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British art therapy pioneer Edward Adamson: a non-interventionist approach*

SUSAN HOGAN†

The images we make (whether we are artists or not) can act as statements which provide a focus of sharing, expression and self evaluation. Edward Adamson, one of the pioneers of art as therapy in Britain, was well aware of this.

Edward Adamson (1911–1996) studied at Beckenham and Bromley Art School (now Ravensbourne). He then completed classes in physiotherapy and also worked in his father's factory. Adamson served in the Royal Medical Corps during World War II as a non-combatant. On demobilization he offered to work voluntarily for the British Red Cross.¹ He had met Cunningham Dax, medical superintendent of Netherne Hospital, Surrey, whilst employed in 1946 by Millicent Buller, MBE, head of the British Red Cross Picture Library, whilst it was touring hospitals to discuss pictures owned by the library.²

The BRC Library art advisor, Mary Campion, had started bringing artworks to Netherne Hospital in 1944. These artworks were discussed and examined by a group of newly admitted patients. Cunningham Dax noted that there was sufficient enthusiasm about this exercise for Mary Campion to be questioned for over two hours about the artworks; their composition, techniques used and actual content all came under scrutiny. Another visit was made the next week by Campion and arrangements were made with

* This research was made possible by John Timlin and the late Edward Adamson. Rona Rumney very kindly let me have a copy of her thesis on art therapy at Netherne Hospital which included several interviews with Adamson's former patients – this was material I was very grateful to have. Particular thanks are due to Dr David Smith from the University of Aberdeen for his constructive criticism of this text. Thanks too to Dr Sonu Shamdasani who suggested that I send material to this journal. I acknowledge financial assistance for this research from The Wellcome Trust.

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Millicent Buller to borrow the artworks, which were also exchanged between different wards. Shortly afterwards a visiting lecture series (based on the borrowed works) began on a weekly basis. These lectures concentrated on impressionism and modern art and Edward Adamson was one of the lecturers invited.³

Adamson described his first visit to Netherne Hospital as intimidating. He remembered being ushered along 'long corridors with many locked and unlocked doors' before reaching his destination. He noted that many among his audience had undergone major brain operations and 'consequently many who had come to listen to me were shaven-headed. Others were swathed in bandages and were disfigured by post-operative bruising.'⁴

After the lecture series had got under way a number of patients expressed their desire to paint their own pictures. However, before this was arranged Dax and others visited Northfields Military Hospital, Birmingham, where art 'free painting' was already being used with patients.⁵ Discussions also took place with hospital staff and Sybil Yates (a Freudian analyst from the Tavistock Institute) and Susan Bach (a 'Jungian' art therapy pioneer who is recorded as having given many valuable suggestions about setting up an art therapy post).⁶ The visit to Northfields Military Hospital was to the unit that had been established by Foulkes and Tom Main for group therapy. Returning from this trip Dax described the Netherne staff as enthusiastic: 'Dr Freudenberg, with many cultural interests, Dalberg, with a wide European experience, and Reitman who had been at the Maudsley before the war with Guttman and Maclay (*sic*), all supported the project.'⁷

The invitation was issued to Adamson to take up the appointment of 'art master' because he had some experience of such work. He had worked as an art therapist in a TB Sanatorium with Adrian Hill who is attributed with having coined the term 'art therapy' in Britain. He said of this work: 'our role had been to lend our professional skills to those invalids who needed an occupation or diversion during their long months of recuperation. In some ways, we practised a form of occupational therapy through art.' (Adamson came to view his way of working as being slightly different from that of Hill, as will be illustrated.)⁸ Dax, who created the appointment, described Adamson as having experience of lecturing in both sanatoriums and mental hospitals. He noted that Adamson had not been 'analysed' and that he did not have any special knowledge of psychology, but that he was particularly interested in the evolution of artistic work. Dax felt that it was important that the appointee be a professional artist and not an amateur, who may therefore speak with 'knowledge' and 'authority'.⁹ Adamson's background was in commercial art though he was a practising artist himself, producing abstract works (Pl. 1).

When Adamson first arrived at Netherne, on 23 April 1946, there were few leisure activities and no art activities.¹⁰ Initially Adamson worked inside the hospital in a committee room with up to forty patients at once,

conducting two sessions per week. Soon after, this had risen to four sessions per week and it then became a part-time appointment.¹¹ Later, in December (17th) 1948, Adamson was appointed to a full-time contract. Adamson referred to himself as 'the artist'.¹² However, Dax felt that a number of terms might be applicable to him including 'art teacher', 'art instructor', 'art occupationalist', 'art therapist' or 'art analyst' depending on the role the worker was expected to adopt. However, 'the artist' was Dax's favoured term.¹³

The accommodation being unsatisfactory, Adamson was in 1948 able to have a studio built in the hospital grounds for his own use.¹⁴ This building was a converted army hut 48 feet by 16 feet, which Dax notes was able to accommodate twenty patients with comfort. The studio had a sink, storage units, central heating and roof light windows.

The roof was of cedar shingles and the floor covered in oil cloth. The chairs were painted green, other furniture cream and the walls primrose.¹⁵

Each morning at 8.30a.m. Adamson found a group of patients waiting outside his studio to come in. Generally he worked with 25–30 patients who had been referred by their individual psychiatrists. Adamson was not involved with the referral process, simply working with whoever came. Even if a patient seemed unresponsive to art therapy Adamson explained that he would never turn someone away because 'even the walk to the studio across the hospital grounds' he thought was of therapeutic benefit. Although some patients were reticent at first, they all painted after a time.¹⁶

After his appointment was made on a full-time basis, Adamson saw from 10a.m. to midday a group of chronically ill (mainly schizophrenic) women patients whom he saw on a ward of the main hospital. This group was established for research purposes. Dax notes that these patients painted for their own pleasure. They had not received the same information about the purpose of engaging in artwork. The women, he observed, were 'not united by a common bond of working to get better, nor with a label of treatment attached to their activities'. Although Dax does not elaborate on these research findings they seem to indicate that the information given to patients about 'art therapy' or 'free painting' greatly influenced their reaction to the activity. Dax also noted that this group of psychotic women patients were



PLATE 1. Edward Adamson, c. 1970

much freer in their behaviour than the studio group, and that Adamson was subject to 'uninhibited transference' from them.¹⁷

Patients referred to the studio tended to be those who had difficulty expressing their feelings rather than people who were exhibiting particularly difficult behaviours.¹⁸ Dax defined his referrals to the studio group as 'mainly young people expected to recover from their illness' and of 'normal intelligence'. Individual psychiatrists were responsible for making referrals. However, Dax defined the broad categories of classification used for referral processes. These categories were as follows: those undergoing psychotherapy for psychoneurotic disorders; those regarded as needing psychotherapy but regarded as inhibited; those receiving insulin coma treatment or 'convulsion therapy' (ECT) who were later intended to receive psychotherapy; those whose artwork Dax wished to examine in relation to specific diagnostic categories as part of his research programme; those cases where self-expression might be aided by the use of art, and patients who were artists prior to their admission to hospital.¹⁹

Each patient had their own easel and Adamson described this as essential in providing each person with their own area in which to work, a place where they could feel secure. Each patient was provided with a colour range of eleven poster paints, two brushes (size one and twelve) along with a small enamelled cake tin with six divisions to serve as a palette, and also with pieces of paper of a standard size.²⁰ All the drawings and paintings were kept at the end of each session and were filed away by Adamson under the name of each patient. Doctors had access to the artwork which provided a visual record of what had been expressed.²¹ It was explained to patients before they started work in the studio that their pictures would be kept as 'case notes' and would not be returned to their possession, but be handed on to the psychiatrist. Likewise, patients were informed that their work would not be displayed during therapy or shown to relatives. Nor were patients allowed to sell or give away their artwork, which remained the property of the hospital. Dax explained that some of these restrictions were imposed to avert the possibility of patients' work being subject to 'praise' which might influence them in a certain direction.²² Although on the face of it these restrictions might seem reasonable, it was not always possible for patients in a confused state of mind to be aware that they would not be given their artwork back.²³ Psychiatrists had the opportunity to see paintings in the middle of each week prior to the work being filed. Alternatively, they could arrange to have artwork passed on to them by Adamson.²⁴

There was relatively little interaction between patients in the studio because they were so 'wrapped up' in their own artwork. Adamson didn't put artwork on the walls because he didn't want the patients to be unduly influenced by each other. He was also opposed to the use of themes. Adamson described the atmosphere in the studios as quite magical and as 'sacrosanct'. He explained that he would never allow visitors into the studio

while the patients were painting – ‘you could feel them working’, he recounted to me in interview. The atmosphere of the studio was described by a former patient: ‘It was quiet and peaceful and one could get on with what one wanted. I needed peace. I couldn’t possibly work without it. He [Adamson] did keep the place quiet so there was only occasional conversation . . . It was very congenial. He had a calm of mind himself which communicated itself’.²⁵

Occupational therapists were introduced into the hospital shortly after Adamson’s arrival and they showed an interest in what he was doing but they had to be turned away because their presence in the studio would have ‘broken the atmosphere’. He felt it was very important that the studio should be separate from the rest of the hospital. The studio provided a place where patients ‘could be themselves without any fear of criticism’.²⁶ However, there were regular visits made to the studio by doctors and the medical superintendent. Dax described the studio as providing ‘ordered freedom’.²⁷ The atmosphere was described by a former patient as ‘. . . serene and deep. Everyone who came there found themselves expressing a new world of ideas that were suppressed in them’.²⁸ A different patient described Adamson as a ‘very quiet’ man, ‘he would just sit down next to someone and ask them if they would like to paint’.²⁹

Adamson said that it was the making of the artworks which was healing, not the talking about it. He was excited to see what would be produced and he found this work of more interest than the modern artwork of the period.³⁰ This was not the attitude of his medical colleagues who had differing opinions as to the value of art therapy.

One of his former patients said of Adamson that ‘he was very encouraging – always saying nice things about our painting. He didn’t look at it from the point of view of art, more self-expression. I used to think what I wanted to say to the doctors and paint it and she [the doctor] used to analyse it and find all sorts of things about my sub-conscious which I [had] painted without knowing it.’³¹ However, the same patient was later to see another doctor with quite a different attitude: ‘When I asked my doctor “can you analyse paintings?” he said “it wouldn’t help you to have your paintings analysed.”’

Art therapy was not regarded as an easy option by patients, but as part of their treatment.³² Indeed, since some occupational therapy work was paid work, those who frequented Adamson’s sessions were willing to forego this income, since art therapy attendance was not paid. Adamson noted that patients related to him as an artist rather than as a member of the medical staff. Consequently they were able to confide things in him that they would not tell their doctor and he kept these confidences.³³

Dax was very clear about the encouraging role he expected Adamson to perform. Adamson was instructed not to interpret paintings, nor elicit the patients’ description of their symptoms (though Adamson could perform a useful role in noting such information for the attention of the psychiatrists).

Adamson was instructed never to make suggestions about patients' art work and to remain in an 'essentially passive' role, giving technical advice if required, using a separate piece of paper.³⁴ Adamson was given instructions not to interfere nor make suggestions regarding colour, form or subject matter.³⁵

Adamson was involved in the life of the hospital as hospital artist. He designed costumes for theatrical performances. He didn't involve the patients in assisting him with such projects because he wanted them to concentrate on their own self-expression. However, he did take groups of patients out to museums, exhibitions, theatre and the opera.

Adamson described himself as working very closely with the psychiatric staff. The pictures were seen by doctors at the end of sessions and an analysis of the pictures would take place in the doctor's consulting room. In turn patients talked to Adamson about their sessions with the doctors.³⁶

The conduct of patients was described by Dax as 'self-regulated'. The studio group (unlike the women's group in the hospital) was bound, he felt, by the common aim of recovery. He explained 'Thus, even though the work is enjoyable, it is nevertheless serious, which modifies the interrelationships of the patients, engenders a mutual respect for their [artistic] productions and breeds tolerance for those who wish to be left in silence and isolation'.³⁷ This statement makes evident Dax's understanding that patients' acceptance of their artwork in the studio as treatment had a pronounced effect upon their behaviour.

Sometimes the behaviour of patients was extremely challenging. Adamson recalled being abused verbally and also assaulted. He described one incident in which a woman patient put her hands round his throat as if to strangle him. Calmly looking her in the eyes he said 'carry on' and she slowly released her grip and took her hands away.³⁸ This description is very reminiscent of those descriptions given by the educationalist A. S. Neill in his book *Summerhill* in which he described calmly challenging violent or potentially destructive behaviour.

It is clear from Adamson's writing that a sharp contrast existed in conditions between his studio and the rest of the hospital:-

Those in the locked wards were all obliged to wear hospital clothes. In the stark dormitories, the long rows of iron beds offered no seclusion, as they were not curtained off from each other. The practice of taking communal showers offered no personal dignity, neither was there any privacy in the bathrooms.³⁹

A paper written in collaboration with Adamson about his work described the presence of the artist in the hospital as 'in itself therapeutic: an antidote to the prevailing atmosphere of white-coated doctors, depersonalised treatment, regimentation, and lack of recognition of the individual'.⁴⁰

Adamson expressed a similar view to that of his colleague Dr Reitman on

the matter of interpretation of images. Adamson thought that patients had a desire to please and that encouragement by psychotherapists to produce artwork would result 'in Freudian phallic symbols or Jungian signs' depending on the theoretical orientation of the psychotherapist.⁴¹ Reitman had been critical of both Freudian and Jungian models of analysis but in an article written shortly before his death in 1955 he singled out H. G. Baynes's *Mythology of the Soul* for particular criticism. He wrote that 'to my mind, the abundant paintings of the Jungian patients are more characteristic of the therapist than of anyone else.'⁴²

Adamson felt strongly that only the patient should furnish an interpretation of artwork, and that the art therapist should not. He never interpreted his patients' artwork but waited for them to talk about it, if they wished to do so. Even the use of particular conceptual models, which might not be explained to the patient, (such as psychodynamic theory) he felt would unconsciously effect the art therapy process, preventing the 'true person' emerging. He described any attempt to use such theory as 'useless'. 'Basically', he explained, 'you are putting your ideas in their head and I don't think that's a healthy thing to do.'⁴³ Adamson felt very strongly that only artists should facilitate art therapy and was disappointed at a movement within the profession towards producing art therapists who are 'amateur psychiatrists or amateur psychotherapists'.⁴⁴

Cunningham Dax's view was slightly different from that of Adamson as his primary focus was on getting for psychiatrists paintings that were not contaminated by an interfering artist. He described the pitfalls of having the artist also analyse the work as twofold: firstly the patient may be 'taught' the 'meaning of so many symbols that he is frightened to lay brush to paper for fear of its meaning'. Conversely, the patients might submit themselves 'to an orgy of symbolic representation of a variety which will satisfy all the needs of their inquiring therapist'; consequently Dax was not keen on proposals made that 'art therapists' 'should be recruited from artists with teaching experience, who have had analysis.'⁴⁵ John Timlin, an urbane and intellectual associate and long-time intimate friend of Adamson, was very forthright on this point. Timlin had had analysis with Anthony Stevens and knew Dr Irene Champernowne in Stanton where he had bought a house, and where Irene and some of the Withymead staff moved after Withymead's demise with the intention of continuing with their work.⁴⁶ Timlin had also attended early art therapy meetings at Netherne Hospital. Timlin felt that 'art psychotherapists' were projecting their problems onto the patients' artwork (using a part of their 'shadow' and projecting it onto the people they are with) and then defending this procedure through an intellectualization of the process.⁴⁷ Timlin explained his view that the artist is capable of entering into the creative fantasy of their patients' work; it is this approach that he considered to be healing.⁴⁸ He wrote that as the artist 'is not a psychotherapist, his patient is not tempted to produce work which reflects his psychological

orientation. Because the client is in a dependency situation, he is often anxious to please and even at the unconscious level he can pick up cues from his therapist to produce 'rewarding' results'.⁴⁹

The tendency towards using reductive theory (particularly psychoanalytic theory), in Timlin's view, was the result of the professionalization of art therapy. He explained 'there was a small caucus of political people who really wanted to push their politics rather than the arts.'⁵⁰ This situation was later exacerbated, he felt, by the development of professional training in art therapy. Training courses validated 'by people who hadn't got the slightest idea about the artistic framework' and who therefore developed course structures based on 'their own anally retentive structured way of looking at the curriculum' which did not suit the artist. He felt that the type of work done by Irene Champernowne and Edward Adamson, which relied on qualitative skills, was hard to duplicate and teach.⁵¹ He elaborated his view that fitting artists into an 'academic paradigm is very constraining', given that an artist's 'whole life has been such that they use their intuition and their feeling'.⁵²

Adamson saw art therapy as being distinct from occupational or diversional therapy. He wrote that 'Harmony is the necessary language through which art finds its own expression. In coming to terms and having to deal with this, the mental patient is thus *exposed* to the beneficial *radiation* of harmony itself.'⁵³ Such an interesting use of metaphor indicated that Adamson felt that there was something intrinsically curative about the creative process. His view was questioned by a psychiatrist Dr Tredgold (editor of the *Journal of the National Association for Mental Health*) in his preface to Adamson's article. Tredgold argued that occupational therapy and art therapy had much in common because an activity in OT might begin as a distraction and end up as a form of self-expression. Clearly Tredgold did not see a clear cut distinction between OT and AT and encouraged art therapists and occupational therapists to work closely together.⁵⁴

It is clear from Adamson's writings that he saw his art sessions performing a function beyond that anticipated by artists in their studios. He described art as a means of 'reassembling the fragments of a disintegrated personality' and useful for patients 'owning and exploring parts of their personality'. Adamson also recognized the cathartic value of art-making. He called this a '*cri de coeur*'. Adamson also noted that one can achieve in fantasy what one cannot achieve in 'reality'. Adamson described the patients as wanting to express their feelings and as 'pouring out their very souls on paper'. Patients, he believed, needed encouragement without interference.⁵⁵ This was also the instruction given to him by Cunningham Dax who, as noted, was wary of the art therapist's influence on the content of artwork.

Timlin explained the value of an artist rather than a psychotherapist performing this work: 'Because of the artist's divergent personality he can accept unconventional and unexpected modes of expression. He incorporates

them in his own work, often welding them into a constructive outcome.... The artist is no stranger to his unconscious; he is in a constant dialogue with it. Here he has a bond of sympathy with his patient, the difference being that while the artist can select and consciously modify his work, his patients cannot ... Now these are just some of the advantages of the presence of the artist in a therapeutic setting. A vastly differing role to that of the OT.⁵⁶

Adamson saw art as a form of communication, particularly for those whose treatment had hindered their ability to communicate. In his book he identifies artwork as useful for providing information about the patient and for diagnosis. He wrote that paintings have a 'unique merit' in revealing the patient's state of mind at a particular moment or in providing a record before, during and after an experimental situation or a new course of treatment. He also noted that a painting might warn of an imminent crisis. However, he was cautious about the use of images for diagnostic purposes. He felt that such diagnoses might reveal more about the mind of the spectator who is analysing the work than that of the artist who made it.⁵⁷

Adamson was well aware of the multifarious ways in which an artwork might be 'read'. He wrote:

Paintings can become a window through which we can see a person's submerged thoughts and feelings ... There is a superficial 'manifest' level, where one accepts the literal meaning of the illustration, then there is the deeper level of symbolism, where the selection of the subject, the objects chosen to be represented, the colour choice, the placing on the paper – everything, in fact, where the choice has been exercised has a much deeper significance.⁵⁸

Diane Waller (1991) points to a close link between Adamson's passive role and that adopted by progressive educators such as John Dewey and Herbert Read.⁵⁹ She argues that in a context other than a hospital this approach could be seen as a form of progressive art teaching rather than art therapy. Waller's analysis points to the fact that location was important in creating a definition of art therapy. However, it is clear that Adamson's non-interventionist presence was considered more than simply an artist in their studio. For example, Dr Stevens says of Adamson's work: 'Intuitively he knew there to be a connection between creativity and healing, and he understood the importance of providing a sanctuary – a space, a temenos – in which this connection could be made. His genius lies in his ability to create an enabling space.'⁶⁰

Adamson felt that his unconditional acceptance of the artwork distinguished his approach from both occupational therapy and art teaching. He also felt that producing fine art was intrinsically healing; this is stated quite explicitly in his writing as I have shown. Although understated, there is also an underlying spiritual dimension to Adamson's approach.

The close contact of doctors with the artworks is also of significance.

Adamson attended the clinical meetings which took place once or twice a week, at which the pictures were discussed by the doctors. The pictures were considered to be important, and some discussions at these meetings were entirely devoted to analysis of the artworks. Through his attendance at this meeting, and his daily contact with doctors, Adamson was aware of the role that the images played in his patient's psychotherapy.⁶¹

As well as having a diagnostic significance, Dax concluded his principal text on the subject by saying that he thought art could be a useful aid to psychotherapy in psychoneurosis. Paintings could, he argued, be treated as dreams and interpreted by the person who had made the image. Such a method Dax regarded as a form of psychotherapeutic treatment in its own right and 'capable of far greater use than has so far been realised'.⁶² It is on this point that there is definite agreement between Dax and Adamson.

Clearly there was a tension between Dax's attempts to create standard research conditions, which now seem quite naïve, and Adamson's views about the curative potential of art therapy. Adamson's appointment was highly regulated, as I have illustrated. Nevertheless, his non-interventionist way of working was to influence many art therapists.

Adamson was a significant pioneer of art therapy. He organized many exhibitions of patient's artwork in Britain and abroad and gave lectures about the artworks. He wrote numerous articles about art therapy. One in particular reached a wide audience in 1962 and helped to raise the profile of the profession, as did exhibitions of patients' artwork held at the Institute of Contemporary Art in London.⁶³

The Adamson Collection of art works was started in the 1940s and now comprises over 60,000 examples of psychiatric patient's art work.⁶⁴ Adamson died recently aged 84.

In conclusion, in this article I have attempted to give a detailed account of an art therapy research post established at Netherne Hospital in 1946. The research objectives of those who established the position were presented. Edward Adamson, who was appointed to this position, worked using standard conditions capable of being reproduced elsewhere for research purposes. The research, conducted by Dr Cunningham Dax, represented an attempt to ascertain the usefulness of art as therapy. It is of significance because Dax concluded that the spontaneous production of images and interpretation of them by the patient could be regarded as a legitimate therapeutic treatment.

Adamson's approach relied on the creation of an atmosphere in which people could be creative. An important aspect of this was the notion of freedom, particularly freedom from the constraints of the hospital routines, which Adamson felt were deeply inhumane. Adamson was prepared to keep his patients' confidences; he did not feel obliged to relay every piece of information entrusted to him by clients straight to their psychiatrists. Patients must have realized this after a time, and trusted him with secrets that they felt they could tell no one else.

Adamson's sense of being different was emphasized by the location of the first studio, and later studios, in the grounds of the hospital, which Adamson felt was crucially important in distinguishing what he was doing from other sorts of staff in the institution. I have noted that Adamson felt that artists had a bond of sympathy with those suffering from mental distress and illness.

Although the department was established in the context of research being completed into visual perception, Adamson managed to co-exist with this different ethos, forming good working relationships with the psychiatric staff. However, he was strident in his view that art therapists should not interpret their patients' artwork, and that those art therapists who worked in this way were damaging their patients, or at least displaying more about themselves than they were elucidating about their patients' psyches.

Like Adrian Hill, Adamson was significant as a pioneer and promoter of art therapy in Britain. Like Hill, Adamson was vehemently opposed to the therapist interpreting the client's art work. He was vociferous in his criticisms of such interpretive work and this article has provided an account of his views on this subject. However, unlike Hill he promoted a non-interventionist approach in which the therapist would passively accept whatever the client presented to him. This has sometimes been misinterpreted as an atheoretical stance. However, Adamson was very sympathetic to the spiritual model of art therapy used at Withymead in which the art therapy process was seen as essentially self-regulating and not requiring interference from the art therapist. It is this Jungian influence from Withymead which led him to concentrate on providing a safe space in the hospital setting in which an unprecedented level of self-expression and self-exploration could take place. Adamson believed, with many other Jungians, that art was healing. Although when first appointed restrictions were placed on his role (which I explored) Adamson outlasted Dax at the hospital and therefore had the opportunity to change his working practices – that he chose not to do so clearly illustrates that he was happy with the model of art therapy practice he had developed. Adamson had strong feeling about psychiatric care and was deeply critical of mental hospital regimes of which he regarded himself very much as an outsider.

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NOTES

1. Timlin (1996), 'Art as a Panacea'. Obituary notice for Edward Adamson. *Guardian Newspaper*, 12/02/96.
2. Adamson (1970: 149) cited Waller (1991: 53).
3. Dax (1953: 18-19).
4. Adamson (1990: 1).
5. Dax in correspondence to Roman, January 1986 cited Waller (1991: 53).
6. Dax (1953: 19).
7. Dax in correspondence with Roman, January 1986 cited Waller (1991: 53).
8. Adamson (1990: 2).
9. Dax (1953: 21).
10. Adamson (1990: 9).
11. Dax (1953:19) and Dax (1948: 592).
12. 1994 Susan Hogan interview with Adamson.
13. Dax (1953:21). In 1949 Dax is hostile to the term 'art therapy'. He noted disparagingly that 'there are as many therapies in psychiatric nomenclature as there were 'phobias', and it bought only disrepute on their experimental methods'. Dax, E. C. (1949), *Psychiatry and Art. Netherne Hospital Exhibition*. BMA Report, 23 July, 228.
14. Musical practice took place in the hut once per week but otherwise it was for artwork only and therefore paintings could be left on their easels when unfinished.

15. Dax (1953: 22). No rationale is given for this particular colour scheme. Later Adamson was to acquire more buildings in the grounds.
16. 1994 Susan Hogan interview with Adamson.
17. Dax (1953: 23).
18. 1994 Susan Hogan interview with Adamson.
19. Dax (1953: 25).
20. Dax (1953: 22).
21. Unnamed former patient (No. 2) in Rumney (1980: 49).
22. Dax (1953: 20).
23. A patient interviewed by Rumney 1980 was not happy about the loss of artwork.
24. Dax (1953: 25).
25. Unnamed former patient (No. 5) in Rumney (1980: 57).
26. 1994 Susan Hogan interview with Adamson.
27. Rumney (1980:4).
28. Unnamed patient (No. 2) cited Rumney (1980: 49).
29. Unnamed patient (No. 1) in Rumney (1980: 47).
30. 1994 Susan Hogan interview with Adamson.
31. Unnamed patient (No 1) cited Rumney (1980: 47).
32. 1994 Susan Hogan interview with Adamson and Dax (1953: 20).
33. 1994 Susan Hogan interview with Adamson.
34. Dax (1953: 21).
35. Dax (1953: 20).
36. 1994 Susan Hogan interview with Adamson.
37. Dax (1953: 23).
38. 1994 Susan Hogan interview with Adamson.
39. Adamson (1990: 2).
40. Timlin (1991: 2).
41. Adamson (1970: 152).
42. Reitman (1955) cited Roman (1986: 37).
43. 1994 Susan Hogan interview with Adamson.
44. Adamson's attitude mirrors that of Dax to a certain extent who distinguished between 'genuine' and 'conscious' pictures.
45. Dax (1953: 27).
46. Withymead (1942–1967) was a tremendously influential residential therapeutic community, founded by Irene and Gilbert Champenowne, which used art therapy as a central treatment method.
47. 1994 Susan Hogan interview with John Timlin.
48. 1995 Susan Hogan interview Timlin. I interviewed Timlin in Adamson's presence and he appeared to be in agreement with Timlin's views.
49. Timlin (1991: 2).
50. 1994 Susan Hogan interview with Timlin.
51. 1995 interview Timlin.
52. 1995 Susan Hogan interview Timlin.
53. Adamson (1963: 53). Italics added for emphasis.
54. Tredgold preface to Adamson's article (1963: 50).
55. 1994 Susan Hogan interview with Adamson.
56. Timlin (1991: 2–3).
57. Adamson (1970: 156).
58. Adamson (1990: 3).
59. Waller (1984: 7).
60. Foreword to Adamson's 'Art as healing'.
61. Dax (1953: 25).
62. Dax (1953: 93).
63. 'Darkness into light', *The Observer*, 1962.
64. Timlin (1991: 1).