A CONVERSATION WITH EDWARD ADAMSON

By LAURA SEFTEL

Edward Adamson has been a primary force in the growth of British art therapy, as much a catalyst in his country as Kramer, Naumburg, and Ulman were in America. His art therapy career began in 1946, when he became the first artist hired by the National Health Service. During the next few decades, he was involved in various efforts to organize and develop the profession of art therapy, along with other pioneers like Adrian Hill and Irene Champernowne. Adamson was the Founder Chairman of the British Association of Art Therapists (BAAT), which was formed in 1964 — five years before its American counterpart. He is currently an Honorary Member and maintains a large private practice in London.

Adamson worked for over thirty-five years at Netherne Hospital, a psychiatric hospital near London. In his early days, Adamson preferred the description "hospital artist" to "art therapist," and he has consistently identified himself as an artist, not a clinician. His working philosophy is summed up simply in the title of his recent book, Art as Healing (1984).

The book is beautifully illustrated with client art work collected during his years as Art Director of Netherne. They were selected from the 70,000-piece Adamson Collection of paintings, drawings, and sculpture, which has been compared with the collections of the Musee de l'Art Brut in Lausanne (MacLagan, 1984), Prinzhorn, and the House of Artists in Klosterneuberg-Gugging, Austria (Parsons, 1986).

What makes Adamson's collection unique is that all of the art work was produced under his personal, non-interfering guidance. A portion of it is on view in a 13th century barn-turned-gallery in Ashton, England.

It was to the tiny, thatched-roof village of Ashton that I trekked in March 1987 to see the collection and interview Adamson. As he guided me through the exhibit, Adamson seemed as interested in the esthetic quality of the art works as in their psychological significance, and he mentioned several clients who had actually gone on to become acclaimed artists. This emphasis on the artistic value of client work may seem alien to art therapists like myself who have been trained in the psychodynamic approach to art, and it brought to mind some of the changes and controversies art therapy has weathered over the years.

While Adamson does focus on the esthetic aspects of client work, the pictures are "not the end product" (Jungels, 1985). He regards them as graphic expressions of the working-through process unhindered by external interpretation. Adamson believes that to interpret or suggest changes in the art work disrupts the client's own healing process. In the continuing debate over product versus process, he takes neither side. What he values most is the client's capacity for self-healing, and he relies on this in his work with clients more than on any specific therapeutic technique.

Each art therapist ultimately makes a personal decision on how to synthesize art's healing powers with the healing potential of psychotherapy. The range of choices is a wide one, but all art therapists can benefit from Adamson's vast experience as well as from his insight, patience, and respect for the individual.

Laura J. Seftel studied painting and art history at Washington University in St. Louis and completed her Masters in Art Therapy and Creativity Development at Pratt Institute, Brooklyn, NY. While residing in Manchester, England for the winter of 1986-87, she researched and wrote several articles on art therapy in Britain. At present, she is an art therapist and consultant for rehabilitation at Northampton State Hospital in Massachusetts.
The Interview

Q. How did you first get interested in the therapeutic use of art?

Adamson: It really started during the war, when I'd left the forces. I was asked by the Red Cross if I would go around sanatoria, talking to soldiers who had T.B. Of course, they were bedridden and couldn't get out, so I used to discuss paintings with them. The superintendent* at Netherne, a mental hospital, heard about this and asked if I would go see his patients. And I said, "No, thank you. That's the last place I want to go to!" Anyway, he was very persuasive.

I used to go in the evenings to discuss reproductions with them. This went on for a couple of years. Then the superintendent asked me if I would get them to paint—which I thought was even more dubious. However, I did, for two days a week. I made lots of mistakes by influencing what they were wanting to paint. I tried to help them out too much instead of encouraging them to paint exactly as they wanted it to be.

Then I was asked to join the medical staff of the hospital as an artist, which was quite unheard of in those days. They gave me the title of "Art Director" of the hospital. I saw that the residents would eventually want to use art as a form of communication. I built a studio on the hospital grounds and when I left Netherne, I left them with five studios (Figure 1), and a purpose-built gallery (Figure 2).

Q. What was your relationship with the hospital psychiatrists? How did they envision your role?

Adamson: Well, it was pointed out to me that I was the hospital artist and that it was important for an artist to do the kind of work I did with the patients. I left the interpretation to the medical men.

Q. Did you ever imagine, back in the early days, that art therapists would someday have clinical training similar to that of psychologists?

Adamson: No. I thought it much better that the art therapist remain an art thera-

*Dr. E. Cunningham-Dax was superintendent at Netherne Hospital and was instrumental in creating the art therapy program there (Cunningham-Dax, 1953).

Figure 1. Adamson's studio at Netherne. "I particularly wanted to have somewhere isolated from the main building. I saw to it that everyone who came to paint had a chair, an easel and a small side table to hold paints, brushes and water. Each art unit was a little island where the person could feel that his privacy was respected." — Text and photo reprinted, by permission, from Art as Healing by Edward Adamson © 1984 by Edward Adamson and John Timils.

Figure 2. The gallery at Netherne. "The paintings of residents were never displayed on the hospital walls, or in the studio... Instead, I designed a purpose-built gallery, within the hospital, to house the growing collection of residents' work. It was open only to selected visitors, and served a didactic purpose for trainee doctors and nurses, in addition to other groups in the helping professions." — Text and photo reprinted, by permission, from Art as Healing by Edward Adamson © 1984 by Edward Adamson and John Timils.
pist — which is very important. And Dr. Dax (the hospital superintendent) wanted that, too. He wanted the artist to develop the person, in every sense. Not only from painting and sculpture, but from theatre and opera, and things like that.

Q. What is the disadvantage of having art psychotherapists instead of artists in hospitals?

Adamson: Well, probably you must be an artist to start with — then you can do art psychotherapy. The important thing is to know about art, to know how to draw and paint, so that you can encourage from that angle the whole time. Because if patients ask you about paintings, you must have a certain knowledge to discuss them. And you must be able to draw for patients if they ask you to. They may want to know how to draw a certain thing — well, you must be able to do it.

Q. When you first went into the hospital — as an artist — and you encountered difficult client issues, did you want more training in psychology to help you deal with them?

Adamson: No, no. I didn’t want to know anything about that side of it at all. I never wanted to read the case histories, as so many people love to do. I wanted to see them just as people and to encourage them from their angle, without any of the jargon that was used previously.

Q. Was it just through your association with people on the hospital staff that you picked up Freudian ideas, or did you study Freud in a more formal way?

Adamson: Of course, one picks it up. And I read about it, but I didn’t want to do any more than that.

Q. You would never make interpretations to clients?

Adamson: I wanted them to interpret to me. Because you can read all sorts of things into a picture which are not true. It’s the easiest thing in the world to do that, to tell a false story.

Q. Do you think that art therapists and hospital artists should work side by side? Isn’t this very confusing for clients — as well as for the staff?

Adamson: The actual “therapy” is purely incidental. The important thing is the art! You see, it’s “therapeutic” for patients to walk across the hospital grounds to get to the studio. If they’re going to sit in a group of patients, it’s therapeutic. But the great thing is the actual art they are producing; that’s the thing that is getting them better. The mere fact that they put their brush to paper and try to paint.

Q. Is it your opinion that art therapists really don’t need all this clinical training, that artists in hospitals are doing a sufficiently “therapeutic” job?

Adamson: If they are real artists, yes.

Q. Then you must be critical of some of the training programs that are now admitting people with backgrounds primarily in psychology rather than in art.

Adamson: Yes. Can’t the psychologist remain a psychologist and not try and take art over?

Q. Perhaps the psychologists would say to us as well, “Why are you trying to take psychology over?” because a lot of art therapists get additional training.

Adamson: The strength of the art therapist is being an artist. The patients appeal to you as an artist, knowing that you can paint and that you are ready to help them . . . Through art — not with all that knowledge of psychology. That’s something completely different.

Q. Back in the early days, did other pioneering art therapists share your approach? For instance, Adrian Hill, who also started in a sanatorium?

Adamson: Well, he was a patient in the sanatorium at the time. He wasn’t working in psychiatric hospitals. That was quite different because he was teaching the persons in the sanatorium how to paint.

Q. I know that in the really early days, you and Adrian Hill and Irene Champernowne were trying to form a professional organization.

Adamson: Yes. We did that with the assistance of the National Association for Mental Health. But it was many years later that I formed BAAT.

Q. About 20 years. Why was there such a hiatus between your forming this idea and its eventual realization?

Adamson: Actually, it was because other people were starting to work and I was trying to stop the lunatic fringe getting in and taking it over. There were so many people saying, “I can do that,” but they were not artists. Unfortunately, the non-artists have crept in now.

Q. The “lunatic fringe” — people who were not artists, but who were trying to use art as a therapeutic modality? Like a therapist or a nurse who would say, “Oh, I can use that technique,” without having any training in art?

Adamson: It wasn’t the medical side so much as it was the people from the outside thinking that they could come in and do this. Just anyone, more or less; those who were compelled by their own problems.

Q. When did you become aware of art therapy as it was practiced in America? Did it influence your own work?

Adamson: I exhibited with the International Society of Psychopathological Art in various capitals, and I met Naumburg and some other American therapists about 1947. I can’t say it influenced me very much.

Q. It would seem to me that of the American art therapists, Kramer would have the outlook most similar to your own. Not completely, but an affinity in such things as the sense of art being the crucial element of the therapy, the decision not to interpret to the patient, and the setting up of galleries so that the entire community can view the art. Was there any interchange of ideas, or did your approaches just develop along parallel lines?

Adamson: Just developed parallel, I think.

Q. Do you have any advice for fledgling art therapists?

Adamson: When they’re dealing with patients, to forget themselves and develop the other person, through art. If they are true artists, they can do that. And to encourage that individual all the time to paint from what he himself wants to paint, not from what the therapist thinks he should paint. So they get a true picture of the individual’s experience.

Q. Do you believe in the idea — I guess it’s really a Jungian notion — that the human organism has a healing process and that if you can just facilitate it, a person will self-heal?

Adamson: Yes, within themselves. And the art therapist should be as passive as possible. Actively passive.
Q. That's a bit of a paradox. But a lot of things about therapy are.
Adamson: But the great thing is, it does work.
Q. When you started out, there were fewer neuroleptic drugs being used, so you had a clearer idea of whether or not people were actually being healed as a result of the art work and the treatment. Whereas today, we have so many factors: the teamwork, the drugs, this and that. You don't know what's actually helping the client.
Adamson: You don't know if you're talking to a person or to a drug.
Q. And you don't know what it is that's helped them. Is it the Lithium or the art? I would imagine that when you started out, it was easier to attribute healing to specific therapies.
Adamson: Yes. It may take much longer, but it does, in the long run, prove right. And more lasting.

REFERENCES


TO ORDER *Art as Healing*:
*After December 15, 1987* Sigo Press, 77 N. Washington Street, Boston, MA 02114. 617-523-2321 or 800-338-0446 (outside of MA only)

EDITOR’S NOTE: *Art as Healing* will be reviewed in the next issue of *AJAT*.

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