibility of supporting the conduction of a similar census survey on a national basis.

Existing evidence about art therapy for the seriously mentally disordered

I have used a range of databases to search for literature that may be relevant to the question about the existing 'evidence' for the use of art therapy for people with serious mental disorders. Primarily this has involved using *PsycLit* an electronic compilation of the international literature on psychology and related fields. *PsycLit* covers the period from 1887 to the present day, it includes 1,400 professional journals and works from fifty countries. The disciplines seen as related to psychology by the database include (amongst others) sociology, linguistics, medicine, physiology and anthropology. It is clear that British publications about art therapy are rarely included, whereas a small though significant number of American publications about art therapy are included. This is interesting and it may be partly explained by a differing American approach to questions of evidence. However, this is not easy to demonstrate because the subject matter of the American literature that is included is similar to literature in Britain.

I used the following search words for *PsycLit* with the following results.

Art therapy and psychosis	66 references
Art therapy and schizophrenia	82 references
Art Therapy and long term groups	1 reference
Art therapy and effectiveness	52 references

Table 9: *PsycLit*

The search phrase 'art therapy and psychosis' was not calculated to produce quantifiable information. Psychosis is the term that tends to be used by the psychotherapeutic community to describe the full range of severe mental disorders, very generally its use will indicate a bias towards approaches which are concerned with enabling the client to make sense of their experience. Although the abstracts for the list of 66 references produced by *PsycLit* in this category contain some very interesting papers none have used experimental designs or controlled trials. Most are theoretical, discursive and based upon case material. They are concerned with describing the psychotherapeutic processes of art therapy with disturbed clients. A significant number discuss the effect of psychosis upon a person's capacity to symbolise and the contribution that art therapy might make to enhance that capacity. Only three of the papers cited are British all by Killick (1993, 1995 and 1997), and only one book is cited which is British, this is a collection edited by Ellwood (1995). *Inscape: The Journal of the British Association of Art Therapists* is clearly not one of the sources for *PsycLit.* The majority of cited papers are published in America, although there is small but significant number included from Europe.

I thought that the search phrase 'art therapy and schizophrenia' would be more likely to produce more empirical or outcome research papers and this was the case. However, the number of papers that had either an experimental design or an empirical element was small. One paper by Nancy Young (1975) included a control study but it involved the participation of only 30 patients and the nature of the control group was not made clear. Most papers in this search were based on case material and discussion.

The one paper concerned with 'art therapy and long-term groups' is British (Saotome, 1998). I have not suddenly taken a turn for nationalism in this counting of British papers included in international databases but it is clear that British art therapists need to address this lack of inclusion if their work is not to remain invisible. Clearly there is much strength in the British tradition and it has resulted in regulated terms and conditions for art therapists that are

internationally envied, but the nature of British practice is not being publicised enough. The wealth of literature concerning work with people with serious mental disorders that is included in the appendix to this chapter is largely unknown outside Britain. The exception to this is the work by Killick (1993, 1995, 1997). The mixed nature of the American and European literature that is included (both qualitative and quantitative) strongly suggests that in part the problem for British literature is one of publicity. There seem to be a cluster of causes for the absence of British literature; comparisons with the literature from other countries suggest the explanation is not due to the small amount of literature concerned with outcome and effectiveness.

The phrase 'art therapy and effectiveness' produced quite a high number of citations in *PsycLit* and the dates of these papers suggests that there is a contemporary concern with the production of evidence of effectiveness. This list of citations shows no control trials, two single experimental case-study design, some forms of pre and post therapy testing and some internationally recognised measures. However, the majority of these papers still simply assert effectiveness. If a larger British sample had been included the level of assertion and statement of belief would have been similar. It seems that even in America, which is often portrayed has having a more empirically based research tradition in art therapy, a paper in 1995 by Terry Tibbetts describes similar concerns to those experienced in Britain in the year 2000. The title of his paper indicates how close the comparison might be, 'Art Therapy at the Crossroads: Art and Science' (Tibbetts, 1995).

A search of the *Medline* the database produced by the US National Library of Medicine makes it possible to search a vast range of medically related topics gathered since 1966. The database uses 3,600 journals and other sources including a range from biology, physical sciences, information technology and the humanities. The physical aspect of serious mental disorders makes the inclusion of some form of medical search appropriate. I used *Medline* with the same search words and had the indicated results.

Art therapy and psychosis	0 references
Art therapy and schizophrenia	21 references
Art Therapy and long term groups	0 reference
Art therapy and effectiveness	0 references

Table 10: *Medline*

The majority of papers cited by *Medline* on art therapy date from before the 1990s (two were published in the 1990s). Although no RCTs are included, those papers that are included have a higher level of experimental design than is common in the papers in *PsycLit.* This may suggest a general historical shift within *Medline* toward systematic study during the 1990s, and this may tend to exclude future art therapy studies from *Medline.*

The National research Register (NRR) is a register of ongoing and recently completed research projects funded by, or of interest to, the United Kingdom's National Health Service. In February 2000 the register contains information on 53,000 research projects plus entries from the Medical Research Council's Clinical Trials register and details on reviews in progress collected by the NHS Centre for Reviews and Dissemination. My use of *The National research Register* (NRR) did not respond to the four categories used in the tables 9 and 10 above, so simply the phrase 'art therapy' was used as a method of searching.

This produced imprecise results and initially suggested that there were eight ongoing projects and eleven completed research projects concerning art therapy. In fact the list of ongoing projects contained only five related to art therapy. A survey in Scotland by the art therapist Michael Hennessy (1998 ongoing) may have some relevance to work with people with severe mental disorders when it is complete. The list of completed projects contained one project that had been listed three times and five that were unrelated to art therapy. This left only four of the eleven that were actually related to art therapy. Of these four, two may have relevance to art therapy with people with severe mental disorders, but, despite being included in this list for completed projects, neither is yet completed. One of these is being conducted by the art therapist Martin Cody and the other by the psychologist and psychoanalyst Professor Richardson (at the Tavistock Clinic) with the art therapist Kevin Jones.

Another significant database is the *Cochrane Systematic Studies* Library. It aims because of Health Service recommendations in the 1970s to 'prepare, maintain and disseminate systematic reviews of the effects of health care' (*Cochrane Systematic Studies* database). Perhaps it is not actually surprising (although cause for concern) that as yet art therapy does not even appear as a phrase cited anywhere in the four international databases contained under the umbrella of *Cochrane Systematic Studies*. These four data collections include updated reviews of research, abstracts of reviews of effectiveness, a database for systematic methodologies and a bibliography of over 100,000 controlled trials.

Finally, I moved to a psychoanalytic database and bravely tried the four search phrases with the following results.

Art therapy and psychosis	1 references
Art therapy and schizophrenia	3 references
Art Therapy and long term groups	0 reference
Art therapy and effectiveness	0 references

Table11: *The PEP Archive* (1920-1997)

The *PEP Archive* contains an astonishing collection of the full text of six psychoanalytic journals, including all of those published since 1920. This represents some 29,000 articles and maybe four million words. The journals included are as follows.

- Contemporary Psychoanalysis
- The International Journal of Psycho-analysis
- The International Review of Psycho-analysis
- The Journal of the American Psychoanalytic association
- The Psychoanalytic Quarterly
- The Psychoanalytic Study of the Child

The database enables endless possibilities for reference and cross-reference so it is disappointing that of the four paltry references produced by my search, none actually referred to art therapy. Nevertheless there is a wealth of material in *PEP Archive* much with obvious relevance to art therapy theory and practice but the frame of reference for psychoanalysis is simply not that of a public sector service, and it is unlikely that it will enter into producing evidence of effectiveness on anything but a small scale. A search of the word 'effectiveness' did produce some 1,223 references but many of these were concerned with the effectiveness of ego-defences. A search of the phrase 'effectiveness and schizophrenia' produced ten references dating from a paper by Fenichel in 1934 to a paper by Willick in 1990 which is critical of psychoanalysis in this area of practice. 'Evidence of effectiveness' produced fifty-eight citations but many of the papers indicated used phrases like 'I believe' or 'it is my opinion'. One of those cited, a paper by Aldrich in 1971 indicates disgruntlement at the success of psychoanalysis in the field of American psychiatry, 'in spite of rather meagre tangible evidence of its effectiveness' (Aldrich, 1971, p. 141). With this greeting for psychoanalysis it is not difficult to imagine the reception for the country cousin of art therapy.

It is worth noting that in contrast to my art therapy search phrases, a search of the *PEP Archive* using the phrase 'art and psychosis' produced forty-eight-citations. This list began with a paper of 1920 by Ferenczi (the psychoanalytic unorthodox) and ended with one by the feminist art critic Griselda Pollock (1994). Her paper considers the nature of the cultural icon that Van Gogh came to represent, 'the poor guy who slashed his ear and committed suicide in loveless poverty' (Pollock, 1994, p. 804).

A number of references I tried to find because of information from ongoing research being conducted by Richardson and Jones (1997) concerned three randomised controlled trials of art therapy seriously mentally disordered clients. Two of these controlled studies were not picked up by any of the search phrases I had been using. I was only able to access literature about them by using the names of the authors provided by the pilot study of Richardson and Jones. This demonstrates the trickiness of learning to use search tools on databases and the need to try a large number of search strategies.

The three control trial studies include one I did find by Tibbetts and Stone (1990) and the two I did not find by Borchers (1985) and Green, Wehling and Talsky (1987). In one sense, these studies although flawed in terms of their controls and design are groundbreaking for art therapy work with this client group because they make the first attempts to systematise research in this area. Unfortunately all three studies use statistically small numbers of clients; Tibbetts and Stone use 20, Green, Wehling and Talsky use 28 clients and Borchers uses 24 and this makes the claims of all three for improvement less robust.

The literature and research that exists in Britain is within a theoretical discursive tradition. Small projects like my census (Wood, 1996) may have been undertaken but they have not been collected or published. There is also likely to be evidence worth gathering and reporting from Art Therapy MA studies. A general list of research was compiled by Gilroy and then reproduced by Payne (1993) but it did not distinguish between qualitative and quantitative work. However, the production of systematic research evidence seems to be problematic for art therapy internationally. In Britain there is an additional issue in that even those data bases that have a remit which is wider than the RCT (e.g., *PsycLit* and *Medline*) have not included British Literature. This remains the case for the papers of the British Journal of Art therapy *Inscape;* in a small search of the latest *PsycLit* (1998-99) showed that an increasing number of British books and their chapters are being included (Skaife and Huet, 1998; Waller and Mahoney, 1999; Rees, 1999). In contrast to this it seems that the criteria for Medline changed during the

1990s, there are generally fewer art therapy references and discursive art therapy literature is much less frequently included. The situation regarding inclusion is not stable.

For databases like the *Cochrane Systematic Studies*, only experimental, empirical works largely in the form of randomised control trials are likely to be included. It remains to be seen what the remit of the National Institute of Clinical Evidence *Nice* will consider for inclusion. However, the *Mental Health Framework* (1999) shows that the requirement for evidence of effectiveness is going to continue and is being designated as 'modern', if not moral and 'new'.

Interestingly there have been three papers in the American journal *Art Therapy* concerning the relatively small appearance of American art therapy in major databases. The first of these appeared in 1983 (Anderson) and it specifically concerned searches made about arts and the 'handicapped'. Two major databases of the time **ERIC** and the *Psychological Abstracts Information Services* were used together with the *Education Index,* the *Music Therapy Index* and the *Art Index* but only a total of 50 references were found by combining the disciplines of art, music and drama therapy. The suggestion is made (already in 1983) that in order to expand knowledge of the arts therapies literature there is a need to use additional research methodologies to the traditional case study. The other two papers produced much later but in the same year and volume (Vol. 13, (2), 1996) and they focussed on literature concerned with (visual) art therapy. The paper by Zeigler and Hays (p. 91-95) surveyed literature between 1983 and 1993 with the idea of discovering the writings of registered art therapists (presumably registered in America). Seven databases were used CINAHL, ERIC, HEALT, MedLine, PsycLit, SPORT Discuss and Wilson Social Sciences Index to show that twice as many articles authored by individuals other than registered art therapists were included in these databases. The concomitant implications are discussed with the suggestion that representation of the discipline is being compromised. The paper by Malchiodi (p. 86-7) is based on the one by Zeigler and Hayes, but it specifically addresses why the American journal *Art Therapy* is not covered by some standard databases and suggests ways of making the literature more accessible.

These three American papers support my impression that although this lack of visibility may be related to the small amount of outcome research internationally this is not the full explanation for the generally low profile of art therapy on the major databases. Some of the explanation must be connected internationally to the discipline's gradual development in

academic terms as well as to the dawning awareness that it needs to expand its research strategies. A part of the discipline's lack of visibility is likely to be due to its relatively small power base compared with disciplines like psychiatry, nursing and psychology. These older more established disciplines also have longer traditions of empirical research. In contrast to strategies that suggest interdisciplinary rivalry it would seem fruitful for art therapists to forge collaborative relationships with other disciplines over research.

Other evidence pertinent to art therapy practice with these clients

Having unsuccessfully used *Cochrane Systematic Studies* for art therapy citations (using 'art therapy' and 'arts therapies') I tried again by using 'psychotherapy'. This produced just forty-eight citations but even these included many examples of approaches only tenuously connected to psychotherapy. For example, one contained a study of ECT and a number were exclusively concerned with the use of medication.

I did find two pertinent studies in *Cochrane Systematic Studies* by looking at a grouping of studies of Schizophrenia. One of these was concerned with the evidence for 'Assertive Community Treatment for those with Severe Mental Disorder' (Marshall and Lockwood, 1999). Another a Finnish protocol is reported as intending to overview controlled-studies of individual psychodynamic psychotherapy or psychoanalysis for people with schizophrenia or severe mental illness (Malmberg, Fenton, Juvonen and Stacey, 1999). This will clearly be of relevance and real interest to art therapists. It may even become a study that can be used to support aspects of art therapy practice with these clients. Indeed there may be many studies of psychological research that can be used in this way. However, as yet although evidence in relation to early intervention (numerous Scandinavian studies) and cognitive behavioural work (CBT) with these clients is accumulating, substantial evidence for psychological intervention by any discipline has not been systematically produced.

There is collected evidence in *What Works for Whom* (Roth and Fonagy, 1996) that is contained in the specific chapter on schizophrenia and in the book's concluding chapter. It recommends: a combination of drug treatment and therapy, family intervention and maintenance work. The contra-indications suggested include 'expressive psychotherapy', although the term is not clearly defined and there is no discussion or evidence provided about the difference supportive styles might make to 'expressive' work. Yet it is clear that there is quite a large body of literature concerned with supportive styles of work for these clients. Short-term work is also contra-indicated. It seems legitimate to pose some questions about trials quoted by Roth

and Fonagy because the numbers of patients involved in the trials that recommend CBT alone were low. Other legitimate questions might be asked about the apparent omission of evidence for group work for these clients.

Group psychotherapy of psychoses?

A search of a selection of databases produced in the region of 10,000 references for the phrase 'groups and schizophrenia'. A cursory examination of these quickly showed that they were not all relevant. However, a large number were. For example, a paper from 1970 (Karon and VandenBos) makes a controlled study of issues at the heart of group practice with disturbed clients in a psychiatric setting. Thirty-six patients were divided into three treatment groups:

1. routine treatment of medication and supportive therapy at a public hospital (controls)
2. psychoanalytic therapy of the active variety without medication
3. ego-analytic psychoanalytic therapy using medication adjunctively

The results suggested that the patients treated by experienced therapists were hospitalised for less time, showed less thought disorder and functioned at healthier levels than did controls. Those patients treated by less experienced therapists not using medication were hospitalised longer but showed greater improvement in their thought disorder: whereas medication and inexperience produced the opposite results. It is not altogether clear how the term 'psychoanalytic' in this study is being used almost certainly too broadly. However, the effects of experience and of medication are interesting and even in opposition to what might be assumed and they tend against the economic rationalisations of policy proposals for skill-mix. Obviously such work needs more substantiation than one study, but studies like this suggests fruitful paths of enquiry that are relevant to art therapy practice.

I came upon the work of Nick Kanas in the book edited by Pines and Schermer (1999). The work of Kanas helped me navigate my way through the massive amount of literature that the databases produce in relation to groups with these clients. He has twice made a review of this literature (Kanas, 1986 and 1996), and his studies seem to be well conducted and well designed.

The literature reviews of controlled studies by Kanas date back to the time that anti-psychotic medications began to be used in clinical settings and this means his work is pertinent to any discipline situated in a psychiatric setting. The time span of his reviews covers the years 1950 to 1990. However, his work does not only involve reviews he has also made a number of controlled studies about groups for schizophrenic patients. Interestingly his work has also

involved looking at the psychological features of groups of astronauts spending long periods working together in space, in isolation (e.g., 1985, 1987, 1996). The isolation of the crew of astronauts working in space with uncertain contact with earth seems metaphorically potent in relation to the experience of psychoses.

The approach Kanas advocates for groups with schizophrenic patients as a result of these outcome studies is integrative and active on the part of the group conductor. The therapist style recommended is supportive and encouraging of focus upon work in the group. These systematic studies suggest that patients value groups as a place to learn strategies for interaction and for making sense of their psychotic symptoms. The conclusion of a number of studies by Kanas is that these groups are a useful adjunct to psychotropic medications for a variety of psychotic conditions.

In relation to short-term time-limited groups, studies by Kanas suggest that they are viable in managed care settings so long as the opportunity exists for needy patients to enrol in a 'repeaters' group later on.

Although Kanas suggests that more control studies are needed both for long-term groups and for time-limited groups; the trials to date suggest that they are 'safe, useful and relevant to the needs of psychotic patients (Kanas, 1999, p. 145). The detail of the work by Kanas can provide useful evidence with which to support art therapy group practice.

Other reviews of research literature on groups for these clients relevant to art therapy are Parloff and Dies (1977) Mosher and Keith (1979). In addition to research reviews there are systematic studies in areas of interest to art therapists in relation to group content. For example, a study by Uglestad in 1964 described the experiences of group psychotherapy that followed the group process through dream material of the 'schizophrenic' patients.

Clear advantages of group work are the possibilities provided for the therapist to work with several people at once and for group members to witness through being with each other ways of dealing with their difficulties.

Manfred Bleuler

The work of Manfred and Eugen Bleuler undoubtedly represents the longest span of research into the needs of people with schizophrenic disorders. The work of both father and son did a good deal to put the case for integrated methods of research that includes systematic empirical and qualitative methods. Manfred Bleuler's seminal work *The Schizophrenic Disorders: Long-*

Term Patients and Family Studies (1978, first published in German in 1972) is a twenty-year study that is still much cited in international databases. There has not yet been a longer study.

In reviewing the contribution made by Manfred Bleuler, Peter Barham (1995) examines the problem of social worth of the mentally disordered in modern societies and what is often their enforced powerlessness. He suggests that the work of Bleuler helps with an understanding of the late nineteenth and twentieth century ideological force field in which the lives of the mentally disordered are caught and that this provides an incisive and optimistic account of prognosis and treatment.

Manfred Bleuler stresses the importance of knowledge of both psychological and hereditary factors and urges that rather than searching for only a single, causal metabolic error, we also accept the possibility that schizophrenia also occurs at the level of human meaning. He advocates repeatedly that we consider the influence of schizophrenogenic influences in the lives and personalities of patients (Bleuler, 1972, 1978, 1979).

A powerful conclusion drawn by the results of Bleuler's twenty-year research is that on average, schizophrenia shows no further change for the worse after a duration of five years and often it has a tendency to improve after this period. He determines the success and limits of therapy statistically showing that many recovered 'schizophrenics' in his study continued to do well even without medication and social care. A broken home in childhood or an upbringing by a schizophrenic parent did not result in any important association with schizophrenia. However, disturbed relationships with relatives and loved ones were more frequently in the origins of 'schizophrenic women' than 'schizophrenic men'. Also most 'schizophrenics' who had been schizoid before the onset of full-blown psychosis had lived in miserable family circumstances (Bleuler, 1972, 1974).

Bleuler provides the results of his twenty-year study of two hundred and eight people with schizophrenia and their families (1972 and 1978). He describes his diagnostic criteria with some criticism of his father's schema. No one specific form of therapy is considered correct, and it is demonstrated that an appropriate combination of therapeutic methods can prevent the most severe forms of psychotic episode and improve all schizophrenic conditions. Although he suggests that with appropriate therapy the intermission between severe episodes become longer and the lapse into chronicity less frequent. He also shows that the number of full recoveries did not increase and nor did the number of severe chronic psychoses decrease. His studies of the origins of the condition found no single cause: results of the endocrine, psychodynamic and

hereditary studies are provided with the conclusion that that there exist 'disharmonic contradictory dispositions' at the level of biology, personality and human relationships. His studies of the children of 'schizophrenics' found nearly 75% to be healthy (1970).

In 1956 he interestingly suggests the importance of clinicians having knowledge of how ***both*** favourable and unfavourable life events have been experienced subjectively by their patients. He points to a mistaken tendency for clinicians to focus on the unfavourable.

There has been wide-ranging reference to the Bleuler studies. A paper written in 1954 (Wyrsch) suggested that the history of Swiss psychiatry for a time had tried to pursue a biological approach to the questions provoked by schizophrenia and that Bleuler's work had been a needed attempt to combine the biological and the psychological when it became clear that the arsenal of somatic treatments did not fulfil all expectations.

An American study (Marengo, Harrow and Galloway, 1991) is repeatedly cited as having favourably replicated some of the features of Manfred Bleuler's studies, at least over a ten-year period after the onset of illness. This study involved a sample of 74 patients. The results are thought to be encouraging of the possibility of estimating the rate of occurrence of particular expressions of the overall course of schizophrenia.

In 1995 Benedetti a colleague of Manfred Bleuler summarised the essence of his work: that healthy and disturbed processes occur simultaneously and that an understanding of the condition involves seeing it within the context of a person's life and the conflicts within that life. The optimistic significance of psychotherapy and social care within the cluster of treatment approaches are stressed. This approach is clearly in keeping with the history of art therapy approaches for these clients.

<u>Early intervention research and research associated with CBT</u>

Similarly optimistic research results have emerged from much Scandinavian work on the results of early intervention with people experiencing their first psychotic episode (Alanen, Ugelstad, Armelius, Lehtinen, Rsoenbaum and Sjöström, 1994). In Britain work in the field of psychosocial interventions based on cognitive behavioural methods has been encouraging (Falloon et al, 1987; Hogary et al, 1986 and 1991; Tarrier, Yusupoff, Kinney and McCarthy, 1997).

Both of these areas of research offer considerable encouragement for art therapy practitioners and other practitioners who wish to see a multifaceted approach to work with people with serious mental disorders develop.

Early intervention work in Scandinavia has had an impressive range of outcome research which has provided a wide-ranging counter approach to fashions in the treatment of schizophrenia that were prevalent at the end of the twentieth century. The trend has been to emphasise the use of medication at the expense of psychotherapeutic and psychosocial methods. This trend is one that has also been challenged by approaches using CBT methods. The paper by Williams (1999) potently suggests that despite philosophical differences comparisons between the approaches of psychoanalysis and CBT in relation to serious mental illness are worth making. He thinks this would be in the service of treatment methods that advocate the significance and effectiveness of working with the client's sense of meaning.

This is in contrast to many treatment and research projects in this field towards the end of the twentieth century that tended to disregard the significance of the client's sense of meaning.

Conclusion

A sobering truth is that **no** systematic investigation of the supportive work art therapists do with disturbed clients has yet been made. This situation can only be remedied in ways that involve a wider research strategy.

Art therapists need to demonstrate the amount and the range of work they do with disturbed and deprived client groups. A collection of census information might be followed by an outcome study of 'maintenance' work using agreed protocols with art therapists gathering results in a number of national locations.

This might mean, for example, twenty therapists having ten clients each or forty therapists having five clients each who are involved in outcome studies. These studies might in the first instance involve outcome studies *[effectiveness studies as defined by Seligman, 1995, see below]* as opposed to randomised control trials *[efficacy studies as defined by Seligman, 1995, see below]* although it seems inevitable that the best features of both will be needed. Systems for gathering outcome research would need to be informed on some level by the professional association and the training institutions. Protocols would have to be agreed and designed. Willing candidates (therapists and clients) for a medium to long-term study would need to be found.

Single case study using experimental designs might provide pilot studies for larger outcome studies. Outcome studies might involve surveys and control studies. Control studies tend to be designed as randomised control trials and the question of the appropriateness and

feasibility of RCTS is vexed for psychological disciplines. The system developed because of the interests of the international pharmaceuticals industry where it is straightforward matter to introduce a placebo. A placebo is not straightforward (either experimentally or ethically) to implement with human controls. Seligman's (1995) reservations about the difficulties of adopting the methods of random control trials for psychotherapy research make this clear. It is apparent that the American phrase for the British equivalent of the RCT is 'efficacy study'.

1. Psychotherapy (unlike other health treatments) in the field is *not of fixed duration.* It usually keeps going until the patient is markedly improved or until he or she quits. In contrast, the intervention in efficacy studies stops after a limited number of sessions — usually about twelve — regardless of how well or how poorly the patient is doing.
2. Psychotherapy (again, like other health treatments) in the field is *self-correcting.* If one technique is not working, another technique — or even another modality — is usually tried. In contrast, the intervention in efficacy studies is confined to a small number of techniques, all within one modality and manualized to be delivered in a fixed order.
3. Patients in psychotherapy in the field often get there by *active* shopping, entering a kind of treatment they actively sought with a therapist they screened and chose. This is especially true of patients who work with independent practitioners, and somewhat less so of patients who go to outpatient clinics or have managed care. In contrast, patients enter efficacy studies by the *passive* process of random assignment to treatment and acquiescence with who and what happens to be offered in the study (Howard, Olinsky, & Lueger, 1994).
4. Patients in the field usually have *multiple problems*, and psychotherapy is geared to relieving parallel and interacting difficulties. Patients in efficacy studies are selected to have but one diagnosis (except when two conditions are highly co-morbid) by a long set of exclusion and inclusion criteria.
5. Psychotherapy in the field is almost always concerned with *improvement in the general functioning* of patients, as well as amelioration of a disorder and relief of specific, presenting symptoms. Efficacy studies usually focus on specific symptom reduction and whether the disorder ends (Seligman, 1995, p. 3).

For someone relatively untrained in systematic research methods these cautionary notes seem convincing. However, perversely I am equally convinced by the sheer weight of psychological research taking the form of control studies that art therapists cannot evade some form of control study if they wish their discipline to be taken seriously in the arenas currently being required by international health care. It may be that a method combining the best features of surveys will need to be combined with the best features of control studies in order to produce an appropriate model of research for art psychotherapy practice.

In addition ways of disseminating research results will be needed as will clear routes for returning the results to training methods and systems for continued professional development (CPD). However, none of this will be possible without funding. Improving the possibilities for

art therapy practitioners to be involved in successful research bids will necessarily need to be a part of a whole research strategy. Funding makes the difference between researches being possible or not... here we have arrived back with the politics of the matter.

The following chapter is a modest attempt to begin to make a systematic study of the clients included on the caseloads of art therapists in one psychiatric service. The figures convincingly demonstrate the numbers of seriously mentally disordered clients seen by art therapists. They also demonstrate that art therapists work with high numbers of socially and economically deprived people. This profile of art therapy caseloads is markedly different form the caseloads of many psychotherapists. Clearly census studies such as the one included in chapter thirteen would acquire greater political potency if conducted on a national scale.

Appendix for chapter twelve: British publications concerning art therapy with the seriously mentally disordered

Books and chapters

Case, C. & Dalley, T. (1992) *The Handbook of Art Therapy.* London: Routledge. A jointly written book with particular sections dedicated to referenced art therapy work with the most disturbed clients.

Gilroy A. and Lee C. (1995) *Art and Music Therapy and Research.* London and New York: Routledge. A collection of chapters including one concerning research in art therapy for people with psychotic illnesses by Killick and Greenwood.

Killick K. and Schaverien J. (1997) *Art, Psychotherapy and Psychosis.* London and New York: Routledge. A collection of chapters all concerning the practice of art therapy with people in the midst of psychosis.

Killick, K. (1995) 'Working with Psychotic Processes in Art Therapy', in J. Ellwood, ed., *Psychosis: Understanding and Treatment.* London: Jessica Kingsley Publishers, pp. 105-119.

Liebmann, M. (1990) *Art Therapy in Practice.* London: Jessica Kingsley Publishers. A collection, with particular chapters on working with people who have manic-depressive disorders and the use of art therapy in community based rehabilitation by Thornton and Lewis respectively.

Schaverien, J. (1991) *The Revealing Image.* London: Routledge. A theoretical account of art therapy practice including some parts concerning art therapy work with disturbed processes.

Skaife, S. and Huet, V. (1998) *Art Psychotherapy Groups: Between Pictures and Words.* London and New York: Routledge. A collection of chapters including several concerning groups for the most disturbed clients by Nicholas Sarra, Sarah Decco, Angela Byers and Jane Saotome.

Waller D. and Gilroy A. (1992) *Art Therapy: A Handbook.* Buckingham & Philadelphia: Open University Press. A collection of chapters including one on the use of art therapy with 'chronic' long-term psychiatric patients by Wood.

Journal Articles

Crane, W. (1996) 'A Consideration of the Usefulness of Art Therapy for Psychotic Clients with Artistic Identities', *Inscape: The Journal of the British Association of Art Therapists.* 1 (1): 20-28.

Evans, K. (1998) 'Sharing Experience and Sharing Meaning: Art Therapy for Children with Autism', *Inscape: The Journal of the British Association of Art Therapists.* 1 (1): 17-25.

Greenwood, H. and Layton, G. (1987) 'An Outpatient Art Therapy Group', *Inscape: The Journal of the British Association of Art Therapists.* Summer: 12-19.

Greenwood, H. and Layton, G. (1988) 'Taking the Piss', *British Journal of Clinical and Social Psychiatry.* 6:74-84.

Greenwood, H. (1994) 'Cracked Pots: Art Therapy and Psychosis', *Inscape: The Journal of the British Association of Art Therapists.* 1: 11-14.

Huet, V. (1997) 'Challenging Professional Confidence: Arts Therapies and Psychiatric Rehabilitation', *Inscape: The Journal of the British Association of Art Therapists.* 1 (1): 14-19.

Killick, K. (1991) 'The Practice of Art Therapy with Patients in Acute Psychotic States', *Inscape: The Journal of the British Association of Art Therapists.* Winter: 2-6.

Killick, K. (1993) 'Working with Psychotic Processes in Art Therapy', *Psychoanalytic Psychotherapy.* 7 (1): 25-36.

Wood, C. (1985) 'Psychiatrica Democratica and The Problems of Translation,' *Inscape: The Journal of the British Association of Art Therapists.* Late Issue 1: 9-16.

Wood, C. (1991) 'A Personal View of Laing and His Influence on Art Therapy,' *Inscape: The Journal of the British Association of Art Therapists.* Winter: 15-19.

Wood, C. (1997) 'Facing Fear With People Who Have A History of Psychosis', *Inscape: The Journal of the British Association of Art Therapists.* 2 (2): 41-48.

Chapter Thirteen:

Appendix to Section Five: A Census of Adult Clients on the Case Loads of Art Therapists Working for the Mental Health Services of Community Health Sheffield

Introduction

This census of the adult clients on the combined art therapy caseload for the mental health service in Sheffield is largely descriptive. It was done as an exploratory measure mainly intended to provide detailed information about the clients receiving art therapy. The information provides the basis for further exploration of the nature of the work provided by art therapists.

The questionnaire and census design that has been used was designed to gather information about the clients on the community psychiatric nurse (CPN) caseload in Sheffield. As a result of the design having been used already by a large professional group, the art therapy results do contain a small element of comparison with the work of the larger CPN group. In making comparisons between the two services no evaluative judgement is intended, it was considered to be helpful to art therapists (a very small professional group) to begin to express the profile of their work load within a frame of reference already negotiated and employed by a Health Service Trust.

It is the case that the questionnaire is not specifically designed for the work of art therapists, nevertheless the use of this questionnaire seemed a good place to begin. The intention is to introduce some modifications to the use of future questionnaires and to make them more art therapy specific. It is also intended to introduce a qualitative element to future surveys.

General summary of the information collected by the Census

Information about the Art Therapists working for the adult mental health service.

- 5 Art Therapists (representing 3.6 full time equivalent posts, as the majority of therapists are part time) provided 2,323 items of data on 99 clients. These art therapists provide a small-specialised service for the community mental health care of CHS.
- Art Therapists working in adult mental health have an average age of 37 years and they have worked as art therapists in Sheffield for an average of 6 years and 4 months. The variation in length of service in Sheffield ranges from 1 year 6 months to 15 years and 7 months.
- The caseload for an art therapy full time equivalent post would be 28 clients on the basis of these figures. This is lower than the caseload for an FTE of a CPN (31)

working for CHS who were completing the same census. The national caseload for a CPN is 34. There are no national figures for art therapy caseloads. The other data collected could help elaborate the reasons for the difference in case load size mainly due to differing working practices and differing lengths of time offered to clients during sessions (art therapists generally provide longer sessions times). In addition two of the art therapists involved in the survey had recently changed their work base that in the case of one had led to a temporary reduction in case load, but this would not have greatly influenced the average size of caseloads.

- The frequency of sessions follows the same pattern across the city. Individual sessions are offered on a regular weekly or fortnightly basis. Group sessions are offered on a regular weekly basis. Any exceptions to this pattern on the part of the therapist are due to sickness or holidays. There is a consistency apparent in comparing the number of sessions offered to clients by art therapists across the city. This is also the case when comparing the regularity and length of sessions. Clients are offered sessions of the same length of time every week. Therapists described their individual sessions as being between 1 hour and 1 hour and a quarter and group sessions as being between 1 hour and a half and 2 hours and a half.
- The ratio of discharges to new clients taken on by the art therapists in the survey is well balanced.
- 4 of the 5 art therapists in the survey are involved in a small number of 'one off' assessments, it is not clear what proportion of these assessments were on behalf of general multidisciplinary team work and what proportion were assessments for therapy. It would be useful to clarify this in the future.
- The average proportion of long-term mentally ill in estimates made by art therapists of their caseloads is 75%. The information collected about the proportion of clients on art therapy caseloads with a diagnosis which includes psychosis, gives the average figure of 49%. Clearly the way in which the art therapists in the survey have judged their clients to be in the category 'long-term mentally ill' involves more than a formal psychiatric diagnosis of psychosis. This was also apparent in the figures provided by CPNs in their survey. It would be helpful to incorporate a definition of the 'long-term mentally ill' in future surveys. Nevertheless the figures for the proportion of therapeutic work with clients with 'long-term mental illness'

are probably higher than those of other psychotherapeutically inclined professionals working in either the public or private sector. Since 1938 the history and tradition of art therapists has involved doing this work, the figures collected for this census seem in a small way to confirm this tradition.

- The qualification to practice as an art therapist involves a two-year postgraduate training. Most art therapists in Sheffield have continued to supplement their original qualification with additional training (generally at their own expense). The census report about the clients on CPN caseloads suggests on page 1, that there is a tendency for CPNs to work with less disturbed clients as they become more experienced and better qualified. This is a tendency often commented upon in relation to the work of most large professional groups. It is not a tendency observed amongst the art therapists included in this survey.

Service users

- The female: male sex ratio for clients on the art therapy caseload is approximately 60:40. All of the art therapists are female (although the work with three clients of one male student art therapist was included in the survey).
- Client socio-demographic information shows that the art therapy client caseload is a similarly disadvantaged group to the caseload of CPNs. There are some differences as a result of a significant number of art therapy clients still living in hospitals.
- 32% of art therapy clients live alone, 72% of art therapy clients are either separated, single or widowed. Only 8% are in full time employment, 6% in part time employment, 4% are students. 46% live in rented accommodation and an additional 23% live in hostel or hospital accommodation makes a total of **69%** in disadvantaged living circumstances.
- The ethnic composition of people on the art therapy caseload is mainly white. Only 10% of clients have ethnic origins that cannot be described as white European. Of these 10%, 9% have Afro Caribbean origin and 1% has African origins. It is surprising that no client can be described as being of Asian origin given the size of the Asian population in Sheffield.
- It is difficult to discern a referral pattern by considering the information provided by the art therapists on a citywide basis, because there is such a wide variety of referral sources in the different sectors (see the pie charts provided). Although the question

was intended only to ascertain the referral source for CPNs, this particular question had a number of limitations (e.g., no sections for recording either CPN or Therapy Referrals). Nevertheless, the difficulty in discerning a pattern does suggest something about the variable knowledge of the reasons for making an art therapy referral amongst different professional groups. It also suggests that referrals to art therapy are dependent on knowledge of the particular practitioner. This area warrants further scrutiny and action from the art therapists as a group.

- There is reasonably close agreement between the art therapy assessment and formulation of the problem and the psychiatric diagnosis given. However, overall the art therapy assessment was more complex than the questionnaire allowed. In addition the range of diagnosis provided by the questionnaire did not make sufficient distinction between those affective disorders with a basis in psychosis and those without such a basis. The limitations of the questionnaire in these respects were also commented upon by the CPNs. Nevertheless 97% of the clients on art therapy caseloads had received a formal psychiatric diagnosis.
- The majority of clients on art therapy caseloads are in the adult care group (including those connected with the rehabilitation services). In future surveys particular identification of those adults using the rehabilitation services will be made.

Diagnosis

- The majority (97%) of clients included on the caseloads of art therapists do receive a psychiatric diagnosis (the total case load being 99).
- The original questionnaire did not make a distinction between those clients whose affective disorders had psychotic features (e.g., manic disorders) and those without. However, because of the relatively small size of the art therapy survey it is possible to include this information.
- 49% of clients on the combined art therapy caseload had a diagnosis that included an element of psychosis (either schizophrenic or manic depressive disorders). 26% of clients were diagnosed as having affective disorders; 5% as having eating disorders and 2% with dementia. 7% of clients had a diagnosis of personality disorder, 5% had a diagnosis of anxiety and 1% had addictive disorders.
- 23% of clients on the art therapy caseload were admitted in the previous year for an average period of 3 months (96 days). An additional 18% of art therapy clients were

permanently in hospital during the previous year. Of those clients not permanently in hospital, those on the art therapy case load for the North East sector had the longest stay in hospital, with an average stay of 6.8 months, whereas those on the art therapy case load for the South East and the old Central sector had the shortest stays in hospital, with stays of 2 months (57 days) and 2.5 months (80 days) respectively.

- The socio- demographic factors which were most involved in the risk of admission for people on the art therapy case loads were unemployment (not seeking work) 59%, living alone 29%, full time work 6% and Afro- Caribbean ethnic origin 6%.
- The diagnostic categories that had most risk of admission were schizophrenia 57%, affective disorders (without psychosis) 38% and personality disorders 5%.
- 25% of those people making up the total art therapy caseload are in receipt of a care programme whereas some 43% of the total group had a key worker (the art therapists themselves were key workers for some 10% of these). It will be interesting to see how these figures are affected once the changes to the care programme approach have been implemented.
- The therapists' ideas about the nature of their intervention are interesting. The original question 21 was changed to the following: 'Which of the following best describes the main art therapy intervention you have undertaken with the client?' The art therapists in the survey chose two of the eight categories available, equally. These two categories were counselling and psychotherapy. All of the therapists commented on the absence of group work from the available categories. It would be interesting and helpful to modify future questionnaires to enable further elaboration of the models of work which therapists consider themselves to be using.

Method

1. I had a number of discussions with Dean Repper the then Director of Clinical Nurse Practice (Mental Health Care Directorate). He helped me to think about the Art Therapy Service profile within a frame of reference appropriate to health service planning. He made the census information for CPNs available to me.

2. Following discussions with the Art Therapists and the Therapy Service Manager for Mental Health, Joan Kenyon, the questionnaire designed by Dr C. Brooker (Director, Nursing Section, SCHARR) and Paul Conway (CPN) for their 1995

Census of CPN workloads was used to make a census of the art therapy workloads in adult mental health (see the appendix).

3. I met with each of the Art Therapists working for the adult mental health services and we completed the caseload census questionnaire for each of their clients. I also completed a questionnaire for my own caseload. This work was undertaken during June 1996.

4. Percentage information was obtained by using Microsoft Excel, Version 5. It is possible to present the results in the form of pie charts using this package; this makes information easy to read at a glance. A number of pie charts describing particular aspects of the art therapy caseload are included in the report.

5. A draft summary of the census information was discussed with the art therapists at a joint meeting.

Recommendations

1. This census is to be used as the basis of further exploration of art therapy work within the NHS; this will certainly be done at a local level and if possible at a national level. NICE is currently considering the possibility of supporting the replication of this census of art therapy case loads on a national basis.

2. This review and those done in the future will be used to draw attention to the nature of the work provided by art therapists.

3. This particular review shows that the sources of referral to the art therapists in the survey are wide-ranging and varied. It is difficult to discern any pattern of referral. The possible reasons for the amount of variation will be explored further with the art therapists and their referral sources.

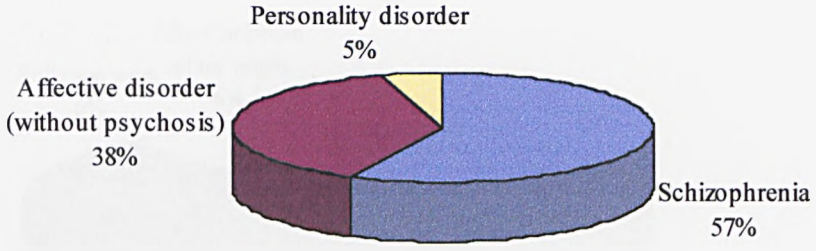
4. There are a large number of people amongst the art therapy clients in the city who receive depot injections. However, there is very little knowledge amongst the art therapists about how and where their clients receive these injections. It may be useful and of interest if art therapists could ascertain this information, especially as the manner in which clients receive medication has been indicated as one the important factors in determining the client's admission risk.

5. Future surveys will allow for the inclusion of more qualitative information, while also trying to maintain a frame of reference that is of relevance to the NHS.

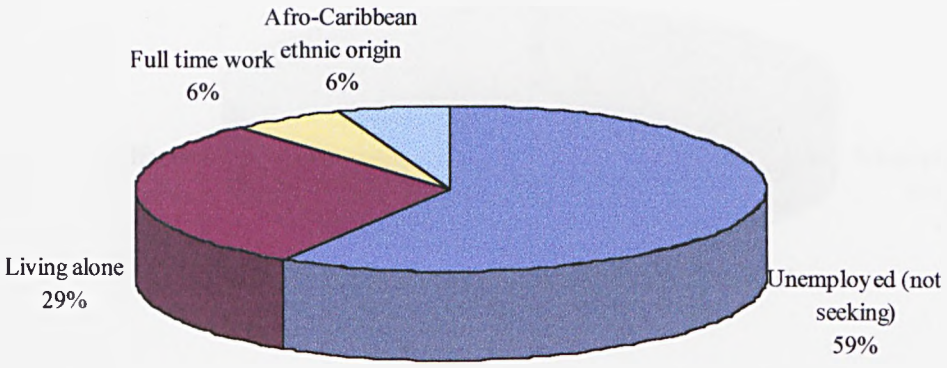
6. Particular attention will be given to the nature of art therapy interventions in subsequent work.

The pie charts that contain information collected by the census:

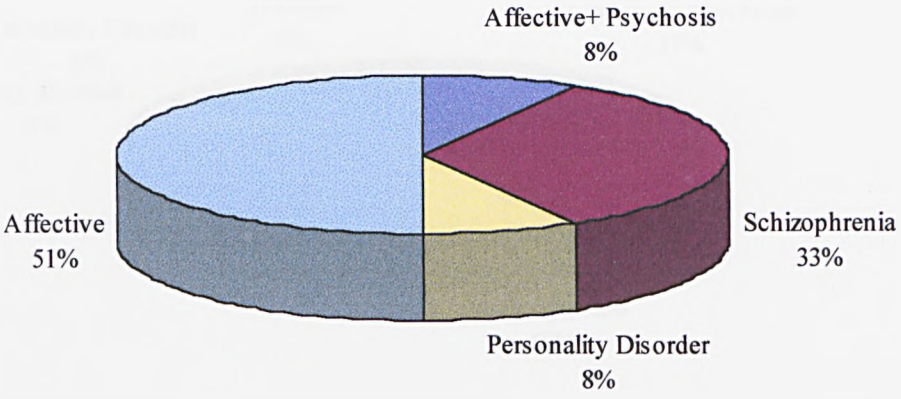
Diagnostic factors most associated with admission risk in the art therapy census:



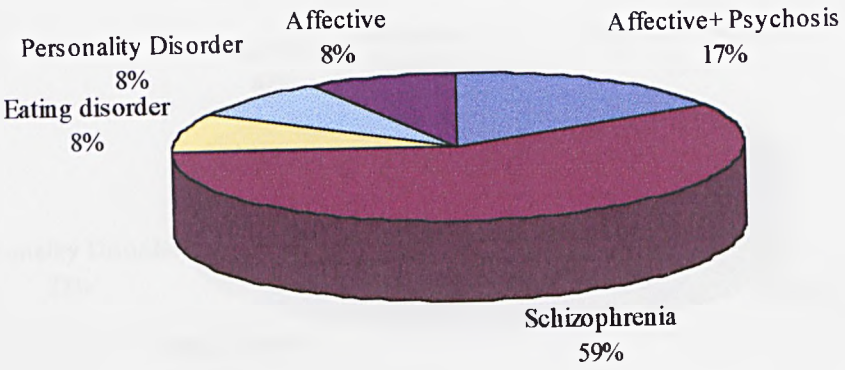
Socio-demographic factors most associated with admission risk in the art therapy census:



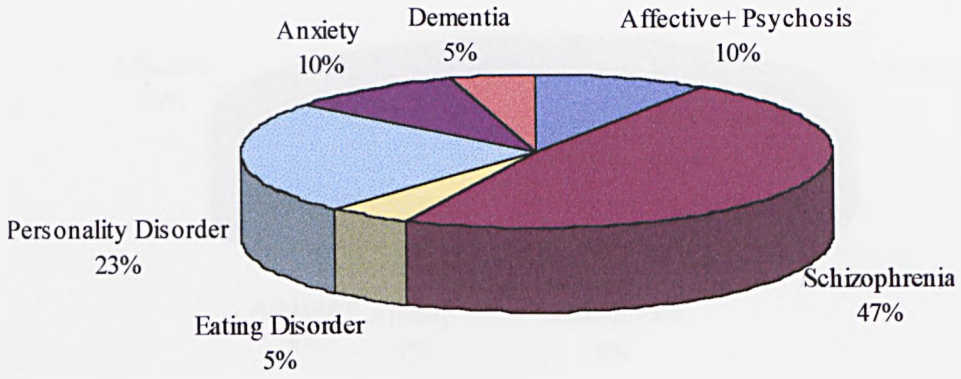
Diagnosis: North East



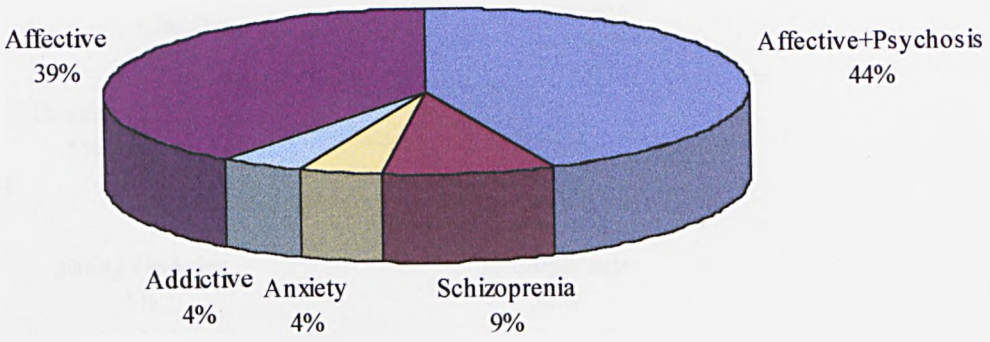
Diagnosis: Central/Citywide



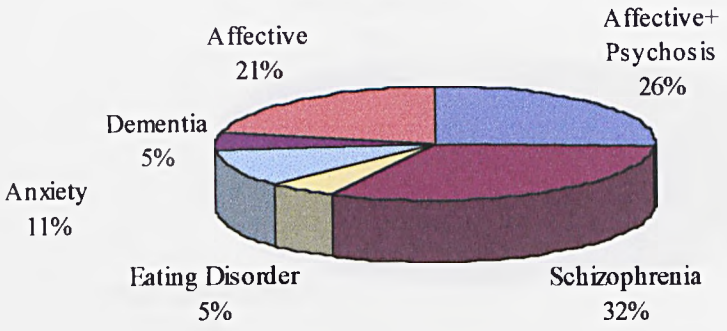
Diagnosis: South East/Central



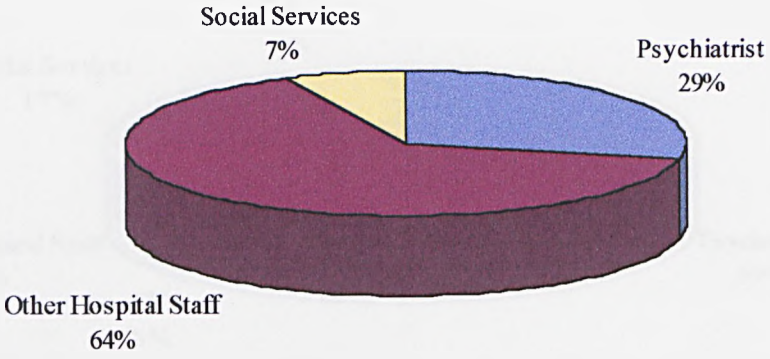
Diagnosis: South West



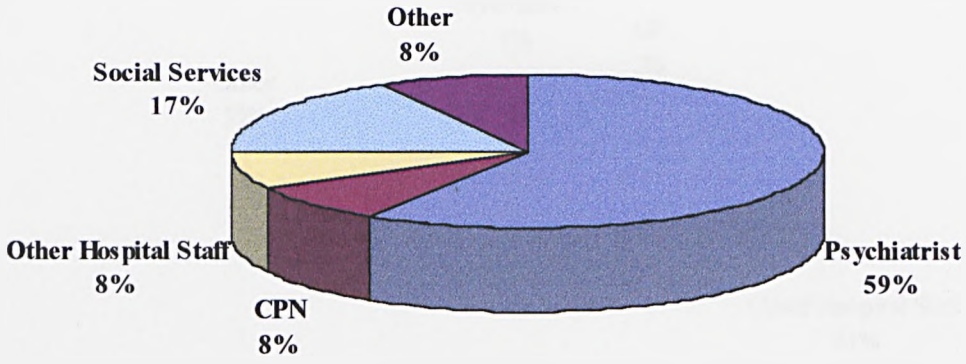
Diagnosis: North West



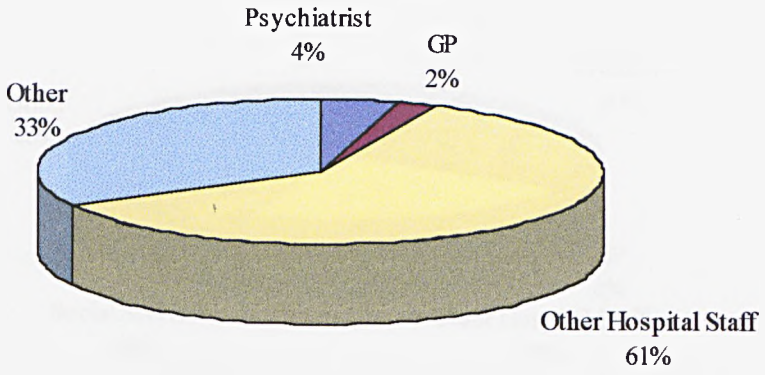
Referral Source: North East



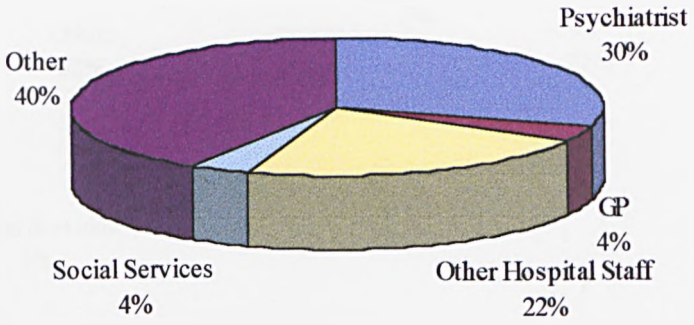
Referral Source: Central/Citywide



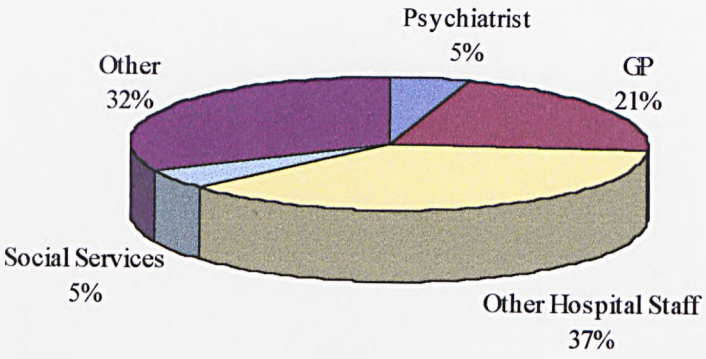
Referral Source: South East/Central



Referral Source: South West



Referral Source: North West



The questionnaire used for the preceding art therapy survey was taken from, *A Census Of Clients On CPN Caseloads in Community Health Sheffield: February 1995* by Dr C. Brooker and P. Conway. The coding sheets follow on pages 302-307.

Data Coding Sheet: Community Health Sheffield

Client Data — SECTION A

1. Age (in years) (1, 2)

2. Sex
   1. Male
   2. Female (3)

3. Referral Source
   1. Psychiatrist
   2. GP
   3. District Nurse/Health Visitor
   4. Other Hospital Staff
   5. Social Services
   6. Relatives/self
   7. Other (4)

4. Marital Status
   I. Single
   2. Married/ Co-habiting
   3. Separated/Divorced
   4. Widowed (5)

5. Employment Status
   1. Works full—time
   2. Works part-time
   3. Unemployed (seeking work)
   4. Unemployed (not seeking work) (6)
   5. Retired (6)

6. Domestic Arrangements
   1. Lives alone
   2. Lives with partner
   3. Lives with relatives (other than partner)
   4. Other (7)

7. Accommodation

1. Owner Occupier
2. Rents
3. Bed and breakfast
4. Sleeps rough
5. Part three accommodation
6. Other (8)

8. C P N's judgment of ethnicity

1. Afro Caribbean
2. White European
3. African
4. Asian (9)

9. Care Group

1. Adult
2. Older Adult
3. Rehabilitation (10)

10 CPN Assessment of Problem

1. Mood related
2. Abnormal experiences
3. Drugs/alcohol
4. Interpersonal problems
5. Organic
6. Financial/housing/employment
7. Behavioural problem
8. Loss/separation-
9. Anxiety related:
10. The CPN could not decide and requested another opinion
11. Other (11, 12)

11-12. Did the client agree with the CPN assessment?

1. Yes
2. No
3. Not appropriate (13)

13a. Has the client ever received a formal diagnosis from a psychiatrist ?

1. Yes
2. No

If the answer to this question is "yes" code item 13b otherwise skip to question 14

(14)

13b. Which of the following is closest to the client's most recent diagnosis ?

1. Affective disorder
2. Schizophrenia
3. Personality Disorder
4. Dementia
5. Anxiety state
6. Alcoholism
7. Drug Abuse
8. Other

(15)

14a. Has the client been admitted to a psychiatric unit in the last 12 months ?

1. Yes
2. No

If the answer to this question is "yes" code questions 14b, 14c, 14d, 14e, 14f and 14g otherwise skip to question 15a (16)

14b. On how many occasions has the client been admitted in the last 12 months? (17)

14c. Was the client admitted under section ?

1. Yes
2. No (18)

14d. How many days has the client spent as an in-patient in the last 12 months ? (combine all admissions)

e.g. If the client had one admission lasting 35 days and another lasting 40 days the figure you code in the box would be 075, i.e. 35 plus 40

(19, 20, 21)

14e. At the last discharge was the client subject to a section 117?

1. Yes
2. No

(22)

14f. Is the client currently on section 17 leave?

1. Yes
2. No

(23)

14g. At the last discharge was the client assessed under the care program approach?

1. Yes
2. No

(24)

15a. Does the client have a key-worker?

1. Yes
2. No

(25)

If the answer to this question is "yes" please answer question 15b otherwise skip to question 16

15b. Are you the client's current key-worker?

1. Yes
2. No

(26)

16. Is the client on the supervision register?

1. Yes
2. No

(27)

17a. Has a full needs assessment been undertaken with this client in the last 12 months?

1. Yes
2. No

(28)

If the answer to question 17a is "yes" please continue to question 17b otherwise skip to question 18a

17b. If so, did you personally undertake the full needs assessment?

I. Yes
2. No

(29)

18a. Does the client receive Depot neuroleptic medication?

1. Yes
2. No

If the answer to this question is "yes" please code item 18b and 18c otherwise skip to question 19.

(30)

18b. Where does the client receive the depot injection?

1. At home
2. At a centralised depot clinic
3. At a Health Centre/GP practice
4. Other

(31)

18c. Who administers the depot injection?

1. I administer the depot routinely
2. 1 administer the depot on rotation at a clinic
3. A district nurse gives the injection
4. A practice nurse gives the injection
4. Other

(32)

19. How many visits have you made to this client in the last 12 weeks? (enter number in the box, e.g. 06, 11, 04 etc)

(33,34)

20. Approximately how much time does this number of visits (amount of session time) represent?

For example, fortnightly visits over the past 12 weeks equals 6 visits, at, say, roughly 30 minutes per visit, total time is equivalent to 3 hours. Therefore enter "03" in the box

(35,36)

21. Which of the following best describes the main intervention you have undertaken with this client?

PLEASE CODE ONLY ONE CATEGORY

1. Drug monitoring/ supervision
2. Counselling
3. Psychotherapy
4. Family therapy
5. Behaviour therapy
6. Cognitive therapy
7. Support/ practical help
8. Other

(37)

22 Please give your CPN staff number and location code

e. g. CPN number (staff number) is 125 , location code is 175 , enter 125175

(38,39,40)

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

Summary and Conclusion:

Chapter Fourteen: **308-325,**

Identity and Relationship: the Synthesis of Art, Psychotherapy and Social and Political Awareness

Summary and Conclusion: Chapter Fourteen:

Identity and Relationship: the Synthesis of Art, Psychotherapy and Socio-political Awareness

Introduction

In this thesis I have considered how the close relationship needed between client and therapeutic practitioner is subtly framed and influenced by the social and political context. I have ambitiously proposed from my examination of the history of the profession that the development of theory and practice in art therapy requires a synthesis of art, psychotherapy and socio-political awareness. Practice in relation to people who experience psychosis provides a powerful case example of the need for this synthesis. As I reach the end of the thesis and as I acquire more critical distance I realise that I have begun to indicate only some of the factors that need to be considered.

For example, the development of skills providing aesthetic criticism for art therapy with a sense of the political and an understanding of context poses a challenge. Nevertheless the continued insistence of the profession upon the value of fine art training before commencing therapeutic training means that the majority of people who become art therapists have a strong sense of contemporary art practice and context and this is finding its way into art therapy. However, because therapeutic work often requires an inward looking attention it is understandable that the aesthetic critical skills employed in art therapy have either tended to maintain a romantic ethos or adopt a formalistic approach. The scholarship associated with the 'art of the insane' and 'art brut' that was current during the first part of the twentieth century tended to provide an extreme example of the formalistic approach. That such scholarship began at the end of the twentieth century to acknowledge the societal influences that are evident in examples of the art associated with psychosis is fascinating. It confirms a central theme in my thesis about the subtle impact of the political and economic changes upon theory and practice. Similarly there are signs that the tendency within art therapy to think about the art made by clients solely from the perspective of a romantic aesthetic seems to be changing during the same period. Art therapy is beginning to include a discussion of influences from contemporary art and popular culture (Case, 1990 and 1998; Aldridge, 1998; Wood, 1999).

The development of theory and practice in relation to the art of art therapy is a necessary balance to the ever-increasing sophistication of its use of theory from the fields of psychoanalysis and psychotherapy. During what I have described as the third period of professional history, art therapists have necessarily acquired much greater psychotherapeutic rigour while at the same time commenting upon the sociological divorce that is apparent in much psychotherapeutic theory. My particular examination of the history of the profession means that I have been able to propose that for practitioners to be able to work well with people with serious mental disorders in the public

sector, they need both psychotherapeutic clarity and socio-political awareness. The location of the majority of art therapy practitioners within the public sector has meant that political understanding certainly at the level of institutional practice has long been important to their practice. I have suggested that the demands of long-term work with the seriously mentally disordered can be made sustainable for the profession and for the practitioner if a longer-term historical, political perspective about practice is adopted. Many strands in the thesis are aimed at elaborating this historical perspective.

Historical context and scepticism about the treatment of madness

In the first section I have explored the ways in which treatment of the insane has emerged out of a historical scepticism about whether it was possible to treat 'pauper lunatics'. The history of treatment since the eighteenth century is used to show how historical rises and falls in therapeutic hopefulness are continually linked to the political circumstances of a period.

Many studies show that poverty increases the incidence of psychosis (see chapter one, p. 16). Poverty and class provide one of three themes that I have identified as spanning several centuries that influence treatment for people with a history of psychosis, the other two themes are those emerging from the philosophy of moral management and questions about mind-body dualism.

In relation to all of these three themes the work of Pinel and Tuke has been widely celebrated. They introduced the turning point in the late eighteenth and the early nineteenth centuries. With their work the care of the insane began to change away from methods that saw insanity as a mark of bestiality into an approach that recognised insanity as a part of what it is to be human.

Samuel Tuke's *Description of the Retreat* (1813) was a remarkably modest though influential account of the moral treatment approach adopted for the treatment of 'insane persons'. The account suggests a gentle and good-humoured approach to the care of people with serious mental disorders. It encompasses care in all matters, medical, diet (including a little alcohol), architecture and the atmosphere of surroundings. The moral treatment itself was based on practical experience and gradual modification in response to three areas of inquiry:

> *I. By what means the power of the patient to control the disorder, is strengthened and assisted.*
>
> *II. What modes of coercion are employed, when restraint is absolutely necessary.*
>
> *III. By what means the general comfort of the insane is promoted (Tuke, 1813, p. 138).*

These three principle questions are remarkable. They incisively foretell areas of inquiry that have been helpful throughout the subsequent history of thinking concerned with the treatment

of the insane. Considering the power of the patient to control their disorder potently introduced the potential agency of the person being treated. This is particularly important in the field of psychosis because so much in the history of disorders associated with psychosis has tended to discredit the patient's contribution to their 'own' recovery and their discovery of a way to live. In contemporary psychiatry there is still a tendency to assume that public sector clients will have things done to them and that they are unlikely to respond to an approach that would elicit the power of their own agency. This tendency seems to be linked to the social economic status of public sector clients and assumptions made about people from lower class backgrounds. Such assumptions are not immediately apparent in psychoanalysis but then it is the case that relatively little psychoanalytic work is undertaken with this group of clients in the public sector.

Tuke gently mocks the use of fear to induce the patient to control their disorder (it was much employed in 'treatment' of the insane during his lifetime). Rather kindness (without being patronising) was employed in all areas of the life of patients at the Retreat. 'The power of judicious kindness over this class of society, is much greater than is generally imagined' (Tuke, 1813, p. 168). In addition efforts were made to enhance the mental life of patients and their opportunities for having company.

The pursuit of mathematical studies was considered as more likely to induce mental stability than works of the imagination that 'are generally, for obvious reasons, to be avoided' (Tuke, 1813, p.183). However, it is important mischievously to mention that 'those who are not engaged in any useful occupation are allowed to read, write, draw, play at chess, drafts, &c.' (Tuke, 1813, p. 181) because several of these might work on the imagination. Indeed some examples of poetry penned by inhabitants of the Retreat are included in the *Description.* One of these is a love poem.

No attempt was to be made to reason with a patient's deluded belief system. All who could be employed were able to make a contribution to the life of the institution. Physical labour was much favoured. This seemed to be a part of the belief and practice that the health of mind and body are linked.

In Tuke's lifetime the methods developed at the York Retreat were widely adopted in several countries (especially America) and by many interpretations seen as successful. However, as Warner (1985) has indicated despite their success in Britain and America the methods of moral treatment gradually fell into disuse during the second part of the industrial revolution. Warner suggests there is an instructive comparison to be made between this disuse of moral treatment and the gradual decline of the social psychiatry movement during the later years of the twentieth century. The failure to continue to develop and use the insights of these two efficacious treatment

methods can only be explained through reference to the prevailing social and economic conditions. The development of effective treatment methods and hopefulness for work with people experiencing psychosis is not simply dependent upon rational evidence or a pure scientific impulse. Prevailing political and economic forces fundamentally influence the methods in use in any historical period. Nineteenth century asylums developed throughout the world, owing some of their origins to the work of Pinel and Tuke, but they declined and became corrupted as the institutions became too large and the demand for labour fluctuated. The social psychiatry movement spawned the progressive ideals of 'community care', but it became similarly corrupted because of the desire of governments internationally to reduce expenditure on health care and again because of fluctuations in the need for labour and the growth of unemployment throughout the world. It became not economically viable to implement rehabilitation treatment methods with the aim of returning erstwhile mental patients to the labour market.

Tuke's book appeared in the same era as Pinel's *Traité Medico-philosophique sur L'Aliénation Mentale* (1801) and it made reference to this work, but 'traitement moral' is not well translated by the phrase 'moral treatment'. Pinel's phrase translates more accurately as 'treatment through emotions' (Jones, 1996, p. xi, cited in the Process Press edition of Tuke's *Description*). This is additional strand to the lineage of the art therapy profession which though 'working through emotions' is often seen to adopt the treatment philosophies of moral management in the way respect for the client is heightened. In art therapy practice this has centrally involved a sense of the client's own agency in the therapeutic relationship and their active engagement with making art. Also the long-term nature of much work needed by clients with serious mental disorders means that art therapists pay considerable attention to the environment in which therapy takes place. Killick's powerful work was often intimately dependent upon being able to work in a studio. I have made a case proposing that the use of a studio both facilitates the absorption of the client in their art making and enhances the capaciousness of the art therapist (chapter eight).

Situating theory and practice

It is interesting that current practice in the art therapy profession manages to combine its increasing clarity about psychotherapeutic theory while maintaining and upholding aspects of eighteenth century moral treatment and twentieth century social psychiatry. All three periods of the historical development of the profession that I have described in the second section centrally maintained the principle of respect for the client. A large part of the profession's work has been and remains with clients who experience psychosis. However, until the third period in the 1980s and the 1990s in Britain, it was hard to discern a particular approach in relation to work with the seriously mentally disordered. Until this third period it seems a broadly similar approach was used for all patients by

art therapists. The second section holds three chapters intended to situate historically and politically central aspects of the profession's practice and *philosophical craft,* particularly in relation to people with a history of psychosis. Here the influence of historical and political context is apparent in the forms of practice adopted in particular periods. During the period when art therapists were developing specific methods for people with particular problems, there was an increasing demand from health policies for treatment rationale. This culminated towards the close of the century with the publication of *What Works for Whom* (Roth and Fonagy, 1996) that advocated that specific psychotherapy treatment modalities needed to demonstrate their effectiveness for specific disorders. This will undoubtedly influence the direction of psychotherapy in health care settings for years to come.

Art Therapists have constituted one of few groups who have sustained since the Second World War psychotherapeutic work with people experiencing psychosis in the public sector. Their experience in the public sector means that they have had to develop what I have described as an oscillating consciousness able to move backwards and forwards between the intimacies of the therapeutic relationship and the political circumstances which frame it. This ability was to some extent developed during the 1960s and the 1970s with the influence of Laing and the anti-psychiatry movement. The ideological vacuum left by the decline of interest in R. D. Laing's ideas about psychosis coincided with and was subtly affected by difficult economic times.

In fact ,although the health cuts in mental health became apparent during the 1980s under the Conservative government, the first cuts in health spending were initiated in the previous decade by the then Labour Government. The figures for the reduction in hospital beds and the rate of increase in hospital admission and 'throughput' during this period of change give the most tangible evidence of the cuts that had an impact on mental health provision (see pages 31-33, in chapter one). During the same period there was only a modest increase in psychiatric outpatient activity (see page 32, chapter one). Barham has written about the uncertain nature of the results of the 'exodus' of mental patients from the old hospitals (1992) suggesting that the economic justifications that had been forecast for the closure programmes were not fulfilled. He writes about the fact that at the time of most closures the majority of mentally ill or learning disabled clients already lived in the community (Social Services Committee, 1985, p. xv-xvi). He acutely points to the idea that those clients who will feel the effects of the closures (the independent advantages and the isolated limitations) are from a new generation. 'If, from a medical point of view, they continue to be active patients, they have perhaps been helped to recognize that is certainly not all they are' (Barham, 1992, p. 23). It is in the area of helping people gain the wider sense of personal

identity needed for survival in the community that art therapists can make a contribution to the mental health of their clients.

Despite the widespread cuts in health spending, the art therapy profession's sense of the political was not highlighted during the most recent period of its history. I have considered the various ways in which the material pressures inherent in the move into the community gave the impulse for the profession to acquire much greater therapeutic clarity from the theory and practice of psychoanalytically orientated psychotherapy. The focus upon inner world solutions can be characterised historically as a defence against the sense that it was difficult during a harsh political period to influence the outer world in provisions practitioners may have wished to make on behalf of their public sector clients. Young has suggested that this kind of historical defence was also a characteristic of people with a leftwing perspective who during this period moved towards engagement with psychoanalysis. I think this thought has explanatory power given the number of people involved. I am sure the list is not complete but it is quite long and it makes the point: Dick Blackwell, Sheila Ernst, Karl Figlio, Stephen Frosh, R.D. Hinshelwood, Paul Hoggart, Joel Kovel, Julian Lousala, Juliet Mitchell, Barry Richards, Joanna Ryan, Joseph Sandler, Susie Orbach, Joseph Schwartz and, of course, R. M. Young. Orbach's subsequent much publicised connections with royalty suggest the inherent potential in this defence for a rightward political drift, although of course, this is not automatic. However, the starkness of Young's proposal in the period after the defeat of the miners strike and at the beginning of the third Thatcher government in Britain, that psychoanalysis is 'the last hope and the last refuge of the disappointed radical' (Young, 1987, p. 1) seems in retrospect to have been influenced by the period.

Certainly solutions about how to practice with people in the midst of psychosis were not easily discovered in the field of psychoanalysis. The difficulties might be seen as dating from Freud's early reluctance to engage with psychosis. The small numbers of psychoanalysts who did work with people in the midst of psychosis and the smaller number still who practised in the public sector were courageous but the work itself was often difficult and it was the subject of considerable controversy. The conflicts between the different psychoanalytic approaches seem to have divided into two main tendencies. The first tendency saw psychosis as a complete obstacle to the techniques of psychoanalysis unless the analytic technique is modified (mainly involving ideas about a reparative relationship and limited acknowledgement of transference). Those in the second tendency felt it was fundamentally mistaken to alter technique and persisted in using only a classical approach. The differences between the two tendencies in relation to their respective theory and practice persisted throughout most of the twentieth century, although some famous figures (notably Winnicott and Fromm-Reichmann) changed position.

Increasingly a pragmatic merging of the two tendencies seems characteristic of contemporary psychoanalytic practice in relation to psychosis. It seems useful to again quote the following:

> First abandon free association, second abandon analysis of the positive transference, third abandon provocation of transference neurosis, because it quickly develops into a transference psychosis in which the analyst becomes the persecutor. Fourth, abandon the analysis of resistances which maintain repression. Phobias are left undisturbed because they protect against deeper fears and conflict...In analysing the psychotic regression must not be increased (Rosenfeld, 1988, p.158, quoting Federn).

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

Art Therapists have made much use of psychoanalytic theory while adopting a pragmatic position in relation to psychosis. Case study accounts of their work, a number of which can be found in the book edited by Killick and Schaverien in 1997, suggest a respectful and painstaking approach which gives a long-enough time scale to allow the client to develop sufficient ego strength 'to assimilate what has been projected' into their artwork and the relationship with the therapist (Killick, 1995, p. 114).

The developing nature of art therapy practice has been reflected in the debate about the title of the profession during what I have described as the third period of its development. This debate has been fierce about how much of the title should indicate the psychotherapeutic ethos, despite a clear allegiance to a psychotherapeutic approach. It has often seemed that confusions and tensions about the titles art therapy, art psychotherapy or analytical art psychotherapy have arisen over confusion about the way in which these titles relate to matters of technique. Any one practitioner might on different occasions adopt the techniques implied by any of the titles and the failure to understand this may be as a result of the failure to situate the development of the profession historically.

Substantial accounts of the different practices of the profession in relation to different client needs are being developed and these will be made more potent if they acknowledge the social economic circumstances of the work. The largest single determinant in decisions about appropriate technique are still those made necessary by the framing of practice in relation to a public sector setting. Many policy matters (in addition to the cuts in spending) have influenced health and social service settings. Community-care policies (1990) have not been widely successful and they are often suspected as a rationalisation for cuts in services. This meant that many workers in all disciplines have felt demoralised. Compulsory treatment orders are still

(2000) the subject of investigation by the existing government and if implemented they will fundamentally challenge the way clients perceive the power of people working for the health and social services. Despite the potential in this for further demoralisation about work with people with serious mental disorders, adopting a historical longer-term perspective about the development of the work can alleviate the sense of stagnation that practitioners occasionally report as accompanying practice with long-term clients.

Art therapy is a small discipline that exists on the cusp of the estrangement of the two larger disciplines of psychiatry and psychoanalysis. This interdisciplinary estrangement manifested itself throughout the twentieth century. Freud's fundamental point about 'physicians not attached to public institutions' (Freud, 1911, p. 387) often not having the opportunity to work with the effects of psychosis indicates the foundations upon which much of the estrangement has been built. Psychiatry receives the majority of people who experience psychosis in public institutions; the practice of psychoanalysis is largely confined to the fee-paying clients of the private sector, the majority of whom do not know psychosis. Confusions of practice and the estrangement of the two disciplines seem often to be born out of a failure to acknowledge the marked differences of their two locations. Joel Kovel has suggested that the social location of psychoanalysis is its main flaw (e.g., 1978, p. 331). The psychoanalytic community cannot always understand the pressures operating in public sector psychiatry and those disciplines that make use of psychoanalytic insights in psychiatry do not always manage to translate psychoanalytic knowledge into a form that can be used in public sector situations.

The estrangement between the two disciplines has regularly been exacerbated by the socio-economic circumstances of the twentieth century. At the end of the twentieth century inadequately resourced psychiatry, the appearance of the 'managed-care' strategies of health insurance in America and the international push towards evidence of effectiveness are all economically driven phenomena that could potentially increase the estrangement. Yet numerous commentators in Britain alone (Jackson, 1994, 1995; Berke, 1995; Barham, 1982, 1992, 1995 and Williams, 1994, 1999) have suggested that fraternization would be in the interests of the seriously mentally disordered.

In America, Luhrmann's book *Of Two Minds: The Growing Disorder in American Psychiatry* (2000) describes the situation of the rift between psychiatry and psychoanalysis starkly. Whereas she acknowledges and documents the ideological conflict between pharmacological psychiatry and psychoanalytic psychotherapy, she suggests that practitioners on both sides of the ideological divide recognise the necessary contribution of the other camp. Indeed there is growing evidence to support the American 'practice guidelines' that optimal practice when faced with

psychosis is a combination of psychotherapy and psychopharmacology (American Psychiatric Association, 1993, p. 6; American Psychiatric Association, 1994, p. 15). Consequently Luhrmann draws the conclusion that what has actually made the situation fraught for American practitioners is the economically driven 'managed-care' policies of the health care insurance industry and not the ideological estrangement. Repeatedly she quotes the exasperation with managed-care of practitioners on both sides of the ideological divide.

> Most of the patients were in the worst phase of their crisis because patients who weren't in that stage were no longer hospitalized. They were heavily medicated and often angry at their doctors. This was particularly true of psychotic patients, who were often discharged before they fully realised how sick they'd been. Older psychiatrists said that in earlier days, the psychotic patient would come on the unit furious at being incarcerated; then, over three or four weeks there, they'd calm down, feel depressed at what they'd done when they were crazy, and by the time they left they'd be so grateful to the psychiatrist for getting them back to normal that sometimes there would be tears in their eyes. "It made us feel good", one psychiatrist said, "and now the patients never get to that point anymore. Now they leave us furious as when they come in and only a little less crazy". So the units were tense, the staff were demoralized, and the patients were sicker than they ever had been. They'd be discharged sick and the psychiatrist would be frantic, feeling responsible for someone who often was suicidal and barely functional. There was a pervasive undercurrent of doom and panic...There was a lot of pressure to move patients out before they were ready and a lot of anxiety because some of the patients were still suicidal. The managed-care company would still say we needed to move them out and the liability of course was on the doctor. If you discharged a patient who then committed suicide, it was *your* fault. And the managed-care company would say, "Please don't do anything you think is clinically unsound". But then would make the family responsible for this huge bill. It was very unfair to the family and unfair to us. And it got worse (Luhrmann, 2000, p. 245).

Luhrmann's account is sobering for practitioners of any discipline. As yet nothing like the strictures of insurance managed-care had reached British or other European shores. The situation of much art therapy practice in Britain is within the public sector. Resources and access to services are not managed according to the amount afforded for insurance premiums but there are a number of aspects of the market in health care that have made commentators describe the situation about access to services as a lottery. It has also been important to articulate another arbiter of access, which is class. Class issues have an impact upon the treatment offered in all heath care (Townsend, Davidson, & Whitehead, 1988; Commission for Social Justice, 1994). They seem particularly evident in the forms of treatment available to people with serious mental disorders.

The debate raged during the 1980s and 1990s about whether class was still an issue in many areas of public life. Meiksins-Wood (1998) in the revised edition of her book *Retreat from Class* (1986, p. *xii*) has suggested that the post-modern and post-marxist tendencies (she dubs these anti-marxist) that emerged during the 1980s and 1990s are being challenged in this new historical period. Their exclusive emphasis on 'discourse' and 'difference' are giving way again to

explanations that involve a unifying social base like class. This was seen even in the ingenuous rhetoric of some government ministers about access to higher education during the early summer of 2000. The relationship between class and health and the particular impact of class and relative poverty in the appearance of psychosis provides an explanation that returns to the circumstances of a person's life. Such explanations also challenge the absence of class-consciousness from discussions about psychoanalysis and its failure to be more represented in the public sector.

Most people have a sense of the class from which they originated, and this shapes their sense of identity. It is possible to see the echo of ancient myth and tragedy in the photographs of the people of Byker by Sirkka-Lissa Kontinen (see chapter four), but they arise from a different set of class conventions than those normally encountered by psychotherapists.

The question of whether or not a client has 'psychological-mindedness' (Coltart, 1988, pp. 819-20) is something that I consider might mistakenly exclude many public sector clients from access to the small amount of talking psychotherapy that exists in the health service. Whereas in art therapy the leisurely process of making art (hopefully in a studio) might provide the client sufficient time to begin to understand something about the therapeutic process. It may also enable the therapist to glimpse aspects of the client's inner world in a way that can be clearly understood as demonstrating psychological-mindedness. In chapter ten I offered the example of one client wrongly diagnosed as 'educationally subnormal' who subsequently made humorous and ironic use of archetypal images. This is not to underestimate the delicateness of approach required to translate a sense of class awareness into principles of practice. There remains a need for the demystification of psychotherapeutic work (something much considered by the practitioners of the North London Women's Therapy Centre). This is in contrast to those psychotherapeutic practitioners and art therapists who have sought a solution to the difficulties of practice in the public sector by leaving it.

The art therapy profession has not been shy of making links with trade unions and this has been a part of what has enabled it to maintain its position in the health and social services. Other strategies that helped the development of the profession have included opposition to cuts in services and the quest for state registration that was successful in 1997. Future strategies for development will necessarily include a combination of all of these strategies that have been used before, and this does imply a level of political awareness (certainly at the level of policy but also on a wider societal level). The period of social psychiatry practice was one with which art therapy developed successfully. Currently most health policies require the demonstration of effectiveness, and this will mean that art therapists have to expand their repertoire of evidence to include some of the tenets of evidence-base practice (EBP). However, Luhrmann's account of managed-care is a

cautionary tale about putting too much store by the rational use of even good evidence or 'optimum principles of practice'.

The misery implied by Tuke of 'the insane poor, whose situation has in general been too pitiable for words to describe,' (1813, p. vii) urged him to make a response '*that nothing has been done, whilst any thing remains to be done*' (1813, p. xiii). Similarly there are high levels of alienation experienced now by people with serious mental disorders who find it hard to ever open their curtains or who spend whole days at a time unable to leave their isolated beds and this without anyone else knowing. This also requires a response, one that moves beyond the confines of psychiatric treatment, psychotherapy or health care costs into a political argument about the nature of civilised society.

Although the Quakers are discouraged from direct political involvement (not unlike psychotherapists) Tuke was one of the first to offer a financial donation to Wilberforce's election in 1807. Subsequently the whole Tuke family supported the campaign against slavery. His other philanthropic concerns might by present day standards be viewed in a political light.

> He devoted his life to his faith, his family, his business, and to the improvement of the condition the poor, the sick and the oppressed. His philanthropic interests ranged from the York Dispensary and Hospital to the Faithful Female Servants Society, from anti-slavery to Irish relief and Catholic emancipation, from popular education to prison reform, from provident societies to temperance movements. But living in the atmosphere of the Retreat, itself a family concern, he devoted himself above all to the care and condition of the insane (Jones, 1996, p.2).

Other famous figures in the history of insanity (notably Pinel) have been similarly politically engaged. It seems hard to escape the implications of Barham's idea of 'the ideological force field in which the whole problem of schizophrenia is entrapped' (Barham, 1995, p. 27). For art therapists this needs to be addressed most immediately at the level of the institutional practice in terms of how they construct a therapeutic frame for their work that is sustainable and understood by the institution. However, there are clearly wider political issues that are relevant, not least of these are the deprived living circumstances in which many clients live.

<u>Adapting the therapeutic frame: using art and psychotherapy in the public sector</u>

The experience of psychosis provokes a dread or even a terror of its return. It is this dread that art therapists and other practitioners are helping clients to face. Sometimes it is hard to understand or enable clients to understand the distinction between primitive inner world anxieties and the influence of their alienated position in society. Kleinman's book (1988) shows the mistake of attempting to understand the impact of a chronic illness in ways that do not allow for the impact of the social world upon the patient's sense of identity. This has helpful relevance.

Psychiatric diagnosis does not generally include the fear associated with psychosis, whereas for psychoanalysis terror and disrupted states of mind are central to a theoretical understanding of psychosis. I do not think that the difference is the result of psychiatry judging schizophrenia solely as a disease process. The history of the work shows how many have attempted to offer a multifaceted response at the level of body, mind and social circumstance. However, it is the case that psychiatry tends not to encourage the client to explore their fear or terror in any depth. It seems there is a long tradition of appealing to the client's sense of rationality or to those things that enable the client to use their 'power to control the disorder, is strengthened and assisted' (Tuke, 1813, p. 138). Searles comes closest to this in a psychoanalytic frame. It is central to his thinking that the therapeutic process at work between patient and therapist 'is a mutual, two-way one' (Searles, 1979, p. 428).

Sometimes for art therapists there is a resulting tension about how to acknowledge terror using the insights of psychoanalytic psychotherapy and still provide a therapeutic frame appropriate to a psychiatric setting. The ways in which a client might make art are used as the central way that containment, transference and engagement are mediated. Absorption in the art making process and eventually in the object that has been made makes it possible for the therapeutic relationship to be sustained even though very frightening primitive material may be present.

The art object may also mediate aspects of the strange holograms of transference that can emerge in the space between client and therapist. Schaverien's work (1982, 1987, 1989, 1991, 1994, 1995 and 1997) has done much to differentiate the ways in which this takes place. The question of whether or not to acknowledge the transference in work with disturbed processes has remained throughout the twentieth century history of such work, Schaverien has shown that in many circumstances the art object can mediate in the space between client and therapist and this can enable a level of engagement in the relationship which might not otherwise be possible for either. Kleinman's strategy attempts to provide the client with what they need to construct the many layers of their illness narrative and image in order that they might again engage with the personal, social and cultural meaning of their experience. This is comparable to the project of art therapy. However, given the alienated nature of most long-term mental health problems it is not surprising that the project is not straightforward.

The jointly written chapter by Killick and Greenwood (1995) was both descriptive and formative of art therapy practice in the third period of its development. Central to their account of the work was the idea based on the concept of symbolic equation.

> The therapist responds to formal aspects of the patient's relating, suspending references to content and meaning, until symbolising functions enable the patient to experience interpretation *as* interpretation. At times, the focus may need to be entirely on the concrete aspects of the relationship, the art materials, and the physical environment (Killick and Greenwood, 1995, p. 114).

I think their account of the work is a powerful crystallisation of the psychotherapeutic rigour that has developed within art therapy during its third period. However, their clarity of description 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 it is only a brief period when their thinking is of a kind described by the concept of symbolic equation. Whereas I recognise that even though a person's thinking may not be consistently disrupted or inwardly attacked over a long period, 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 would also tend to confine the expressions of people in midst of psychosis to the terrain of the incomprehensible and this would run counter to much progressive historical development in ways of relating to insanity. It seems extremely important to avoid this possibility by balancing close therapeutic attention and the understanding gained from theories about the inner world with what is known about the social world. This is a powerful example of why I am proposing that the development of art therapy will be most potent if the discipline in both its theory and practice can find its own synthesis of art, psychotherapy and socio-political awareness.

It can be enlightening to work in groups with people with a history of psychosis because the ways in which they often manage to help one another can defy those aspects of the diagnostic criteria that suggest that they are not able to relate much to others. It often seems that art psychotherapeutic groups created for them can make a stepping-stone upon which it is possible for them to move between the concerns of the inner world and the effects of the outer world. In such groups there is the possibility of meeting others and sharing many of the special qualities of art making and artwork.

None of this is likely to happen quickly. Long-term work is generally involved. For the client the use of art provides a vehicle that can potentially traverse the inner world and the social. When it is possible to base the work in a studio, the work can be leisurely and this can enable the possibilities for absorption in art making. It can also offer the time during which it might be possible to grasp some understanding of the processes of therapy. I recognise the extent to which the idea of leisurely time runs counter to the market culture in health care and indeed in the contemporary zeitgeist which sets off many people rushing around. Needing a slow time to recover is what people with a history of psychosis speak to me about. The nature of the condition repeatedly suggests that it exists where there is a failure of containment. Killick suggests that this is

> at the level of "unintegration" as proposed by Bick (1968), with particular reference to the patient's use of "intrusive identification," as defined by Meltzer *et al.* (1986), as a defence against catastrophic anxiety (Killick, 1997, p. 38).

The existence of a studio and the institutional containment it represents can expand the capacity of what the therapist is able to contain for the clients. Searles draws attention, throughout his writings about the extent to which the therapist is emotionally engaged and at risk in therapeutic relationships with people in the midst of psychotic processes. A studio can also do much to enable the therapist to sustain the work.

The politics of the aesthetic in art therapy: some anachronisms in the use of art

There are three distinct histories of art made by people in the midst of psychosis. One is concerned with its status as art and the others are concerned with its uses as diagnostic and therapeutic tools. Fascination with such art has understandably endured throughout the twentieth century. However, there are formalist aspects of the scholarship of the 'art of the insane', particularly that concerned with the problematic group the 'golden age of psychotic art', that are comparable to the attempt to focus art psychotherapy practice exclusively within a frame of therapy that does not acknowledge the institutional or political world.

There are interesting connections between the scholarship associated with the 'art of the insane' and 'art brut'. For example, both assume a nostalgic view of works of art made in the past. It is as though they wish to study preserved specimens that have not been 'contaminated' by contemporary cultural influence. In part this explains their antagonism to art therapy.

Scholars of the 'art of the insane' often on the basis of ignorance regularly convey (together with proponents of art brut) that there was a time, now past, when people in mental hospitals were able to produce art which was unadulterated by either drugs or therapy. This art they feel was neither sanitised nor watered-down. The present day practice of art therapy is not one they would feel to be an honourable tradition because they see it as a part of the process of

contamination of erstwhile spontaneous art. This is not calculated to win the hearts and minds of art therapists. However, I was powerfully affected by some of the works from the Prinzhorn collection that were shown at the Haywood Gallery at the end of 1996. I also had some of my assumptions about the way such work is exhibited disrupted, because the essays included in its catalogue offer a finely drawn outline of the collection. Unlike scholarship I had grudgingly encountered previously in this area, the essays by Brand-Clausen, Jadi and Douglas provided my first encounter with a discussion of the late twentieth century themes that emerge from such work. Brand-Clausen shows how the difficult history of the period in which the Prinzhorn collection was made is apparent in many references in the artwork. Jadi takes the work of the patient artist Weiser to propose the idea that such art is made 'close to the core of the artistic experience, and *belongs* the context of twentieth century art' (Jadi, 1996, p. 25). Douglas expands on this concern with the links between contemporary artistic practice and the art housed in such collections. She also convincingly suggests that it is unsurprising that it was those *psychiatrists* who worked most respectfully with their patients who first noticed their spontaneous art making. All of this is in contrast to what I had been able to take from scholarship concerned with 'the golden age of psychotic art' which tends to characterise the practice of psychiatry and therapy as at best a species of the philistine and at worst as barbarism in relation to spontaneous art making. It seems that fascination with such art will continue but that modern consciousness will increasingly not allow for the use of the diagnostic category 'psychotic art', because it is too difficult to generalise about the features of such art and because psychotic processes are now more widely understood to be ubiquitous. Also a modern consciousness such as that indicated by Brand-Clausen, Jadi and Douglas would tend to see the ways in which psychotic processes may offer a vantage point from which to see the mainstream culture afresh. Again this in contrast to earlier scholarship that seemed to wish to maintain a distinction for this art as a way of evading its 'contamination' by contemporary culture.

In stark contrast to this I make the beginnings of a case for the greater inclusion of contemporary influences in thinking about how art therapists work with the art made by clients, it is important not to isolate the mentally ill, either by incarcerating them or by leaving them and their art on the margins of society and culture. The incorporation of the art associated with psychosis would be valuable to the host culture. In addition knowledge of the wider culture could provide sustenance, containment and inspiration to people who experience psychosis.

Consequently I suggest that the romantic tradition of understanding art that is widely adopted in art therapy practice could be augmented by more inclusion of themes from contemporary art and popular culture. This would involve an aesthetic that has a sense of history

and context. A project that 'involves thinking through the relations between universal and particular once again, this time on some mode other than that of the singular law which flattens all specificity to its own image and likeness' (Eagleton, 1990, p. 345-6).

What is needed is a system of aesthetic criticism appropriate to art therapy practice that can move backwards and forwards between the art object and the context in which it is made and received. It is enlivening to struggle to hold in mind the essentials of *identity* together with a grasp of the changing *relationships* in which identity exists. This flux and the conflicting tensions between identity and relationship are always present. These dynamic forces are seen at play in many disciplines, aesthetic criticism, history and politics are examples of just three that are relevant to the practice of art therapy.

The inclusion of art in psychotherapeutic relationships can be a messy business, because it tends to challenge the traditional psychotherapeutic frame. The inclusion of a wider notion of art and the use of suggestion that this implies is potentially even more challenging, but it could contribute both to the empowerment of clients and the creative mental health of therapists.

> The construction of the modern notion of the aesthetic artefact is thus inseparable from the construction of the dominant ideological forms of modern class-society, and indeed from a whole new form of human subjectivity appropriate to the social order. It is on this account, rather than because men and women have suddenly awoken to the supreme value of painting and poetry, that aesthetics plays so obtrusive a role in the intellectual heritage of the present. But my argument is also that the aesthetic, understood in a certain sense, provides an unusually powerful challenge and alternative to these dominant ideological forms, and is in this sense an eminently contradictory phenomena (Eagleton, 1990, p. 3).

The inclusion of contemporary art and influences form popular culture is exciting and it demonstrates that art therapy is a living and developing discipline. The need to demonstrate effectiveness can in contrast to this seem dry and even pedestrian.

<u>The politics of evidence-based practice</u>

Yet if art therapists do not manage to enter the race in health care to produce evidence of effectiveness this will risk excluding them and their clients from contemporary accounting. In section five I have used the word 'gathering' to suggest a metaphorical way of understanding the politics of what is needed in relation to this push for evidence. There are some understandable fears elicited in psychotherapeutic disciplines about what might be lost in terms of human inspiration for the work, if too much is accounted for in systematic studies. That so much in psychotherapy depends upon human qualities does not mean however, that it should not be subject to scrutiny of a certain 'scientific' kind.

The fears about what might be lost gain a sobering and realistic perspective when it is recognised that despite the significant contribution to psychotherapeutic work with people with

serious mental disorders; no systematic investigation of the supportive work art therapists do with disturbed clients has yet been made. This situation can only be remedied in ways that involve a wider research strategy. Art will be needed to ensure the profession retains its core identity. My knowledge of art therapists suggests that they will be tenacious in this. However, it is the case that surprisingly large numbers of them have made a start in the process of gathering evidence. My own modest contribution to this has involved a census that demonstrates the amount and the range of work they do with disturbed and deprived client groups. A proposal is being considered by NICE (National Institute for Clinical Excellence) to extend this kind of census study upon the work of art therapists. The potential benefit of government umbrella organisations like NICE will be forthcoming if it is able to provide the kind of funding needed. Funding would to some extent assuage the scepticism with which NICE is understandably often currently greeted. Funding makes the difference between researches being possible or not.

Evidence that optimal treatment for people with serious mental disorders is a combination of medication and psychotherapy should be used together with strong international evidence that the organisation of services for the seriously mentally ill is not adequate if it is modelled on primary care alone (Goldberg and Thornicroft, 1998). This is because there is a wide-range of services that are needed. They include complex psychotherapies, administration of mood stabilising medications and the humane management of suicidal, homicidal and seriously disturbed clients. All this needs to be fitted to the increasingly complex needs of massive cosmopolitan conurbations; indeed, rampant urbanisation suggests that many cities are becoming megalopolises. The massiveness of the urban sprawl makes the delivery of services on a human scale much more challenging.

That primary care is not enough is the place in the argument that allows disciplines such as art therapy to make their case.

The future

Katherine Killick's comment that her engagement in art therapy with patients in the midst of psychosis 'differed from that which I had been trained to understand' (Killick, 1999, p. 106) is something that I recognise. The prevailing anti-psychiatry ethos that was present at the time of her art therapy training and mine left too many unanswered questions in relation to work with disturbed processes.

The interesting story by Clements (1987) (on pages 106-8 above) of the capacity of Mme. Victoire to understand but not be in a position to practice analysis powerfully evokes for me some of the issues that need to be understood in order to retain the feasibility of art therapy training. The

impact of fees upon access to higher education and training is just one contemporary strand. Many socio-political issues need to be woven together with sensitive inner world knowledge.

The whole thrust of my thesis has involved showing the need to include in the practice the elements of art, psychotherapy and political awareness. This is in the interests of clients and it is why I have made the case that it is important that future trainings in this area are able to offer students a well-woven account of the synthesis of these three powerful threads, all of them essential to the nature and politics of art therapy practice. I hope I have made it clear that the history of art therapy has provided the necessary loom and that many of the threads are already woven.

What is needed now is the continued persuasion by art therapists of our communities and our politicians that respect and valuing of ourselves is proportional to the respect and valuing we are able to acknowledge for people with serious mental disorders.

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