ATOL: Art Therapy OnLine

The Lost Studio:
"You don't know what you've got till it's gone"

Christopher Brown

The subtitle is from a Joni Mitchell song and the line continues 'they paved paradise, put up a parking lot'. I felt something of that sentiment through a recent experience of losing the art therapy studio in which I had worked for 17 years. This experience made me think about the elements I missed and why they were important to me. In this paper I will briefly describe the studio spaces created within three different social contexts, all driven by government legislation, they are: the mental asylum, care in the community, and managed care. I will then focus on one particular element: the display of pictures in the room providing containment for the therapist.

The mental asylum

The county asylum act was passed in 1808 but it was not until the Lunacy act of 1890 that asylums really took off and became the cutting edge of care for the mentally ill. Hill End Hospital in St Albans, Hertfordshire was a fine example of this. Figure 1 shows a

view of the rear seen from the edge of the grounds done by a patient sometime in the 1970's.

Figure 1

I went to work in the art therapy department there in 1991. The department was located in an old ward and set up as a large studio with individual space allocated to each patient. This was in the tradition of art therapy studios developed by founding fathers of the profession such as Adrian Hill and Edward Adamson, but with a twist. The twist was the application of psychoanalytic ideas to the practice of art therapy with patients in psychotic states by the former head art therapist Katherine Killick. A key part of her approach was use of the studio space to engage with psychotic patients on the concrete rather than the symbolic level.

The large tables (see Figures 2 & 3) allowed patients to leave work undisturbed and there was plenty of room to move around with easy access to the outdoors.

Such spaces have been described as ‘the asylum within the asylum’.

Figure 2

Figure 3

Care in the community

The 1990 NHS and Community Care Act saw the beginning of large scale closure of the old asylums and provision for locally based services integrated into the communities they served. In 1995 the art therapy department moved from Hill End Hospital to a delightful old building in the middle of the town (Figure 4).

Figure 4

We were able to specify our need for a dedicated art therapy studio as a discreet space separate and clearly boundaried from the other services using the building we shared. As a result of this move the demographics of who we worked with moved away from those with psychosis towards those more integrated outpatients who could use a psychotherapeutic approach. This was the time when there was a rise in the popularity of the term ‘art psychotherapy’. We ‘seeded’ the space with pictures gleaned from the old Hill End archives and over time the patina of patients’ artwork on the walls became a feature of working in the space. The space was large enough not to feel too claustrophobic yet small enough to feel cosy when making art and sitting talking. I had experience of using other rooms available that had a cooler, more restrained aesthetic without work on display, but in recent years only used this studio. This immersion in the studio heightened my aesthetic sensibility to the art produced and displayed there. I had

also undertaken a psychotherapy training at the Tavistock Centre in London, which enabled me to work in more depth with transference. Through these developments in my practice the emotional experience of being a therapist became, to some extent, located in the studio. The studio was a containing frame for my clinical work. See Figures 5,6,7,8,9

Figure 5

Figure 6

Figure 7

Figure 8

Managed care

Managed care is a term used to describe the United States health care system, which aims to provide cost-effective treatments with outcomes that can be measured and set against targets. In the United Kingdom, each successive government initiative and reorganisation has brought managed care more fully into the NHS. In this context, cost-effectiveness resulted in the closure of the building in which the studio just described was housed, and a move into the local Community Mental Health Centre. Furthermore, it meant we had to share a room with dramatherapy. We quickly discovered how our needs differed from theirs and learned about the dogma of multi use rooms. Our new manager - a dramatherapist - was against us putting any pictures up on the walls.

Figures 9, 10, 11 show the bareness of this space.

Figure 9

Figure 10

Figure 11

My initial encounters with this new clinical space were characterised by anxieties about being able to contain feelings evoked in me by the move and the changes it had brought. Over time we negotiated a two-tier system of displaying pictures, one set always on display, another set to be put up and taken down when art therapy used the space. Figures 12 & 13 show some of the art therapy set.

Figure 12

Figure 13

Discussion

There are very good reasons for maintaining sole use of an art therapy studio. It allows a high degree of confidentiality, security and continuity for the art that is produced, displayed and stored within the space. This holding function has been an integral part of studio based art therapy practice and is often crucial in allowing engagement with the creative and therapeutic encounters we provide.

Art therapists such as Chris Wood (2000) and Sarah Deco (1998) have commented on the way the closure of dedicated mental hospitals and the loss of studios was paralleled with a shift from attachment to the setting towards a focus on the centrality of the relationship between the therapist and the patient. Wood describes a studio used by Chris Lyle with a cool, uncluttered ambience with very few images on display, which

gives the tenor of a more psychotherapeutic frame. She cautions against the potential loss of vitality in such a shift in the setting and warns that working in spaces without adequate provision can affect the sense of containment for the therapist that might affect their own mental health.

In an earlier paper 'Very toxic: Handle with care. Some aspects of the maternal function in art therapy' (Brown 2008) I likened the studio to Winnicott's idea of a holding environment, which exists 'in a complex psychological field, determined by the awareness and empathy of the mother' (1965, p.44). The mother's attunement to her infant means that his experience can be felt to be contained and he feels securely held. The studio functions as a container, not only for the art but also for the creation and continuity of a boundaried therapeutic space, essential to the therapeutic relationship. Intrusions upon this space by other activities and objects fundamentally impact on the boundaries and thus the patients' sense of feeling sufficiently 'held' by this space. This might equally apply to the therapist, who requires a secure setting in which the exposure to emotional turmoil can be contained. It is this last point about the need for the therapist to feel held and contained that I now turn to.

The experience of having and not having pictures on display led me to think about the impact this experience of looking at art had on my own mental state in the clinical setting. I decided that I really had to have some pictures to look at whilst seeing patients. I found myself drawn to one particular picture that I had placed centrally in my field of vision (see Figure 14).

Figure 14

I had found this picture only recently, while sorting through some stored work from Hill End Hospital, it immediately caught my eye and I put it aside. I don't know who created it but my sense is that it was done by someone in crisis, perhaps in an art therapy group on one of the old acute wards. It appears to be left in an unfinished state. I do not find it an easy picture to look at; there is something in the concentric circles that draw the eye into the black, which itself seems to recede deeper into the picture plane, giving an experience of being momentarily visually unbalanced. For me, this experience of being held in a momentary unbalanced state resonated powerfully with my recent experiences of a particular patient. The work had been reaching a crescendo in the transference resulting in some fragmentation in the patient and putting me under pressure not to lose my own mind. We were both in crisis. The patient struggling with unbearable feelings of separation and loss, myself unsettled and anxious following the move. The sense of

crisis, the patient's fragile ego, the fear and danger of imminent catastrophe were all palpable as I sat immobile in my chair, feeling trapped and on the verge of panic. This was intense emotional turmoil needing containment. There was a moment of identification with the picture on the wall where my unbalanced mind was met by the unbalanced aesthetic quality I found there. A mental space opened up, I could think again and put something into words to my patient. How extraordinary!

I was struck by the powerful impact this experience had on me and started wondering how to understand it. Bion (1967) used the term 'reverie' to describe a state of calm receptiveness necessary for the maternal function of giving the infant a sense of the meaning of his mental state being understood. I was familiar with this psychoanalytic way of thinking, what caught me by surprise was the power of the image to embody this function. I re-read Andy Gilroy's paper 'Taking a long look at Art: Reflections on the context of production and consumption of art in Art Therapy' (2007). Around an intense experience of looking at Piero della Francesca's 'The Resurrection' in Sansepolcro, she explores her emotional and aesthetic response to the painting and talks about a profound sense of presence, a connection that makes the viewer feel at home or somehow part of the picture. She goes on to suggest that the way we look at art in art therapy is profoundly influenced by our professional socialisation. Professional socialisation is a process through which a person learns the particular requirements, values and attitudes of an occupational group or place of work. In other words, it is how we turn ourselves into the kind of person the situation demands (Gilroy, 2007).

Managed care in the NHS puts pressure on us to conform to a particular ideology that demands antiseptic rather than humanised spaces. If we lose the humanised spaces that art therapy has traditionally provided, how can we protect the integrity of our core professional self? It is, after all, the arts that give expression to our humanity.

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