

Unexpected Connections: Cultural-Historical Psychology in a Community Mental Health Setting?

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This paper will reflect on the influence of Vygotsky and Luria in my work as an occupational therapist in the community mental health setting of an ‘Activity Centre’ in the National Health Service, between 1991 and 2001. The paper will discuss a limited study, referencing Vygotsky during that period, with the benefit of hindsight and subsequent developments in the field of cultural-historical psychology. The original study raised the questions of what evidence could be found to support the application of Vygotsky’s Zone of Proximal Development (ZPD) with a mixed group of adults in a community setting, and how this process of learning might be assessed and evaluated. At the time, these questions were informed by literature sources no later than 1998, and learning theory was often absent from professional training in mental healthcare. However, I will propose that some models of practice in mental health – particularly those founded in psycho-analytic group therapy and occupational therapy – could be enhanced by a deeper understanding of Vygotsky’s ZPD, Luria’s model of field research, and the discussion of some less established connections in psychoanalytic praxis.

Keywords: Community Mental Health, Vygotsky, Luria, Mediation, Agency, Dynamic Assessment, Ezriel, Occupational Therapy.

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Introduction

Cultural-Historical psychology has offered a wealth of ideas about theory and innovative practice in recent years. These exciting developments inspired me to reflect on my earlier career as an occupational therapist, working in a community mental health setting in the National Health Service (NHS). I was especially driven to review a limited study, undertaken in 2002, following records of increased levels of social and creative activity at an ‘Activity Centre’ over the decade 1991-2001. This was a period of great change in the NHS provision of mental health and social care, when thousands of patients were moved from the hospitals where they had lived for many years, to receive care in the community. The Activity Centre was set up to provide a meeting place and optional activities for people transferred to care homes in a small seaside town. Reflecting on our shared experience of collaborative learning, as part of my teacher training, my study referenced Vygotsky’s Zone of Proximal Development (ZPD) and Luria’s model of field research in the early 1930s, as an attempt to explain the unplanned positive outcomes at the Activity Centre. While these ideas were well received in teacher training, they did not readily connect with the medical model of psychiatry dominating much of NHS practice and professional training, which was often

similarly resistant to models founded in psychoanalytic theory. So, it is very much with the benefit of hindsight and the freedom to pursue independent research that I now hope to reach a deeper understanding of the potential of ZPD in community mental health, and to explore its unexpected resonance with a less well-known model of psychoanalytic intervention.

Background to the 2002 study and discussion of operational policy in an NHS Trust

In the context of my NHS employment from 1991 to 2001, the workplace to be discussed was an occupational therapy department, but as such it functioned with an unusual degree of autonomy, located miles away from the hospital base, and in a house indistinguishable from neighbouring residential properties. This unusual setting, which began as part of a rehabilitation project for long term psychiatric patients, undoubtedly influenced attitudes towards the service it provided, from the perspectives of both service users and NHS management. To potential clients it looked like the kind of place where you might meet friends and drink tea, but I was once told by an NHS Trust publicist that the client’s drawing of the premises we were using for our service description did

not meet the required 'corporate image.' This perceived requirement was probably founded in changing management systems, following successive government policies to advance privatisation of the NHS, which like many large organisations is itself full of contradictions. Public relations departments quite rightly promoted 'client centred' and 'evidence based' practice, 'service-user involvement' and consultation, but these ideas were not fully realised in practice. They existed alongside human rights issues around stigma, social inclusion, capacity for active, informed consent, and the availability of choice vs. compliance with treatment. So, funded by and appearing on the fringe of a psychiatric institution, we experienced many of the challenges described by Daniels [5] in his discussion of multiagency work, which often extended to inter-disciplinary relations. Nevertheless, we succeeded in developing and writing an operational policy, which was agreed and approved by the local NHS Trust. In this policy, our Introduction and stated aims were as follows:

This policy is being written in consultation with staff and clients from February 2000 and may be reviewed and revised.

The Activity Centre is part of the Trust's Occupational Therapy Service within the Adult Mental Health day care provision for the community. It is a converted house in the town centre and is open from 9 a.m. to 4 p.m. from Monday to Friday, including most Bank Holidays. It serves a mixed group of about 80 people who attend "because they want to" at an average rate of 30 per day.

Aims/Philosophy

We (staff and clients) manage the Activity Centre together on a day to day basis, and share responsibilities as far as possible. We aim to provide a friendly, informal atmosphere where people are encouraged, but not directed to take part in planning and decision-making processes, and to participate in activities where clients and staff can teach and learn skills from each other.

We aimed to apply the principle of mutual learning to social interaction, as well as practical and creative activities at the Centre, and there are precedents for such an approach in NHS mental health care provision. For instance, there is the therapeutic community (TC) model of care, in which clients "have a significant involvement in decision-making and the practicalities of running the unit." [3, p. 365] and where the "promotion of belongingness which is likely to be a substantial feature of integrated treatments" can have "an independent effect on well-being and mental health" [29, p. 636]. Here TCs look to the field of psychology [2] and to psychotherapy, to promote service users' agency as a force for development [1]. However, the situation of TCs in the NHS has often proved problematic, as has their representation and/or reputation; not only regarding the history of particular units [14], which vary greatly in their intake of service users and methodologies [17], but also within their own network [36]. Some of these issues might well reflect the inherent difficulty of sustaining a collective model of care, given the medical hierarchy integral to the organisation of the NHS.

However, the Activity Centre faced less of a challenge in this respect — making no claim to TC status and

situated in a management structure where several professional disciplines were represented. In addition, the medical cover we required was shared between a number of consultant psychiatrists based in the local mental health clinic and hospital. Around 2000, this arrangement was extended to allow doctors in general practice (GPs) to refer directly to the Activity Centre. This offered easier access and choice to potential service users, insofar as their self-referral could be supported by a nearby GP surgery without waiting for an appointment with a consultant psychiatrist, or indeed reaching a point of crisis in their mental health which would lead to urgent psychiatric intervention. At the same time, this more open referral system shifts some of the responsibility for initial assessment to the service provider. This is advantageous to both potential service-user and provider in terms of their mutual assessment of the suitability of therapy on offer, but in some cases, access to further information, such as any relevant social care, medical or criminal history is necessary for effective risk management. Where good communication prevails within the multi-disciplinary teams and between the care agencies involved, this information is obtained in advance of a meeting on site, as was generally the case at the Activity Centre. However, before discussing the study, and in the interests of demonstrating the consistency of our approach, the following extract from our Operational Policy describes the referral and assessment process through to treatment:-

REFERRALS

Introduction and/or first visit can be informal, but assessment and registration requires medical referral by a psychiatrist of GP. Clients' Planning Group to be given notice of new referrals — Client friend/mentor to look after each new client on 1st day.

ASSESSMENT

Assessment interviews to be offered within two weeks of referral. Assessment is a mutual process and begins with an interview between a staff member and potential client, who jointly write and sign an agreement, which should include a check-in day.

TREATMENT

Each client's agreement with the Centre names a staff member to monitor their care. Treatment is activity-based and founded on effective working relationships between staff and clients — to be mutually assessed on an on-going basis. The core activity is social — working together as an informal group and maintaining a friendly atmosphere.

Although a multi-agency assessment process cannot be wholly dynamic, the psychodynamic interaction between a service-user and provider during an assessment interview, is a crucial factor in the development of any future therapeutic relationship. This can be fraught with complications. For example, if the general psychiatric and/or social 'Care Plan' of a potential client stipulates compulsory attendance of day care, then their choices are seriously limited. So, when one young man with such limited options, and a history of reported 'challenging behaviour' made an informal visit to the Centre, he expressed

understandable reservations. In response to his guarded statement that he “might” attend, I told him not to do us any favours and emphasised that people attended our place because they wanted to. Thankfully, this young man proceeded to an assessment interview, attended regularly, and became keen on growing plants. He also self-diagnosed his autistic spectrum disorder, after watching a television documentary on Asperger’s syndrome. The next day, on arrival at the Centre, he declared, “I think I might be artistic.” Our view was that he might well be autistic *and* artistic, since in addition to experiencing relationship difficulties, he had already shown appreciation of the use of imagery and self-reflection. This young man’s insight into his own problems with socialising proved to be enormously helpful to our mutual learning and relationship building at the Centre thereafter.

The ZPD at the ‘Activity Centre’?

The project ‘Vygotsky – Social Learning, Theory & Practice’ was submitted in my teacher training for a Post Graduate Certificate of Education in 2002. The core problem, as defined in 2002, was to understand how a selection of positive, but unpredicted outcomes of teaching and learning amongst a mixed group of adults were achieved, with reference to these research questions:

The following indented text is copied from the original study, with References inserted –

- What evidence can be found to support the application of Vygotsky’s theory of social learning with a mixed group of adults in a community setting?
- How might the process of learning, determined by “problem solving ... in collaboration with more capable peers” [41, p. 86] be assessed and evaluated?

The student/client group

The individual participants at the Activity Centre range in age from 18 to 75, and in educational background – from the personal and social isolation and/or deprivation associated with years of institutional life and mental health problems, to the relatively fulfilling experiences of post-compulsory education, professional training and employment. There are approximately 90 clients registered at the Centre. All are former psychiatric patients with a history of between 5 and 45 years of treatment beginning with hospital admission, and continuing in the community, where the majority are living in residential care homes, with NHS mental health provision co-ordinated by teams based at the local psychiatric hospital and/or other agencies, such as mental health and social care centres. Clients attend the Activity Centre on an entirely voluntary basis, describing it as an “informal meeting place for people who attend because they want to”. The average daily attendance of 30 conveniently coincides with the health and safety limit for the premises. There are four occupational therapy staff members – all committed to further education and training within and beyond the Activity Centre, and throughout any given year, there is a succession of under-graduate O.T. students on fieldwork placement. Like the staff, they have

access to in-service education sessions at the Centre, and elsewhere in the NHS Trust

The student/client group of the original study included 4 professional staff and a succession of 1 or 2 students in training throughout the period 1991-2001. The clients themselves were a largely self-selecting group with diagnoses ranging through schizophrenia, bi-polar disorder, depression, anxiety, learning disabilities, autistic spectrum and personality disorders. It is important to acknowledge the socio-political context for psychiatric patients in the late 20th century in the UK, when there was a shift from long-term hospital confinement to ‘Care in the Community’. This was particularly life changing for former psychiatric patients with severe and enduring mental health problems, many of whom had been institutionalised for decades. Regarding this cultural shift, Luria’s approach to field research in the 1930s [26] was an inspiration, in that the lives of the people he was meeting were also experiencing change, albeit on a grander scale, in the wake of a revolution. With great wisdom, sensitivity and good humour, Luria met with his subjects in locations such as fields, tea houses and cafes, where a sense of belonging, and continuity with their social lives would promote good communication and, as far as possible – equal status between the visiting researchers and members of the host communities. The sense of belonging associated with such environments resounds with that promoted in the therapeutic communities discussed earlier. Furthermore, it was in the cafes, lounges, and outdoor spaces on the sites of the old psychiatric hospitals that patients, visitors and sometimes staff would mix convivially. So, the perception of the Activity Centre as an informal meeting place, resembling a café, contributed to its potential as a social space for learning.

Following the research questions, our stated aims were “To explore the implications of Vygotsky’s ideas for post-compulsory education and occupational therapy” in mental health, and “To assess the relevance of social learning theory to the experience of adults with diverse learning and teaching needs.” The matter of finding evidence to support the application of Vygotsky’s theory of social learning in a mixed group of adults was addressed primarily with reference to Vygotsky [41], Luria [26] and Kolb [20], in *Experiential Learning*, which was inspired by Vygotsky. Additionally, there were the contemporary sources of Kozulin [21], on the sociocultural approach to language development, including its use with immigrant communities, and Daniels [6], examining individual experience in mainstream education. Our supporting evidence was drawn from records spanning 10 years of practice, during which time we developed an operational policy. This reflected our commitment to shared learning, by encouraging clients’ active participation in the day-to-day management of the Centre, planning activities *with* them rather than for them, and interacting with a view towards co-operation, rather than correction. With hindsight, this is what we would now describe as a mediational process [30], in keeping with sociocultural theory [22]. During the period 1991–2001, we observed a steady climb in referral and attendance figures and a marked increase in service-users’ participation in the activities we had organised together. We associated these positive outcomes with the

changes we had made in the management of the Centre with our clients, and with an improved view of ourselves as lifelong learners, as well as therapists alongside our clients.

To summarise, again from our Policy, activities at the Centre included:

- A weekly planning meeting led by clients and minuted
- Paid cleaning duties (NHS Trust cleaning contract)
- Cooking
- Gardening (includes access to allotment)
- Arts and crafts
- Using the computer (with supervised internet access)
- Writing and publishing a poetry magazine [35]
- Weekly keep fit sessions
- Video-making
- Snooker
- The website project and poster 2000

In the original study, these activities and others were presented as a 'Table of Collaborative Achievements since 1991'. Activities initiated by individual clients were listed as "Client-lead sessions (in the Centre) and included: Teaching Basic Navigation, Teaching Latin, Tap dancing, Keep Fit and Dressmaking & Beading. In addition, all clients had daily opportunities to take on work, which would benefit the group, and receive tokens exchangeable for lunches, or craft items, in the Credits for Work initiative from 1997. The study featured another graphic illustration, attempting to show the progressive transfer of agency from staff to clients, with a time scale over the decade to 2001. However, client records of attendance and engagement with operational changes or clients' initiatives were not sufficiently detailed or dated to achieve this with sufficient validity. Nonetheless, prior to 1991, the daily life of the Centre was programmed by former staff and included craft activities such as woodwork and candle-making, under their direction. Many clients showed no interest in these activities, remarking "The staff are making candles again", and preferring to use the Centre to socialise and enjoy the lunch provided there. Between 1991 and 1995, 'under new management', this lack of participation was addressed by inviting clients to elect a chairperson for a Clients Planning Group, and offering new activities and opportunities for clients to teach sessions themselves. Hence, in respect of timing, we saw a distinct 'before and after' progression in service-users engagement with activities at the Centre. As evidence for consideration, given this outcome, the study claimed that:

The clients' motivation to initiate and or negotiate activities indicates their sense of empowerment, to the extent that roles were reversed – most strikingly in the case of client lead sessions and the Clients' Workshops, where a group were invited and paid to visit the University to teach undergraduate O.T. students, from 1999 to 2001 [24].

Two individual case studies, with related session plans on 'Learning French' and 'Reading Greek' were also included, and raised interesting possibilities for further development, with reference to second language education [30] and to the model of case studies pioneered by Luria [27; 28] and later advanced and examined by Sacks [33].

Towards the study's conclusion, it was argued that positive learning outcomes had emerged:

For instance, practical teaching resources – in the form of videos, essays and articles have been produced by students and clients. These are the tangible outcomes of peer group learning. Work from the Centre, presented by staff and students in O.T. training, and at conferences has stimulated invitations for the clients and students themselves to become facilitative teachers.

However, despite the evidence supporting social learning in a mixed group of adults, in relation to the study's first research question, the second question regarding assessment and evaluation was not fully addressed. It is here that developments in the field of cultural-historical psychology since 2000 may offer new ideas and offer a deeper understanding of Vygotsky's thinking and recover meanings, which have literally been lost in translation.

Reviewing the past in relation to current research and praxis

Hardman reminds the reader that, "For Vygotsky (1978, 1986), teaching and learning are dialectically related. In fact, the Russian word *obuchenie*, which he uses to discuss teaching, is best translated as teaching/learning" [16, p. 4]. She attributes this recognition to Daniels [7] and cites Fleer and Hammer [11] for their exposition of Vygotsky's use of the concept of *perezhivanie*, to unite emotion and thinking. The latter is strikingly appropriate in the general context of mental health, as is the dialectical connection between teaching and learning. With reference to the Zone of Proximal Development (ZPD), Kozulin offers an enlightening exposition of its three facets, and the Russian scene, in relation to the growing diversity of dynamic assessment [23]. Furthermore, Valsiner and van der Veer expose an interesting cultural-historical connection by reviewing their 1993 definition of Vygotsky's *zona* as "essentially a field-theoretical concept" [38, p. 148]. There, they acknowledge the "gargantuan efforts by Kurt Lewin to adopt topology for purposes of psychological discourse." [39, p. 36]. In 1947, Lewin explored the 'Frontiers in Group Dynamics' [25] and following a ground-breaking examination of social factors contributing to change, presented "Three Steps: Unfreezing, Moving, and Freezing of Group Standards" [ibid. p. 34]. Only a few years later, in 1951, psychoanalysts, Stengel [34] and Ezriel [8] simultaneously published papers discussing 'The Scientific Testing of Psycho-Analytic Findings and Theory', with Ezriel proposing the psycho-analytic session as an experimental situation. Questions of any communality of purpose between Lewin, Stengel and Ezriel and of the compatibility of their ideas with Vygotsky's ZPD are worthy of further discussion; as are the implications for Zavershneva's work on Vygotsky regarding the problem of consciousness [45], and her comprehensive exposition of 'Vygotsky vs. Freud' [46]. However, it was Ezriel's model of intervention, which influenced my reflections on our work at the Activity Centre, despite its absence from the 2002 study.

As I have written previously [36], Ezriel described his psychoanalytic peers' response to his early papers

as working against the 'art' or 'spirit' of psychoanalysis. However, he was employed by the Tavistock Clinic in London, in the 1960s and ran supervision groups there, prior to his retirement. In 1952, Ezriel wrote about 'Psychoanalytic Group Therapy' [9], having developed a method of intervention defining three kinds of relations in 'here and now' transference (i.e. thoughts and feelings towards the group and/or the therapist). In short, these relationships are described as:

1. The "required relationship" [ibid], maintaining a minimal level of tension in the group

2. A more anxiety provoking relationship which group members "avoid in external reality, however much they may desire it" [ibid] and,

3. A "calamity" which group members seem convinced would follow if they were to give in to their "secret desire of entering into the avoided relationship." [ibid]

In constructing such an interpretation, the analyst should echo the ideas expressed and words used by group members, as far as possible, and specify the nature of the imagined calamity. If the interpretation is correct, there is an observable shift from the required to the avoided relationship — perhaps apparent in a freer expression of avoided issues, and/or a sense of relief from tension. If on the other hand, the required relationship is reinforced and the level of tension increased, the interpretation is incorrect. In this way, group members are empowered to approve or disapprove of any given interpretation, having engaged in what Goodburn described as a process of 'mutual research' [12]. It may be for cultural-historical psychologists to consider how the process of reaching a correct interpretation, as proposed by Ezriel, may compare with the process associated with Vygotsky's ZPD.

The relevance of psychoanalytic theory to occupational therapy, and to the Activity Centre study may be less clear. However, when my study was in progress, I discussed it with Goodburn, who was reflecting on his unpublished work on the concept of transference to the institution [13]. He proposed that in the Activity Centre, some predictable examples of Ezriel's avoided relationship in transference might be demonstrated in the social interaction between staff and clients, without ensuing calamity, in keeping with the 3-part formulation above. For instance, a recurrent dynamic associated with institutionalisation is the perceived requirement to accept leadership and follow instructions. Claiming agency and making controversial choices might be avoided for fear of a calamitous deprivation of any kind of relationship, loss of identity or existential crisis. So, if therapists show no interest in authoritarian leadership, but a readiness to learn from service-users, this may reduce anxiety and encourage clients to develop their teaching/learning skills. Interestingly, in a recent study referencing Ezriel [8; 10], Reghintovschi [32] formulated predictions such as "sibling rivalry in psychoanalytic institutions" [ibid, pp. 94–96] to be tested in interviews, with some success. However, further resonance might be found in Cultural-Historical psychology.

In his discussion of Dynamic Assessment (DA), Kozulin [23] includes occupational therapy (OT) as one of the fields making progress. DA was pioneered in the 1960s in OT by Griffiths [15], but it was then presented for the care of the

elderly. Kozulin acknowledges more recent work Katz et al. [19], which can be followed by Togliola and Cermak [37], with signs of support from the field of psychiatry [43]. Additionally, in clinical psychology, Carl Haywood and Lidz [4] present a wide range of applications from children to adults and seniors, in clinical and educational settings. Kozulin hopefully predicts that all these disciplines will continue to develop their own systems of DA of cognitive modifiability and learning potential, retaining "the main postulates of Vygotsky's theory that any study of human mental processes should be done in a situation of interaction and change rather than passive observation and acceptance of the given conditions." [23, p. 143] The wider field of cultural-historical psychology has also presented many stimulating publications such as Xi and Lantolf's [44] critical examination of the relationship between scaffolding and the ZPD, Hopwood's [18] extraordinary project on Transformative Agency with children and their families, and Potapov's [31] engaging account of the use of new technology, shown to improve social, emotional communication and promote mental health amongst adolescents in education.

Conclusion

The original conclusion of the 2002 Activity Centre study owned that although there were positive learning outcomes and indications of a transfer of agency at the Centre, the second research question on assessment and evaluation was not fully addressed. Despite the inspirational work on Dynamic Assessment (DA) presented in Cultural-Historical Psychology, this remains problematic for several reasons. While Ezriel hoped to see advances in researching and testing psychoanalytic interpretations by sound or video recording therapy sessions, this would be difficult in a community centre where activities and interactions were dispersed throughout the building and on other sites such as the garden and allotment, on any given day. Also, service-users with negative experience of static testing in psychiatric hospitals may well be reluctant to give consent. In fact, on several occasions Activity Centre staff supported clients in declining a psychologist's request to conduct tests there. However, given the growing use of DA in both occupational therapy and psychiatry, it is hoped that many disciplines will work together for further developments in mental health services, in keeping with Kozulin's thinking. Sadly, these hopes are not applicable to the current service at the Activity Centre, since in 2010, the NHS Trust withdrew its staff from there, despite our joint proposals with another agency, that we should collaborate and share the premises. At that time, both staff and clients experienced the frustration which seems to be shared by many researchers in the field of cultural-historical psychology, in relation to the limited recognition of their work. However, the potential for advancement has been significantly energised by researchers, such as Hardman examining 'Vygotsky's decolonial pedagogical legacy in the 21st century: back to the future' [16]. There is a clear need to examine the hierarchical and political management of other public services, including healthcare provision, from a decolonial, anti-institutionalised perspective, for broader social change.

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Неожиданные пересечения: культурно-историческая психология в городском центре психического здоровья?

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В настоящей статье я размышляю о влиянии Выготского и Лурии на мою работу в качестве оккупационного терапевта (эрготерапевта) в центре психического здоровья «Центр деятельности» ('Activity Centre') национальной системы здравоохранения с 1991 по 2001 год. Обсуждается небольшое исследование того периода, с отсылками к Выготскому, с позиции ретроспективного анализа и последующих разработок в области культурно-исторической психологии. Исходное исследование ставило вопрос о том, какие свидетельства можно найти в пользу применения концепции зоны ближайшего развития для работы со смешанной группой взрослых людей в амбулаторных условиях и как можно было бы зафиксировать и оценить результаты этого процесса обучения. В то время, когда проводилось исследование, ответы на подобные вопросы можно было искать в источниках, изданных до 1998 года, а теории обучения зачастую и вовсе отсутствовали в программах подготовки специалистов в сфере психического здоровья. Тем не менее, я выдвигаю тезис о том, что некоторые практические приемы, применяющиеся в работе таких специалистов (в особенности разработанные в психоаналитической групповой терапии и эрготерапии), можно было бы доработать и обогатить за счет более глубокого понимания концепции Выготского о зоне ближайшего развития, модели полевого исследования Лурии, а также обсуждения менее заметных пересечений с психоаналитической практикой.

Ключевые слова: амбулаторные условия, психическое здоровье, Выготский, Лурия, опосредование, агентность, динамическое оценивание, Эзриель, эрготерапия.

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