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A Historical Overview of Art Therapy
Since the Advent of Deinstitutionalization

Martha Foster

A Thesis

in

The Department

of

Art Therapy

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montreal, Quebec, Canada

September 1989

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DEDICATION

I would like to dedicate this thesis to my parents, Eileen and Bill Foster, for their constant support and encouragement and to Ann Auclair and John Langenbach for helping me find and develop my own voice as a way of knowing.

ABSTRACT

A Historical Overview of Art Therapy
Since the Advent of Deinstitutionalization

Martha Foster

The subject of this thesis is the use of art therapy with chronically mentally ill individuals since the advent of deinstitutionalization. Deinstitutionalization, in this context, refers to a movement that promotes the shift from hospital-based care to community-based care of the chronically mentally ill.

Art therapy has been affected by the changes that deinstitutionalization has had on the mental health system. As a means of reviewing the evolution of this process, the thesis will define the concept of deinstitutionalization and examine the specific factors that led to its implementation. A broad historical overview of art therapy's origins and evolution in the United States, Britain and Canada will be presented charting deinstitutionalization's and art therapy's simultaneous shift from a traditional and established medical and psychiatric model of mental health care towards a more holistic and systemic approach to client treatment of the chronically mentally ill.

Art therapy's integration into a community-based mental

health center will be examined as a means of assessing the expectations and environmental considerations that practicing art therapists may encounter within a deinstitutionalized setting.

The thesis will conclude with personal impressions of art therapy's future role in the treatment of the chronically mentally ill with special emphasis placed on the role that fantasy and reality play in a deinstitutionalized, psycho/social model of community mental health.

TABLE OF CONTENTS

CHAPTER I

1. Introduction

Deinstitutionalization of the chronically mentally ill is a topical issue in the late 1980s for it may have far reaching implications for the chronically mentally ill, society and the mental health field in general.

The concept of this thesis originates within a clinical setting and reflects the author's interpretation and quest to understand more completely the influences that have affected the field of art therapy within a deinstitutionalized milieu. Various areas were explored including the differences between: the institutional-clinical team approach found in many deinstitutionalized settings; the subjective differences experienced between deinstitutionalized and institutionalized settings; and the differences that exist in the artist's and art therapist's role within a deinstitutionalized milieu. To adequately study the differences within institutionalized and deinstitutionalized settings and their implications on the field of art therapy, further examination of the literature pertaining to the deinstitutionalization movement was undertaken.

Until recently, the treatment of the chronically mentally

ill has generally been associated with institutionalization.
A variety of factors have combined to force rapid change in
the concept of their treatment:

1) Research results that demonstrated that hospital
   treatment is relatively ineffective in helping patients
   establish a sustained community adjustment after
   discharge from the hospital.

2) The post-World War II explosion in the number of mental
   health professionals of all disciplines.

3) The availability of effective psychotropic drugs.

4) Ideology of the 1960s, with strong emphasis placed on
   social reform and civil rights.

5) Legal reform.

6) Economic motives for reducing or shifting the cost of
   care for these patients, and

7) A changing concept of mental health care.

In light of these changes, it has become important to
question what the art therapist's present role is in community
mental health and how community-based centers and art
therapists will most efficiently respond to this trend.

A recurring pattern which appears with reform movements
is that vacuums are inevitable. A mental health services'

ability to produce long term solutions for the care and treatment of the chronically mentally ill, the deinstitutionalization movement, which replaced ineffective institutional policy for the chronically mentally ill, is no exception. It is argued in this thesis, that deinstitutionalization has left yet another vacuum in the mental health system. That is, the lack of psychodynamic treatment available to the chronically mentally ill in community-based settings. Art therapy is presented as being a viable alternative to verbal therapy in filling this vacuum. Both the deinstitutionalization movement and the field of art therapy converge in the late 1980s with art therapy vying for a position in the holistic care and treatment of the chronically mentally ill in community-based settings.

2. <u>Definition of Terms</u>

<u>Deinstitutionalization</u>

Many have objected to the term 'deinstitutionalization' for its imprecise, inaccurate, or confusing definition and use. Its uncertain origins and users' vague understandings, however, have not prevented its widespread use as a planning concept.

Deinstitutionalization has been referred to negatively as

a policy fashion which, by condemning traditional care for chronically mentally ill patients, romanticizes the benefits of community-based care (Etzioni 1976). Further, deinstitutionalization has been categorically condemned by some as nothing more or less than a polite term for the cutting of mental health budgets (Dumont 1982).

The current NIMH (National Institute of Mental Health) definition of the term 'deinstitutionalization' proposes a process involving three elements. First, the prevention of inappropriate mental hospital admissions through the provision of community alternatives in treatment. Second, the release into the community of those institutionalized patients who have been given adequate preparation for such a change. And third, the establishment and maintenance of community support systems for non-institutionalized people receiving mental health services in the community (Braun et al. 1981).

More specifically, the Province of Quebec in a recent Report of the Provincial task force on mental health (also known as the Harnois Report) refers to deinstitutionalization as:

- la reintegration, dans des condition, appropireés, de personne ayant sejourné ou sejournant dans des milieux institutionnels;

- l'humanisation des milieux de vie subsituts et

4

institutionnels afin de permettre aux personnes qui y
sejournent de jouir d'une qualité de vie décente;

-   la disponibilite du'un réseau de services en mesure
    d'offrir à la personne et à son mileiu l'aide et le
    support nécessaires pour le maintien dans la communauté;

-   l'acquisition de capacités et de compétences qui vont
    favouriser, pour la person quel que soit son milieu de
    vie, la reprise en main de sa situation (Harnois Report
    1987,24).

The shift in services from institutional care to
community-based care permits the creation of a new
configuration of mental health services in Quebec and
effectively aims at cutting in half the patient capacity of
large psychiatric establishments.

The Harnois Report documents the rise of the
deinstitutionalization movement:

> "Que le ministere de la Santé et des Services Sociaux
> limite le mandat specifique des grands établissements
> psychiatriques à la dispensation de services
> de'intervention prolongée requis en fonction de la
> persistance et de la complexité de troubles mentaux
> sévères, incluant:
> - le traitement spécialiseé;
> - les activités de réadaptation;
> - les services de protection, d'assistance et
>   d'encadrement requis à long terme pour les personnes
>   les plus vulnerables.
> Au'exceptionnellement, un mandat additionnel en matière
> de services de traitment intensif de courte durée soit
> octroyé a certains grands établissements, lorsque requis
> par des particularites regionales, de facon à assurer une
> accessibilité aux service le plus pres possible du milieu

de vie des personnes" (Harnois Report 1987,116).

The definition of deinstitutionalization has grown from the basic NIMH concept of extracting patients from psychiatric hospitals and redirecting them into the community to a more comprehensive and specific emphasis on the localization and quality of the services offered in the communities.

Deinstitutionalization has sociological as well as physical connotations. Sociologically, it implies widespread and basic adjustments in traditional patterns of care for a basically dependent and persistently disabled population. In addition, public awareness of their needs that ideally was supposed to accompany deinstitutionalization has not occurred.

Deinstitutionalization is no longer merely a philosophy. It is now a movement with a history. The outcome appears mixed. On the one hand, it has generated and clarified some principles that may be applied in designing effective programs for the chronically mentally ill in non-traditional settings. On the other hand, the deinstitutionalization movement in a global sense is beset by serious difficulties often resulting in inadequate programs for the majority of individuals with severe mental disabilities.

Chronically Mentally Ill

Changes in the locus of care resulting from deinstitutionalization have made it more difficult to define the term 'chronically mentally ill'. Individuals once defined as long term residents of psychiatric hospitals now live in many different institutional and community settings. Some have experienced long histories of hospitalization and aftercare while others have never been in psychiatric institutions (Bachrach 1982).

In a work prepared for the National Plan for the Chronically Mentally Ill, the following operational definition was developed:

> "The chronically mentally ill population encompas.ses persons who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, and paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to three or more primary aspects of daily life - personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation - and that erode or prevent the development of their economic self-sufficiency" (Bachrach et al. 1980,36).

As evidenced by this definition, chronically mentally ill patients vary greatly in many respects. More specifically, three types of handicapping factors can generally be described: intrinsic, extrinsic, and secondary (Wing 1978).

Intrinsic or primary factors consist of persistent psychiatric symptoms that are part of the illness itself, such

as thought disorder, delusions and psychomotor retardation. One to two-thirds of discharged chronically mentally ill patients are significantly disabled by psychiatric symptoms.

Extrinsic factors include handicaps such as lack of social or vocational skills and intellectual or physical disabilities. Various studies have demonstrated that twenty to thirty percent of chronically mentally ill patients have no friends and only a minority have any significant community involvement (Minkoff 1978).

Secondary factors, which represent maladaptive reactions to the illness rather than being part of the illness itself, include loss of self-esteem and self-confidence, helplessness and passivity. The characteristics of the chronically mentally ill patient include high vulnerability to stress, deficiencies in basic coping skills required for everyday living, extreme dependency, perceiving themselves often as helpless, as having difficulty with working in the competitive job market and difficulty with interpersonal relationships.

3. **Methodology**

The direction of my argument in the thesis will be from the general to the particular - from the overview to the personal, from the social to the psychological.

As a means of examining how the field of art therapy has been affected by the changes that deinstitutionalization has had on the mental health system, the thesis will include a literature review defining the concept of deinstitutionalization and the specific factors that led to its inception as a movement.

Due to the sparse available written literature on the subject of art therapy's historical origins and evolution in Canada, Chapter II, which addresses the decentralization of art therapy in the U.S.A., Britain, and Canada is supplemented with interviews with Pioneer art therapists including Irene Dewdney, Beth Robinson and Maurice Brault and interviews with contemporary art therapists Rachel Garber and Yvon Lamy. The selection of these interviewees was based generally on a random sampling of Canadian art therapists with specific consideration given to the subjects' past or current involvement with issues related to the deinstitutionalization movement and its effects on the field of art therapy.

The interview format included specific questions related to the subject area of this thesis with instruction that the questions be used only as a guideline and could be answered directly, be modified, or disregarded (See questions in Appendix, pp.110). The subjectivity of the claims made by

9

these interviewees and the arguments made and based upon the information derived from these sources is acknowledged.

As a means of assessing art therapy's potential contribution to a community-based center, Chapter IV of this thesis includes further interviews with a program's coordinator, social workers, art therapy intern, and art therapist. Specific questions related to art therapy's integration in community mental health care were presented in a written format to the interviewees and a written reply elicited. These questions are cited in the text of the thesis on pages 76 and 79. A documentation of the applications of art therapy with the chronically mentally ill in a community center aim to illuminate and contribute to the sparse information available in this subject area.

The final Chapter of this thesis concludes with personal impressions of art therapy's future role in the treatment of the chronically mentally ill and examines the role that fantasy and reality play in deinstitutionalization mental health care by comparing the ideas of H.R. Lamb and James Hillman.

4. **Limitations of the Thesis**

Deinstitutionalization affects a variety of people with widely differing residential and treatment histories. Those

affected fall into at least five groups:

1) Individuals who have been institutionalized and released to the community.

2) Individuals who have never been institutionalized, precisely as the result of deinstitutionalization policies and practices (although they probably would have been placed in hospitals twenty-five or thirty years ago).

3) Individuals who have remained in institutions despite deinstitutionalization efforts - that is, residents of hospitals who are unlikely to be released.

4) Individuals who are now entering institutions for the first time and are unlikely to be released to the community.

5) Individuals who are not entering institutions for the first time and are likely to be released within a short period of time, with the expectation that they would be readmitted (Bachrach 1982).

This thesis limits itself to addressing specifically the first two groups affected by deinstitutionalization listed above. These two categories encompass the major population types that utilized the community-based services and art therapy that is further discussed in Chapter IV of this thesis.

Groups 3, 4, and 5 deal with the chronically mentally ill within the institutional or hospital framework and require further elaboration and study beyond the scope of this paper. Art therapy's potential contribution to the care of the chronically mentally ill in this type of setting also warrants a more extensive exploration.

The socio-cultural implications represented by various social, political and cultural movements that took place over the past forty years have not been addressed in this paper, although its varying influences on the deinstitutionalization movement and the field of art therapy are acknowledged. Further study in this subject area might contribute to a more complete analysis of the interrelatedness of these trends to each other.

This thesis is specifically geared towards co-art therapists as well as to other CLSC and community-based organizations who might profit from art therapy in their programs.

The following Chapter will examine specific factors that have influenced the deinstitutionalization of the chronically mentally ill, charting how the deinstitutionalization movement has created a vacuum in the mental health care of this population.

CHAPTER II

DEINSTITUTIONALIZATION IN NORTH AMERICA

In the nineteenth and twentieth centuries, a recurring pattern appears in mental health reform movements. Repeatedly, priorities are identified and a focus developed to ameliorate the prevailing ideology of mental health care and the specific needs of the chronically mentally ill at a given time. Each reform movement encounters problems of implementation and adaptation resulting in a subsequent decline in supplying effective long term solutions.

This chapter explores the ineffectiveness of institutionalization on the care and treatment of the chronically mentally ill and will examine specific factors that contributed to the reform of this system by a new movement called deinstitutionalization.

1. The Advent of Deinstitutionalization

Research results that demonstrated conclusively that hospital treatment was relatively ineffective in helping patients establish a sustained community adjustment after discharge, was one of many factors responsible for the trend towards decentralization of the treatment and core of the chronically mentally ill. Specific causes that influenced the advent of the deinstitutionalization movement included:

a)   the ineffectiveness of institutionalization

b)   the post World War II explosion in the number of mental health professionals of all disciplines and the emergence of humanistic psychology

c)   the availability of psychoactive drugs

d)   the ideology of the 1960s with strong emphasis placed on social reform and civil rights

e)   legal reform

f)   economic restraint, and

g)   a changing concept in mental health

A)   The Ineffectiveness of Institutionalization

In the mid-nineteenth century, psychiatric reformers in the United States, shocked by the condition of the chronically mentally ill in the community, fought for humane hospitalization. They were victorious in institutionalizing the chronically mentally ill, but within a few decades, the institutionalized treatment of these patients created unanticipated problems. Conditions in hospitals steadily deteriorated with criticism leveled at the harmful and dehumanizing effects of institutionalization on patients. Nevertheless, the pattern of institutionalization continued, until the mid 1950s, with state hospitals providing nearly fifty percent of all psychiatric care. Overcrowded and understaffed administration placed more emphasis on management than on treatment. This led to abuses and to the institutionalization syndrome characterized by the patients' withdrawal, apathy and infantile behaviour (Paul & Lentz 1977).

Over the last thirty years there has been a dramatic shift from primary reliance on long term hospitalization to short term and community based treatment of the chronically mentally ill. At one time, state hospitals fulfilled the function for society of keeping the chronically mentally ill out of sight. It was also believed by some, prior to the

advent of modern psychoactive medications, that the controls and structure provided by hospitals had value for the long-term chronically mentally ill. Although institutionalization had served a limited function, various trends were setting the stage for a new era in mental health care.

Beginning in the mid 1950s a new trend started. The number of state hospital beds in the United States decreased from 559,000 in 1955 to 138,000 in the late 1970s, with the average length of stay dropping from six months to three weeks. By 1977, state hospitals provided only nine percent of all mental health care in the country. These changes, it should be noted, reflect differences in where and how treatment is provided, not the prevalence or effects of chronic mental illness. The decline in state hospital beds has been accompanied by an equally dramatic increase in psychiatric beds in general hospitals and other local facilities. Readmissions of patients to hospital increased to seventy percent of all admissions, creating what is known as the revolving door syndrome (Sharfstein 1984).

The Ineffectiveness of Institutionalization - Canada

Although Canada has never had a national mental health center's program, it did have a mental health movement that took various shapes in different provinces. Some of the

programs, eg., those in Nova Scotia and Saskatchewan, are examples of successes in establishing comprehensive services in the community. But in Canada, as in the United States, countertrends have arisen.

In 1931, for instance mental hospital reports told of problems of the chronically mentally ill patient for whom hospital care was no longer essential but for whom no other accommodation was possible. Psychiatric care in 1948 was described by the Department of National Health and Welfare as "the day of the snake-pit". Patients and their relatives used the hospital only as a last resort. There were few mental health clinics or psychiatric units in general hospitals. By 1960, 0.4% of Canadians were in mental institutions; of these one-half (37,000) had been hospitalized more than seven years. Death in the hospital was more likely than discharge for the 53,000 long-stay patients (Richman & Harris 1983).

B)   <u>Post World War II Explosion in the Number of Mental Health Professions</u>

In the years following World War II, there was a mushrooming of a variety of mental health disciplines often grouped under the rubric of humanistic psychology. These therapies included Gestalt psychology, Existential psychology,

Org.. ismic psychology, and Social psychology. It also included personality formulations by individuals such as Carl Rogers and Rollo May.

Expansion and professionalization of these therapies in their own right developed primarily due to the restrictive role assigned to them by the psychiatric profession. Therapies that failed to carve out a systemic rationale for their own unique contributions to the field of mental health found that subsisting on "crumbs from the psychiatric table" had little sustenance to offer (Pattison 1969). The disengagement of these adjunctive therapies from their psychiatric underpinnings has encouraged many alternative therapies to branch out into untraditional, deinstitutionalized settings. The field of deinstitutionalized art therapy follows this model in some respects.

Reflecting on the explosion in the number of non-medical mental health professions in the 1960s and early 1970s, Mary Lee Hodnett states, "Changes in social attitudes and politics are occurring with great rapidity, almost telescoping each other in a pace accelerated, at least in part, by a disenchanted mental health system seeking change" (Hodnett 1972,113).

Recently, the Coalition of Independent Health Professions was formed by various professional groups as a means of maintaining a voice in their own professional destiny vis-a-vis organized medicine. An earlier plea against the medical domination of psychoanalysis is found with Freud's (1926) The Question of Lay Analysis which includes many insights about the unfortunate effects of such a domination on all other professions.

Because many humanistic psychologies influencing therapy disengaged themselves from the dominance of the psychiatric profession, they were potentially free to explore new and innovative ways of challenging existing institutional strategies of patient mental health care. As an outgrowth of this expansion, these therapies have branched out into deinstitutionalized settings promoting the decentralization of treatment for the chronically mentally ill.

C)   Availability of Psychoactive Drugs

In the 1960s, psychoactive drugs were revered as a virtual cure-all for core psychotic symptoms experienced by the chronically mentally ill. The medical profession forecast that these drugs would have far reaching effects on institutionalized chronically mentally ill patients enabling them to live in the community and receive maintenance

treatment in deinstitutionalized settings.

President Kennedy expressed the prevailing ideology on psychoactive drugs in a response to the Community Mental Health Centers Act of 1963. "This was a national mental health program to assist in the inauguration of a wholly new emphasis an approach to care for the mentally ill. This approach relies primarily upon the new knowledge and the new drugs acquired and developed in recent years which make it possible for most of the mentally ill to be successfully and quickly treated in their communities and returned to a useful place in society" (Leighton 1982,71).

Evolving from their original adjunctive role in the care and treatment of the chronically mentally ill, drugs became a primary means employed by the medical profession in controlling disabilities such as schizophrenia, depression and anxiety. Many chronically mentally ill patients who, prior to breakthroughs in drugs, would have been treated on an in-patient basis in hospitals were then able to live in the community and receive drug treatment on an out-patient basis from deinstitutionalized treatment centers.

Drugs, however, did not prove to be a panacea for the problems of mental illness. Patient response varied greatly. Reversible and sometimes irreversible neurological side

effects such as sysphoric and parkinsonian damage caused by secondary effects of medication have since dispelled the ideological expectations of drugs being the answer to mental illness. It has been estimated that as many as 50% of schizophrenics may not benefit from neuroloptics (Gardos & Cole 1976). Of those who did respond, 25-30% relapsed within one year and 50% relapsed within two years (Hogarty, Schooler, Ulrich et al. 1979). While medication had proven to be demonstrably effective on symptoms such as hallucinations and delusions it had not appreciably reduced negative symptoms such as apathy, anergia, and withdrawal (Carpenter, Heinrichs & Alphs 1985). Moreover, 15-50% of patients experienced serious side effects from using these drugs (Johnson 1985). While medication may have been a necessary part of some treatment programs, the side effects often proved to be a disruptive and distressing as core psychotic symptoms.

Despite discrediting studies conducted in the 1970s and 1980s that highlight the limitations and adverse effects of psychoactive drugs on the chronically mentally ill, the medical profession has consistently supported drug programs and early dismissal of chronically mentally ill patients back into the community. Perhaps the medical profession refuses to accept the fact that these drugs have had only a modest effect on the plight of the chronically mentally ill in general. Perhaps, there was no foreseeable means to reverse the process

of deinstitutionalizing these patients on a global scale once such a universal program was implemented. Whatever reason the medical profession had, and still has, for their continued use of drugs, coupled with early discharge of the chronically mentally ill from hospitals, their actions have had a major effect on the deinstitutionalization of mental health care.

D)   Social Reform and Civil Rights

In response to public anger aimed at state mental hospitals and because of the work of journalists such as Albert Deutsch (1948), the Joint Commission on Mental Illness and Health was formed in 1961 (Lamb 1982). Public outcries concerning deplorable conditions in these hospitals gave impetus to the Commission's recommendation to halt the construction of new mental hospitals. All existing state hospitals that had more than one-thousand beds were to be progressively turned into centers that treated long-term chronic diseases, including mental illness. Effective lobbying by the public promoted a re-evaluation of traditional institutional care and consequently encouraged the deinstitutionalization of this patient population.

A variety of civil rights protests gained widespread support in the 1960s and 1970s. These initiatives were

ideologically committed to improving the lives of those perceived as helpless in gaining access to life's entitlements. Connected to other civil rights protests of that era, the deinstitutionalization movement emphasized the unalienable rights of the mentally ill and their legitimate claims on society.

Deinstitutionalization sought to exchange treatment in hospital settings for services provided in the patients' community on the assumption that community-based treatment is more humane and more therapeutically effective than treatment in hospitals. The physical isolation of patients within institutionalized settings was understood to be directly connected to their social exclusion and had to be corrected.

E)   Legal Reform

The move towards deinstitutionalization of the chronically mentally ill began prior to changes in mental health law that was initiated in the 1970s and 1980s. The influence of courts and legislatures on a declining population of chronically mentally ill patients in hospitals can be surveyed by examining three categories that relate to law and the deinstitutionalization movement:

i)   A changing criteria for civil committment

ii) The right to treatment, and

iii) The least restrictive alternative

Political reform, often influenced by financial considerations, is a major factor in the overall policy of the chronically mentally ill back into the community. Although legal reform aimed at protecting the rights of the chronically mentally ill, a hidden agenda aimed at their deinstitutionalization is evidenced in the legal make-up of each of these policies.

i)   Civil Committment

In the United States, the due process clause of the Fourteenth Amendment of the U.S. Constitution contends that a state cannot deprive a citizen of "life, liberty, or property without due process of law". Only under two conditions are the chronically mentally ill civilly committed to hospital. First, because it benefits the committed person, or second, because it benefits society. The first condition is based on the sense of moral obligations that society has to its citizens. Society must care for those individuals who cannot care for themselves due to a mental illness that renders them unable to exercise proper judgment. The second condition is based on the public's right to protection from the presumed danger posed by a mentally ill individual.

In Canada, committment laws vary somewhat from province to province. In Ontario, for example, under the 1978 Amendments to the Mental Health Act, a person can be forcibly hospitalized where serious harm to himself or others is anticipated. Although forcible confinement to mental institutions is a reality in Canada, it is not resorted to as frequently as in the United States (Cragg 1987).

Civil libertarians place greater emphasis on criticising forced institutionalization for the protection of the public, while the medical model proponents argue that society has an obligation in some instances to forcibly institutionalize persons (Bachrach 1983). Since the 1970s, there has been a trend in law towards favouring the protection of the public. This bias works at abolishing involuntary hospitalization, because danger to the public by the mentally ill patient must be proven through due process of law, an extremely difficult task in many instances. This emphasis promotes an increase in community placement of the chronically mentally ill (Chadoff 1976). This trend might lead to mental health workers in the community being asked to work with and treat more difficult and potentially dangerous clients. Civil committment legislation strongly promotes the deinstitutionalization of the chronically mentally ill over other alternatives that would involve their institutionalization.

ii) The Right to Treatment

The concept of a Right to Treatment was first introduced by Birnbaum in 1960 (Slovenka 1977 & Stone 1977). Under this legislation a mentally ill patient has the legal right to adequate medical and psychiatric treatment in a public hospital. Today, this concept is widely accepted as a mcral imperative and a feature of many state mental health laws in the United States.

Right to treatment sometimes has been wavered in favour of economic considerations, because treatment requires an increase in hospital spending to adequately meet the needs of the chronically mentally ill seeking aid. By discharging patients into the community, the costs of improving quality of care is reduced. Promoting deinstitutionalization of the chronically mentally ill versus providing the right to treatment in institutions, becomes a partial solution to the fiscal problems facing institutionalized mental health care.

iii) The Least Restrictive Alternative

An extension of the doctrine of the Right to Treatment has been that this treatment be provided in the least restrictive environment. The least restrictive alternative

was first recognized by the United Stated Supreme Court in 1960 (Shelton v. Tucker 1960). Because hospitals are generally considered restrictive settings, the least restrictive alternative could be seen as yet another strategy aimed at the deinstitutionalization of chronically mentally ill patients. In Canada, as in the United States, chronically mentally ill patients are often dismissed from hospital settings for hospitals are legally labelled restrictive environments.

Despite legal deliberations that encourage community placement and treatment of the chronically mentally ill, the fact still remains that some patients wish to employ hospital settings. In a statement to a California Senate Select Committee on proposed phasing out of hospital services in 1973, for example Priscilla Allen, a former patient, wrote "there are people who will never be able to adjust to life within the community". She added that community care and treatment "may actually mean less real participation than a person would enjoy confined within an out-of-the-community state hospital" (Allan 1974,4). Where hospitals had been identified as an evil to be exorcised, Allan raised an important question concerning the function that hospitals today might still play in the care of the chronically mentally ill. Alternatives are required to the moral absolutes that suggest that either hospital or community-based care must

27

prevail.

Besides the changing criteria for civil committment, the right to treatment, and the least restrictive alternative, other major factors contributing the deinstitutionalization were sweeping reforms in the committment laws of various states in the United States. Two significant federal developments in 1963, the Community Mental Health Centers Act were brought into being to help the estimated two million schizophrenics in the United States. The primary goals of the Community Mental Health Movement were to develop new and more effective treatment programs and to improve the quality of life for schizophrenics and the chronically mentally ill in general. This movement was dubbed the third mental health revolution (Hobbs 1964). THe Lanterman-Petris-Short Act of 1968 provided further impetus for the movement of patients out of hospitals by advocating civil rights for psychiatric patients. The act mad involuntary committment of psychiatric patients a much more complex process. The holding of psychiatric patients indefinitely against their will in mental hospitals was made virtually impossible (Zusman & Lamb 1977). These legal reforms were fundamentally constructive in supporting a general trend towards the deinstitutionalization of the chronically mentally ill.

F)   Economic Restraint

Levine and Levine, in the book <u>A Social History of the Helping Services</u> 1970, cite a phenomenon connected to general economic trends in society.   Economic buoyancy and expansion in the community was held responsible for causing emotional and mental disorders and was also considered responsible for correcting these disorders through community programs.   In time of conservatism and retrenchment, on the other hand, individuals were held responsible for their own disorders.

An example of this phenomenon is evidenced by contrasting the financially expanding economic period of the early 1960s with the progressively limited fiscal periods succeeding the 1970s.   During the early 1960s, active programs were aimed at public awareness of the issue of mental illness and fund raising through public contributions.   Clearly, during this period, society felt that they were responsible for the care and treatment of the chronically mentally ill.   By the mid 1960s, however, reservations and criticisms about the mental health movement began to appear.   In 1975, only 591 community mental health centers were created in the United States, in contrast to a projected 2000.   Of 591, only 443 centers were in actual operation (Leighton 1982).   Efforts to abandon the mental health program were made by the Nixon administration and in 1974 President Ford originally vetoed legislation to

amend the Community Mental Health Centers Act which was designed to expand community mental health services.

Since the 1970s, society has been faced with a period of gradual fiscal retrenchment. Emphasizing the Levines' concept cited earlier, in times of fiscal restraint, individuals are expected to be responsible for their own disorders. Because of economic pressures, society on various political, social and economic levels appears to have shifted its responsibility of providing mental health care for the chronically mentally ill by redirecting this population back into the community to fend for itself.

The mental health care system in Canada, particularly since the shift of hospital care for the chronically mentally ill from provincially run institutions to community-based care has been subject to various economic forces. Since 1958 for hospitals and 1968 for direct medical services, health care in Canada has generally been funded from public money in a cost sharing agreement between federal and provincial governments. Recently, the shift to block funding jeopardized some of this financing. There now exists the danger that money could be diverted from health care to other areas of public expenditure. Because drastic reductions in monies allocated to health care could be a sensitive topic politically and may be met with marked public opposition, failure of funding to

keep pace with inflation represents a more subtle and more widely practiced method of cost cutting that has been experienced by community mental health services. More than ever, deinstitutionalized settings are facing economic hardships that require them to reassess the needs of the clients that they serve and, with minimal financial support, find the means to adequately meet those needs.

An important economic event that has affected the advent of deinstitutionalization has been the development of comprehensive, universal, medical insurance programs which provide payment for medical services for mental disorders in the same way as for physical disorders and ensure accessible medical and psychological treatment for all Canadians. This program was introduced in Canada in 1971. A case could be made that universal medical insurance prompted the deinstitutionalization movement through tactical efforts aimed at limiting hospitalization of the chronically mentally ill, thereby limiting the financial expenses incurred by patients using psychiatric hospital services. Due to deinstitutionalization, the chronically mentally ill who previously employed hospital services were directed back into the community where many of them have become part of the homeless, the untreated and the ignored of society. In this manner, society divested itself of the financial burden placed on it by the chronically mentally ill.

Since the 1970s, Canada has seen a reversal in the economy from one of almost limitless expansion to one of cost containment. Much of the theory and many of the arguments for mental health services originated in the expanding economy of the 1960s. For the most part the economy was genuinely buoyant despite inflation. The community psychiatric movement which took place in Canada in the 1960s promised the closure of mental hospitals and people with mental disorders were to be treated in the community in mental health centers. This was an era which felt that adequate justification for funds for health services consisted simply in the need for the services.

In contrast, in the 1980s, there is less money available than there was in the 1960s and early 1970s. Governments at various levels and political persuasions have promoted budget cuts or severe cost constraints in government sponsored services. Mental health services have been subject to these restraints. Emphasis on the models of service delivery of the late 1960s is no longer feasible. In the late 1980s, there exists a contradiction between the mental health service approach to treatment delivery and economic conditions. Furthermore, recent economic council reports recommend that cost containment and cuts be continued (Toews 1980).

G) A Changing Model of Mental Health

The mental health community has in the past subscribed to an infectious disease model of illness in which treatment was viewed as a short term process for dealing with a limited and temporary disturbance. The system thus was frustrated when many schizophrenics did not respond to this model of treatment. Nevertheless, there is some evidence of this model still present today.

In respect to this population, as many as one third of the chronically mentally ill patients will have only minimal recovery and remain substantially dysfunctional. Most chronically mentally ill patients will be dependent on the social service system and mental health establishment for some services throughout their lives. Periodic relapse should be viewed as a plausible, almost natural part of their illness rather than a sign of treatment failure.

The philosophy of treatment resulting from an infectious disease model was not only ineffective for schizophrenics, but may have actually increased stress and provoked unnecessary relapse (Schooler & Spohn 1982). In effect, schizophrenia was better treated according to a chronic illness model, similar to that employed for individuals suffering from illnesses such as renal disease, juvenile diabetes, and Down's

Syndrome.

The progressive movement in mental health care towards a chronic illness model of care and treatment implies that this treatment be multi-dimensional, multi-disciplinary and long term. The goals in such a model would include managing symptoms, teaching living skills and coping skills, and enhancing the client's quality and experiencing of life rather than focusing on curing the illness. This type of holistic and systemic treatment approach has not been adequately met within traditional hospital institutions. In response to this trend, deinstitutionalized settings have moved to the foreground in attempting to provide the various services needed for comprehensive mental health care for the chronically mentally ill.

Mental health practitioners appear to be returning to a focus on the whole-person, characterized by the treatment of ailments before the development of extensive specialization and division of labour which had characterized modern health care. Increasingly, a living skills model of client troubles is being coupled with the notion of quality of life, offering a way of looking at the client's whole life situation rather than focusing narrowly on pathology.

This trend is reflected in a move made by the World

34

Health Organization which took a step away from the traditional definition of health as merely the absence of disease and adopted the definition of health as a "state of complete physical, mental and social well-being" (Baker & Intagliata 1982,70).

2. Summary

The ineffectiveness of hospitals to adequately meet the needs of the chronically mentally ill, the explosion in the number of mental health professionals of all disciplines, the availability of psychoactive drugs, legal reform, economic restraint and a changing concept in mental health in general have all contributed to the deinstitutionalization of the chronically mentally ill.

A pattern of neglect is displayed by the mental health professions which is rooted in an inability to meet the chronic dependency needs of the chronically mentally ill. Society in general has had an inclination to exclude the chronically mentally ill and maintain a distance from them. The other side of this trend is that when attention is finally turned to the chronically mentally ill, neglect often gives way to unrealistic expectations of rehabilitation. Economic restraint in the 1970s and 1980s has only served to encourage this pattern of neglect.

Neither anti-psychotic medications, immersion in the community, nor legal reform have had a significant effect on clients' ability to overcome their pervasive social deficits. New and innovative treatment strategy oriented to the chronic nature of severe psychiatric illnesses is needed to fill a vacuum in the mental health system created by deinstitutionalization.

As will be argued in the next chapter, the decentralization of, and establishment of, art therapy as an independent and recognized alternative to traditional mental health therapies have occurred at a time which has allowed it to fill this vacuum.

CHAPTER III

THE DECENTRALIZATION OF ART THERAPY IN THE UNITED STATES, BRITAIN AND CANADA

The development of the field of art therapy and the deinstitutionalization movement span approximately the same time frame in history. Art therapy was established in the 1940s and the concept of deinstitutionalization came into being in the 1950s. Both the field of art therapy and the deinstitutionalization movement converge in the late 1980s with art therapy filling a vacuum in mental health care created by the shift from institutional to deinstitutional treatment of the chronically mentally ill.

Art therapy's origins and evolution coupled with its drive towards educational standardization and professionalization of the field in the United States, Britain and Canada are surveyed in this Chapter as a means of charting trends that have led to art therapy's integration into deinstitutionalized settings. Specific attention is drawn to economic factors in Canada that influenced art therapy's professionalization and decentralization in this country.

1. The Origins and Evolution of Art Therapy in the United States

Art therapy in the United States grew out of the psychiatric movement. Originating in the early 1940s, art therapy developed from the pioneering efforts of Margaret Naumberg. Naumberg developed her theory of art therapy as a sub-specialty of psychiatry or more specifically, psychotherapy. She became involved in the world of art therapy through her contacts with psychoanalysts whose children were students of the progressive school she directed. Naumberg used art as a tool in a form of psychotherapy which she called "analytically" or "dynamically" oriented. In practice, she encouraged her clients to draw spontaneously and the verbally free associate with their pictures. In her opinion, the practice of art therapy does not require previous training in art but could be used effectively by any well trained psychotherapist who had an interest in the creative arts (Ulman, Kramer & Kwiatkowska 1977).

Naumberg's bias toward art as psychotherapy aligns art therapy with the psychiatric/medical model of the 1940s when all psychoanalysts were medical doctors. It is not surprising therefore, that early art therapists in the United States would be more apt to be working in institutional than in deinstitutional settings.

A decade later, in the 1950s, Edith Kramer came onto the art therapy scene. Like Naumberg, she relied on psychoanalytic theory. Unlike Naumberg, she emphasized the healing and therapeutic potential inherent in the creative process itself and did not emphasize verbal interpretation of art work by her clients. Kramer's bias towards art as therapy, sets the stage for art therapy's eventual separation from the psychiatric / medical model towards new theoretical approaches that promoted its creative links to therapy. A polarity between art as an extension of psychotherapy as expressed by Naumberg and art as therapy expressed by Kramer remains a continued differentiation in how art therapy is applied today.

This polarity forms a spectrum where on one end, art is used as a means of nonverbal communication in a psychotherapeutic process. The art process is used to enhance or clarify verbal associations and interpretations. This has come to be known as 'art psychotherapy'. At the other end of this spectrum, therapy is achieved through experiencing the artistic process itself. Art is recognized for its own therapeutic value. This use of art has come to be known as 'art as therapy' (Ulman 1976). All art therapists fall somewhere in between these two extremes.

With the aim of bringing these two theories of art therapy together, Elinor Ulman formulated a synthesis of the differing psychoanalytic approaches employed by Naumberg and Kramer. Ulman simply defines art therapy as an experience including both art and therapy.

Hanna Yaxa Kwiatkowska was an artist. She entered the field of art therapy after supplementing her skills as an artist with clinical training. Her work in art evaluation and family group therapy was directly influenced by art therapy's relatedness to the psychiatric trends of the 1960s and 1970s.

In addition to art therapy being used in the strictly psychiatric field, the therapeutic use of art was being developed in the educational system. Viktor Lowenfeld developed concepts of therapy specifically geared to the field of art education which he termed 'art education therapy'. According to Lowenfeld, art education therapy relies on "neither the interpretation of symbols, nor a diagnosis reached by speculative inferences based on certain symbols" (Ulman, Kramer & Kwiatkowska 1977). His approach to art education differs from traditional art educators only in degree of intensity but does not differ in kind. Broadening definitions of art as therapy within deinstitutionalized settings, such as the educational system, promoted art therapy's further professional development towards an

independent status removed from its psychiatric and institutionalized origins.

As part of a trend in the 1960s and 1970s, artistic expression was encouraged as a means of enriching life experience for individuals who were not necessarily suffering from severe mental or emotional stress. Janie Rhyne purposely avoided the word "therapy" when she titled her book The Gestalt Art Experience. Like Naumberg, Rhyne employed art as a tool. Unlike Naumberg, however, she put little emphasis on the translation into words of formerly unconscious conflicts. Theoretically, Rhyne saw the art making process as enhancing self-perception and intensifying exchange among individuals (Rhyne 1973).

From its early connection to psychiatry and psychoanalytic theory art therapy has branched out and diverged. Theories that hold the client actively responsible for his of her psychological well being are contrasted with the earlier and more deterministic influences proposed by psychoanalytic theory. As a result, art therapy has grown to encompass many frameworks and approaches.

Because of art therapy's flexibility, it is able to meet the diverse needs of various patient and client populations. Art therapy has grown past the limitations imposed on it by

its traditional applications within hospital settings to encompass a wider range of deinstitutionalized settings in the community.

Conversely, as art therapy is applied within deinstitutionalized settings, it would appear that a bias towards the creative process of the art therapy experience is evidenced. This could suggest that deinstitutionalized settings might be more conducive to a creative environment in which both the clients and the field of art therapy can experiment and grow with more freedom.

2.   The Origins and Evolution of Art Therapy in Britain

Art therapy originated in Britain in the 1930s. Its roots are in art. Emphasis placed on the art aspect of art therapy is related directly to those individuals who pioneered the field. Adrian Hill, considered to be the first art therapist in Britain, for instance, was an artist. While convalescing in a sanatorium during the Second World War, he painted as a means of release from the effects of his illness. He encouraged other patients to do the same. Through these creative efforts he discovered the therapeutic value that the art making process had on himself and his fellow patients (Ulman 1976). Hill went on to publish the books, Painting out Illness and Art Versus Illness (1940). These books are

42

seminal works in the development of art therapy in Britain.

Another artist, Edward Adamson, was employed in the state psychiatric hospital, Netherne, in 1946. Adamson acted as a facilitator of his patients' creative process. Analysis or interpretation of his clients' art work was discouraged by the psychiatric profession in the hospital. He termed what he did as "creative therapy", placing emphasis on the art activity and process of his patients. Insofar as the act was creative, it was also considered therapeutic by Adamson.

Hill's and Adamson's contributions to the field of art therapy is evidenced by the importance placed on the art therapist's artistic background as an integral element in their training. For example, at Barnsley Hall Hospital, Bromsgrove, Worchestershire, patients are encouraged to create freely with emphasis placed on the process of self expression. Functioning as a therapeutic community, it is characterized by informality and freedom from old hospital rigidities (Betensky 1971). Both Adamson and the Barnsley Hall Hospital supported patient art exhibitions, highlighting the British approach to art therapy as an artistic endeavour.

Another seminal figure is Marion Milner who as an educational psychologist became interested in the relationship between creativity and psychodynamics. She and Melanie Klein

worked with children using drawings and games as a means of accessing the child's fantasies and fears. They and Donald Winnicott helped to create the post Freudian school of psychoanalytic aesthetics. Milner went on to become the President of the British Art Therapy Association. As a result of these endeavours, children's art became an area of great interest.

In England, all child guidance clinics are adjuncts of the Department of Education, offering to school children up to the age of seventeen, remedial help for both academic and emotional difficulties. Art therapy is part of this program. The Acton Child Guidance Clinic in London is an example of this system. Therapeutic value is seen in the combination of doing and interpreting by the child himself (Halliday 1970).

The ideas of Carl Jung, influenced the early year of art therapy, particularly through the efforts of Irene Champernowne whose Withymead Center was a training ground for several prominent art therapists including Michael Edwards (Edwards instituted the art therapy program at Concordia University in Canada).

At present in England and Scotland art therapy is available to people in schools, community centers, hospitals, and prisons, among other places. The variety of settings in which art therapy has developed in Britain, both institutional

and deinstitutional, could be viewed as resulting from its artistic roots and its early alignment with the field of education rather than being linked to psychiatric model of mental health care. Not developing as an adjunct to a traditional psychiatric model of mental health care allowed it to explore alternative settings and approaches to therapy.

Art therapy's early fundamental ties with the Department of Education, and its early established bias towards art as therapy is contrasted with art therapy's initial identification with the psychiatric field in the United States and Canada. As an emerging profession, art therapy in the United States and Canada modeled themselves after the parent profession of psychiatry. Art therapy in these two countries was dependent on the field of psychiatry from which it eventually separated. However, art therapy in Britain, has always encouraged its clients and patients to identify with their role as an artist.

3. The Origins and Evolution of Art Therapy in Canada

i) Pioneer Art Therapists in Canada

Art therapy originated in Canada in the 1940s. Early on it became obvious that art therapy in Canada developed along the lines of the same spectrum that was found in the United

States and Great Britain ie. on one end of the spectrum, art as psychotherapy and on the other end of the spectrum, art as therapy. One end of this spectrum was represented by Dr. Martin Fisher whose primary emphasis seemed to be using the client's art work as an adjunct to their psychiatric treatment within institutional settings. The other end of this spectrum is represented by Marie Revai who emphasized the therapeutic value of the creative process itself. In the case of Fisher and Revai, the theory on which their approach to art therapy is based likely stems from their respective professional backgrounds. Fisher came to art therapy in the early 1950s as a psychiatrist working in a psychiatric hospital in Toronto, while Revai came to art therapy as a professional artist. As Fisher moved out of his hospital setting and into a residential treatment center for disturbed children, Revai in 1953 started working in another community setting, the Iverlly Community Center. These moves might be seen as the initial seeds for the growth of the deinstitutionalization of art therapy in Canada and reflect art therapy's initial disengagement from psychiatric domination of its applications within institutionalized settings. In 1957, Revai moved again, this time from a community setting to the Allan Memorial Hospital, a psychiatric hospital setting. She brought with her, her background as an artist and her theoretical background that emphasized the therapeutic value of the art making process. Revai also brought an independence

that was fostered by working initially in a community setting
rather than in a hospital.

As therapist, Revai saw herself as a resource person.
She relied on her intuition, encouraging her patients to
express themselves in their creative efforts. She contended
that therapeutic value was intrinsically inherent in the
artistic process.

Selwyn and Irene Dewdney represent yet a third approach
to their introduction as art therapists. Though they came to
art therapy like Revai, initially as artists, unlike Revai
they started their work in an institutionalized psychiatric
setting. Selwyn Dewdney worked in London Ontario, initially
conducting art workshops which eventually developed into art
therapy sessions. He was the first person in Canada to be
hired specifically as an art therapist with the title
"psychiatric art therapist". Irene Dewdney was appointed his
assistant. Though their primary theoretical emphasis was such
that they viewed the clients' art as a diagnostic tool,
because of their background as artists, they recognized and
promoted the therapeutic value of the process of artistic
creation.

There appears to be a period through the 1960s where
little new comes on the scene from the profession of art

therapy in Canada. This is likely due to a combination of factors. First, there were very few art therapists working in the field. Second, there was no educational system nor standard of education to produce additional art therapists. Third, there were no professional organizations representing art therapy at that time, and finally, the large geographical distances between major Canadian centers augured against easy communication between the few existing art therapists in Canada.

In the 1970s, we see some new developments in the field of art therapy. Beth Robinson had started her career as an occupational therapist in the mid 1940s, working with the Department of Veteran Affairs and the Workman's Compensation Board. Between 1943 and 1945 she was employed at St. Anne de Bellevue, a military hospital. After taking time out to raise a family, she was re-certified as an occupational therapist. In 1968 s..e worked in Riverdale Hospital. It was during this period that Robinson became aware that the imagery evoked in the Hospital's art workshops was more than arbitrar; markings and acts. This inspired her to take training at Fisher's Toronto Art Therapy Institute in 1972, receiving a diploma in art therapy. After completing her training, she worked part time in a public junior high school and carried on her own private practice for thirteen years.

Though Robinson came to art therapy from an institutional setting and had her initial training as an art therapist according to the psychoanalytic model, after having received training as an art therapist she moved out of institutionalized settings. Thus, her professional training as an art therapist was followed by a distancing from the institutional setting. The very fact that she was able to set up her own practice as an art therapist is indicative of a movement away from art therapy as an adjunct to psychiatry.

Maurice Brault came to art therapy as an artist. In 1970, Brault worked for the Atelier Francois Michel, a center that was geared to assisting the mentally handicapped. In 1974, he took a position with the Lethbridge Rehabilitation Center. Brault based his ideology and theory on Victor Lowenfeld's philosophy of teaching. Emphasis was placed on the environment in which he and his clients worked, ie., an environment resembling an art studio. He promoted the artist in his clients and placed emphasis on the creative process as therapy.

Brault claims that there is a fundamental conflict between being an artist and working in institutional settings, because he felt that institutions tended to discount the therapeutic usefulness of the arts. If there is an element of truth in what Brault says, this can be seen as one more factor

in encouraging art therapists to move out of institutionalized settings and to establish their credibility as therapists in alternative settings.

As stated earlier, Canadian pioneer art therapists have developed along the lines of the same spectrum that is found in the United States and Britain. Universally, the approach employed by early art therapists appears to stem from their respective backgrounds using art as psychotherapy or art as therapy. Regardless of where they are placed on the spectrum, however, a significant trend is evidenced in the art therapists' attraction and gradual gravitation towards deinstitutionalized settings.

It can be argued that this trend results from a tendency by institutionalized settings to discount the usefulness of art and undervalue the artistic background and sensibilities that art therapists bring to mental health care. Because of art therapy's ties with the artist, it could be suggested that art therapy might function to its fullest capacity on the fringe of society as does the artist, thus its attraction to deinstitutionalized settings.

ii) <u>Contemporary Art Therapists in Canada</u>

Turning to contemporary art therapists, Rachel Garber

50

perceives art therapy's evolution as one affected by the outside world. Cost effectiveness and art therapy's marketability has required the field to reassess its methodology with respect to the needs of clients and patients, a changing mental health system, and its incorporation into varied settings. Garber contends that art therapy no longer has to concern itself with whether it is a viable form of therapy. Its present concern is meeting current needs and exploring new approaches. "Edith Kramer's definition of art therapy as one of producing a lasting change in the client is no longer the sole mandate of art therapy as it broadens its scope to include populations such as Alzheimer's patients, prison inmates and the chronic mentally ill" (Garber 1988). Garber views this as a trend away from a medical model of health care towards one which addresses the chronic nature of many illnesses. She perceives the present period in art therapy's history as a potentially flourishing time for therapists to create jobs as they forge into areas previously unresearched. Economic restraint has encouraged art therapists to look to alternative settings within the community. Garber's working in a community center is one more indication of art therapy establishing itself in deinstitutionalized settings and its viability as a professional and independent field in mental health care.

Yvon Lamy presents a specific example of art therapy's

integration into a deinstitutionalized setting. In 1984, Le Centre d'Apprentisage Parallel was established to serve individuals with emotional problems. This center is a unique and contemporary example of the use of art therapy in a deinstitutionalized setting. The center caters to approximately forty clients. The staff consists of Yvon Lamy as art therapist and two artists.

Lamy focuses on the artist in each of his clients. This methodology was derived in part from the clients' expressing a need to separate art from therapy, therefore allowing clients to choose to what extent directive and non-directive intervention is used by a therapist. We have noted that in Great Britain, the United States and Canada there is a spectrum in the theory of art therapy where on the one end the therapist uses the clients' art diagnostically while at the other end the clients' act of creation is seen as part of the therapeutic process. In response to his client's expressed needs, Lamy offers both art therapy and strictly art in his atelier. The client is brought into deciding on which end of the spectrum he wished to be place in accommodating his own healing process. According to Lamy, art and art therapy are complementary. The therapeutic aspect helps the clients deal with the frustration of being artists.

One aim of this program is to support systems among peers

which encourage understanding of each other's pathology and symptoms. Through these efforts, the clients learn a tolerance which they may transfer eventually to creating healthy relationships in their community at large. This theoretical approach encourages the clients to transpose the interrelational skills that they acquire in the center to other relationships that they will have outside this setting. The center acts as a bridge that links clients with society.

Lamy warns that a delicate balance must be maintained between the professional, who has been traditionally equated with the medical institution and the artist, who has been equated with the social outcast. The art therapist must not lose the open-ended perspective that artists intrinsically possess in their efforts to create a professional status. Art therapy concepts, therefore, should remain in flux as they constitute a part of a constantly changing process. At the same time it highlights art therapy's responsibility to develop its own language and theory.

Contemporary art therapists are challenged by restrictive economic times. This circumstance has encouraged art therapists to diverge from traditional settings and to look to alternative possibilities for employment. The field's viability as a recognized profession in mental health care gives art therapists the impetus and credibility required to

open up new avenues for the application of art therapy in deinstitutionalized settings.

Because of art therapy's professionalization, contemporary art therapists have gained an independent identity that is no longer contingent on the medical institution to support it. A link between the field of art therapy and the artist can now be strengthened and attention drawn towards further establishing its own language and theory.

4. Training and Professionalization of Art Therapy in the United States, Britain and Canada

A major trend in art therapy in the United States, Britain and Canada has been its drive to define its role as an independent field in mental health and, through accreditation, gain professional status.

i) Training of Art Therapists in the United States

The first two master's degree training programs in art therapy were initiated in 1970 at Habnemann Medical College in Philadelphia and at the University of Louisville in Kentucky. Today in North America, the American Art Therapy Association (AATA) approves the master's degree, or equivalent training in

art therapy, as preparation for entrance into the profession. AATA represents a landmark in establishing art therapy's identity and independence from other mental health professions and also established codes of ethics with the intention of having their registry requirements eventually become requirements for government licensing to practice. In the meantime, evolving and increasingly exclusive requirements are constantly being redefined within the organization as the field of art therapy grows into new settings and develops new approaches to therapy.

ii) Professionalization of Art Therapy in the United States

It was in the 1960s that art therapy became a recognized profession in the United States. The creation of the American Journal of Art Therapy, published initially as the Bulletin of Art Therapy in 1962, and the establishment of AATA, were two significant events in the development of the field. AATA has grown rapidly. Its annual meetings which began in 1970 are highly professional and reflect an organized membership active in setting standards towards accrediting art therapy training programs and lobbying for the development of the profession.

iii) Training of Art Therapists in Britain

Where art therapy in the 1940s and 1950s in Britain

concerned itself with establishing its identity, in the 1960s and 1970s, it concentrated its efforts on accrediting the field through the establishment of certified training programs.

Because of economic restraint experienced in the 1960s and 1970s, art therapy's initial efforts to implement training programs were thwarted. For example, a training sub-committee began negotiations with the University of London in 1965. By 1967, it appeared likely that a course could be started in the Institute of Education, but the strained economic climate prevented the realization of the venture.

In 1970, negotiations took place to start an art therapy training course at the University of Birmingham in the School of Art Education. This training program was later recognized by the BAAT registration and Training Sub-Committee in 1976. It developed into an MA in Art Education and offered a Mode in Art Therapy. In 1969, from a pilot scheme at St. Albans College of Art, a program entitled the Certificate in Remedial Art, which later became the Post Graduate Diploma in Art Therapy, was offered. In 1981, the college introduced an MA in Art Therapy. A third program emerged in 1974 at Goldsmiths' College. Also afflicted with economic difficulties, the course went through several stages of evolution as an in-service course before being approved as a

separate Diploma in Art Therapy. Additionally, a diploma level training program was established in Sheffield University in 1984. These diploma programs are recognized as professional qualifications by the British National Health Services.

iv) <u>Professionalization of Art Therapy in Britain</u>

In art therapy's formative years in Britain (1940s and 1950s), various mental health practitioners, both from institutional and deinstitutionalized settings, pooled their resources to explore the various ways that art therapy could be applied and to delineate the boundaries of art therapy as a professions in its own right.

In 1949, Adrian Hill directed his committee's efforts towards the question of the integration of art therapy within both general and mental hospitals. In the same year, at the National Association for Mental Health, a meeting was held to explore the topic and gather finding concerning the necessary standards, background and training to be required in the field of art therapy in institutional and community settings. Hospital administration, directors of community services, psychiatrists, occupational therapists, music therapists and a dancer/choreographer contributed.

In 1950, Trevelyan, Director of Research into hospital administration, chaired a conference of art therapists in hospitals and clinics gathering suggestions about standards and training for art therapy. These suggestions were later discussed at a working party which met at the National Association for Mental Health in 1951, chaired by Adrian Hill. It was concluded at this meeting that an art therapy panel should be created to assist programs interested in employing art therapists. Art therapy was to be viewed as a separate discipline from occupational therapy and play therapy. The Withymead Center, espousing Jungian principles of psychotherapy, was established to further encourage the practice of art therapy and its professionalization as an independent field in mental health care.

Prior to the 1950s, art therapists were few in number and considered themselves to be above all, artists. Because the development of art therapy itself became the priority, their status was not an immediate issue.

As a means of strengthening the art therapist's role in hospital and community settings in Britain, the formation of the British Association of Art Therapists (BAAT) took place in 1964. An additional aim was to develop training programs and a structure for employment for art therapists. The British Association of Art Therapists allied with the National Union

58

of Teachers in 1967. For a period of time, members of BAAT
were required to have a teaching qualification. Art therapy's
alliance with the educational system appears to have
encouraged assimilation of art therapy within diverse
institutional and deinstitutional settings.

The diversity of art therapy's application within a
variety of settings was enhanced by the ideological spirit of
the 1960s and the anti-psychiatric movement. Art therapists
explored the possibilities of becoming centrally involved in
the treatment of patients and clients and were influenced by
writers such as Goffman, Szasz, Illich, and Laing. Joe Berk
and his work with Mary Barne at Kingsley Hall, as described in
the book Two Accounts of a Journey Through Madness, is an
example of the use of art as therapy within alternative
settings.

Over the past three decades, there has been an increase
in activity to engage in efforts to enhance the status, the
role, the training and the general professionalization of art
therapists through BAAT. Its professional journal, Inscape,
provides a record of this evolution over the years.

v)   Training of Art Therapists in Canada

The training of art therapists in Canada started in the

mid 1970s. In Ontario, the Dewdneys trained a small group of art therapists which formed the Ontario Art Therapy Association in 1979. During this same period, Dr. Fisher formed the Toronto Institute and funded the Canadian Art Therapy Association in 1977. An art therapy journal, edited by Dr. Fisher was published in 1983. Both the Ontario Art Therapy Association and the Canadian Art Therapy Association established annual conferences. Concerted efforts were made by both associations to educate the mental health system about art therapy. In 1987, a university program was established at the University of Western Ontario. In March 1988, initial approval for a Creative Arts Therapies program at York University in Toronto was established.

On the West Coast of Canada, art therapy originated in 1968 through a training program initiated by Kay Collis in Victoria, British Columbia. This group formed the British Columbia Art Therapy Association in the late 1970s. Typical of the difficulties imposed by geographical distance across Canada, Collis was familiar with art therapy activity in the United States before she was aware of its presence in Eastern Canada. Lois Wolf, a graduate of the Toronto Institute, established the Vancouver Art Therapy Institute in 1977. From the late 1970s to today, there has been a steady growth in the number of art therapists in British Columbia centering around these two cities.

In Quebec, following successful establishment of the Diploma in Art Therapy in 1980, at Concordia University, the first Masters program in Canada was instituted in 1983, to meet the needs of the profession and of the community. It followed the guidelines for training established internationally and in 1987 was recognized as an accredited training program by AATA, the first one to be honoured as such outside the United States. Concordia University sets a standard for the tra·ning of art therapists throughout Canada.

vi)   Professionalization of Art Therapy in Canada

The Quebec Art Therapy Association established as a non-profit organization in 1981 (now called Association des Art-Therapeutes), is an active leader in propagating professional standards and ethics for art therapists in Quebec and across Canada. In 1933, the creation of the National Art Therapy Council, which consists of the British Columbia, Ontario and Quebec Associations, heightened interprovincial communication and cooperation by acting as a meeting ground for the exchange of ideas and information with a mandate to aid in the common goals of all the associations. The Council aims to unify standards and goals across the country, to create better exchange amongst Canadian art therapists and encourage the field's continued growth as a profession in this country.

Lately, there have been developments in the Prairie Provinces due in part to the influx of art therapists from Ontario, British Columbia and Quebec. In 1982, the Alberta Arts Therapies Association was established.

The training of art therapists in the United States, Britain and Canada has been fundamental in accrediting the field of art therapy. Various therapies originating during the same period in history as art therapy, yet never gaining professional status in their own right, attest to art therapy's diligent organization of its members and points to the importance of training standards in achieving professional status and independence from other mental health fields.

Art therapy's drive towards professionalization in Britain appears to be motivated by its need to consolidate its theoretical stance as a primary therapy with its artistic origins, whereas Canada and the United States appear to seek professionalization as a means of disengaging itself from its traditional attachment to psychiatry. This contrast is reflected in Canada's adherence to standards and practices set forth by the American Art Therapy Association versus the independently organized and established British Association of Art Therapists. All three countries emphasize training and professionalization as a means of strengthening their identity

as a unique and professional mental health field.

The field of art therapy is constantly redefining its standards and requirements within its respective organizations whether it be the American Art Therapy Association in the United States, The British Art Therapy Association in Britain, or the Canadian Art Therapy Council in Canada. It is these organizations that simultaneously set standards for the profession while retaining the flexibility needed within a constantly growing and changing mental health field.

5. **Economic Influence on the Professionalization and Decentralization of Art Therapy in Canada**

Economic influence on the professionalization and decentralization of art therapy in Canada spans from an expansionistic period in the 1950s, which fostered further development of the field, to one of cost constraint in the 1980s, encouraging art therapists to look to alternative and deinstitutionalized settings. Evidence for this trend is found in interviews with Canadian pioneer art therapists Marie Revai and Maurice Brault (1988) and contemporary Canadian art therapist Rachel Garber (1988).

Canada experienced an expansionistic financial surge in the 1950s. An increase in veteran's hospitals was in effect

63

to accommodate returning soldiers from war who were in need of physical and psychological treatment and care. These hospitals attracted both psychiatrists and psychologists because they offered new potential in the treatment of the mentally ill. Other than psychiatry, the only treatments available previous to the early 1950s to patients was shock, both insulin and electric, and lobotomies. At a time of flux when treatment modalities were being challenged by health care professionals and at a time in which there was economic incentive to expand existing staff in many of these hospitals, art therapy came onto the scene. Economic buoyancy was primary factor that fostered the development of art therapy in general, and art therapy in the institutional setting in particular.

As discussed earlier in this thesis (p.27-31) because of financial constraints, the mental health system in Canada started to experience a reduction in the provision of new hospital facilities from the mid 1970s on. Treatment strategies for such programs might well have overcome those initial difficulties if adequate community resources had been ensured and a better working relationship established between the community and hospitals. With the reversal in the economy occurring just when a reworking of this relationship was most necessary, the system became entangled between community and institution. As a result, many patients today remain in

limbo, inadequately fitting into the institutional service system or into understaffed and underserviced community programs. That patients are caught in this bind indicates that there is a vacuum in the delivery of mental health services.

Maurice Brault, through personal experience with budgetary cutbacks in his work as an art therapist with the Lethbridge Center in the 1970s and early 1980s, highlights the devastating effects that economic restraint can have on the limiting or cutting back of art therapy positions within institutional settings. He argues that art therapy must professionalize as a means of gaining accreditation as a primary therapy in its own right amongst other mental health professions. For, without professional recognition, art therapy would be the first area to be cut in times of budget restraint.

Rachel Garber confirms Brault's observations on the effects of fiscal restraint on the field of art therapy. Garber points to art therapy's evolution as one affected by the outside world. Cost effectiveness and art therapy's marketability has required the field to reassess its methodology in respect to the needs of clients and patients, a changing mental health system, and its incorporation into alternative settings. Garber contends that economic restraint

has encouraged art therapists to look to alternative settings within the community. She perceives the present period in art therapy's history as a potentially flourishing time for therapists to create jobs as they forge into areas previously unresearched.

6. **The Inclusion of Art Therapy in Community Mental Health Care**

Initially, the vacuum in mental health care created by deinstitutionalization was filled by traditional alternative therapies such as those provided by social workers, psychologists, case workers, nurses and others. However, this group of professionals were often overworked and were primarily trained in the reality-based needs of their clients. This left a more specific vacuum related to the psychodynamic needs of these clients which art therapy was able to fill.

In the late 1980s, art therapy's inclusion into reality-based systems of community mental health care is promoted by a mental health system that places emphasis on the holistic care of chronically mentally ill patients and a systemic approach to meeting their needs.

The ineffectiveness of traditional modes of medical interventions in treating or caring for the chronically

mentally ill has encouraged clients to look to alternative services which emphasize more client involvement and active participation in the healing process of their illness.

How can art therapy fill the vacuum in mental health care of the chronically mentally ill created by deinstitutionalization? Art has played a vital function found in dreams, myths, fairytales, popular culture and in the art of living generally. Because of its connection to art, art therapy finds its roots in the very basis of culture itself. It is not surprising therefore, that chronically mentally ill clients have instinctively responded to art therapy as if it were a natural process. Art therapy creates an environment that allows their innate creative and imaginative potentials to be brought out (Gregoire 1989). Art therapy's expansion into deinstitutionalized settings is a natural outgrowth of an expressed need by clients and patients for access to a creative means to explore their illness.

Conversely, art therapy appears to have been drawn towards deinstitutionalized settings because of its artistic origins and its identification with the artist as an outsider. Just as the artist finds himself living on the fringe of society, art therapists often may feel drawn to working on the fringe of institutional care or in deinstitutionalized settings.

Reflected in its adolescent stage of professional development, art therapy distances itself from the parental image of the institution. Simultaneously, art therapy's coming of age has enabled it as a profession to stand on its own academically and professionally, making it a viable and valuable alternative in the job market where other alternative therapies have failed.

The deinstitutionalization setting is an environment which encourages experimentation and development (despite economic restraint) unlike the stringent resistance met by art therapists in most larger institutions. Because of this creative interface, art therapy is an adaptable and creative alternative to traditional modes of client intervention. Outside the limitations of the larger institutions, art therapy is more likely to thrive and be able to meet the diverse needs of uncertain, and less structured environments found in deinstitutionalized settings.

7.   Summary

A historical overview of art therapy in the United States, Britain and Canada chronicles a gradual trend toward its application in deinstitutionalized settings of mental health care. A tendency by institutionalized settings to

discount the usefulness of art and undervalue the artistic background and sensibilities that art therapists bring to mental health care coupled with art therapy's intrinsic links to the artist as an outsider are cited as major forces uniting the field of art therapy with mental health care in deinstitutionalized settings. Special emphasis, in this chapter, has been placed on economic factors involved in the decentralization and professionalization of the field of art therapy and the effects of fiscal restraint on a changing job market.

The field of art therapy, through the diligent efforts of its members, has gained professional status. The training and professionalization of the field set the stage for its insertion into a vacuum in the mental health system left by the deinstitutionalization movement.

Art therapy's application within deinstitutionalized settings has been promoted by a general trend in mental health care that places emphasis on the holistic care of the chronically mentally ill and a systemic approach to meeting their needs. Art therapy also fills a more specific vacuum related to the psychodynamic needs of the chronically mentally ill. Overall, art therapy's application within deinstitutionalized settings is a natural outgrowth of an expressed need by clients for access to a creative means to

explore their illness.

Having distanced itself from the parental image of the institution, the field of art therapy comes of age. In a creative interface, deinstitutionalized settings provide art therapists with an environment that encourages experimentation while art therapists bring to deinstitutionalized settings a creative adaptability and versatility to client care of the chronically mentally ill.

CHAPTER IV

ART THERAPY IN A COMMUNITY-BASED MENTAL HEALTH CENTER - AN EXAMPLE

Having shown that there exists a vacuum in the mental health system caused by deinstitutionalization, the following Chapter will explore art therapy's integration into a community-based center for the chronically mentally ill as a means of establishing in what manner art therapy can be involved in the holistic care and treatment of this population.

Commentaries by team members as to art therapy's efficacy in a systemic team approach to mental health care and commentaries by an art therapist presently employed by the program and an interning art therapist will be presented as we examine the integration of art therapy into a deinstitutionalized setting for the chronically mentally ill. Art therapy's potential contribution to community-based programs is explored and an argument made as to the need for art therapy's continued accessibility for the chronically mentally ill in the community.

1. Description of CLSC (Amitie/Friendship) Program - its History and Current Structure

Amitie/Friendship is a program housed and supported by the Centre Locale de Service Communautaire, or Local Community Service Center (CLSC). The CLSC is a provincially funded and governed organization whose mandate is to provide primary health and social services through a comprehensive and continuous treatment program. The creation of the CLSC was the result of the restructuring of the health care system in Quebec after the introduction of medicare. Its organization was based on the belief that diminished reliance on hospitals as primary care centers would improve the link between professional health services and the community.

Amitie/Friendship is a program that grew out of the medical clinic of the CLSC at Guy Metro in Montreal, Quebec, in 1984. The CLSC was especially convenient for the chronically mentally ill in this area. The clientele is composed of men and women who have been discharged from psychiatric departments or institutions and are presently living in the community. The clinic is both visible and easily accessible by metro or bus, situated in the core of the city that also houses several large psychiatric institutions.

Initially, nursing staff took a supportive community

nursing approach to those mentally ill employing their services. This approach was found to be particularly effective with chronic mental health patients, especially when combined with supportive listening. This method included listening to the clients' comments on all aspects of life as a means of more effectively assessing the patients' needs. Many clients, for example, presented themselves to the clinic exhibiting needs of a physical nature whereas it became evident to staff members that their primary distresses resulted from a lack of communication and emotional support within the community, inadequate living accommodation, and underdeveloped daily living and coping skills. It was concluded by the team working at the clinic at this time that this population of clients had numerous unaddressed needs. Unfortunately, adequate community resources and the psychodynamic understanding needed to provide all the required services were lacking.

Amitie/Friendship's description as an alternative resource is a misnomer as it implies that there existed other choices for the clients. The reality is that the clients of this program have no alternative within the community. Some of the basic needs, such as food and shelter are not even met and therapy in any form is not an available option for these individuals.

Although professionals have a responsibility to offer the chronically mentally ill a variety of services, psychiatrists have consistently chosen medication as the primary intervention because of the chronic nature of the illness. Many medical or psychiatric doctors do not want to treat incurable patients and are not willing to provide the time and attention required for intensive therapy. Supportive therapy, which relieves the suffering and alienation caused by chronic mental illness, is essential. Ex-psychiatric patients require a choice of therapies and should not be discriminated against because of the chronic nature of their illness.

Statistics collected by Amitie/Friendship on the frequency of health services used by the program's clients (other than those provided by Amitie/Friendship) found that the majority of these clients see their psychiatrist once every two months for fifteen minutes or less; their social worker for thirty minutes when deemed necessary; and a nurse for fifteen minutes or less on a weekly, bi-monthly, or monthly basis. It becomes evident that on all levels of intervention there exists a paucity of consistent and quality care (Appendix, Tables 3 & 4).

Through the efforts of a small number of professionals, an incorporated non-profit organization was established which envisaged the creation of a community mental health program

offering a variety of services from a multi-disciplinary team functioning with the concept of a holistic approach to treatment. In 1984, the organization received a Canada Works Grant and implemented the first phase of the Amitie/Friendship program.

The program's initial objective was to attempt to relieve some of the isolation and alienation experienced by most ex-psychiatric patients now living in the community. Volunteers were recruited as friends to the clients, offering weekly visits and outings. In some cases, the volunteers were the only consistent contact in the clients' lives. Two animators were hired to establish a referral policy, train volunteers, assess clients through home visits and match the clients with an appropriate volunteer. Although initial contact had been made, the program was still far from offering the comprehensive services it had originally envisaged.

In 1985, the research arm of the Regional Council of the Ministry of Social Affairs was interested in collecting data to study the hypothesis of Amitie/Friendship with the contention that intervention by organized volunteers could improve the integration of ex-psychiatric patients into the community. A rapid expansion of the program followed. A drop-in center previously affiliated with the Ville Marie Social Services was transferred to a new location in close

proximity to the Amitie/Friendship office.

2. A Meeting Between Art Therapy and the Amitie/Friendship Program

In 1983, Mira Krol, a student of the Art Therapy Program of Concordia University, approached Joan McCrimmon, Director of the CLSC, proposing the integration of art therapy into the Amitie/Friendship program. Krol was contracted for a period of five months as an interning art therapist. Clients were referred by a social worker. No team work was involved.

In 1985, Coleen Gold (Masters student in Art Therapy at Concordia University) interned as an art therapist with the Amitie/Friendship program. In 1986, on completing her internship, she was hired to continue with her clients on a part-time basis. The team was augmented by two social work students, three nursing students and three art therapy students. The team encompassed in total, eight full and part-time team members, eight student interns and various affiliated professionals such as researchers and CLSC workers. Phase two of the program had begun. The team is currently engaged in the process of accommodating the ongoing changes that a budding program encounters, growing closer with time to the original holistic approach first postulated.

A coordinator of Amitie/Friendship, who has been with the program from the beginning, makes the obvious point that the more contact the program's professionals and volunteers have with the clientele the more they become aware of their needs. A dialectic discourse between the services that Amitie/Friendship provides and the needs expressed by the clients has been established. Because the initial method of referring clients to outside resources proved ineffective, the program concluded that it should incorporate these services into its own structure as funds became available.

3. The Role of the Art Therapist as an Adjunctive Member of a Team

The role of the art therapist in the Amitie/Friendship setting differed from that in a hospital psychiatric ward run by a psychiatrist. The team, functioning on a consultant basis, avoided the hierarchical structure encountered in a hospital setting. However, the informal manner in which client information was often shared created an uneven dissemination of information resulting in recent efforts to implement a more formal and consistent meeting structure. Being a small program, communication between team members was often hampered by the presence of part-time workers and a steady turnover of students and volunteers.

A combination of chance and available funding played an important role in the hiring of Amitie/Friendship's first art therapist on a part-time basis. Coinciding with the internship of an art therapist with the Amitie/Friendship program, a position for therapist or psychologist became available. This paralleled the expansion of the program which was a catalyst for the increase in staff. Underpinning the expansion of the program was the timely arrival of various financial grants which made these expansions possible.

The chronically mentally ill in the community were a fundamental source in the program's choosing appropriate mental services to meet its needs. Treatment services that related to the inner psychodynamics of these clients' lives was lacking in the reality-based resources made available to them. Art therapy filled this vacuum and added a new dimension to the team by providing a creative means for these clients to explore the psychological dynamics of their lives, thereby introducing a more holistic and systemic approach into their treatment. Art therapy's professionalization and its economic feasibility could be seen as contributing factors in its inception into the program.

4. <u>Art Therapy's Integration into the Amitie/Friendship Program: A Commentary</u>

As a means of assessing art therapy's potential contribution to a community-based center, the following section consists of answers to a series of questions related to the integration of art therapy into the team format created by the Amitie/Friendship program. Answers to these questions were elicited from team members comprised of:

a)   the program's coordinator and two social workers, and

b)   an art thera_y intern and an art therapist employed by the program.

The subjects' written replies are compiled and given below.

a)   <u>Commentaries by Amitie/Friendship Coordinator and Two Social Workers</u>

1)   What unique qualities do you perceive art therapy bringing to the team structure?

2)   What problems did you encounter with art therapy's integration into the team?

3)   How do you perceive art therapy functioning in relation to your clients in an adjunctive capacity and complementary to a social/community-based model of mental health?, and

4)   How does art therapy enrich your understanding of the

clients you work with?

In response to Question #1, the team social worker found
that art therapy played an important role in confirming or
denying her own perception of her clients. She also felt that
art therapy enlightened her as to the deeper psychodynamic
workings of the client. The visual recording of a client's
experiencing of himself and his environment, as expressed in
the art therapy drawings, was viewed by her as being a useful
tool in eliciting psychodynamic material from those clients
who, in particular, had difficulty expressing their needs and
feelings verbally. It was also felt that art therapy provided
a framework where the clients could explore the dynamics of
their lives, past, present and future with an intensity not
available within the constructs of other modes of intervention
offered by the program.

It was felt by another social worker also, that those
emotions and feelings which clients often had difficulty
expressing in a verbal language, found symbolic expression in
the art therapy session. The art therapist was viewed as an
individual who could foster and help the client externalize
and integrate neglected or unrecognized psychological aspects
of him or herself.

In response to Question #2, all members of the team

80

reported that they perceived absolutely no problems with art therapy's integratio.: into the program. As a mode of intervention, art therapy was acknowledged for the therapeutic attributes that the art experience offered their clients. The therapeutic alliance between art therapists and clients was noted as being a supportive and crucial element in therapy. Interchange between team members concerning client intervention was felt to be enriched by the presence of art therapy on the team.

Art therapy's capacity to work adjunctively and complementarily within the constructs of a social, community-based model of mental health was perceived by the team members in a positive light. Although this could be interpreted as a smooth integration of art therapy into an existing team structure, it could also indicate a hesitancy on the part of team members to explore and confront team dynamics at such an early stage of a budding program.

Question #3. Team members claimed that their common goal was to enhance the quality of life for their clients. They perceived themselves as working directly in the midst of their client's external environment. It was felt that clients would benefit from a therapeutic mode of intervention that could explore the inner environment and psychic realm of the clients' lives. Art therapy's integration into a social and

community-based model of mental health was seen as complementing a more holistic approach to client treatment. One without the other, would portray only a partial analysis of a client's problems and strengths. This type of information is fundamentally necessary in making interventions that will benefit the client.

Question #4. Team members found that art therapy functioned as an aid in clarifying and illuminating the clients' pathology. It was also noted as helping team members to more fully understand the layers of their clients' unconscious and often unexpressed perceptions which otherwise, would remain inaccessible to team members. In this manner, they acknowledge art therapy's ability to bypass verbal defenses and tap into the inner dynamics of their clients' lives with accuracy and depth.

b)   Commentaries by Amitie/Friendship's Art Therapy Intern and Art Therapist

The following questionnaire was submitted to one art therapist presently employed by the Amitie/Friendship program and one interning art there   t:

1)   How many clients do you work with on a weekly basis?

2)   What have you found to be the average length of therapy per client?

3)   What attracted you to the CLSC as a place of employment or internship?

4)   What were your reservations, if any, about working in this environment?

5)   What therapeutic issues were raised (ie. ethical, legal, etc.)?

5)   How did you perceive art therapy integrating into the already existing team format?

In response to Question #1, average client case load and frequency and length of therapy varied greatly. While some clients attended up to two sessions per week for several years, others had come only for an initial consultation and opted not to continue. Two clients have terminated, that is, that had accomplished the goals set on entering therapy (one after ten months/40 sessions and another after six months/25 sessions).

Question #2.   Some clients attended the art therapy sessions in phases while others had been in art therapy continuously for over a year.   Art therapy conducted by interns was limited to approximately eight months due to the restraints imposed by the school year.

Question #3.   Both the art therapist and the interning art therapist reported that they were attracted to the CLSC

because they were interested in working with community mental health patients in a outpatient setting. Both therapists expressed doubts about the institutional environment of hospitals, stating that they were more comfortable and as a result more effective in a smaller setting. It was felt that in a smaller setting, the therapist could offer closer contact with team members and case workers. One therapist wrote that she enjoyed the idea of working with deinstitutionalized clients because they entered therapy of their own free will and with a genuine desire to participate in a therapeutic process. This situation was contrasted with the art therapist's experience within a hospital setting where patients were often found to be chronically resistant or who entered and exited the hospital frequently thereby never really engaging in the process or therapeutic alliance.

Question #4. Initial reservations about the integration of art therapy into a community-based program concerned the possible lack of psychodynamic clinical experience of the team and the small size of the program. As an art therapy intern, on art therapist recalled that she was worried that the setting would not be able to provide enough clinical guidance or support. Since the program was young and small, she had worried that the program could not provide her with the clients and direction that she needed. In retrospect, she reported that although she suffered the isolation that a

psychodynamically oriented therapist may initially encounter in many reality-based community environments, the community setting also provided her with exposure to a flexible environment that readily accepted and encouraged art therapy's growth and expansion within its structure.

Initial concern as to a gap between the reality-based workers and art therapist was perceived. Confusion about the therapeutic framework of art therapy versus a familial, friendly, social interaction with case workers required the art therapist to maintain a psychotherapeutic posture. This was not perceived as a problem, but rather an observation about the fferences in approach within the psycho/social structure of the team. The difference in approach in terms of formal hospital procedure vis-a-vis charts, diagnosis, and case histories also proved difficult. It was noted, however, that case workers were open at all time to the exchange of information and the differences between approaches within the team respected and integrated.

Areas deemed problematic were understood by art therapists as being a required compromise. The art therapy room, for example, follows the model of the counselling room. The studio facilities were limited since the art therapist was advised not to dirty the floors or walls. There were no interpersonal problems in terms of personality clashes but

there was a profound difference in approach. The art therapist, presently employed with the program, presented many cases in an effort to develop an understanding, appreciation and acceptance among the team members of her work in art therapy.

Question #5. Art therapists subscribe to the Association des Art-Therapeutes du Quebec's code of ethics to which they can refer when faced with an ethical dilemma. In concrete terms, issues that were raised included how to proceed in terms of client confidentiality; storage and maintenance of client art work; files; and dealings with other professionals who were in mutual contact with clients outside the program. Special measures included locks being put on cabinets and cupboards containing art work and a system being developed for reporting in client files. The therapist who developed these procedures reported that she still felt insecure about these issues due to her own inexperience and lack of available guidance from the team who had a different and less stringent perspective on those ethical issues.

Question #6. In summary, the art therapists interviewed felt that there was a positive blending of art therapy into the team structure. This was fostered by the team's openness and an environment which was favourable to changes within its existing structure. It was felt that the team appreciated the

complexity of the art therapy process even if it did not always understand all of its implications. The team fully supported and gave full credibility to the art therapist and employed the information derived from her to the betterment of their clients.

Ideally, the art therapists felt that there could be a stronger orientation towards the inner psychic dynamics of the client. Despite this observation, given the name of the program, Amitie/Friendship, it was exciting for everyone to witness the incorporation of a psychodynamic approach within this milieu.

A unifying force amongst the interviewees and many art therapists (see page 79) seems to stem from a common belief and value of the visual arts in general and specifically in its potential to provide a means for expression and communication not usually available in hospitals and other clinical settings.

5. **Art Therapy's Potential Contribution to Community-Based Programs**

Little has been published on art therapy's current employment status in North America. However, two studies conducted by Helen Landgarten in the Greater Los Angeles Area

of the United States (1972, 1974) and one Canadian study (1987) produced by Johanne Kielo ard Rachel Garber, are indicators that there has been a perceived shift in art therapy employment from a primary reliance on hospitals to an increase of employment in deinstitutionalized settings (Refer to Appendix). Because there exists a perceived trend in art therapy towards establishing itself in deinstitutionalized settings, art therapists must address its potential contribution to community-based programs.

In the community setting, art therapy functions to bridge the chasm that lies between the chronically mentally ill and society. Coleen Gold, art therapist with the Amitie/Friendship program, echoes this reality in her reflections on art therapy's function in a deinstitutionalized setting.

> "The deinstitutionalized clients came, because they wanted to be there. They were, for the most part, insightful, intelligent, and had a genuine desire to sort out the inner conflicts that affected them. Out of hospital, they became citizens that operated and functioned, even if marginally at times or on the fringe or outskirts within a society that continues on without them and at a pace that they find difficult to keep up with" (Gold 1988).

The expansion of art therapy into the community is an inevitable outgrowth of deinstitutionalization. Its potential contribution lies in direct proportion to its ability to sensitize itself to the diverse and changing needs of the clients it serves and its practitioners' ability to integrate and work with other professionals and non-professionals in a systemic and holistic treatment approach.

Referring to my own experience as an intern, I found that art therapy, in the context of the Amitie/Friendship program, is for many clients, the first opportunity to examine their life process. Based on the premise discussed above, that all individuals have the right to be offered access to therapy regardless of financial status or other restraints, art therapy provides the opportunity for individuals to examine and explore issues concerning the quality of life.

Unlike the medical model that bases its success on results, art therapy is concerned with encouraging clients to experience their own process more intensely regardless of its quantifiable outcome. Unique to the Amitie/Friendship program is the fact that it encourages clients to develop a therapeutic relationship that may be fostered over several years of therapy. Most mental health practitioners could not or would not invest such a long period of time in this

endeavour.   The widely subscribed to hospital model which promotes short term goals demanding results or improvement by the clients makes long term therapy virtually obsolete.

Art therapy provides a holding environment for the clients' otherwise unacceptable thoughts.   It provides them with the opportunity to explore what they perceive as norms and what sanity and insanity means to them.

The sessions center on defining the therapeutic relationship between client and therapist; issues of trust; working through the client's fears of being labeled and perceived as crazy; and the logistical problems of the client adhering to scheduled sessions. Areas of personal inquiry by the client are explored in the context of his inner world of fantasy versus external reality.   Issues of identity are addressed, with the client exploring and expressing numerous aspects of him or herself.

The clients symbolically employ art therapy as a means to avoid, engage, reject, defend, and play out any process which they experience through the art work and therapeutic interchange.   This becomes a validating experience for the clients, giving importance and significance to their acts and in essence gives them their sense of being.

The clients are allowed to regress within a framed and trusting environment with the understanding that this is acceptable and considered part of the therapeutic dynamics. Perhaps most of all, art therapy within a deinstitutionalized setting provides an environment that is able to adapt to the clients' changing needs.

Throughout the art therapy sessions, the client becomes increasingly committed to bridging artistic sensibilities with the active exploration of the psychological aspects which they have expressed. In so doing, art therapy plays a central role in fostering and externalising the client's innate urge to create.

The drawing page serves as a surface for the client to draw his inner world, including the degree of ability he has to mobilize his inner resources to explore and integrate psychodynamic conflicts both interpersonal and intrapsychic. It also serves as a frame and container for the psychological material thus tapped.

The materials employed in the art therapy sessions, become a metaphorical means to describe the client's inner psychodynamics. Often, clients actively and independently continue drawing after termination of therapy. The simple fact that the clients choose to attend sessions or not,

encourages a sense of personal autonomy and responsibility. Art therapy, in psycho/social and systemic approaches to mental health, also provides a unique opportunity to teach other professionals, staff, and team members a new way of understanding their clients through the creative process.

6.   Continued Accessibility of Art Therapy in the Community

As the community assumes responsibility for its holistic health, moral issues in the face of economic restraint must be addressed. Certainly a case must be made for the continued accessibility of art therapy within the community.

The combination of art therapy and cognitive restructuring techniques successfully mobilize a patient's motivation to understand their illness. Clearly the ability to be self-sufficient affects the quality of a person's life. Therefore, training in social and independent living skills are encompassed within the holistic treatment philosophy. Social and independent living skills training specifically tailored to the individual needs and deficiencies of the client is an integral part of an ideal community-based treatment program. Art therapy, however, not only compliments but completes the concept of holism in the context to the psycho/social treatment offered by the Amitie/Friendship program.

One aspect of the holistic approach highlights the role of the patient as an active and responsible participant in the process of self-healing. The patient is no longer the passive victim of a disease or the passive recipient of a cure. What is unique about this approach is its insistence that individuals have both the responsibility and the ability to influence the course of their illness toward health. The patient is encouraged to explore his own illness and the factors which affect his recovery and his relapses (Pelletier 1977).

The acceptance of the holistic approach by professionals is diverse. Holistic treatment can be viewed as assisting the individual in all his levels of being; body, mind, and spirit. Some view the holistic approach as integrating traditional medical practices with techniques which emphasize the patient's responsibility for self-cure and self-healing. Others view the holistic model as an alternative to the traditional medical mode. However, many therapeutic professions have created a dilemma by spurning the unconscious, the dreams, the delusions, and the fantasies of the chronically mentally ill. These are the very elements that art therapy actively acknowledges and explores.

In conclusion, an important contribution by art therapy

to community-based programs is its ability to foster spontaneous healing through emphasis being placed more on the healing forces of the psyche than on the psychopathology. This is accomplished by accepting the patient's inner chaos as meaningful and symbolic. As a necessary state to be explored, it should be neither reasoned nor drugged away. Helping the patient to look at the positive, healing and purposive elements of his delusions of fantasy can lead to a sense of hope and reconciliation of the splintered parts of an individual into a whole.

7. Summary

Art therapy's integration into community-based centers for the chronically mentally ill functions to fill the vacuum in the mental health system created by deinstitutionalization. Its integration into the Amitie/Friendship program is one example of its potential implementation into a deinstitutionalized setting. Commentaries by team members and art therapists within the program point to art therapy's creative potential in exploring the psychodynamic aspects of the clients' lives and in complementing a systemic and holistic treatment program when coupled with the reality-based structure of a team.

Art therapy's contribution to community-based programs

lies in its ability to create a bridge between chronically mentally ill clients and society through an artistic process. Its continued accessability relies on community-based programs that accept the moral challenge of providing holistic care to the chronically mentally ill despite economic restraint.

The following Chapter will conclude this trend with a review of the concept of deinstitutionalization and a proposal regarding therapy's identity in the face of a changing mental health system; also it will address art therapy's future role in the treatment of the chronically mentally ill. The question of reality versus fantasy in the treatment approach of chronically mentally ill in community settings will be presented as an area of research which requires further study.

CHAPTER V

SUMMARY/CONCLUSION

1. **A Review of the Concept of Deinstitutionalization and Art Therapy's Identity in the Face of a Changing Mental Health System**

As we have seen, deinstitutionalization is a vague term acting as a catch all word to describe two concurrent trends in the mental health care system. It signals the release into the community of formerly institutionalized psychiatric patients and the subsequent expansion of community-based services created to receive this population. Various competing factors, discussed at length in this thesis, resulted in the formation of the movement.

The concept of deinstitutionalization has a thirty year history. As a result, a critical analysis can now be viably made of its implementation and effectiveness. Despite the early enthusiastic and idealistic expectations, it has been argued that the immersion of the chronically mentally ill into the community has had a limited effect on the quality of life of these individuals. Deinstitutionalization has brought to the forefront, however, the need for acknowledgement of the common responsibility shared by the chronically mentally ill,

mental health professionals and the community. These groups are intrinsically affected by its implementation as defined in this thesis.

Chronically mentally ill patients, one of these major groups, have been encouraged to abandon a passive attitude toward their illness. By availing themselves of the ongoing development of treatment and services, they are assisted in their attempts to reintegrate into the community.

Professionals, in all fields of mental health care, have seen their role affected by the implementation of deinstitutionalization. They have been called upon to reassess the changing needs of the chronically mentally ill brought about by the shift in treatment of this population from hospital-based care to community-based care. As a result, treatment strategy and methodology have undergone stringent re-examination and re-structure.

Within the evolution of art therapy's own professional history, spanning over forty years of growth, art therapists have witnessed an expansion from its pioneering inception as an appendage to psychiatry in institutional settings to full recognition as an independent profession. Ultimately, art therapy's role will be defined by its ability to perceive the changing needs of the chronically mentally ill and to develop

97

creative and insightful interventions with this population in the community setting. Deinstitutionalization of the chronically mentally has placed new responsibility on the community, and the society in general, to acknowledge the right of each of its members to adequate mental health care. This expanded view has necessitated a broadened understanding and acceptance of the plight of the chronically mentally ill. This process has resulted in a difficult transitio1 and slow adaptation for all three major groups concerned (the chronically mentally ill, mental health professional, and society).

The future for an adequate holistic system that can cater to the current needs of the chronically mentally ill appears to lie in the capacity of patients, community-based services, hospital-based psychiatric services, and the community at large to pool resources in order to provide an integrated and multi-faceted mental health program.

2. <u>Art Therapy's Future Role in the Treatment of the Chronically Mentally Ill</u>

As mentioned several times, the deinstitutionalization movement created a vacuum in the mental health system. This period of flux encouraged creative license for the budding profession of art therapy to develop innovative intervention

strategies and treatment programs for the chronically mentally ill. In proposing new programs, the former emphasis placed on short term reality-based approaches to therapy and crisis intervention requires modification by means of complementing the presence of long term insight oriented therapy that addresses the chronic nature of many mental illnesses.

Art therapy's integration into community-based settings highlighted the need to educate co-professionals concerning art therapy's unique use of the language of art as a vehicle of communication and self expression for clients and as a therapeutic tool for mental health professionals.

Unfortunately, no form of psycho-social treatment has demonstrated an impact on the revolving-door, discharge-readmission pattern of the chronically mentally ill. Despite the development of the psychoactive drugs and community care facilities over the past thirty years, the rate of relapse and hospitalization has not diminished. The need for more effective treatment for the ninety percent of the schizophrenics whose illness takes an episodic course is apparent. The lack of joint efforts by community services and hospitals to work cooperatively together must be addressed.

A time of fiscal restraint and cutbacks threatens the quality and variety of support systems available to the

chronically mentally ill. The resulting uncertain financial backing, job permanency, and basic limitations in terms of appropriate space, materials and work environment challenge art therapists to find more effective strategies to ensure the systemic and holistic care of the chronically mentally ill. Art therapy's potential contribution to community-based care and its continued accessability to the chronically mentally ill in the community point to its potential value in helping to fill the vacuum in the mental health system left by the deinstitutionalization movement.

3. **The Question of Reality versus Fantasy - Contrasting Ideologies in Treatment Strategy that Require Further Study**

Art therapists working in a systemic team with other professionals and non-professionals must find the means to dynamically work with the fantasy and reality aspects of their clients' lives.

This thesis terminates with a focus on the issue of fantasy versus reality as treatment strategy to be used in community mental health care. Presently, reality-based treatment strategies are systematically incorporated as necessary elements of the care of the chronically mentally ill. Imagination and fantasy encompassed within the art

therapy experience, reflect a stage of integration in the evolution of community mental health ideologies which complete and encourage holistic insights into a wider range of client needs ranging from the concerns of basic living skills to the personal experiencing of the self through the language of art.

Stemming from clinical experience, art therapists acknowledge the need for a stronger psychological engagement with the expressive, communicative and creative aspects of the individual.

Art therapy's role is the recognition and accessing of the value of fantasy in the problem solving, choice making, bridging of the aesthetic process as integrated with treatment modalities available in current community mental health programs.

In evaluating the consequences of this position, art therapists address the following questions. Should the goal of art therapy be to reinforce ego strength and reality testing? Does art therapy's emphasis on fantasy and symbolic reality hinder team efforts to mobilize their clients effectively? Are a client's delusions and fantasies valuable? How does the issue of fantasy versus reality effect treatment strategy?

As a means of further exploring these questions, the ideas of H.R. Lamb, who has written extensively on schizophrenia and chronic psychiatric care (1982) will be contrasted with those of James Hillman (1970). The contrasting ideology of fantasy versus reality inherent in the multi-disciplinary structure of a community-based team will be examined.

As a consequence of deinstitutionalization, art therapy finds itself face to face with various non-psychodynamically oriented methods such as those practiced by Lamb and implemented in many social services. Art therapy must find its place alongside or, as is often the case, integrated with these modalities without compromising its theoretical underpinnings.

Most differences between the established team approach and the art therapy approach to client care are related to their differing focus on separate clinical objectives. An area of possible conflict is the treatment of hallucinations, delusions, and fantasies. The behavioural approach views them as asocial behaviours which serve to attract attention. This approach encourages a basic treatment strategy of ignoring them entirely of discounting their validity and reality. The art therapy modality takes the opposite track by encouraging clients to express and explore their psychotic experiences.

Sessions are specifically scheduled and designed to facilitate verbal and non-verbal expression of hallucinations, delusions, and fantasies.

Lukoff, in his dissertation on <u>The Comparison of Holistic and Social Skill Training</u>, cites a pertinent divergence between treatment approaches. His study employed art as a form of treatment in which the patients were encouraged to explore their delusional experiences. In this study, an illustration of one approach towards delusions as exemplified by the treatment given a patient. The patient heard the voice of Frankenstein during his psychotic episode. He was encouraged to read the novel, Frankenstein. Jungian-based sessions focused on the parts of the patient he himself was not accepting or expressing and therefore needed to split off. The result was the creation of an independent voice in order to be heard and further integrated (Lukoff 1981). The behavioural assumption that hallucinations and delusions increase with attention was not supported by the finding in Lukoff's study.

A social or medical model of treatment might insist that this delusion was not real, encouraging more sociably acceptable modes of functioning through repression. Some of the nursing staff and members of the treatment team in this study expressed the concern that encouraging the exploration

of the patient's delusional systems and hallucinations by giving them attention may augment their effects. This did not appear to be the case.

H.R. Lamb, outlining a reality-based approach to psychotherapy with chronic psychiatric patients, suggests that

"with the emptying of hospitals, mental health professionals are being called on to provide community treatment to increasingly large numbers of long term, severely disabled patients. Individual psychotherapy is often dismissed if it is thought of at all, when professionals plan community programs for these patients. Individual psychotherapy, however, can play a central role, but first there must be a clearly understood point of view and rationale." (Lamb 1982,121).

Lamb describes the particular approach which he believes is the most successful with this population. Its rationale is based on Fenichel with its emphasis on ego strength.

"Above all, we should direct our efforts to giving patients a sense of mastery - the feeling that they can cope with their internal drives, their symptoms, and the demands of their environment. With the development of mastery, patients achieve not only a better adaptation to their world but also a significant rise in self esteem. To attain our objective, we need to work with the well part of the ego" (Lamb 1982,121).

From Lamb's point of view, this goal is achieved by the therapist learning to focus on reality to the exclusion of fantasy, placing emphasis on the present and the future rather than on the past. Regression is discouraged. The patient or client is encouraged to develop insight into their symptoms as a means of understanding their delusions, hallucinations and feelings of falling apart as reactions to stress. Stress is

104

identified and a plan enacted between worker and patient to decide together on logical purposeful actions to resolve the problem. Aid is given to the patient to understand that increasing his medication will alleviate his symptoms and maintain his problem solving abilities. The patient is helped to either deal with or avoid anxiety provoking situations. Inviting a transference psychosis in which the closeness of the therapeutic relationship becomes threatening is avoided. Long silences and the opposite, rapid pace eruptions of unconscious material are also to be avoided. Limit setting is encouraged. Advice is given if the patient is unable to arrive at his own solutions. The patient is assisted to rationalize the situation if it will help him to deal with his feelings. A stance against the superego is taken to reduce guilt, and corrective emotional experiences are offered.

These are examples provided by Lamb to illustrate how to stay with the reality component of psychic material instead of addressing the fantasy. There is no doubt that there can be successful interventions which follow Lamb's criteria. He appears to underestimate, however, the chronic schizophrenic's ability to explore primary process material without it clearly leading to psychotic decompensation. It is important to acknowledge that in some cases it does. It is the responsibility of both the client and the therapist to ensure that when deep and difficult material surfaces there is

adequate support to frame it. This is an inherent function of the therapeutic relationship in art therapy.

Reality in Lamb's case appears to be defined in terms of things that have a so called actual existence and reflect a true state of affairs; a real thing or actual fact. These notions, however, are based on societal standards and on a need to conform to its norms. Ethically, this stance appears to prohibit clients from exercising their freedom of choice and individuality. Fantasy, as a free play of creative imagination, can also be considered real whether in the form of day dreams, fancies or whims. By splitting off or repressing these elements of a client's personality, Lamb appears to be neglecting the treatment of the whole individual for the sake of conformity.

In what manner are Lamb's ideas relevant to the practice of art therapy in the team context? I concur with some of the practical advice cited by Lamb. Increased anxiety or tension in the session can result in a psychotic reaction and become non-therapeutic. Overall, however, Lamb's reality approach has more in common with the mode of intervention practiced by reality-based community care and is less applicable to the field of art therapy.

James Hillman presents an alternative to the ego

strengthening reality approach to therapy. Hillman contrasts Freud's famous "where id was there ego shall be" and Fenichel's notion of strong ego rather than a weak ego. The problems in Hillman's opinion, is that an opposition is created and a language of muscle, strength and will is employed to maintain a disconnection between strong and weak ego (Hillman 1969,2). Reason, understanding, intellect and will are ego words that traditionally have implied a greater strength and value than concepts such as images, affects, fantasies, dreams and visions.

Hillman acknowledges how imagination has been mistrusted throughout history. He states that the Greeks determined that reason was the way of truth while fantasy was merely the way of opinion. Imagination, according to Hillman, came to be considered alien to the ego and at its extreme could be conceived as the enemy. Therefore, one must rule and control fantasy through reason.

Hillman argues that the term ego refers simply to the individual's experience of himself. One need not be strong or weak to experience oneself. Preoccupation with judging the ego as strong or weak has not so much to do with the individual or the nature of ego, as it does with ideas that people should conform to societal standards. This viewpoint is critical of a world in which one uses a strong ego to adapt

or bend circumstances. The theories of H.R. Lamb make a case for reality to the exclusion of fantasy and exemplify the polarization of this issue.

In fact, Freud addressed the vaguely defined boundaries of fantasy when he described psychic reality and external reality in his essays On Narcissism: An Introduction (1914) and Instincts and Their Vicissitudes (1915). Psychic reality-based on drive theory is qualified as real with external acts corresponding to internal instincts and therefore coloured, tinged and ultimately created by the individual's psychic reality and fantasy. The terms fantasy and reality correspond ultimately not to objectifiable, factual, external objects and events but originate from the need to satisfy internal drives. The ego mediates between psychic reality and external reality and decides what reality is at any given time. External reality which traditionally has been defined by societal norms, reflects, in Freud's opinion, the unconscious expression of an individual's internal world. An inevitable conflict as to what is considered to be the individual's 'real' experiencing of himself is set up with those who view the true nature of man as one defined by his reason, on one hand, and those who would say that man is a "poetic or mythical being" on the other (Hillman 1969,5).

Hillman believes that therapy, based on the concept of

ego strengthening, makes therapy a tool of the establishment. Therapists become problem solvers instead of "fantasy spinners".

> "Would it be possible to move towards another kind of ego and realize another kind of approach where the complex is encouraged to spin out its fantasies and where therapy becomes an exercise of fantasy and where problems themselves are simply part of the fantasy? (Hillman 1969,6).

Hillman approaches therapy, not through the concept of ego but by working with complexes in a Jungian sense of the word. The psyche is a complex phenomenon and the complex is the root of psychic life. On the one hand the complex is a problem, something to be dealt with but on the other hand, it is a fantasy, dream, wish, image, game, fear, role. Hillman believes that when art therapists become problem solvers they are disregarding the significance of the art aspect of their work.

Artists, poets and writers do not want their fantasies turned into problems to be solved. They want their complexes to produce more fantasies. Art therapists provide the environment where clients can create a new imaginal world which they can interact and live in.

Hillman advocates therapy not as a means of developing ego strength but as a way of entering the imaginal world for the sake of the imaginal world itself, like art for art's

109

sake. The result would be the development of an imaginal ego that can live in the imaginal world. This does not contradict the reality-based notion of having to live in the 'real' world. It relates to the client's perception of his world whatever that may mean or be to him.

Although both Hillman and Lamb believe in insight, Hillman dismisses the need to necessarily find solutions. Hillman states, "What insight is I couldn't tell you. But we know that we can't make insight. Insights happen independent of will and reason. They seem to happen out of the imaginal realm" (Hillman 1969,7).

The experiences of depression, psychosis, or whatever form the complex takes is an opportunity to build the new imaginal ego. Hillman believes that art speaks the same unprofessional language as the imagination. Insights and creative inspiration come the same way, directly, unwilled, and irrational. Hillman would like psychology to sound like the language of imagination speaking directly to the soul, using insight and evocation instead of interpretation and exploration. In this context, the role of the art therapist would be to encourage and seduce the fantasy process to go further.

In view of Hillman's ideas, is it possible for art

therapy to conform to Lamb's reality ego strength approach described earlier? We have already seen in the work of Hodnett and Waller and in the reflections of practicing art therapists examined earlier in this thesis, that art therapists have invested in the art aspect of art therapy as the essential vehicle for self enquiry and expression.

Does emphasis on the art aspect necessarily exclude reality-based considerations? In the comments evaluated from the prior interviews the consensus seems to indicate that the concepts of reality and fantasy need not exclude each other. The onus, however, is placed on art therapists to develop and to ensure a language and aesthetic theory of their own.

Artists experience the poetic, mythical and imaginative aspect of art making and are often equally aware of the real, concrete, tangible and phenomenological elements involved. Art therapy is often described as symbolic, expressive or as sublimation. We say, for example, that the red slashes on the paper are not real anger by symbolic of anger. Yet these slashes are real, they exist and were made by the clients. The client experiences real emotion while making them. While the art making process encompasses fantasy it also has a concrete aspect requiring action and decision-making.

Finally, in the specific example of the Amitie/Friendship

111

program, I readdress the interrelatedness between the reality-based community health approach employed by the animators on the team and the fantasy and symbolic approach inherent in art therapy. The challenge of encompassing reality and fantasy as a means of working with clients appears to be central as does the need to educate and sensitize animators in community centers to the richness of client's inner lives as expressed through the language of art. Ultimately, the aim of art therapy is to provide a comprehensive, holistic outlook towards the chronically mentally ill through an array of diverse services of both the tangible and concrete and the symbolic and imaginal kind within the deinstitutionalized, psycho/social model of community mental health.

> "As psychology moves beyond itself towards a psychology which is not a translation of psychic events into a professional language, but a psychology that speaks directly of psychic events, a psychology of insight and evocation, not interpretation and explanation, it could then speak directly in the soul language of imaginal speech. Then psychology would begin to sound like the language of imagination, and perhaps, I hope, take more and more the forms of art and its play" (Hillman 1969, 8).

The concept for this thesis was derived from personal experience as an art therapy intern working in a community-based setting that catered to the needs of the chronically mentally ill. It appeared evident at that time that there was a vacuum in the treatment of clients because of the lack of psychodynamically oriented therapy accessible to them. Art therapy filled that vacuum by providing a means for the

112

clients to explore their inner lives through their own creative process. Art therapy's emphasis on the imagination and the fantasy aspects of the clients' lives complemented the reality-based team approach, providing a more holistic and comprehensive set of services for the chronically mentally ill clients using the program. It is my contention that art therapy's integration into other similar community-based programs for the chronically mentally ill will likely have the same success.

One area that requires further study is the relationship between reality versus fantasy in treatment approach. Reality-based objectives that include coping and living skills, housing and food are indisputably crucial to the care of the chronically mentally ill. Art therapy, works with the imaginal and symbolic aspects of the clients' lives and is equally fundamental in the treatment of the chronically mentally ill individuals living in the community and in need of long term support. The challenge lies in the ability of reality-based workers and art therapists to encompass both the tangible and symbolic realities of their clients' needs and to work together to provide comprehensive services that are able to respond to the diversity of need in this population.

APPENDIX

The following questions were asked in interviews with Marie Revai (March, 1988), Beth Robinson (April, 1988), Maurice Brault (March, 1988), Rachel Garber (April, 1988) and Yvon Lamy (April, 1988):

1)   How did you become involved with the field of art therapy?

2)   What types of institutional frameworks did you work in?

3)   What changes or trends have you witnessed in art therapy?

4)   What are your perceptions of art therapy's current professional status?

Art Therapy's Current Job Status - A Perceived Shift From Institutionalized to Deinstitutionalized Treatment

In two surveys conducted by Helen Landgarten in 1972 and 1974, the issue of art therapy's changing status is addressed. A ·idely divergent sample of human service facilities was taken from the Directory of Health, Welfare, Vocational and Recreational Services in Los Angeles County (Landgarten 1976a,1976b).

In the 1972 study, nine percent of the institutions responding to the questionnaire stated that they had art therapists on their staff. In 1974, twenty-one percent of the institutions employed art therapists.

Concerning the possible future employment of art therapists by respondents, the 1972 study noted that eleven percent stated that they intended to employ art therapists at some future date with mental health and residential treatment centers showing the greatest interest.

By 1974, there had been a marked change (Refer to Table 1). In this survey, eighteen percent of the respondents indicated that they intended to initiate or expand employment of art therapists in the next two years. An additional fourteen percent indicated that is was possible that they might hire art therapists within that period. Thirty-two percent were at least considering hiring an art therapist within two years. The tables also indicate what types of facilities expressed interest in the future hiring of art therapist. Institutions with the greatest interest were outpatient and inpatient mental health facilities.

Since the 1972 study was based on only eighty responses, the results would not be considered reliable enough to reveal more general trends. The data suggested that both knowledge and use of art therapy was limited at that time. The 1974 sample was based on one hundred and eight replies indicating a c eater reliability.

The 1974 study showed an increase of twelve percent in the employment of art therapists. Art therapy departments increased by eight percent and psychiatric departments in which art therapists were functioning increased seven percent. The comparison of responses to both the 1972 and 1974 surveys suggests an increase of interest in art therapy in that region with employment possibilities remaining mainly within mental

health facilities.

A study in 1987 was conducted by Joanne Kielo and Rachel Garber on the status of art therapy in Canada with quite different results. Out of one hundred and twelve questionnaires sent to art therapists residing throughout Canada, there were fifty-six replies. Seven questionnaires did not reach their destination (Garber & Kielo 1987).

Half of the respondents had two or more years of training in the arts and over half had qualifications in other than art therapy (ie. another profession such as nursing or psychology).

In respect to practicum experience and training, seventy-seven percent of the respondents had practicum experience in a psychiatric setting, forty-seven percent in a rehabilitation setting, thirty-five percent in a social preventative setting, and nine percent had had practicum experience in a school setting.

Twenty percent of respondents replied that they had worked as art therapists ten or more years; twenty-five percent have worked five to nine years; the majority of respondents, forty-four percent, had worked one to four years and four percent had been working in the field for one year or less.

Between the years 1983-1985, twenty-one percent of the respondents reported that they had been working full-time as art therapists; twelve percent were not working; and the rest were employed half or part-time. In 1987, nineteen percent of the respondents reported that they were presently employed full-time, nine percent reported that they were not working in the field of art therapy and the remainder stated that they were employed either half or part-time.

What is of particular interest to those reading this thesis, are the settings in which art therapists are employed today and whether deinstitutionalization appears to have had any effect on whether art therapists are working predominantly in institutional/psychiatric or community-based settings. Unlike the earlier studies (Los Angeles 1972 and 1974) cited earlier, the highest number of facilities hiring art therapists has shifted from psychiatric settings to community-based settings (Refer to Table 2).

These statistics could suggest that art therapists and the organizations that hire them are responding to the shift in emphasis from institutional to community-based care. The data is also an important consideration for future art therapy students entering the field when considering the choice of

practicum setting and training.

It is interesting to note that at least thirty-three percent of the respondents were working with schizophrenic clients in various settings, while only two percent worked in a preventative mode of intervention, exemplifying a move away from psychiatric/ preventative measure of intervention to longer term care of clients and patients.

Table 1

Facilities Contemplating Employment of Art Therapists in Los Angeles - 1974

Type of Facility	Number of Facilities	Definitely Percent	No.	Possibly Percent	No.	Total Percent	No.
Day care (adult)	1	100	1	-	-	100	1
Drug abuse	3	100	3	-	-	100	3
Mentally retarded (residential training)	5	20	1	60	3	80	4
Residential treatment (child adolescent)	19	10	2	21	4	32	6
Outpatient	21	14	3	14	3	28	6
Inpatient	11	27	3		-	27	3
Geriatric	4	25	1		-	25	1
Rehabilitation	4	25	1		-	25	1
Community mental health; family counseling	29	14	4	10	3	24	7
School (educational-therapeutic	11	-	-	18	2	18	2
Day treatment (child; adolescent)	0	0	-		-	-	-
Totals	108		19		15		34

Table 2

Types of Facilities Hiring Art Therapists in Canada - 1987

Clinical/Psychiatric settings	28.1%
Other (Socio Preventative, Rehabilitation, private practice)	57 9%

Table 3

Care given to clients of Amitié/Friendship
by professionals other than those employed
by Amitié/Friendship * (Refer to pg. 74)

*Amount of time spent with professional	Professional Group						
	Psychiatrist		Social Worker		General Practitioner		Others
	No.	%	No.	%	No.	%	No.
15 minutes	54	72	3	25	8	80	0
30 minutes	18	24	9	75	1	10	2
60 minutes	3	4	0	0	1	10	0
TOTAL	75	100	12	100	10	100	2

Table 4

*Frequency of visit to professional	Professional Group								
	Psychiatrist		Social Worker		Nurse		General Practitioner		Others
	No.	%	No.	%	No.	%	No.	%	No.
weekly-bi-monthly	10	13	5	42	9	50	2	20	1
monthly	26	35	0	0	9	50	3	30	0
every 2 months	7	9	1	8	0	0	4	40	0
every 3 months	6	8	0	0	0	0	0	0	0
every 4 months	5	7	0	0	0	0	0	0	0
every 6 months	10	13	0	0	0	0	0	0	0
yearly	2	3	0	0	0	0	0	0	0
as needed	9	12	6	50	0	0	1	10	1
TOTAL	75	100	12	100	18	100	10	100	2

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127

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