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CREATING ART PSYCHOTHERAPY TRAINING IN AUSTRALIA

JOHN HENZELL

Missing years – 1959-1989.

By way of introduction I start with some historical details of my profession that touch on biography and autobiography, and involve the styles and idioms of three countries. Once formed professions become conservative and resistant to change, yet at their beginning, before they become regulated by the state and interested parties within organisations and guilds, involve a small number of inventive individuals operating in novel social contexts who, through an adventitious combination of circumstances, discover unforeseen way of looking at human dilemmas. The historical contexts I am referring to, and the countries in which they occurred, are the years after the Second World War in Australia, Britain and the United States when the use of art in psychotherapy was becoming known as art therapy.

At present there is a small art therapy profession in this country and it appears I think to those involved in it that things started here in the 1980s when a number of art therapists, either Australians who had trained in Britain or the United States, or nationals of those countries, decided to live and work in this country. Towards the end of the decade postgraduate training in art therapy started in Australia. The first university accredited training, a Postgraduate Diploma, started at Edith Cowan University – at the same time as this university was replacing a number of higher education and training colleges in the Perth metropolitan area. This was a common story all over Australia and reflected international developments in higher education. In 1991 it became a Master of Arts. It was preceded by an attempt to start a course in Brisbane and was followed shortly by Masters courses at the University of Western Sydney in 1992 and later by a third at La Trobe University here in Melbourne.

All of these initiatives reflected practice in the two countries in which art therapy had already become established professions, namely Britain and the United States. Annette Coulter, an Australian who had trained as an art therapist in the UK, a student of mine there in the late 1970s, played a part in the Masters programmes in Perth and Sydney, and the preliminary attempt in Brisbane. On her return to Australia in the 1980s she added American professional registration to her UK registration. She played a prominent part in setting up the Australian National Art Therapy Association (ANATA), which is affiliated to PACFA. All three established Australian courses have been led by art therapists from Britain or the USA and have undergone various crises and transformations – of which more later.

I speak of this from detailed knowledge. I was asked to be an international consultant in the attempt to start postgraduate art therapy training in Brisbane and attended the Inaugural International Conference of ANATA in Brisbane in 1989 where I was a keynote speaker. At the time I was Director of the Centre for Art and Psychotherapy Studies at the University of Sheffield where we ran one of the four accredited British training courses. In 1992 we decided to share resources with the Sheffield MA in Analytical Psychotherapy and other masters courses and formed the Centre for Psychotherapeutic Studies. Three years later I was an artist in residence at ECU where my specific brief was to act as a consultant to the fledgling MA in Art Therapy and in 1993 I spent several weeks in a similar capacity at UWS. In both instances my advice was that the courses urgently needed more staffing and resources, a psychotherapeutic ethos which reflected Australian needs, international connections, and the appointment of course leaders with experience of training in countries where the connection of art and psychotherapy had been well established – the UK or USA. A

year later an English colleague of mine, Andrea Gilroy, with whom I collaborated in a book concerning research in the arts therapies (Henzell, in Gilroy and Lee 1995), led the Masters at UWS for a year before they appointed an art therapist who had been a student of hers at Goldsmiths College to the post. This was Jill Westwood who still leads the course. ECU appointed Michael Campanelli, an American trained clinical psychologist and art therapist to lead their course until his untimely death in 1999. I took over the course leadership early in 2001. La Trobe has been led by two American trained art therapists, the second of these Hannah Menahemi, grew up in Melbourne and, after her time in the States, worked in Israel before returning here. She is attending this conference.

What then of the missing years I refer to in the heading above? The practice of art therapy here has interesting but largely forgotten origins in its Australian setting. I would locate these around two people, one a psychotherapist and psychiatrist, the other a painter. The first was the psychiatrist, psychotherapist and hypnotherapist, Ainsley Meares, who worked in Melbourne from the 1950s to 1970s. He published a book which I read in the early 60s in Britain, called somewhat romantically, *The Door to Serenity* (Meares 1958). It deals with his prolonged work with a schizophrenic patient for whom painting pictures was an essential ingredient in her therapy. Later on he became best known for his popularisation of self-hypnosis as a method of relieving severe pain. Nevertheless, this was a potential beginning of greater public awareness of art and psychotherapy in Australia which might have formed a basis for practice by others.

The second potential beginning of Australian art therapy arose from the Western Australian painter, Guy Grey-Smith. The son of a farmer in the WA wheatbelt he flew as a member of a bomber aircrew over Europe during World War II. He was shot down and incarcerated in a German POW camp, of 'wooden horse' and 'Great Escape' fame, along with another Western Australian, Howard Taylor, who was also to become a prominent artist. Grey-Smith's way out of captivity however wasn't to be by means of the wooden horse, providentially as it turned out he contracted tuberculosis and was repatriated back to Britain in exchange for a similarly ill German POW. He was a patient at King Edward VIII Hospital at Godalming in Surrey where he benefited from meeting Adrian Hill who encouraged him to paint and draw as part of Hill's novel 'art therapy' work at the hospital (Hill 1945, 1951). After his recovery from TB Guy went to art school in London before returning with his English wife, the artist Helen Grey-Smith, to Western Australia. He then suffered a brief recurrence of TB and on his recovery continued to paint and helped support this by using Adrian Hill's art therapy methods with TB and psychiatric patients in Perth. I suspect this was with the assistance of my father, Linley Henzell, who was a specialist in the treatment of TB and held a government position making him responsible for the management of chest illnesses in WA.

Though born in England I grew up and was educated in Perth. Then TB was still an epidemic and often fatal illness. As far as I know Grey-Smith was the first person to be called an art therapist in Australia – all this was in the 1950s. He was ideal for the job with his combination of enthusiasm for art, talkativeness, perceptiveness and warmth. He became a friend of my parents and after I finished art school in 1957 he offered me some of his hospital work so he could progressively devote more of his time to painting. He became a prominent artist on account of his vividly coloured images of the bush and his campaigning for artist's rights. He died in 1981. I, being so young, hardly realised the full importance of the work he had introduced me to,

fascinated as I was by it, and left for England in 1959 where I began working with psychiatric patients and immersed myself in the experimentation and rich events of the 1960s and later years in Britain.

I played a part in founding an organized art therapy profession in Britain, was an active and published practitioner who specialized in work with those suffering from severe psychosis, one of the participants in the creation of state recognised postgraduate training, a training course director, clinical supervisor, researcher, and a UK delegate to the European Consortium of Arts Therapies Education (ECArTE) set up by the European Union in late 80s. I had no idea during this of how close I had been to people and events that could have been an earlier antipodean parallel to my British experience.

There were other Australian influences in the background. Post-War Australia became a great centre of narrative, historical and mythical painting, particularly the work of the ‘angry penguins’ in Melbourne, that stood out from the non-figurative art of Europe and Abstract Expressionism in the USA. Sydney Nolan – who re-invented Ned Kelly as an Aussie icon, Arthur Boyd, Albert Tucker, Russell Drysdale, Brett Whiteley, etc. This was part of the Australian propensity for accounting in one way or another for one’s past in the form of stories and images, then later on movies – to be expected given the emotionally and socially powerful events these images and stories dealt with; forcible transportation, the persecution of indigenous people, the redemption of a convict past, stories about wrecked Dutch navigators, immigration, the great 19th century treks of white explorers, Gallipoli and the World Wars, asylum seekers, the ‘stolen generation’, and, by European standards, the harsh nature and stark beauty of the environment for white settlers in Australia’s vast and ancient geography. Here was an extraordinarily rich well of communal experience and images which had the potential to inform psychotherapeutic work and the arts which could have played a part in this.

What then prevented Meare’s and Grey-Smith’s work, and the burgeoning imagery of those Australian artists contemporary with them – Grey-Smith being one of them, from forming deeper roots in psychotherapeutic work? One answer, I am sure there are others too, is that it was the ‘medical model’.

The British psychiatrist Eric Cunningham-Dax wrote a book in the early 1950s, *Psychiatric Explorations in Art* (Dax 1953), about art produced by patients at Netherne Hospital in Surrey. This work was elicited by Edward Adamson, but Dax writes as if Adamson was no more than a hand-maiden to the interpretations of psychiatric diagnosticians like himself. Adamson’s role is little more than a footnote in the book though he had an extraordinary ability to enable powerful expressive work in the patients who worked in his studio, the work that in fact formed the basis of the book.

Adamson was an artist and prominent figure amongst those pioneering the uses of art in various kinds of therapy. These included Adrian Hill, who coined the term ‘art therapy’ during his work with tuberculosis patients in the 1940s, and a number of artists, psychoanalysts and psychiatrists, including E. M. Lyddiatt, Marianne Segal, Irene Champernowne, Jan Glass and Stephen MacKeith, who were devising ways of working with psychiatric patients through art. Champernowne had created a therapeutic community, the Withymead Centre in Devon, specifically structured around a working alliance of Jungian psychotherapists and artists in relation to the community’s residents.

Like the United States, Britain had become the host country for the many psychoanalysts who had escaped from fascism in continental Europe before and during the war, the most famous of whom was Sigmund Freud who spent the last two years of his life in London. Indeed, Britain and the United States became the homes of psychoanalysis, particularly Post-Freudian psychoanalysis. After his death, Anna Freud and Melanie Klein, together with Michael Balint from Hungary, were formative influences on the development of psychoanalysis and psychotherapy in the UK. Of the British born psychoanalysts, Marion Milner and the paediatrician D. W. Winnicott both used artistic creativity in their clinical work and theoretical writing. C. G. Jung's interest in the arts also exerted great influence on psychotherapy and progressive education in these years, from the 1920s he regularly encouraged his patients in Zurich to make drawings and paintings which they brought to their analytic sessions with Jung and his associates (there is an archive of several thousands of these images at the C. G. Jung Institute in Zurich). It was also a period in which a growing interest was being shown in 'outsider art' and the art of those suffering from mental illness. Collections of this work were being gathered together by collectors, art galleries and hospitals.

To return to Cunningham Dax, he was one of three psychiatric advisors to the Minister of Health in the UK concerning the role of the ancillary professions in the revolutionary new National Health Service formed in 1948 after the landslide victory of Atlee's Labour party in 1945. The others were Doctors Guttman and Maclay. All three had begun a collection of 'psychiatric art' at the Maudsley and Bethlem Royal Hospitals in London. Given that psychiatry had only been included in the NHS by the skin of its teeth, their conservative professional advice to the Minister was in principle that art therapy should be a 'recreational' activity for patients, that it should be supervised by occupational therapists, and that actual therapeutic or diagnostic work through pictorial work should only be undertaken by psychiatrists or clinical psychologists. However, given the resistance to this of art therapists, the support they received from prominent psychiatrists and psychotherapists, and from the National Association for Mental Health, this ruling was in considerable measure circumvented and a decade later the British Association of Art Therapists (BAAT) was formed. Subsequently, in conjunction with universities and higher education institutions, BAAT created postgraduate training courses and was officially recognised as the body from whom relevant government departments and the NHS sought advice concerning the professional training and practice of art therapists (Waller 1991).

In 1952, before all this happened, Cunningham-Dax went to Australia as the newly appointed Director of the Victorian Mental Hygiene Institute and subsequently worked for the Federal Government. Apart from his administrative duties he took it on himself to build up a collection of 'psychiatric art' along the lines of the Guttman Maclay collection at the Maudsley. He took with him many of the art works produced in Adamson's studio and added works by Australian psychiatric patients. These works have been collected together in an archive in Melbourne. This is a part of Melbourne University and is housed in Carlton. I visited this in the early 90s. It is an amazing collection, a potential treasure house. A star in the collection when I saw it were the woven and knitted garments made by a woman who was a psychotic patient. Suspended on coat-hangers inside the front door they made an unearthly impression as you entered the building. All the other works however were collected in plan chests and classified like specimens in clinical categories as if they were exhibits in an old-fashioned museum. So the drawers of art works are pulled out, each of them

according to simplistically generalized diagnostic labels, such as hebephrenia, schizophrenia, paranoid-delusional states, manic-depressive psychosis, depression, psychopathy, neurosis, and so on – just as if the collection was an illustrated version of DSM IV.

Cunningham Dax was an old man when I met him in Melbourne and the administration of the collection was left to a retired occupational therapist. As far as I can see from visiting the website all this is how things still stand, the website is organized in the same way, although there is now a ‘Lecturer in Psychiatric Art’ associated with the collection.

I do not know how Cunningham-Dax used his administrative office in Australia in relation to psychotherapy in the public sector, but I doubt, on the evidence of the website, that it would have been helpful to those who wanted to use image-making in their practice or respond to those who requested it.

The fact is the potential of Grey-Smith’s initiative in Perth, and of the work of Meares in Melbourne, failed to develop as they could have done. Cunningham-Dax aside, the conservatism of much psychiatric and clinical psychology practice in Australia would not have encouraged it. My impression is that psychotherapy, certainly mainstream dynamic psychotherapy, has remained mostly outside public sector health care here and is mostly restricted to private practice. The result of this has been that for those who cannot afford to seek psychotherapeutic help privately, therapy and counseling in the public sector are usually of the cognitive behavioural variety while psychiatry is positioned very firmly within the medical model.

Returning to Australia I have been sharply reminded by contrast of the enormous influence in Britain of what were known as the ‘Balint groups’ in past decades, whereby Michael Balint, a Hungarian émigré psychoanalyst, and other psychoanalysts, including Winnicott, realising that psychoanalysis in its pure form was simply impractical within a mass health service free at the point of delivery, as the NHS was, decided to disseminate psychotherapeutic ideas and ways of working amongst key groups of health care professionals. These included GPs, nurses, midwives, psychologists, psychiatrists, paediatricians, social workers, managers and ancillary workers (Balint, M 1957, Balint, E 1993). The more experienced people became at working in this way so they could repay their debt to the process by clinically supervising others, and so on; a ‘benign chain reaction’ as it was called. This was particularly successful in the Midlands and North of Britain, geographically removed as they were from London’s psychotherapeutic and intellectual melting pot with its affluent middle class suburbs. When I started working in Sheffield working class people suffering from acute psychological distress were able to access psychotherapy from a great many NHS and social services staff who in turn were sensitively supervised by their peers. All this was of enormous benefit to art therapists and art therapy trainees who were able to position themselves within these psychotherapeutic networks and benefit from the supervision it provided. Sadly, post the Thatcher years, this is less in evidence than it was.

A later and similar process was that brought about through a combination of feminism and psychotherapy. In the 1970s Suzie Orbach and others started the London Womens’ Therapy Centre. This was staffed by women psychotherapists and provided a service for disadvantaged working class and ethnic minority women. The idea spread and there are now few major British cities without their version of the original.

Art therapy is a predominantly female profession and many UK women art therapists have contributed to this movement.

Finally there was an obvious logistic difficulty preventing psychotherapy and art therapy developing as fully as it did in Britain and the USA – compared to now the relative difficulty, time and cost of travel as well as communication between one end of the world and the other. When I traveled to England in 1959 it took me five weeks by sea and the single passage cost the equivalent of half a year's salary, one used the phone sparingly costing the minutes, and postal communication involved three weeks to a month for a reply. At the time Perth was especially isolated in these respects, even from Australia's more populous and cosmopolitan Eastern cities. There was no television in, no relatively inexpensive air travel, or the immediacy of email and the internet.

Recent years and the present.

It was through my return visits to this country in the 80s and 90s that I become interested in bringing my experience back with me should the opportunity arise, as it did when I successfully applied for my present position at Edith Cowan which I took up at the beginning of last year. I was particularly interested in this as the Masters in Art Therapy exists in the School of Visual Arts within a practical arts faculty – the Western Australian Academy of Performing Arts (WAAPA). This was fairly unique internationally, and completely so in Australia. I can now ruefully admit to increasing shock as the months have passed that, far from cultivating my own garden in academia, working with students and writing a long projected book, I have been immersed in university politics, endless business plans, recruitment, course design, and meeting students' training needs. Perth's Mediterranean climate beckons outside but I've spent more days than I care to remember clacking at my keyboard inside my office.

Over the past three years the ECU course has been substantially redesigned, making it much less 'basic skills' based and richer in its experiential, practical and intellectual teaching – fully integrated into the School of Visual Arts, now the School of Contemporary Arts, so that their staff make inputs into the MA and our students do electives in visual arts. Prior to my arrival the course had always been a law unto itself and cut off from its art school context. In fact it was less a course than a collection of what seemed like freely orbiting course units, fourteen of them, enrolled in and paid for by students separately, each staffed by sessionally employed teachers or the Course Co-ordinator, so that students could take an inordinate time to progress through the course and often met few other students than those completing the same unit as themselves. There was little sense of a cohort of students progressing through the course together and learning from each other as they went. Similarly, sessional staff rarely had time to meet each other in paid time and plan the course as a whole. Because one had no sense of when students would complete, or how many might be enrolled in the same unit in the next semester, it was expensive to teach.

The problem wasn't just that the course was delivered as a disorganised succession of units. To be sure later units had earlier units as prerequisites, but there was no timetable or maximum duration within which students should finish their training or a proper timescale in which units should be completed. One of the essential problems was that course units, particularly the more oriented they were towards therapeutic work and practice, were designed as if psychotherapy experience could be taught didactically in a packaged way as 'basic skills'. Unit descriptions and outlines were

littered with headings like ‘aims’, ‘method’, ‘objectives’, ‘the student will be able to demonstrate knowledge of...’, ‘students will have acquired skills in...’, and so on, as if students were rolling off an assembly line as identical products rather than the individual people they were. And this often in areas where one simply needs the student to experience a process in depth in order to begin to understand and practice the essentially interpersonal nature of psychotherapy.

In short, an attempt had been made to remodel the subject matter of the course to fit an increasingly prevalent skills acquisition model of higher education. Of course acquiring skill is important in psychotherapy but the more fundamental goal of training is understanding people, and if we are to speak of skill it is more in the sense of overall skill than several separate skills.

If the conservatism of the medical model has hindered the development of art psychotherapy here so too has another Australian orthodoxy, the dominant influence of cognitive behavioural therapy in clinical psychology and counselling. The remit of CBT runs far wider than I remember being the case in Britain and Europe. As an odd counterpoint to this there are the ‘new age’ therapies that appear in the market place of the personal columns in local papers, emphasising the transpersonal, spirituality and one’s ‘journey’. The ‘therapy’ in art therapy has always been of the mainstream psychodynamic kind, and its practitioners and students need the availability of supervisors and therapists in sympathy with their way of working. I think this last point is one point we can agree on without a CBT versus dynamic psychotherapy argument. The difficulty we face in Perth, and I’m sure this is true in other Australian cities, is the scarcity of appropriate supervision or training therapy for students. There is not enough to go round, and if this is the case in Perth, what about Albany, Kalgoorlie, Port Hedland and far less populous towns? Sometimes the problem seems insurmountable, then I must remind myself that because we can only get something 80% right is no reason not to do it!

Connected with this is a further issue, the unusual demographic nature of Australia – a few big cities and a sparsely populated outback. Western Australia is the size of a good chunk of Europe but with a tiny population of about two million, more than a half of them living in Perth. There are endless small towns of a few hundred people serving as centres for vast areas of land dedicated to agriculture, mining, fishing, indigenous communities and latterly tourism – or just scrub and desert. The social and personal problems of this hinterland are huge. A letter may take a week or two to reach a remote town or community and as we know the collapse of Ansett has left some of these locations desperately isolated. They are also beset by drought, floods, bushfires and salination. It’s always been hard to attract professional expertise in health care to these areas and is becoming even more so. One of our aims on the ECU course is to reach these locations rather than just sticking to the metro area around Perth.

So what about the 80% that is right? Students and the staff of some of the agencies and settings where they do placements, are enthusiastic in a way that sometimes takes your breath away. Many students are prepared to deal with unnerving difficulties and unknowns – and with no promise of secure employment and generous financial reward at the end of their training, in spite of the considerable cost to them in course fees and travel to undertake training. This is partly I think because what we’re presenting to them on the course is unexpected and new, and this leads people to apply to train who want to explore these possibilities. It is also linked to the

propensity Australians have, or perhaps I should say some Australians, that I referred earlier in this paper, that of story telling. It is interesting that perhaps the most-home grown of Australian psychotherapeutic models that has made a mark on the international scene is that of narrative therapy.

Finally I will finish with a story concerning someone who has recently started training on our MA. I think it illustrates what I've been saying about the 80%. She is aboriginal and a mother whose extended family has lived through the many decades in which her people have been disadvantaged and oppressed. She lived in a remote part of Northern Australia. She has worked in her community as a manager and support worker, been involved in education, health, the arts and many ordinary social activities and entertainments. She is a talented artist. Her portfolio contains images about her family life, 'seen through their eyes', and moving stories about life and death are woven around the details of these rich paintings. They also concern her emotional reaction to events in her life and her attempt to understand this and herself through the medium of painting. They are indeed beautiful paintings. She is a natural, and I am glad she has joined us.

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