

into ... his psychopathology – pitilessly self-destructive and ultimately fatal masochism’ (Buckley 2008). Caravaggio was indeed a suicidal Goliath.

According to Dubuffet, all art requires instability, rather than moderation and reason, at its core. Art is the pursuit of the abnormal. Caravaggio – a homosexual, brawler and murderer hunted down by authority across Italy – was the typical artist as doomed rebellious outsider.

The association between art and mental illness is an old one. We could not cope without the insight of Clark & Crossfield that art is a dialogue, but they are denying the history and essence of art in divorcing the mental state from what is depicted and displayed. Art seeks the heart of shadows that is in us all.

Buckley PJ (2008) Images in psychiatry: Caravaggio (1571–1610). *American Journal of Psychiatry*, **165**: 201–2.

Fujimoto A, Douglas-Fujimoto M (2008) Images in psychiatry: art as a portal into the minds of those with mental illness. *American Journal of Psychiatry*, **165**: 819.

Rao A, Keshavan MS (2006) Images in psychiatry: can psychiatrists recognise mental illness in paintings? *American Journal of Psychiatry*, **163**: 599.

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Author's reply

I am grateful for the responses to my article from Clark & Crossfield and from Ibrahimi. In reply to both letters, I probably did not express myself clearly enough. I was not intending to re-express the old idea that there is any simple way in which one can infer an artist's 'mental state' from their painting. My article was intended to point to something rather different: that our aesthetic response to paintings occurs because we put ourselves into a relationship to them which is 'as if' the painting itself had a 'mental state'. This is not at all the same as suggesting that what one is looking at in a painting is simply a reflection of the artist's mental state. The painting has a life of its own which is often unpredictable. As both sets of correspondents point out, the meaning made from looking at the painting is as much up to the observer as to the artist.

I did say in the article that I did not suggest a simple correspondence of form and artists' mental state, particularly in the art of adults; there are too many factors of culture, style and history that affect the formal choices that an artist makes. Thus, there can be passionate emotion in Renaissance painting as well as in expressionism, and interpretation

needs to take into account the stylistic conventions within which the artist is working. With young children the situation may be a little different just because their artistic productions are so much more spontaneous and cultural style has not yet a very big influence (children's drawings are pretty much the same around the world and through history). My research findings on the way that young children's formal expression reflects their mental state does therefore seem to hold in a slightly different way than for adults.

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Recovery without medication: choice, not moral superiority

We feel that it is important to provide a response to the commentary by Dr Feeney (Feeney 2009) on our article in the May issue of *Advances* (Calton 2009) and to make our position absolutely clear. Given the many difficulties associated with use of antipsychotic medication (that Feeney himself readily accepts), we do believe that recovery with minimal or even no medication, where possible, is preferable. However, this does not mean that this is a 'morally superior' position, nor indeed, as Feeney implies, that people who take medication are somehow 'morally inferior'. Far from it. We are fully aware that medication is often necessary, given the context and preferences of the individual. Indeed, we have the utmost respect for people who make an informed decision to take medication and we refute absolutely the suggestion that we would feel otherwise. Dr Feeney should not confuse a personal view relating to the experience of taking powerful psychotropic medication ('chemical sanitation') with a moral imposition of these views on others. Our concern, however, is that people often take medication not from a position of informed choice, but because of coercion or a lack of alternatives.

We wonder whether Dr Feeney is being rather disingenuous when he claims that he (and the psychiatric profession as a whole) work holistically with people's 'informed choices', when he believes that the effectiveness of medication for treating psychosis is 'beyond dispute'. This 'holistic approach' to the treatment of psychosis appears to be predicated on the presumed necessity of medication. It is hard to see how Feeney and his colleagues do not impose this 'personal view' on

patients. Therefore, to our minds, this practice does not support the option – and informed choice – of recovery with minimal or no medication. This is because true informed choice is possible only if viable alternatives exist within which to exercise these choices. The purpose of our article was to draw attention to the existence of such alternatives. Such recovery without these facilities (as in the UK at the present time) is currently possible only through luck or the good fortune of having an unusually robust network of support. We – along with large sections of the service user/survivor movement, who have

long advocated for non-medical crisis services – do not believe that this is good enough.

Calton T, Spandler H (2009) Minimal-medication approaches to treating schizophrenia. *Advances in Psychiatric Treatment*, **15**: 209–217.

Feeney L (2009) Invited commentary: Minimal – no, minimise – yes. *Advances in Psychiatric Treatment*, **15**: 218–220.

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CORRECTION

Correction

Rao H, Luty J (2009) The future of specialised alcohol treatment services: a matter of policy? *Advances in Psychiatric Treatment*, **15**: 253–259.

On p. 253 of the above, the author affiliation for Dr Rao should read:

Harish Rao is an honorary specialist registrar at the South Essex Partnership NHS Foundation Trust. He works as a higher specialist trainee in addictions in East London. He has published research on stigma and addictive disorders.

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