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Art therapy-based organisational consultancy: a session at Tate Britain
Val Huet
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Val Huét

Abstract
Looking at the increase of insecurity, anxiety and stress at work, the need for effective staff and organisational support has never been more evident. This article introduces art therapy-based organisational consultancy and describes its use for a session at Tate Britain with a staff team working within a Secure Unit for People with Learning Disabilities. The intervention was recorded and all art works photographed. Thematic analysis was used to analyse the session’s content. The strongest themes identified through the discussions of art works and the staff’s own art making are discussed and linked with the work context, the organisational dynamics and the human experience of working with such a marginalised client group. Implications for the practice and development of art therapy-based organisational consultancy are discussed.

Keywords: Art therapy, art, work-related stress, secondary traumatic stress, learning disability, thematic analysis

Introduction
Work and its effect on people has been a topic of study since the twentieth century. Initially a relatively simple quest to make the physical environment safer within factories (Briner, 2004), this scope was later widened by the ‘Human Relations Movement’ to studying the negative impacts of mechanised and repetitive activity and advocating work environments that provide involving and enriching tasks for the workers (Jaques, 1955, Trist & Bamforth, 1951). From these beginnings, the concept of work-related stress is a relatively recent area of study that has attracted a growing interest from professionals and the public alike (Arthur, 2004).

Although Briner (2004) cautions against perceiving work as the source of all stress, and points out that work is an important factor in wellbeing, interest in this field is likely to continue. The world of work at the start of the twenty-first century is in a state of radical change. Factors created by the global economy (outsourcing, downsizing, virtual organisations) have led to a prevalence of short term and temporary contracts and an increase of job insecurity and high levels of stress at work (Arthur, 2004; Dewe & Kompier, 2008). As the world is paying the price for the banking crisis, business bankruptcy and public funding cuts leave few unaffected. The full extent of the human cost is yet to be evaluated and issues such as workplace bullying and violence at work are reported by many trade unions as being on the increase (Dewe & Kompier, 2008). Significantly, there does not seem to be much evidence that the study of the causes of work-related stress has brought an efficient way of addressing it. Interventions such as workplace counselling still focus mainly on individuals rather on the organisations, which leads to putting the blame for stress firmly back on the individual employee (Arthur, 2004).

Workers within health and social care organisations have been at the forefront of experiencing all the above issues, whilst attempting to meet severe and complex needs. People working in the caring professions are among the occupational groups identified as being at high risk of work stress (Smith, Brice, Collins, Matthews, & McNamara, 2000). Research on occupational stress in health service staff has found levels of stress and minor psychiatric disorders to be higher in the National Health Service (NHS) than for other occupational groups in the UK (Hardy, Shapiro, & Borrill, 1997; Wall et al., 1997).

Countering the trend for individual focus, interventions based on organisations as human systems, influenced by socio-cultural factors and by unconscious processes, were developed in the twentieth century (Lewin, 1947; Miller & Rice, 1975; Rice, 1990). For example Menzies Lyth’s study on the social defence mechanisms within nursing (1959) analyses the impact on nurses of working with people in physical and emotional pain. In order to cope with the resulting ‘intense and unmanageable anxiety’ (1988, p. 52), mechanisms such as splitting up the nurse-patient relationship, depersonalisation, categorisation and denial of the significance of the individual, detachment and denial of feelings are put in place. Her observations are still useful today, and later publications such as Obholzer and Zagier-Roberts (1994) develop some of these...
themes further. One of the foci is on exploring the unconscious impact of emotions on dynamics of work and how these can detrimentally affect clients, staff and the health of organisations if left unattended. Long (2002) identifies the rise of a narcissistic culture of individualism and consumerism in our society, where corruption is ignored and thrives. This allows perverse and destructive dynamics to develop and thrive within organisations, as evidenced by the many publicised cases of abuse within institutions. She reflects on the privatisation of public services and the damaging effects of consumerism. Cooper and Lousada (2005) discuss the emergence of a ‘Borderline Welfare’ whose roots can be traced, firstly, to failure of containment by care organisations; secondly, to pressure to eradicate all risks; and thirdly, to political interventions and regulations, reactive to the first two points. They argue that this has created ‘social conditions for the delivery of ordinary welfare that seem to us analogous to living in the shadow of a permanently scrutinizing, punitive superego’ (Cooper & Lousada, 2005, p. 13). Within mental health work, this has detrimentally affected the professional mind and the ability to trust one’s judgement and authority. Dartington (2010, p. 33) identifies an ‘adolescentiation of society. […] Adolescence is a state of mind characterized by desperate but temporary attachments, fierce competitiveness, and a preoccupation with status. It is crucially self absorbed, confusing high ideals and selfish acts’. Whereas adolescence is a normal developmental phase for all young people, society now seems to be in a state of arrested adolescent development. This has led to a denigration of dependency and authority, where the professional knowledge and competence of professionals is undermined or attacked.

The more recent publications seem to highlight the increasing pressures and complexity of working within the care system (Dartington, 2010). The impact of the resulting stresses on staff is as yet unknown but a rise in detrimental effects seems inevitable. The provision of effective and innovative support for health care workers has never been more needed.

Art therapy-based organisation consultancy

As an organisational consultant, I often found myself missing the creative dimension of art when working with teams. I felt that art would be a useful tool within organisations that, like my art therapy clients, were often in chaotic and conflicted states. It is important to differentiate between the use of art making in organisation consultancy and its use as a tool for reflective practice and supervision. There are many references to the latter within health care professions such as nursing (Warne & McAndrew, 2008) and art therapy (Brown, Meyerowitz-Katz, & Ryde, 2003), but they concern clinical work with patients rather than engagement with an organisation.

Two art therapists, Tobias Arnup and Tim Wright, had, like me, completed the Tavistock & Portman NHS Trust Consultancy Training, and together we presented to the British Association of Art Therapists (BAAT) Council a proposal for a pilot project on art therapy -based organisational consultancy, which was approved (BAAT Council minutes, 1 March 2008). We envisaged offering this to any group of professionals within the public or private sector, for the purpose of team-building events or ongoing staff development. The proposal states:

Why Art?

- It enables staff to connect with hidden creativity
- It facilitates expression and reflection
- It allows new ways of thinking to emerge
- It helps teams to reach creative outcomes and fulfil their creative potential. (BAAT Council minutes, 1 March 2008)

It is worth noting that these statements were a list of desirable outcomes; they were not supported by any other evidence than our working experience of doing this with teams. The intervention was work-focused. Boundaries between professional and personal issues had to be clearly kept, as this was not a therapeutic intervention. Whilst we felt confident in the practical aspects and the protocol of the consultancy, we did not clearly define how we would work with art within the sessions.

Although there is a paucity of published literature on the subject, anecdotal evidence from organisational consultants indicates that many do use images for certain group exercises. Asking staff to draw a real and an emotional map of their organisation is a quite common approach in consultation (Huffington, Armstrong, Halton, Hoyle, & Pooley, 2004, p. 211). Mostly, images are made as a response and illustration to a theme and as part of trust-building exercises in teams (Wasdell, 1997). Stiles (1998) makes a strong argument for the use of the image in qualitative research with organisations. He describes pictorial representation techniques such as personality images and focus group images. Redding Mersky (2008) asks participants in social dreaming workshops to draw their dreams. She discusses challenges and limitations
such as lack of artistic ability, accuracy of dream representation, and potential for distortion. She states that the ‘strongest basis for advocating this methodology is its capacity to access deep unconscious material’ (2008, p. 46). Sievers (2008) describes how digital photographs taken by participants of their organisation are used as a ‘Social Photo Matrix’ that helps understand unconscious organisational dynamics. Sapochnik (2010) describes the use of visual ethnography in organisational research and employs drawing as a tool to process material from consultation sessions.

There is also little in art therapy literature that discusses the use of art as an intervention with staff teams and organisations. Most of the published material stems from working within palliative care; staff within this particular setting seem more attuned than others to the need for support. Murrant, Rykov, Amonite, and Loynd (2000) describe a workshop for hospice staff that were offered an art therapy segment, consisting of theme-based exercises graded from ‘safe’ (drawing a line to illustrate how one felt) to more risk-taking (representing how individual workers cared for themselves). Feedback from participants was very positive, with comments on ‘how art touched their feelings and experiences. Reconnecting to one’s creativity was a powerful and emotional experience’ (Murrant et al., 2000, p. 47). Nainis (2005) describes an ongoing art therapy group for nurses on an oncology ward, which helps them to better understand their patients’ relationship with art and alleviate their own anxieties. She describes the use of art therapy during a staff retreat when small groups were asked to make an image together on the meaning of working on an oncology ward. A ‘caring quilt’ was made of all the staff’s images put together, which illustrated powerfully conflicted feelings of loss, pain, hope and compassion (Nainis, 2005, p. 153).

Anecdotal evidence from conversations with colleagues shows that some art therapists do work with staff teams, although there is a dearth of publications and evidence as to what constitutes good practice.

Setting up the consultation
This intervention was set up for the staff team of a secure unit for people with learning disabilities. Most of the clients have serious cognitive, behavioural and emotional problems and the staff team consists of a mix of qualified nurses, nursing assistants, an art therapist, occupational therapists and psychologists. Working with this client group is challenging in itself but as the organisation was undergoing changes, the level of stress in the team was increasing. A new nurse manager had been appointed, with a brief to implement changes and revitalise the organisation’s culture.

Shaer and Springham (Shaer et al., 2008) had developed an art and art therapy-based intervention at Tate Britain for an ‘Information Prescription’ (IP) pilot, initially working with service users and carers. The IP project was set up by the Department of Health to provide accessible information of good quality for people with long term health conditions. Art was used to describe mental states. The clients of this secure unit were one of the groups included in this pilot and managers felt that staff members themselves may benefit from a similar session.

I was recruited as a member of the BAAT Organisational Consultancy, as the IP team felt that the skills offered would be needed for this project. I needed to gather information, as this would be a one-off session and work would have to be focused. I met with the psychologists who provided the staff support groups and felt reassured that staff would not be left without a space to discuss things further, should they need to do so.

Arranging the session proved challenging, with many starts and stops, emails unanswered and meetings postponed. After a wait of six months, I finally managed to set a date with the staff from the unit and the Tate Britain curator. Significantly, emails sent throughout this period show that the responsibility to manage this project within the organisation progressively slides down the hierarchy, with the task being passed to the deputy manager and finally to a nursing assistant, whom I shall call Sandra, who participated in the session. Although the nurse manager was supportive of the project (she had agreed to give time off in lieu to participants), her withdrawal from active involvement in the planning may be linked to the low turn-out.

The session
To parallel the clients’ experience, the staff’s session was planned for an evening after the gallery closed to the public, to ensure an uninterrupted space. Shaer et al. (2008) describe the different roles taken on by a curator and an art therapist and this format was replicated here. In order to work comfortably within the time available to us (we only had two hours and were expecting 10 participants), we decided that the curator would select three to five art works and would
introduce the aesthetic and historical context of each piece. I would facilitate a discussion exploring how staff members responded to the art and made links with work issues. We would then go to the art room in the education department and the staff would use art to make a response to this experience. The session would be recorded and art work photographed. Staff would be asked to give consent for this material to be used for research and publication.

A few days before the session, I discussed with the curator the context of the work and some of the clients’ issues to help him select the images.

Although we were expecting 10 participants, only two staff members, Sandra and Helen, turned up, bringing with them apologies from their colleagues who were off sick, on duty or just unable to come. This felt like a downbeat start to the evening. Sandra had tried to coordinate the team and apologetically wondered if we were happy to go ahead. I reassured them that this would still be worthwhile and when we arrived in the gallery, being alone in the space did feel very special for all of us. I started the session by reminding all that this exercise was to ‘think about work’. Some personal feelings may come up in the course of the evening and although we would pay attention to these, the focus was on work issues and articulating and understanding these. We spent two thirds of the time discussing three art works in the gallery and one third making art in the education department art room.

The art works

We looked at three of the art works selected for their resonance with people who are marginalised from society, either because of their subject matter or through the artist.

- ‘The Vagrants’ by Frederick Walker, a painting depicting a group of travellers.
- A copy by Francis Bacon of a painting by Van Gogh on his way to paint.
- ‘Fallen Leaves’ by Gilbert and George, a photograph of a homeless person living in their neighbourhood.

As a response to the discussion in the gallery, Sandra made a painting, ‘Boat at sea with a patient and a member of staff’ and Helen made a clay piece representing the clients, the doctors and the staff. These art works will be discussed further on.

Method

I have used thematic analysis to identify the most important issues present in this exercise. Boyatzis (1998, p. 1) describes thematic analysis as ‘a way of seeing’, and stresses the importance of being able to see patterns within data and coding these:

Recognising an important moment (seeing) precedes encoding it (seeing it as something), which in turn precedes interpretation. Thematic analysis moves you through these three phases of enquiry.

Themes have a manifest and a latent content and cognitive complexity is the ‘only pre-requisite for using thematic analysis’ (Boyatzis, 1998, p. 8), which can be described as the ability to navigate between multiple layers of meaning and interpretation. Boyatzis identifies three blocks to good thematic analysis: projection (too much familiarity from the researcher with the topic), sampling and the researcher’s own mood and style. His description of the latter is similar to describing transference and counter-transference. Although Boyatzis addresses fully the subjective nature of thematic analysis, he does not see it as a research method in itself. This view is contested by Braun and Clarke (2006, p. 78) who see it as a method in its own right: ‘the first qualitative method of analysis that researchers should learn as it provides core skills that will be useful for conducting many other forms of qualitative analysis’. Braun and Clarke acknowledge the lack of consistent definition and approach to thematic analysis and attempt to remedy this by identifying good practice and a step-by-step guide to this approach. They identify six steps:

- Familiarising yourself with your data
- Generating initial codes
- Searching for themes
- Reviewing themes
- Defining and naming themes
- Producing the report

For each of these steps, they give a clear definition of concepts and a practical guide to the tasks. They also identify potential problems such as failure to analyse data, the use of data collection questions as themes (another failure to analyse data) and a ‘weak or unconvincing analysis where there is too much overlap between themes or where the themes are not internally coherent and consistent’ (Braun & Clarke, 2006, p. 94).
As stated earlier, discussions were taped and art works photographed. I transcribed the taped conversations, thereby familiarising myself with the data. I also looked at pictures of the art works when transcribing text. I wanted to stay as close as possible to an art therapy approach when the art therapist looks at images when writing notes. I decided to do a separate section for the images that were made by the staff as it felt right to differentiate between the two different modes involved in this exercise, one of looking, the other of making.

My sample is very small and this study is therefore limited in terms of research validity. However, my concerns about paucity of data were not borne out; the session yielded a lot of rich material full of relevance for staff and clients. I coded each significant statement and identified several themes which I ended up grouping in three main categories, some with sub-themes, as I will now discuss: ‘alienation’, ‘control versus containment’ and ‘working with fear’.

Thematic analysis of the session in the gallery

Alienation

Perhaps unsurprisingly, ‘alienation’ was the strongest theme in the data and had three sub-categories. Each theme is a two way statement and works:

- between clients and society
- between staff and clients
- between staff and society.

Society’s wish to keep these clients at bay was often referred to by Helen and Sandra: ‘We are employed to keep these difficult people out of everyone else’s way. Everyone is paying for them to be there but would rather not know the “ins and outs” of it’. Clients are perceived as firmly out of society and for all the rhetoric about attempts to correct this, the status quo seems firmly embedded. Clients themselves prefer to stay away from society, even shunning opportunities to participate in events outside of the hospital.

Alienation between staff and clients seems to be a strong feature, as clients tell them they are ‘unable to understand because you don’t have this problem’ and staff feel that they indeed will never fully understand. Disappointed expectations from clients also feed this feeling of alienation. Clients do want intimate relationships and have some expectations that these should come from staff members: ‘It ends up with them (the clients) expecting a lot from us, they want to be friends with us, they want to give us a hug because we are the only people there I suppose’. Staff acknowledge that having a learning disability makes it that much harder for clients to understand appropriate boundaries. Staff and clients seem to develop a ‘false self’ in order to cope with the feelings engendered: ‘We will put on a front with them and they will put on a front with you’, and this strengthens feelings of alienation.

A striking feature is how much the staff members felt themselves alienated from society when it came to their job. Helen and Sandra described how initially they discussed their work with friends, but rarely do now as a common response is: ‘What do you want to do this job for?’ This parallels the alienation between the clients and society, but with an added element of staff members feeling they are detrimentally judged as jailers rather than carers: ‘It is a bit like working in a prison’. ‘If I talk to someone about something that has happened at work, people are really shocked by it. To me it is something you see every day.’

Some aspects of these themes resonate in the next theme of ‘control versus containment’.

Control versus containment

This theme related to the tension of being a ‘secure unit’ as well as a therapeutic resource. The need for strict boundaries and consistent responses was highlighted: ‘You do have to be very strict; there are strict therapeutic guidelines’. Having to physically restrain clients was mentioned, as was the fact that some clients end up either associating care with restraint (and provoking situations that lead to restraint), or feeling that staff members had wronged them by restraining them.

Interestingly, both staff members discussed feeling constrained themselves in their formal roles, for instance when responding to clients who may wilfully misbehave: ‘There is not supposed to be any sort of reproach (towards the clients)’, ‘There is obviously no sort of comeback’, or ‘That was the wrong thing to do’. Being shouted at by clients was a situation that demanded staff kept calm and showed restraint themselves, although they felt anything but calm on the inside.

Furthermore, decisions were made about the care of clients by people such as doctors who were comparatively remote from the clients and the reality of the work. Although the care staff might not always agree with these, they had to implement them.

Being in a volatile environment, violence erupting regularly seems an accepted, if feared aspect of working within this setting. The NHS
posters on the wall warning against being violent to staff ‘don’t really mean anything’. Staff have to keep on the alert at all times and ‘think about how you might deal with it’ (any incident). ‘You learn how to assert yourself in an appropriate way.’ The pressure is to appear ‘confident that you will be able to react in the right way’ as failure to do this would have dire consequences not only for the clients but also for other staff whose safety would be compromised.

Despite this, a genuine caring concern towards the clients is present in sustained attempts to understand clients and help them contain their emotions: ‘You have to understand the actual person, you have to get to know someone’. This seems at odds with the theme of alienation between staff and clients and may denote a constant tension between the wish to have a genuine professional rapport and the knowledge that volatile behaviour may alter this in seconds.

Significantly, new employees seem to have to learn how to best cope by themselves, with little help or guidance from established carers: ‘When you start your job, nobody tells you about these qualities you are supposed to have, you have to work it out’. This issue can be seen as one of the factors underlying the third theme, ‘working with fear’.

**Working with fear**

This theme gathers the often underlying and conflicted feelings of fear that staff members experience every day within their work.

‘I am always looking over my shoulders. Although I may be friendly and helpful, I am aware that at any point they could be trying to attack me or someone else.’ This constant threat of violence is a daily reality and both Sandra and Helen refer to times ‘when people have got hurt’. The violence appears at times casual (clients throwing chairs across the room for the slightest of motives) and there is real fear borne out of experience that this can be dangerous, unpredictable and therefore shocking, however much clients are known within the unit. The language used to describe this fear is significant: ‘Gosh, if I say the wrong thing, I am going to get pelted’, says Sandra. ‘Getting pelted’ does not sound as traumatic as getting physically assaulted, although this is in effect what could happen.

The potentially disturbing effect of working under a constant threat of violence seems evident: ‘It has happened that when people have got hurt, you can’t dwell on it’. ‘You carry on as normal although it is not normal at all.’ This denotes a culture where denial of fear and its impact prevails: scary stories are used to show new recruits that existing staff are survivors who are not afraid: ‘You hear stories from people who have worked in this place for a long time and it is always dramatic incidents which people remember and talk about which for a new member of staff can be quite intimidating’.

Although this can be seen as a way of warning new people to be on their guard, the fact that these stories are given without much advice on how to respond (see above: ‘You have to work it out’) denotes a culture commonly found within organisations coping with extremely challenging clients, where a ‘macho’ front is developed to mask the persistent presence of fear and vulnerability.

Presenting a strong front is another way of coping with vulnerability. Helen refers to herself as a ‘puny little girl’ potentially ‘facing a very big man’. Hiding one’s fear and looking in control is important to keep things safe, although the internal feelings may be very different. ‘I feel I put on a good show when I am at work’ denotes the level of effort put into this, and the discrepancy between manifest behaviour and real feelings. Sandra states: ‘It is quite an unsettling situation to be in. I feel a bit fake sometimes’. The task of working whilst consistently using a high level of self-censorship does have a detrimental impact on the health and wellbeing of employees, as will be discussed later.

**The staff’s art works**

Helen made a clay figure where patients were represented by a ‘manic smiling face’ and the small shapes at the bottom represent the doctors and other professionals who have the ‘decision-making power’ over treatment of clients (see Figure 1). They are ‘quite a long way from the clients and can’t really see what is really happening’. The small shape climbing the column represents care staff that constantly mediate between doctors and patients and bear the consequences when things don’t work out. ‘It is all a bit messy and unfinished because this is how it feels with our approach to things: it is never going to be polished and perfect.’

Sandra made an image ‘Boat at Sea’ (see Figure 2) within which were a member of staff and a patient:

> In this picture, it is a lovely sunny day and they are basking in the sun and enjoying it and it is all going very nicely but at the same time it is a tiny little boat in a big, big sea and there is always a potential that you could go into a storm and you
always have to bear that in mind and think about how you might deal with it.

Looking at the staff’s art works, it is striking to see how these capture some of the themes found in the gallery session and also develop new ones. Of the themes already identified, the ones on alienation between staff and clients, on staff’s own conflicted position (restraint) in their formal role and on the constant presence of potential danger are echoed in the art works here. Looking at the ‘Boat at Sea’ image, the appearance of serenity is indeed hardly there, as the sea looks choppy and the size of the sun gives it a manic quality too. The circling black birds look menacing when comparing their size to that of the staff and patient. One can surmise the level of tension that the feelings represented in this picture would engender for both staff and client.

Interestingly, a new theme emerges from the clay figure, as clients can be seen as being both powerful and powerless; the manic smiling face looks like it could easily topple off itself and possibly roll back over the staff, squashing them in the process. The whole edifice seems dedicated to keeping a fragile balance that can be shattered at any point by the clients’ behaviour. In this instance, one could see the clients as having a powerful influence on staff as the volatility of their response does exert control through fear. As Helen states, the smile represents the uncertainty of the task as ‘we assume that we know of someone’s feelings but what’s happening on the outside is not really connected with what’s happening on the inside’. People with learning disabilities do use smiling as a defence against potential attacks (Stokes & Sinason, 1992, p. 52) and the lack of connection between inside and outside can also be seen as a feature of a learning disability. Furthermore, a smile can be used aggressively (Sinason, 1992). However, as Helen states, ‘they [the clients] are watched all the time, they have people observing them so when they are up there they can’t really hide from anything’. She adds: ‘I would not want to be up there’. The fact that these clients are there because of a legal process and that treatment is part of a sentence does mean that their actions, good or bad, would have a limited impact on the sentence they have been given. Ultimately, the
powerlessness is also related to the fact that the clients’ state of being is one that cannot be changed and that Sinason (1992) refers to as ‘Mental Handicap and the Human Condition’.

Discussion of the themes

The theme of alienation between clients, society and staff was prominent and one can see parallel processes between clients’ marginalisation from society and staff feeling themselves marginalised and judged by society. The uneasy feelings generally held towards people with learning disabilities are well evidenced by a constant change of label to describe the condition. As Sinason states:

No human group has been forced to change its name so frequently [. . .]. What we are looking at is a process of euphemism. Euphemism, linguistically, are words brought in to replace the verbal bedridden when a particular word feels too raw too near a disturbing experience. (Sinason, 1992, p. 39)

As these clients are also offenders, some having committed violent crimes, one can surmise that the level of uneasiness and fear they engender in society is even greater. The staff themselves and their motives for working there end up being seen with suspicion (‘What do you want to do this job for?’). The lack of value and respect towards the staff is further evidenced by the low status of work in these services, where jobs are often poorly paid. This in turn has a further detrimental effect on staff morale.

Brown (1992) sees several factors at play in the potential motivations of people who work with learning disabilities. The wish to identify with an oppressed minority may bring ‘sensitivity and dedication to the task’ but may also lead to controlling behaviour because of the power imbalance between staff and clients (Brown, 1992, p. 193). Ultimately, this controlling behaviour may lead to abuse, as has been sadly evidenced in recent cases that have come to light. A further impact of power dynamics may be found in some of the staff mirroring the clients’ powerlessness. It was evident here that neither Sandra nor Helen could find a voice in the organisation and that significant decisions were made by other, more powerful people who did not involve them. It also seemed that they lost their voice outside of the organisation as they found it difficult to talk about what really happened at work and ended up silencing themselves rather than risk opprobrium. This may be seen as a constant censorship dynamic, which also has its impact on the level of stress at work.

The theme of ‘control versus containment’ highlights that both Sandra and Helen expressed opinions and took actions at odds with their true beliefs. Although this is described in a positive light at times—‘I feel I put on a good show when I am at work’—it is modified by statements such as ‘I feel a little bit fake sometimes’. This conflicted dynamic can easily lead to burnout. Briner (2004, p. 11) analyses the psychosocial aspects of work and wellbeing and writes:

It is suggested that those in human service works have particularly strong emotional demands at work and it is these demands which, over time, lead to burnout. One way in which these may happen is where employees are repeatedly required to display emotions, such as compassion and sympathy, which they do not actually feel.

One of the most conflicted feelings seemed to be the one evoked by having to respond calmly and sympathetically to challenging behaviour from clients that staff suspected was premeditated. Stokes and Sinason (1992, p. 55) discuss the concept of opportunist handicap which ‘covers a more pernicious use of handicap to express hostility and envy’. Foster (2001) discusses how the duty to care for the most damaged and demanding clients in society puts an expectation on staff in helping professions to be emotionally in touch with their clients’ feelings. However, this means also being close to disturbing feelings and behaviour and to clients who often react against the closeness of the staff’s involvement, and attack the care and/or the staff who deliver it. Hence, staff are presented with ‘an emotional conflict’ of their own as they swing between persecutory anxiety and depressive anxiety. Foster argues that the duty to care causes us to split off parts of our awareness and that, providing this does not become extreme, it is necessary to do so in order to survive in this context. The split-off feelings should then be enabled to be re-integrated within reflective spaces such as supervision or consultancy sessions.

Although the staff team was provided with a regular support group, the description here is of working under a constant level of fear with occasional violent incidents occurring. Staff may themselves be hit or witness a colleague being assaulted. Several sources of potential trauma for staff seem possible: critical incidents and chronic stress that stems from working within a forensic setting and dealing daily with the clients’ emotional primary trauma of having a handicap (Stokes & Sinason, 1992, p. 50). Secondary
Traumatic Stress (STS) refers to the impact of work with trauma survivors on professionals who may themselves become affected by the trauma of hearing shocking and distressing testimonies from victims (Tehrani, 2007). Although the concept of secondary (or vicarious) traumatisation remained poorly defined and researched for a long time (Sabin-Farrell & Turpin, 2003), later studies bring further evidence.

Tehrani (2007) points out that although some evidence exists that caring for traumatised clients can have a ‘salutogenic (health enhancing) effect on carers’ (2007, p. 326), 60% of carers in her survey report experiencing negative changes. This is tempered by a belief that they had done a worthwhile job, and may explain why STS is not higher than one could expect from such a high rate of negative changes. However, terminology for STS still remains poorly defined (terms such as compassion fatigue and burnout are used interchangeably). As Sabin-Farrell and Turpin (2003) point out, focus on professional groups rather than types of client groups may miss out an important factor in the survey, although the ongoing impact of work seems to be considered a factor.

Van der Ploeg, Dorresteijn, and Kleber (2003) research the impact on forensic doctors of critical incidents and chronic stressors at work, and find that critical and chronic stressors are interrelated. They identify a cumulative effect of acute stress:

The more events someone was exposed to, the more symptoms like intrusions and avoidances were reported. This finding seems self-evident, but another hypothesis states the opposite. This hypothesis suggests that the more incidents, the more resiliency and consequently the fewer problems. People who had already experienced traumatic events may be better able to cope with new stressors. This last hypothesis was not confirmed in this study. (Van der Ploeg et al., 2003, p. 164)

These findings contradict the appearance given by longstanding staff members that they are immune to fear and therefore to stress and almost welcome the challenge. This brings to mind the experience of an art therapist employed in a forensic setting who described how new workers were not seen as really being part of the team until they had been hit by a client and preferably had a black eye to show for it, as a ‘badge of honour’. Although not all units may develop such an outwardly ‘macho’ culture to cope with their real vulnerability, it is clear that providing care within this setting to these clients does have an emotional cost for staff. Van der Ploeg et al. (2003) argue that greater control and influence within the workplace does help to relieve the effect of acute and chronic stressors. There is little evidence that Sandra and Helen felt this in relation to their work. However, the fact that they took part in this consultation and the level of insight they contributed may denote that, as newer recruits to the team, they had not yet succumbed to the prevailing organisational culture.

**Reflection on the art therapy-based consultation session**

The intervention had limitations in terms of impact on the staff team and the organisation, as so few people attended. The low turn-out may have been due partly to the event being out of the workplace and this made it easier to opt out if feeling anxious. Anxiety may have been compounded by coming to an art gallery, which is intimidating, and discussing or making art oneself, an even more intimidating task. Being out of a work context for such an intervention does have positive aspects; having a bit of distance and more perspective on issues and not being intruded upon by clients or colleagues all help. However, it also means that as these interventions are all based on voluntary participation, the people attending may be the more dynamic and involved staff and the ones missing this may be the ones who should really participate.

Both staff members used the session fully and valued the experience, saying when they left that they would go back and tell the others what a great event they had missed out on. My fear about possible paucity of material was not borne out. Using thematic analysis to understand this material seemed to fit the task well. Boyatzis’s description of thematic analysis (1998) has interesting connotations for art therapy research as it does indicate a strong visual and interpretative component to the task. Braun and Clarke (2006) have articulated a rigorous and reasoned defence of this method and a clear ‘good practice guide’ which I found extremely useful. However, a recent search of the Qualitative Research in Psychology journal yielded very few articles that used thematic analysis as a research method in its own right. This thematic analysis clearly shows that both the looking at works in the galleries and the making of art as a response to this experience have yielded a lot of information that encapsulates the experience of working as a care assistant in this setting.
My own experience of being a member of several staff groups has been mixed. With hindsight, several 'consultants' came to the task believing that their training as individual (and occasionally group) therapists should equip them well to work with teams. In practice, this led to an unhelpful confusion between personal and work issues that sometimes made matters worse amongst staff members. I feel that my role is to ensure that the focus of this intervention remains firmly on work and on the participants' professional identity. This exercise may bring up feelings for participants but is clearly not in the realm of therapy and should not be so. My task is to ensure that this boundary is safely maintained.

Participants' feelings about art and art making should be carefully considered. I have found that introducing artists' works for an initial discussion helps participants gain a bit of confidence towards an activity many have not engaged in for a long time, if ever. Here, the curator introduced the narrative of the images. Hearing the artists' and the art works' stories always facilitates the start of the discussion, as it helps participants to access a world that may feel intimidating and obscure. This process is still possible without a curator and can be done by the art therapist. The discussion of art works enables the replication of the triangular space between consultant, participants and art work; all our gazes are directed towards an image and this enables a 'side-by-side' stance to develop. This seems a more collegial process, possibly less intimidating than sitting in a circle with the consultant as the 'expert'.

Art therapy-based organisational consultancy does need developing and researching further in order to address some of the challenges described above. My next research project will be within the workplace and will use art that is available within the work setting instead of a gallery.

Both Sandra and Helen acknowledged their surprise at how much came out and how helpful art was as a medium. I found writing this very moving, as themes reflect their harsh work reality, although their generosity and thoughtfulness really shone through.

Sievers, B. (2008). Perhaps it is the role of pictures to get in contact with the uncanny: The social photo matrix as a method

References
to promote the understanding of the unconscious in organizations. *Organisational & Social Dynamics, 8*, 234-254.


**Biographical details**

Val Huet (SRAsT, BA Fine Arts (Sculpture), Dip. Group Psych., MA Art Therapy, MA Organisational Consultancy) trained in Sculpture at Camberwell School of Art and qualified as an Art Therapist in 1986. She has practised since then in Adult Psychiatry and later within a Child and Adolescent Mental Health Service. She is also a qualified Group Psychotherapist and Organisational Consultant. Val is the Chief Executive Officer of the British Association of Art Therapists, a post she has held since 2003. She also works as a consultant within organisations and as a private supervisor. She co-founded the Art Therapy Practice Research Network with Neil Springham and Dr Chris Evans in 2000 and has been actively engaged in it since. She is currently developing and researching an Art Therapy Approach to Organisation Consultancy.

Email: val@baat.org