John Stuart Mill, in his treatise on "Representative Government", wrote: "The authority which is most conversant with principles should be supreme over principles, while that which is most competent in details, should have the details left to it." In an effective federal system, the national government should be responsible for the things which are of national concern. And have we not already decided that nothing could be of greater national concern than education? Indeed the fact that the Federal Government has already ventured so far into this field demonstrates that it does regard it as greatly important. However, the present situation is an unhappy example of a constitutional or traditional division of powers which is completely at variance with the requirements of Australia. The financial relations between the Commonwealth and the States leave the latter, in Alfred Deakin's prophetic words, "legally free but financially bound to the chariot-wheels of the Commonwealth".

However much one may object to the dangerous irresponsibility involved in a situation in which one government raises money for other governments to spend, it cannot be expected that the Commonwealth Government will restore to the States sufficient revenue-raising potential to finance an adequate educational programme. As a general proposition, I think we should aim as a people to spend at least twice as much on education as we do at present. For the State to do this would involve, I understand, the committing of half its budget to education. For the Commonwealth, it would mean raising its contribution to universities from 2·5% to 5% of the Federal budget. Of more importance even than money — if that is possible — is the fixing, upon one authority of the responsibility to act, together with the ability to finance such action. I therefore suggest that education should be accepted as the constitutional responsibility of the Commonwealth. The alternative is a long discordant jangle as the educational machine runs down, because this is how a school or a university disintegrates — it never dies, it simply fades away.

I should like to close by saying that while I am aware that my proposals are likely to be branded, even by those most kindly disposed, as "unrealistic". I hope that it is not thought that I place the blame for the present situation on any person or institution, and still less that I have not the very greatest regard for the able and faithful men and women who keep on doing the almost impossible. I have simply tried to state some of the facts as I see them. The blame lies equally on all of us for the years which have been squandered and the opportunities which have been neglected. We are all equally guilty of the gross and mistaken materialism which takes it for granted that as long as we have a high standard of living our children can get along with half an education and no philosophy of life. There is no point in showing, by reference backward, that we have at last begun to remedy past errors. What we have to do is brace ourselves for the demands of the future. This is not merely a matter for governments. It is much more a matter for the great business organizations, all of which depend and will increasingly depend for their very existence on a sound and thorough educational system, and most of which have as yet given little indication that they are aware of this. But finally and fundamentally it is a matter for all of us as citizens. If we cease from criticizing the products of modern university education and concentrate upon convincing governments that education is to be their first care, the situation can be retrieved.

I conclude with another sentence from Mill:

> The worth of a State, in the long run, is the worth of the individuals composing it; and a State which postpones the interests of their mental expansion and elevation . . .; a State which dwarfs its men . . . will find that with small men no great thing can really be accomplished. . . .

# ART AND PSYCHOTHERAPY.

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IN this paper we shall describe how painting is being used as a method of non-verbal communication between patients. Since Adrian Hill (1945) and E. Cunningham Dax (1953) helped to focus attention on the value of painting to long-stay hospital patients, "art therapy" has become routine in many hospitals and other treatment centres. Dax points out that creative activities may, among other things, provide emotional release and be an aid to diagnosis, treatment and prognosis, may give useful information as to the patient's progress during treatment, and may be used as an adjunct to psychotherapy. In the neurosis unit to be described, which is part of a general hospital, painting is used in conjunction with group psychotherapy. We agree with Dax's observations, but find that the main value of painting in our particular unit is the way in which it helps patients to express their feelings and conflicts to each other.

## Structure of Neurosis Unit.

The unit comprises 20 in-patient beds, 11 for male and nine for female patients, and the average number of patients at one time is approximately 15. Drugs and electroconvulsive therapy are used when they are considered helpful, and all patients receive some form of psychotherapy. A "slow open" group (Foulkes and Anthony, 1957) of five or six patients meets twice a week for one hour, and the remaining patients are on individual psychotherapy.

All patients join in an hour-long unit meeting conducted by a member of the medical staff twice a week. Present also at this meeting are the psychiatric social worker, an occupational therapist and members of the nursing staff.

A one-and-a-half to two hours' painting session, supervised by a visiting artist, is attended by all unit patients one afternoon a week, and on the following morning patients discuss their paintings for one hour with a member of the medical staff.

## The Painting Session.

The subject is chosen by the medical staff, usually from a consideration of current group dynamics. On less frequent occasions patients are free to choose their own topics for painting. Among subjects chosen have been: "Myself and the Group"; "Discord": "Myself and the Doctor"; "As Others See Me"; "Mother"; "My Loneliness"; "Embarrassment"; "Growing Up".

The artist is given the subject at a preliminary talk with the doctor; then, to use his own words, "I get them (the patients) to express in an abstract or symbolic form their first reaction to a particular subject, to seize it with both hands and keep it simple, to let themselves go and enjoy painting once they have the idea". His preliminary talk on the subject "Myself and the Doctor", included the following injunction: "Don't pull your punches. If you feel the doctor is bone idle, here is your opportunity to say so." Little attention is paid to developing painting technique, as it is impossible to teach this to some 15 patients who are seen only once a week, and whose stay in hospital varies from several weeks to several months only. The artist may discuss with a patient who appears stuck the idea the patient is trying to "get across", and in general terms may indicate the possible significance of different colours and shapes; but such help is minimal, and the finished product is essentially the outcome of the patient's own idea and effort.

### The Painting Discussion.

The painting discussion is conducted in a "group" situation. Each painting is mounted in turn on a frame and described by the patient concerned. Anyone may ask questions or say anything about the paintings. After this more formal exhibition, a general discussion ensues, with the doctor as conductor. So that there may be a permanent record, it has become the accepted practice for patients to record in writing their own interpretation of their own paintings after the discussion.

### Report of the Case.

A., a single man, aged 22 years, a compositor, is nine years younger than his only sibling, a married brother. His father had wanted a girl as second child. A. remembers always being frightened of his father. A close bond exists between him and his mother, upon whom he feels dependent. Parental quarrels were frequent from the patient's early childhood. He dates his symptoms from the age of 11 years, when he lost his way on a school cross-country race and developed feelings of unreality. These persisted

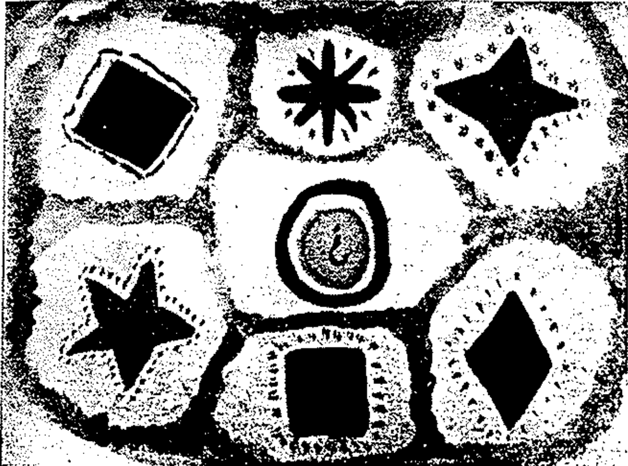

FIGURE I.

alone till the age of 19, when he was learning a new aspect of his job, and at which time his parents were quarrelling. He says: "This seemed to mix me up." Hysterical loss of touch sensation in his hands, shortness of breath, travel fears, contemplation of suicide and a constant state of tension were added to depersonalization and derealization. An electroencephalogram in 1958 was normal. A. was treated in a mental hospital during the first five months of 1960, where he received electroconvulsive therapy, "Stelazine" and "Largactil", with little effect. Leucotomy was considered, but not carried out. He was referred to us from the out-patient department of a teaching hospital, not having been to work for some nine months.

At his initial interview he produced a neatly typed list of symptoms, as he feared he would forget some; his mind, in fact, would go blank in such new situations. A. attended his first unit meeting on the day of his admission to hospital, and his first painting session in the afternoon after his second unit meeting. The subject was "Myself and the Group". At the discussion A. was hesitantly able to describe his painting (Figure I) as follows:

> I depict myself with the pale yellow centre circle, feeling weak, unimportant, and rather confused, hence the query sign. I am surrounded by a black barrier, unable to get through to the group and feeling cut off from them. The outside shapes are the group, everyone being different, gay and colourful in their way.

This brought a response from the other members, who had thought the patient aloof and superior. At this time group methods and the doctor were under adverse criticism from the patients, and one of them pointed out: "Well, if we can make this chap feel at home, then it will be something worth while."

The same subject "Myself and the Group" was dealt with on two subsequent occasions, at intervals of four and six weeks. On the first of these occasions A.'s description of his painting (Figure II) included the following:

> I feel more accepted into the group, but not entirely. I am joined up to them in a way, but there is still a thin barrier around me that stops me from saying or taking part as I would wish. I still see myself with the largest problem and feel that no one can really help me.

On the last occasion A., who had become a member of the small group seven weeks earlier, produced two

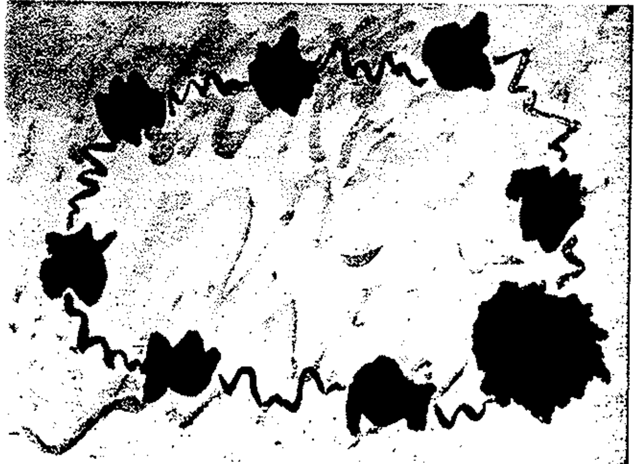

FIGURE II.

paintings, one of the small group, the other of the unit meeting. He felt an integral part of the small group, which was warm, closely linked and more helpful. The unit meeting at this time seemed to him cold and empty. He did not feel interested in this large group, and felt that they were not interested in him (being a member of another group). Of this theme "Myself and the Group", the patient says: "I found this subject fairly easy to put into paintings rather than tackling it with words alone."

That parental disharmony caused A. much concern is shown in his painting of "Discord" (Figure III), and in part of his subsequent description:

FIGURE III.

> I had no trouble over this subject. It came to me easily. I expect I know what it means as well as anyone. Immediately the word "discord" was used, I thought of my parents and my past three or four years. I have black, ugly, sharp points cutting into and breaking up the creamy-yellow colour representing peace and calmness. Behind the jagged black lines are brutality, evil and confusion. This confusion was the state of my mind, while bickering, which usually

ended up with violence, went on between mother and father, each in their turn trying to make me side with them. At the time I feel there was a percentage of love and also a little hate towards each parent. I was scared of speaking the truth in case I upset one party and in so doing started more rowing and violence. I am certain that this period has a great bearing on my state at the moment, although not wholly to blame. At the moment I feel only love towards my mother, and, to an extent, my father.

## Discussion.

At the present time we have devised no satisfactory way of assessing the value of painting sessions and discussions, and, indeed, this may be impossible with so many uncontrollable variables in the unit. It is purely an impression, but we see painting as part of the thing which is, in a sense, breaking the ice, allowing the patients to appear in front of the barriers they build up about themselves. What they paint may or may not be apparent to the observer. However, the patients are later free to verbalize their feelings in a "group situation", and the fact that they have expressed them in one medium appears to facilitate this. This happened in A.'s case. We are of the opinion that his acceptance into the unit was facilitated through painting, and that through painting he was able, initially at least, to express his feelings more adequately; and what occurred in A.'s case is seen to happen in others.

There are some theoretical objections, no doubt, to setting a topic for painting in a unit that is "permissive", but it has at least two advantages. Firstly, the problems of interpersonal relationships within the unit are opened out in simple terms unhampered by psychiatric jargon. Secondly, the patient is set a problem to solve—how to get an abstract thought down on paper—and the solving of this problem may be the beginning of his dealing satisfactorily with other problems. Also, though we tend to choose subjects which have a relevance to the situation in the unit, patients do not confine their attention to problems within the unit. For example, the subject "Discord" produced representations of discord between parents in A.'s case, and between child and parent, and between siblings in others.

Occasionally, material not previously produced in psychotherapy comes to light, or one sees for the first time through his paintings the intensity of a patient's feelings.

Some patients prefer to talk rather than paint; but for the sake of those who find it difficult initially to talk about their feelings, we consider it worthwhile persisting with the painting sessions. It is found, almost without exception, that patients grow to like painting as a different mode of expression, and have nothing to lose, but much to gain, from participation.

## Summary.

A brief description of a neurosis unit has been given. The use of painting as an adjunct to psychotherapy has been described, and comments have been made on one case. The writers express the view that painting is a valuable aid to verbal communication; it helps the patients to convey to the doctor and to each other the conflicts within themselves and within the group.

## Acknowledgements.

We are grateful to Mr. J. E. Barsby, the artist, for his invaluable help, to the nursing and secretarial staff of the Psychiatric Unit, and to the Clinical Photographic Department, North Middlesex Hospital.

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# ACTIVE IMMOBILIZATION PLUS PHENYLBUTAZONE FOR RHEUMATOID ARTHRITIS.[1]

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ACTIVE IMMOBILIZATION means the splinting of painful joints together with activity of the limb and the rest of the body. It is founded on Lorenz Böhler's active method of treating fractures in skin-tight plaster casts. Sir Robert Jones (1918) emphasized the principle that active movement with fixation of the painful joint made for good nutrition and rapid repair. The expression is borrowed from the late Sterling Bunnell (1946), who wrote of active splinting. From time to time the fact has been rediscovered that continuous immobilization of arthritic joints is not followed by ankylosis if the joints have cartilage in them (Thomas, 1878; Phelps, 1890; Kindersley, 1936, Phillips, 1937; Bell, 1940; Tippett, 1940; Duthie, 1952; Gariépy, 1956; Swanson, 1956).

Splinting is necessary for painful joints, both to relieve the pain and to permit activity of the healthy joints. The patient must use the limb within painless range. Active immobilization has been made possible by the use of light plaster casts applied next to the skin—although bony points have always been padded (Kelly, 1959 *a* and *b*). Most doctors who treat rheumatic patients recognize the value of splinting, but very few use continuous immobilization. For 15 years I have proceeded by trial and error in an attempt to develop practicable methods for every joint. In the upper limb the wrist is the key joint; when it is fixed the condition of the joints of the hand improves unaccountably. In the lower limb the knee is the key; if it is kept straight the condition of the whole leg improves.

Rest in bed is an evil; my experience for 15 years indicates that the patients who have done well were those who had something to do; those who took to bed were the ones who became cripples. There is a common belief that the patient with rheumatoid arthritis must begin treatment with several weeks in bed. A booklet used by the Empire Rheumatism Council (1954) says so; but I do not agree.

## Muscle Balance.

As a cause of deformity, arthritis is a great deal more common than spastic paralysis or poliomyelitis. However, in these disorders prevention of deformity has been grounded on certain accepted principles, because the deformity is due to the loss of balance of the muscles. Jones (1918) emphasized that the deformities of arthritis were also due to the loss of balance of the muscles. This assertion may seem an exaggeration; other causes cannot be ignored, and there is always a combination of four factors (Kelly, 1959*a* and 1960): (i) muscle balance, (ii) external forces, (iii) shortening of ligaments, and (iv) softening of cartilage and bone. Disturbed muscle balance is first in time and in importance. External forces (the pressure of the shoe on the foot or the weight of the limb or of the body) are less important. Only after many weeks does fibrotic shortening of the muscles, the ligaments and the capsule appear. To become permanently shortened, the inflamed tissues must have been held in an incorrect position for a long time; the opposing muscles and ligaments become lengthened. Later again comes destruction of the cartilage and bone, which makes the deformity permanent. It takes years of sitting in a vicious posture to make the ends of the femur and the tibia lose their rounded shapes and flatten against each other.

In arthritis there are five different ways in which muscle balance may be disturbed; the first two are reversible. They are: (i) vicious postures (for example, wrists being allowed to droop and knees resting on a pillow in bed, or being kept bent for long periods while the patient sits); (ii) muscular spasm (the associated

[1] Part of the script of a motion picture exhibited at the tenth Rheumatology Congress, Rome, September 7, 1961.