Dress as therapy

Working with dress on the self in therapeutic settings

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abstract

This thesis constitutes a critical analysis of “dress as therapy”. Hitherto unconnected dress-related therapeutic approaches to the self, rooted in different countries and medical disciplines, are brought together, systematically documented and critically scrutinised for the first time: “Therapy of Fashion” in mental hospitals in the US during the 1960s, contemporary *vêtothérapie* (fashion therapy) in France, and sensory stimulation treatment for people with anorexia in Germany. Approaching “dress therapy” as a cultural phenomenon rather than clinical technique, this thesis analyses the way the relationship between dress and the self is constructed and mobilised in the different dress-related therapeutic settings, and the way dress is employed to work on the self.

Qualitative research methods are used to investigate the settings’ respective structure, content, aims, implementation and theoretical/scientific underpinnings – or lack thereof. Underlying notions of self, both implicit and explicit in these therapeutic practices, are explored and analysed in their relation to discourses on the body, gender, dress and therapy. Cultural and national specificities concerning these discourses and arising dress-related therapeutic approaches are also addressed.

My thesis draws on a Foucauldian analytical framework to explore how the relationship between dress and self is discursively constructed in the respective settings, and how these discourses are formative of particular therapeutic practices. It argues that dress-related therapeutic approaches form part of contemporary ‘technologies of the self’, and as such analyses their conditions of possibility, the truth games behind each setting, and considers the knowledge/power relations embedded within them. Moreover, this thesis explores the ‘zero point’ of dress-related forms of therapy: how and when dress began to be considered as a therapeutic means in relation to the self. It thus provides a comprehensive overview of different uses of dress in relation to the self in institutionalised psycho-medical history since the mid-eighteenth century, a ‘history of the present’ of contemporary dress-related therapeutic approaches.

Both the role of dress in psycho-medical treatment as well as its employment in relation to the self in these institutionalised settings remain largely unanalysed. Hence, this thesis is the first analytical study of “dress therapy”. It also constitutes a new investigation into the way discourses are formative of therapeutic practices and the underlying assumption that dress has the ability to facilitate change in how we perceive our selves and our bodies. As such, the main contributions of my thesis concern the creation of new knowledge and new connections, as well as the extension of theory. It contributes to both dress studies and Foucauldian studies by exploring dress as a normalising and disciplining gendered technology of the self in the therapeutic realm, a key discourse of our time. It argues that these “dress therapies” bring together two central coordinates defining our experience and understanding of ourselves: (fashionable) dress and therapy.

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source: Grunwald, Martin (2008) 'Haptic Perception in Anorexia Nervosa' in: Grunwald, Martin (ed.) *Human Haptic Perception: Basics and Applications.* Basel: Birkhäuser Verlag, p. 342

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source: mdr (2010) 'Hier ab vier – Mit Rat & Tat: Neuer Therapieansatz mit Neoprenanzug bei Magersucht' [television programme], https://www.youtube.com/watch?v=O2wEVHqqQLM (24.5.2016)

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source: mdr (2010) 'Hier ab vier – Mit Rat & Tat: Neuer Therapieansatz mit Neoprenanzug bei Magersucht' [television programme], https://www.youtube.com/watch?v=O2wEVHqqQLM (24.5.2016)

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abbreviations

AI	Author Interview
APA-MHS	American Psychiatric Association – Mental Hospital Service
AP	Assistance Publique
APHM	Assistance Publique Hôpitaux de Marseille
APHP	Assistance Publique Hôpitaux de Paris
CAEH	Commission des Arts et de l'Esthétique Hospitalière
CBT	Cognitive behavioural therapies
DSH	Department of State Hospitals
DSM	Diagnostic and Statistical Manual of Mental Disorders
E.M.A	Espace Méditerranéen de l'Adolescent
FFPPF	Fédération Française du Prêt-à-Porter Féminin
fMRI	Functional Magnetic Resonance Imaging
IMM	Institut Mode Méditerranée
MMMM	Maison Méditerranée des Métiers de la Mode
MHASF	Mental Health Association of San Francisco
VA	Veterans Affairs
WFMH	World Federation of Mental Health

introduction

> [The aim of] "Therapy of Fashion" is to recreate healthy feminine characteristics in a selected group of women patients.
> (Miller et al. 1960: 42)

> I can't promise a cure-all for every anorexic woman [...] But [*vêtothérapie*] fashion therapy is a great way of getting some girls to appreciate their bodies again. Many women find another side to themselves in our wardrobes.
> (Battista in Groskop 2001b: 63)

> We proposed intensive somatosensory stimulation of the whole body […] A conventional custom-made neoprene diving suit was worn by a female anorectic patient over underclothes for one hour three times per day. […] Increased body weight, normalized theta activity, and improved body image were the apparent results of wearing a diving suit.
> (Grunwald et al. 2005: 379)

The above statements were made in the context of three dress-related therapeutic settings rooted in different countries and medical disciplines: "Therapy of Fashion", a programme of grooming, dress design and self-presentation classes piloted at a Californian mental hospital in 1959; contemporary *vêtothérapie* (dress therapy), where therapeutic sessions take place in a biannually changing fashion library (*vêtothèque*) in France; and sensory stimulation treatment in Germany which proposes the use of haptic stimulation through the prolonged wearing of a diving suit in the treatment of anorexia. These three statements, made over the last fifty years, are indicative of an understanding of the contemporary self as reflexive, embodied, gendered, dressed and therapeutable. This contemporary self can seemingly be changed, treated and even cured through dress. Dress is said to be able to normalise women's gender, girls' bodies and the self perception of patients with anorexia nervosa.

This thesis analyses the way the relationship between dress and the self is constructed and mobilised in these three therapeutic settings. It systematically documents and critically scrutinises these hitherto unconnected practices, which are approached as cultural phenomena rather than clinical techniques, for the first time. Each chapter gives a 'thick description'[1] (Geertz 1993) of the respective settings, examining their structure, content, aims, implementation and theoretical/scientific underpinnings – or lack thereof – and exploring the underlying notions of self that are both implicit and explicit in these therapeutic practices. Overall my research focuses on

[1] Unless otherwise specified this is the correct citation for the concept of 'thick description' as subsequently used throughout the thesis. For easier reading, I will not repeat the citation every time I mention a key concept within my analysis, nor will I use inverted commas to identify it as a key concept.

four key questions: What are these therapeutic practices? How have they become what they are? How have they been discursively constructed? How do they mobilise dress in relation to the self?

The different "dress therapies" under review emerge from particular historico-cultural contexts, from particular discourses of a gendered, embodied, dressed self and of therapy, an impression of which is given in the opening quotations. This thesis analyses how far these are formative of therapeutic practices. It also takes into account national and cultural differences concerning the discourses and related therapies. While "Therapy of Fashion" was solely targeted at women, the other two therapeutic approaches are intended for both sexes, and consequently, although not the main focus of this thesis, they are all also explored as gendered and gendering practices.

My thesis draws on a Foucauldian analytical framework and a number of cultural theories of the contemporary self in order to analyse the way in which the relationship between dress and self is discursively constructed and how it, thus, gave rise to particular dress-related therapeutic practices in the past and present. It argues that dress-related therapeutic approaches form part of contemporary 'technologies of the self'[2] (Foucault 1982), and as such it analyses their 'conditions of possibility'[3] (Foucault 1963/2003: xxii), the naturalisations behind each setting, and considers the knowledge/power relations embedded within them. Moreover, this thesis explores the 'zero point'[4] (Foucault 1961/2001: xi) of dress-related forms of therapy, that historical moment of differentiation, asking: how and when did dress begin to be considered as a therapeutic means in relation to the self? It thus provides a comprehensive overview of different uses of dress in relation to the self in institutionalised psycho-medical history from the mid-eighteenth century, a 'history of the present'[5] (Foucault 1975/1995: 31) of contemporary dress-related therapeutic approaches, reflecting how the past lays down the tracks for the future.

The structure of this thesis follows a tripartite division between concept and context, history, and the three therapeutic settings. Its theoretical and methodological framework is explored in Part One, Chapters One and Two respectively, while the zero point and history of the present of "dress as therapy" are analysed in detail in Part Two (Ch.3).

[2] Unless otherwise specified this is the correct reference for the concept of 'technologies of the self' as subsequently used throughout the thesis.
[3] Unless otherwise specified this is the correct reference for the concept of 'conditions of possibility' as subsequently used throughout the thesis.
[4] Unless otherwise specified this is the correct reference for the concept of 'zero point' as subsequently used throughout the thesis.
[5] Unless otherwise specified this is the correct reference for the concept of 'history of the present' as subsequently used throughout the thesis.

Chapters Four to Six, the final part, focus on the analysis of the three selected dress-related therapies.

Chapter One details the Foucauldian framework this thesis draws on and addresses the existing literature on the chosen settings, or lack thereof, alongside accounts of the role of dress within psycho-medical non-institutional therapeutic practice. Moreover, it reviews the relevant discourse of 'therapy culture'[6] (Furedi 2004, Weatherill 2004), and arising notions of a therapeutable self, within which this analytical study of "dress as therapy" is situated.

The methodological choices made in the development and realisation of this doctoral research are explained in Chapter Two. It outlines the underlying multi-disciplinary and reflexive qualitative approach, and the sociological and historical methods I employed. It details the parameters of the empirical study of the three "dress therapy" projects, and the specificities of the application of discourse analysis.

Chapter Three explores the zero point of dress-related forms of therapy, investigating how and when the self came to be regarded as therapeutable through dress. It describes the historical precedents for the use of dress in relation to the self within institutionalised psycho-medical and therapeutic practice, considering some of the common conditions of possibility intrinsic to the formation of the therapeutic practices under review in this thesis. Chapter Three argues that, contrary to what popular representations and the current state of research might suggest, both implicit and explicit therapeutic use has been made of dress in relation to the self for over 250 years. It contributes an overview of some of the different discourses and practices relating dress to the self in formative ways at particular historical moments in the development of psycho-medical institutionalised treatment. Moreover, it maintains that right up to the present day dress is employed as a controlling mechanism in such settings and constructed as a technology of the body and self. This chapter constitutes a history of the present thus providing not only the historical, but also some of the analytical groundwork for the analysis of the chosen therapies in the following chapters.

Chapters Four to Six are respectively dedicated to the three settings in chronological order. "Therapy of Fashion" is analysed in Chapter Four against the backdrop of a humanising discourse in mental hospitals in the US of the 1960s, coinciding with the advent of psychotropic drugs, and the promotion of open-door policies which entailed a growing interest in the dress of patients. As the only approach exclusively aimed at women, this chapter also elaborates on its gendering intent, arguing that it aims to exact a normative gender performance.

[6] Unless otherwise specified this is the correct reference for the concept of 'therapy culture' as subsequently used throughout the thesis.

Chapter Five investigates *vêtothérapie*, originating in an adolescent psychiatric unit in Marseille, France in 1999, in relation to its foundational approach of cultural therapy (*soins culturels*). It analyses how the hardly acknowledged, yet highly subjective and diverse, discursive constructions of the relationship between fashionable dress and the adolescent self by the variety of people involved in the treatment result in very different therapeutic practices.

Sensory stimulation treatment is the subject of Chapter Six, which analyses the discursive construction of a neoprene diving suit as a haptic suit in the treatment of anorexia nervosa. Piloted in Germany in 2003, this dress-related therapy which uses only one garment, is explored in a shorter chapter, because of its limited scope and application. This chapter analyses the underlying discourse of the importance of touch to the self, the resultant treatment approach of the haptic suit, and, the suit itself, in their formation as a counter-discourse to largely language-based and vision-centred approaches said to be the dominant methods of researching and treating anorexia.

My thesis explores what is said, silenced and naturalised about the correlation between dress and the self in these three settings, and analyses what is done in the resultant therapeutic practices. It argues that throughout the psycho-medical past and present, dress has been and is still employed as a normalising, gendering and often disciplining technology of the self.

Both the role of dress in psycho-medical treatment as well as its employment in relation to the self in these institutionalised settings remain largely unanalysed. Hence, this thesis is the first analytical study of “dress therapy”. It also constitutes a new investigation into the way discourses are formative of therapeutic practices and the underlying assumption that dress has the ability to facilitate change in how we perceive our selves and our bodies. As such, the main contributions of my thesis are threefold, concerning new knowledge, new connections and the extension of theory. Firstly, it is original in subject matter by charting a new field of experience and opening up an archive of “dress therapy”, thus contributing to the production of knowledge. Second of all, this research draws numerous new connections, for example, between the three chosen therapeutic approaches, or the many different historical settings and uses of dress to work on the self. This thesis finally aims to extend theory through its systematic development of a Foucauldian framework and the extension of some of Foucault’s analytical approaches, both methodologically and theoretically. In terms of academic disciplines my thesis contributes primarily to fashion and dress studies as well as Foucauldian studies by exploring dress as a normalising and disciplining gendered technology of the self in the therapeutic realm, a key discourse of our time. It argues that these “dress therapies” bring together two central coordinates defining our experience and understanding of ourselves: (fashionable) dress and therapy.

part I
Concept, context & methods

chapter one
Concept & context

Introduction

> Pascal: "Men are so necessarily mad, that not to be mad would amount to another form of madness." And Dostoievsky in his *Diary of a writer* "It is not by confining one's neighbour that one is convinced of one's sanity."
>
> We have yet to write the history of that other form of madness, by which men, in an act of sovereign reason, confine their neighbours, and communicate and recognize each other through the merciless language of non-madness; to define the moment of this conspiracy before it was permanently established in the realm of truth, before it was revived by the lyricism of protest. We must try to return, in history, to that zero point in the course of madness at which madness is an undifferentiated experience, a not yet divided experience of division itself.
> (Foucault 1961/2001: xi)

Anyone who writes about anything concerning the Western psycho-medical realm owes an intellectual debt to Michel Foucault. Whatever one takes or indeed leaves from his two seminal works on the subject, *Mental Illness and Psychology* (1954/1987) and *Madness and Civilization* (1961/2001), his radical critique of madness as a social construction to stabilise and normalise the self, cannot be circumnavigated. As such Foucault's radical social constructivism has informed my thesis lastingly. Moreover, his concern with the history of practices (rather than things) and how they make ourselves particular human beings, the genesis of the modern perception of self, offer a compelling framework for the exploration of "dress as therapy". Hence, this chapter focuses on the Foucauldian analytical framework of my thesis, by detailing its theoretical and methodological debt, so to speak. It goes on to address the limited existing literature on the chosen dress-related therapeutic settings alongside accounts of the use of dress in relation to the self within non-institutional psycho-medical therapeutic practice, and reviews the pertinent discourse of therapy culture and arising notions of a therapeutable self as project, within which this analytical study of "dress as therapy" is situated. To begin with, however, this chapter provides a discussion of the key terminology used in this thesis.

1.1 Definition of key terms

In the context of this thesis, I propose the term “dress therapy” as an operative one, to refer to a number of different dress-related therapeutic practices, both historical and contemporary. ‘Therapy’, in its meaning of healing and curing, is used synonymously with treatment. The cultural signification of therapy in Western Europe and the US, the setting of this thesis, and the notion of therapy culture are addressed in detail in Ch.1.4.

Of the terms ‘dress’, ‘clothing’, ‘fashion’ and ‘appearance’, ‘dress’ is the most comprehensive one and will be employed most frequently. It denotes the ‘total repertoire of body modifications and supplements that a particular social group makes available to its members’ (Eicher & Roach-Higgins 1992: 9). As such it is able to incorporate the diversity of practices considered in this research, ranging from fashionable dress, undergarments and the make-up that feature in “Therapy of Fashion”, to the diving suit which is the focus in sensory stimulation treatment.

‘Clothing’ refers to body coverings, to garments or clothes collectively and omits body modification. ‘Fashion’, as opposed to the previous terms, can refer to many kinds of material and non-material cultural products and processes, and is also used for modes of behaviour or dress ‘in which the key feature is rapid and continual changing of styles’ (Wilson 1985: 3). The meaning of ‘appearance’ is similarly expansive as that of ‘dress’. It includes the visible surface of the body, the outward aspects of a person, yet also the naked body, as well as gestures, facial expressions, posture and deportment.

Another layer of meaning attributed to ‘dress’, namely ‘situated bodily practice’, coined by sociologist Joanne Entwistle (1997: 266), has been important for this research, as it takes into account both the centrality of the body to an understanding of dress, and dress as the outcome of specific social practices, contexts and structures. Thus, this phrase and its underlying analytical perspective inform the understanding of dress in this thesis.

Within my thesis ‘self’ is understood as the most abstract and inclusive concept, expressed concisely by sociologist and fashion theorist Susan B. Kaiser (1997: 193) as ‘a global sense of who one is, composed of a subset of identities’. The self is, thus, primarily a social construction. This is formulated by the intellectual father of symbolic interactionism George Herbert Mead (1863–1931) (1925: 270) as follows: ‘We appear as selves in our conduct insofar as we ourselves take the attitude that others take toward us. We take the role of what may be called the “generalized” other. And in doing this we appear as social objects, as selves’. Consequently, the self is profoundly shaped through the individual’s social interaction with others, it is ‘a mental construction of the person,

by the person, but inevitably formed from social experience. Thus the person sees him/herself reflected by others, in their reactions, and these are interpreted through the lattice of self-perception' (Jary & Jary 1991: 285).

Dress is said to play an important role in this process of symbolic interaction. The school of thought of symbolic interactionism, in its conceptualisation of the central role of appearance and non-verbal communication in the social process of subjectification, has been taken up in a number of sociological examinations of the dressed self (Hunt & Miller 1997, Kaiser 1997, Stone 1962). Such an understanding of the self is ever more relevant for the analysis of "dress as therapy" as it enables the exploration of a series of actual and imagined interactions and (power)relationships in the act of dressing "for therapy", not only between therapist and patients, or among patients, but also between patients and their peer group, families, or even the media or body politics, who although not in the room, are still symbolically present.

The fact that the understanding of self differs according to time and place is taken into account in this thesis by exploring the specific notions of self underpinning each of the respective dress-related therapeutic settings.

The distinction, and indeed the relationship between self and identity, has been usefully defined by Kaiser (1997: 193) who argues that identity signifies the 'self-in-context; constructed and negotiated through social processes (person interacting in context); composed of a subset of roles'. My understanding of identity in this thesis is inherently social, centred around the body and based on a multi-sensory experience of the world, as argued by sociologist Fred Davis (1992: 16) in his definition of identity in relation to dress as 'any aspect of self about which individuals can through symbolic means communicate with others, in the instance of dress through predominantly non-discursive visual, tactile, and olfactory symbols, however impressive, and elusive these may be'.

Concerning the perception we have of ourselves, which is addressed in all the therapeutic settings, two terms will be used within this thesis: 'body image' and 'body schema'. 'Body image,' which refers to 'a conscious visual representation of the way the body appears from the outside' and whose 'scientific concept corresponds roughly to the everyday use of the term' (Haggard & Wolpert 2005: 1) is much more commonly used and will be considered below. 'Body schema' generally connotes our unconscious self representation, as will be discussed in the context of sensory stimulation treatment, which it specifically targets (Ch.6).

The prevalent understanding of 'body image' which is also adopted in this thesis, goes back to the definition of Austrian psychiatrist Paul Schilder (1886–1940) (1935/1970: 11): 'the picture of our own body which we form in our mind, this is to say the way our body appears to ourselves' in his seminal *The Image and Appearance of the*

Human Body. Psychologist Thomas F. Cash (2004: 1) has extended this definition by arguing that body image encompasses not only 'one's body-related self-perceptions', but also 'self-attitudes, including thoughts, beliefs, feelings, and behaviour' towards one's body. As such it is not a physical construct but a mental image. Consequently, one's body image is inherently subjective and not static (Pruzinsky 2004: 72–3). Whether or not it incorporates dress remains debatable. The majority of contemporary work on the subject does not acknowledge dress to be part of body image (e.g. Blood 2005, Cash 2004 & 2008, Cash & Pruzinsky eds. 2002, Grogan 1999, Grogan et al. 2013, Thompson 1996, Thompson et al. 1998), in spite of the fact that '[t]he human body is a dressed body,' as Entwistle (2000: 6) puts it so poignantly, even though she herself is not directly concerned with its image.

From the moment we are born we get dressed and remain so in most social situations. The way we perceive ourselves is mediated through dress. Yet, judging from the lack of engagement with the subject of dress in most contemporary analyses of body image, the body in body image is seemingly naked, in spite of the fact that it is almost always dressed (Entwistle 2000)[7]. Whether the concept of body image is a strategic attempt at isolating the naked human body in our perception remains unclear, as the role of our relationship with dress is generally not thematised at all. Schilder (1935/1970: 203), however, who coined the term, took a clear position on this subject, by stating: 'Whatever article of clothing we put on immediately becomes a part of the body-image'.[8] My understanding of self-perception follows Schilder's conceptualisation in taking dress to be part of the way we see, sense and feel about our bodies, but distinguishes between body image and body schema, between conscious and unconscious forms of self representation, as will be discussed in Chapter Six.

[7] The work of Grogan et al. (2013) constitutes a case in point. While their study investigates 'women's experiences of dress fit and body image' (380), thus thematising dress, it starts from the premise that the 'fit of clothes […] can impact body image' (380) rather than the notion that dress forms part of one's body image.

[8] While Schilder's account has to be read with care, as it singles out women's attitude towards clothes, thus tending towards essentialism, it is path-breaking in its acknowledgement of dress, particularly at the time of writing. He recognizes dress to be part of the body-image and dedicates a sub-section to 'Changing the body-image by clothing' (1935/1970: 201–6), maintaining that body image is fundamental to life experience (201). Only very few theorists have since built on this view. Psychoanalyst Garma (1949: 184) has argued that 'in the constitution of the ego, clothing is included in the body image', while psychologist Seymor Fisher (et al. 1968: 23), with reference to Schilder, acknowledges 'the intimate relationship between clothes and other body decorations and psychological variables of a body-image order'. In turn one of Fisher's students, Norma Compton (1964), conducted similar research, and maintains that dress influences the boundaries of one's body image, potentially changing the body image itself (1.3.2.1)[8]. Moreover, in one of his later works Fisher (1973), proposes the term 'body consciousness' to describe the touch sensations and haptic effects of costume on the wearer, thus drawing attention to ocularcentrism within dominant understandings of bodily self-perception and moving towards what has now become understood as 'body schema' (6.1.1).

1.2 'I write for users, not readers.'[9]: A Foucauldian analytical framework

1.2.1 Truth games, power relations and technologies of the self: The analytical triangle

In its analysis this thesis draws on a Foucauldian framework. Both Foucault's concern with the genesis of modern perceptions of self and his radical social constructivism lend themselves to this study. Foucault (& Sennett 1982: 9) once summarised the overall aim of his work as 'a genealogy of the modern subject as a historical and cultural reality'. More specifically, it was his intention to deconstruct those naturalised practices which make us particular human beings, as he elsewhere states with hindsight:

> in my […] work, the target of analysis wasn't 'institutions', 'theories' or 'ideologies', but *practices* – with the aim of grasping the conditions which make these acceptable at a given moment. […] But my project is precisely to bring it about that they [those who work in the institutional setting of the prison or in psychiatric institutions] 'no longer know what to do', so that the acts, gestures, discourses which up until then had seemed to go without saying become problematic, difficult, dangerous. (Foucault 1981: 5 & 12)

This thesis does not share Foucault's 'project' to 'bring about' that practitioners 'no longer know what to do', indicative of a somewhat 'top-down' (Hacking 2004) approach of his early writings in particular, which will be addressed later on. However, his work is very useful in helping to explore and unpack what is naturalised in these settings, to decompose[10] the assumptions and truth games that are formative of the respective dress-related therapeutic practices. What notions of self, dress, body and gender underpin such practices? How is the relationship between dress and self discursively constructed and mobilised in these settings to work on the self?

Moreover, my thesis is not only concerned with the 'acts, gestures, discourses' of practitioners and how these are formative of therapeutic practices, but also with the way these practices are seen to shape subjectivity, the way dress is constructed as a normalising and disciplining technology of the self in such settings, for example. Finally, this thesis, in considering the 'conditions of possibility'[11] of "dress as therapy" and of the respective therapeutic practices, asks how they became what they are, and also explores their emergence[12] and their zero point as Foucault terms it (cited at the

[9] Foucault (1974: 524), this passage has been translated by Clare O'Farrell (2005: 50).
[10] Foucault and the act of decomposition of 'great certainties' is discussed in: Rose, Nikolas (1994) 'Medicine, History and the Present' in: Jones, Colin & Porter, Roy (eds.) *Reassessing Foucault: Power, Medicine and the Body.* Routledge: London & New York, pp. 48–72.
[11] In his introduction to *The Birth of the Clinic* Foucault (1963/2003: xxi–xxii) uses this term: 'The research that I am undertaking here therefore involves a project that is deliberately both historical and critical, in that it is concerned – outside all prescriptive intent – with determining the conditions of possibility of medical experience in modern times. […] It is a structural study that sets out to disentangle the conditions of its history from the density of discourse, as do others of my work'.
[12] For a discussion of Foucault's understanding of the differences between origin (*Ursprung*), descent (*Herkunft*) and emergence (*Entstehung*) and the relevance of the latter two for his genealogy see: Foucault, Michel (1971) 'Nietzsche, Genealogy, History' in: Rabinow, Paul (ed.) (1984) *The Foucault Reader: An introduction to Foucault's Thought.* London: Penguin, pp. 76–100.

beginning of this chapter), providing a history of the present of dress-related therapeutic practices. It thus builds on Foucault's early and late work, drawing on an analytical triangle of his concepts and approaches for both theory and methodology, as outlined below.

The Foucauldian framework of this thesis combines the three analytical cornerstones of his work: truth games, power relations and technologies of the self. Foucault (1984c: 387–8) describes his own work in an interview just before his death in 1984, addressing some of the criticisms that his early work had received concerning a lack of human experience and overemphasis on structures in the process:

> in these three areas – madness, delinquency, and sexuality – I emphasized a particular aspect each time: the establishment of a certain objectivity, the development of a politics and a government of the self, and the elaboration of an ethics and a practice in regard to oneself. But each time, I also tried to point out the place occupied here by the other two components necessary for constituting a field of experience. It is basically a matter of different examples in which the three fundamental elements of any experience are implicated […] each time I have tried to show how the other two elements were present, what roles they played, and how each one was affected by the transformations in the other two.

Here Foucault singles out certain analytical aspects in the three temporal axes of his work, generally divided into archaeology (1961/2001, 1963/2003, 1966a/2002, 1969/2002), genealogy (1975/1995, 1976/1990) and care of the self (1984a/1990 &1984b/1988). In *The Use of Pleasure: Volume 2 of the History of Sexuality*, Foucault (1984a/1990: 4) illustrates his approach through an analysis of sexuality:

> Sexuality was conceived as a constant. The hypothesis was that where it was manifested in historically singular forms, this was through various mechanisms of repression to which it was bound to be subjected in every society. […] To speak of "sexuality" as a historically singular experience also presupposes the availability of tools capable of analyzing the peculiar characteristics and interrelations of the three axes that constitute it: (1) the formation of sciences (*savoirs*) that refer to it, (2) the systems of power that regulate its practice, (3) the forms within which individuals are able, are obliged, to recognize themselves as subjects of this sexuality.

Foucault (1984a/1990: 4–5) goes on to explain that '[t]he analysis of discursive practices made it possible to trace,' firstly, 'the formation of disciplines (*savoirs*)', connoting archaeology; secondly 'the analysis of power relations and their technologies' referring to genealogy; and finally 'modes according to which individuals are given to recognize themselves as sexual subjects', that is, the care of the self. He terms these three the 'archaeological dimension', the 'genealogical dimension', and 'practices of the self', respectively (1984a/1990: 11–2). Rather than theoretical, paradigmatic or methodological shifts, these axes seem to build on and extend one another. Methodologically, archaeology, for example, is still part of genealogy, and, in retrospect, it is the connections between these three analytical aspects, which form the core of his work. As the sociologist Nikolas Rose (1994: 52–3), one of the most prolific British

Foucauldians, puts it: 'it is a matter of the meticulous investigation of the varied and complex ways in which practices of truth situate persons in particular relations of force'.

Consequently, while this thesis is primarily concerned with technologies of the self, explored in detail later on (1.2.3), it also necessarily analyses truth games and power relation at work in respective therapeutic settings which are all three inherently linked in the work of Foucault. The application of this Foucauldian analytical and methodological triangle in my work is indicated briefly, before addressing the concept of discourse, which is central to it.

Foucault (1982: 18) defines technologies of self, this late readjustment to his work, as 'permit[ting] individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality'. This thesis argues that dress in general, and dress-related therapeutic approaches in particular, form part of these technologies of the self. They are employed as ways of transforming patients, normalising their social behaviour, and gendering them or disciplining their "disorder".

Yet, my thesis also addresses the other two 'components necessary for constituting a field of experience,' as Foucault argues: truth games in the production of knowledge and power relations, their mutual dynamic expressed by him as follows:

> We should rather admit that power produced knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault 1975/1995: 27)

Analysing the truth games of "dress therapy", as indicated earlier, means exploring underlying notions concerning the self, body, gender, dress and therapy; and examining the production of objectivity, of a 'regime of truth', defined by Foucault (1984d: 73) as follows:

> Each society has its regime of truth, its "general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanism and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true.

Thus, examining the production of truth around "dress therapy" involves the analysis of the respective regimes of truth and their naturalisations. It entails the analysis of what is naturalised in each of the settings, or the 'common sense' underpinning these, as Catherine Belsey (2002: 2) usefully terms the ''obvious' mode of reading, the 'natural' way' in the context of literary criticism, enabling an analysis of the way these naturalisations are formative of specific practices. It means understanding them as

contingent occurrences. It also means considering their conditions of possibility. What notions of self and of dress enable such practices? How is the knowledge they are based on produced? What made their emergence possible at the time they appeared? Implicated in such an analysis is an exploration of the zero point of dress-related therapeutic practices, investigating when dress began to be considered as a form of therapy in relation to dress, as will be done in Chapter Three, which follows Foucault's genealogical approach. Moreover, the zero point and nature of contemporary therapy culture, and the rise of the notion of a therapeutable and perfectible self, which form the context of the emergence of the dress-related therapeutic practices under review in this thesis, are investigated in some detail later on (1.4).

To illustrate the process of analysing both truth games and correlated relations of power, I will consider the explicitly formulated aim of "Therapy of Fashion", undertaken with female patients in the US throughout the Sixties: to 'recreate healthy feminine characteristics in a selected group of women patients' (Miller et al. 1960: 42). Underpinning this approach are normative notions of femininity, naturalisations of what 'healthy feminine characteristics' are, and the assumption that fashionable dress could 'recreate' these in women, an "obvious" and "natural" constructive relationship between fashionable dress and women. This type of naturalised knowledge enabled such a therapeutic approach in the first place. In turn, however, this type of knowledge was created within a patriarchal tradition, as well as trajectory of medico-scientific and fashion expertise, under whose authority these 'women patients' were being 'recreated' or instructed to 'recreate' themselves.

The use of Foucault's analytical triangle in this thesis draws attention to these power/knowledge relations and power practices, concerning and constitutive of, the self, in which dress is constructed as a normalising, gendering, and ultimately disciplining technology of the self. It should be noted, however, that what is missing from Foucault's work is a differentiation of gender/power relations (Buker 1990, McNay 1992). The example above is indicative of the gender context of "Therapy of Fashion", necessitating an articulation of the gendering intent of this approach. Not only knowledge/power relations, but also the respective gender/power dynamic at work, need to be considered, as they make for distinctive discursive constructions. They determine the discourses that are constitutive of practices, as theorised by Foucault, and can thus be explored in terms of their intended normalising production of body and beauty stereotypes, of gendered identities.

1.2.2 Discourse and its limits

The notion at the heart of the analytical triangle laid out above, which indeed lies at the heart of all of Foucault's work, is that of discourse. While his subject matter ranges from madness, clinics and prisons to sexuality – and the resultant making of the modern self – his objects of study are always discourses. As he puts it: 'The problem which I have set myself is that of the *individualization* of discourses' (Foucault 1968: 54). In *The Archaeology of Knowledge*, his most explicitly methodological work, Foucault (1969/2002: 141) expresses his objective as follows: 'to deal with a group of verbal performances at the level of the statements and of the form of positivity that characterizes them; or, more briefly, it is to define the type of positivity of a discourse'. Thus, the notion of discourse is central to Foucault's work and is defined in this way: 'discourse is constituted by a group of sequences of signs, in so far as they are statements, that is, in so far as they can be assigned particular modalities of existence' (Foucault 1969/2002: 121). This thesis takes up Foucauldian discourse analysis as a qualitative analytical approach for a number of reasons, which are outlined below.

While Foucault's notion of discourse takes language as its starting point, its promise lies in the fact that it extends beyond the purely linguistic dimension. Referring back to his work on *The Birth of the Clinic* Foucault (1969/2002: 37) explains:

> I had to […] recognize that clinical discourse was just as much a group of hypotheses about life and death, of ethical choices, of therapeutic decisions, of institutional regulations, of teaching models, as a group of descriptions; that the descriptions could not, in any case, be abstracted from the hypotheses, and that the descriptive statement was only one of the formulations present in medical discourse.

Thus, to better understand the emergence of the clinic and of medical knowledge as a determinant of the modern individual Foucault (1969/2002: 37–8) argues that one has to study both discursive and non-discursive practices, words and things: 'purely perceptual descriptions, together with observations mediated through instruments, the procedures used in laboratory experiments, statistical calculations, epidemiological or demographic observations, institutional regulations, and therapeutic practice'.

While Foucault worked mainly with textual sources, he draws out practices from texts. Moreover, as indicated above, he resorts to a great variety of sources for his analyses, sources which might be considered unorthodox, unscientific or too informal in the context of more traditional or monodisciplinary academic analyses. 'The juxtaposition of formal with informal knowledges leads to results that are strikingly different from those found in traditional, single discipline studies,' observes Lois McNay (1994: 53) 'The boundaries between different types of knowledge are redrawn and things generally considered unrelated are found to be connected and vice versa'.

Thus, one of the reasons Foucauldian discourse analysis lends itself to this study of dress-related therapeutic practices is that it is such an integrative and open analytical

approach, enabling the incorporation of linguistic and material practices, permitting the study of what is said, thought and assumed about the self, dress, gender and therapy in the respective settings, and of what is done with dress, including how it is used to work on the self. This Foucauldian approach also allows an analysis of the way these discourses are formative of dress-therapeutic practices, of how they are generative of practices of self, and of how they are constitutive of a therapeutic reality, employed to shape subjectivity. Foucault insisted on the subjectifying effect of discourse, he 'emphasized the way the subject was itself produced in the discourse' (Nixon 1997: 303). Foucault (1969/2002: 54) also describes discourses as 'practices that systematically form the objects of which they speak'. Hence, his notion of discourse as constitutive of reality, as 'devices of meaning production' (Rose 1996: 130) is not only useful in terms of the types of data to analyse, but also relevant to what questions to ask of that data, and the way particular discursive constructions underpinning the respective therapeutic settings are formative of particular practices of the self, as illustrated in relation to this study later on (2.3).

Moreover, Foucauldian discourse also contains silences: 'There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses' (Foucault 1976/1990: 27). It thus permits the study of linguistic gaps, of everything that is not said but could be (both grammatically and logically) (Gutting 1989: 231), and of silences that are normally difficult to conceptualise, yet, that are prevalent in the under-researched and under-analysed field of "dress therapy". Finally, as Foucauldian 'discourse itself is a regulative and regulated formation' (Hall 1996: 11), it draws attention to questions of power, as indicated earlier, indeed, to the multi-directional nature of power relations (Foucault 1976/1990); and it facilitates their analysis in relation to truth games and technologies of self.

It is precisely the multi-dimensional nature of Foucauldian discourse that is of interest to this thesis, and which has been taken up in the work of a number of theorists (e.g. King 2003, Maasen 2003, Nixon 1997). Yet, the notion of discourse has also been criticised for being too vague, for not designating a 'well-defined theoretical object' (Freundlieb 1994: 153). There are two main points of critique, raised by several writers: firstly that the relationship between discursive and non-discursive practices is never clearly delineated by Foucault, and secondly its denial of human agency (Freundlieb 1994, Gutting 1989, McNay 1994), which will be discussed in some detail below.

While Foucault studied both discursive and non-discursive practices as well as institutions in the context of his analyses of the clinic, the mental asylum and the prison, he never clearly addressed the relationship between the two in these works. 'In fact, I deal with practices, institutions and theories on the same plane,' Foucault (1966b: 262)

states in an interview and adds 'All these practices, then, these institutions and theories, I take at the level of traces, that is, almost always at the level of verbal traces'. But he does not delineate the way these are related (Freundlieb 1994: 175, Gutting 1989: 249 & 259). One brief comment can be found in a discussion of *Discipline and Punish* where Foucault (1981: 5) explains: 'practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect'. In the context of this thesis, practices are thus understood as existing on two levels: non-discursive practices ('what is done') that form part of discourse, and practices that have been formed by discourse ('places [where discourse] interconnect[s]'). For example, everything that is said and done in the context of "Therapy of Fashion", all the discursive and non-discursive practices constitute its discourse which in turn forms the overall therapeutic approach, the practice of "Therapy of Fashion".

Other issues concerning Foucauldian discourse, which need to be addressed when applying it, are questions of completeness, cultural specificity and ethnocentricity. For *The Birth of the Clinic* Foucault (1966b: 263) claims to have 'read every medical work' and insists that 'One ought to read everything', as will be discussed in more detail in Chapter Two. Undertaking an analysis of three dress-related therapeutic settings rooted in different countries and disciplines, one has to concede that the discourses described and analysed will be incomplete. I would argue that any cultural analysis is 'intrinsically incomplete' (Geertz 1993: 29) and had better acknowledge its limits.

Thus, taking into account the cultural specificity of the three therapeutic settings under review in this thesis, acknowledging the national, cultural and academic particularities of discourses, an exhaustive description and analysis cannot be the aim. Indeed, Foucault has been criticised for somewhat generalist accounts of his 'fields of experiences,' as McNay (1994: 26) writes in relation to his *Madness and Civilisation*: '[the] argument that the specificities of French, English and German experiences of madness are effaced under the general term of the classical experience signals later criticisms that were to be made about the ethnocentricity of Foucault's analyses'[13].

Consequently, particular attention is paid in this thesis to the specificity of the respective experiences of "dress therapy". To counter generalist assumptions concerning Western culture my thesis attempts to take into account the national, cultural and discipline-specific distinctiveness of the discourses of self, dress, the body and gender underpinning and in turn formative of the dress-related therapeutic practices it examines, as outlined in Ch. 2.3.

[13] McNay refers to H.C. Erik Midelfort essay 'Madness and Civilization in Early Modern Europe: A Reappraisal of Michel Foucault' in: Malament, Barbara C. (ed.) (1980) *After the Reformation: Essays in Honor of J.H. Hexter.* Manchester: Manchester University Press, pp. 247–65.

Returning to Foucault's notion of discourse, the second point of critique, the denial of human agency, raised by a number of writers (Freundlieb 1994, Gutting 1989, McNay 1994) will now be addressed, as it constitutes an important parameter for this thesis, particularly in its methodological consequences. In his conceptualisation of the term Foucault (1969/2002: 60–1) maintains that discourse does not originate from man:

> Thus conceived, discourse is not the majestically unfolding manifestation of a thinking, knowing, speaking subject, but, on the contrary, a totality, in which the dispersion of the subject and his discontinuity with himself may be determined. It is a space of exteriority in which a network of distinct sites is deployed. I showed earlier that it was neither by 'words' nor by 'things' that the regulation of the objects proper to a discursive formation should be defined; similarly, it must now be recognized that it is neither by recourse to a transcendental subject nor by recourse to a psychological subjectivity that the regulation of its enunciations should be defined.[14]

Foucault aims to decentre the coherent, all-knowing Cartesian subject, but is ultimately vague about the origin, or rather emergence, of discourse and the capacity of humans to influence it, stating only that people are subjectified by the discourse they are the object of. While it is important to acknowledge the contingency of discourses and the exteriority of social and scientific institutions and structures, is it not people who comprise these institutions and structures? In the context of dress-related forms of therapy there are certainly key-figures who determine what is said and done in the respective settings: scientists providing academic legitimisations; doctors contributing clinical expertise; therapists giving practical experience; fashion designers, stylists, and volunteers supplying dress and advice. The sum of all these individual opinions and statements might be greater than their individual parts, it might be contingent, might indeed have become independent. That sum and these individuals are certainly influenced by clinical structures, institutional practices, regulations, and official discourses concerning the self, therapy, gender, body and dress. However, scientists, doctors and therapists – the people working with the patients with dress on their self constitute vital components, and indeed are agents in determining the everyday workings of the therapeutic practices under review.[15]

One of the frequent criticisms of Foucault is his neglect of agency, the fact that 'he attributes more power to institutions than to people' (Tynan 2016: 187). Particularly within, his early works, his archaeologies, little attention is paid to human agency, as can be seen in *Madness and Civilisation* (1961/2001), for example. However, an important counterbalance can be found in another work on madness and its institution, published in the US in the same year, 1961, by the sociologist Erving Goffman. As an influential critic of institutional psychiatric treatment[16], Goffman undertook a field study at St

[14] For further comments on 'the subject of the statement' see Foucault (1969/2002: 107).
[15] Not forgetting the capacity of the patients to influence therapeutic practices. This will be discussed later on, but is ultimately not the concern of this thesis.
[16] For a discussion of Goffman's thinking concerning mental illness and institutionalisation see: Manning, Philipp (1999) 'The Institutionalization and Deinstitutionalization of the Mentally Ill: Lessons from Goffman' in: Chriss, James J. (ed.) *Counselling and the therapeutic state*. New York: Aldine de Gruyter, pp. 89–104.

Elizabeths Hospital, Washington, D.C., a federal institution of approximately 7000 male and female 'inmates' at the time (1961: 7), which he published in the form of essays on the 'Social Situation of Mental Patients' in his book *Asylums.* Through this yearlong observational study, he intended to 'learn about the social world of the hospital inmate, as this world is subjectively experienced by him'[17] (7) in the context of 'total institutions', Goffman's overarching concern, as he explains:

> The total institution is a social hybrid, part residential community, part formal organization; therein lies its special sociological interest. There are other reasons for being interested in these establishments, too. In our society, they are the forcing houses for changing persons; each is a natural experiment on what can be done to the self. (Goffman 1961: 22)

The fact that the sociologist considers dress to be a vital component of the 'social world of the inmate' and 'total institutions' makes his work ever more relevant for this thesis, which effectively explores how dress is being employed in specific psycho-medical therapeutic settings to work on the self, how dress is seen to 'change' people. Goffman's analysis of the role of dress in 'total institutions' will be discussed in Chapter Three (3.3.2.1).

While both Foucault and Goffman were interested in the way institutions subjectified people, their approaches to studying this process differed. Goffman followed a micro-sociological approach, undertaking participant observation and interviews; while Foucault pursued with his archaeology, as outlined above, a much more 'top-down' approach, as Canadian philosopher and Foucauldian Ian Hacking (2004) puts it. In an insightful article he brings these near-contemporaries together and argues in relation to their key works of 1961 that Foucault and Goffman's differing methodologies reinforce and complement each other, which is also illustrated, in some ways, in this thesis.

Hacking (2004: 278) describes Foucault's work as 'top-down' because it is concerned with 'discourse in the abstract,' as 'he starts with a mass of sentences at a time and place, dissociated from the human beings who spoke them, and uses them as the data upon which to characterize a system of thought'. Goffman's approach, in contrast, is termed 'bottom-up', as it focuses on 'face-to-face interaction', and on 'individuals in specific locations entering into or declining social relations with people' (278). Hacking (2004: 278) argues that both theorists were effectively concerned with discourse, but Goffman was also concerned with 'concrete conversation' and 'social exchanges' including silences and how they 'constitute lives'.[18]

[17] Although St Elizabeths Hospital was an institution for both men and women, Goffman generally refers to patients as 'he'. Even when discussing the dress of patients, he does not make any distinctions.

[18] Hacking (2004: 278) details: 'He scrupulously notes the social exchanges between individuals, not only the words but also the tone, the accent, the body language, the gestures, the withdrawals, the silences. But Goffman was not reporting individual exchanges for their own sake. One of his projects was to understand how people were constituted, defined themselves and were understood by others, in terms of exactly such interactions. I call this 'bottom-up' because we start with individual face-to-face exchanges, and develop an account of how such exchanges constitute lives'.

Although Hacking (2004: 299) maintains that Goffman's work is 'essential for coming to understand how people are made up day by day, within an existing institutional and cultural structure,' he sees limits in the way Goffman 'completely omitted […] the question of how institutions come into being and what organizations of thought and statements have to do with our thinking of them as natural, as part more of the found order than the order of things made by people'. The answers, however, can be found in Foucault, who, Hacking (2004: 300) argues, also gave us 'ways in which to understand what is said, can be said, what is possible, what is meaningful – as well as how it lies apart from the unthinkable and indecipherable'. Yet, '[h]e gave us no idea of how, in everyday life, one comes to incorporate those possibilities and impossibilities as part of oneself. We have to go to Goffman to begin to think about that'. Consequently, Foucault's archaeology and Goffman's interpersonal sociology complement and reinforce each other as methodologies, according to Hacking (2004: 288), who summarises their combined potential as follows:

> Foucault proposed his various ideas of a structure that determines discourse and action from the top down. Goffman gave us the local incidents and idiosyncrasies that lead us from the bottom up. Both are essential for understanding what I call making up people.

Since his own work is concerned with 'making up people', as Hacking (2004: 287) puts it, he proposes the use of both the archaeological and sociological approach 'to better understand the ways in which the actual and possible lives of individuals are constituted' (2004: 288). This methodological combination informs this thesis to a certain extent, since it combines historical methods for its genealogical enquiry of "dress as therapy" with sociological methods to explore the three therapeutic settings – as a basis for the analysis of their discursive construction, as outlined in Chapter Two.

Building on Hacking's remarks, I would further argue that Foucault's approach tends to be 'top-down' in the way he writes about the people that make up the institutions he studies, while Goffman's 'bottom-up', actor-oriented approach results in a more empathetic reading of the employees in such institutions. For example, in addressing an ambiguity between official and unofficial functions of total institutions Goffman (1961: 73) states: 'This contradiction, between what the institution does and what its officials must say it does, forms the basic context of the staff's daily activity,' thus displaying an understanding of the possible dilemma the practitioners at such institutions might find themselves in. Foucault (1981: 12), on the other hand, defines his 'project' as bringing about a situation whereby the staff 'no longer know what to do', as quoted at the beginning of this section, in which their hitherto naturalised practices become 'problematic, difficult, dangerous'. I found Foucault's predicament itself problematic, not only for my face-to-face interaction with different practitioners, whereas Goffman's actor-

oriented approach proved more helpful and viable in the process of both studying and writing about the people involved in “dress therapy”.

In conclusion, it can be said, that, while some aspects of Foucault’s notion of discourse are contentious, it offers a fruitful analytical approach to processes of subjectification based on concrete practices. Moreover, it should be noted that Foucault himself pre-empted some of the criticism directed at his early writings and showed greater concern with agency in the final axis of his work: the care of the self. In particular his notion of technologies of the self, as outlined below, is compelling for a conceptualisation of the way the physical practices of “dress therapy” are employed to act on and determine the self.

1.2.3 Technologies of the self

> So it is not enough to say that the subject is constituted in a symbolic system. It is not just in the play of symbols that the subject is constituted. It is constituted in real practices – historically analyzable practices. There is a technology of the constitution of the self which cuts across symbolic systems while using them.
> (Foucault 1983: 369)

The notion of technologies of the self was first conceptualised by Foucault in seminar presentations in 1982, and developed in his late publications (1984a/1990 & 1984b/1988). It describes specific historico-cultural physical or mental practices directed at transforming the self 'to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (Foucault 1982: 18). Foucault identifies such technologies in his analyses of ancient Roman and Greek practices of the self, such as dream analysis, diary writing or particular diets.

As previously argued, this notion emerged in the process of a self-critical revision of Foucault's earlier work, which placed almost exclusive emphasis on power:

> Foucault concedes that the emphasis he placed there on the effects of power on the body resulted in a one-dimensional account of social agents as 'docile bodies' and a correspondingly monolithic account of power. In order to obtain a fuller understanding of the modern subject, an analysis of *techniques of domination* must be counterbalanced with an analysis of *techniques of the self.* (McNay 1994: 134)

While technologies of the self are still 'conducted within fields of power-knowledge and within the domains of a discrete number of discourses' (Nixon 1997: 322), this notion opens up the analytical triangle outlined above, to permit a greater concern for human agency. In the context of this thesis, it constitutes a fruitful line of inquiry, enabling the analysis of dress-related therapeutic approaches as concrete, analysable practices, which are seen as constitutive of notions of self, and relatable to the body. Moreover, the idea that there are 'historically specific ways of making ourselves particular human beings,' as Entwistle (2000: 113) defines such technologies, suggests that the relationship between body and self is not natural but constructed. 'Foucault's major contribution to this line of thought,' of subjectification, argues Armstrong (1994: 22), 'is the insight that individuality was not simply an idea but its concrete realization in the facticity of the body. New knowledges (pathological medicine) serve new social practices (those of clinical medicine), which produce real objects (the body)'.

While Foucault, throughout his work, was concerned with the way human bodies were normalised, categorised, surveyed, and (de)sexualised, as well as the way particular human bodies and beings were created in the process, it is in the idea of technologies of the self that he links the human body to the notion of self in a systematic way. As early as 1975 in *Discipline and Punish*, Foucault had charted the genealogy of the modern Western penal system and its practices of disciplining human bodies to

create 'docile bodies'.[19] One year later in *The History of Sexuality: Volume 1* Foucault (1976/1990) formulates his notion of biopower[20], describing the way power is used on the body, the way particular bodily practices are imbued with power that force the self to be transformed or oblige people to transform themselves. Finally, in the phrase technologies of the self Foucault identifies a discrete term for the physical and mental practices that make us individuals, shaping our bodies and selves. This concept together with his notion of biopower, is highly useful for the exploration of coercive bodily practices, such as dressing patients in mental hospitals. Moreover, dress itself can thus be analysed as a form of regulation and control, which is employed to impact on bodies and to fashion them, and which is situated in, and comes out of specific moments that require consideration. Foucault's notion of technologies of the self draws attention to their contextual specificity, as they are not universal, but constitute 'historically varied performances' (Nixon 1997: 323) which can potentially be analysed for each culture and period. Further particularities concerning the analysis of technologies of the self are highlighted by Foucault (1983: 369–70) himself:

> Techniques of the self, I believe, can be found in all cultures in different forms. Just as it is necessary to study and compare the different techniques of the production of objects and the direction of men by men through government, one must also question techniques of the self. What makes the analysis of the techniques of the self difficult is two things. First, the techniques of the self do not require the same material apparatus as the production of objects; therefore they are often invisible techniques. Second, they are frequently linked to the techniques for the direction of others. For example, if we take educational institutions, we realize that one is managing others and teaching them to manage themselves.

While the dress-related therapeutic approaches under review in this thesis might present themselves as 'visible techniques' of the self, as they are openly concerned with the self, they also constitute invisible techniques in their naturalised notions of femininity and physical beauty. Moreover, they are certainly 'techniques for the direction of others'. The "dress therapist", not unlike the teacher, manages patients and teaches them to manage themselves with the use of clothing. This didactic dimension also illustrates the power relations embedded in technologies of the self, which 'are always practiced under the actual or imagined authority of some system of truth and of some authoritative individual, whether these be theological and priestly, psychological and therapeutic or disciplinary

[19] Concerning critiques of Foucault's formulation of the body as a passive entity, the sociologist and fashion theorist Elizabeth Wilson (1992: 10) makes the following comment: 'He has been accused of discussing the body as a passive object, of treating it as the ultimate 'given', as a kind of bedrock or raw material for the play of the social, but at least he puts the body back into the social sciences, understanding that it is a social construction as well as a biological entity'.

[20] Foucault (1976/1990: 140) defines biopower with reference to 'an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations' and describes biopolitics, biopower at state level as follows: 'In concrete terms, starting in the seventeenth century, this power over life evolved in two basic forms; these forms were not antithetical, however; they constituted rather two poles of development linked together by a whole intermediary cluster of relations. One of these poles – the first to be formed, it seems – centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forced, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the *disciplines:* an *anatomo-politics of the human body.* The second, formed somewhat later, focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and *regulatory controls: a bio-politics of the population*' (1976/1990: 139).

and tutelary' (Rose 1996: 135). Consequently one has to consider the Foucauldian analytical triangle, as outlined above, made up of technologies of truth, power and self, in its totality.

This section has shown the different ways in which the work of Foucault informed my thesis, both theoretically and methodologically. The analytical framework brings together different temporal stages of his work, consolidating his early and late writings, as well as considering its limitations and looks to other theorists and theories to complement it. Foucault (1974: 523–4) himself practiced and encouraged the 'unfaithful' engagement with and application of his work, stating: 'I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area [...] I don't write for an audience, I write for users, not readers'.

Thus, the analytical framework of this thesis combines the different approaches and themes of his work. His notion of discourse will be adapted and extended to contain spatial, visual and tactile elements, the non-discursive dimensions of what is done in the various therapeutic settings, such as the dress involved or the layout of the rooms. The notion of discourse will be broadened to contain a degree of human agency, which is enabled through the adoption of Foucault's late concept of technologies of the self in its acknowledgement of the specificity of different cultural contexts. These are important for my analysis of the different ways in which the relationship between dress and the self is discursively constructed and mobilised in the various therapeutic settings, and of how these very discourses are formative of therapeutic practices. Moreover, the concept of technologies of the self, which enables the consolidation of discourses and agency, in turn, constitutes a compelling concept to explore such practices employed to make patients particular human beings through dress, as normalising and disciplining technologies of a dressed, embodied, gendered, therapeutable self.

Having introduced my project and sketched its analytical framework, I will now discuss the different thematic strands which form the context of this thesis, firstly literature on "dress as therapy" and, secondly, therapy culture and attendant notions of a therapeutable self, within which the therapeutic practices under review in this thesis are situated.

1.3 "Dress as therapy"

1.3.1 Working with dress on the self

Recent decades have seen the rise of discourses linking dress to the self in a formative way. The dress-related therapeutic approaches which are the subject of this thesis constitute only one example. Besides some psycho-medical publications (1.3.2), and a growing body of academic theoretical accounts on the relationship between dress and identity[21], the period from approximately 1985–2016 has witnessed a vast expansion of a popular discourse of fashion and identity. Apart from the vast apparatus of the fashion press, the prominent field of image and style consulting, which also grants a particular productive importance to dress in relation to the self, constitutes a prime example of this increase. It comprises popular practices and publications where dress is employed, appearances are managed and bodies shaped to project a particular image, one that promises a more "successful" self. The period from approximately 2005–2016 in particular has seen a significant number of style guides, marketing advice on life/style, dress and fashion in different media, predominantly to women, but also increasingly to men (e.g. Freer 2015, Halbreich 1997, Kressley 2005, Levene & Mayfield 2001, Lustig 2012, Mather 1996a&b, McWilliams 2004, Plummer 2009, Reed 2005, Wan 2009, Woodall & Constantine 2000, 2001, 2002, 2003, 2005, 2008)[22]. The titles of these books and programmes are indicative of their authoritative claims: by telling people *How to Dress* (Reed 2005) or how to *Dress for Success* (Molloy 1975) the authors and presenters assume authority over their readers on questions of style and taste. By determining *What not to Wear* (Woodall & Constantine 2001, 2002, 2003) they play with, and bank on, social anxiety connected to appearance (Clarke & Miller 2002).

Moreover, these style and dress manuals suggest that the self can literally be made-over and developed through dress: that it can be treated and perfected. They could thus be said to have been enabled through, what Rose (1996) terms the 'generosity' of the "psy" disciplines, the way the 'psychosciences and disciplines – psychology, psychiatry and their cognates' (Rose 1994: 2) have expanded into informal knowledge spheres. As such, they lend their 'vocabularies, explanations and types of judgement to other professional groups' (Rose 1996: 139), which, in turn, take on the role of 'assistant therapists', according to Hellerich (1985), who describes this 'therapeutic penetration of

[21] The body of theoretical publications on the relationship between dress and the self is rich and diverse, rooted in a number of disciplines, as indicated here in relation to some of its key works: sociology (Blumer 1969, Crane 2000, Davis 1992, Goffmann 1959/1971, König 1973, König & Schupisser eds. 1961, Lipovetsky 1994, Stone 1962, Wilson 1985) sociology of the body (Entwistle 2000, Turner 1979/1993); cultural studies (Craik 1994, Hebdidge 1979, Kaiser 2012), social psychology (Atkins 1976, Dubler & Gurel 1984, Flugel 1930/1950, Hoffmann 1985, Humphrey et al. 1971, Kaiser 1997, Kwon 1991, Lennon et al. 2017, Solomon ed. 1985, Sommer 1989), gender studies (Barnes & Eicher eds. 1992, Tseëlon 1995), material culture studies (Clarke & Miller 2002, Woodward 2007) and anthropology (Eicher 1995, Johnson & Foster eds. 2007, McCracken 1990, Weiner & Schneider 1989) with very few interdisciplinary works (Horn 1968/1975), or anthologies (Gonzales et al. eds. 2012, Roach-Higgins et al. eds. 1995).

[22] Some identity aspects of these practices are discussed in Holdermann (2003).

professions'[23] (94) as a 'revolution of assistant therapists'[24] (119). Consequently, it could be argued that these publications and practices have also, just like the chosen dress-related therapeutic practices, come out of our prevalent therapy culture, developed since the 1960s (1.4). Moreover, both, the dress-related psycho-medical therapeutic practices and the more populist field of style guidance are underpinned and ultimately enabled by a certain perception of the self, an understanding of the self as immanent in appearance.

As previously outlined, particular notions of the self underlie the dress-related therapies analysed in this thesis. Such notions are part of the conditions of possibility of working with dress on the self in therapeutic settings, and also in the context of dress guidance. They are all predicated on the idea of the self as changeable and therapeutable (1.4.2), specifically through dress which is capable of altering both body and self. Consequently these practices and therapies are distinctly contemporary, not only because they are enabled by the rise of therapy culture, but also because they rely on the modern idea that our outer appearance is linked to the self.

The seminal work of sociologist Richard Sennett (1976), *The Fall of Public Man*, explores in rich detail the way in which industrial capitalism and secularisation have given rise to the notion of personality and the belief that appearance is indicative of it. In his analysis of the dichotomy between the public and private realms in modernity Sennett addresses the contemporary belief that clothes communicate an authentic self (1976: 153): 'One is what one appears; therefore, people with different appearances are different persons. When one's own appearances change, there is a change in the self' (152). His account is based on a number of literary sources, such as the Scottish writer Thomas Carlyle (1798–1881), for whom clothes had become 'unspeakably significant' (1833–4/1987) because, as Sennett (1976: 153) explains:

> appearances made in the world are not veils but guides to the authentic self of the wearer. One really knew about the person by understanding him at the most concrete level – which consisted of details of clothes, speech, and behaviour. […] clothes […] were clues to private feeling; conversely, "the self" no longer transcended its appearances in the world.

Similarly, in the work of the French novelist Honoré de Balzac (1799–1850), 'clothes are a favourite subject for showing the presence of individual personality in all appearances. Not only do clothes reveal the character of those they drape; changes in clothing prompt Balzac's characters to believe they have become new persons' (Sennett 1976: 159).

In many ways Sennett's writing on the subject constitutes an extension of the work of the German sociologist Norbert Elias (1939/1978) on the 'civilising process' in Western Europe from the Middle Ages onwards. Although dress as a technology of the

[23] Quotations from works, which are referenced in the bibliography in a language other than English, have been translated by me. The original language version is always included in a footnote. In this case: 'Die therapeutische Penetration der Professionen.' (Hellerich 1985: 94)
[24] 'Die Revolution der Hilfstherapeuten.' (Hellerich 1985: 119)

self is not directly addressed, it is implied by Elias' analyses of manners and codes of behaviour.[25] Sennett's work in turn has been taken up by a number of contemporary academic writers concerned to contextualise the belief that appearance and self are linked. Fashion in relation to dress has become a metaphor for modernity (Wilson 1985), while contemporary theoretical discussions highlight the importance of dress in relation to the self: in a late-modern consumerist setting, fashionable dress, in particular, is said to play a central role in the construction and maintenance of identity (e.g. Davis 1992, Finkelstein 1991, Giddens 1991, Kaiser 1997). It is heavily theorised as a central marker of identity within late twentieth-century consumer society (e.g. Finkelstein 1991 & 1996, Simmonds 1990, Wilson 1992); and as the most important form of non-verbal communication (e.g. Stone 1962, Hoffmann 1985, Davis 1992, Barnard 1996); while appearance is said to be a 'central element of the reflexive production of the self' (Giddens 1991: 99–100).

With regards to Sennett's work it should be noted that his use of French, American and British literary sources is very rich, yet he does not acknowledge their cultural differences, thus, seemingly erasing the cultural specificity of modernity under the rubric of the 'fall' of public modern Western man. This notwithstanding, his assessment of the modern self as immanent in appearance, and, his influence on other cultural historians and theorists as outlined above, are vital for an understanding of one of the general, and indeed key, conditions of possibility for working with dress on concepts of self, be that therapeutically or in the context of style guidance.

While I have argued that both these fields of experience have been determined by therapy culture and are underpinned by particular notions of the self as visible in, and changeable through, dress, and that dress guidance could be seen as part of the discourse of "dress therapy" in a wider sense, there are nevertheless clear differences between the two fields. The psycho-medical institutional context of "dress therapy" as explored in this thesis marks a distinct field, including a particular trajectory of emergence, as explored in detail in Chapter Three. In contrast, it is essentially consumption which lies at the heart of style and image guidance. Despite the fact that they might be didactically or therapeutically underwritten, and that some of them might emphasise dressing for the 'inner' self (McWilliams 2004) or to alter one's body shape (Woodall & Constantine 2008), rather than following trends, virtually all of these popular guides and consultants are contributing to a fashion dictate by telling people 'what to wear' – now. Alongside the fashion media, and the two are often directly connected through employment, endorsement or sponsorship, style guidance is involved in

[25] For a discussion of Elias' 'civilizing process' in relation to dress and fashion see: Evans, Caroline (2003) *Fashion at the Edge: Spectacle, Modernity and Deathliness.* New Haven and London: Yale University Press.

artificially and discursively producing changing fashion rules which in turn accelerate consumption. As such it is a commercial endeavour, not only part of therapy culture, but also of the beauty and fashion industry in a wider sense. This more or less overtly commercial context demands a different framework and analysis, and while it remains to be seen how far the dress-related therapeutic practices under review might also be implicated in this, it is not the focus of this thesis.

In contrast to the wealth of popular literature on style guidance and academic works on dress and identity, only very limited material on "dress therapy" is available. The fact that there is no analytical study of this field might not be surprising, because "dress therapy" as a term is an operative one, proposed in the context of this thesis to comprise a number of different dress-related therapeutic practices, both historical and contemporary. However, even in relation to the specific settings selected for this research ("Therapy of Fashion", *vêtothérapie*, and sensory stimulation treatment) no analytical studies exist. Consequently, this thesis not only analyses the conditions of possibility and discursive construction of each practice as technologies of the self, it also documents and collates evidence of the practices as important primary material.

The available accounts of the three chosen practices can be roughly divided into two categories: academic papers and popular journalistic articles. Moreover, in the context of *vêtothérapie* two unpublished documents of practice notes were given to me, intended for internal use only, see Descloux et al. (2001), and Kagan (2008). The academic papers are written by medical staff involved in the therapies. They are mostly published in medical journals or conference proceedings: for "Therapy of Fashion" see Miller et al. (1960); for *vêtothérapie* Battista Dubreuil (2004), Kagan et al. (2012), Rufo (1999 and 2007); and for sensory stimulation treatment Grunwald & Weiss (2005), Grunwald (2008), ÖGKJP (2015). In the second category of publications, popular journalistic articles, sensory stimulation treatment only received limited media attention[26], however, both "Therapy of Fashion"[27] and *vêtothérapie*[28] generated a number of articles and television and radio programmes when they were first launched, as these therapies were also actively endorsed by the respective fashion professionals involved. While these sources will be employed and some of them discussed in the way they present their research in the respective chapters, their different uses are briefly indicated below.

[26] science journalism (Blakeslee 2007, Henschel 2004), popular journalism: television (3 sat 2010 & 2016, mdr 2010), online or print (Hilgemeier 2016, Mazhar 2013, Niemann 2009, Segler 2011, Stoll 2014)
[27] daily newspapers (e.g. Andresen 1962, Cline 1960, Clinton 1960a–i, elena 1962&64, Nelson 1960, Sweeney 1963a–i &1964, Thompson 1962a, Tucker Neep 1962&1963, Willis 1962), magazines & journals (Silverman & Silverman 1961, Thompson 1962b)
[28] daily newspapers (e.g. Carquain 1999, Rotman 2001, Saint-Jean 2001), weekly and monthly magazines (e.g. Gaulme 2001, Rachline 2000, Rault 2001, Sultan 2001a&b), radio (Banoun 1999, Baudu 1999, Chimot 1999, Loriol 1999), television (France 3 2000a&b, Lacombe 1999, Leymergie 2001, Pallet 2000, Purdon 2000), international press (Goodchild & Sheppard 2001, Groskop 2001a&b, Rose & Allan 2001, Sage 2001)

Within both categories a descriptive mode prevails, including very little analysis. Three types of data can be gathered from these sources: visual data (e.g. primary evidence regarding therapeutic spaces, garments and physical demeanour), statistical evidence (e.g. number of staff and patients involved, dates), and discursive data (syntax as indicative of underlying values and intended aims), providing invaluable information about settings, structures, objectives and therapeutic processes, participants and the dress used as well as contact details. What is striking about virtually all of the academic papers is their lack of evaluation.[29] Hardly any of the authors comment on the success or limitations of the respective therapeutic approaches, for which one has to turn to the popular accounts. These in turn, although not analytical, provide quotations and evaluative statements made by both staff and patients. While I have focused on direct quotations included in the articles to assure a greater likelihood of authenticity, this is not guaranteed and the material has to be read accordingly. Moreover, some of the sources on both "Therapy of Fashion" and *vêtothérapie* throw up a number of ethical concerns in their unanonymised representation of patients, as will be discussed within my methodology (2.2.6).

As indicated above, the limited material available on "dress as therapy" has certain methodological and analytical consequences. Firstly, it entails charting the field of "dress therapy" as a contemporary field of experience in which two key defining discourses concerning present-day notions of self come together: (fashionable) dress and therapy. Secondly, it involves the research and documentation of individual practices that make up this field. And thirdly, it calls for an analysis not only of what these practices are and do, but also of how they have become what they are, their conditions of possibility. Consequently, this thesis explores how the relationship between self and dress is discursively constructed and mobilised in the respective settings, generative of particular therapeutic practices; and how these, in turn, are employed as technologies of self. Moreover, as part of their conditions of possibility, it investigates the zero point of such practices, exploring the various roles and uses of dress in relation to the self in institutionalised psycho-medical history from the mid-eighteenth to the twentieth century in the countries concerned (Ch.3). While the perception and role of dress in relation to the self in the psycho-medical institutional context is analysed in detail in Chapter Three, there is also what might be termed, a non-institutional psychological body of work, a series of writings by psychologists and psychoanalysts on the use of dress in psychotherapeutic practice, which will be reviewed before the exploration of therapy culture.

[29] Grunwald (2008) and Grunwald & Weiss (2005) on sensory stimulation constitute an exception, presenting statistical data in the form of a table of measurements taken at different points of the research and giving evaluative commentary, indicative of their disciplinary background of natural sciences.

1.3.2 From 'conspicuous attire' to 'psychotherapeutic experiences with the healing power of dress': Reflections on the use of dress in relation to the self in non-institutional psycho-medical therapeutic practice

1.3.2.1 Dress as part of the diagnostic process

> An examination of clothing may be of help to the clinician. Badly-fitted clothing, for example, in an adult may suggest a marked recent change in body weight. Unexpectedly odd clothing, or dirty clothing, are characteristic of the lax habits of the tramp or the drug addict; they may suggest the presence of mental disease. (Renbourn 1971: 12)

The role of dress in psycho-medical history has received little attention.[30] The way it has been used in relation to the self remains under-analysed. While the seemingly "naked" patient within institutionalised psycho-medical history will be explored in Chapter Three, this section brings together and reviews the few existing sources by psychologists and psychoanalysts on the use of dress in psychotherapeutic non-institutionalised practice.[31] These somewhat scattered reflections by Western Europe and North American practitioners originate from different contexts and moments, mainly in the twentieth century. They are, however, all underpinned by the belief that the modern self is immanent in appearance, as outlined above. As such, these reflections could be regarded as a preparatory discourse, part of a wider psycho-medical discourse, which makes the inclusion of dress in the institutionalised therapeutic setting viable, which enables dress-related therapeutic practices, part of their conditions of possibility. Moreover, such therapeutic texts, as Illouz (2008: 178) points out 'become translated into practice because from the start they were texts that were *performed*'. While some of these texts are accounts of a therapeutic performance involving dress, most include instructions for such a performance. They also constitute treatment manuals for working with dress on the self, a discourse intended on generating practices.

These sources can be categorised into two groups: the first arguing for, or employing, dress as part of the diagnostic process (Bergler 1953/1992, Bonelli 2012, Compton 1964, Garufi 1983, Kawohl 1990, Marjasch 1983, Renbourn 1971), the second arguing for it to be part of the treatment itself (Garufi 1983, Giddon 1985, Hall 1898, Kawohl 1990). This

[30] Three detailed articles on dress in the psycho-medical setting of, predominantly, nineteenth-century England should be mentioned in this context: Andrew (2007a&b) exploring representations of and actual dress provisions of the mad poor in England between 1650–1850; Wynter (2011) analysing appearance and dress at Staffordshire County Lunatic Asylum from 1818–1854; and Baur & Melling (2014) discussing the uses of dress in the admission, care and employment at provincial asylums in Devon between 1860–1960. These analytical studies are of some relevance in Chapter Three, although their focus lies on the role and provision of dress rather than its therapeutic employment.

[31] The distinction between institutionalised and non-institutionalised treatment is drawn here, because the former entails different dress needs and considerations regarding clothing inpatients for the different occasions of institutional life, as will be discussed in detail in Chapter Three.

section focuses on the first group, on dress as a diagnostic tool, while reflections that move towards a "therapy of dress" are discussed below (1.3.2.2).

> I have the feeling that working hour after hour in the consulting room, many analysts feel rather remote from the fashion scene. This is a pity, because such an attitude might further the shifting of attention from the creative process of fashion to the end product. Generally speaking: an increased awareness of on-going processes is needed to balance all the accumulated knowledge that wants to be applied. [...]
>
> Not long ago a young man came to see me because he felt very blocked. He was clad in old black clothes and had very thick glasses. He dressed as if he wanted to make himself invisible and was all the more conspicuous. Soon afterwards he could vent his anger very successfully and as a result of unblocking, his outer appearance changed considerably in the following weeks. He now wore jeans and shirts of light, washed-out colors and had exchanged his glasses for contact lenses. He had literally brightened up. (Marjasch 1983: 143)

The above therapy notes by psychotherapist Sonja Marjasch are indicative of the prevailing approach to interpreting dress in relation to the self in these psycho-medical sources: literal, stereotyping, and somewhat reductive. They are seemingly predicated on the notion that the outer self is indicative of the inner self, as well as its converse argument, that the negligence of appearance or divergence from normative dress standards could thus be seen as revealing a "disordered" mind. In *Behaviour in Public Places* Goffman (1963: 27) comments on such appearance-based judgments of mental states:

> the importance of a disciplined management of personal front is demonstrated in many ways by the mentally sick. A typical sign of an oncoming psychosis is the individual's "neglect" of his appearance and personal hygiene. […] Similarly, when a mental patient starts "taking an interest in his appearance," and makes an effort at personal grooming, he is often credited with having somehow given up his fight against society and having begun his way back to "reality".

Accordingly, the concept of 'conspicuous' dress runs through the different writings, as does, apparently, the binary opposition of "normal" and "abnormal" appearance, and of "sane" and "insane" dress behaviour.

At the beginning of the twentieth century, the French psychiatrist Gaëtan Gatian de Clérambault (1908/2002) writes about his diagnosis and subsequent therapeutic treatment of 'woman's erotic passion for fabrics'[32]. Four case studies of women, allegedly showing an autoerotic passion for pieces of stolen silk, are reported in detail. The women are deemed hysterics and mentally ill on the basis of their "abnormal" preoccupation with silk, indicative of the author's essentialising and even misogynist discussion.[33]

Some fifty years later but in similarly essentialising terms, the American psychoanalyst Edmund Bergler (1953/1992) accords a central role to dress in the

[32] The original title reads: *Passion Érotique des Étoffes chez la Femme.* To my knowledge this work has not been translated into English.

[33] These case studies are analysed in detail in: Papetti, Yolande & Françoise, Valier & Bernard, de Freminville & Serge, Tisseron (1980) *La Passion des Étoffes chez un Neuro-Psychiatre G.G. de Clérambault (1872-1934).* Paris: Solin. Again, no English translation exists. The psychoanalysts Tisseron-Papetti and Tisseron, later developed de Clérambault's work for their study of the 'eroticism of touching fabric'. See: Tisseron-Papetti, Yolande & Tisseron, Serge (1987) *L'Érotisme du Toucher des Étoffes.* Paris: Séguier/ Garamont-Archimbaud.

psychoanalytic diagnostic process. In *Fashion and Unconscious*[34], published just before the launch of "Therapy of Fashion" in California, he states: 'The thesis is promoted that there are – sartorially speaking – no "tasteless" women, only neurotically inhibited ones' (1953/1992: xxiii). His objective, is to analyse the various forms of neurotic inhibition largely on the basis of his, mostly female, patients' dress, as illustrated in the following example:

> Mrs. X., a woman in her thirties, was an inhibited and deeply depressed writer in analysis with me. She dressed well and inconspicuously. [...] She was conspicuous in only one way: her favourite (only?) hat was in the shape of a helmet, a long pointed affair that unduly and unfavourably emphasized her skinniness and her towering height. The purpose of this procedure – unconscious, to be sure – was *an unspoken reproach directed at her mother:* "See what an enormous misfit you produced!" (18–9) [35]

Bergler's case descriptions illustrate both, his emphasis on the role of dress in psychoanalytic practice and his reductionist approach. They are indicative of his detailed acknowledgement of and engagement with dress, and the importance he grants it in his therapeutic practice, which was uncommon in a period when even the study of dress was still very much at the academic margins, limited mainly to museum-based studies of costume and art history. Yet, in their description these case histories are also essentialising and openly homophobic.[36] Moreover, Bergler's sartorial interpretations are highly subjective and judgmental, his way of analysing 'troubled' minds on the basis of 'conspicuous' dress is literal and reductive (Radford 1993). While Bergler and most of the other therapists mentioned here consider the dress of both women and men as part of the diagnostic process, comments on women predominate, marked by stronger essentialising tendencies. The interpretation of their dress is even more literal, indicative

[34] There is not much published work on the subject of psychoanalysis and fashion. Two further books dedicated to the subject are J. C. Flugel's classic account *The Psychology of Clothes* (1930/1950) and Alison Bancroft's *Fashion and Psychoanalysis* (2012). Both of these concern themselves with the application of psychoanalytic theory to fashion, focusing on Freud and Lacan respectively, rather than commenting on the role of dress in the process of psychoanalytic therapy.

[35] In a similar manner, the preference of a 'schizoid' patient for dyeing her hair red is linked by Bergler (1953/1992: 209) to a repressed early childhood encounter of a red-haired prostitute and the 'conspicuous' hair colour diagnosed as a 'weapon in the patient's unending fight to disprove her masochistic attachment to her mother'. Another example of Bergler's approach to using dress as a diagnostic tool in his psychoanalytic practice can be found in the following detailed account of one of his patients: 'A woman in the early forties, in analysis because of neurotic depression which had allegedly been caused by "constant disappointments with men", dressed expensively and in good taste. What made her attire conspicuous was that she always wore one colour, a mixture of blue and violet. A superficial observer would assume that she had only one dress; closer inspection would prove that she had dozens. Their uniformity in color blotted out the differences in style. She had no answers to inquiries about her preference for this colour, although she volunteered additional information: she was so obsessed with the color of her choice that, when she looked at a white wall, she frequently imagined a thick blue-violet line. Analysis of her personality revealed a banal "penis envy" type of the hysterical variety. She "hated" men, using her numerous disappointments as excuses. All men were impotent, she said. Naturally, she did not suspect that she herself unconsciously engineered her disappointments by choosing all her men from one conveyor belt – that is, of the one type already found unsatisfactory. Her total emphasis on blue-violet could be clarified after a previously repressed recollection from her fourth year come to the surface. At that time she had inspected the penis of a boy much older than herself; she was startled by the sight of the thick vein at the "bottom" of the organ. This sight-seeing expedition stabilized, in her mind, the old (pre-Oedipal) feeling of being deprived by mother, she rescued herself to the Oedipal level, using two defenses. These were, "First, man's penis is non-existent – an impotent man can be identified as a castrated one. And second, I have a bigger penis – my whole body is a penis." Exhibitionistically, therefore she displayed the organ – in her dresses' (Bergler 1953/1992: 212–3).

[36] Bergler (1953/1992: 3) discusses a patient of his, a male fashion designer and as he terms 'homosexual', as follows: 'My patient co-operated by putting me on the alert with a sudden outburst. He shouted: "I HATE WOMEN, I HATE WOMEN, I HATE THEM!" [...] What struck me was my own association: "If he hates women, his fashion creations must reflect this pseudo-hatred too. Women who trust this type of 'guidance' are delivering themselves into the hands of their worst enemies".' For a discussion of the homophobic tendencies in Bergler's work see Radford (1993).

of the gendered cultural tradition in which, as John Berger (1972: 47) aptly writes: 'men act and women appear'.

Writing from the perspective of scientific objectivity the American child development psychologist Norma H. Compton (1964) undertook a study to delineate the significance of dress preferences amongst 'psychotic women' patients and consequently their diagnostic value which was published at the time of "Therapy of Fashion". Compton (1964: 43) concludes, for example: 'emotionally elated and physically active patients prefer the warm and brighter colors (red, yellow, orange) and […] emotionally depressed and physically inactive patients prefer cooler colors (green, blue, purple)', thus producing scientific knowledge as a basis for the construction of diagnostic truths. Fifty years on, from a perspective of much more diverse and complex sartorial codes this analysis seems reductive. Moreover, the value of quantitative research into the relationship between dress and the self is limited, because it can hardly take account of the highly individual embodied experiences and practices of dress that are negotiated on a diversity of social stages.

Whether dress is employed in the diagnostic process on a scientific basis or not, the tenor of these reflections is remarkably similar: dress is regarded as useful to assess a patient's state of mind or psyche and its interpretation is very literal. A contemporary account by Austrian psychiatrist Bonelli (2012: 169) is no exception: 'People need the desire to be beautiful; it is a sign of psychic health,' he proclaims in his account on the 'interdependence of fashion and the human psyche' (160), and he defines the analytical relevance of dress thus:

> The outfit is actually of imminent importance for psychiatric assessment of patients in daily clinical practice, and changes in clothing often reflect mood changes. In psychiatry, observation of the outfit is part of the diagnostic method. Fashion is actually a method of self-revelation and therefore communication. (161)

This statement constitutes one of the most explicit comments on the role of dress in the psychotherapeutic diagnostic process found among its theorists. While Bonelli (2012: 159) does not reflect on the limits of this analytical methods he does elaborate on the correlation between certain illnesses and dress behaviour[37], and comment on the therapeutic potential of dress by arguing: 'In fact, art and aesthetic play a major role in the healing process of some psychiatrically ill persons'. As such, his account typifies the lack of critical reflection inherent in writings on dress as a diagnostic tool presented here. Neither the parameters of this method nor its limitations are addressed. Dress is literally

[37] Bonelli (2012: 159) details: 'In fact, we find increasing interest in fashion in our depressed patients at the moment when depression wanes and people start to participate in society again. Similarly, schizophrenic patients gravely neglect their attire to a radical extent, and improvement in their symptomatology can be noticed by improvement in personal appearance'.

interpreted as indicative of a person's state of mind: dark clothes stand for a gloomy mood, and dishevelled dress for a disturbed mind. The novelist Alison Lurie (1983) conceptualises dress in similarly literal terms as a 'silent visual language' with its own distinctive and fixed grammar, syntax, and vocabulary, a language that can be read literally and unproblematically. Yet, dress details such as the colour black, a skirt, a certain type of fabric or cut are all highly context-dependent and unstable in their meaning. They can signify very different things in different social, cultural or economic settings. Thus, and precisely because of the inherently unstable relationship between signifier and signified, the symbolic communicative properties of dress are more constructively conceptualised as a 'clothing code' (Davis 1992), one of 'low semanticity' that is 'more like music, where the emotions, allusions and moods that are aroused resist, as they always must, the attribution of unambiguous meanings' (3). Consequently, dress cannot be interpreted literally because it cannot produce permanent symbolic solutions: its symbols are too ephemeral, its ambivalence too deeply rooted, an excess meaning can always escape.

Nonetheless, it could be argued that we all judge and are judged by appearances every day – treating dress like a language not a code most of the time, as Finkelstein (1991: 128) maintains: 'Clothing is frequently seen as symbolic of the individual's status and morality, whether actual or contrived'. She describes the process thus: '[W]hen we encounter a stranger as initially mysterious and inaccessible, we refer to clothing styles and physical appearance, in the absence of any other means, as a reliable sign of identity' (128). Consequently, dress is used as a diagnostic tool both outside and inside the consulting room. However, while we might reach reductive conclusions in our daily judgments of people's attire, the explicit inclusion of dress in the psycho-medical diagnostic process entails very different consequences: making diagnoses that determine treatment, attesting psychological improvements, marking patients, and potentially stigmatising them.

A critical reflection on the limits of using dress as part of the diagnostic process is to be found, however, in a conference paper by Italian psychotherapist Bianca Garufi (1983), given incidentally at the same congress on analytical psychology as Marjasch's. Writing about fashion as a 'body-soul relationship' (145), Garufi argues for the value of dressing-up practices prevalent during infancy in therapeutic treatment. She claims that such information is useful in the analytical process, because she looks on '*fashion*, on *body* and *soul* as an inseparable whole'.[38] Yet, Garufi (1983: 152) is also careful to

[38] Garufi (1983: 152) writes: 'Another question: whatever became of the little girl, who dressed up for carnival as a fairy, gypsy, pirate, nun, or as Barbarella or Little Lord Fauntleroy, and thus gave free reign to her fancy, instilling life into the images of her fantasy? One could ask as well about the little boy, who dressed up as a beggar, emperor, veiled odalisque, musketeer, magician, astronaut, or superman. Most people have some sort of sentimental memories of these childhood fantasies, and yet they take on significance when we consider them as elements that allow us to understand and attend to the disturbances of the adult psyche. This is more or less the attitude we adopt when a dream image stands out for the dress which is worn, be it a shabby fur, a lace skirt, velvet pants, a coarse monastic frock, or even an abstract or geometric

address the limits of this method and what she considers to be prevalent reductive practices of using dress within diagnosis:

> On the whole it would seem that dress has always been dealt with in the analytical context reductively, that is, in moralistic terms of improvement or deterioration, or, in the eyes of the ego subject undergoing analysis, as an expression of a positive or negative phase. Even in dreams the need to wear clothes and to decorate oneself, and fashion, as the direct product of this need, have been dealt with as pertaining exclusively to the world of ego. Too frequently, a person's manner of dress is reduced to something other than the reflection of the psyche's image in the body, and body's image in the psyche.

Garufi warns against simplistic interpretations of dress in the diagnostic process, such as those evidenced in the sources reviewed here. With regards to using the colour of patients' dress in the process of analysis, as fervently practiced by Bergler, she writes: 'Despite its usefulness and the best of therapeutic intentions, typology and its color symbolism can also be used schematically and in routine fashion' (152). She argues for a holistic diagnostic approach to the relationship between dress, the body and the mind, thus moving towards "dress as therapy", not unlike some of the authors discussed below.

construction. While this information may be very useful therapeutically, I wonder what else we do with this wealth of data? Do we actually use it to pursue the dialogue with the soul, with these curious images of male and female figures? Perhaps not very often, at least not along the lines of thought pursued in this paper, that is by looking on *fashion*, on *body* and *soul* as an inseparable whole'.

1.3.2.2 Dress as part of the psychotherapeutic process: Towards a "therapy of dress"

> A wise application of clothes-psychology can do very much in rightly poising a child at the golden mean between too much and too little self-consciousness if not between excessive shyness and over-boldness. (Hall 1898: 367)

At the end of the nineteenth century, the American psychologist Granville Stanley Hall (1844–1924), the first president of the American Psychological Association, comments on the potential influence of dress on the self in the psycho-medical setting. His notion of 'clothes-psychology' is not elaborated further and it remains unclear whether or not he ever applied this concept in his therapeutic practice. However, his statement is indicative of a growing belief that dress has a very direct psychological influence on the self in terms of its development and maintenance.

Throughout the twentieth century a number of (socio)psychological theorists have commented on this psychological effect of dress on the self, for example Hall (1898), Flaccus (1906), de Clérambault (1908/2002), Hurlock (1929), Flugel (1930/1950), Garufi (1983), Giddon (1985), Solomon (ed. 1985), and Kawohl (1990). Amongst these, some – particularly Giddon and Kawohl – conclude that such an effect could be employed intentionally and constructively within the psychotherapeutic process. Rather than just taking dress to be indicative of the self, as the authors commenting on the role of dress in the diagnostic process had done, they elaborate on the "potential" of dress to influence the self and propose its therapeutic employment. Thus, in the writings of these authors, dress moves from being perceived as a passive diagnostic aid to being seen as having the potential to actively aid the recovery process itself, a form of therapy: "dress therapy".

Writing about 'Ethical Considerations for the Fashion Industry', the American psychologist Donald Giddon (1985: 227) states that 'the fashion industry and related services can and do help to enhance the mental health of some people by making them feel better about themselves'. Yet, he decries the exclusivity of fashion, its discriminating body and beauty ideals, and calls for fashion to 'modify its target groups to extend its range beyond the fit, young and pretty to the old and fat [as] there are more of the latter than of the former' (230). If one is able to conform to the normative standards prescribed by fashion, he argues, 'there are significant mental health benefits' (230) and suggests the creation of a fashion 'counsellor' for the rest.[39] The irony in his proposal does not

[39] Giddon (1985: 230–1) expands: 'Perhaps we could consider two marketing strategies: one for those who can benefit from the prevailing standards and one for those who cannot. The latter approach would be similar to alternative education programs for those who cannot be mainstreamed because of physical or mental handicaps; in a sense a marketing subculture could be created for the needs of this previously neglected group. Most people who want to change their shape or size do not know whether or how much of an exercise program or diet or even surgery is appropriate. Given certain physical, financial, or psychological limitations, a change in hairstyle, cosmetics, wardrobe, lifestyle or posture might be better suited to them. Unfortunately, these [fashion] services that contribute so positively or negatively to mental and physical health are for the most part unregulated in the United States. Consequently, there should be some kind of

detract from the seriousness of his overall message, but rather emphasises the absurdity of the fact that the majority of garments on sale are aimed at young, thin and standardised bodies. At the same time, Giddon maintains that fashion can have both a negative and positive effect on its consumers, and argues for the therapeutic employment of the psychological effect of dress on the wearer.

From a rather different perspective and with decidedly less irony the German psychotherapist Marianne Kawohl (1990) proposes dress as a form of therapy in her book *Beautify yourself! Psychotherapeutic experiences with dress*[40]. Writing about the capacity of dress to cure both body and mind, and the healing power of different fabrics (66) and dress styles (84), she claims that: 'Many people aggravate their pain and depression through unflattering dress'[41] (93). Kawohl (1990: 90) offers detailed 'assistance' in her self-help book, marked by religious and moralising undertones, as she writes about the potential of dress in the therapeutic process and in everyday life:

> Thus, to be rightly dressed soothes nerves, improves concentration, increases vitality, leads more easily to professional and private success, grants inner and outer health, and appreciation of oneself. The right dress at the right time is no luxury, no waste of time, but time saving and life help.[42]

Particularly in the third part of her book, entitled 'Dress as therapy in practice'[43] (88), Kawohl (1990: 89) gives detailed advice on 'increasing self-confidence and self-esteem'[44] through dress, based on her practical therapeutic knowledge.[45] She suggests a distinct form of therapy based on dress: 'One could add "dress therapy" or rather the "healing power of dress" to the different forms of psychotherapy […] as an effective one and a very pleasant one, too!'[46] (88). Her understanding of "dress therapy" is based on her advice to her clients on the 'healing power' of certain fabrics and styles or even on fabrics and fashions that can 'make you sick'. Not only does Kawohl read dress in a very literal manner, as noted above about the other works, she also adopts normative

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counsellor who can advise individual clients and consumers how to do the best with themselves relative to their physical, fiscal and psychological resources'.

[40] '*Mach dich mal wieder schön! Psychotherapeutische Erfahrungen mit Kleidung.'* (Kawohl 1990)

[41] 'Viele Menschen verstärken ihre Schmerzen und Depressionen durch unvorteilhalfte Kleidung.' (Kawohl 1990: 93)

[42] 'Richtig angezogen zu sein, schont also die Nerven, verbessert die Konzentration, steigert die Lebensfreude, führt leichter zu beruflichem und privatem Erfolg, verleiht innere und äußere Gesundheit, Wertschätzung der eigenen Person. Die richtige Kleidung zur richtigen Zeit ist kein Luxus, keine Zeitverschwendung, sondern Zeitgewinn und Lebenshilfe.' (Kawohl 1990: 90)

[43] 'Kleidung als Therapie in der Praxis' (Kawohl 1990: 88)

[44] 'Steigerung des Selbstbewußtseins und Selbstwertgefühls' (Kawohl 1990: 89)

[45] Kawohl (1990: 85) summarises her therapeutic experience with dress as follows: 'In my counselling practice, I make the observation that women's dress style clearly changes in the course of a longer talking therapy (less so men's) – of course without deliberate manipulation. The "wallflowers" blossom into attractive women who pluck up the courage to wear more striking shapes and colours. The ones who would only dress in trousers and loose jumpers, suddenly enjoyed wearing skirts and dresses. Those who were always very elegant tried something casual etc. Sometimes, these women point out their changed dress behaviour that they perceive as therapeutic success, to me personally'. // 'In meiner Beratungspraxis mache ich die Beobachtung, daß sich der Kleidungsstil - natürlich ohne bewußte Manipulation – bei den Frauen (bei den Männern ist es meistens weniger auffällig) im Laufe einer längeren Gesprächstherapie offensichtlich ändert. Die "Mauerblümchen" entfalten sich zu attraktiven Frauen, die auch Mut bekommen, auffälligere Formen und Farben zu tragen. Die, die nur Hosen und weite Pullover trugen, finden plötzlich Freude an Röcken und Kleidern. Die, die immer super-elegant waren, probieren etwas Legeres aus usw. Manchmal weisen diese Frauen mich persönlich hin auf ihre veränderten Anziehgewohnheiten, die sie als Therapieerfolg bemerken.' (Kawohl 1990: 85)

[46] 'Man könnte zu den verschiedenen Formen der Psychotherapie [...] noch die "Kleidungstherapie" bzw. die "Heilkraft der Kleidung" als eine wirkungsvolle hinzufügen – und eine sehr angenehme sogar!' (Kawohl 1990: 88)

standards of feminine beauty in body and dress in her writing[47]. Moreover, she does not reflect critically on the parameters of using dress within her psychotherapeutic practice, on the essentialising risk of this method, or even on her responsibility and power as a therapist. This is illustrated by her promise of the success of "dress therapy": 'So, don't wallow in your sorrows, but take the steps that will help overcome the frustrating situation and sometimes these can lie in the suitable wardrobe. Try it! The success rate is at least 75%'[48] (97).

The writings of psycho-medical practitioners reviewed here not only indicate an understanding of self as immanent in dress, but also a shifting discourse linking dress and the self in formative ways within the psycho-medical setting. However marginal some of them might seem, they constitute part of the context and conditions of possibility of the dress-related therapeutic practices under review in this thesis. Some were published around the same time (Bergler 1953/1992, Compton 1964), while others are precursors of the therapies to come. Moreover, they all situate the human body in psycho-therapy, a field which has traditionally been 'quite removed from bodily experience' (Shapiro 1996: 297). Just as the body had been absent from the social sciences and even from analyses of dress until recently[49], so too has it been absent from the theory and practice of psycho-medical therapy. Its inclusion marks another condition of possibility for dress-related therapeutic practices.

Since the early 2000s this absence has been addressed within theory, and Petrucelli (2008), for example, discusses the encounter between therapists' and patients'

[47] For instance, Kawohl (1990: 107) writes about 'beautiful lingerie' as a remedy for 'unhealthy marriages', commenting in this context on women's obligation to dress erotically in order to keep a man interested and well-disposed towards her. If wives fulfilled such male desires, she maintains, they would have to worry less about being abandoned or treated brutally in mind or body (105–6). This example is indicative of Kawohl's essentialist approach to dress, gender, and physical beauty.

[48] 'Also nicht im Frust versinken, sondern die Schritte gehen, die die frustrierenden Situationen überwinden helfen – und die können manchmal in der entsprechenden Garderobe liegen. Probieren Sie es aus! Die Garantie liegt bei mindestens 75 Prozent.' (Kawohl 1990: 97)

[49] In this context the work of Featherstone (1991) should be mentioned, alongside a number of socio-cultural theorists who have been influential in linking the social self to the body (Burkitt 1999, Csordas ed. 1994, Foucault 1982, Giddens 1991, Turner 1984). Drawing on Sennett's work, Featherstone focuses on the modern belief that physical presentation expresses the self (1991: 189) and analyses the body in consumer culture, its active maintenance promising a more 'marketable self' (171). In a similar vein Giddens (1991: 56) acknowledges that '[t]he self, of course, is embodied', and explains: 'the body is not just a physical entity we 'possess', it is an action-system, a mode of praxis, and its practical immersion in the interactions of day-to-day life is an essential part of the sustaining of a coherent sense of self-identity' (99). While Featherstone does not consider dress in his analysis of the body, Giddens acknowledges it. Generally speaking, however, it is noteworthy that until recently, in the majority, theorists of the body had not thematised dress, while most theorists of dress had not taken the body into account in any detail. An important corrective to these omissions is constituted in the work of Joanne Entwistle (1997 & 2000), who sets out 'a theoretical and methodological framework for the sociology of dress as a situated bodily practice.' (1997: 266). The sociology of embodied dress was naturally shaped by other writers (Lee 1959, Turner 1979/1993, Hillestad 1980, Rudd & Lennon 2001, Wilson 1985), most importantly by phenomenologist Merleau-Ponty (1962). His concern to return the body, the lived physical experience, to philosophy in general and an understanding of self in particular, arguing clothes to be 'appendages' (91) of the body, has thus helped to promote an understanding of the self as essentially embodied and dressed. But it is in the writing of Entwistle (1997 & 2000) that the inextricable link between the embodied social self and dress is explored in great detail. Here the sociology of the body is applied to dress to formulate a framework for a sociology of dress that moves away from abstract disembodied analyses of dress. Her investigation is empirically grounded in an interview-based study of twenty-two professional women's dress for work. By explicitly granting the body its long overdue central position to social accounts of dress, Entwistle focuses the field around a physical perspective. She argues dress to form part of contemporary technologies of self and conceptualises dress as an 'embodied situated practice', as previously discussed in its relevance to this thesis (1.1).

bodies. In 2009, the British psychotherapist Susie Orbach (2009: 13) dedicated a book to the subject of 'the varied expressions of body dissatisfaction and the search for solutions' aptly entitled *Bodies.* She aims to 'leave the reader with an expanded understanding of our bodies' (14), and urges therapists in particular to recognise this 'if they wish to be of use to those who consult them' (142). Such arguments, in themselves, can be taken as indicative of a changing discourse of the relationship between body and self in therapy (1.4.2).

Similarly, within therapeutic practice the body has been granted a more central role, with a growing number of physical forms of therapy involving movement, dance, massage or therapies concentrating on 'body image work'. Particularly in the context of the treatment of eating disorders, a number of accounts describe therapeutic approaches addressing the body or its image (Böse 2002, Field 2000, Forster 2002, Pacifici 2008, Rabin 2003). While these commentaries locate the body within therapy, however, that body is evidently naked, as dress is rarely thematised[50], in spite of the fact that the human body is dressed in virtually all social and even in most private situations (Entwistle 2000).

The emergence of dress-related therapeutic approaches, and of a growing body of literature linking dress to the self in formative ways, as well as a great variety of other forms of physical therapy, is indicative of what has been termed therapy culture. As argued above, the dress-related therapeutic practices under review in this thesis bring together two important parameters of our contemporary understanding of self: (fashionable) dress and therapy. Having outlined the notion of the "dress as therapy", the final section will now focus on therapy culture as a key context of this thesis.

[50] The work of Forster (2002) on physical therapy for women with eating disorders constitutes an interesting case in point. As one of the few accounts to include any references on dress, it does not address these in any detail. For example data on dress can be found in the appendix, where 'Symptoms at physical level' connected with eating disorders are listed by the author according to the importance that her patients have granted them (2002: 197). Dress features several times. Top of the list is the conscious decision to buy and wear garments, which are too tight, to motivate weight loss. Another symptom is given in the practice of covering the body with pieces of clothing, bags or wraps in order to hide it. Dress-related comments make up almost a quarter of the list but are not analysed.

1.4 Therapy culture

1.4.1 The medicalisation, psychologisation and therapeutisation of everyday life

Contemporary Western culture, it has been argued, is defined by a dominant discourse of therapy and therapeutic interventions at all levels from the individual to the state. A growing body of research has emerged that critically examines the rise of these practices and their underlying discourse of the 'care of the self' (Foucault 1984b/1988) (Cohen ed. 1990, Chriss ed. 1999, Furedi 2004, Hellerich 1985, Nolan 1998, Weatherill 2004). 'Therapy culture', as it has been termed (e.g. Furedi 2004, Weatherill 2004), thrives on a late modern understanding of the self as project (Giddens 1991, Rabin 2003, Rose 1991, Sennett 1976), something to be worked on, developed and enhanced (1.4.2). Therapy culture is characterised as a culture of emotionalism, a confessional culture concerned with verbalising the self, in which the religious authority of priests is replaced by psycho-medical professions (Furedi 2004, Nolan 1998, Rieff 1966). Furedi (2004: 10) explains:

> The monumental increase in the psychologization of modern life is also evident in the fact that there are more therapists than there are librarians, fire-fighters, or mail carriers in the United States, and twice as many therapists as dentists or pharmacists. Only police and lawyers outnumber counsellors, but only by a ratio of less than two to one in both instances. […] The authority of counselling rests on its ability to give meaning to experience in a world strongly wedded to a therapeutic ethos.

While analyses of this 'therapeutic ethos' are mostly concerned with the cultural-political sphere, they make a compelling argument about the growing dimensions of therapy culture within which "dress therapy" can be contextualised.

In their cultural and social constructivist critiques of psychology and psychiatry, the analysts of therapy culture can be considered the intellectual heirs of Foucault[51] and, more generally, of the "anti-psychiatry"[52] movement of the 1960s, with which Foucault was retrospectively connected.[53] Foucault charts the construction of psychology and

[51] While this intellectual heritage is arguably evident, it cannot be generalised. Chriss (ed. 1999), for example, repeatedly refers to Foucault's *The Birth of the Clinic,* however, it is noteworthy that, in spite of the common concern, there is reference to Foucault's work in Furedi (2004).

[52] This term was coined by British psychiatrist David Graham Cooper (ed. 1967). Other proponents of this unorganised movement included the Scottish psychiatrist Ronal David Laing (who rejected the term anti-psychiatry), Italian psychiatrist Franco Basaglia, and Hungarian-American psychiatrist Thomas Szasz (1962/1972: 269), who in his aptly entitled book *The Myth of Mental Illness* argues: 'Mental illness is a myth. […] scientifically crippling. […] undermines the principle of personal responsibility, the ground on which all free political institutions rest. For the individual, the notion of mental illness precludes an inquiring attitude towards his conflicts which his 'symptoms' at once conceal and reveal. For a society, it precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients.' The work of Erving Goffman (1961), as previously discussed, also contributes to this school of thought. For further reading on anti-psychiatry, see: Shorter, Edward (1997) 'Antipsychiatry' in: *A History of Psychiatry: From the Era of Asylum to the Age of Prozac.* New York: John Wiley & Sons, pp. 272–77; or: Dain, Norman (2000) 'Antipsychiatry' in: Menninger, Roy W. & Nemiah, John C. (eds.) *American Psychiatry After World War II (1944–1994).* Washington: American Psychiatric Press, Inc, pp. 277–98.

[53] Hacking (2004: 292) describes the constellation of related works as follows: 'The era of anti-psychiatry had been heralded […] with Ronald Laing's *The Divided Self* (1960). Foucault's *Folie et Déraison* […] was simultaneous with

psychiatry as knowledge spheres (1954/1987 & 1961/2001), the rise of confessional culture (1976/1990) and ultimately of the "psy" professions as well as therapy and, most relevantly for this thesis, the resultant notions of self. In *Madness and Civilisation* he writes:

> If we wanted to analyze the profound structures of objectivity in the knowledge and practices of nineteenth-century psychiatry from Pinel to Freud, we should have to show in fact that such objectivity was from the start a reification of magical nature, which could only be accomplished with the complicity of the patient himself, and beginning from a transparent and clear moral practice, gradually forgotten as positivism imposed its myth of scientific objectivity; a practice forgotten in its origins and its meaning, but always used and always present. What we call psychiatric practice is a certain moral tactic contemporary with the end of the eighteenth century, preserved in the rites of asylum life, and overlaid by the myths of positivism. (Foucault 1961/2001: 262)

Foucault outlines the naturalisations underpinning the discipline and practices of psychiatry, thus addressing their conditions of possibility. He illustrates the contingency of madness and delineates the technologies of truth, power and self, which constitute the field of experience of psychiatry. In his analyses of the history of the present, Foucault encountered not only psychiatry and psychology but also repeatedly and more generally medicine. 'Foucault encountered medicine as he sought to discern some of the central coordinates that have defined our contemporary experience of ourselves, and the present which we inhabit' (Rose 1994: 49).

It is particularly in *The Birth of the Clinic*, 'a text which reveals the formation of the individual, or rather the individual's body, as an object of scientific medical examination and analysis,' that Foucault 'documents the importance of medicine as the first scientific discourse concerning the individual' (Smart 1985: 27). Yet, most of his works are in some way or other concerned with the medicalisation of everyday life, with how medical knowledge determines social practices and constitutes particular human bodies and selves. This medicalisation of life, which in turn gave rise to therapy culture, represents another condition of possibility for dress-related therapeutic approaches, all rooted in psycho-medical disciplines. It thus constitutes an important point of contextualisation for their analysis.

In its development of the Foucauldian theme of subjectification[54] in relation to "psy-culture", the work of Rose is of considerable contemporary relevance. Rose (1994:

Asylums. […] Add Tomas Szasz's *The Myth of Mental Illness* (1961), and you have the four-sided platform upon which anti-psychiatry marched into the world. […] These four books were extraordinarily powerful, but their unmatched success was a case of right time, right place. Local authorities and health services were beginning to be strapped for funds after the initial post-war boom, and in the late 1960s and early 1970s were delighted to discover that it was politically incorrect to incarcerate fairly harmless mad people at public expense'.

When Foucault (1984c: 385) was asked about this association, he stated: 'I'm not sure that at the time when I wrote the history of madness, there was a pre-existing and receptive "we" to which I would only have had to refer in order to write my book, and of which this book would have been the spontaneous expression. Laing, Cooper, Basaglia, and I had no community nor any relationship'.

[54] Rose defines his project as 'a genealogy of subjectification', focusing 'directly upon the *practices* within which human beings have been located in particular 'regimes of the person'' (1996: 131). He defines subjectification as 'all those heterogeneous processes and practices by means of which human beings come to relate to themselves and others as subjects of a certain type' (130–1). For a discussion of a genealogy of subjectification, see: Rose, Nikolas (1996) 'Identity, Genealogy, History.' in: Hall, Stuart & du Gay, Paul (eds.) *Questions of Cultural Identity*. London: Sage, pp. 128–50, which

67) insists on the central role of medicine in making up our present, as he explains: 'The remit of medicine extends beyond the dimension of illness and cure and into the management of normality itself'. In line with Foucault, Rose (1994: 68) maintains that it is in medical terms that we experience ourselves and our lives:

> Clinical experience and the anatomo-clinical method have a decisive *epistemo-ethical* significance, in constituting 'man' as an object of knowledge, in making possible a science of the human individual as a complex of specifiable processes and attributes that can be diagnosed, calibrated, compared and generalized.

Rose analyses this medicalisation of life particularly in relation to the aforementioned "psy-professions", and how they aid the constitution of the contemporary subject (1991) and the invention of ourselves (1998). His interpretation of these shifts sets him apart from other prominent analysts of contemporary therapy culture and the therapeutic self. While all the authors discussed here agree on the central role of "psy" in shaping our lives and ourselves, their assessments of this development differ. While Rose speaks of 'Therapies of Freedom' (1991: 255), Furedi describes therapy culture as promoting self-limitation (2004: 21), and most of the authors mentioned here share his view. Rose, on the other hand, criticises such evaluations of therapy culture as 'melancholic' (1991: 215), 'sceptical' and 'partial' (216). Naming Lasch, Sennett and Rieff[55] in particular, he argues: 'Social analysts, however, have tended to take a rather jaundiced view of the therapeutic culture of the self. […] Historians also tended to see therapeutic culture as part of a modern obsession with the self, a negative phenomenon consequent upon the breakdown of some previous, more desirable state of affairs' (215). And Rose retorts: 'The paranoid visions of some social analysts, who see in the expansion of the therapeutic a kind of extension of state surveillance and regulation throughout the social body, are profoundly misleading' (257). While he acknowledges that the 'desire for therapy may have been a response to the psychic damage wrought by capitalism, reflecting people's desperate search for a better way of living and being' (215), Rose (1991: 257) articulates the 'power' of therapy as follows:

> These technologies for the government of the soul operate not through the crushing of subjectivity in the interests of control and profit, but by seeking to align political, social institutional goals with individual pleasures and desires, and with the happiness and fulfillment of the self. Their power lies in their capacity to offer means by which the regulation of selves – by others and by ourselves – can be made consonant with contemporary-political principles, moral ideals, and constitutional exigencies. They are, precisely, therapies of freedom.

Against such a view of therapy culture Furedi (2004: 21) argues:

> that the therapeutic imperative is not so much towards the realisation of self-fulfilment as the promotion of self-limitation. It posits the self in distinctly fragile and feeble form and insists that the management of life requires the continuous intervention of therapeutic expertise. The elevated concern with the self is

was republished as Chapter One in: Rose, Nikolas (1998) *Inventing Ourselves: Psychology, Power and Personhood.* Cambridge University Press.

[55] Rose arguably refers to specific works of these three authors, namely: Lasch, Christopher (1979) *The Culture of Narcissism.* New York: Norton.; Sennett, Richard (1976) *The Fall of Public Man.* Cambridge: Cambridge University Press; and Rieff, Philip (1966) *The Triumph of the Therapeutic: Uses of Faith after Freud.* Chicago: University of Chicago Press.

> underpinned by anxiety and apprehension, rather than a positive vision realising the human potential. Therapeutic culture has helped to construct a diminished sense of self that characteristically suffers from an emotional deficit and possesses a permanent consciousness of vulnerability. Its main legacy so far is the cultivation of a unique sense of vulnerability.

Balancing both sides of the argument, Giddens (1991: 33–4) reasons: 'Therapy is not simply a means of coping with novel anxieties, but an expression of the reflexivity of self – a phenomenon which, on the level of the individual, like the broader institutions of modernity, balances opportunity and potential catastrophe in equal measure'. While it is widely accepted that Western society is marked by a 'therapeutic ethos', and has indeed become a therapy culture, the interpretations of its consequences differ. The analyses of therapy culture outlined here, irrespective of their point of view, provide a useful backdrop for the de-composition, de-naturalisation and contextualisation of dress-related forms of therapy, drawing attention to different understandings of the way they determine subjectivity.

The emergence of "dress therapy" as a cultural phenomenon is a symptom of a contemporary therapy culture as this thesis argues. Moreover, my thesis maintains that the notion of a therapeutable self underlies these therapeutic approaches that are 'instrument[s] for the management of subjectivity' (Furedi 2004: 22). They are predicated on a particular notion of self which obliges us to take care of ourselves (Foucault 1984b/1988), as I discuss below.

1.4.2 The therapeutable self as project and the duty to "be well" and "look good"

At the core of therapy culture in general, and "dress therapy" in particular, lies a notion of the self as therapeutable, as changeable and perfectible, as project. As Rose (1994: 69) puts it, in relation to contemporary medico-therapeutically underwritten technologies of the self:

> The infusion of medical values into ethical judgements can be located in relation to the successive ways in which humans have been urged to engage in practices of self-formation, to master themselves, improve themselves and regulate themselves in the name of certain problems and through the use of certain technologies.

Ours is a sense of the self as 'perfectible through the application of medical techniques' (Rose 1994: 50) or of therapeutic techniques. Thus, the engagement with, and the exploration of, the 'inner self' are important constituents of contemporary self-identity (Furedi 2004: 17). In the 'emotionalism' of therapy culture, as touched on above, the self is verbalised. Confessional culture, which can be traced back to at least the Middle Ages when 'confession became one of the West's most highly valued techniques for producing truth' (Foucault 1976/1990: 58–9), occupies all spheres of life, private and public. The confession, argues Foucault (1976/1990: 59):

> plays a part in justice, medicine, education, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites […] One confesses in public and in private, to one's parents, one's educators, one's doctor, to those one loves; one admits to oneself, in pleasure and in pain, things it would be impossible to tell to anyone else, the things people write books about. One confesses – or is forced to confess.

Within the psycho-medical context, this confessional culture, indicative of the so-called 'humanizing approaches of medicine', has, 'while offering patients liberation through the confession of their thoughts and feelings, succeeded in fashioning subjectivity itself' (Armstrong 1994: 25). 'Western man has become a confessing animal' maintains Foucault (1976/1990: 59).

While therapy culture has given rise to a particular notion of the self which is not only confessional but also therapeutable and perfectible, as addressed in more detail below, it should be noted that therapy culture is only one paradigm of contemporary Western culture and subjectification. It is a pervasive and powerful one, however, as Furedi (2004: 22) reiterates:

> Therapeutic culture does […] provide a system of meaning and symbols through which people experience and make sense of the world. Arguably it offers a web of meaning that is distinctive to contemporary times. Although in competition with other currents, therapeutic culture has acquired a powerful influence over the conduct of individual behaviour. It has no monopoly over the way society gains meaning over life, but it is arguably the most important signifier of meaning for the everyday life of the individual.

The contemporary notion of a therapeutable self stands in contrast to an early modern notion of self, the Cartesian subject, defined as rational, coherent and centred, particularly in structuralist accounts (Giddens 1991, Hall 1992).[56]

> The Enlightenment subject was based on a conception of a human person as a fully centred, unified individual, endowed with the capacities of reason, consciousness and action, whose "centre" consisted of an inner core which first emerged when the subject was born, and unfolded with it, while remaining essentially the same – continuous or 'identical' with itself – throughout the individual's existence. (Hall 1992: 275)

Hall (1992) marks five conceptual shifts by which this coherent subject was decentred in the nineteenth and twentieth centuries, ranging from Marxist and Foucauldian social constructivism to psychoanalysis (for its formulation of the unconscious as opposed to the rational mind) and lastly to linguism and feminism.[57] Moreover, a number of structuralist thinkers have characterised the pace and scope of change in modernity, influenced by the developments of nineteenth-century industrial capitalism and twentieth-century consumer capitalism and their globalising forces, as giving rise to, first, a modern, then a post-modern notion of self, described as fragmented (Harvey 1989), dislocated (Laclau 1990) and individualised as well as reflexive (Giddens 1991, Beck 1992). As Anthony Giddens (1991: 5) argues in his analysis of the self in the 'Late Modern Age':

> In the post-traditional order of modernity, and against the backdrop of new forms of mediated experience, self-identity becomes a reflexively organized endeavour. The reflexive project of the self, which consists in the sustaining of coherent, yet continuously revised, biographical narratives, takes place in the context of multiple choice as filtered through abstract systems, because of the 'openness' of social life today, the pluralisation of contexts of action and the diversity of 'authorities', lifestyle choice is increasingly important in the constitution of self-identity and daily activity. Reflexively organized life-planning, which normally presumes consideration of risks as filtered through contact with expert knowledge, becomes a central feature of the structuring of self-identity.

In a similar vein, Beck (1992) conceptualizes our society as a 'risk society' marked by unprecedented post-industrial environmental risks and social individualisation, where

[56] Rose (1998: 4) questions this understanding by arguing that the pre-modern unified self is rather a 'regulative ideal': 'This ideal of the unified, coherent, self-centered subject was, perhaps, most often found in projects that bemoaned the loss of self in modern life, that sought to recover a self, that urged people to respect the self, that urged us each to assert our self and take responsibility for our self – projects whose very existence suggests that selfhood is more an aim or a norm than a natural given'. Yet, the question poses itself, whether any theoretical construct is not a strategically reductive ideal to some extent. Rose (1996: 130), however, not unlike Foucault, aims to distance his approach from that of the structuralist thinkers discussed here, who view changing forms of subjectivity as 'consequences of wider social and cultural transformations'. While he concedes that they have significance in relation to the problem of subjectification, Rose (1996: 130) insists, in his seminal essay 'Identity, Genealogy, History': 'such changes do not transform ways of being human by virtue of some 'experience' that they produce. Changing relations of subjectification, I want to argue, cannot be established by derivation or interpretation of other cultural or social forms. To explicitly or implicitly assume that they can is to presume the *continuity* of human beings as the subject of history, essentially equipped with the capacity for endowing meaning (Dean 1994). But the ways in which humans 'give meaning to experience' have their own history. Devices of 'meaning production' – grids for visualization, vocabularies, norms and systems of judgement – *produce* experience; they are not themselves *produced by* experience (Joyce 1994). These intellectual techniques do not come ready made, they have to be invented, refined stabilized, they have to be disseminated and implanted in different ways in different practices – schools, families, streets, workplaces, courtrooms'.

Foucault repeatedly distances himself from structuralism, most explicitly in 'Sexuality and Solitude', an article co-written with Richard Sennett, where he states: 'Let me announce once and for all that I am not a structuralist […]' (Foucault & Sennett 1982: 9).

[57] Although not referenced by Hall, Foucault writes about the decentrings of the sovereign subject operated by Marx, Nietzsche, psychoanalysis, linguistics and ethnology in *The Archaeology of Knowledge* (1969/2002: 14).

'[o]ne even has to chose one's social identity and group membership, in this way managing one's own self, changing its *image*. In the individualised society, risks do not just increase quantitatively, qualitatively new types of personal risk arise, the risk of the chosen and changed personal identity' (136). Furedi (2004), in turn, argues that the psychological dimension of this risk society is located in contemporary treatment culture, or therapy culture[58]. Thus, when Giddens writes about risks being 'filtered through contact with expert knowledge', he refers, among other things, to the professional and non-professional psy-occupations, the counsellors, therapists and "assistant therapists" (1.3.1). The "dress therapists" whose work is analysed in this thesis constitute precisely this form of expert knowledge involved in the structuring of self-identity.

Moreover, within therapy culture individuals are required to become experts, everyone his or her own therapist, a 'self-therapist' (Hellerich 1985: 133). We are being asked to perform ourselves through therapy, observes Illouz (2008: 178): 'Because of its wide institutional resonance, the therapeutic narrative has become a basic self-schema, organizing stories about the self and, more specifically, autobiographical discourse. It is the form as much as the content of how we make sense of ourselves in the world'. This therapeutic narrative is governed by the ethos of personal responsibility, as addressed above by both Giddens and Beck. It is 'dominated by the principle that says one must "take care of oneself"' determines Foucault (1984b/1988: 43) who charts the emergence of this obligation. The notion of self-care can take many forms, as he demonstrates. Today it is linked not only to self-therapy, mental health and emotional intelligence, but also to physical health and appearance, being closely connected to the body and self-presentation.

In relation to biomedicine, Greco (1993: 357) describes a rising narrative of 'healthism', predicated on an understanding of health as 'the enterprise of oneself' and, in turn, of disease as 'a moment of verification of the moral aptitude of individuals to form part of the society within which they live'. Consequently, Greco (1993: 358) argues: 'the categories of health and illness have become vehicles for the self-production and exercise of subjectivities endowed with the faculties of choice and will' that bring with them a 'duty to stay well' (357).

On a more fundamental level, our bodies, in both illness and health have come to be seen as a form of work in which we are expected to engage. The care of the body, both inside and out, is our responsibility. In her aforementioned book *Bodies* Orbach (2009: 8) describes a 'current cultural discourse' on both the male and female body,

[58] It should be noted that while Furedi analyses North American culture, Beck explores German society, and Giddens, Hall and Rose focus on developments in Britain, all these authors draw conclusions about contemporary Western culture in general. Hardly any distinctions are made between the cultural and social experience of late modernity in the countries concerned. This generalised analytical approach might be adequate for theorists who live and work in different Western countries and are involved in a vibrant cultural intellectual exchange. This thesis, however, aims to pay cognisance to the cultural specificity of notions of self, dress, gender and therapy that underpin the three different dress-therapeutic settings in France, Germany and the US, as has been touched on in the discussion of Foucauldian discourse analysis (1.2.2).

marked by the naturalised assumption that 'looking good for ourselves will make us feel good' and by 'a belief in both the perfectible body and the notion that we should relish or at least accede to improving our own body' (2). This discourse, she argues: 'means that we have entered a new epoch of body destabilisation' (8), which Orbach (2009: 4) portrays in the following words:

> The body has become a new focus in both women's and men's lives, no longer something secure or ordinary in itself. A new rhetoric of detox, weight training, brushing, irrigation, cleansing is proposed, inclining us to watchfulness and determination where our body is concerned. Those who had previously paid little heed to fashion or health now find themselves caught up in attempts to make the best of themselves and take responsibility for their health and well-being. The individual is now deemed accountable for his or her body and judged by it. 'Looking after oneself' is a moral value. The body is becoming akin to a worthy personal project.

As such, our current understanding of the body is deeply embedded in the therapeutic narrative with its very recent constituents of 'self-monitoring' and 'self-optimisation', and its corresponding idea of the individually responsible self-therapist. 'The way the body looks and functions is seen as a crucial personal responsibility' reiterates Orbach (2009: 136). Its neglect is considered to be a form of personal risk.

The notion of the body as a form of work entails dress, although Orbach does not cover this. The clothes we wear, our hair and make-up are all crucially involved in the project of self. They form part of the notion of a therapeutable self, as this thesis documents. Dress can thus be understood as a technology of the optimised, presentable and successful self. The 'discursive explosion' (Foucault 1976/1990: 17) around the relationship between dress and self is indicative of this development, whether in its popular forms of dress advice and style guidance (1.3.1) or in the shape of psycho-medical texts and practices, such as the dress-related therapeutic practices under review in this thesis.

1.5 Conclusion

This chapter outlines the concept and theoretical context of my thesis. It explores the fields of two of the key discourses currently defining both our experience and understanding of self, the discourse of (fashionable) dress and its use in relation to the self, and that of therapy. The chapter focuses on the Foucauldian framework of this thesis, and delineates the different ways in which Foucault's work lends itself to my project, both theoretically and methodologically, while also indicating some of the ways my thinking diverges from his.

In this respect I would position my thesis between structuralist accounts of the self and the approach of a genealogy of subjectification as proposed by Foucault and developed by Rose. My critical analysis of "dress therapy" is informed by structuralism, as I argue that the self is influenced by wider social and cultural transformations, such as industrialisation and the attendant modern notion of the self as immanent in appearance, or the medicalisation of everyday life and the rise of therapy culture. But it is also informed by a genealogical approach focusing on discourses as 'devices of meaning production' (Rose 1996: 30), as outlined above.

A number of methodological considerations arise from this contextual review, particularly from the limited existing sources on the chosen dress-related therapeutic approaches. These methodological consequences will be discussed in the following chapter.

chapter two
Methodology

Introduction

> For *The Birth of the Clinic* I read every medical work of importance for the methodology of the period 1780-1820. The choices that one could make are inadmissible and shouldn't exist. One ought to read everything. In other words, one must have at one's disposal the general archive of a period at a given moment. (Foucault 1966b: 263)

The work of Michel Foucault has impacted very directly on the development, conceptualisation and analytical framework of this thesis, as outlined in Chapter One. Methodologically, his ideas about genealogy and, most importantly, his notion of discourse and its analysis have been influential. The latter is highly useful in determining what type of data to analyse and what questions to ask of my data. However, Foucault's writing offers little on actual research methods, or ways and parameters of gathering data. One of his rare comments on the specifics of doing research is quoted above, somewhat indicative of his radical, philosophical and less practice-oriented approach. 'One ought to read everything.' A dangerous imperative, I came to realise when researching 250 years of institutional psycho-medical history of three countries for Chapter Three. Moreover, the challenge to read every work 'of importance' seems odd coming from the man who ground-breakingly demonstrated the deconstruction of epistemological hierarchies. Nonetheless, I heeded his advice to some extent and read widely for the genealogical exploration of "dress as therapy", as I tried to identify the works that made up or influenced the discourses that gave rise to the respective dress-related therapeutic settings. However, in order to investigate these settings and obtain the data necessary for their analysis, other methods had to be used, another methodology constructed, one that combines the Foucauldian 'top-down' approach with more 'bottom-up' (Hacking 2004) sociological methods, as previously discussed (1.2.2). In order to be able to analyse the specific discursive construction of each of the therapeutic practices with their local idiosyncrasies, to discern the face-to-face interaction of individuals in concrete situations, this thesis requires a qualitative methodology: one that builds on the Foucauldian framework and draws on his notion of discourse in its analysis, whilst corresponding to the full scope of my project.

In its exploration of “dress as therapy” this thesis follows a multi-disciplinary approach. It combines historical and sociological methods. It employs historical methods ‘to construct interpretations’ of past discourses and practices ‘from its surviving remains’ (Tosh 1991: 53), for their ‘historical re-creation […] as a preliminary’ (29) to explanations of the therapeutic present, which, in turn is explored through sociological methods. The project is qualitative in design, drawing on textual and visual sources as well as interview and observation data to explore the structure, content, aims, implementation and theoretical/scientific underpinnings – or lack thereof – of the respective therapeutic approaches and to explore underlying notions of self, both implicit and explicit in these practices. These notions of self are analysed in relation to discourses of the body, gender, dress and therapy, national and cultural differences concerning these, and arising dress-related therapeutic practices.

The main focus of this chapter is on the empirical study of dress-related forms of therapy and its underlying research design. This part of my study requires particular methodological attention because of the unchartered nature of the field of “dress as therapy”. There are no methodological models I could follow, more so considering the closed nature of the psycho-medical setting and its ethical implications, as well as the self-reflexivity required of me as a researcher. Moreover, the research design had to take account of the diverse nature of the three therapeutic practices under review, and their specific cultural and disciplinary contexts. Consequently, this chapter concentrates on the sociological methods employed. The first part reflects on my role as a researcher and the nature and quality of qualitative research. It also addresses the use of historical methods in my thesis. The final part discusses discourse analysis as influenced by Foucault.

2.1 A reflexive qualitative approach

Undertaking social and cultural enquiry in times of postmodern and (post)feminist theories, in 'the most self-reflexive age' (Beck 2001), means that the reflexive engagement with one's subject of enquiry is not only expected, but also seems internalised. Whereas traditionally the experience of both researcher and researched 'was erased in favour of abstract analysis', today his or her subjectivity 'is treated as being of equal interest to the actions of the observed' (Murdock 1997: 186).

Reflexivity is described by George Herbert Mead (1934: 134) as the 'turning back of the experience of the individual upon' her/himself, as an interchangeability of standpoints. Yet, the claim to see the world through other people's eyes is impossible – however much we try we cannot know, but only attempt to understand. It is just as inconceivable to see everything from nowhere, as it is to see everything from everywhere.[59] Donna Haraway's notion of 'situated knowledges' is fruitful in this context, as it describes 'partial', 'critical' knowledges, a 'usable, but not innocent doctrine of objectivity':

> only partial perspective promises objective vision […] All these pictures of the world should not be allegories of infinite mobility and interchangeability, but of elaborate specificity and difference and the loving care people might take to learn how to see faithfully from another's point of view, even when the other is our own machine. (Haraway 1991: 190)

Consequently, the aim of this study is to produce a reflexive interpretative analysis, to offer 'situated knowledges' of the way the relationship between dress and the self is constructed and mobilised in the different dress-related therapeutic settings. The methodological considerations behind my thesis are detailed here to counter two things: the objective myth of an abstract analysis, and a subjective relativism that could arise from this intended form of interpretative cultural analysis.

The study of dress-related therapeutic practices as a field of human experience, including the exploration of the 'acts, gestures, discourses' (1.2.1) inherent to and formative of each practice, necessitates interpretative qualitative modes of enquiry. The main characteristic of qualitative research is that it emphasises words rather than quantification, both in the collection of data and in its analysis (Bryman 2004: 266).[60]

> Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. […] that describe routine and problematic moments and meanings in individuals' lives. (Denzin & Lincoln 2005: 3–4)

[59] As such, I need to acknowledge that it is not just with a sociological eye that I explore and analyse "dress as therapy". My perspective is also determined by my profession of a lecturer and fashion theorist, my background of a white German woman, my roles of mother and daughter, but also of relative and friend to people who have experienced psycho-medical institutions from within.

[60] The importance of qualitative enquiry for the study of human group life was established by Max Weber in the early twentieth century and institutionalised by the Chicago School in the 1920s and 1930s (Denzin & Lincoln 2005: 1), as it allows for a constructivist and interpretivist approach.

As such it is highly suitable for an exploration of differing dress-related therapeutic approaches: their respective construction, meaning and materiality. Moreover, "dress therapy", as a cultural phenomenon, calls for an interpretative approach which takes into account its transient nature. It is often assumed that objects of analysis are stable and so are their methods of research and analysis (Law 2007). However, "dress therapy" is not a fixed but an operative term, a field in the making, evolving with every practitioner and setting. Thus a reflexive qualitative approach to enquiry and analysis, which is 'not an experimental science in search of law but an interpretative one in search for meaning' (Geertz 1993: 5), is most appropriate for my project. Moreover, qualitative research methods such as interviewing and participant observation are the most suitable to answer its key research questions and provide the kinds of data to expressly address the different ways of working with dress on concepts of self in each of the therapeutic settings. They are the most appropriate to investigate underlying assumptions and naturalisations concerning notions of a gendered, embodied, therapeutable self in its relationship to dress, their discursive construction, and ensuing therapeutic practices.

In the course of this study different techniques of data collection, ranging from archival research and on-site visits to interviews and participant observation, were combined with modes of qualitative analysis, such as thematic analysis, discourse analysis, and thick description. 'Thick description' is defined by Geertz (1993: 18) as 'taking us right into the heart' of one's subject or object of study. It denotes a self-reflexive 'elaborate' (6) form of cultural analysis 'in search for meaning', as Geertz explains above and is taken up in this thesis to describe the way in which the dress-related therapeutic settings are analysed not only in their discursive construction, but also their rich cultural specificity.

The notion of a kind of methodological bricolage (Denzin & Lincoln 2005), lends itself to this study, as well as to qualitative research in general, and has been conjured up by several cultural and social enquirers (Lévi-Strauss 1966, de Certeau 1988, Kincheloe 2001, Weinstein & Weinstein 1991).[61] This is by no means an excuse for methodological randomness, but strategic and reflected integration of a number of perspectives that my subject as a whole demands. The multi-disciplinary nature of my research will be addressed below. Furthermore this form of triangulation, the 'combination of different methods, theories, data in the study of one issue' (Flick 2007a: 120), not only makes for a richer study, but also promotes the quality of qualitative research.

While quantitative research is evaluated through standardisation of research situations, this method is not viable for qualitative research, as my study of academically

[61] Denzin & Lincoln (2005: 4) describe the qualitative researcher in the following terms: 'The qualitative researcher may be described using multiple and gendered images: scientist, naturalist, field-worker, journalist, social critic, artist, performer, jazz musician, filmmaker, quilt maker, essayist. The many methodological practices of qualitative research may be viewed as soft science, journalism, ethnography, bricolage, quilt making, or montage. The researcher, in turn, may be seen as bricoleur, as a maker of quilts, or, as in filmmaking, a person who assembles images into montages'.

and culturally differing therapeutic settings illustrates. The research approach and interview questions developed for one setting cannot simply be mapped onto the next, for one is a historical project ("Therapy of Fashion"); another a pilot study currently applied differently in different hospitals (sensory stimulation treatment); and the third has been practiced for more than a decade (*vêtothérapie*) by different practitioners in three cities (Marseille, Fréjus and Paris). To assess and enhance the quality of qualitative research other measures have to be found, as a growing literature on the subject indicates (Flick 2007a&b, Patton 2002, Seale 1999). While there is no consensus across the literature, a number of pertinent evaluative measures have been identified, such as the indication of research procedures, adequacy of methods, rigour and consistency in their employment, as well as flexibility and diversity management (Flick 2007a). All of these aspects are rooted in reflexive and careful research design which increase the quality and validity of the research methodology. Consequently, the multiple data collection techniques and different modes of analysis outlined above are proposed because they can triangulate (Flick 2007a&b) and reinforce conclusions on "dress as therapy" in the context of an exploration of its discursive construction. While the diversity of settings might not allow for standardisation, it offers different perspectives to reflect on, test out and even, to some extent, compare ideas of self and dress in the therapeutic context, potentially enhancing research.

2.2 "Dress as therapy": An empirical study

2.2.1 A multi-disciplinary approach for an unchartered field of experience

As discussed in Chapter One, until now dress-related therapeutic approaches have hardly been explored, let alone analysed. There are no previous studies, few primary documentary sources, and limited discursive data to draw on, and so primary empirical data has to be collected at the therapeutic sites themselves. Moreover, the term "dress therapy" includes a variety of hitherto unconnected dress-related forms of therapy, which originate in a number of medical disciplines (pedopsychiatry, haptology, and psychology) and cultural contexts (France, Germany and the US). Therefore, this thesis delineates a field of experience which has not been analysed before, and proposes an exploratory empirical approach to take account of the specificities of each of the settings within it.

It should be noted, and the above remarks illustrate this already, that this thesis does not involve medical ethnography. I approach dress-related therapeutic practices as a cultural phenomenon, not as clinical techniques. The aim is not to investigate ways of treating psychological "disorders" related to the self, but to explore how the relationship between dress and the self is discursively constructed, and put into therapeutic practice.

Apart from the detailed examination of the three modern-day dress-related therapeutic approaches, this thesis also explores their zero point as well as a history of the present of such practices, as previously touched on. Thus, Chapter Three constitutes a discussion of the role and use of dress in relation to the self in psycho-medical institutions of the countries concerned from the mid-eighteenth to the twentieth century. While the parameters of this chapter will be addressed in more detail in its introduction, here I briefly outline its rationale and methodology.

In explaining why he 'would like to write' the history of the prison, Foucault (1975/1995: 31) states: 'Simply because I am interested in the past? No, if one means by that writing a history of the past in terms of the present. Yes, if one means writing the history of the present'. Foucault interrogates specific historical moments and changes to analyse how they make ourselves particular human beings in the present, and how they determine our contemporary landscapes. The history of the present refers to the way in which the past lays down tracks for the future. Thus, Chapter Three contains a history of dress-related therapeutic practices, the better to analyse their present. It provides an analysis of their historical trajectory and some of their common conditions of possibility. This historical investigation changes their reading considerably, as some practices can be understood as a continuation of the past, and others as departing from it. Moreover,

the straitjacket emerges as a dress-therapeutic means that runs like a red thread throughout psycho-medical history until the present.

Such a historical enquiry is pertinent as the role of dress in relation to the self in psycho-medical treatment has hardly been analysed, in spite of the fact, that, as I argue, implicit and explicit therapeutic use has been made of it in such settings for more than 250 years. Consequently, Chapter Three addresses a gap in the literature and constitutes an original contribution by way of providing an overview of some of the different discourses and engendered practices which relate dress to the self in formative ways at particular historical stages of psycho-medical institutionalised treatment. The chapter both draws on a range of primary sources such as medical books and manuals, and proposes a re-reading of secondary sources on the history of madness by focusing on the previously overlooked topic of the role of dress in the treatment of the "mad".

In order to explore historical dress-related discourses and practices, I drew on a rich variety of textual and visual sources for Chapter Three as well as Four to Six. While Foucault found evidence of discourse, of what is said and done (1.2.2) in written accounts almost exclusively, this thesis brings together texts and images. The majority of my historical source were written, published material, however. They include: medical books and manuals; journal, magazine and newspaper articles; autobiographies, novels, a political report, an inspection report, analytical texts of the respective period, a contract, guidelines, delivery notes, advertising copy, and song lyrics. These were, however, combined with a great variety of visual sources, such as: medical drawings and illustrations, paintings, advertisements, news photographs, a documentary film still and photographs of therapeutic settings (Ch.4–6, published in medical journals or newspapers at the time of the respective therapeutic practice, or taken by myself where possible).

Combined with the sociological methods employed to explore the contemporary dress-related therapeutic practices, the historical methods used make for a multi-disciplinary approach that can take account of the scope of this thesis. As Palmer (in Repko 2012) argues: 'The real-world research problems that scientists address rarely arise within orderly disciplinary categories, and neither do their solutions'. Moreover, the use of both sociology and history lends itself to this research, as they are 'engaged in different branches of the same study: the study of man and his environment, of the effects of man on his environment and of his environment on men' (Carr 1964: 86 in Tosh 1991: 29).

The remainder of this section will detail the research design of the empirical study of the three modern-day therapeutic practices, discussing principles concerning the selection of therapeutic settings, access, interview and observation research as well as data analysis.

2.2.2 The selection of and access to therapeutic settings

Any decision regarding sampling involves a choice as to which materials, cases, persons, groups or sites to research. I began this study with visits to different settings in order to delineate the field of "dress as therapy" and to assess their willingness to cooperate, as the development of the study very much depended on the level of access granted. Early on, the focus was wider, as I looked at dress-related "work" on the self, that is, numerous approaches or projects addressing "issues" related to self and its perception. I used dress in its broad definition, including the 'total repertoire of body modifications and supplements that a particular social group makes available to its members' (Eicher & Roach-Higgins 1992: 9). Thus, my research potentially included non-therapeutic approaches, such as the image and style guidance discussed earlier (1.3.1), as well as therapeutic practices using hair and make-up. At that stage, I considered including a separate study of cosmetotherapy, as a widely established and practiced form of dress-related therapy with chemotherapy patients.[62] However, I decided to limit the focus of this thesis to psycho-medical therapeutic settings working with clothing, as the realms of both clothing and therapy delineate distinct fields of experience. I finally selected the following three settings: "Therapy of Fashion", *vêtothérapie*, and sensory stimulation treatment.

"Therapy of Fashion", practiced in the US in the 1960s, was chosen because it constitutes an explicit, intentional and clearly delineated attempt to integrate fashionable dress within the psycho-medical therapeutic process, to work on the self with fashion. Moreover, it was the first dress-related therapeutic approach I encountered and as such inspired some of the thinking behind this research. *Vêtothérapie* followed and is currently the most established of the approaches, working with fashionable dress on the self of adolescents in a space set up specifically for that purpose, the *vêtothèque*. Sensory stimulation treatment was chosen because it constructs an altogether different, haptic-based discourse of the relationship between dress and the self, which produces a distinct therapeutic practice: the wearing of only one, rather functional, garment, a diving suit, to impact on the "anorectic" self.

The form of this thesis was also determined by a number of practical constraints, which needed to be considered for its research design, such as access, language, money and time. Gaining access to any field, institution and people can be difficult (Flick 2007a: 34),

[62] I conducted extensive research into the cosmetotherapy workshops offered by *Look Good Feel Better* (LGFB), a non-profit 'cancer support charity', a public service programme developed in the US in 1989 by the Personal Care Products Council Foundation, available in more than twenty-five countries worldwide. Its aim is to 'help women manage the visible side effects of cancer treatment' through complimentary self-help workshops that follow a '12-step skincare and make-up regime' (http://www.lookgoodfeelbetter.co.uk/site/index.cfm, 17.1.2012). My research concentrated on their work in the UK, where I was kindly permitted to observe one of their sessions at Maggie's West London at Charing Cross Hospital. I am also grateful for the opportunity to interview organisers and practitioners of LGFB and the time they granted me.

but access is a particular sensitive issue in a psycho-medical or clinical setting. Getting access to the two contemporary dress-related therapeutic practices turned out to be very different experiences. While the scientist behind sensory stimulation treatment, Dr Grunwald immediately agreed to an interview, took half a day off to talk about his work and shared all his contacts of relevant practitioners, getting access to *vêtothérapie* turned out to be much more problematic. Following the inauguration of the first *vêtothèque* at a newly founded adolescent psychiatric unit in Marseille in 1999, the concept of *vêtothérapie* had received much critical attention in the local and national French press (5.3.1) and although several journalists had initially been allowed into the *vêtothèque*, access was later restricted. While I had conducted a first interview with the coordinator of the project at the Marseille fashion institute (IMM) in preparation for this doctoral research, my requests for interviews or visits following her retirement were not met with a positive response. As *vêtothérapie*, practiced in Fréjus, Marseille and Paris at that point, was the most established of the contemporary "dress therapy" approaches, the refusal of access was a concern for the orientation of this thesis. Eventually, I secured an interview with the initiator, Professor Rufo, who also took me on a visit to the Marseille *vêtothèque*, and introduced me to staff there and at the Paris site. Subsequently, visits and interviews were conducted at all three *vêtothèques* and I observed a *vêtothérapie* session in Paris.

Access was just one of the practical constraints which determined this study. Language too has naturally influenced the parameters of my research and its resultant Western context. The selected therapeutic settings are situated in three different countries and linguistic areas. Not only did this necessitate organising and financing several research trips, it required me to take cultural and linguistic differences into account. While I have a command of the three languages concerned, I do not speak them to the same degree. I felt the implications of Ludwig Wittgenstein's (1922/1963: 5.6) observation: 'The Limits of my language mean the limits of my world,' quite acutely on several occasions during this research and especially when attempting to read Foucault in French or during the glacial transcriptions of my French-language interviews. Moreover, Wittgenstein's observation does not only apply across different languages, but also within the same language: how to speak to a French or a German psychologist, how to talk to a haptologist, a child psychiatrist, a nurse or even a patient, should the situation arise in the course of a visit or observation? Translations have become an important feature of this research, not just linguistic but also temporal, which will be discussed later on in the context of data transcription and analysis (2.2.5).

Finally the choices as to who to interview or observe largely followed the internal logic and workings of each therapeutic setting. Thus interviewees were selected for their involvement in “dress therapy” as initiators, coordinators or practitioners, and because of their accessibility, suitability and participant consent. This process was purposeful and systematic to some degree, in that I decided in interviews to focus on the executive side – initiators, practitioners, medical and therapeutic staff – rather than patients. This choice was not only made for reasons of ethics and access, but also because the focus of this thesis is on how the relationship between dress and the self is constructed and mobilised. My aim to establish the underlying discourses and see how they engendered the respective therapeutic practices, could best be achieved through interviews with the executive side, albeit without forgetting the capacity of patients to shape these practices. While this decision might constitute a limit to my method, somewhat contributing to a psycho-medical history that traditionally emphasises the viewpoint of the therapist rather than the patient (Digby 1985: 54), I would argue that it has also, largely, enabled this research and is adequate for its purposes. It allowed me to focus on the discursive constructions of therapists as formative of their practice, rather than on the experience of patients. In a similar vein I decided to aim for a series of interviews first, and to undertake participant observation only when offered, and where appropriate (2.2.4).

2.2.3 Interviews

Interviews constitute the main qualitative research method in this study because they are epistemologically and ethically the most appropriate for the project. The aim of the interviews was not only to explore the respective therapeutic approaches, with their underlying assumptions about the relationship between dress and the self, and to discover how they determine each therapeutic practice. It was also to generate data. As pointed out above, relevant discursive data is limited and interviews represent an invaluable way to gain just that. Thus, in order to take account of the specificity of each therapeutic setting, which is very much shaped by the medical staff involved, a series of face-to-face interviews were conducted with the initiators of each dress-related therapeutic approach and the therapeutic staff practicing it.[63] In the course of this research twenty interviews were conducted[64], the majority of which in the context of *vêtothérapie*, as this was the most widely practiced form of therapy. Here the interviewees range from the project initiators, the child psychiatrist Professor Rufo, and the president of the Marseille fashion institute (IMM) at that time, to its project coordinator, the practicing psychiatrist, a medical nurse, an education officer and two stylists who were part of the therapeutic team in Paris.

The format of the interviews was semi-structured to encourage the open participation of the interviewee, while still allowing the pursuit of themes which might emerge during the interview, as well as some control over its direction (Kvale 2007). The intention was to allow interviewees to say how they understand, devise and experience "dress therapy" in their own words, and, whilst monitoring what was emerging and guiding them towards themes relevant to the research, to allow them to emphasise their priorities too.

Interviews are periods of social interaction, a fact which has been overlooked for some time (Wooffitt & Widdicombe 2006: 32). This means that interviewer and interviewee act and speak in relation to, and 'reciprocally influence each other' (Kvale 2007: 13–4). The interactive dimension of semi-structured interviews means they adhere more closely to the 'normative conventions of conversation' (Wooffitt & Widdicombe 2006: 48). Thus my role as researcher was not strictly directive, working with a topic guide rather than pre-determined questions to leave the interaction relatively unconstrained, following the themes I wanted to explore. These included: the background and development of the therapeutic approach; its aims and their implementation; the understanding of notions of

[63] Prior to the interview, interviewees were given an information sheet, tailored to every therapeutic setting, outlining the nature of my research and explaining why their work is of interest. They also received a participant consent form with the choice of identity disclosure or assured anonymity. All interviewees opted to disclose their identity.
[64] See Bibliography & Sources for details of the interviews.

dress, self, body, gender and therapy in order to delineate the discursive constructions and naturalisation informing the work of doctors and therapists; institutional and personal evaluation, patient feedback and written documentation. Fully formulated questions related to these 'domains of interest' (Angrosino 2007: 47) were only used when interviewing in French, to ensure clear communication and flow. In a similar vein interviews were recorded, with permission, to avoid interrupting the free-flow of the "conversation" and to enable me to concentrate on the topic and dynamics.

As instances of social interaction interviews contain both verbal and non-verbal communication and the role of the interviewer in shaping responses needs to be carefully considered (King 1996: 175). To lessen the interviewer effect, the interviewer has to exhibit an openness and 'presuppositionlessness' (Kvale 2007: 12) especially in the way questions are phrased, avoiding over-direction. Effective listening skills (King 1996: 175) as well as an awareness of the power relations within the interview setting (Kvale 2007: 14–5) are equally important.

Traditional perceptions of the researcher as the one holding the power within the research setting (King 1996) are not wholly appropriate for this context. The interviewees in this study were mostly established medical professionals, experienced in their respective fields and older in years. Although it is difficult to generalise about the power relations I experienced across such a diverse range of interviewees, in most of the situations my role was that of a research student, and a novice to the psycho-medical field, asking for their time and knowledge. Moreover, all interviews took place in the offices of the interviewees, on their territory so to speak and in their language, both culturally and professionally. One of the French interviewees made her understanding of our (power) relationship clear by addressing me with the informal personal pronoun "tu" from the beginning and without asking, which is very uncommon in formal encounters in France and signals an inferior or junior position.

Nonetheless, I observed that a number of my questions, particularly concerning the underlying reasons for including dress in the therapeutic setting, seemed to catch some of the interviewees "off guard". One of the interviewees told me that she was developing her thinking on dress and the related therapeutic practice, and asked to stay in touch to exchange ideas. Yet, when in a second interview I asked her more directly than previously about any possible subjective and normative notions of physical beauty within *vêtothérapie*, the interviewee reacted quite disapprovingly, became noticeably more reserved, and did not reply to further contact requests thereafter. This episode illustrates the mutual dynamics of power of an interview, but also my dependence as a researcher on key informants, and how power relations impact on questions and answers. Generally speaking, however, a good rapport was established with many

interviewees and future cooperation offered. Follow-up interviews were conducted where possible and necessary in order to take account of developments concerning the respective therapeutic settings and practices, as well as their evaluation.

2.2.4 Observation research

Where possible and viable, I intended interviews to be complemented by participant observation, as 'a way of gaining access to the meaning of social action through either empathetic identification with those one is observing, through witnessing how the behaviours of actors acquire meaning through their connection to linguistic or cultural systems of meanings or forms of life, or both' (Schwandt 2007: 220). This type of research is potentially very useful, as it can give an insight into what interviewees have been describing without subscribing to the classical view that there is an authentic and true account of social situations (Seale 1998: 206). Rather, it can both illustrate their accounts and possibly also reveal what is taken for granted, or naturalised in them. Moreover, observation research can convey the ordinary and routine practices and behaviours that are so hard to describe when they are part of one's daily life or work. I thus considered that participant observation of dress-related therapy sessions could potentially allow for an analysis of the therapists' intended, actual and perceived actions, versus what they might actually do, an analysis of what is being put into practice. Additionally, it could enable me to step back from what might be obvious conclusions and to look at the nature of social interactions and the lived reality of "dress therapy".

In the course of this research, I finally decided to observe only one "dress therapy" session, mostly for reasons of ethics. While there are currently three *vêtothèques* in France, only the one in Paris was a viable choice for observation research, as the other two were either not active (Marseille) or were working with children (Fréjus). Although I had found the observation of *vêtothérapie* in Paris a very useful addition to what I had read and heard about the approach, and observing this session certainly enriched my analysis, I also felt uncomfortable even in this open group session, as discussed later on, and decided against observing further sessions. As for sensory stimulation treatment, I was given the opportunity to observe a body therapy session in Berlin but declined, as I felt it would be too intrusive to observe the individual treatment of a minor with anorexia. While these decisions might be a limitation of my method in that they restricted the available data, they were important ethical decisions for me.

Observational research, as indicated above, encompasses logistical, ethical and political concerns, because it means 'entering the world of those one studies, gaining their trust, developing empathy, and understanding their ways of talking about and acting in their world' (Schwandt 2007: 219–20). Even when doing individual or short-term observation, the observer's role in the process of a therapy session has to be taken into account. Particularly when assuming an overt role, which in my case was a given, both practically and ethically, there is a tendency to change one's behaviour because one is being

observed (Angrosino 2007: 61). Observer bias, it has traditionally been claimed, can be lessened by remaining a 'complete observer' (Gold 1958), by not participating, but remaining at the edge of the field. However, feminist critique has argued against such critical distance as a myth, calling for closeness (Haraway 1991), advocating a form of research *with* not *on* the people being studied (Schwandt 2007: 219).

Consequently, I entered the observation in the knowledge that any form of participant observation constitutes a balancing act between perceived and real influence on the subject and objects of study. I entered assuming the strategic position of a sociological form of stranger (Simmel 1908: 143):

> not bound by roots to the particular constituents and partisan dispositions of the group [thus enabled to confront] all of these with a distinctly "objective" attitude, an attitude that does not signify mere detachment and nonparticipation, but a distinct structure composed of remoteness and nearness, indifference and involvement.

I thus observed with a strategic objectivity or rather a reflexive subjectivity, as discussed at the beginning of this chapter.

The one *vêtothérapie* session I observed in Paris constitutes an interesting example in this context. "Dress therapy" is conveyed here as an informal undertaking: a large room housing several wardrobes filled with fashionable clothes, walls lined with mirrors, music playing. The five girls who took part in this session looked through the wardrobes and selected some garments. They tried them on next door to come back and look at themselves in the mirror, asking the education officer in charge of the *vêtothèque* for her opinion. Meanwhile I sat in the background, introduced as 'just a student', I was observing. Halfway through the session one of the girls approached me with the words: 'Do you think this suits me?' While the girl might have felt uncomfortable with my remote involvement, while she might have wanted to draw me into the activity, there was nothing unusual about her question in the context of this session. Rather, it illustrated the tone of *vêtothérapie* here: girls trying on clothes, asking each other for advice, using each other and the therapist, or indeed anyone else in the room, as mirrors. In order to remain the 'sociological stranger' I turned the question back to her: 'what do you think?', she shrugged and moved on. This one question illustrates the myth of the 'complete observer'. Particularly in the process of dressing, observation means participation, because the perception of ourselves relies so heavily on that of others, as theorised in symbolic interactionism (Stone 1962, Kaiser 1997) (1.1).

In an attempt to lessen my effect as an observer, I took no notes during my observation. Much more than interviews, however, observation research focuses on both verbal and non-verbal human behaviour and requires the researcher to fully and systematically document, record and analyse all observations. Moreover, observing is the act of 'perceiving the activities and interrelationships of people in the field setting through the

five senses of the researcher' (Angrosino 2007: 37). Whereas verbal communication can be and was recorded digitally, it is the non-verbal communication and behaviour which have to be noted in as detailed a way as possible after each session. The observation notes I took afterwards were extensive, detailing what I saw, heard and felt (Gibbs 2007: 31). I described the therapy setting, numbers and appearances of participants, including their dress, their behaviours and interactions (Angrosino 2007: 40). Moreover, as the transcription of audio records is more difficult than that of interviews, due to several simultaneous layers of conversation, I used observation notes to aid reconstruction.

2.2.5 Transcribing & translating

From a linguistic perspective transcriptions are always translations (Kvale 2007: 93). They are transformations from oral into written text, with different sets of rules underlying each. One cannot recover the experience of conversation as it actually occurs, the 'inner experience of language-spoken-now' (Basso 1992: 228). Furthermore audio recordings in themselves are never a comprehensive record of an event.

> The recording of the interview involves a first abstraction from the lived bodily presence of the conversing persons, with a loss of body language as posture and gestures. The transcription of the interview conversation to a written form involves a second abstraction, where the tone of voice, the intonations and the breathing are lost. In short, transcripts are impoverished, decontextualized renderings of interview conversation. (Kvale 2007: 93)

Thus transcribing is an interpretative process, best performed by the researcher to bring a closer appreciation of the meanings of data (Seale 1998: 207). It is also in these 'partial and selective textual representations' (Rapley 2007: 50) that analysis begins. I produced verbatim transcriptions of all interviews, using a code where viable (e.g. Poland 2002 or Jefferson 2004) to allow for more detail, such as intonation, volume, pauses or social interaction, to achieve a more textured re-production.[65] As most of the interviews were conducted in either French or German, the translation of key material, identified in the process of coding and thematic analysis outlined below (2.2.7), constituted an important (and time consuming) stage, already very much part of the analytical process. All translations were undertaken by me and the original language quotations are included in the footnotes.

[65] This summary of interview transcription constitutes a case of post-research rationalisation, as addressed in the conclusion of this chapter. While the transcription of interviews conducted in English and German was a relatively easy process, transcribing the French interviews added significant time periods and some moments of despair to this research. Following my first interview in French it took me one hour to transcribe one minute of conversation and I did not dare to do the maths for the four hours of interviews I had conducted during my initial week of fieldwork in France. Over the years and with proper transcription software (F5) I got faster, ten minutes per minute, which made the total transcription time for the approximately ten hours of conversation recorded in the context of my research on *vêtothérapie* more manageable.

2.2.6 The use of visual data

In this thesis, interview and observation data was complemented with visual research notes. In spite of the fact that the social sciences are 'disciplines of words' (Banks 2007: 95), the use of visual data is propagated within the context of visual sociology (Banks 2001, Mead 1975/1995) and this study of dress-related therapeutic practices called for the recording and use not only of words but also of images. As previously touched on, the Foucauldian notion of discourse is extended to include visual and spatial dimensions (1.2.2).

I worked with two types of images, which are also included in the thesis: existing visual documentary material connected to the respective therapeutic settings and my own photographs, which constituted my visual field notes. Just as I took written research notes in the context of interview and observation research, I also took photographs of the "dress therapy" setups, documenting both the spaces used and the dress worked with. I did not, however, photograph my observation research, in order to ensure the anonymity of the participants.

It is important to note that in some of the media coverage of both "Therapy of Fashion" and *vêtothérapie* patients are represented in an unanonymised manner. In several popular press articles on the *vêtothèque* in Marseille, for example, the under-aged patients are readily identifiable to the reader and no attempt is made to even anonymise their names[66]. Where such images of *vêtothérapie* are reproduced in my thesis, I added a censor bar to obscure the eyes of the under-aged patients.[67]

The relevance of the visual data lies in its capacity to illustrate descriptions given by interviewees or by me. Yet, photographs, for example, are not objective records (Sontag 1977), but, rather, they constitute another form of depiction that helps to document and subsequently to analyse aspects of "dress therapy". Among other aspects, they can show the nature of institutional space and the enactment of power through it (Foucault 1975/1995). The rooms where therapy sessions take place, for instance, are not neutral spaces. They have been set up by doctors, nurses or therapists and – intentionally or not – they both illustrate and enact some of the naturalisations and notions of power underpinning the respective treatment approach. The *vêtothèque* in Paris, for instance, is situated in a multi-purpose space lined with mirrors and contains an enormous wall of windows, in a building specifically designed for the psychiatric treatment of adolescents. The notions of transparency and self-reflection are very much present and need to be analysed in relation to this space, which constitutes a form of discourse in itself.

[66] In this respect Rotman (2001) constitutes a rare exception.
[67] Photographs of "Therapy of Fashion" which feature patients are included without such bars, because only adults are concerned. Moreover, this treatment took place fifty years ago and the images have been in the public domain since then.

Moreover, the wardrobes in the *vêtothèque* in Marseille are marked with astronomical gender symbols, so they are designated as exclusively either “male” or “female”. Some of the shelves inside are labelled “small”, “medium” and “large”, referring to the sizes of the garments they contain. Both of these aspects are analysed in terms in terms of the technologies of truth, power and self they form part of.

2.2.7 Coding & data analysis

> Nothing has done more, I think, to discredit cultural analysis than the construction of impeccable depictions of formal order in whose actual existence nobody can quite believe. (Geertz 1993: 18)

The process of research and analysis did not necessarily follow the sequence presented here: the analysis of "dress therapy" data was concurrent with its research and constitutes a central part of this study. Different stages and modes of qualitative data analysis were applied: from descriptive or thematic analysis, involving coding to elements of comparison, and discourse analysis (2.3). The overall analytical aim was the achievement of a critical, interpretative analysis of dress-related therapeutic practices, moving away from the 'impeccable depictions' evoked above.

While this sub-section addresses the process of organising, coding and thematically analysing data, the final section outlines the application of discourse analysis. Following the collection and generation of material for the respective fields of enquiry, I broke down the stream of my research data into its component parts for a descriptive analysis (Angrosino 2007: 67) to ask what patterns and themes emerged from the data. In order to record, manage and structure the wealth of individual data collected and generated throughout this research, I developed an analytical table (appendix 5) organised by theme. 'The formation of themes,' according to Holliday (2007: 200), 'represents the necessary dialogue between data and researcher, which emerges from and then helps to further make sense of data, and then to provide a structure for writing'. This thematic way of collating and structuring my material proved a vital strategy throughout the process of the thesis, guiding me through both research and analysis, keeping me focused and enabling me to return to the project time and again, an important aspect when undertaking a PhD part-time.

The thematic categories included in the table have grown throughout the research process, influenced by both my Foucauldian analytical framework and by my empirical enquiry.[68] They were first developed during the conceptual stages of this project and developed further during data collection and analysis, depending on how useful and effective they proved. As categories they are partially prescriptive, guiding what to research, and in part a post-hoc reaction to the findings and the issues thrown up by the data. This type of thematic analysis, rather than a linguistic one, was useful in the context of this study, as certain themes run through all "dress therapy" projects, such as underlying assumptions concerning notions of self and the relationship to dress,

[68] An extract from the table is included as appendix 5. The categories grew from twenty-five in the original table to forty-three at the point of submission, although the table remained very much a dynamic work-in-progress tool. To the categories under 'description' I added themes like the target group or diagnoses, number of patients treated, training received, dress worn by patients and practitioners outside of therapy and their evaluations. While the 'research' categories remained the same throughout, the themes under 'analysis' were developed to include, for example: the discursive construction of the relationship between dress and mental health, conditions of possibility, the way naturalisations shape therapeutic practice, or discursive strategies.

suppositions concerning the body, gender and beauty ideals, or the nature of therapeutic intervention.

While this table might suggest a comparative approach to analysis, it was not the focus of this project. Saying that, some comparisons were drawn both within and between therapeutic settings. The consideration of similarities and divergences among these apparently very disparate projects of differing disciplinary and cultural contexts, defined their distinction and highlighted their parameters more clearly.

Following the identification of key themes and their evidence, transcriptions were coded to indicate that a passage is an example of a particular theme, on the basis of which can be analysed who said what about a theme (Gomm 2004: 189–90). The process of coding, of labelling my data provided a sound basis for the analysis of the respective dress-related forms of therapy. Moreover, this thematic engagement with the data enables an initial theoretical analysis, answering the following: How do component parts fit? How can patterns be explained? How to account for perceived ir/regularities? (Angrosino 2007: 68). It enables thick descriptions of “dress therapy” that can contribute to an understanding and eventual analysis of the way the relationship between dress and the self is constructed and mobilised in the respective settings. Accordingly, each of the chapters in Part Three of this thesis gives a thick description of one dress-related therapeutic setting, considering national and cultural particularities to counter generalist assumptions concerning Western cultural practices, as detailed in Chapter One. These chapters give a description ‘that demonstrates the richness of what is happening and emphasizes the way that it involves people’s intentions and strategies. From such thick description it is possible to go one stage further and offer an explanation for what is happening’ (Gibbs 2007: 4).

2.3 Discourse analysis

> The form of analysis that Foucault offers is a reflexive one. Analysis – in which can be included bodies of knowledge and their accompanying techniques and practices – is the process through which the reality of the body is created. (Armstrong 1994: 25)

This thesis takes up Foucauldian discourse analysis as a qualitative analytical approach in order to explore the way dress-related therapeutic practices, have, firstly, been formed by particular notions of self, body, gender, dress and therapy; and secondly, how they employ dress to work on the self. The notion of discourse lends itself to this study, as outlined before (1.2.2), because it draws attention to the type of analysable data: what material to look for or generate; and to the questions asked of that data: what to do with the material.

Having outlined the qualitative research approach of my thesis, and previously discussed the types of data that make up discourse (1.2.2) this section focuses on the analysis of the data gathered as discourse. On the basis of a thematic organisation and coding of data, Foucauldian discourse analysis permits particular questions to be asked of that data, considering technologies of truth, power and self that make up the field of experience of "dress as therapy". Some of the key questions I asked in order to delineate how the dress-related therapeutic practices were generated, and were, in turn, employing dress as a technology of the self, are listed below:

• What notions of self, body, gender, dress, therapy, mental health and illness underpin these therapeutic practices? What type of language is used? What are the differences between what is said or written and what is done, for example, in terms of the gendering of practices?

• How is the relationship between dress and self, and between dress and mental health/illness, discursively constructed? And how are these discursive constructions mobilised? How are they formative of therapeutic practices?

• What are the conditions of possibility of each therapeutic setting: how did and could it become what it is?

With regards to technologies of power, I questioned the multidirectional power dynamic between medical staff and patients, and asked what networks of power relations the practitioners found themselves positioned in. More generally, I explored power/knowledge relations, and gender/power relations (1.2.1).

The consideration of technologies of truth incorporated the following questions:

• What are the truths embraced in the respective approaches?

• What are the truths to be legitimated?

• What are practitioners' strategies for truth creation?

• What truth games are the practitioners caught up in, and in which of them do they participate?

The notion of discourse enables the consideration of both naturalisations and silences, that is, what is unspoken in the acts and utterances of medical staff. Moreover, it facilitates the analysis of the way these truths and naturalisations shape practice. Finally, attention can be drawn to the discursive strategies: what discursive strategies do the practitioners draw on to legitimate their versions of self and other underlying notions, and of the truth of "dress therapy"? Interviews, for example, can thus be understood as spaces of self-construction and representation that form part of such strategies.

To illustrate the concrete application of Foucauldian discourse analysis, but also ways of extending it, I will consider an example in the analysis of cultural conditions of possibility concerning the respective therapeutic practices. As previously argued (1.2.2), Foucault has been criticised for the somewhat generalist nature of his accounts of fields of experience (McNay 1994), and for failing to distinguish between gendered or culturally specific discourses. By contrast, this thesis aims to pay particular attention to the specificities of the respective experiences of "dress therapy". In order to avoid and, indeed, counter generalist assumptions concerning "Western culture" this thesis attempts to take into account the national, cultural and discipline-specific distinctiveness of the discourses of self, dress, the body, gender and the dress-related therapeutic practices that such discourses inform.

While the general Western contextualisation of therapy culture (1.4) or the role of dress in institutionalised psycho-medical settings (Ch.3), for example, is adequate for the subject matter due to an active inter-cultural exchange, as addressed later on (Ch.3), one has to bear in mind that each of the settings, situated in three different countries mobilises a specific history and contextualisation of the self. Nations might be invented (Powell 1969, Gellner 1983, Smith 1991), and they might only be 'imagined communities' (Anderson 1991) in decline in an increasingly globalising world, but there are vital and lasting differences in the way they are imagined (Anderson 1991). If national culture is understood as a discursive construction, discourses which make up different nations and cultures will vary. French discourses on fashion and femininity or taste, for example, are said to be culturally specific, as forcefully demonstrated by Rocamora (2009) and Bourdieu (1984). As such they are likely to be different from German or American ones. Moreover, the dress-therapeutic approach of *vêtothérapie* has to be contextualised within a French cultural setting, as it comes out of a cultural therapeutic approach (*soins culturels*) developed within a movement of the humanisation of hospitals in France throughout the twentieth century. In contrast, "Therapy of Fashion", whilst correlating with an initiative to humanise mental hospitals in the US from the 1950s, was not primarily concerned with the notion of culture. Finally, sensory stimulation treatment needs to be read against the backdrop of a particular German haptological tradition. These instances illustrate that, although it is not a primary aim of this thesis to analyse

the way the relationship between dress and the self is constructed and mobilised in terms of respective cultural settings, these cannot be ignored. Moreover, this example of applying discourse analysis indicates the usefulness of my Foucauldian analytical approach, enabling the analysis of discourses as ‘devices of meaning production’ (Rose 1996: 130), as having real effects: the formation of therapeutic practices which use dress to work on the self.

2.4 Conclusion

> I am concerned with the way rationality is constructed. A shallow example: We tend to think of scientific decisions as rational. But, actually, he only researched this or that because, mmh, there was this device standing in the corridor, no one was using it, so he took it and turned it on to see what would happen. That's science, really. And afterwards rationality is constructed. Afterwards it is said, here, we had the following research question, the following objective, because of x or y. (Grunwald, author interview (AI)[69], 24.8.2007)[70]

This thesis first began when I came across a short journal article on "Therapy of Fashion" (Miller et al. 1960)[71] at the library of the London School of Economics several years ago. What followed was a journey of discovery, including uncertainties, interruptions, some inaccessible paths and even dead ends; but also many exciting explorations and encounters – in short the messiness of research in the best possible sense. Some of my guiding principles, decisions and choices made along this research journey are presented here in a rational and chronological manner. Final papers and their methodologies constitute a process of post-research rationalisation, as one of my interviewees, Dr Grunwald, points out above. Naturally, that process was not linear (but also less arbitrary than Grunwald's example might suggest). Rather, it took the form of a movement back and forth between research and analysis, conceptualisation and conclusion, reading, thinking and writing.

> The overall focus continues to be on how the principles of doing research are realized in the structure, conventions and language of the written study, while addressing the inevitably difficult task of squeezing the rich experience of the shifting realities of social life into a written product that demonstrates scientific rigour. (Holliday 2007: xi)

As detailed at the beginning of this chapter, my approach is that of an interpretative discursive analysis of "dress as therapy", one that acknowledges that it is 'intrinsically incomplete' (Geertz 1993: 29), but tries to *understand* the individual therapeutic approaches and their particularities and make them accessible as cultural phenomena. This type of analysis also calls for a particular mode of writing that is self-reflexive, that includes different perspectives and voices, and that makes 'available to us answers that others […] have given, and thus to include them in the consultable record of what man has said' (Geertz 1993: 30). In order to 'make available' some of the wealth of 'consultable records' on "dress as therapy" both collated and generated by this thesis, a great variety of quotations are incorporated.

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[69] The abbreviation 'AI' denotes 'author interview' in the context of my thesis and will be used hereafter in references to interviews I conducted.

[70] 'Also, mir geht es darum, eigentlich, wie wir so Rationalität rekonstruieren. Also, plattes Beispiel: wir denken immer, mmh, wissenschaftliche Entscheidungen sind rational, aber eigentlich hat der das und das nur geforscht, weil, mmh, da stand das Gerät halt im Flur rum und es hat keiner benutzt und da hat er das halt genommen. Und da hat er mal angemacht und geguckt was passiert. So ist eigentlich Wissenschaft. Und nachträglich wird dann Rationalität konstruiert. Nachträglich wird gesagt, hier, wir haben die Fragestellung gehabt und wir hatten das Interesse, wegen dem und dem.' (Grunwald, AI, 24.8.2007)

[71] The article was reprinted in: Roach, Mary Ellen & Eicher, Joanne B. (eds.) (1965) *Dress, Adornment, and the Social Order.* New York: John Wiley & Sons, pp. 269–70.

Interpretative analysis also calls for a mode of writing which acknowledges its own interpretative nature. Just as the act of transcribing is a form of translation, so is the act of writing: from 'the rich experience' of passing events to written thesis, translating the reality of others. Thus the interpretative discursive analysis proposed by this thesis calls for a careful consideration of its modes of writing and representation[72], aiming to offer situated knowledges about "dress as therapy", to draw large conclusions from small, but very densely textured facts (Geertz 1993: 28) in the interrogation of the way the relationship between dress and the self is constructed and mobilised in the three therapeutic settings under review.

[72] This has been demonstrated very successfully in the allegorical writing by Law (2007), and the textual juxtaposition of parallel realities by Mol (2002).

part II
A history of the present

chapter three

The naked patient:

The role and use of dress in relation to the self in psycho-medical institutions from the mid-eighteenth to the twentieth century

Introduction





figure 1: 'Variété de la grande attaque hystérique – Violence de grands mouvements', Hôpital de la Salpêtrière, Paris, France, ink drawing by Paul Richer, c1880 (23x20cm)

figure 2: 'One of the participating experts instructs a patient in the proper method of applying cosmetics.' (Miller et al. 1960: 42), "Therapy of Fashion", Napa State Hospital, Imola, California, US, 1959

1880, La Salpêtrière hospital, Paris, France: a manic-looking, nearly naked woman, her robe or blanket slipping to the floor, is sitting upright in a four-poster bed, a tense energy surging through her bare chest and shoulders, her jaw and even her hair. She is surrounded by six female and one male attendant, tightly gripping her wrists and ankles, trying to restrain her.[73]

1959, Napa State Hospital, Imola, California, US: as part of a therapeutic approach entitled "Therapy of Fashion", a program of grooming, dress design and self-presentation classes is trialled at the psychiatric women's ward, where an 'expert instructs a patient in the proper method of applying cosmetics' (Miller et al. 1960: 42). While a nurse overlooks the scene, the 'expert' holds the women's head, angling it so as to apply make-up, which she has set up on a mirror table behind her. Her hold on the patient's head seems firm, yet, without the presence of the nurse, one could not tell whether the photograph was taken at a beauty salon or a mental hospital.

Eighty years lie between these two representations of the treatment of "madwomen", of "mentally ill" female patients. The eight decades that separate them have seen different conceptualisations of what it means to be "mad" or "mentally ill", and different ideas of their treatment. They have seen the emergence of psychoanalysis and the subsequent rise of therapy culture (1.4), as well as the notion of a therapeutable self that can be worked on and improved – among other things, through dress (1.4.2). Prior to that, "madness" was constructed, and so was the "madman"[74], to normalise the man of reason, as Foucault (1961/2001) argues so forcefully in *Madness and Civilization*. "Insanity" was discursively constructed as a socially determined and gendered experience (Showalter 1985).

The evidence suggests that until the second half of the twentieth century the psycho-medical patient was naked, both literally and conceptually. Foucault observes (1961/2001: 69–70): 'It was common knowledge until the end of the eighteenth century that the insane could support the miseries of existence indefinitely. There was no need to protect them; they had no need to be covered or warmed'. Writing in 1856, English psychiatrist and asylum reformer John Conolly (1794–1866) (1856: 32) described their 'meagre diet' and 'scanty clothing'. Moreover, referring to the experiences of his French counterpart Esquirol (1772–1840), who succeeded Philippe Pinel (1745–1826) at the Salpêtrière in 1810, some seventy years before Richer's above illustration, and 'visited almost every asylum in France', Conolly (1856: 19–20) stated: 'Writing in 1818, […] he

[73] The French anatomist and physiologist Paul Richer (1849–1933) drew this medical illustration as part of his research into hysteria. Richer was an assistant to Jean-Martin Charcot (1825–1893) at Salpêtrière hospital in Paris, where he later headed the laboratory.

[74] These categories are always, as Foucault (1969/2002: 25) argues 'principles of classification, normative rules, institutionalized types' and as such they form part of discourse and determine subjectivities. As a way to acknowledge the constructedness of these categories in relation to human beings, they will be used in inverted commas throughout this thesis: "insane", "lunatic", "mad", "madwo/man", "mentally ill", "mental patient".

found the insane naked, or covered with rags, and only protected by straw from the cold damp pavement on which they were lying'.

From the beginning of institutionalising the "insane" (both women and men) and their treatment in the mid-eighteenth century, they tended to be described and depicted in states of undress (Andrews 2007a&b) (figure 1). In his study of representations of the "mad" poor in the arts in England, Andrews (2007a: 5) emphasises how 'commonly they are found in states of undress' and adds that these depictions were 'partially based on authentic encounters with the poor insane, for [...] they were in reality often witnessed semi-naked or tearing their clothes and hair' (13). The above observations suggest that the dress of patients and its relationship to the self was not considered significant in institutionalised psycho-medical history. Neither was it studied in subsequent analyses of the treatment of the "insane" or the asylum, as Wynter (2011: 40) argues in her essay on dress at Staffordshire County Lunatic Asylum between 1818 and 1854: 'in readings of the lunatic asylum as a part of this repressive state apparatus, the study of dress – anything that is worn on or fashions the body [...] has largely been absent'[75].

Moreover, this evidence suggests that dress only began to enter therapeutic practice explicitly in the form of "Therapy of Fashion" (figure 2) in the US at the turn of the 1960s, a time when both fashion and psychiatry underwent significant changes, becoming more popular and more accessible. Psychiatry was popularised through the rise of psychotropic drugs which, in turn, enabled open door policy in the context of a renewed movement to humanise mental hospitals (4.2.2); and fashion through the wide establishment of prêt-à-porter and the increasing impact of youth culture. While the historical specificity of "Therapy of Fashion" will be analysed in more detail in Chapter Four, generally speaking, the 1960s marked a time when the concepts of both fashion and psychiatry changed considerably and in a way that evidently made them compatible under one roof. However, even if the coincidence of fashion and psychiatry in the US of the 1960s can be explained by the circumstances above, questions about dress must have arisen in the institutionalised treatment of the "mentally ill" from the eighteenth century onwards. Dress must have featured and decisions are likely to have been made about the acquisition and care of the patients' dress from their admission to their release.

Consequently, this chapter explores the role of dress in relation to the self in the institutionalised therapeutic treatment of the "mad". It investigates the zero point of dress-related forms of therapy: how and when did dress begin to be considered as a therapeutic means in relation to the self? Informed by Foucault's genealogical approach, as previously addressed, it provides a comprehensive overview of some of the

[75] Wynter (2011), Andrews (2007a&b) and Baur & Melling's (2014) article on 'The Uses of Clothing in the Admission, Care and Employment of Residents' in provincial hospitals in Devon, c.1860-1960' constitute notable exceptions in that their main focus lies on dress, which is used to unpack specific moments in English asylum history. They do not, however, thematise therapeutic uses made of dress in relation to the self.

precedents for the use of dress in relation to the self, some of the preceding discourses and how they were put into practice in the psycho-medical institution. As such this chapter writes a history of the present of the dress-related therapeutic approaches under review in this thesis to better understand and analyse them. It explores some of the common conditions of possibility intrinsic to the formation of these "dress therapies".

Moreover, the present chapter demonstrates that contrary to popular representations and the current state of research, dress played an important and varied role in madhouses, asylums, and mental hospitals, as it was supposed to fulfil their reforming function. The chapter argues that in these settings, both male and female dress constituted a controlling mechanism and was employed as a disciplining and normalising technology of the body and self. It maintains that implicit and explicit therapeutic use of dress in relation to the self has existed for more than 250 years. As such, the chapter contributes an overview of some of the different discourses and practices relating dress to the self in formative ways at particular historical moments in the development of psycho-medical institutionalised treatment.

Some concrete dress examples are considered in the course of this chapter and also inform its structure: the straitjacket, patients' gowns and doctors' uniforms. With regards to the straitjacket, my research also addresses a gap in the literature, as no study of this enduring sartorial symbol of psycho-medical care has been published to date. The aim of this chapter, however, is not to explore what exactly was worn in some specific psychiatric settings, but to analyse how dress was perceived and employed in relation to the self. Nor is its aim to make a cross-cultural comparison of the different ways of using dress in the treatment of mental illness in the US, France and Germany, despite the fact that the above two representations of psycho-therapeutic treatment span eighty years and two continents: France in 1880 and the US in 1959. Instead, I explore some of the common roles that dress tended to play in the psycho-medical past of these three countries, as well as in Great Britain, which constituted a central point of reference for doctors across western Europe and North America (Goldstein 1987, Showalter 1985). This chapter thus provides an overview of some of the common "dress-therapeutic" discourses and how they were put into practices. This is viable because of the dynamic exchange between psycho-medical theorists and practitioners of these countries in the nineteenth century. As social and literary critic Elaine Showalter (1985: 6) argues: 'Beginning in the 1830s, there was an active exchange of ideas between English, US-American, French and German psychiatrists, who visited each other's asylums and eagerly read each other's publications'. While the twentieth century saw the rise of distinct therapeutic traditions, and of discrete 'moral, medical, and mental boundaries,' according to Showalter (1985: 6) these traditions continued to share 'many

characteristics across national frontiers' and a common legacy remains. Consequently, this chapter explores their shared meanings, not their idiosyncrasies. The latter are analysed in the following chapters, dedicated to the individual therapeutic projects respectively.

In a similar vein, this chapter considers discursive and non-discursive practices involving the dress of both men and women. The perception of madness was a gendered one. The institutions for the treatment of the "mad" constituted 'gendered landscapes'[76] (MacKinnon 2011: 84). Within them, dress, as one of the key 'signifiers of sexual difference' (Entwistle 2000: 141) was employed as a gendering technique. This chapter does not focus on gender as a determinant of the dressed experience of madness, however, so much as on the way dress was perceived and instrumentalised in relation to the self, constructed and employed as a normalising and disciplining technology of the self. That said, part of this analysis will draw attention to sartorial gender differences and particular normalising practices around female dress (3.2.3.1 & 3.2.3.3), especially if gender was explicitly thematised in the accounts of doctors or asylum reformers.[77] Many, however, made no reference to gender, and even ignored or naturalised differences in dress, especially in relation to forms of restraint dress, such as the straitjacket discussed below.

[76] For a detailed discussion of gender as a determinant of the experience of madness see Chesler (1972) or Showalter (1985).

[77] It is important to note that these accounts, written almost exclusively by men, refer to 'the patient' in its generalised form as 'he', even when writing about institutions for both women and men. In a similar vein, the German authors discussed in this chapter use 'der Patient' to refer to both sexes, although the female form 'die Patientin' could be used. Nowadays, it is more common to write 'PatientIn', the capitalised 'I' signalling a mixed group. French accounts also refer to 'le patient' without further distinction. The female ending 'ée/s' is employed for a group of women only, as soon as there is one man in the group, the male ending 'é/s' is used. This linguistic subsumption can make it difficult to determine whether the authors are referring to men only or to both sexes.

3.1 The straitjacket as an early form of ''dress therapy'': The role of dress in times of coercive treatment of the ''mad'' from the mid-eighteenth to the early nineteenth century

3.1.1 From securing to curing: Different phases of treating madness

Historically, the institutionalised treatment of the "mad" can roughly be divided into four phases: coercive, moral, confessional and chemical. This division which is based on several narratives (Pietikainen 2015, Porter 2002, Shorter 1997 & 2005), is not successive, but is proposed in this thesis to describe shifts in approaches to treating the "mentally ill" from seclusion to cure.[78] 'Insanity was basically […] for long, a domestic responsibility,' argues medical historian Roy Porter (2002: 89), and he describes how 'more formal segregation began to emerge towards the end of the Middle Ages' (90). He is not alone in disagreeing with Foucault's (1961/2001) concept of the seventeenth-century 'Great Confinement' of madness.[79] Porter (2002: 95) maintains that in the eighteenth century '[i]n urbanized Europe and in North America, the rise of the Asylum is better seen not as an act of state but as a side effect of commercial and professional society [outsourcing the care of "mad" relatives to private madhouse] operating for profit within the market economy in what was frankly termed the 'trade in lunacy''. The poor "insane", on the other hand, were secluded in huge purpose-built public madhouses (97) with a coercive reputation, resulting in a 'highly stratified asylum system' (Tomes 1988: 193).[80] While both class and gender clearly determined the experience of madness (Showalter 1985), it is difficult to say which had more impact, and how.

Concerning the general treatment of the "mad", Showalter (1985: 8) locates an 'ideological shift' at the end of eighteenth century in the perception of "lunatics" – from 'brutes' to 'sick human beings'. Subsequently, she argues 'the advent of the Victorian era coincided with a series of significant changes in society's response to insanity [...] New legislation made the public asylum the primary institution for the treatment of the insane' (17).[81] It also instituted psychiatry as a medical discipline for the treatment of

[78] The US-American historian of psychology Edward Shorter (2005: 3) summarises these developments in relation to the history of medicine in three periods (whilst acknowledging vast oversimplification): 'the asylum period of the years 1770–1870, in which biological concepts held sway; the psychotherapy period of the year 1870 to around 1970, in which Freud's doctrine of psychoanalysis came increasingly to the fore; and the second biological psychiatry, from the 1970s to the present, in which biology has come rushing back with a vengeance and psychodynamic explanations have largely been unhorsed, psychotherapy sliding from the psychiatrists to the psychologists'.

[79] Other critics include, for example, Erik Midlefort and Ian Hacking. For a thorough analysis of Foucault's claim see: Porter, Roy (1990) 'Foucault's Great Confinement' in: *History of the Human Sciences.* Vol.3(1), pp. 47–54. A detailed discussion of the reception of Foucault's *Madness and Civilization* can be found in Gary Gutting's essay: 'Foucault and the History of Madness' in: Gutting, Gary ed. (2003) *The Cambridge Companion to Michel Foucault.* Cambridge: Cambridge University Press, pp. 49–73.

[80] Showalter (1985: 27) argues that for the pauper "insane", the asylum would have nonetheless been a living solution: 'For the poor, however, the public asylum was a welcome alternative to the workhouse or to home care; lunatics maintained in poor families had often been neglected, brutalized and starved. Given the barely liveable conditions that many working-class families had to endure, patients were materially better off in the asylum than they would have been at home'.

[81] In England, for example, the County Asylum Act of 1808 and the Lunacy Act of 1845 defined the "mad" as patients and determined their treatment in purpose-built asylums with a medico-scientific underpinning.

"mental disorder".[82] The predominantly coercive treatment of the "mad", marked by seclusion and restraint, was shifting towards their 'moral' treatment in order to correct, reform and cure them. The emergence of psychoanalysis at the end of the nineteenth century gave rise to a confessional approach, which was augmented rather than superseded by the chemical treatment of the "mentally ill" in the 1950s, with the advent of psychotropic drugs (4.2.2). [83]

Changing attitudes to the "mad" and their treatment are mirrored in the changing language used to describe, diagnose and care for them. Showalter (1985: 27–8) documents these linguistic shifts in her study of 'women, madness and English culture' between 1830 and 1980:

> By 1858, "madhouse" had become an "opprobious epiphet," replaced by "asylum" or "retreat" – "benignant refuges for the 'mentally afflicted'." "Mad-doctors" became "alienists," "asylum superintendents," or "psychiatric physicians"; "keepers" became "attendants." Madness itself became "lunacy," "mental derangement," "insanity," or "mental deficiency"; and its treatment became "mental science" or "psychiatry". These polite and euphemistic terms coincided with a new respectability accorded to the profession of caring for the insane.

Not only does this changing terminology indicate differing approaches, it also illustrates the way in which power is constructed and represented through language in specific therapeutic settings, some examples of which will be given throughout this thesis. My own usage of terms such as 'madness', 'mentally ill' or 'psychiatry' is intended in the widest sense to describe 'manifestations of mental disorder and the medical speciality devoted to them' (Showalter 1985: 255).

Having briefly outlined the different phases of institutionalised psycho-medical history, I next explore the corresponding role and use of dress in relation to the self, its perception and possible changes: first in the coercive treatment of the "insane", then in their moral treatment in the nineteenth century and finally in times of their psychoanalytic and psychotropic treatment of the twentieth century.

[82] Porter (2002: 100) writes on the subject: 'The asylum was not instituted for the practice of psychiatry; psychiatry rather was the practice developed to manage its inmates'.
[83] For detailed histories of the "mad" and their treatment see for example: Pietikainen (2015), Porter (2002), or Shorter (1997).

3.1.2 Between pragmatism and power: Dress as more than diagnostic indicator and marker of status

'Significantly one of the key symptoms of madness that led to many female admissions was dressing improperly or immodestly or appearing naked' (Labrum 2011: 69). Dress, both male and female, was used as a diagnostic indicator, not just in twentieth-century psycho-medical practice (1.3.2), but since the inception of the systematic and institutional treatment of the "insane". Andrews (2007a: 16) describes the role of dress in the diagnostic process as follows: 'Medical theories surrounding insanity, as well as practitioners' direct recorded experience of the symptoms that derangement precipitated, did much to confirm the sense in which denudation and degraded appearance seemed intimate indicators of mental disease'. He concludes 'forms of flouting dress norms were significant constituents of madness in this period' (18). States of un/dress could initiate and confirm a medical verdict and were used as part of the diagnostic process with a similarly literal approach found in some of the twentieth-century sources discussed earlier (1.3.2). The outer self was taken as indicative of the inner self, and negligence or divergence from normative dress notions was seen as a sign of mental disorder.

The understanding of appearance as linked to the self is a modern and Western one (Miller 2010, Sennett 1976, Wilson 1992) (1.3.1). The rise of industrial capitalism from the mid-eighteenth century, which had in turn influenced the institutionalisation of the "mad", as argued above, gave rise to the notion of personality and the belief that appearance is indicative of it (Sennett 1976: 153). This understanding also entailed the perception that those who did not fulfil the unspoken obligation to care for the self were not in their "right" minds. Moreover, this belief in the correlation of appearance and mental health (Goffman 1963: 27), was held more strongly in relation to women than men, due to the representational roles women were expected to fulfil. 'Female dress in particular frequently formed part of the portraiture of the insane patient provided in medical notes, drawn from initial certification of insanity and from the reflections of asylum staff following the entry of women into the institution' Baur & Melling (2014: 148) argue in the context of their study of provincial asylums in Devon. While men's dress attracted less attention, however it was still taken as a visible sign of the mental state of a patient, and used as a diagnostic point of reference.

Dress-related indicators of mental disorder could take different forms: undress, mismatched dress, dirty clothes, the destruction of clothes, inappropriate garments for the weather or the occasion, the misuse of garments, or the theft of clothes. Taken to betray 'incompetence in the presentation of self' (164), these forms of 'flouting dress norms […] featured as one visible passport of the dirty and disruptive individual to the asylum' (153). Yet, the role of dress in early institutionalised psychiatric treatment did not

stop at that. Appearance in general, and clothing in particular, were not just reasons for being diagnosed as "mad" they also marked the medical and social status of "mental patients" and could thus be instrumentalised. The loss of social status inherent in institutionalisation was made visible immediately through dress, be that uniform or corrective, as this extract from a report on a psychiatric asylum of 1875 indicated:

> [t]here are few patients so far lost as not to be able to appreciate the distinction between the ordinary dress of civilians and that which is furnished to them at their admission. A consciousness of degradation owing to the change may exercise a prejudicial influence on many patients, and may obviate or retard their progress towards recovery (in Labrum 2011: 68).

While some "mental patients", mainly at fee-paying institutions were permitted to wear their own clothes (Baur & Melling 2014, Wynter 2011), indicative of how class determined the experience of madness and its treatment, most were dressed in institutional garments. Such garments not only made them 'always distinguishable from outsiders' (Crowther in Labrum 2011: 68), but they also institutionalised them, a process described by Goffman (1961: 30) in the mid-twentieth century as the loss of one's 'identity kit' (3.3.2.1). Dressing the "mad" in standardised asylum dress, whether casual or uniform was common practice until the twentieth century, and can be regarded as a disciplinary measure, a form of control, and an attempt to align their behaviour.

Dress, in the institutionalised treatment of the "mad", fulfilled several functions ranging from diagnostic aid and status marker to control mechanism, determined by both pragmatism and power. Moreover, it was not just used passively to observe and classify patients, but also, significantly, actively to restrain them, control them, make them uniform. Dress, in this context, is thus 'inscribed with conflicting narratives' (Baur & Melling 2014: 145). While the different motivations in dressing "mental patients" are amalgamated, they will be separated strategically to some extent throughout this chapter to highlight and investigate certain temporal priorities. Thus, the following section explores possibly the most enduring sartorial symbol of psychiatric history: the straitjacket, epitomising the disciplining role dress could and did indeed play in psycho-therapeutic settings from the mid-eighteenth century.

3.1.3 The straitjacket: Remedy and coercive technology of the self

> No small share of the management of mad people consists in hindering them to hurt themselves, or do mischief to other persons. It has sometimes been useful to chain and to beat them, but this is both cruel and absurd; since the contrivance called the Strait Waistcoat, answers every purpose of restraining the patients, without hurting them. These waistcoats are made of ticken, or some such strong stuff; are open at the back, and laced on like a pair of stays; the sleeves are made tight, and so long as to cover the ends of the fingers, and there drawn close with a string, like a purse, by which contrivance the patient has no power of using his fingers; and, when he is laid on his back in bed, and the arms brought across the chest, and fastened in that position, by tying the sleeve-strings fast round the waist, he has no power of his hands. A broad strap of girth-web is then carried across the breast, and fastened to the bedstead, by which means the patient is confined on his back; and if he should be so outrageous as to require further restraint, the legs are secured by ligatures to the foot of the bed. It is of great use in practice to bear in mind, that all mad people are cowardly, and can be awed even by the menacing look of a very expressive countenance; and when those who have charge of them once impress them with the notion of fear, they easily submit to any thing that is required.
> (MacBride 1772: 591–2)

The one garment that single-handedly epitomises the psychiatric treatment of the "insane" is the straitjacket (figure 3). While it might justifiably symbolise the first period of institutionalised treatment of "lunatics" – in particular madhouses of the late eighteenth and early nineteenth centuries, as illustrated in the words of Irish medical writer David MacBride (1726–1778) above – the straitjacket remains a potent symbol of psychiatry today (Labrum 2011). Given the endurance of the straitjacket in the psychiatric imaginary, it is noteworthy that no comprehensive analysis of this highly ambiguous garment exists.[84] Sources differ as to its place and date of origin. MacBride, who praised the usefulness of the strait waistcoat and detailed its application in 1772, has been credited as its inventor by some (e.g. Esquirol 1838a: 536, Kraeplin 1918: 7). However, the strait waistcoat was already in use in private madhouses in the 1730s, as its first mention in print in 1738 suggests (Hunter & Macalpine 1963: 358).[85] Regarded as a more humane way of restraining the "mad", as argued by MacBride, the strait waistcoat played a central part 'in the management of the insane for almost one hundred years' (449) and continues to feature in their treatment, up to the present day (3.3.3).

[84] The articles by both Labrum (2011) and Wynter (2011) constitute exceptions to some extent, as they touch on the straitjacket in psychiatric history.

[85] In some accounts, Guilleret, a French tapestry-maker is credited with the invention of the *camisole de force*, the straitjacket at Bîcetre hospital in Paris in 1770 (Tricot 2010) or 1790 (Foucault 2003: 121). However, Hunter & Macalpine (1963: 449), in their comprehensive annotated anthology of key documentary sources of psychiatric history, trace its use back to the 1730s adding the following remark: 'Although it has been impossible to establish by whom or when it was introduced, it was certainly in use in private madhouses in 1730s [see Cruden 1739] and had by 1754 found its way into literature in Samuel Richardson's *The history of Sir Charles Grandison* and in 1762 in Smollett's *Sir Launcelot Greaves*'.

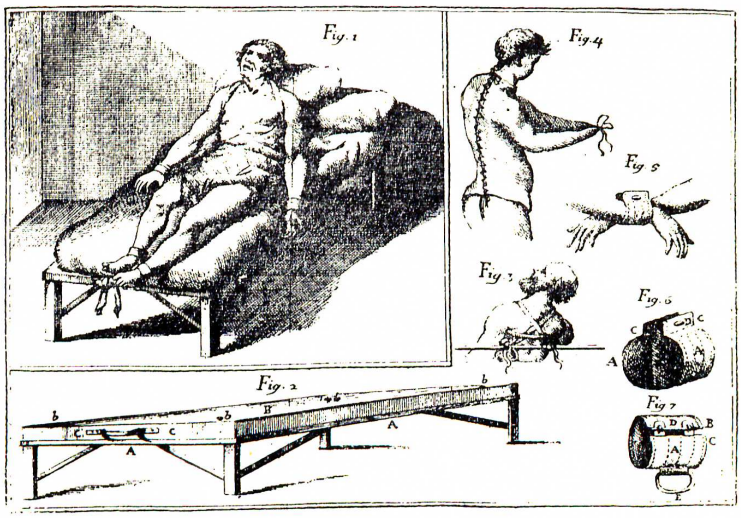


figure 3: 'The first illustration of the 'English camisole' or straitjacket, Fig.4 from Vincenzi Chiarugi's *Della pazzia,* vol.2, Florence, 1794.' (Hunter & Macalpine 1963: 450) The other figures show details of the 'maniac's bed'.

While the straitjacket was originally intended as a form of mechanical restraint for both men and women 'less injurious than cords and chains for difficult and violent patients' (Hunter & Macalpine 1963: 449), it soon became a form of treatment, too.

> MDLXII.
>
> Restraining the anger and violence of madmen is always necessary for preventing their hurting themselves or others: But this restraint is also to be considered as a remedy. Angry passions are always rendered more violent by the indulgence of the impetuous motions they produce; and even in madmen the feeling of restraint will sometimes prevent the efforts which their passion would otherwise occasion. Restraint, therefore, is useful, and ought to be complete; but it should be executed in the easiest manner possible for the patient, and the strait waistcoat answers every purpose better than any other that has yet been thought of. (Cullen 1790: 196)

The Scottish physician and teacher William Cullen (1710–1790) praised the straitjacket for fulfilling a double function of restraint and remedy. It was 'soon raised to the status of a treatment on the reasoning that the suppression of physical excitement would tranquillise the mind and so allow the patient's reason to return' (Hunter & Macalpine 1963: 449). Consequently, it can be argued that the straitjacket constitutes an early example of dress being used as a treatment in the psycho-medical setting, a treatment to act on the self, to control it, discipline it and possibly normalise it. It was employed as a regulating technology of the self: an early form of "dress therapy".

As an enduring symbol of repressive psychiatry, the straitjacket has come to be regarded as a remnant of its coercive past, making it difficult to understand the early humanising and healing claims made for it by both MacBride and Cullen. This apparent contradiction is indicative of an overriding paradox, which the straitjacket illustrates vividly: the uneasy proximity of control, care and cure in psycho-medical treatment. This proximity can also be found in the prominent work and writings of Dr Benjamin Rush (1746–1813), 'the father of American psychiatry' (Porter 2002: 126), advocate of the straitjacket and

inventor of the 'tranquilizer chair' (figure 4) in the early nineteenth century (Goodman 1934), 'the most complete restraint of a patient's every movement ever devised' (Hunter & Macalpine 1963: 671). Widely employed in asylums in the US and Europe, these two most popular forms of restraint were appreciated for their effect of 'sensory deprivation' (Pietikainen 2015: 143), which was claimed not only to render patients immobile, but also to calm them.



figure 4: The 'Tranquilizer' chair by Dr Benjamin Rush, 1811

Dr Rush recommended the use of both the 'Tranquilizer' and the strait waistcoat in 1812 with the following words:

> Before we proceed to mention the remedies for mania […] it will be necessary to mention the means of establishing a complete government over patients afflicted with it, and thus, by securing their obedience, respect, and affections, to enable a physician to apply his remedies with ease, certainty and success. The first thing to be done, to accomplish these purposes, is to remove the patient from his family, and from the society of persons whom he has been accustomed to command, to a place where he will be prevented from injuring himself and others. […] the first object of a physician, when he enters the cell, or chamber, of his deranged patient, should be, to catch his eye, and look him out of countenance. The dread of the eye was early imposed upon every beast of the field. The tyger, the mad bull, and the enraged dog, all fly from it: now a man deprived of his reason partakes so much of the nature of those animals, that he is for the most part easily terrified, or composed, by the eye of a man who possesses his reason. [...] If all the means that have been mentioned should prove ineffectual to establish a government over deranged patients, recourse should be had to certain modes of coercion. These will sometimes be necessary in order to prevent their destroying their clothes and the furniture of their cells, as well as to punish outrages upon their keepers and upon each other. […] 1. Confinement by means of a strait waistcoat, or of a chair which I have called a tranquillizer. He submits to them both with less difficulty than to human force, and struggles less to disengage himself from them. (Rush 1812: 174–5 & 181–2)

To cure means to control. The reasonable man is to govern the unreasonable man, as Rush articulated his understanding of the role of the physician in the treatment of the "mad", and the relationship between the two. What became much more pronounced after the so-called abolition of restraint from the mid-nineteenth century, was already apparent in its heyday: underlying this system of treatment was the mental superiority assumed by one man over another. This is the central point of critique levelled by Foucault (1961/2001: 239), at the 'moral treatment' of the mainly English asylum reformers who from the 1830s advocated moral and mental control of the "mad", rather than the use of physical force or mechanical restraint.

Moreover, Rush's statement is indicative of a particular scopic regime that was established in the medical clinic, but also the asylum. Different practices of looking at patients, ranging from observation and visual assessment to the 'dread of the eye' all contributed to the development of a systemic gaze, of what Foucault (1963/2003: 103) terms 'the clinical gaze'. Such a medically underwritten gaze established 'the knowing subject' (doctor) and the 'known object' (patient) (168). It thus objectified and disciplined its target, as Foucault (1975/1995: 73) outlines in relation to prison inmates and the 'disciplinary gaze' they are subjected to. The clinical gaze, in its objectifying and corrective nature, it can be argued, constitutes a defining feature of moral treatment, but also institutionalised psycho-medicine in general from the beginning.

Moral treatment, its instrumentalisation of dress and its critique will be discussed later on (3.2); but from Rush's statement alone, it can be seen that theory and practice diverged considerably. If the isolation of the patient and the 'dread of the eye' were ineffective, Rush recommended coercive treatment, albeit to prevent destruction and the harm of self or others. Indeed, he expressly contrived an intricate device of total restraint for the treatment of the 'deranged patient' and praised the strait waistcoat as highly useful for that purpose.

While the straitjacket was regarded as a more 'humane' form of care and indeed cure, by numerous psycho-medical scholars in its early days, its application was much more concerned with control, and abuse was prevalent, according to the German psychiatric reformer Wilhelm Griesinger (1817–1868) (1867: 508). The autobiographical account by Clifford Beers (1908/1923: 129–30), the US-American founder of the mental hygiene movement, gives an impression of how a straitjacket felt from a patient's perspective:

> No incidents of my life have ever impressed themselves more indelibly on my memory than those of my first night in a strait-jacket. Within the hour of the time I was placed in it I was suffering pain as intense as any I ever endured, and before the night had passed it had become almost unbearable. My right hand was so held that the tip of one of my fingers was all but cut by the nail of another, and soon knifelike pains began to shoot through my right arm as far as the shoulder. After four or five hours the excess of pain rendered me partially insensible to it. But for fifteen consecutive hours I remained in that instrument of torture; and not until the twelfth hour, about breakfast time the next morning, did an attendant so much as loosen the cord. During the first seven or eight hours, excruciating pains racked not only my arms, but half of my body. Though I cried and moaned, in fact, screamed so loudly that the attendants must have heard me, little attention was paid to me.

Beer's account, albeit some hundred years after Rush, MacBride and Cullen, conveys not only the use and abuse of the straitjacket, which varied between different decades, hospitals and staff, but also the physical and mental impact on the patient. It illustrates how dress was employed as a controlling technology of the self, a coercive technology, not only calming "mental patients" into cooperation, but also immobilising them and forcing them into submission. It indicates how dress in this context was essentially employed as a form of 'biopower' (Foucault 1976/1990) (1.2.3).

Similar experiences of the straitjacket were described in a number of fictionalised versions of first hand accounts (e.g. Kesey 1962, London 1915, Ward 1946)[86]. They add to the image of the straitjacket as the symbol of the exertion of power through the psycho-medical profession, and of the coercive treatment of the "mad" well into the twentieth century. The 'prevailing attitudes to the insane as brutes inform[ed] accordingly brutal approaches to care,' writes Andrews (2007b: 138) of the eighteenth century. This period was characterised by restraining the "mad" first with chains (Schott & Tölle 2006) and then with the straitjacket which finally superseded chains in the mid-nineteenth century, the time of widespread asylum reforms. Paradoxically, it was this abolitionist movement, that whilst "unchaining" the "mad", consolidated the employment of the straitjacket and other forms of secure dress, as I discuss below.

[86] The 1915 novel *The Jacket* by Jack London in particular, focuses on the abusive employment of the straitjacket in the long-term solitary confinement of protagonist Darrell Standing, based on real life robber Ed Morrell, who London interviewed (Morrell 1924). He writes, for example: 'When, at the conclusion of my first ten days' term in the jacket, I was brought back to consciousness by Doctor Jackson's thumb pressing open an eyelid, I opened both eyes and smiled up into the face of Warden Atherton. "Too cussed to live and too mean to die," was his comment. "The ten days are up, Warden," I whispered. "Well, we're going to unlace you," he growled. "It is not that," I said. "You observed my smile. You remember we had a little wager. Don't bother to unlace me first. Just give the Bull Durham and cigarette papers to Morrell and Oppenheimer. And for full measure here's another smile." "Oh, I know your kind, Standing," the Warden lectured. "But it won't get you anything. If I don't break you, you'll break all strait-jacket records."' (London 1915: 85). The book was published under the title of *The Star Rover* in the US.

3.1.4 The non-restraint movement: The abolition of chains and the consolidation of the straitjacket



figure 5: 'William Norris: confined in this Manner in Bethlem Hospital. Sketch'd from the Life May 2. 1814: & Etch'd by G. Arnald A.R.A.'



figure 6: 'Portrait of William Norris – Sketched from the Life […] This unfortunate Man was confined about Twelve Years, in the Manner represented in this Engraving, in Bethlem Hospital. […] Norris is Dead.' A broadside condemning the treatment of the insane at Bedlam 1815 by George Arnald.

William Norris is restrained by chains at the neck and ankles, his upper body and arms locked by a harness, 'confined in this manner in Bethlem hospital' (figure 5). Drawn 'from life' and depicting a prevalent way of restraining the "insane" in this period, this etching was used by the English abolitionist movement in 1815 to illustrate a broadside condemning coercive treatment (figure 6) which deplored that Norris had been kept like this for 'twelve years', and declared: 'Norris is dead'.

The first half of the nineteenth century saw the rise of lunacy reform movements across the western world. Social reformers and doctors in England, France, the US and Germany campaigned for more compassionate care in asylums underpinned by medico-scientific expertise.[87] Among them were: Samuel Tuke (1813), John Conolly (1845 & 1856), Robert Gardiner Hill (1857) in England; Benjamin Rush (1812) and Dorothea Dix[88] (1843) in the US; Philippe Pinel (1809), Jean-Baptiste Pussin, Jean-Martin Charcot

[87] As previously addressed, these four countries are singled out because of their relevance to this thesis. The three dress-related therapeutic practices under review are located in France, Germany and the US respectively. England is included, as is constitutes an important reference point for the asylum reformers in the other three countries (Goldstein 1987, Showalter 1985).

[88] The work of Dorothea Dix is the only one by a female author that could be found to have had a wide public impact and reputation in this field.

(1880), and Etienne Esquirol (1838/1845) in France; and Johann Christian Reil (1818), Wilhelm Griesinger (1867), Ludwig Meyer (1863) and Christian Friedrich Wilhelm Roller (1838 & 1874) in Germany. Their respective writings testify to their pervasive determination to reform the treatment of the "mad", replacing coercion with what became known as a 'moral' approach. As texts to be performed (Illouz 2008: 178), these works not only evidenced, but also discursively constructed, the age of the asylum. Moreover, they are indicative and indeed part of, a 'medicalization of madness' (Pietikainen 2015) which transformed the perception and treatment of the "mad" and saw the rise of psychiatry as a 'medical specialism' (Shorter 1997: 1), a distinct discipline. While each country would naturally write its own history of madness and psychiatry[89], what emerges from these texts is a common medical and psychiatric culture of 'considerable mutual borrowing' (Goldstein 1987: 1). The writings listed above, referencing and critiquing one another, speak of reciprocal visits and influences and are testimony to an active exchange of ideas.[90] Focusing on England and the United States in her work, Tomes (1988: 192) summarises the developments as follows:

> powerful reform movements advocating a new approach to the treatment of the insane emerged in the early 1800s. The embodiment of this approach, and a rallying point for change, was the York Retreat, a small Quaker institution that achieved remarkable results with a technique that came to be known as 'moral treatment'. Arguing that insanity might be cured by a more humane regime, combining a gentle system of rewards and punishments, varied amusements, and a kind, firm discipline, Anglo-American reformers successfully crusaded for the expansion of asylum facilities, especially for the poor.

In France Esquirol contributed to a detailed new law in 1838, containing the rights of patients and obliging all 81 *départements*[91] to establish an asylum (Schott & Tölle 2006: 552–3), effectively instituting a national asylum system and regulating physical restraint. This legislation served as an example for legal initiatives in other European countries (553). Prior to that, the efforts of Esquirol's teacher Pinel and another student of his Pussin, to raise the status of the "insane" to that of medical patients and replace their chains with straitjackets at Bicêtre Hospital in Paris[92], had a deep and lasting impact on the work of other European and US-American doctors (Griesinger 1867, Schott & Tölle 2006, Weiner 1994). Writing in 1816, the *Conseil général administratif des hopitaux*

[89] For country specific accounts of nineteenth-century psychiatric history, see, for example, for Germany (Blasius 1994, Engstrom 2003, Schott & Tölle 2006), France (Castel 1988, Goldstein 1987, Murat 2011), UK (Scull 1993, Showalter 1985), US (Gamwell & Tomes 1995, Grob 1994, Rothman 1990). For a large-scale discussion see Part II of Pietikainen (2015), or the very comprehensive *Cultural Sociology of Mental Illness: An A–Z Guide.* (Scull ed. 2014). Moreover, Scull (1989) and Tomes (1988) constitute comparative studies of Anglo-American psychiatry in the nineteenth century.

[90] The work of US-American abolitionist Dorothea Dix, for example, was based on visits of and exchanges with British asylum reformers and in turn her campaigns reached England (Brown 1998). Following a stay in England that 'unlocked her social disposition' (69), Dix took up the cause of the "insane" in the US and, after visiting numerous madhouses, prisons and almshouses in Massachusetts, made the following infamous report to state legislature: 'I proceed, gentlemen, briefly to call your attention to the *present* state of insane persons confined within this Commonwealth, in *cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods,* and *lashed* into obedience' (Dix 1843: 2). Dix, thus influenced the expansion of public asylums, and of the State Hospital system (Gamwell & Tomes 1995: 55).

[91] This term refers to the administrative division of France which is divided into *régions*, sub-divided in *départements*.

[92] This event is often mistakenly referred to as 'le geste du Pinel', crediting him with 'freeing' the "insane" (Schott & Tölle 2006: 245). The much-quoted narrative has been criticised as a psychiatric myth (e.g. Foucault 1961/2001: 222) and is discussed by Weiner (1994). Moreover, contrary to popular belief, the Italian physician Vincenzio Chiarugi is credited with unchaining his patients in Florence in as early as 1786 (Schott & Tölle 2006: 244, Shorter 1997: 10).

evaluated this formative measure, illustrating the progressive perception of the straitjacket:

> The idea of chaining the mad so as to dominate and confine them more easily had been adopted in all insane asylums in Paris and all other European establishments. A dedicated, intelligent and courageous supervisor who recently died, M. Pussin, brought about a useful and humane change. His efforts were entirely successful. The excitement of maniacs subsided instead of growing when they are not chained. They are now restrained, even during their most violent attacks, in a straitjacket made of strong cloth, with sleeves longer than their arms that can be tied at their ends. The sleeves can be used to fasten the inmates to their beds, without shackling their limbs. (Seine in Weiner 1994: 238)

Arguably a radical continuation of Pinel and Pussin's reforms, the 'no-restraint' policies introduced by Hill at Lincoln Asylum and Conolly at Hanwell in the late 1830s, in turn lastingly influenced the concept of psychiatric treatment[93] (Schott & Tölle 2006, Pietikainen 2015). They took moral treatment to 'its logical conclusion,' explains Porter (2002: 113–4) and 'renounced all forms of mechanical coercion whatsoever: not just irons and manacles but fabric cuffs and straitjackets too. These would be replaced by surveillance under amply trained attendants and a regime of labour, which would stimulate the mind and discipline the body'. Although their radical position of no-restraint was influential, it was predominantly practiced as a form of 'low-restraint' and, paradoxically, this period saw the consolidation of the use of the straitjacket as part of psychiatric treatment for decades to come (de Young 2015: 234). While there was a general consensus among asylums reformers regarding a more humane treatment of the "mad", treatment responses evolved differently and according to ideology rather than nationality. The following two statements by Conolly and the conservative German psychiatrist Neuman, illustrate the diversity of approaches to the straitjacket:

> I have never known *all* the patients properly attended to so long as even a few of them were habitually subjected to mechanical restraint. Restraints and neglect may be considered as synonymous. (Conolly 1856: 323)

> No psychiatry without coercion.[94] (Neumann 1883: 108)

Considering the persistent role of the straitjacket in psychiatric treatment, Neumann was arguably proven right. Despite the fact that Hill and Conolly's results were considered impressive, and they effected both the regulation and stigmatisation of restraint (Scholl & Tölle 2006: 247), the ideals of many reformers came up against the realities of institutional life characterised by underfunding, understaffing and overcrowding (de Young 2015: 220). As its abolishment was cost and labour intensive, restraint remained a fundamental part of psychiatric treatment, in spite of its 'moral' turn in the nineteenth

[93] This direct influence can be seen in the writings of German asylum reformers Griesinger (1867) and Meyer (1863), for example. Although neither was as radical as their English counterparts and both continued to employ the straitjacket, their perception of the psychiatric profession itself was changed, as evidenced in their works.
[94] 'Ohne Zwang keine Psychiatrie.' (Neumann 1883: 108)

century when it took on the “softer” shape of garments. ‘When moral treatment […] failed to instil self-control, rule could be imposed through ‘secure dress’: restraint worn on the body’ (Wynter 2011: 40). Even Conolly himself, though once its fervent opponent, eventually permitted the use of the straitjacket, under his watch, and in emergencies as Griesinger (1867: 505) documented. This re-iterates the discrepancy between theory and practice, and between ideals and reality of psycho-medical care.

The compatibility of the straightjacket with moral treatment was advocated by numerous reformers (e.g. Rush 1812, Tuke 1813) and only radically challenged by few, effectively underpinning and justifying the institutionalisation of the straitjacket, even if its employment was increasingly regulated. It had to be recorded and was never again unquestioned. Throughout the nineteenth century, it was an integral part of the treatment of the “insane”. In France, both Esquirol and Charcot documented the use of straitjackets with maniacs in their publications (figure 7 and 8), the former stating: ‘If the violence of the patient is extreme, we confine him to his bed, and control his movements with the camisole’ (1838/1845: 310).

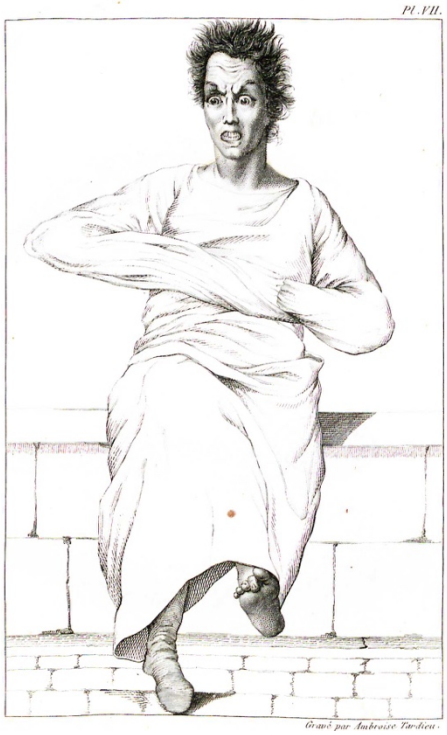


figure 7: ‘Maniaque’, engraving by Etienne Esquirol, 1838



figure 8: 'Mania', drawing by Jean-Martin Charcot, 1854

Griesinger (1867: 504–5) described common practices of restraint in German asylums in 1867 as follows: ‘At present the straitjacket is principally being used, a linen camisole, that grants the sick man no or only very limited use of his arms and hands. Many madhouses also employ the tranquilizer, a chair to which the sick man is fastened; as

well as belts to strap him to the bed at night'.[95] Equally, in the US 'asylum doctors retained a strong belief in the therapeutic value of mechanical restraint,' states Tomes (1988: 190) and she argues that as a result a controversy unfolded with their English counterparts, who used it infrequently and largely doubted its remedial effect, although never totally abolishing mechanical restraint either (190). In this regard, Wynter's (2011: 51) situated analysis of dress in an English county asylum is illuminating:

> The use of secure dress at Stafford had moved through several phases. Firstly, indiscriminate mechanical suppression was rejected. Secondly, secure dress was an integral part of individualized treatment. Thirdly, restraint was used to diminish self-harm as the asylum authorities were gradually dispelling its former therapeutic use. Precisely because it was used less, secure clothing was then utilized as a stigmatic punishment.

This form of chastisement was made more efficient by the fact that it 'visibly distinguished the most disturbed or 'worst' patients, especially as many continued to participate in everyday activities' (51). At the same time, Wynter argues for a differentiated perception of restraint practices: 'Those put into secure clothing were not, however, a homogenous mass: there were different degrees of restraint and therefore freedom of movement' (41–2). Detailing six indicative categories: 'manic/violent, mischievous, undressing, suicidal, self-harm and the effect of treatment' (49–50), she also describes different types and 'gradations' of secure dress in use: 'handcuffs were the mildest restraint, increasing in severity to the muff, the body-belt and the strait-waistcoat' (49).

While this discussion focuses largely on the straitjacket as the most dominant form of restraint, it should be noted that 'secure dress' came in many different forms, indicative of the thought and effort that went into controlling the "mad", for example: boot hobbles, belt bracelets, locked dress, webbed petticoat, masks, the enveloping bag, handmuffs, pocket muffs, criss-cross vest, restraining girdle, side-arm dress, spring straps, locked gloves, various belts, high collar, locked jumpsuit, and monkey jacket (de Young 2015).

'No-one is able to tell the beginnings of abuse with restraint, it seems abuse here is inevitable' Griesinger (1867: 508) stated in 1867.[96] Accordingly, the history of the psycho-medical treatment of the "mad" is characterised by an uneasy propinquity of care, cure and control, epitomised by the role of dress as described above. Throughout, it emerges, dress was instrumentalised for all three purposes: consulted in the diagnostic process, used to calm patients as a physical sedative before the rise of psychotropic drugs, and employed to control and discipline them. When the use of chains was abolished in the

[95] 'Gegenwärtig ist hauptsächlich noch die Zwangsjacke, ein leinenes Camisol, das dem Kranken keinen oder nur einen sehr beschränkten Gebrauch der Arme und Hände gestattet, im Gebrauch; viele Irrenanstalten wenden auch noch den Zwangsstuhl, einen Lehnsessel, auf welchem der Kranke befestigt wird, auch Gürtel, um ihn Nachts im Bette zu befestigen, an.' (Griesinger 1867: 504–5)

[96] 'Niemand ist im Stande zu sagen, wo bei den Beschränkungsmittel der Missbrauch beginnt; es scheint fast, der Missbrauch ist hier unvermeidlich.' (Griesinger 1867: 508)

early nineteenth century, it paradoxically instituted the straitjacket and various other textile forms of restraint as an integral part of treatment. So-called ‘secure clothing’ was regarded as more humane, possibly through its softer materiality and its proximity with everyday wear. Yet, precisely this proximity makes it arguably more perfidious. To re-image and re-appropriate a piece of clothing, normally worn for adornment, protection, warmth and identification so that it immobilises and disciplines its wearer seems crueller, and may explain why the straitjacket persists as a symbol. To elaborately re-design everyday garments as means of control speaks of a rationally pragmatic, yet also, morbid imagination – one that condones the inextricability of ab/use.

Effectively, secure dress, in particular the straitjacket, was used as a controlling technology of the self. It was employed as a coercive form of therapy: to manage minds by regulating bodies through dress. Moreover, this garment runs like a red thread through psycho-medical history, its powerful presence looming over the asylum even today, as I will briefly explore at the end of this chapter (3.3.3).

3.2 Patients' gowns between pedagogy, play and power: The therapeutic use of dress in nineteenth-century moral treatment

3.2.1 Moral treatment: Its meaning, practice and limits

Psycho-medical history took a moral turn from the end of the eighteenth century. The notion of 'moral treatment' was developed and put into practice by a number of doctors, such as Pinel in France, Tuke in England, Chiarugi in Italy (Shorter 2005: 180–1), Reil in Germany (who coined the term *Psychiatrie* (Porter 2002: 140)) and to some extent Rush in the US. In 1847 in England it was defined by the The Commissioner in Lunacy (1847: 957) as follows: 'The Moral Treatment of Insanity comprehends all those means which, by operating on the feelings and habits, exert a salutary influence, and tend to restore them to a sound and natural state'. Underpinning the moral approach was a belief that patients could return to a 'natural' state, that they could be cured by re-educating them. Thus, 'those means' refers to a series of largely non-medical treatments, such as occupational therapy, outdoor activities, physical exercise, manual labour, entertainment and dress, as this section demonstrates. While the meaning of 'moral treatment' varied among its practitioners, the common guiding principle was a a gentle regime in which physical restraint was replaced by self-restraint. Moreover, there was a widespread belief among doctors, Showalter (1985: 30) argues, 'that in most cases insanity was preventable if individuals were prepared to use their willpower to fight off mental disorder and to avoid excess. Mental health was to be achieved by a life of moderation and the energetic exercise of the will'. Moreover, the importance of 'enforcing good habits in patients' was stressed, 'in an effort to teach them the steadiness and self-discipline of good citizens' (31).

> The triple cornerstones of Victorian psychiatric theory and practice were moral insanity, moral management, and moral architecture. "Moral insanity" redefined madness, not as a loss of reason, but as deviance from socially acceptable behavior. "Moral management" substituted close supervision and paternal concern for physical restraint and harsh treatment, in an effort to re-educate the insane in habits of industry, self-control, moderation, and perseverance. "Moral architecture" constructed asylums planned as therapeutic environments in which lunatics could be controlled without the use of force, and in which they could be exposed to benevolent influences. (29)

Accordingly, moral treatment constituted a holistic approach to the care and cure of the "insane": considering living conditions to civilise, social intercourse to humanise, and various morally upright activities to restore the mental health of patients. As such, argues Scull (1989: 80), it 'represents a decisive epistemological break in the history of Western responses to madness'.

Another distinct feature and vital element of moral treatment was the quality of the relationship between staff and patients (Digby 1985: 57). The former were supposed

to be moral role models for the latter, their treatment exemplary of “sane” social contact and conduct. It envisaged a highly individualised form of care that might have been realisable in the familial setup of small asylums such as the York Retreat with thirty to one-hundred patients, but it was hardly feasible in the growing number of sprawling asylums that counted more than 1000 inmates (Porter 2002). As a result, moral treatment deteriorated into ‘moral management’ (Digby 1985: 69) in order to deal with growing numbers of “insane” persons in large-scale institutional settings, the ‘repressive’ management of patients (Scull 1989: 80), that increasingly relied on surveillance and ‘forms of psychological control’ (Digby 1985: 69). Moreover, the looming presence of the straitjacket and other forms of restraint in virtually all asylums throughout the nineteenth century and beyond, as previously argued, was a constant reminder of the power relations in place, undercutting the humanising intentions of the moral approach to a considerable degree.

From the outset, this system of gentle care and psychological control has been criticised as a form of ‘gigantic moral imprisonment’ by Foucault (1961/2001: 264). Moral treatment, as a form of social therapy (Digby 1985), constituted a method of conformity, of internalising normative standards of behaviour, including dress. As deviation from accepted dress behaviour was taken as a diagnostic indicator for deviant minds (3.1.2), “moral” dress practices and aesthetic conformity were hoped to aid the recovery of the “insane”.

3.2.2 'In the treatment of lunacy dress should be an instrument of control, and therefore of recovery.': Asylum reformers' reflections on the role of dress in moral treatment

> A refractory patient at Colney Hatch was in the habit of tearing his clothes into shreds. Mr. Tyerman, one of the medical officers, ordered him to be dressed in a bran-new suit. The poor man, a tailor by trade, either from a professional appreciation of the value of his new habiliments, or from being touched by this mark of attention, respected their integrity, and from that moment rapidly recovered. Before leaving the asylum he stated that he owed his cure to the good effect produced upon his mind by being intrusted with this new suit of clothes.
> (anon. 1857: 366)

The dress of patients constituted a subject of interest to asylum reformers during the nineteenth century, many of whom, even if in passing, commented on its importance (e.g. Browne 1837, Conolly 1845 & 1847, Esquirol 1838/1845, Granville 1877, Griesinger 1867, Groß 1832, Rush 1812, Tuke 1813, Wynter 1860). As treatment reports and manuals, they represent texts to be 'performed', a discourse generative of therapeutic practice. This discourse, it should be noted was largely undistinguished with regards to gender. All patients were summarised as 'the patient' and collectively referred to as 'he'. Only very few distinctions are made, as addressed below. Gender differences were naturalised. The dress of patients in general was of concern.

English physician Andrew Wynter, for example, asserted that the "insane" are particularly susceptible to the impact of dress: 'Among the sane,' he argued, 'self-respect is increased by the possession of decent clothes, and the lunatic is often still more amenable to their influence' (anon. 1857: 365)[97]. Reporting observations of his asylum inspections, he condemned the uniform aesthetic and shabby state of male dress: 'It is infinitely depressing, even to the visitor, to see nothing but dull grey garments; and the lunatics themselves feel degraded by a uniform dedicated to the gaol-bird. The medical officers of both this asylum and Hanwell are deeply impressed with its injurious effects, and they have long denounced it' (365). Moreover, Wynter described a belief in the therapeutic qualities of dress among staff, who were not only aware of the 'injurious effect' of low quality institutional dress, but also of the remedial potential of garments, as conveyed in his example of a patient 'cured' by the redeeming effect of a new suit. The physician also reported on a dress-based reward system instituted at Hanwell, 'the most celebrated English establishment for the treatment of the insane, [where] patients are rewarded for good conduct by allowing them to wear a fancy waistcoat. This fact of itself shows the aversion to the [asylum] garb, and the necessity of discarding it' (366). Within the asylum, dress was thus not only used to penalise patients through restraint, but also to reward them.

[97] Wynter's essay 'Lunatic Asylums' was published anonymously in *Quarterly Review* in 1857. His authorship can be deduced from a reprint of the essay three years later as part of a collection of Wynter's works from the *Quarterly Review* and *Edinburgh Review* in: Wynter, Andrew (1860) *Curiosities of Civilization.* London: Robert Hardwicke, pp. 150–99.

Wynter's comments are indicative of a wider belief in the therapeutic qualities of dress, observable among asylum reformers, as one of the most prominent ones, John Conolly (1847: 59) noted: 'The clothing of the patients in an asylum of any description merits very careful attention, both as one of the means of preserving health, and as one of the things reacting on the mind'. Both the physical effect of dress on the "insane", as well as its psychological or moral effect were addressed in their writings and employed in treatment. The latter was also associated with a social impact of wearing 'proper' dress and the way patients would be perceived and treated as a result. Before analysing this assumed correlation and the moral effect attributed to dress in more detail, I want to briefly focus on the way it was believed to impact patients' minds through their bodies, the physical effect of dress.

Two of the main recurring themes in writings on the dress of the "insane" were the importance of warm clothing and the curative effect of particular fabrics. Scottish doctor and activist James Makittrick Adair (1790: 65) observed correspondingly:

> invalids ought rather to exceed than be deficient in the warmth of their cloathing, those especially […] whose nerves are week and irritable [...]. Such persons ought in the beginning of September to wear a flannel waistcoat over the shirt or shift, and, towards the end of October, next to the body; taking care to defend the lower limbs by flannel petticoats, or woollen drawers and stockings.

Esquirol (1838/1845: 82) equally emphasised the importance of warm clothing and woollen garments. While Conolly (1845: 584) blamed 'thin clothing' among other things for 'prevent[ing] the healthy development of the body, of the brain, and of the mind'. He is said to have been particularly 'convinced as to the importance of clothing to somatic and psychic well-being' (Andrews 2007b: 144). Conolly (1847: 59–64) wrote in detail about the 'Clothing of the Insane' and listed fabrics he found most useful in their treatment, such as flannel waistcoats and drawers, warm worsted stockings, or stout linen for men's shirts and women's undergarments (60). In a similar vein, the German doctor Herman Groß (1832: 35–6), dedicated an entire section to the dress, upkeep, care of the "insane" in his work on asylums in 1832.[98] He argued that the dress of the "insane" 'often demands manifold cautiousness'[99] and listed appropriate fabrics. It is noteworthy how the physiology of dress, its functional aspects were emphasised in these accounts that even highlight the physical properties of specific fabrics. 'Material was not only the remedy for disease, but, more markedly, it became the host, and therefore also offered the promise of moral health,' Wynter (2011: 42) explains prevalent corresponding convictions.

[98] '§25. Uebersicht über die Bekleidung, Wartung, Pflege und Verköstigung der Hospitaliten im Landes-Hospitale Merrhausen.' (Groß 1832: 35–6)
[99] 'Die Bekleidung der Geisteskranken erfordert oft und mannigfaltige Umsichten.' (Groß 1832: 36)

A further example of this can be found in the work of English doctor Joseph Mortimer Granville (1877: 51–2) who wrote in detail about dress as part of the treatment of the "insane". 'Clothing for the insane,' he asserted 'should be sufficiently heat-conserving without being so dense in texture as either to consolidate and grow hard in wear, or oppose an obstacle to proper evaporation'. Reflective of a common assumption at that period that vapours were among the causes of (mental) diseases (Watkins 2010), Granville (1877: 51–2) added: 'It is especially undesirable that the vapours thrown off by the skin of a lunatic should be retained in clothes which are to be worn for a lengthened period'.

As evidenced in the above remarks, several asylum physicians argued that clothing was of vital importance to physical- and therefore mental health, and that patients should dress accordingly. Thus the notion of 'moral' dress referred to the physical as well as the psychological impact of dress, and came to be regarded as 'essential for moral treatment' (Wynter 2011: 40). For example, dress was said to have been a key feature in the moral treatment practice of English doctor Francis Willis (Porter 2002: 103), famous for treating the madness of King George III (Schott & Tölle 2006: 254). A visitor to his Lincolnshire madhouse, impressed by the high aesthetic standards, made the following observations at the turn of the nineteenth century:

> all the surrounding ploughmen, gardeners, threshers, thatchers, and other labourers, attired in black coats, white waistcoats, black silk breeches and stockings, and the head of each *bien poudrée, frisée* and *arrangée.* These were the doctor's patients; and dress, neatness of person and exercise being the principle features of his admirable system, health and cheerfulness conjoined toward the recovery of every person attached to that most valuable asylum. (anon. quoted in Porter 2002: 103)

Such dress practices were underpinned by a rising "dress-therapeutic" discourse that linked appearance to moral betterment and mental health, and highlighted the nature of moral treatment as a form of social therapy.

Benjamin Rush (1812: 237), made corresponding remarks when writing about remedies 'applicable to all the forms of general madness':

> 1. Great regard should be had to cleanliness in the person and apartments of mad people. This is indispensably necessary, not only for their comfort, but their cure. A deranged man, with a ragged dress, a dirty skin, long nails and beard, and uncombed hair, or with his dress and person in neat order, in a filthy room, loses his consciousness of his personal identity; and until this be restored, it is in vain to expect a return of the natural habits of his mind.

While the notion of moral dress was interpreted differently in each asylum, there was a common concern with 'proper' dress to normalise dress habits and general behaviour in patients. Comments to that effect can be found in the treatment manuals of several asylum reformers, as argued above, which thematised dress among detailed considerations regarding the care and cure of the "insane" and its designated location, the thought-out therapeutic asylum.

John Conolly, for example, included detailed dress considerations in his *The Construction and Government of Lunatic Asylums* of 1847. Apart from the previously mentioned physical effect, he commented on the importance of 'wearing neat articles of dress', outlining an attainable wardrobe for male patients: 'a short coat, […] a cotton neck-handkerchief of a dark colour, or a stock; and a straw hat or cap for the summer, and a black hat for the winter. […] But it is best,' he noted, 'in regard to the handkerchiefs, and the covering for the head, to allow the patients to choose that colour or kind which they prefer' (62). The neatness of dress is also a duty of attendants, who should 'set a good example' (61) in both social conduct, as well as dress behaviour: 'Slovenly attendants,' he asserted, 'generally increase the number of dirty patients' (61). With equal conviction, he rallied against the wanting dress provisions of some asylums:

> Many private asylums are open to the charge of great neglect as respects the dress of patients of the classes far above pauperism. Tattered and threadbare coats, very shabby hats, trowsers not always free from an offensive smell; and equally slovenly dresses on the female side of the asylum, shoes out of repair, hair in curl-papers, make the unfortunate patients objects of pity or of ridicule. They feel themselves degraded, lose their self-respect, and with it the little self-control their malady has left them. (63)

Conolly included his reflections on dress among instructions on such categories as building sites, sleeping arrangements, food, recreation and entertainment. He, thus, deemed it to play a key role in the physical and mental convalescence of his patients. 'In short,' he summarised, 'in regulating the dress of insane patients, as in every regulation for them, we must consider not only its first and indispensable uses, but its effects on the mind' (63). Likewise, in Germany, albeit a decade earlier, Christian Friedrich Wilhelm Roller in his *Principles of the Construction of New Lunatic Asylums*[100] of 1838 'spelt out detailed directives for such matters as non-slip, smell-proof flooring, good drains, apparel, diet, and exercise at the influential Illenau asylum in Baden, where music and movement therapies were also pioneered' (Porter 2002: 116).

Just as the architecture of mental asylums during the nineteenth century was therapeutically re-inscribed, so was the dress of patients. 'Inside the asylum, every detail [...] assumed a strong moral character,' argues Showalter (1985: 36), 'By controlling the lunatic's environment down to the last detail, doctors and administrators hoped to make the new public asylums instruments as well as places of therapy, the building itself was a "special apparatus for the cure of lunacy"' (33). An illustration of this holistic approach can be found in the writings of Granville (1877: 77):

> It is by domestic control, by surroundings of the daily life, by such details as the colouring of walls, the patterns on floorcloth, the furniture and decoration of rooms, by the influence of pictures, birds, and draperies, the judicious use of different kinds of clothing, suitable occupation and diversions, and, generally, by moulding and controlling the life of a lunatic, the psychologist hopes to reach, capture, and re-educate the truant mind, and perhaps reseat the dethroned intelligent will of his patient.

[100] *Grundsätze für Errichtung neuer Irrenanstalten.* (Roller 1838)

Granville (1877: 51) identified dress as a key feature of moral treatment, and positioned it next in order of interest and importance 'to the question of feeding lunatics'. Moreover, he outlined the 'judicious use of clothing' in some detail, arguing against uniformity in institutional dress but for a greater diversity. The question of clothing "lunatics" was, according to him, key to their cure:

> The use of uniform, or anything resembling it, is objectionable. The moral effect is fatal to the idea of an [sic] hospital and the sense of being only resident for a period undefined, it may be, but always capable of being shortened by the patient's own effort to restore self-control. Anything, […], that tends to strengthen the sense of difficulty in getting well, or to weaken the effort, increases the obstacle to recovery; and I cannot imagine a more depressing sensation than that produced by being put into an asylum uniform. […] One of the chief requirements in regard to the attire of lunatics is variety. This is especially important in the case of females, and I am persuaded that if it were more commonly recognized and acted upon we should hear less, perhaps little or nothing, about the need of "strong" dresses. There is not only much method, but generally a motive, in madness. One-half of the refractory lunatics who tear off their clothing do so because their skin is so sensitive that they cannot endure to wear it. (52)

What emerges from Granville's writings, indicative of a wider perceptual and discursive shift – if only in reform asylums, is a notion of "lunatics" as fellow "human beings" who remain part of society, and who, contrary to prior beliefs, have similar emotions, sensations and needs. A different notion of self: embodied, individual, social and therapeutable, was replacing a former understanding of the "insane" patient as insensitive to temperature or pain, a "lesser" human being. This notion also involved dress, not only as a physical and social necessity, but also as a form of therapy. Patients became therapeutable through dress.

Accordingly, Granville (1877: 53) noted their 'strongly indicated wish for better clothing' and even criticises the dis-identifying effect of uniforms some ninety years before Goffman (1961: 30) analysed their impact in total institutions (3.3.2.1). Moreover, Granville advocated variety in the dress of "lunatics" in order to establish a positive and respectful relationship to their garments and more importantly through their garment to their selves. Restraint, he argued, could be avoided by clothing patients properly and quoted the following example in support: 'I have been much struck with the ingenuity displayed at West Riding Asylum – one of the best-conducted institutions in the country […] . By a little cheap trimming the dresses of the female patients are made so attractive that they come to be worn with pride, and I believe the recourse to strong dresses is by that means nearly obviated' (Granville 1877: 53). Granville (1877: 53), in his conviction of the remedial impact of dress, effectively sketched a form of "dress therapy", which incorporated the above-mentioned dress reward system:

> I should like to see greater diversity of dress, at least on the female side of an asylum, and the best attire allotted to patients as the reward of especially good conduct and the most intelligent self-control. Dress is women's weakness, and in the treatment of lunacy it should be an instrument of control, and therefore of recovery. On the male side variety may not be equally important; but, even in dealing with minds supposed to be less readily affected by trifles, the avoidance of a dull uniformity, indicative of a permanent separation from society, is of essential importance in the interests of the cure.

Among the psycho-medical practitioners considered here, Granville dealt with dress most extensively, one of the few to distinguish between the dress of women and men, notwithstanding his essentialist understanding of dress as primarily a female activity. While Granville purported to empathise with what he deemed the dress desires and needs of patients to be, he also stands for the prevalent proximity of care and control: dress proposed here by him as 'an instrument of control', albeit one directly linked to recovery.

Dress, it emerges from the above reflections, these instructions for therapeutic performance, constituted a crucial part of moral treatment, as it was seen to act directly on the patient by encouraging self-control, thus, theoretically obliterating the need for external force. As Baur and Melling (2014: 152) argue in relation to asylums in Devon: 'clothing figured as a significant facet in the making and management of patients over these years'. The self-restraining effect of moral dress was supposed to reduce, if not abolish, the need for restraint. Consequently, dress, within moral treatment, was not only employed as a normalising and gendering, but also a disciplining technology of the self. Three different dress practices can elucidate the mechanisms of this process well: dressing for tea at the Retreat, the prevalent "lunatics" costume balls, and dress-related occupational therapy, the latter two offered in asylums across England, France, Germany and the US, particularly during the second half of the nineteenth century.

3.2.3 Dressing morality: Applications of the moral effect of dress in the treatment of the "insane"

3.2.3.1 'All who attend dress in their best clothes.': Dressing for tea at the Retreat

In 1813 the English mental health reformer Samuel Tuke, grandson of the founder of the Retreat, the small Quaker asylum near York, published his influential *Description of the Retreat* in order to popularise the moral treatment of the "insane". Under the heading 'Of the means of assisting the patient to control himself' he listed dress (Tuke 1813: 144). Not only did Tuke (1813: 144) proudly proclaim that 'all the patients wear clothes,' he also designated dress to be a vital tool to induce 'orderly habits'. To illustrate his point, Tuke (1813: 177) described the following practice:

> The female superintendent, who possesses an uncommon share of benevolent activity, and who has the chief management of the female patients, as well as of the domestic department, occasionally gives a general invitation to the patients, to a tea party. All who attend, dress in their best clothes, and vie with each other in politeness and propriety. The best fare is provided, and the visitors are treated with all the attention of strangers. The evening generally passes in greatest harmony and enjoyment. It rarely happens that any unpleasant circumstance occurs; the patients control, in a wonderful degree, their different propensities; and the scene is at once curious, and affectingly gratifying.

Dressing up for tea parties as the Retreat – what is constructed as a playful activity for a benevolent, unconstrained social gathering, a clear contrast to the overtly coercive treatment of the "insane" in the past, was, also intended as an exercise in social conformity and self-restraint. 'Proper' dress was to induce 'proper' behaviour, as Dr Willis had demonstrated two decades earlier. Dressed 'in their best clothes' the patients 'vie with each other in politeness and propriety'. Governed by a didactic and disciplinary agenda, these tea parties, as most activities at the Retreat were intended to re-educate and re-socialise the patient, to increase her or his self-control (Tuke 1813: 177). Self-restraint constituted one of the key principles of moral treatment, which replaced physical coercion with moral coercion in order to manage the "mad", as has been argued most prominently in relation to the Retreat by Foucault (1961/2001: 237–8):

> We see that at the Retreat the partial suppression of physical constraint was part of a system whose essential element was the constitution of "self-restraint" in which the patient's freedom, engaged by work and the observation of others, was ceaselessly threatened by the recognition of guilt. Instead of submitting to a simple negative operation that loosened bonds and delivered one's deepest nature from madness, it must be recognized that one was in the grip of a positive operation that confined madness in a system of rewards and punishments, and included it in the movement of moral consciousness.

Foucault thus conjures up the notion of a systemic straitjacket, one which invisibly controls patients. Moral treatment, he maintains, constitutes a treatment system in which 'The keeper intervenes […] without instruments of constraint, with observation and language only' (239). Accordingly, it can be argued that the clinical, or more specifically,

the psycho-medical gaze in its objectifying and disciplinary qualities was already established as an unspoken, yet, defining feature of this system.

Consequently, the presiding power relations had been reconfigured: not through force but through mental superiority would one man dominate the other, just as Rush had instructed in 1812 (3.1.3). 'Reason's victory over unreason was once assured only by material force,' writes Foucault (1961/2001: 239) and continues: 'Now the combat was always decided beforehand, unreason's defeat inscribed in advance in the concrete situation where madman and man of reason meet. The absence of constraint in the nineteenth-century asylum is not unreason liberated, but madness long since mastered'. As an example of these changed parameters, Foucault (1961/2001: 236–7) refers to the practice of dressing for tea at the Retreat and critiques it as follows (whilst subsuming the particular experience of "madwomen" in this context under the generalised term of "madman"):

> Curiously, this rite is not one of intimacy, of dialogue, of mutual acquaintance; it is the organization around the madman of a world where everything would be like and near him, but in which he himself would remain a stranger, the Stranger *par excellence* who is judged not only by appearances but by all that they may betray and reveal in spite of themselves. Incessantly cast in this empty role of unknown visitor, and challenged in everything that can be known about him, drawn to the surface of himself by a social personality silently imposed by observation, by form and mask, the madman is obliged to objectify himself in the eyes of reason as the perfect stranger, this is, as the man whose strangeness does not reveal itself. The city of reason welcomes him only with this qualification and at the price of this surrender to anonymity.

While Foucault has been criticised for 'overemphasiz[ing] the disciplinary function' (Digby 1985: 68), for not recognising 'why one might reasonably prefer the manipulation and ambiguous "kindness"' (Scull 1989: 80) of someone like Tuke to the overtly coercive treatment of "lunatics" a generation earlier, he equally needs to be acknowledged for popularising a critical re-evaluation of asylum reforms and the dominant meaning ascribed to them, for eliciting how the rhetoric of moral treatment concealed its power.

In the case of Tuke's tea parties, for example, Foucault unpacks this overtly benevolent ritual, thus enabling not only the recognition of exertion of psychological control over the "madwoman", but also a more nuanced reading of its mechanism: the role of dress in the process of controlling her through objectification. The female patients dressing up for these social gatherings, whether or not they found this preferable to seclusion and restraint (which cannot be determined), are objectified. Their bodies and minds were to be regulated through dress. As such, dress, was employed as a disciplinary therapeutic intervention, not physically coercive as the straitjacket, but socially coercive. These women were meant to be regulated through observation and thus regulate themselves.

These tea parties at the Retreat which arguably constituted a dress-related therapeutic practice indicate the particular role of dress in the treatment of women.

Throughout the institutionalised psycho-medical treatment of the "mad", both female and male patients were judged by appearance, observed, diagnosed, classified and treated according to it. Yet, for women, this journey into, through and potentially out of the asylum was mediated through dress in a more direct way. This essentialising process is recorded in some of the comments made by reformers (e.g. Conolly 1847, Granville 1877), is visible in the tea parties at the Retreat, and it is evidenced in photographic documentations of the recovery of female patients (figure 9) popularised in the nineteenth century.



figure 9: 'Puerperal Mania in Four Stages', 'The illustrations furnished by the admirable photographs of Dr. Diamond, and skilfully copied by the engraver […] present various forms of expression of face, incidental to puerperal insanity.' (Conolly 1858 reprinted in Gilman ed. 1976: 59)

Based on photographs of Dr Hugh Diamond, the pioneer of psychiatric photography in England and superintendent of the women's department at Surrey County Lunatic Asylum (Gilman 1982: 164), this engraving illustrates not only the different facial expressions, as Conolly remarked above (figure 9), but changes in dress behaviour said to accompany the course of mania: unkempt hair and crumpled clothes indicate insanity, while the normative feminine looks of groomed hair, bonnet and decorated shawl represent her return to sanity.

Conolly (1858: 60), who had included it in a discussion of case studies in 1858, based his diagnostic analysis of 'this young mother' largely on her appearance. He remarked of the second portrait that 'she tore clothes out of an excess of animal spirit', of the third that 'a great change took place, and recovery seemed to commence. She became quite comfortable, and was employed in needlework […] she is neatly dressed. (60) and finally: 'she left the asylum quite well, – an event commemorated by the fourth portrait, wherein she is represented in bonnet and shawl, with composed features […] her general appearance indicating the restoration of the health and strength […]' (60–2). The aforementioned equation of outer appearance and inner state continued to be prevalent, interpreted in a particularly literal manner in the case of female patients. While Conolly, like many of his colleagues did not distinguish much between the dress of male and female patients in his general reflections on the treatment of the "insane", rare hints to that effect are to be found in some sub-clauses. Writing about the diagnostic relevance and resultant use of dress, for example, Conolly (1847: 59–60) observed very generally: 'Among the most constant indications of insanity are to be observed negligence or peculiarity as to dress; and many patients seem to lose the power of regulating it according to the seasons, or the weather, or the customs of society'. However, with regards to dress provisions, he noted that men were issued clean shirts twice a week, not permitted 'to be worn without buttons' (Conolly 1847: 61), while 'a neat, or even a pretty cap' was supplied for women on Sundays with the following explanation: 'It is not natural to the woman to neglect the dress of her head, and if the faculty is impaired, care will often restore it' (61). Underpinning the writings of Conolly and other asylum doctors was a belief in the 'natural' female preoccupation with dress, thus its maintenance taken as a sign of mental health. Consequently, if women lost the power to 'regulate' their own dress, it was to be regulated for them and they were to be regulated through it. The "mad" in general but "madwomen" in particular 'became subject to the moral management of their appearance, argues Showalter (1985: 84):

> Victorian psychiatrists had strong views about the way their women patients should look. Female lunatics were expected to care more about their appearance than males, and indeed, their sanity was often judged according to their compliance with middle-class standards of fashion.

Therefore, their medical progress was also more literally determined by "improvements" in appearance, level of grooming, and the ability to maintain clothes in good order, to care for themselves, as illustrated above. It was determined by male observers, invariably male "mad-doctors", applying their very own normative notions of femininity, imposing 'cultural stereotypes of femininity' (Showalter 1985: 86), thus defining female insanity and illustrating the gender/power relations at work in these settings.[101]

In conclusion, dressing for tea at the Retreat, as well intended as these events might have been, constituted a gendering practice and an exercise in social conformity and control – and by no means an exception, as the corresponding reflections on the role of dress in moral treatment and their implementations in reform asylums of doctors like Willis or Conolly suggest.

[101] In relation to such photographs of female patients Showalter (1985: 98) makes the following observation: 'That we should have so many remarkable pictures of Victorian madwomen, and so few of their words, reminds us how strongly the power of definition rested with the male observer. In the photographs of Victorian madwomen by Diamond and others, we are made to *see* the moral management of female insanity, as well as its reduction, in Victorian terms, to visual conventions'. It can be argued that this reduction was reinforced by the medium of photography, which became widespread in asylums in the second half of the nineteenth century (Gilman 1982: 166) and corroborated a prevalent physiognomic belief in the exact parallel between the appearance of the "insane" and her/his mental state (Gilman 1982: 164). Praised for their 'unerring accuracy' (Diamond 1856: 2) at the time, photographs were taken to fulfil several functions in the treatment of the "insane": 'most concise' and 'most comprehensive' record of the course of illness, permanent patient record for future treatment, and therapeutic tool facilitating their treatment by making their progress visible and recording it lastingly (Diamond 1856). Diamond (1856: 3–4) highlights particularly the latter in relation to the series of images shown above: 'This patient could scarcely believe that her last portrait representing her as clothed and in her right mind, would even have been preceded by anything so fearful; and she will never cease, with these faithful monitors in her hand to express the most lively feelings of gratitude for a recovery so marked and unexpected'. Just as the tea parties at the Retreat acted as a mirror for female patients' appearance and conduct, enticing them to 'vie with each other in politeness and propriety' (Tuke 1813: 177), so were these photographs shown to patients, reflections of their "wrong" and 'right mind', permanent reminders of im/proper dress and behaviour. Not unlike dress, photographs 'were enrolled in the service of […] institutions of control,' as Susan Sontag (1977: 21) explains, becoming 'a useful tool […of] surveillance and control' (5).

3.2.3.2 Dressing up insanity: "Lunatics" costume balls



figure 10: 'Le bal des folles à la Salpêtrière' (Paris), painting by Eugène Mesplès, undated (c. 1890)

Like two puppets dancing on strings, their movement frozen mid-step, swaying dress, empty stares: an incongruous couple in costume surrounded by introverted dressed-up characters, by a group of older, plainer women staring at them – into nothingness; by a lost child, a fiddler, a sad king; by two bespectacled male observers, black frocks, white collars, reason personified, the medical gaze – rendering the scene ever more "insane".

'Memory of a costume ball at Salpêtrière' reads the inscription of Eugène Mesplès' painting of one of the many "lunatics" balls organised in asylums in France (figure 10), Germany, the US (figure 11) and England (figure 12) throughout the second half of the nineteenth century, 'the most popular form of asylum recreation', according to Showalter (1985: 38). Another dress practice during moral treatment, prevalent in many institutions for the "insane", was the dressing up of both male and female patients for mixed costume balls. The patients themselves were known to 'concoct special costumes for the[se] festivities' (39).

A 'monthly (sometimes weekly) event in most asylums' (Scull 1989: 79), the "lunatics" ball was meant to fulfil several functions: from playful diversion to cure, from reform showcase to practice of sociability, display of manners, rehearsal in reason, and lesson in self-restraint. 'The joy of dance is granted by the balls,'[102] observed German

[102] 'Die Freude des Tanzes gewähren die Bälle […].' (Roller 1874: 104)

reformer Roller (1874: 104) and praised them as salutary exercise. Armand Husson (in MAP-HP 1986: 29–30), the director of the Parisian 'Assistance Publique' from 1859, described frequent forms of recreation, for women in this case, and noted both the remedial qualities of the *bals costumés* as well as the potential diversion from delusions:

> Singing teachers come several times a week to give lessons to the lunatics. Parties, balls are organised, at certain times of the year. And these pleasant distractions, if they cannot be considered a certain means of cure, are at least a diversion from the the crazy or dark ideas of these unfortunates.[103]

Besides the intended distraction from the monotony of institutional life, such events were also 'frequently used to display the asylum's achievements to outsiders' (Scull 1989: 79), as visitors were often admitted to observe (Showalter 1985: 38)[104]. On boxing day of 1851 one such visitor was the writer Charles Dickens (1852: 387–8), who published his observations of one of the fortnightly dances at St. Luke's Hospital for Lunatics in London in a magazine article entitled 'A Curious Dance round a Curious Tree':

> As I was looking at the marks in the walls of the galleries, of the posts to which the patients were formerly chained, sounds of music were heard from a distance. The ball had begun, and we hurried off in the direction of the music. It was playing in another gallery -- a brown sombre place, not brilliantly illuminated by a light at either end […] the musicians were cheerfully engaged in getting all the vivacity that could be got, out of their two instruments. At one end were a number of mad men, at the other, a number of mad women, seated on forms. Two or three sets of quadrille dancers were arranged down the centre. […] There were the patients usually to be found in all such asylums, among the dancers. There was the brisk, vain, pippin-faced little old lady, in a fantastic cap […]; there was the old-young woman, with the dishevelled long light hair […]. For partners, there were the sturdy bull-necked thick-set little fellow […]; the wry-faced tailor, formerly suicidal, but much improved; the suspicious patient with a countenance of gloom […]. There was the man of happy silliness, pleased with everything. But the only chain that made any clatter was Ladies' Chain, and there was no straiter waistcoat in company than the polka-garment of the old-young woman with the weird gentility, which was of a faded black satin, and languished through the dance with a love-lorn affability and condescension to the force of circumstances, in itself a faint reflection of all Bedlam. Among those seated on the forms, the usual loss of social habits and the usual solitude in society, were again to be observed. […] The last figure of the set danced out, the women-dancers instantly returned to their station at one end of the gallery, the men-dancers repaired to their station at the other; and all were shut up within themselves in a moment.

As asylum authorities had intended, by granting visitors access to the balls, Dickens appreciated and publicised their reform efforts. He praised the abolition by observing that ladies' necklaces had replaced chains and men's colourful waistcoats straitjackets.

[103] 'Des maîtres de chant viennent plusieurs fois par semaine donner des leçons aux aliénées. Des fêtes, des bals sont organisés, à certaines Epoques de l'année, et ces distractions agréables, si elles ne peuvent être considérées comme moyen certain de guérison, font au moins diversion aux idées délirantes ou sombres de ces infortunées.' (Husson in MAP-HP 1986: 29–30)

[104] From the dawn of institutionalisation, both expert and general public were commonly admitted to visit asylums, as Wynter described in 1857: 'In former days the public were admitted to perambulate Bedlam on the payment of two-pence. A writer in 'The World' gives a narrative of a visit to it in Easter-week, 1753, when he found there a hundred holiday-makers, who 'were suffered unattended to run rioting up and down the wards, making sport of the miserable inhabitants' (anon. 1857: 357). The practice of putting the insane on display was prevalent into the nineteenth century (Schott & Tölle 2006: 103).

'[T]he Lunatic Ball marked a break with the unenlightened past,' de Young (2015: 106) argues, 'Patients were no longer chained, but moved freely across the dance floor; no longer naked, they were dressed in what passed for their finery'. Although Young's statement or Dickens' observation constitute one reading of these balls, they are reductive. While one might understandably prefer a costume ball to incarceration, there is another layer to this seemingly free and light form of distraction. The relations of power in the "modern" asylum were less visible, but the aforementioned 'systemic straitjacket' was in place. Patients usually had to earn the privilege to the balls 'by good behavior and adherence to asylum rules over the weeks prior to it' (106), they had to dress "properly" and behave "properly" in order to take part. Social conformity, both visual and behavioural, was a means to control them without force, at the same time the straitjacket loomed over the asylum, regulating it as an unspoken potential punishment.

These prevalent 'lunatics balls' for men and women, like the tea parties for female patients at the Retreat, were well-intended undertakings: conveyed as playful, social activities permitting a certain degree of 'role release' (Goffman 1961: 90), of dressing up, of self-adornment, of moving beyond the "mad", as Dickens observed above. Yet, they also constituted the "carrot" in a system of benign control. Moreover, like the tea parties, they were to give an illusion of normality, to encourage conformity, a form of social coercion, an exercise in self-restraint.

'The lunatics' ball was the demonstration *par excellence* of the Victorian asylum's exercise of disguised control,' argues Showalter (1985: 49) and illustrates her point in reply to Dicken's praise: 'What confined women in the Victorian asylum was precisely the ladies' chain of feminine propriety and the straitjacket of a weird but mandatory feminine gentility. […] Victorian psychiatry silenced women as effectively through its ideology as the scold's bridle had muzzled noisy women in Bedlam before reform' (98). This ideology was twofold: dominant was a rhetoric of moral treatment, of kind care and cure; yet, underneath was one of social coercion and self-restraint, as epitomised by the 'lunatics balls'.[105]

[105] It is noteworthy in this context that Michel Foucault visited a *Narrenball*, namely the carnival of the mental hospital at Münsterlingen in Switzerland on the 2 March of 1954. This experience, it has been argued, had a profound impact on the writer and in some ways constituted a starting point for his *Madness and Civilization* published in 1961. For full details of the argument see: Bert, Jean-François & Basso, Elisabetto & Verdeaux, Jacqueline (eds.) (2015*) Foucault à Münsterlingen: À l'Origine de l'Histoire de la Folie.* Paris: Editions de l'EHESS.



figure 11: 'Ball of Lunatics at the Asylum, Blackwell's Island, East River, N.Y.' from *Frank Leslie's Illustrated Newspaper.* 9 December 1865

What also emerges from Dickens account is a sense of uncanny in both, his characterisations of patients (some of which can oddly be matched to the figures 10–12) and his descriptions of their behaviour – intensified by an 'oppressive silence throughout the asylum' (Dickens 1852: 387). '[S]hut up within themselves in a moment' after each dance, observed Dickens of the patients and pointed to a certain incongruity in the event. This is also described by a reporter covering the Bedlam Ball in 1859 for the *Illustrated Times*: 'Certain signs sufficiently indicate that the society is not *sane.* It is not disorder – it is sadness; it is not extravagance – it is silence. The contradiction of the countenance, a certain *désaccord* in the dress, the monotony of the movements, many exterior signs betray the disorder of thought, and scarcely permit a mistake to be made' (in Showalter 1985: 49).



figure 12: 'A lunatic's ball at the Somerset County Asylum' with superintendent Robert Boyd in the foreground (Scull 1989: 79), lithograph by Katherine Drake, c. 1848

Showalter (1985: 50) argues that a 'note of the uncanny, of a parodied ceremony, is struck in many accounts of the lunatics' ball'. This is the case for their visual representations, too. Katherine Drake's lithograph of a 'lunatic's ball' at the Somerset County Asylum (figure 12) captures this incongruity in some detail: the "ballroom" a converted kitchen; the patients 'shut up within themselves' even in the midst of dancing, a group of introverted characters, moving together, alone; their appearance strangely unfitting: too short a dress, too long a sleeve, too wide a pairs of trousers – somewhat lost in their clothing; above it all: 'HARMONY', ornate large letters on the wall, between watchword and demand.

Remarkably, English physician Andrew Wynter, quoted previously, also used the (far-fetched) expression of 'general harmony' to describe one of the weekly Monday-night balls at Hanwell, but equally spoke of a 'jarring note', this time presented by the patients' 'uniform of sad-coloured grey' (anon. 1857: 375). Had the patients been dressed differently, he added, 'it would have been impossible to have guessed that we were in the midst of a company of lunatics' (375), thus pointing to the impact of dress on the perception and classification of people in the institutional setting, to the different ways in which dress was used in the asylum to dress patients up or down, to equalise them, conform and therefore discipline them. To Wynter, another dissonance was constituted by the ending of the ball: 'At nine precisely, although in the midst of a dance, a shrill note is blown, and the entire assembly, like so many Cinderellas, breaks up at once, and the

company hurry off to their dormitories' (376). As a vivid illustration of the power relations in the reformed asylum, this scene captures to what extent the patients throughout these "unconstrained" gatherings, were obeying the commands of the keepers, restrained by their watchful eyes, restraining themselves. Like puppets on a string, their masters moving them to dance and to stop, to behave well, to socialise and to dress up.

3.2.3.3 'Every conceivable kind of needlework is dividing their attention.': Textile-based occupational therapy

The moral use of dress in nineteenth-century asylums was not limited to the wearing but also included its making. Both, the maintenance and making of clothing, including textile-creation (figure 13), sewing, repairing, cleaning, labelling and sorting, constituted 'a major source of employment for patients as well as staff from the early days of these institutions' (Baur & Melling 2014: 158). Work in general was regarded as therapeutic in the institutional setting (158) and occupational therapy was widely favoured (Porter 2002: 116). This meant that textile-based activities were prevalent both as labour and leisure.



figure 13: 'Pounding linen fibers', Zurich Asylum, by Johann Konrad Fäsi-Gessner, 1840s

The nature of activities, however, depended on the social status and gender of patients. German asylum doctor Roller (1874: 91–6) listed, alongside 'female' activities such as sewing, washing, cooking and gardening, a series of workshops suitable for 'working-class men' – tailor, cobbler, carpenter, glazier, turner, locksmith, bookbinder, and saddler. His colleague Flemming (1833: 30) recommended only the 'finer female handcrafts' for upper class patients. Similar suggestions were made by French "maddoctors". 'Rich women' at Lafond asylum, for example, reportedly used to 'sew, embroider, knit,' whereas lower class women at Marseille mental hospital used to work in the linen room or make clothes from rags (Sueur 1997: 43). Likewise, occupations found in English general asylums at the time were washers, menders, knitters or spinners among the women; and weavers, tailors, saddlers, and shoemakers, among the men (Showalter 1985: 41). Generally speaking, the poor "insane" were engaged in more 'heavy-duty occupational therapy' (Porter ed. 1991: 325).

Moreover, as indicated above, there was a clear distinction between the work for men and women (Sueur 1997: 43–4) and occupational therapy was clearly gendered. 'While physical exercise and manual labor seemed more necessary therapies for male

patients,' according to Showalter (1985: 82), 'social activities and social decorum were regarded as more important for women'. And their primary tasks in the asylum were cleaning, laundry, and sewing. 'Female patients supplied the asylum with thousands of dresses, shirts, aprons, chemises, petticoats, and caps,' Showalter (1985: 82) claims and adds, 'the institution into which Victorian madwomen were moving were places in which women seemed strangely at home, and in their proper sphere' (80). With a view to both men and women, she notes:

> In planning and constructing the new asylums, Victorian reformers were inevitably reproducing structures of class and gender that were "moral," that is, "normal," by their own standards. In the façades they created for the houses of madness, they defined their façades of sanity as well. (34)

The intended normalisation concerning both class and gender becomes acutely visible in the dress of patients and related practices. Thus female madness was to be domesticated and 'brought into the sphere of rationality' (Showalter 1985: 17) and textile-based occupational therapy was one of the means to do so. On one of his visits to Bedlam Lunatic Asylum in 1857, Wynter observed such a "domestic" or rather domesticating scene of women engaged in "feminine", improving and rather passive activities.

> If we pass on the female side of the hospital, we find the apartments occupied by a score of busy workers, the majority of whom appear to be gentlewomen. Every conceivable kind of needlework is dividing their attention with the young lady who reads aloud 'David Copperfield' or 'Dred;' while beside the fire, perhaps, an old lady with silver locks gives a touch of domesticity to the scene, which we should little have expected to meet within these walls. (anon. 1857: 358–9)

The occupations of female patients, both recreational and labour-related were to strengthen normative gender roles. As such, they were, expected, even forced to perform femininity – through their occupations, their behaviour and their appearance, as seen above.[106] Their textile-based activities, in turn, were used 'to assess inmates' mental state' notes Wynter (2011: 48). Moreover, as the quality of work and attitudes towards it were evaluated psychiatrically, so was women's maintenance of their garments still taken 'as an indication of the progress of the individual' (Baur & Melling 2014: 156).

These practices illustrate the pervasive power of male psychiatrists over definitions of femininity and insanity in the context of moral treatment. 'Instead of the surgical knife, moral management looked to the physical design and domestic routines of the asylum to regulate […] female behaviour,' Showalter (1985: 78) argues, 'While there can be no question that women were better off in Victorian asylums than in the days before moral management, they were nonetheless subject to ubiquitous male authority'. The purpose of textile-based occupational therapy for women was, then, not only their "re-feminisation" but also their control, as well as their occupation. 'To relieve

[106] The performance of femininity in relation to dress in the institutional setting will explored in more detail in Ch. 4.4.1.

the languor of idleness, and prevent the indulgence of gloomy sensations' read the value definition of work in an Annual Asylum report of 1797 (in Digby 1985: 63). Four decades later, the English asylum doctor W. A. F. Browne (1805–1885), who believed that the majority of patients would benefit from occupation, recorded a corresponding observation: 'A melancholic "placed at a loom, and induced to produce ten or fifteen yards of cloth a day" would soon find his mind distracted from its morbid imaginings (in Showalter 1985: 40–1). 'He would also contribute substantially to the finances of the asylum,' Showalter adds and argues 'institutional self-sufficiency' to be the actual goal of occupational therapy (41), an unsubstantiated claim, however, as only a certain percentage of patients engaged in paid work (Sueur 1997: 42).

Another purpose underpinning the different occupations and recreations offered in asylums as part of moral treatment was educational: the notion of self-improvement. At Bicêtre, for example, to learn or practice a trade was regarded as 'the most important precondition for the patient's survival outside hospital once his or her medical condition has improved' (42). As the reform asylum did not only aim to care for, but also cure its patients, life "inside" was meant to prepare for the "outside" world. While dress-based occupational treatment had a clear therapeutic intent, it was equally concerned with the management of patients. A complex and ambiguous combination of motivating factors underpinned such programmes, indicative of the variety of roles performed by dress in moral treatment.

3.2.4 'Woven into every aspect of life inside': Conclusive remarks on ''dress as therapy'' in moral treatment

Dress constituted an essential element in the moral treatment of the "insane" in nineteenth-century asylums in England, France, Germany and the US. '[W]oven into virtually every aspect of 'life inside'' (Wynter 2011: 41), it played an important role in the diagnosis, admission, care, occupation, recreation and control of patients, as this section has demonstrated. Part of a holistic approach, dress was intrinsic to a wider canon of care and cure proposed by moral treatment. It 'played a notable part in sustaining this enterprise,' argue Baur & Melling (2014: 153) and explain: 'We could say that patients' clothing was one way in which the institution dressed itself, contributing to an interior landscape perceived by members of the hospital community and also defining a nexus between that community and the wider world' (149). In a similar vein, Wynter (2011: 51) notes: 'Dress was crucial to realizing the promise of moral treatment. The appearance of the institution and its patients was vital to secure patronage […] the appearance of the lunatics was used by the institution, its senior staff and visitors […] to assess how enlightened was care inside the asylum and outside, in wider society'.

Characterised by pragmatics, pedagogy, play and power, dress within moral treatment fulfilled a variety of functions. Essentially, it was used as a therapy, however, not only curatively, but also coercively. As a normalising and disciplining technology of the self, a self that was perceived as embodied and therapeutable, dress was employed as a direct power in the shape of restraining garments, but more frequently as an indirect power, as a form of moral coercion. By enforcing "good" dress habits in patients, they were meant to conform socially, to be normalised and disciplined, to discipline themselves. In short, patients were to dress "properly" in order to behave "properly". This was particularly the case for female patients, whose minds were managed by controlling their bodies, through both the wearing and making of dress. Consequently, the roles of dress within moral treatment were as complex and contradictory as the asylum itself.

'The rise of the asylum is the story of good intentions gone bad' summarises Shorter (1997: 33) the complexity of nineteenth-century "insane" asylums, where reform had not been as profound as first appeared (Andrews 2007b: 144). Heralded as progressive, humane and curative at the beginning of the nineteenth century, asylums came to be regarded as a problem towards the end of it. As Porter (2002: 118–9) argues: 'Discharge figures showed that expectations that the asylum became a panacea were grossly over-optimistic. Cure rates dipped as public asylums silted up with long-stay […] patients. […] The asylum became a dustbin for the hopeless cases'. They increased substantially in size, the average English institution by at least ten times according to

Porter (2002: 120), who describes asylums as degenerating ‘into sites dominated by formal drills, financial stringency and drug routines’ (120). ‘In the USA,’ he continues ‘there was a slide from the optimism of moral therapy to a preoccupation with security and sedation’ (120). The turn of the twentieth century saw a growing scepticism towards the asylum as an institution for the treatment of the “insane” throughout western Europe and the US, yet in its prevalence it had taken on a life of its own. Within the asylum walls the importance of moral treatment declined and the management of significant numbers of patients was foregrounded with an ‘increasing value attached to medical treatments’ (Digby 1985: 65), the establishment of psychiatry and the rise of psychoanalysis. The legacy of the nineteenth-century “insane” asylum was so strong, that it was felt throughout the twentieth century until the present day, so was the legacy of dress practices established within it.

3.3 Sartorial dis/empowerment: Patients stripped of their 'identity kits' by doctors in white coats – dress practices in psycho-medical treatment of the twentieth century

3.3.1 'Bedlam 1946'

> Thousands spend their days – often for weeks at a stretch – locked in devices euphemistically called "restraints": thick leather handcuffs, great canvas camisoles, "muffs," "mitts," wristlets, locks and straps and restraining sheets. Hundreds are confined in "lodges" – bare, bed-less rooms reeking with filth and feces – by day lit only through half-inch holes in steel-plated windows, by night merely black tombs in which the cries of the insane echo unheard from the peeling plaster of the walls. (Maisel 1946: 103)

What reads like an eighteenth-century account of the coercive treatment of "madmen", was, in fact, recorded in 1946 by journalist Albert Q. Maisel, based on numerous personal visits and interviews, published as a very detailed report on the state of US mental hospitals in *Life* magazine in May of that year.[107] Its title 'Bedlam 1946' sums up the message. Maisel (1946: 118) reported on overcrowded, understaffed and underfunded mental hospitals nationwide, comparing them to camps in their often negligent and inhumane treatment of patients, who are incarcerated rather than cured: 'concentration camps that masquerade as hospitals'. The article, which detailed '400,000 guiltless patient-prisoners of over 180 state mental institutions' (102) sparked a humanisation debate and together with the author's 'testimony before a congressional committee' (102) helped instigate renewed reform efforts in mental hospitals, some of which will be discussed in the following chapter, in relation to "Therapy of Fashion", launched only a decade later (Ch.4)[108].

Including a series of explicit images of 'restraint', 'nakedness' and 'neglect' (figures 14–16), Maisel (1946: 102) denounced the inattentive, even abusive treatment of patients, also symbolised by their dress: 'We give them little and shoddy clothing at best. Hundreds – of my own knowledge and sight – spend twenty-four hours a day in stark and filthy nakedness'.

[107] Maisel's article is based on his 'own observations on a dozen hospitals, in addition to court records and the reports of occasional investigating commissions' (1946: 103), and on reports written by more than 3000 conscientious objectors, 'who, under Selective Service, volunteered for assignment as mental hospital attendants, [who] have been filling out questionnaires and writing "narratives" for use in the preparation of instructional material for mental-hospital workers' (103).

[108] Another highly influential, even if fictional, account of mental hospitals, *The Snake Pit*, was published the same year by Mary Jane Ward (1946). Serialised in *Reader's Digest* and made into a film in 1949, it tells the semi-autobiographical story of a schizophrenic women's institutionalisation, treatment and recovery. It has been termed 'the most vivid and influential portrait of mental hospitals' (Grob 1994: 206), as it reached millions of readers and viewers, drawing attention to the state of mental health care in the US at the time.

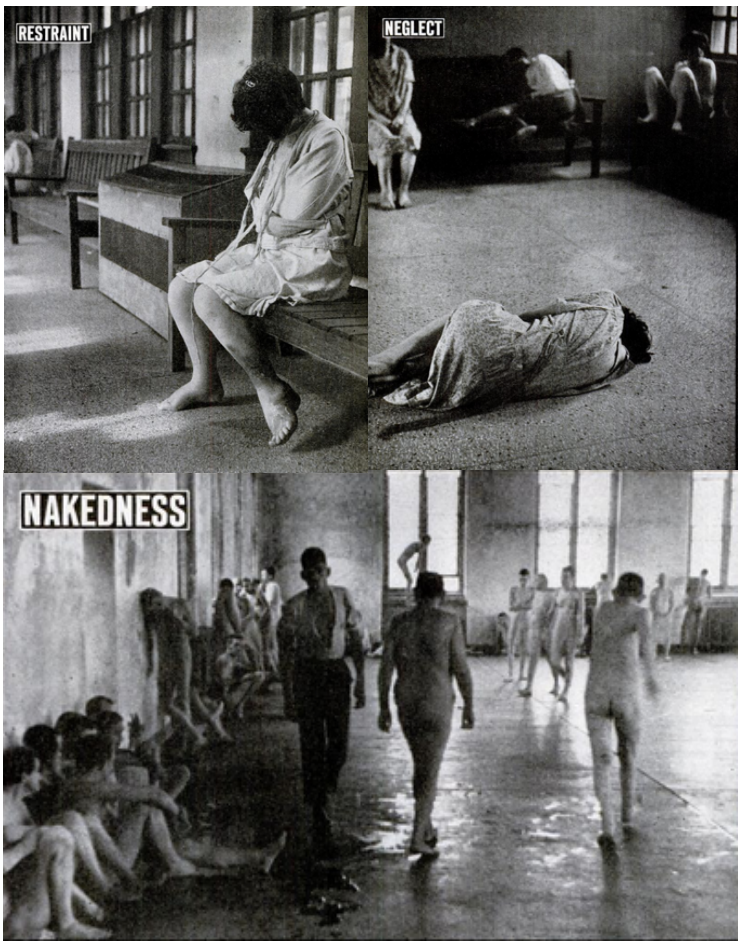


figure 14: 'Restraint', 'This woman wears a camisole with sleeves tied behind her, ulcers on legs are unbandaged.' (Maisel 1946: 103)

figure 15: 'Neglect', 'In Cleveland Hospital's bare wards a patient lies unnoticed and unattended on stone floor.' (Maisel 1946: 102)

figure 16: 'Nakedness', 'At Byberry Hospital near Philadelphia these male patients get no clothes to wear, live in filth.' (Maisel 1946: 105)

Taken at three different institutions, these photographs are reminiscent of early representations of the "insane", the notion of the naked psycho-medical patient, was evidently still alive – not just in the imaginary, but in many mental hospitals in the US. Moreover, Maisel (1946: 107 & 108) observed the extensive use of both mechanical and chemical forms of straitjacket:

> Far more frequent than beatings are the endless cruelties involved in the use of constraints. Although some hospitals have managed to dispense with physical restraints entirely and others permit their use only on written order from doctors, the all-too-widespread practice is to leave the decision to tie down a patient or throw him into solitary up to the harassed and fearful attendant. […] In the more "enlightened" hospitals chemical restraints (i.e., drugs) are used to keep the patients under control so that they will be less trouble to the attendant. In theory these drugs can be prescribed only by physicians or registered nurses. In practice they are often sent up to the wards in batches and administered at the discretion of untrained attendants.

While practices must have varied between different mental hospitals, the legacy of the asylum prevailed and, as Shorter remarked above, it had gone bad.

Clearly, Maisel's report cannot be taken as a statement about mental hospitals in the other countries considered here, since they had begun to develop distinct therapeutic traditions in the twentieth century, as argued at the beginning of this chapter. Yet, his thorough investigation can be taken as indicative of a common legacy with regards to treating the "mentally ill", because psychiatry in the US, France, Germany and England continued to share 'many characteristics across national frontiers' (Showalter 1985: 6).

This section, then, whilst concentrating on US-American sources in the lead up to the analysis of "Therapy of Fashion", also draws larger conclusions from its discussion of dis-identifying dress practices in the psycho-therapeutic context of the twentieth century, marked by drug treatment and psychotherapy. After having explored the use of dress as a disciplining and normalising technology in relation to the "insane" self by restraining patients (3.1) and by clothing them "properly" or dressing them up (3.2), this final section focuses on stripping patients of their 'identity kit', as Goffman (1961: 30) termed it, a prevalent practice in the institutionalisation of patients from the outset.

3.3.2 Unmaking people: The loss of personal dress and identity in mental hospitals

3.3.2.1 'Identity kits' versus 'Garments designed for mental and retarded patients'

Fifteen years after Maisel's article another publication gave detailed insight into US-American mental hospitals, into 'total institutions': Goffman's aforementioned *Asylums* (1.2.2). The sociologist had observed 'the social world of the hospital inmate' (1961: 7) at one of the large mental hospitals described by Maisel, and wanted to find out how this is subjectively experienced by patients.

Countering academic convention of his time, Goffman considered dress to be a vital component of this social world. He wrote: 'It is characteristic of inmates that they come to the institution with a 'presenting culture' […] derived from a 'home world' – a way of life and a round of activities taken for granted until the point of admission to the institution' (23). Dress, according to Goffman (1961: 24), constituted an important part of this 'presenting culture', part of 'a conception of himself made possible by certain stable social arrangements in his home world' and expressed in his material possessions, his appearance and demeanour. For reasons of institutional efficiency, upon his entrance into the mental hospital, the patient, however, 'is immediately stripped of the support provided by these arrangements. In the accurate language of some of our oldest total institutions, he begins a series of abasements, degradations, humiliations, and profanations of self. His self is systematically, if often unintentionally, mortified' (24). Goffman (1961: 25) described the admission procedures as a process of 'loss and mortification' from the perspective of the patient:

> taking a life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage, undressing, bathing, disinfecting, haircutting, issuing institutional clothing, instructing as to the rules, and assigning to quarters. Admission procedures might better be called 'trimming' or 'programming' because in thus being squared away the new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operations (25–6).

In this process of dis-identification, he ascribed a particular role to the dress of patients, for both men and women, as he does not make a distinction. Briefly but poignantly Goffman analysed (1961: 30) the way they are undressed, stripped of their 'identity kits':

> One set of the individual's possessions has a special relation to the self. The individual ordinarily expects to exert some control over the guise in which he appears before others. For this he needs cosmetic and clothing supplies, tools for applying, arranging, and repairing them, and an accessible, secure place to store these supplies and tools – in short, the individual will need an 'identity kit' for the management of his personal front. He will also need access to decoration specialists such as barbers and clothiers. On admission to a total institution, however, the individual is likely to be stripped of his usual appearance and of the equipment and services by which he maintains it, thus suffering a personal defacement.

Drawing attention to the naturalised process of standard admission procedures, Goffman (1961: 30) highlighted the defacement of self that he argued comes with a 'loss of identity equipment'. Moreover, he evocatively illustrated the process of disempowerment which marked the beginning of a patient's hospitalisation: being stripped off one's dress, a means whereby an individual controls the way s/he appears to others, can signify a loss of power. Having one's 'identity kit' taken away, an individual lacks the means to maintain his former image, which further explains the change in one's sense of self that comes with illness and institutionalisation, as argued by Goffman. While Goffman's conclusions were drawn from his observations of an US-American mental hospital in 1955–6, they illuminate the meaning and impact of the process of institutionalisation in general, both historically and contemporaneously. In short, what he reveals, in detail and with great insight, is how a person is meant to be 'unmade' (Hacking 2004: 298) in such circumstances.

Goffman's 'special sociological interest' in total institutions in general and the mental hospital in particular, lies in their very purpose of being 'forcing houses for changing persons' (1961: 22), as previously mentioned (1.2.2). He argued that they constitute 'a natural experiment on what can be done to the self' (22) and, most relevantly for this thesis, on how dress is employed in relation to the self. Goffman's formulation of dress as 'identity equipment', as an essential part of our 'identity kit' is ground-breaking, as it expresses not only a particular relevance of dress to identity, but also the process of constructing and maintaining one's identity through dress and dress-related practices. As such it is a similarly embodied and seminal understanding of dress as Foucault's notion of technology of self, which, although never explicitly adapted to dress by the author, lends itself well to its reading.

In his writing, Goffman (1961: 28), not only drew attention to the process of taking away patients' 'identity kits', but also to replacing it with a standardised institutional version:

> Once the inmate is stripped of his personal possessions, at least some replacements must be made by the establishment, but these take the form of standard issue, uniform in character and uniformly distributed. These substitute possessions are clearly marked as really belonging to the institution and in some case are recalled at regular intervals to be, as it were, disinfected of identifications.

Like Granville (3.2.2), Goffman (1961: 30) pointed to the dis-identifying and disempowering implications of such practices and noted a subsequent and common loss of sense of personal safety.

In a detailed manner, he described the clothing 'substitute for what has been taken away' from patients as 'typically of a 'coarse' variety, ill-suited, often old, and the same for large categories of inmates' (28–9) and gave an impression of the process of dressing inmates to go outside:

> the quickest assurance that patients going on the grounds will be warmly dressed is to march them past a pile of the ward's allotment of coats, allowing no choice as to whether to wear one or which to wear, and requiring them for the same purposes of health to give up claim to these collectivised garments on returning to the ward (76).

What was an efficient practice in the institutional context, constituted a process of 'mortification' of self for the patient, according to Goffman, a process that ignored the 'de-humanising' side-effects of non-personalised clothing. Having been stripped off her/his 'identity kit' the patient is presented with replaceable 'equipment', thus lacking a continuous 'presenting culture', which results in the erosion of a sense of self, he argued.

Moreover, Goffman (1961: 31) observed that, after admission, the patient's self-image is attacked in another way, as he 'has to engage in activity whose symbolic implications are incompatible with his conception of self'. Goffman detailed a series of 'physical indignities', of forced movements and activities, such as making patients eat all food with a spoon at mental hospitals (30), yet, he does not take up dress here, albeit it being an obvious example. Forcing a certain dress behaviour on patients constitutes a physical indignity, be that in the extreme forms of restraining dress, or denying them anything to wear as evidenced in Maisel's report; or else, more ordinarily, in requiring patients to wear the old garments of a stranger. 'Complaints about unclean [...] shoes and clothing impregnated with previous users' sweat' were common, noted Goffman (1961: 33) later, an indication of the level and awareness of mortifications.[109]

Another form of sartorial indignity was constituted in standardised institutional dress (figure 17 and 18). 'All-in-one garment, designed and tested by institutions for mental and retarded patients. Inhibits the exposure impulse, resist tearing. Slips on over head,' read an advertisement for Karoll's Super Cloth Jr. Dresses in 1955 (figure 17).[110] Such institutional garments, designed for both female and male patients, for functionality and efficiency rather than individual taste or comfort, illustrate the priorities of mental institutions at that period. One-size had to fit all, equalisation rather than self-enhancement, as Goffman (1961: 77) remarked: 'The very structure of a garment can be determined by the interest of efficiency'.

[109] Another form of sartorial indignity, prevalent at the time and used until the present day, is the practice of keeping 'unruly residents' in night clothes during the day, 'on the principle that they could be more easily managed' (Baur & Melling 2014: 156), thus disorientating and infantilising them.
[110] The text of this particular advertisement is quoted by Goffman (1961: 77), yet, without the inclusion of the image.



figure 17: Advertisement for Karoll's Super Cloth Jr. Dresses, 1955, 'CHEERY, STURDY! SNAP-FASTENED BUILT-IN PANTY All-in-one garment, designed and tested by institutions for mental and retarded patients. Inhibits the exposure impulse, resist tearing. Slips on over head. No brassiere or other undergarment needed. Snap-fasteners at crotch aid toilet training. Pleasing patterns or 2-tones with round, V or square neckline. Needs no ironing.'

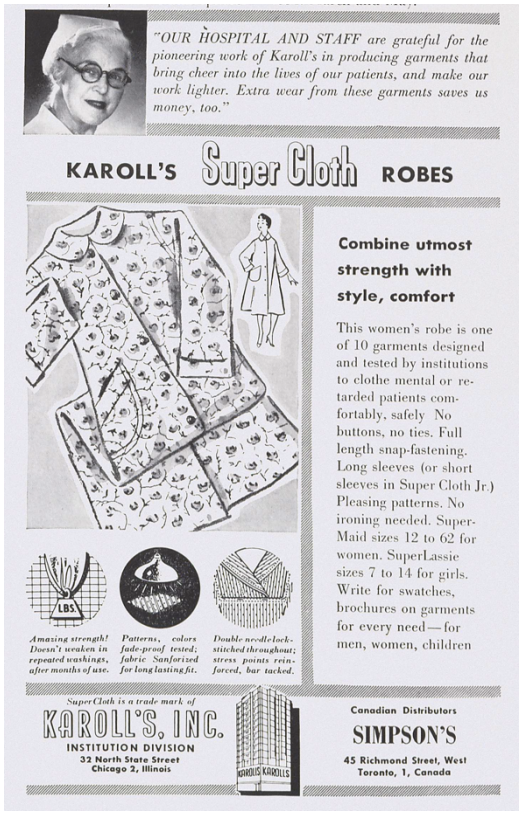


figure 18: Advertisement for Karoll's Super Cloth Robes, 1955, '"OUR HOSPITAL AND STAFF are grateful for the pioneering work of Karoll's in producing garments that bring cheer into the lives of our patients, and make our work lighter. Extra wear from these garments saves us money, too."'

According to him, efficiency both characterised and governed the mental hospital. Rather factually he made the following observation:

> Many institutions, most of the time, seem to function merely as storage dumps for inmates, but […] they usually present themselves to the public as rational organizations designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends. It was also suggested that one frequent official objective is the reformation of inmates in the direction of some ideal standard. This contradiction, between what the institution does and what its officials must say it does, forms the basic context of the staff's daily activity. […] The obligation of the staff to maintain certain humane standards of treatment for inmates presents problems in itself, but a further set of characteristic problems is found in the constant conflict between humane standards on one hand and institutional efficiency on the other. (73 & 76)

Goffman (1961: 76–7) re-cites the management of personal possessions, of dress in particular as an example:

> The remarkable efficiency with which a mental-hospital ward can adjust to a daily shift in number of resident patients is related to the fact that the comers and leavers do not come and leave with any properties but themselves. [...] Further, the efficiency with which the clothes of these patients can be kept clean and fresh is related to the fact that everyone's soiled clothing can be indiscriminately placed in one bundle, and laundered clothing can be redistributed not according to ownership but according to approximate size.

He stresses the vital role of personal possessions in the construction and maintenance of identity and the sense of defacement and dispossession that comes with a lack of private space, with 'periodic searches and confiscations' (28).[111] Writing about the history of Australian mental hospitals, Willis (1994: nn) equally noted: 'There was little official sense that people were individuals who deserved their own possessions [… which] illuminates the way institutional life sets out to destroy individuality'. An insightful account of such depersonalisation of "mental" patients is given in the following personal recollection of institutionalised times in the UK, indicative of the fact that Goffman's observations, although made in the US at the turn of the 1960s, had wider relevance:

> Female inmates no matter what age would have been forced into these 'boil wash, one-size-fits-all' uniforms with name labels sewn in. People rarely rocked the boat and complained of the shockingly drab and heavy costumes they were forced to wear. Institutionalisation ruled and extra meds were written up for those that 'questioned' too much […] the days of institutions kitting people out in recognisable uniforms for the purpose of stripping out individuality from people. ('Pete' 2007 in Labrum 2011: 79).

Mid-twentieth-century mental institutions, according to Goffman, were characterised by two contradictory discourses. The former was what he termed, 'effective machines' for the reformation of 'inmates'; the latter, their 'storage' thus their management, which entailed the regulation of their bodies and minds. The effective running of such machines could not be disturbed by the individuality of patients, according to Goffman. In the logic of the 'total institution' they had to be stripped of their 'identity kits', to be dispossessed, had to be equalised physically and mentally:

> Just as personal possessions may interfere with the smooth running of an institutional operation and be removed for this reason, so parts of the body may conflict with efficient management and the conflict may be resolved in favour of efficiency. If heads of inmates are to be kept clean, and the possessor easily categorized, then a complete head shave is efficacious, despite the damage this does to appearance. On similar grounds some mental hospitals have found it useful to extract the teeth of 'biters', give hysterectomies to promiscuous female patients, and perform lobotomies on chronic fighters. (Goffman 1961: 77)

Bodies were made manageable, made 'docile' (Foucault 1975/1995). Behaviour was streamlined. And the dress of patients had to be efficient. At the same time, the staff involved in the institutionalisation of patients, undertaking administration procedures, guarding and treating patients, or performing operations were wearing medical uniforms. While this contrasting detail is not discussed by Goffman, it is deeply symbolic of the totality of the institution, and of the relations of power inherent in them. Moreover, what made the process of stripping patients of their 'identity kits' appear so coercive, even insidious, was the fact that the doctors or nurses stripping them were wearing white coats or equivalent medical uniforms, as addressed below.

[111] On similar grounds, British psychiatrist Russel Barton (1959: 5) had warned of 'institutional neurosis', of the 'dreadful mental changes that may result from institutional life' in his book of the same title.

3.3.2.2 'Those nice young men in their clean white coats, and they're coming to take me away ha-haaa!': The authority and impact of the doctor's white coat

They're coming to take me away ha-ha!
They're coming to take me away ho-ho hee-hee ha-ha!
To the funny farm,
Where life is beautiful all the time.
And I'll be happy to see those nice young men
In their clean white coats,
And they're coming to take me away ha-haaa!
'They're coming to take me away ha-haaa!', song by Jerry Samuels aka Napoleon XIV, 1966



figure 19: Hospital hierarchy & the medical gaze: A patient wearing a short-sleeved, above-the-knee hospital gown, sits on a bed in a mental hospital, naked arms, legs and feet; while his psychiatrist (Dr Fink) in a white coat and an interviewer (Jonathan Miller) in a suit stand, look down to him, question him. Department of Psychiatry, Stony Brooks Hospital, N.Y.. Documentary film still, *Madness*, 1991.

Hospital hierarchy: A patient, in the middle of a treatment course of Electroconvulsive therapy (ECT) in the Department of Psychiatry at Stony Brook Hospital on Long Island, is sitting on a bed, wearing a short-sleeved, above-the-knee hospital gown, naked arms, legs and feet; while a doctor in a white coat and an interviewer in a suit are standing, look down to him and question him (figure 19). The patient's discomfort is palpable, sloped shoulders, hands hidden, sitting half-naked opposite two men, who are dressed as authorities. Having been stripped of his 'identity kit' this man seems lost in his revealing examination gown: 'dis-identified' through dress, disempowered. In stark contrast the psychiatrist: identifiable through what he wears, empowered by his white coat, a simple garment, yet 'loaded with hierarchical symbolism' (Picard 2012). It endorses his authority to observe, question, touch, diagnose, treat, medicate or operate. It essentially sanctions the medical gaze.

The white coat, which was first adopted by physicians in the late nineteenth century (Blumhagen 1979: 111), motivated by the valorisation of hygiene and cleanliness (Hardy

& Corones 2015), remains the pre-eminent symbol of doctors until the present day (Hochberg 2007: 310).[112] It is said to have originated in 'operating rooms, scientific laboratories, and modern hospitals' (Blumhagen 1979: 111), all contributing to 'the social understanding of what it means to be a healer' (111).[113] Since the authority of science was supposed to validate the practice of medicine, doctors sought to represent themselves as scientists (113) and the white coat granted them both 'professional dignity' and 'scientific credibility' (Hardy & Corones 2015: 44 & 42). As the care of the sick shifted from home to hospital, a move previously witnessed in the care of the "insane" (3.1), the profession of medicine was transformed radically, so was the understanding of hospitals as places of healing rather than dying. Black shifted to white (Blumhagen 1979: 113).

Doctors, who had now been granted the privileged physical access to strangers so far only held by psychiatric physicians, wore the white coat also to legitimise private and 'otherwise socially taboo behaviour' in a public place, as US-American doctor Blumhagen (1979: 111) notes.

> The kind of access to the body of the patient that a physician in our society has is a uniquely privileged one. […] A mechanism was needed that would reinterpret an ordinarily taboo activity into a socially acceptable, even desirable, one. […] The white coat, with its meaning of bilateral protection, purity, goodness, and unaroused sexuality, was ideally suited for this task' (Blumhagen 1979: 114 & 115).

The symbolism of the white coat, as Blumhagen (1979: 113) details, is varied and combines not only protection and purity, but also power: 'The social image of the physician,' he argues, 'had become one of immense power and authority. These attributes were associated with the white clothing he wore' (112). Writing two decades later, professor of medicine Wear (1998: 736) breaks down this notion of power associated with the white coat, which she terms 'the occupational clothing of a prestigious group with substantial power over human lives'. The white coat, she maintains, 'can symbolize caregiving hierarchies and spheres of practice, the social and economic privilege of physicians,' (734) because of 'the asymmetry inherent in the physician-patient relationship, an asymmetry that derives from educational, technical, social, and economic differences between physicians and patients' (735)[114]. In a similar vein Huber (2003: 364) comments on its significance with a view to the inherent unequal

[112] Practices of wearing the white coat in the medical context vary considerably and depend on culture and tradition (Anvik 1990: 91).
[113] For a discussion of the history and meaning of the white coat see Blumhagen (1979), or more recently Hardy & Corones (2015) (reliant on, yet, dismissive of the former).
[114] Wear (1998) makes this argument in relation to a controversy over the White Coat Ceremony. Founded in 1993 by the Arnold P Gold Foundation, this ceremony is practiced at the majority of medical schools in the US to welcome new students into the medical profession and named after the ritual of presenting them with their first white coat (http://humanism-in-medicine.org/programs/rituals/white-coat-ceremony, 13.5.2016). The "controversy" concerns the relevance of both the ceremony itself and the symbolism of the white coat given to entering students. Joining the discussion, Druss (1998: 743) notes the following observation concerning the meaning and purpose of the white coat as a form of psychological protection: 'how could these young people face so much human suffering – cries of pain, wasting away, the blood and deformity of disease – seen in any modern hospital, without their magic white coats as shields for their soul?'

power relations between doctor and patient: 'the historico-anthropological meaning of the white coat itself includes more than virtue and humanism and, in fact, represents an imbalance of power, separatism, entitlement, and paternalism in medicine'. This imbalance of power is captured in figure 19 and illustrates how 'a basic relation of power, or "who controls whom," is conveyed through organizational use of uniforms' (Kaiser 1997: 362).

Writing about the contrast between the physician's white coat and the patient's examination gown, Blumhagen's (1979: 115) comments on the way their 'shared meaning direct patient and physician behavior' could have been made in relation to figure 19: 'The physician is an active scientist, the patient is passive material; the physician prescribes, the patient complies; the physician is self-concealing, the patient is self-revealing. Clearly as long as this social definition of the healing encounter exists, the physician will dominate the setting'. It is in the co-dependence of doctors' white coats and patients' gowns, whatever standardised shape they take, that their dis/identifying and dis/empowering effect is amplified. Through their inevitable concurrence the two garments reach their powerful potential: to make and unmake a person respectively.

While the white coat 'remains a sign of medical professionalism' (Hardy & Corones 2015: 44) and is prevalent particularly in the clinical setting, the second half the twentieth century saw a move to less formal wear for medical, notably nursing staff under different models of care (Labrum 2011), coinciding with efforts to de-institutionalise the dress of patients (4.2.3). Some physicians, such as paediatricians and psychiatrists, argues Blumhagen (1979: 115), 'have found that the meanings communicated by the white coat were so overpowering that it interfered with their practice […] and they therefore tend to wear pastel coats or normal street clothes'.[115] Yet, medical dress practices vary considerably and cannot be generalised, as shown in figure 19. The only common characteristic was a growing concern of what is worn by both patients and staff.

Such considerations also underlie two of the dress-related therapeutic projects analysed in this thesis: "Therapy of Fashion" (Ch.4) and *vêtothérapie* (Ch.5). Explaining the premise of the latter, child psychiatrist Marcel Rufo (1999: 9) warns of both, the effect of medical uniforms on patients on the one hand, and the risk of making patients dressed in hospital gowns feel inferior on the other: 'Respect for patients and their integration into the world passes, without a doubt, through their self-presentation'[116]. Rufo's words stand in contrast to Goffman's remarks on the dis-identifying role of dress in the mental asylum, pointing to a shifting discourse in late twentieth-century psycho-medical treatment, as

[115] The overpowering effect of the white coat has even been medically diagnosed as 'white coat syndrome' which describes 'unrepresentative high blood pressure recordings due to a patient's anxiety upon seeing a doctor in a white coat' (Hochberg 2007: 312).
[116] 'Le respect des patients et leur intégration au monde passe sans doute par leur présentation.' (Rufo 1999: 9)

will be discussed in Chapter Five. Yet, it is Goffman's observation concerning the unmaking and equalising of patients through dress in mental institutions which evidently corresponds with dominant dress practices throughout most of the twentieth century. Whilst commenting on a noticeable change in the style of dress and the scope which patients were allowed 'to make choices about their clothing' since the 1950s, Baur and Melling (2014: 159), for example, maintain that 'the clothes issued by institutions were intended to integrate patients into a shared identity' (157). 'Patients,' they add 'remained part of an enforced collective of issued and laundered apparel without control over the return even of the most personal underwear' (159). In a similar vein Labrum (2011: 69) argues that clothing in twentieth-century psychiatric hospitals 'was still not considered to be part of patient dignity and comfort' and 'patients' appearance continued to be seen in uniform or corporate terms, and neglected as an integral aspect of the presentation of an autonomous, functioning self'.

While patients' dress was used predominantly as a depersonalising, equalising and disciplining technology of the self in the asylum and later the mental hospital, efforts to de-institutionalise and individualise their dress ran alongside, as this chapter demonstrates. Such attempts and the move towards personal clothing for both patients and staff in more recent times could be regarded as dress-related therapeutic measures in themselves, whose implications will be discussed in relation to *vêtothérapie* (Ch.5).

Following the disillusionment with reformed asylums (3.2.4) and its aftermath in the first half of the twentieth century, as depicted by Maisel, the notion of a therapeutable self re-emerged, a self that could again be treated through dress among other things, just as some of the asylum reformers had maintained (3.2.2). This shifting discourse engendered a series of dress-related therapeutic practice and a distinct form of "Therapy of Fashion" (Ch.4).

The dress of patients throughout psycho-medical history stood and acted in contrast to that of their doctors and other medical staff. Not only are their relationships defined by what they wear, but the practices of dis/identification, dis/empowerment, essentially the un/making of both patients and doctors, inherent in such total institutions are effectively mediated through dress, as Goffman argued in relation to patients.

Garments as different as the doctor's white coat, patients' examination gowns and other forms of institutional clothing (or lack thereof), as well as the straitjacket all coincide in the mental hospital. Dress practices as diverse as stripping patients' of their 'identity kits', constraining them, dressing them uniformly or dressing them up, could all be found under one roof. Yet, it is the straitjacket which arguably holds the greatest symbolic power for the treatment of the "insane" until today. The final section of this chapter will briefly explore its role in contemporary psycho-medical care.

3.3.3 'Protecting' the patient: The contemporary use of the straitjacket

> To begin unbuckle all buckles on the rear of the jacket. Put the patient's arms through the sleeves with the opening in the back. Close the back by feeding the ends of the straps through each of the four corresponding buckles, starting with the waist strap. Cross the patient's arms in front and pass each arm through the vertical loop located in the chest area and then under each vertical loop located on the sides of the jacket. Secure the two sleeve ends behind the patient's back using the attached straps. Pass the pelvic strap between the patient's legs and secure with the buckle behind the patient's back. Check all the straps to secure that they are snug enough to prevent escape, but do not interfere with circulation or breathing. (Posey 2016)

While the straitjacket justifiably stood for the coercive treatment of the "insane" in the eighteenth century (3.1), it continues to be a potent symbol of psychiatry (Labrum 2011). Moreover, it is still present in contemporary institutions of "care" for the "mentally ill" in both the US and Europe (de Young 2015: 234), albeit under a somewhat different rhetoric, exemplified by the way the straitjacket is marketed by one of the leading providers of medical products, US-based company Posey. The tone of the instruction video is calm and friendly. A woman's voice talks the audience through the 'proper application' of a straitjacket, while a female nurse is dressing her male, motionless "patient" (figure 20 and 21).



figure 20: 'Posey Straitjacket', advertisement on the website of: Posey® First in Patient Safety, 2013



figure 21: 'Posey straitjacket', front and back, now sold under 'Patient Safety & Protection', 2016

The 'Machine washable' straitjacket, made out of cotton canvas in sizes S, M, L, XL is offered by Posey, self-proclaimed 'First in Patient Safety', as a prescription device. The language used on the company website is indicative of shift in psycho-medical discourse and arising treatment: 'Helping Caregivers with products and education since 1937' (www.posey.com). 'Keepers' are now 'caregivers', 'lunatics' are 'patients' and their 'protection' and 'safety' rather than their seclusion are said to take priority. The straitjacket, however, even if somewhat altered in design, is still in use in the treatment of the "mentally ill" after 300 years.

While the use of psychotropic drugs, the "chemical straitjacket", is far more prevalent than its mechanical counterpart, this form of restraint is still employed, its legislation a somewhat grey area. According to US law restraining patients is an emergency procedure, only permitted to prevent patients 'from seriously harming themselves or others and only after other interventions have been tried' (Foderaro 1994). However, both the reduction of restraint and seclusion, and their abuse remain current debates.[117] Similarly, in Europe, legislation around the use of straitjackets is vague. Although its employment is discredited, it is not outlawed and still in use, even if strictly documented in both the UK and Germany, for example (O'Hara 2005, Westhoff 2013). Commenting on the 'types of restraint' in use in 'psychiatric establishments' the

[117] For further details, see, for example, the Positive Alternatives to Restraint and Seclusion (PARS) initiative launched by the New York State Office of Mental Health (http://www.omh.ny.gov/omhweb/News/2011/pars.html). Moreover, see Saks (1986) for an account of the use of mechanical restraint in psychiatric hospitals in the US during 1970s and 1980s.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) records the current employment of 'various methods of controlling agitated and/or violent patents', such as straps and straitjackets (CPT 2015: 58–9). It calls for their 'proportioned' use and recommends 'oral persuasion' as the best method, conceding, however, that 'at times it may be necessary to resort to other means directly limiting the patient's freedom of movement' (59).[118]

As no official statistics on the use and misuse of restraint appear to exist, it is impossible to assess what role exactly the straitjacket plays in contemporary psycho-medical treatment. However, practitioners in the UK, for example, have raised concerns 'that wider use of mechanical restraints is being considered as a means of getting around staff shortages [because] inadequate staffing levels on some wards, and a reliance on under-qualified agency staff, puts "enormous stress" on psychiatric nurses' (O'Hara 2005). Reminiscent of the circumstances that consolidated the use of the straitjacket at the end of the nineteenth century (3.1.4), its ongoing employment, continues to be determined by a lack of both finances and qualified staff. Moreover, the accompanying concern over the difficulty to determine abuse, voiced by Griesinger in 1867 (508), as previously quoted, is still alive.

As seen from current examples, the straitjacket is much more than a psycho-medical cliché and remains a therapeutic reality, even in 'the deinstitutionalised present' (Labrum 2011: 80), an era of drug treatments, community care and psychotherapy. While its use is much rarer and more regulated, 'secure dress' continues to be 'fundamental to therapeutics' (Wynter 2011: 40). The straitjacket continues to be employed, potentially, as an interventional coercive form of "dress therapy". In its looming presence, the straitjacket remains one of the varied dress practices in psycho-medical treatment. Its coercive past and ambiguous present illustrate the continuing conflict between care and control in psychiatry and the way dress is directly implicated in it.

[118] It is noteworthy that the straitjacket is regarded as an accepted form of restraint in such circumstances by the CPT, as the report continues: 'Certain mechanical restraints, which are still to be found in some psychiatric hospitals visited by the CPT, are totally unsuitable for such a purpose and could well be considered as degrading. Handcuffs, metal chains and cage-beds clearly fall within this category; they have no rightful place in psychiatric practice and should be withdrawn from use immediately' (CPT 2015: 59).

3.4 Conclusion

Dress was as fundamental to the total institution of the asylum and mental hospital as their purposive architecture, their exterior and interior spaces, daily routines, occupational schemes, their furniture and food, and the prescribed social interaction with other patients and staff (Labrum 2011). This chapter demonstrates that dress has played a central and varied role throughout psycho-medical history, contrary to what popular representations and the current state of research suggest. It argues that implicit therapeutic use in relation to the self has been made of it for more than 250 years. While the patient was naked time and again, dress was always instrumentalised in these 'forcing houses for changing persons' (Goffman 1961: 22), it was meant to fulfil their redirective function. Constituting an exploration of historical discourses of what could be 'done to the self' (22) through dress, this chapter shows how it was instrumentalised during the different phases of institutionalised psycho-medical history: first in the coercive treatment of the "insane", then in their moral treatment and finally in psychotropic treatment of the twentieth century.

Underlying these strategically separated stages are changing notions of self, as argued at the beginning (figure 1 and 2): from an insensitive, disembodied, irrational self, to be secluded and restraint in the eighteenth century (3.1); and the notion of a therapeutable self, one that could be educated and improved through the moral treatment of the nineteenth century (3.2); to an embodied and individual self, contemporaneously, in need of supervision, but also 'protection' and 'care'. Evidence of a changing discourse of care can be found in the corresponding terminology, as argued above. Such trajectories are, however, neither linear nor progressive, as this chapter shows (3.3). It is also questionable, if the substitution of physical constraint with surveillance and moral as well as confessional treatment, imposed another and perhaps more total restraint, as Foucault argues (1961/2001) (3.2.3.1).

One aspect of the notion of self, underpinning the treatment of the "mad", which is enduring, is the belief that dress, appearance and bodily representation are indicative of the self, that the modern self is immanent in appearance (1.3.1). While this correlation has gained greater and more overt significance in late modernity, as will be shown in relation to the explicitly dress-related therapeutic projects analysed in the chapters to come, it co-determined the various functions dress fulfilled in the asylum from the outset.

Throughout psycho-medical history dress performed a multiplicity of roles, often contradictory in nature. Not only was it used to cover and protect the body of patients, it also constituted a tool for diagnosis and classification, a form of diversion and treatment social conformity and a control mechanism. The dress of patients, in all its different

institutional forms, from straitjacket to standardised or specialised institutional clothing, was intended to discipline, equalise and normalise them. As such is stood in contrast to the medical uniforms of ward staff and white coats of doctors, creating clear hierarchies and sustaining relations of power. Whether stripping patients of their 'identity kits', constraining them or dressing them up or down, different dress practices were critical to the project of these total psychiatric institutions, the efficient management and control, even the intended cure of patients' bodies and minds. Therefore, dress was central to the inherent process of unmaking a person, and of remaking them in a compliant and conform manner. This process was particularly pronounced for female patients, since normative notions of femininity and an essentialist understanding of women's relationship to dress determined their treatment and occupations within the asylum.

The process of dressing both female and male "mental patients" was determined by a diverse set of motivations: organisational, medical, therapeutic, educational, social, cultural and political. Just as the resultant variety of functions of dress, these motivations are all inherently linked, enlaced in each of the featured garments and sartorial practices. In the total institution, dress was inscribed with multiple and often conflicting narratives. While these are inseparable in the worn reality and should be considered together, they have been singled out in this chapter to some degree, to permit detailed analysis. Essentially, it is this very proximity of care, control, and cure, characteristic of psycho-medical treatment through the ages, which dress can capture so precisely, which it symbolises in all its paradoxicality, as argued here.

This chapter constitutes an exploration of the zero point of dress-related forms of therapy. In its attempt to investigate how and when dress began to be instrumentalised in relation to the self, it also forms the foundation for the analysis of three dress-related therapeutic projects (Ch. 4–6) that are much more explicit in their use of dress. Moreover, this chapter writes a history of their present by considering preceding discourses and how they laid the tracks for contemporary practices. As such, it explores some of their common conditions of possibility: the institutionalisation of madness, thus its very constitution; the treatment of the "in-sane" in the designated space of the asylum governed by a particular authority; their perception as 'forcing houses for changing persons'; underlying notions of self, as summarised above; the role of dress in relation to the self; and finally the understanding of dress as a coercive, normalising and didactic tool. Following on from here, the three dress therapeutic projects under review in this thesis can be analysed as part of a much longer and wider trajectory, as continuing with or breaking from some of the longstanding, spoken and unspoken, silenced and naturalised traditions of instrumentalising dress in relation to the self in psycho-medical settings.

part III
Three therapeutic settings

chapter four
"Therapy of Fashion"

Introduction

At the same time that Erving Goffman (1961: 30) was observing institutional life at St Elizabeths Hospital in Washington, D.C., noting the 'personal defacement' of patients stripped of their 'identity kits', made to wear 'collectivised garments' (76) and subjected to 'physical indignities' (30), a very different approach to dressing patients was trialled at a mental health hospital on the West Coast of the US. In 1959 a pilot study entitled "Therapy of Fashion", a programme of grooming, dress design and self-presentation classes, was undertaken with a group of forty female patients at the psychiatric ward of Napa State Hospital in California.[119] Sponsored by the Mental Health Association of San Francisco (MHASF), "Therapy of Fashion" was carried out as a volunteer project by The Fashion Group of San Francisco[120], 'the local branch of a national organization of key professionals in the fashion field' (Miller et al. 1960: 42). Following a fashion show was a series of three weekly classes where 'fashion experts advised individual patients about the type of clothes best suited to them [and…] gave demonstrations and instructions concerning correct facial make-up, hair styling, dress designing, proper foundation garments, and simple exercises to improve posture and develop poise' (42). 'With professional guidance each patient was given the opportunity to design a dress for herself', selecting fabrics and colours, which were presented, 'after a practice session in modelling' (42) in a show staged by the patients, as Dr Theo K. Miller, then hospital Superintendent and Medical Director, described the new study in an article co-written with two colleagues for the medical journal *Mental Hospitals*.

This chapter documents and critically analyses "Therapy of Fashion" from pilot study to national volunteer service programme, which, although publicised quite extensively in the early 1960s, has not been written about let alone analysed since. To give a thick description of "Therapy of Fashion" the present chapter draws on a wide variety of sources: medical journals, local newspapers, contemporary publications about gender

[119] The term 'State Hospital' refers to state-funded psychiatric hospitals in the US.
[120] The Fashion Group of San Francisco will be referred to as the Fashion Group hereafter.

and mental hospitals, advertisements for psychotropic drugs and institutional garments, an author interview with one of the participating volunteers, and photographic documentation of different sessions. As well as analysing the discursive construction of "Therapy of Fashion", the chapter discusses a number of related initiatives that preceded it and that, in turn, were inspired by it, all contributing to a moment when dress was employed as a therapy in mental hospitals of the US.

This chapter argues that "Therapy of Fashion" has to be read against the backdrop of a humanising discourse in both medicine and psychiatry in the US, with the advent of psychotropic drugs and subsequently the rise of open-door policies in mental hospitals. Moreover, this treatment approach needs to be seen in the context of the popularisation of dress and fashion in the 1960s in general, but also in mental hospitals in the US, with the creation of a Central Clothing Committee and clothes centres for patients (4.2.3). Targeting only female patients, "Therapy of Fashion", also necessitates a consideration of the gendered nature and context of this treatment practice, and of normative notions of femininity at the turn of the 1960s in the US that were underlying this therapeutic approach, and indeed generative of it.

Foucault argues that the modern institutions of the asylum (1961/2001), clinic (1963/2003) or prison (1975/1995), under a dominant and ultimately humanising ideology of therapy, care and rehabilitation respectively, have brought forth non-coercive, yet equally controlling techniques, transforming bodies and behaviour, and shaping subjectivities. Building on his work, this chapter maintains that although "Therapy of Fashion" was brought into hospitals with good intentions and under a humanising mission, it was employed as a normalising and disciplining technology of the self, and also constituted a form of social therapy. As such this chapter explores the notions of self, body, gender, fashion and therapy underpinning and determining this treatment approach. It analyses the discursive construction of "Therapy of Fashion", the way this "dress therapy" was constructed as a practice to produce normalised gendered and fashionable subjects.

4.1"Therapy of Fashion": A pilot study designed to 'recreate healthy feminine characteristics in women patients'

> On the morning of the first fashion-therapy class, Mrs. Winthrop awoke with what she termed an absolute paralysis of the brain. *I can't go*, she thought. *I'm terrified*. "When I was a young girl," she said afterward, "the only scary tale my mother ever told me was about the time she went through a mental hospital, seeing people tied up in strait jackets. Real horror stuff. I suddenly felt Napa would be like that. I couldn't take it." But her husband […] told her, "Janey, this is just another fashion show with people. You know fashion. You like people. Now get in the car and drive up there". On the way to Napa Mrs. Winthrop relaxed somewhat. "I'd been thinking," she recalls, "that any woman who's got a cold in the nose, or a sinus attack, or corns – immediately after she gets home, she removes her girdle and her stockings and her shoes, and she looks simply ghastly. So, though I'd never seen a mental hospital – and moreover didn't want to – I reasoned that if you were really mentally sick you'd feel even nastier and you'd care even less how you looked." The only way to reach such patients, she figured, was to "slap 'em in the face with fashion – not demure little house dresses, but the most beautiful evening gowns, gorgeously wild hats, plenty of jewelry, and false eyelashes that stretched out to here." (Jane Winthrop, Regional Director of The Fashion Group of San Francisco, in Silverman & Silverman 1961: 79)

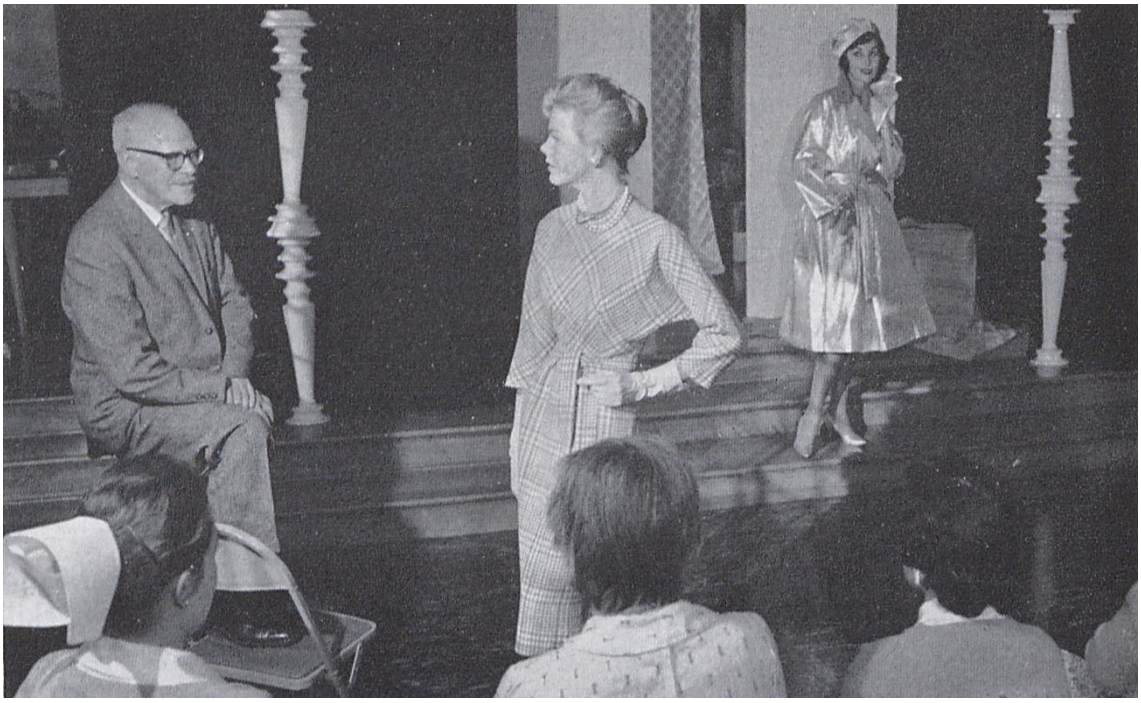


figure 22: "Therapy of Fashion", the opening fashion show at Napa State Hospital, 1959, 'Professional models display ensembles from one of San Francisco's exclusive apparel firms.' (Miller et al. 1960: 42)

In October of 1959 a group of 'forty selected patients in both the chronic and the acute categories'[121] (Miller et al. 1960: 42) and some medical staff gathered in the auditorium

[121] No further details are given concerning the diagnoses of participating women. One article described some of the female patients as either depressed, hysteric or schizophrenic (Silverman & Silverman 1961), but it is unclear whether these terms correspond to their diagnosed illnesses or are general terms used by the journalists to describe behaviour they deem as such. In terms of psychiatric classifications, the official reference employed in the diagnosis of "mentally ill" patients at that time in the US was the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) first published by the American Psychiatric Association (APA) in 1952 and revised in 1968. The DSM is now in its fifth edition (2013) and remains 'the standard classification of mental disorders used by mental health professionals in the United States and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.' http://www.dsm5.org/about/Pages/Default.aspx (5.11.2016)

of the Gothic building of Napa State Hospital, opened in 1875, fifty miles northeast of San Francisco (DSH 2015). Not only did they witness a fashion show, featuring 'three professional models […] with nine glamorous fashions that were colorful, impractical, for fun' (Thompson 1962a: 2B), they also participated in the pilot study of "Therapy of Fashion", carried out by the Fashion Group, whose Regional Director at the time, advertising executive Jane Winthrop, recalled her memories of that day above.

The idea to bring fashion into a mental hospital in the late 1950s originated with the practical concern over what patients would wear when leaving the hospital to go home. 'Like many creative and therapeutic concepts, this one was almost accidental,' recollected Margaret Kuhns (in Willis 1962: 15), then vice president of the MHASF. Writing and speaking about "Therapy of Fashion" on numerous occasions, Fashion Group member Thelma L. Thompson (1962b: 835) described the beginnings of the treatment as follows:

> No one person takes credit for initiating Fashion Therapy in California. It has evolved from the ideas and experience of many people. […] This is how it started: Ruth Baham, head of volunteers at the hospital, called Hazel Holly of the San Francisco Association for Mental Health regarding suitable clothes for patients about to be released from the Hospital. Miss Holly enlisted the help of a Fashion Group member who obtained some clothes from local manufacturers. Later they decided to put on a fashion show to help bring patients up to date on fashion, hairstyling, and make-up. Dr. Theo Miller, hospital superintendent, decided that this fashion news should be brought to women who had not responded to any treatment, along with the women about to be released. Step by step, the Fashion Therapy project grew to involve professional models, hair stylists, and even a fashion designer to design a dress for each patient – a dress the patient was to make, with volunteer help.

"Therapy of Fashion" was conceived as a sponsored volunteer project. Members of the Fashion Group and MHASF would give their time and knowledge. Local fashion companies donated make-up and cosmetic kits, undergarments and dress fabric. And 'One of San Francisco's most exclusive dress shops agreed to supply a collection of the latest fashions for a style show to open the course' (Silverman & Silverman 1961: 79). This show (figure 22) was later described as a form of 'shock therapy', both by Winthrop who headed it and by the press: '[T]hey started off with a bang, a gorgeous model sweeping on stage wearing a strikingly beautiful gold lame evening gown of Grecian cut,' wrote one journalist (Cline 1960: 27) (see the model to the right in figure 22). Another one, who published a dozen articles about this therapy in various regional newspapers that year, wrote of the show:

> The therapists used a "shocker" treatment in dealing with apathetic and dowdy patients. They gathered San Francisco's choicest mannequins, dressed them in stunning gowns and had them parade before the bath-robe-clad congregation of sick women. Women who had uttered little more than a "yes" or "no" during months at the hospital flushed when they thought of their own shabby appearance. (Clinton 1960b: 11)

'Choicest mannequins' versus 'sick women' and 'stunning gowns' versus bathrobes and 'shabby appearance', Clinton's article constructs two contrasting worlds, the world of fashion and that of the mental hospital. Her words re-iterate the contrast visible between the dress of patients and models in figure 22, between a simple, slightly creased cotton gown and a soft-looking tweed dress worn with pearl necklaces, or a gold lamé coat. She described the patients' embarrassment of their own appearance, their "shocker" treatment, the 'slap in the face with fashion', as Winthrop expressed her intentions in the opening quotation. This fashion show which stood at the beginning of the course of treatment constructed the 'key professionals in the fashion field' (Miller et al. 1960: 42) as figures of expert knowledge and authority. However, the relations of power in the auditorium that day were not as clear or one-sided as the article suggests, because power is always multi-directional and contains resistances (Foucault 1976/1990). This is also illustrated in Winthrop's statement, describing her reservations about the very first "Therapy of Fashion" session, her fear of contact with the "mentally ill", who up to that point had been largely hidden away and stigmatised. At the same time, Winthrop's words illustrate her attempt to identify with these women through dress, and to find a common ground in the "essentially female" activities of grooming and dressing. Moreover, her statement elucidates some of the key underlying premises, or naturalisations, of this therapeutic approach: firstly, the existence of a "natural" connection between women and appearance. 'The experimental treatment is based on the assumption that every woman has an inborn desire to be beautiful,' (Clinton 1960b: 11) observed one journalist and added the explanatory remark: 'A clean, fresh and neat woman is invariably charming and interesting' (11). Consequently, and secondly, it reveals a naturalised belief in a female obligation concerning appearance management and behaviour. As Winthrop (in Cline 1960: 27) herself described their 'selling point adopted for patients': "You are a woman and you must look pretty", echoing the wartime advertising slogan 'Beauty is your duty!' (figure 23).

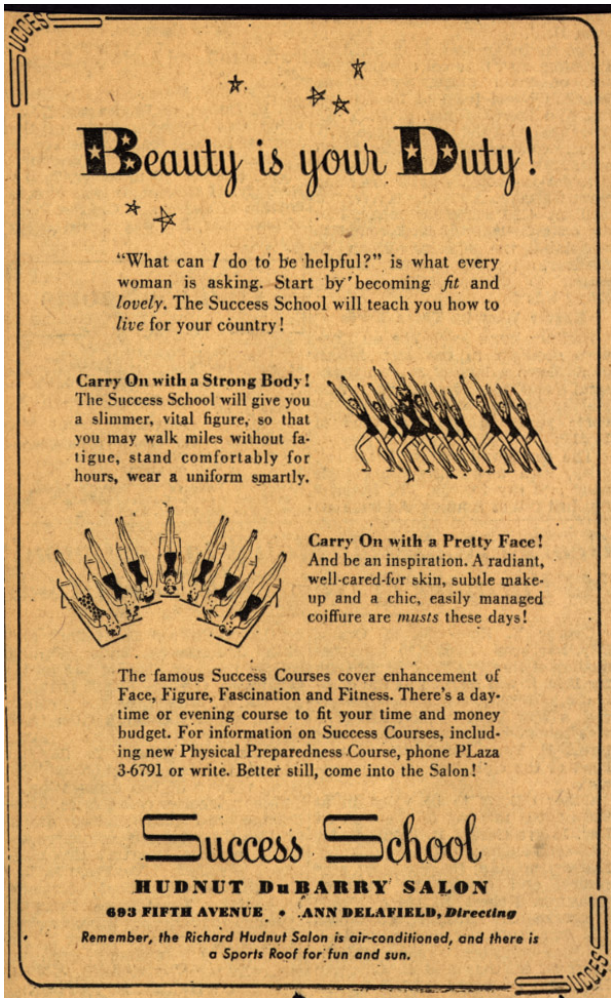


figure 23: 'Beauty is your Duty!' advertisement for the Success School at Hudnut DuBarry Salon in New York, 1941, *New York Herald Tribune*.

These notions of what it meant to be a woman, and of women's roles were, thirdly, complemented by a belief in the rehabilitating effect of dress, especially on women. Looking back on the project, Fashion Group member Jane Meek-Barker, volunteering at Napa in the early 1960s, reflected: 'And, as you know from all of the things that you have seen since then in ad campaigns or in breast cancer awareness, or in any of those, if you look good, you feel better. And that is both in make-up, hair styling and clothes. And that is particularly true of women' (AI, 17.11.2015). The correlation between looking good and feeling better, including this very expression, runs through descriptions and evaluations of "Therapy of Fashion" and related "dress-therapeutic" initiatives at the time.[122] The logical assumption of a "natural" link between women and fashion, and its arising obligations on the one hand, and the therapeutic belief in fashion, on the other, constituted the naturalised ground on which this treatment was constructed. It was made explicit in the official aim of "Therapy of Fashion", as defined by Dr Miller (et al. 1960: 42) and his colleagues: 'to recreate healthy feminine characteristics in a selected group

[122] It is noteworthy that 'Look Good Feel Better' is the name given to the global cosmetotherapy programme developed by the Personal Care Products Council Foundation in the US in 1989, to help women manage the visible side effects of cancer treatment, as previously referred to (Ch.2).

of women patients'. Thus, the notion of self that both underpinned and determined this therapeutic approach was gendered and aestheticised. Its starting point was a normative notion, not only of gender roles but also of feminine beauty and behaviour, as analysed in more detail later on (4.2 and 4.4). This essentialising and often naturalised connection between appearance, dress-related behaviour and women was found in both the writings of some psychotherapeutic practitioners (1.3.2) and a number of asylum doctors, and formed the basis of some specific "dress-therapeutic" measures in psycho-medical history, as previously discussed (Ch.3).

In the context of the treatment approach piloted at Napa State Hospital, it was fashion that was said to be able to 'recreate healthy feminine characteristics'. 'Women patients' were to be shown the 'proper' way to dress themselves and the 'correct' manner of grooming, as outlined by Dr Miller (et al. 1960: 42) at the beginning of this chapter. Moreover, he explains: 'It is the combined opinion of the authors that fashion as a therapy may well prove to be an additional tool in the reactivation of women patients, especially among those on the chronic group with long-term periods of hospitalization' (43). Fashion was thus constructed as a therapeutic tool. It was re-appropriated as a form of psycho-medical treatment to 'reactivate' female patients. The 'fashion professionals', in turn, were, constructed as 'assistant therapists' (Hellerich 1985: 119) on the basis of their expert knowledge, the 'regime of truth' (Foucault 1984d: 73) they formed around fashion and brought to the mental hospital, as will be discussed later on (4.4.2).

Following the show the 'forty patients were divided into two equal groups, which met the fashion experts on three successful Fridays' (Nelson 1960: 12F) as one journalist noted. The chosen format was very much that of a style make-over, which had been popular in US-American women's magazines since the 1920s (Miller 2008). Another journalist summarised the process: 'Each member of the therapy group was given personal counselling for her beauty and fashion needs by Mme. Irina Roublon, a top couturiere. The next week, patients were taught hair style and grooming. Posture, the importance of foundation garments and lessons in graceful walking were taught the third week' (Clinton 1960b: 11). The treatment ended with a fashion show featuring the patients this time.



figure 24: Fashion Group member, designer Irina Roublon, 1962

Several accounts of "Therapy of Fashion" emphasised the role of Irina Roublon (Cline 1960, Clinton 1960b, Silverman & Silverman 1961, Thompson 1962b, Tucker Neep 1963). They suggest that the Russian-born designer Irina Belotelkin née Roudakoff (1913–2009) (figure 24), known by the name of her label Irina Roublon played an important part, not only in the styling session, where 'each [patient] was shown her good points, the tricks of fashion best suited to her and the kind of clothes that complimented her' (Cline 1960: 27), but also in the overall development of the therapy at Napa and other mental institutions in the country. The following journalistic account gives an impression of Roublon's approach and the overall treatment:

> Another apparent trick – actually one of the key therapeutic measures – is the design of a special dress for each patient, under the spectacular direction of Madame Irina Roublon. Exotic, Russian-born Madame Roublon is known as one of the most successful, temperamental and expensive designers in California. With her wealthy customers in her salon, she may sulk or explode in any of half a dozen languages. With mental patients she is incredibly kind, gentle and understanding. "With some natural insight," a Napa psychiatrist says, "she can find something pretty in any patient, create a dress around it, and make the patient feel wonderfully attractive." […] To one patient with shockingly pocked skin she declared, "What delicate shoulder bones! For you, a peasant blouse. You like this fabric? […] So. We will cut it like this and here – ah, sensational!" To a young Mexican girl, crippled in both body and mind, she exclaimed, "*Dios!* But never have I seen such magnificent, golden skin! For you only, I have brought this metallic cloth. You will be dazzling!" And facing another woman, who seemed to be built wrong everywhere – bad legs, figure, posture, hair, skin, and even teeth – she called, "Girls, look at this beautiful line of the cheek! Inspirational! On this we will create a complete masterpiece."
>
> An experienced psychiatric worker watched one of Madame Roublon's performances and said, "You know, her comments are probably the first compliments that some of those patients have ever had." A nurse told us, "At first, you listen to Madame Roublon and decide she could not possibly be sincere. But then you look again, and you suddenly realize that the patient really does have pretty skin, or nice ankles, or a beautiful line of the cheek. It sounds corny, but you learn to ignore the bad features, no matter how bad they are, and find the pretty thing that's actually there in every woman." (Silverman & Silverman 1961: 80)

Asked about her way of working, the designer stated: '"It is very important to have a good-looking woman compliment a woman. It is great for the morale. And, you can always find a good feature – even if it is only an interesting slant to the eye"' (Roublon in Tucker Neep 1963: 6). While the authoritative role of volunteers will be discussed later on (4.4.2), what Roublon's words and the above account illustrate is a function of dress which is highlighted in accounts of both "Therapy of Fashion" and *vêtothérapie* (Ch.5), namely that of tool for contact and communication. The social function of dress was described by several of my interviewees, mostly as an unintended and unexpected, yet, positive side-effect. Moreover, many of them defined the spheres of fashion and dress as providing not only contact and collective conversations, but also activities to fill the long hospital day, activities that can be shared. Equally, the important role of textiles-based activities in occupational treatment throughout the institutionalised treatment of the "mad" was also socially underpinned (3.2.3.3).

Including dress-making as an activity in "Therapy of Fashion" followed the same principles. Apart from the therapeutic intentions, it was also regarded as a 'socializing activity' (Miller et al. 1960: 42) and form of occupation. 'Artists drew individual fashion sketches for each patient. With this background of instruction, patients were then given two weeks to style and manufacture their own dresses from accessories and fabrics which were handed to them. Hospital attendants helped in the fitting and sewing' (Nelson 1960: 12F) described one journalist. Another one commented on this stage of the treatment as follows: 'Even withdrawn schizophrenics, content to sit in silence in their rooms, took a new interest in life and soon were stitching gay dresses on hospital's sewing machines' (Clinton 1960b: 11).



figure 25: 'One of the participating experts instructs a patient in the proper method of applying cosmetics.' (Miller et al. 1960: 42)

'One of the participating experts instructs a patient in the proper method of applying cosmetics,' commented Dr Miller (et al. 1960: 42) of an image of the 'grooming' session (figure 25), the next stage in the course of "Therapy of Fashion". If the nurse overlooking the scene were to be cropped, this shot could have been taken in a beauty salon. Yet, the relationships captured here are very different. What does the intimate act of having one's make-up done feel like in the public setting of a hospital? How much say did the patient have in what was done to her? Did she mind being touched by a stranger or even welcome the tactile interaction in the often sterile hospital setting? Moreover, did she welcome the diversion this programme offered to the hospital routine? While the answers to these questions are locked in the past, it is clear that this grooming session differed substantially from the normal client-service provider relationship regulated by the commercial context of the beauty parlour. While make-up and styling are employed as technologies of a gendered self in both situations, the normalising intent is of particular significance here, illustrating in a very direct way how "mentally ill" women were being 'made over' and 'made up', that is, how they were meant to be fashioned.

This sense of a forced physical and mental transformation, of the 'biopower' (Foucault 1975/1995) at work in "Therapy of Fashion", was reiterated in the 'practice session in modelling' that followed (Miller et al. 1960: 42) (figure 26), and featured the intimate act of fitting the patients with 'proper foundation garments' as well as teaching 'simple exercises to improve posture and develop poise' (42). All these techniques, too, were aimed at fashioning patients, at disciplining, transforming and 'improving' their bodies, making them apt to perform, both in life in general and in the patient fashion show, which was to finalise this treatment.



figure 26: 'This woman is learning the art of graceful and relaxed walking from a professional model.' (Miller et al. 1960: 43)

'Two weeks after the classes were finished, twenty-six patients had completed their dresses. After a practice session in modelling they staged their own fashion show with the aid of the fashion experts before an audience of nearly 400 other women patients' (Miller et al. 1961: 42). The scale of the event was large, considering the original context: a psychiatric pilot study in a hospital. Moreover, even journalists were present at the show, as one of them wrote: 'When the course was completed the participating patients, once stoop-shouldered and defensive, donned their prettiest dresses and put on a fashion show for the rest of Napa's patients' (Clinton 1960b: 11). Another mentioned the emotional strain of the day on some of the patients:

> The two-week period [of patients making their own dresses] was climaxed by a full-scale fashion show, held in the Napa Hospital auditorium, during which patients demonstrated their abilities. Of the 40 patients attending the classes, 23 finished their dresses on time and took part in the show. Four others finished on time, but were too agitated to participate. (Nelson 1960: 12F)

The fact that some patients were 'agitated' or did not participate was not mentioned by medical staff or volunteers, and whether or not this was a form of resistance by some patients remains unknown. Comments on this show were overwhelmingly positive. Mrs. Winthrop, following her dictum that "You are a woman and you must look pretty", was

quoted as asserting: 'they did look pretty' (Cline 1960: 27). And Dr Miller (et al. 1960: 42) singled out the positive benefits for one patient:

> For some patients in the group, effects of the fashion project were dramatic and immediate. One woman in her early thirties had persistently refused to enter any socializing activities and had even been unwilling to use her privilege of going out on the grounds. She finally admitted that she was ashamed of her appearance and said that she never went to parties or dances because she "looked so terrible". After being fitted with proper foundation garments, she looked into a mirror and said, "My, I look so different." At the fashion show she went on stage clad in her new dress and looking confident and happy.

Immediately after the patient fashion show a first evaluation of the pilot study was undertaken by Dr Miller and his team using questionnaires 'to provide more systematic and comprehensive information on the results of the project' (Miller et al. 1960: 42). Participating patients were asked: '(1) whether they thought the project had helped them look "very much better," a "little better," or "no better," and (2) whether attendance at the classes had made them feel "much better," a "little better," or "no better". The staff filled out similar evaluation forms except that the variable "acting" was substituted for "feeling". A second evaluation with the same questions was made a month later' (Miller et al. 1960: 43). It is noteworthy that the correlation between looking good and feeling good touched on above, was central to the official assessment of the treatment – and in that order. The results of the enquiry were summarised by Dr Miller (et al. 1960: 43):

> One conclusion was immediately apparent. In both first and second evaluations of both chronic and acute patients, a large majority of patients and staff indicated they noticed some improvement. However the patients tended to downgrade their improvement on the second evaluation, especially in the "looking better" and "feeling better" categories. The shift, however, was not great enough to present a basically different pattern. Also noteworthy were the stimulating effect this project had on other patients, and the interest displayed by the ward staff. News of what was transpiring spread rapidly and resulted in many requests from other patients to be included in a subsequent series of classes. There was also a noteworthy improvement in their appearance.

In this instance it was male doctors who imposed their stereotypes of femininity, illustrating the persistent role of male psychiatrists in creating definitions of femininity and "mental disorder" in the institutionalised treatment of "madwomen" up to the second half of the twentieth century (Ch.3). But it should be noted that in the case of "Therapy of Fashion" it was almost exclusively women who had developed this approach and who conducted the therapeutic sessions. The degree to which they were imposing their own stereotypes of femininity and the power dynamics involved in this process will be discussed later on (4.4.2).

"Therapy of Fashion" was regarded as an experimental success by hospital officials, who singled out individual stories to illustrate the immediate and positive effect of the treatment. For example: 'A patient in the acute ward felt that the fashion project was the turning point of her illness. She reported enthusiastically that after one of the classes "all

at once the clouds rolled back, the sun was shining, and I felt like myself again". She left the hospital not long afterwards' (Miller et al. 1960: 42). The project also received very positive feedback from the two organisations involved in its conception, realisation and sponsorship. Margaret Kuhns of the MHASF drew the following conclusion: 'The results are more than satisfactory. The demonstration showed that even the very sick mental patients can be helped to develop interest in themselves as human beings' (anon. 1962b: 2C). Speaking for the Fashion Group, Mrs. Winthrop (in Clinton 1960b: 11) was similarly positive in her assessment and also commented on the reciprocity of the process, calling it 'a two-way therapy. "We feel something wonderful has been done for us"'. Moreover, Dr Miller (in Clinton 1960b: 11) was reported in saying he hoped it would be emulated in other psychiatric hospitals: 'It is therapy; there's no question in my mind about it. It is excellent therapy. I think this will develop into something of national scope in our state hospitals. We are tremendously enthusiastic over the results'.

In relation to the official aim of "Therapy of Fashion", Miller's positive evaluation suggests that 'healthy feminine characteristics', as he termed in his article, had been 'recreated' in the women patients (Miller et al. 1960: 42). Nowadays this aim, which pervades all stages of the treatment, might be criticised for essentialism[123]. Standardised notions of femininity and naturalised ideas of 'proper' dress and behaviour and the 'correct' way to groom themselves underpinned and determined this treatment approach. Yet, in how far "Therapy of Fashion" was regarded as an essentialising approach in 1959 cannot be established. Whether or not its openly publicised nature, the access given to press and numerous outsiders, or the authority granted to untrained volunteers to tell "mental" patients how to dress and move, and to touch them, raised ethical concerns remains unknown. As such, "Therapy of Fashion" has to be seen in the context of its time. Only a decade earlier Maisel (1946: 112) had published his report on the inhumane conditions in mental hospitals in the US (3.3.1), their discharge rate a mere 6%, yet, here was a 'new' therapeutic treatment, producing 'very positive' and, in some cases, 'immediate results' according to its instigators (Miller et al. 1960). This local pilot study that developed into a therapeutic programme of national scope throughout the following decade needs to be read in the context of a wider discourse in the US at the turn of the 1960s, taking into account not just its socio-cultural and political climate, but also the circumstances of women and their dress and treatment in mental hospitals at the time.

[123] While "Therapy of Fashion" might have been criticised at the time it was piloted, I have not come across a critical comment in my research, as the related articles are overwhelmingly positive in their evaluation.

4.2 Blondes, 'fine drugs', de-institutionalisation and The Clothing Committee: "Therapy of Fashion" at the turn of the 1960s in the US

4.2.1 'The feminine mystique': Normative notions of femininity at the time of "Therapy of Fashion"



figure 27: 'If I've only one life… let me live it as a blonde!' advertisement for New Ultra-blue Lady Clairol Hair Lightener, 1960

At the turn of the 1960s 'across America three out of ten women dyed their hair blond. They ate a chalk called Metrecal, instead of food to shrink to the size of the thin young models. Department-store buyers reported that American women, since 1939, had become three and four sizes smaller. "Women are out to fit the clothes, instead of vice versa," one buyer said,' observed writer and activist Betty Friedan (1963: 5) in *The Feminine Mystique*. Published in 1963, her study of young US-American women in the late 1950s and early 1960s was subsequently credited with 'reigniting the women's movement' (Fox 2006) and termed 'one of the most influential works of non-fiction in twentieth century America [which] challenged the idea that women's most important roles are as mothers and wives' (Guenther 2013: 107).

At the time, images of perfectly made-up, coiffed blond young models looked down from billboards, and advertisements in magazines and newspapers nationwide (figure 27). They were promoting much more than 'New Ultra-Blue Lady Clairol hair Lightener'. They were promoting the "feminine mystique", according to Friedan.

The term the "feminine mystique" described the public image of women fulfilled in their role as feminine, well-groomed and dedicated housewives and mothers – a role expectation internalised so thoroughly that striving for and compliance with that role felt natural to women. According to Friedan (1963: 30), this image 'created by the women's magazines, by advertisements, television, movies, novels, columns and books by experts on marriage and the family, child psychology, sexual adjustment, and by the popularizers of sociology and psychoanalysis – shapes women's lives today and mirrors their dreams'. Moreover, this public image had become so pervasive, indeed normative, she argues, that there was little, or no 'independent self' (43) left, no 'private image to tell who she is, or can be, or wants to be' (63). It was this public image that underpinned "Therapy of Fashion" from conception to realisation.

Friedan's premise was that the US-American suburban housewife, celebrated and promoted as the "all-American dream", epitomised the "feminine mystique":

> The suburban housewife – she was the dream image of the young American women and the envy, it was said, of women all over the world. The American housewife – freed by science and labour-saving appliances from the drudgery, the dangers of childbirth, and the illnesses of her grandmother. She was healthy, beautiful, educated, concerned only about her husband, her children, her home. She had found true feminine fulfilment. As a housewife and mother, she was respected as a full and equal partner to man in his world. She was free to choose automobiles, clothes, appliances, supermarkets; she had everything that women ever dreamed of. In the fifteen years after the Second World War, this mystique of feminine fulfilment became the cherished and self-perpetuating call of contemporary American culture. (15–6)

And all over the US, as Friedan reported – rather generalising the situation of the white middle-class – women were trying to live the "feminine mystique", and to conform to this normative image in both behaviour and appearance.[124] Thus, the 'spirited' New Woman of the 1940s, who had done the work of men during World War II (all the while knowing that 'beauty was her duty'), was replaced by the 'Happy Housewife Heroine' (60) in the post-war 1950s. Within ten years, Friedan (14) argued, the "feminine mystique" had been promoted so thoroughly, and had been internalised by women so naturally, that by the late 1950s young US-American women were living their lives accordingly:

> By the end of the nineteen-fifties, the average marriage age of women in America dropped to 20, and was still dropping, into the teens. Fourteen million girls were engaged by 17. The proportion of women attending college in comparison with men dropped from 47 per cent in 1920 to 35 per cent in 1958. A century earlier women had fought for higher education; now girls went to college to get a husband. By the mid fifties 60 per cent dropped out of college to marry, or because they were afraid too much education would be a marriage bar. […] By the end of the fifties the United States birth rate was overtaking India's.

[124] Some of Friedan's original data and related claims are now contested and she has subsequently been criticised for naturalising the experience of white, heterosexual, middle-class women (e.g. hooks 1984, Coontz 2011). While a critical re-reading of *The Feminine Mystique* lies outside the parameters of my thesis, it has been employed as a key discursive element of the time, on the basis that 'even Friedan's critics […] agree that [it] was a book that helped to change the world, or at least the way a lot of people saw the world' (Menand 2011).

At the same time, however, a pervasive, yet undefined dissatisfaction was beginning to be felt among women, Friedan (13) reported and termed it: 'The problem that has no name'. She was moved by her own personal situation, trying to balance being a wife and mother of three small children with her work and further studies in psychology, to ask other women about their lives. 'Gradually, without seeing it clearly for quite a while, I came to realize that something is very wrong with the way American women are trying to live their lives today,' (9) she wrote at the beginning of her enquiry.

Formalised as a large-scale qualitative study, Friedan's project revealed what she termed a female 'identity crisis' (69) of unexpected dimensions. She concluded that women in the US, relegated to their roles as housewives and mothers, trying to live their lives through others, and attempting to live the "feminine mystique", had lost their individuality and their sense of identity. One of Friedan's interviewees told her: 'I begin to feel I have no personality […] but who am I?' (19) expressing a common sentiment, according to Friedan. A pervasive sense of discontent and loss, 'the problem that has no name', was pathologised as the 'housewife's syndrome' (17) by one Cleveland doctor and medicated, as '[m]any suburban housewives were taking tranquillizers like cough drops' (28). Any tension in the role of women was negated, as were issues arising from such a reductive self-image. 'The 'woman problem' in America no longer existed,' argued Friedan (16–7), 'If a woman had a problem in the 1950s and 60s, she knew that something must be wrong with her marriage, or with herself'. The psychologisation and therapeutisation of Western culture and everyday life meant that women who struggled to live up to the "feminine mystique" were considered to have an individual problem not a social one. 'I talked to women who had spent years on the analyst's couch, working out their 'adjustment to the feminine role', their blocks to 'fulfilment as a wife and mother,' reported Friedan (18) and added, 'They got all kinds of advice from the growing armies of marriage and child-guidance counsellor, psychotherapists, and armchair psychologists, on how to adjust to their role as housewives' (23).

Consequently, it can be argued that 'healthy feminine characteristics' (Miller et al. 1960: 42) were required of women more widely at that time in the US, not just the psychiatric patients at Napa State Hospital. 'Feminine adjustment' was the project not only of advertisers or the media, or the many proponents of the rising therapy culture at the time (1.4), but also of women themselves. Yet, it was women who were beginning to acknowledge fissures in the perfect image they were expected to, and tried to live up to, according to Friedan:

> Anatomy is woman's destiny, say the theorists of femininity; the identity of woman is determined by her biology. But is it? For the first time in their history, women are becoming aware of an identity crisis in their own lives, a crisis which began many generations ago, has grown worse with each succeeding generation, and will not end until they, or their daughters, turn an unknown corner and make of themselves and their lives the new image that so many women now so desperately need. In a sense that goes beyond any one woman's life, I think this is the crisis of women growing up – a turning point from an immaturity that has been called femininity to full human identity. (Friedan 1963: 69–70)

When it was published, *The Feminine Mystique* allegedly gave momentum to second wave feminism in the US. It 'ignited the contemporary women's movement in 1963 and as a result permanently transformed the social fabric of the United States and countries around the world,' according to Friedan's obituary in *The New York Times* (Fox 2006). Only a year later, in 1964, the song 'You Don't Own Me' by seventeen-year-old Lesley Gore climbed to number two in the US charts, indicative of a shifting discourse:

You don't own me
I'm not just one of your many toys
You don't own me
Don't say I can't go with other boys

And don't tell me what to do
Don't tell me what to say
And please, when I go out with you
Don't put me on display.

The Feminine Mystique was part of a decisive decade for gender equality in the US (Collins 2009). The decade had begun with the approval of the birth control pill in 1960 and saw important legislation such as The Equal Pay Act being passed in 1963, although gender disparities remain concerning both pay and career opportunities in the US (Stevenson 2015).[125]

If a selection of books was used to contextualise "Therapy of Fashion", alongside *The Feminine Mystique,* the following works, published in the US around the same time, could be taken to define its contemporary discursive cornerstones[126]: *To Kill a Mockingbird* by Harper Lee, addressing racial inequality and winning the Pulitzer Prize in 1960; Rachel Carson's *Silent Spring*, on the detrimental effects of the widespread use of pesticides, serialised in the *New Yorker* from June 1962 and influential for the modern-day environmental movement; and an important science fiction novel of the decade: Arthur C. Clarke's *2001: A Space Odyssey*, coming out in the US alongside Kubrick's film in 1968, exploring the dangers and promises of technological advances in the space age. These works formed part of the discursive landscape underpinning a treatment approach like "Therapy of Fashion" that stood at the turn to a decade of socio-cultural and political change in the US. The 1960s saw a rejuvenation of the country, illustrated by the fact

[125] For further key primary sources on women in the US of the 1960s, see the very comprehensive anthology: Morgan, Robin (ed.) (1960) *Sisterhood is Powerful: An Anthology of Writings from the Women's Liberation Movement.* New York: Vintage Books. For a fuller history of women in the US of the 1960s, see, for example: Collins, Gail (2009) *When Everything Changed: The Amazing Journey of American Women from 1960 to the Present.* New York: Little, Brown and Co; Echols, Alice (1989) *Daring to Be Bad: Radical Feminism in America, 1967–1975.* Minneapolis: University of Minnesota Press; Evans, Sara (1979) *Personal Politics: The Roots of Women's Liberation in the Civil Rights Movement and the New Left*. New York: Knopf; Harrison, Cynthia (1988) *On Account of Sex: The Politics of Women's Issues, 1945–1968.* Berkeley: University of California Press.

[126] Such a contextualising approach is viable because books were of particular significance as a 'more accessible form of social criticism and dissent' during the early 1960s in the US 'when television was still muzzling itself, from fear of provoking advertiser displeasure or F.C.C. reaction' as Menand (2011) argues, likening books to bombs in their impact.

that a forty-three-year old John F. Kennedy replaced a seventy-year old Eisenhower as its 35th president in January of 1961. The new First Lady, thirty-one-year old "Jackie", in turn, became a national fashion icon, marking the beginnings of an increasingly style-conscious era, where fashion became much more pervasive and accessible, with US-American ready-to-wear fully established and progressively independent of European houses (Tortora ed. 2010). Politically speaking, this decade was defined by the Civil Rights Movement with the ratification of the Civil Rights Acts in 1964 and 1968, but also by the Cold War and the second decade of the Vietnam War, the Cuban Missile Crisis in 1962 and the assassination of John F. Kennedy a year after that. At the same time, the 1960s were a decade of technological developments, from television colour broadcasting and countless household appliances, to telecommunications, computing and space travel. [127]

In order to consider the more immediate context of "Therapy of Fashion", two further books could be added to the small selection above, two influential accounts of psychiatric institutional life at that period in the US, one fictionalised, the other empirical: Ken Kesey's *One Flew Over the Cuckoo's Nest* and Erving Goffman's aforementioned *Asylums.* The former, written the year of the pilot study, but published in 1962, was based on the author's own professional experience and addresses the everyday life and treatment of the "mentally ill" in an Oregon psychiatric hospital, complete with the misdiagnoses, the power plays, abuse, electroshock therapy and a lobotomy, that made up the persistently negative image of mental institutions. Goffman's *Asylums*, published one year earlier, painted a similarly de-humanising picture of the handling of patients, as previously discussed (1.2.2 and 3.3.2.1).

Both of these highly acclaimed books became key texts for the anti-psychiatry movement of the 1960s[128] (1.4) and the processes of making hospitals more humane – the subsequent de-institutionalisation that saw a shift in the service for the "mentally ill" towards community-oriented models. Thus, "Therapy of Fashion", in its collaboration with the regional fashion community to sponsor and carry out the project, in its attempt to open the hospital to local volunteers, was part of the development to humanise mental hospitals.

[127] For a fuller understanding of US history in the 1960s see, for example: Isserman, Maurice & Kazin, Michael (2000) *America Divided: The Civil War of the 1960s.* New York: Oxford University Press; Lytle, Mark Hamilton (2006) *America's Uncivil Wars: The Sixties Era – From Elvis to the Fall of Richard Nixon*. New York: Oxford University Press; Monteith, Sharon (2008) *American Culture in the 1960s.* Edinburgh: Edinburgh University Press; or: Dowd Hall, Jacquelyn (2005) 'The Long Civil Rights Movement and the Political Uses of the Past' in: *Journal of American History*. Vol.91(4), March, pp. 1233–63.

[128] There are, of course, a number of influential contemporary publications that could be added here, perhaps most notably: Szasz, Thomas (1962/1972) *The Myth of Mental Illness.* St Albans: Paladin. However, the books listed above have been chosen in their capacity to capture key concerns of this period and strike a cord with a wide audience, not just their professional readerships.

4.2.2 The humanisation of hospitals and the rise of psychotropic drugs, open-door policy and dress needs

The 1950s saw a growing call in the US to render hospitals more humane, and a persistent critique of the treatment of both physically and "mentally" ill patients (e.g. Cameron 1954, Evans 1956, Silverman 1955, Snow 1958). Based on visits to more than one-hundred hospitals, science journalist Milton Silverman (1955: 114) published an article in 1955 entitled 'Are Patients Human Beings', reporting on changing perceptions of patients from 'symptoms with relatives attached' to 'customers' with individual needs, 'whole people' rather than illnesses. He described the efforts of 'progressive' general hospitals to 'humanize the hospital routine' (19): more privacy, less noise, better food, prettier décor, later waking hours and more appropriate dress: 'There is even a new hospital gown,' Silverman (1955: 116) reported 'touted as the first improvement in 2000 years – which uses three snaps instead of the usual ribbon ties, and will neither bunch at the back of the neck nor expose tender portions of the anatomy to any passing breeze'. According to him, the new hospital was to model the home and all areas were to be re-considered under the humanising principle, including dress. It is noteworthy that Silverman went on to write the most extensive news report about "Therapy of Fashion" together with his wife (Silverman & Silverman 1961), which will be discussed later on.

In the case of mental hospitals, there was a growing call not only to render these 'total institutions' more humane, but to open their doors. Even though reports like Maisel's (1946: 112) had alerted the US-American public to the inhumane conditions of mental hospitals after World War II (3.3.1), and had 'helped to instigate important changes' in some of them, the fundamental change lobbied for was lengthy and costly. As a result, there was a persistent demand to treat the "mentally ill" like humans, instead of locking them away, also evidenced in the pages of *Mental Hospitals – The Hospital Journal of the American Psychiatric Association* (e.g. Cameron 1954, Evans 1956, Goodman 1961, Maddison & Prior 1956, Snow 1958), the journal in which Dr Miller had reported on "Therapy of Fashion". 'It is still widely believed that [mental hospitals] are places of permanent incarceration rather than centres for active treatment and rehabilitation,' read one of the articles (Maddison & Prior 1956: 16), describing their prevailing image at that period. This image was confirmed in contemporary descriptions of institutional life by both outsiders, as touched on above, and insiders to the psychiatric medical system. 'To lock doors, bar windows, strip furnishings and otherwise deprive the sick of their dignity and status as persons is, save for the very few, utterly unnecessary. Yet this is still the experience and fate of an exceptionally large number of patients,' wrote Medical Director Cameron (1954: 3) in 1954, decrying 'the manifest absurdity of locking up a man because he has asthma or a gastric ulcer!'

Some seven years later, Erving Goffman (1961: 28) was still noting the de-humanising nature of the daily processes in mental institutions, not just concerning dress (3.3.2.1), but also the rationalisation of patient's bodies, from forced movements and activities, to shaved heads or the performance of lobotomies or hysterectomies on 'unruly' patients (77). For reasons of institutional efficiency, patients continued to be stripped of their individuality in appearance, and, according to Goffman, in character, too. At the time of his research, Goffman (1961: 7) noted '7000 inmates' at St Elizabeths Hospital in Washington, D.C.. When "Therapy of Fashion" was piloted at Napa State Hospital there were 5000 patients in residence (Asylum Projects 2016). A total of 560,000 institutionalised "mentally ill" were recorded in the US in 1955 (PBS 2016). In order to deal with the substantial patient numbers, the levelling of patients, described by Goffman, was, if not intentional, at least accepted.

Consequently, State mental institutions continued to stand for the intensive mass management of 'inmates' (Goffman 1961) resulting in a renewed movement to humanise mental hospitals. While asylum reformers throughout the eighteenth and nineteenth centuries had repeatedly drawn attention to the inhumane living conditions and treatment of the "mentally ill" in western Europe and the US (Ch.3), the movement gained momentum in the middle of the twentieth century with the creation of the World Federation of Mental Health (WFMH) in 1948, the same year that the Universal Declaration of Human Rights was adopted by the United Nation. The aim of the WFMH was to raise awareness and increase the level of research, organising events like the World Mental Health Year in 1960. In the US this contemporary reform movement entailed the creation of research agencies, an increase in federal funding and new legislation around mental health in the late Fifties and Sixties, such as The Community Health Centers Act of 1963, which confirmed de-institutionalisation legally. All these measures, in turn, were part of and contributed to the rising psycho-medical discourse of humanisation.

The ethical concern over the inhumane treatment of "mental" patients in the 1950s coincided with the rise of psychotropic drugs, a new generation of drugs, different from the 'chemical restraint' (Maisel 1946: 108) of the 1940s, that were accompanying and allegedly enabling the process of de-institutionalisation in the US, as one doctor wrote in 1954 on the subject of opening up mental hospitals: 'we have today more effective means of controlling deviant behavior than were available some 30 years ago – sedatives, electro shock therapy, sleep treatment, psychotherapeutic procedures and many new drugs' (Cameron 1954: 3). Thus the development of psychotropic drugs was seen to facilitate a different type of treatment of the "mentally ill", not only enabling open-door policies, but also new forms of therapies. Dr Marsh (1962: 9), Representative of the

Second Clearfield District in the State Legislature, writing in one of a series of articles 'concerning the problems of mental health and their treatment', summarised these new developments as follows: 'Management of the mental patient has been greatly aided by Chemo-Therapy. This is the use of the many fine drugs, now available, and this has contributed to the "Open Ward" Policy. This lead the patients more into association with the others and to all types of therapies'. He mentioned the 'positive effect' that recently opened beauty parlors had on patients in mental hospitals, and specifically described "Therapy of Fashion" as an example of one such new type of treatment:

> An interesting fashion therapy was tried in Napa, Calif., several years ago [sic]. Fashion designers and pretty models staged a fashion show to induce the women patients to take an interest in looking better in personal appearance. It was amazing how this got through to the minds of many of the patients, whose sense of fashion and tidiness had long since disappeared. There is no evidence this cured anything by itself, but in combination with the other treatments, drugs, physical and occupational therapies, it did wonders for them. (9)

It could thus be concluded that "Therapy of Fashion" itself was, at least to a certain degree, facilitated by the 'fine drugs' Marsh spoke of, and the 'open-door policy' they had, in turn, enabled. While his assessment is uncritical, Marsh's comments highlight the correlation between psychotropic medication and changes in the treatment of "mental patients", including the impact such drugs were said to have on the daily routine in mental hospitals with regards to the interaction of patients, their movement and level of activity – essentially making them more therapeutable. These are the very qualities promoted in advertisements for psychotropic drugs at the time, which often featured photographs of both female and male patients involved in textile activities – sewing, dressmaking, weaving or embroidering (figures 28–35).

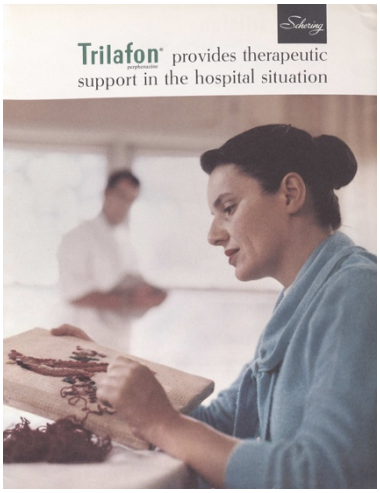


figure 28: Advertisement for Trilafon by Schering, 1961, 'Provides therapeutic support in the hospital situation.'



figure 29: Advertisement for Trilafon by Schering, 1961, 'Provides support that favors rapid remission.'



figure 30: Advertisement for Trilafon by Schering, 1961, 'Maintains functional gains – supports the patient's readjustment to home and community life.'

These advertisements, placed in *Mental Hospitals* between 1956 and 1961 by pharmaceutical companies convey the message that psychotropic drugs facilitate well-groomed, calm and cooperative patients, happily participating in the (textile-related) occupations on offer. The accompanying copy spells out the company's claims: Trilafon 'Provides therapeutic support in the hospital situation.' (figure 28), 'Provides support that favors rapid remission.' (figure 29), or 'supports the patient's readjustment to home and community life' (figure 30). The last slogan gives an insight into the activities that signal the rehabilitative effect of the new drugs. Textile crafts such as sewing and embroidery were not only important pastimes at that period, but were also seen to have positive connotations of home-making, and of caring (Burman ed. 1999). They are closely linked to what Friedan termed 'feminine fulfilment' or what Dr Miller called 'healthy feminine characteristics'. Their use by the drug company as an image of the process of recovery, and of role 'readjustment', suggests by association a state of "normality" that reinforced the conventional role of women.

Some of these advertisements, however, also featured men working on textile-based activities. While textile-based occupational treatment was offered to both men and women, the advertisements illustrated here make a clear distinction between the women engaged in finer needlework, and the men who do the coarser work of rug weaving and knitting (figures 31–33).[129] The copy for these three examples, published from 1958, promises 'rapid' behavioural improvement, the simplification of care and the reduction of 'supervisory problems' (figure 33) and the speeding of 'social rehabilitation' (figure 32). 'Two days ago, he was manic, hostile, aggressive …today he is calm, sociable, easy to manage,' read an advertisement for Sparine 'established as an effective drug for the management of patients with acute or chronic mental disturbances. It rapidly subdues excitation and facilitates patient contact' (figure 31).

[129] It is noteworthy that the photographs in advertisements featuring men are in black and white, while a certain part of those featuring "well-groomed" women are in colour. Moreover, they all depict white "patients". These details are indicative of dominant notions of mental illness at that period which were informed by gender, class and race. It needs to be acknowledged that these advertisements throw up more issues that can be addressed in the context of this thesis.



figure 31: Advertisement for Sparine by Wyeth, 1958, 'Two days ago, he was manic, hostile, aggressive …today he is calm, sociable, easy to manage. Sparine is established as an effective drug for the management of patients with acute or chronic mental disturbances. It rapidly subdues excitation and facilitates patient contact.'

figure 32: Advertisement for Sparine by Wyeth, 1959, 'After the fact… rehabilitation. Sparine quickly controls the excitement and hostility of acute and chronic psychoses. As a practical adjunct to formal psychiatric measures, Sparine simplifies care, facilitates accessibility, speeds social rehabilitation.'

figure 33: Advertisement for Trilafon by Schering, 1959, 'Leads turbulent patients towards rehabilitation.' 'Trilafon provides emotional control and social recovery […] keeps patients alert – promotes active cooperation instead of drowsy, passive obedience […] reduces supervisory problems in wards, mess halls and recreation rooms.'

Some of the commercials show the 'before and after' effect, and include an image of the patient prior to taking the medication. An advertisement for 'the important new psychoactive agent' Catron (figure 34), for example, which allegedly 'revitalizes depressed patients', shows a despairing woman from behind, head in hands, and then a well-groomed, content-looking version of the same woman, now happily sitting at a sewing machine. 'Patients hospitalized for many years…' reads another advertisement,

depicting a desperate-looking man in gloomy black-and-white, half-naked, hiding behind his contorted fingers, wrists restrained by leather bracelets (figure 35), and continues on the next page: '…improved after taking Thorazine and are now at home', with the same man, this time photographed in colour, well-dressed and styled, sitting in an armchair, smiling as he assists in winding up wool. The position of his hands suggests a visual comparison with his former self which symbolises his passage from restraint hospitalisation to domestic happiness and health.

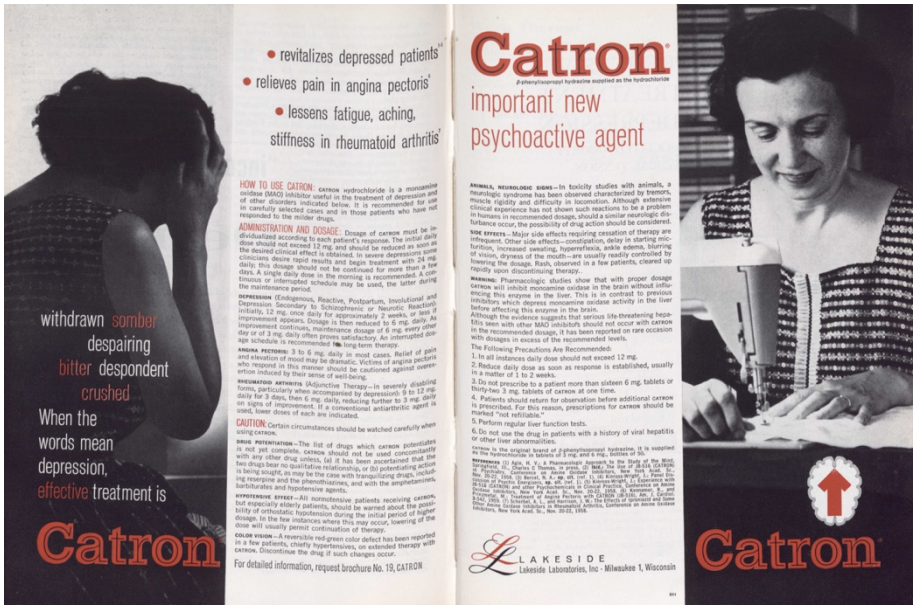


figure 34: Advertisement for Catron, 1959, 'revitalizes depressed patients'

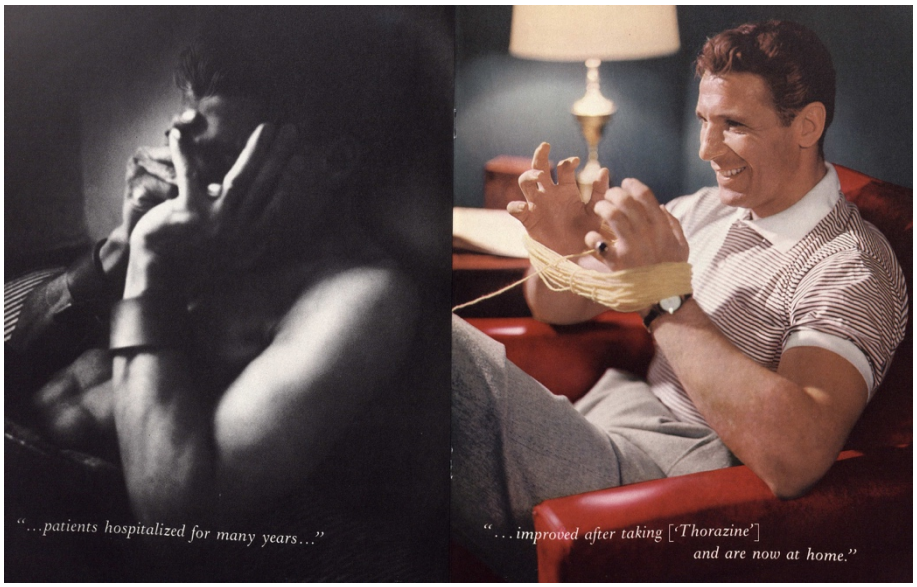


figure 35: Advertisement for Thorazine by Smith, Kline & French Laboratories, 1956, 'Thorazine is helping many mental patients to leave the hospital.'

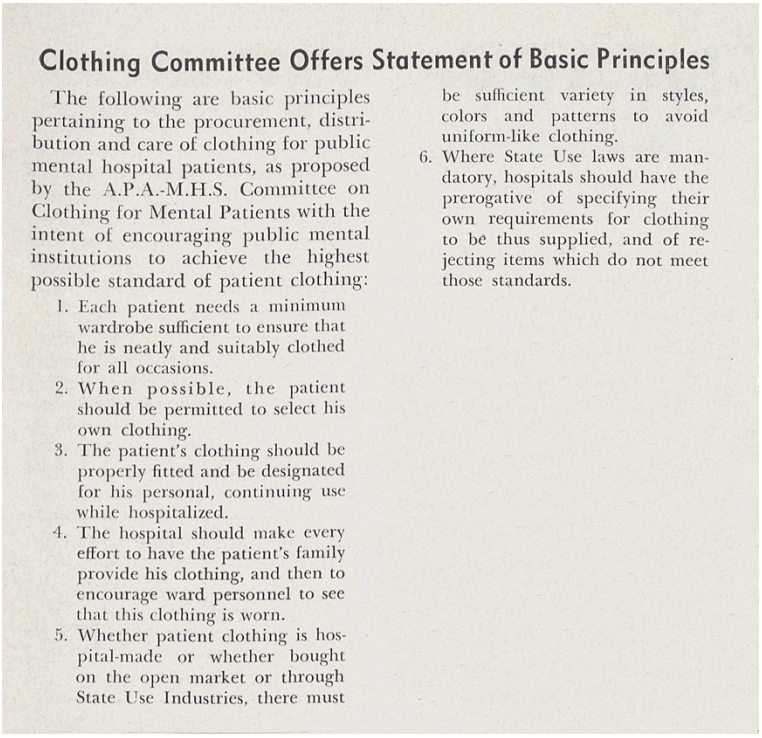
These advertisements, which effectively proposed psychotropic drugs as a normalising technology of the self, form part of the humanising discourse analysed here. Another aspect highlighted in Marsh's statement above and emanating from these advertisements, is a change in the appearance of mental patients and the increased significance of their dress. Arguably a side effect of the psychotropic drugs administered since the 1950s was a change in the way patient's dress was thematised, giving rise to a discourse of the de-institutionalisation of their outfits. Discussing 'open hospital philosophy' in 1957 one doctor observed: 'a certain dignity was restored to the patients when they were allowed to go about as they chose. […] they begin to take interest in their appearance. Men go to the barber shop more frequently. Women go to the beauty parlor. They want different clothes' (Snow 1958: 34&35). Whether these gendered dress behaviours were discursive constructions cannot be determined, but the causal relationship between psychotropic drugs, open-door policy and patient dress was reiterated in several accounts as detailed by the Head of the Volunteer Services and the Chief Supervising Nurse at Hudson River State Hospital (N.Y.) at the time:

> As open doors became more prevalent [September 1957], it became apparent that everyone must move from the custodial method to the motivational, and all efforts must be directed towards activities which would help rehabilitation. Wards were taking on a more homelike atmosphere; the volunteer program was functioning in practically every area of the hospital; and patients were demonstrating their capacity for social behavior. The freedom to be on view about the grounds, however, dramatized the fact that patients behavior was better than patient appearance – their clothing was still stereotyped. (Cartmell & Quinlan 1960: 40)

The newly established open-door policy accentuated the dress needs of "mental" patients, who had hitherto been more or less hidden. Their increased visibility highlighted the levelling uniformity of their dress: collectivised, institutional garments, designed for functionality and efficiency rather than individual taste or comfort as Goffman (1961) had observed (3.3.2.1) (figure 17 and 18). Accordingly, as part of the movement to humanise the treatment of the "mentally ill", their dress became the subject of consideration which resulted in the creation of clothes shops and dress programmes at mental hospitals throughout the country.

4.2.3 The de-institutionalisation of patient dress

4.2.3.1 The Clothing Committee



Clothing Committee Offers Statement of Basic Principles

The following are basic principles pertaining to the procurement, distribution and care of clothing for public mental hospital patients, as proposed by the A.P.A.-M.H.S. Committee on Clothing for Mental Patients with the intent of encouraging public mental institutions to achieve the highest possible standard of patient clothing:

1. Each patient needs a minimum wardrobe sufficient to ensure that he is neatly and suitably clothed for all occasions.
2. When possible, the patient should be permitted to select his own clothing.
3. The patient's clothing should be properly fitted and be designated for his personal, continuing use while hospitalized.
4. The hospital should make every effort to have the patient's family provide his clothing, and then to encourage ward personnel to see that this clothing is worn.
5. Whether patient clothing is hospital-made or whether bought on the open market or through State Use Industries, there must be sufficient variety in styles, colors and patterns to avoid uniform-like clothing.
6. Where State Use laws are mandatory, hospitals should have the prerogative of specifying their own requirements for clothing to be thus supplied, and of rejecting items which do not meet those standards.

figure 36: Statement of Basic Principles 'pertaining to the procurement, distribution and care of clothing for public mental hospital' by the American Psychiatric Association – Mental Hospital Service (A.P.A.-M.H.S.) Committee on Clothing for Hospital Patients' (anon 1954c: 19), 1954

In 1954 The Committee on Clothing for Hospital Patients of the American Psychiatric Association – Mental Hospital Service (A.P.A.-M.H.S.) issued a list of principles (figure 36) concerning the dress of "mental" patients with the 'intent of encouraging public mental institutions to achieve the highest possible standard of patient clothing' (anon. 1954c: 19).[130] This statement, and the very existence of a dedicated Committee, illustrate the importance granted to dress-related matters in mental hospitals at that period. While dress has played an important role throughout institutionalised psycho-medical history, particularly among the asylum reformers of the nineteenth century who were concerned with clothing the "insane" cheaply, appropriately and with a moral impact (Ch.3), it was thematised explicitly in US mental hospitals from the mid-twentieth century.

What the above statement also elucidates is the nature of some of the Committee's concerns: from dressing the significant number of patients in appropriate and clean clothes on a very limited budget, to the importance placed on individuality in dress.[131]

[130] Upon contacting the A.P.A. about the work of The Clothing Committee and its founding date, I received the following answer: 'we do not have any information in our archives'. (Hall, personal correspondence, 9.12.2015)

[131] The Committee Chairman, Miss Helen Edgar added the following comment regarding these principles, illustrating an increased attention paid to the individuality of patients regarding their dress needs: 'These proposals will find their major application to clothing the bulk of the hospital population – the approximately 75% who most of the time are tidy and non-destructive. All too often these patients are penalized, clothing-wise, for the small percentage of destruction which does

Concerning the latter, there was a discrepancy between theory and practice if one considers Goffman's descriptions of dress practices. Yet, the intentions of The Clothing Committee to improve the dress situation of the "mentally ill" were evidenced in their many activities: reviewing institutional clothing for hospital recommendations (anon. 1954b), or developing suitable dress with manufacturers and running dress tests on the appropriateness of synthetic fabrics or clothes for mental patients (anon. 1954e, anon. 1954f). They also issued "Recommendations for a Central Unit for Clothing Distribution" (anon. 1954a), complete with specific and practical recommendations on laundry procedures, a sewing room, the use of volunteer workers, clothing quotas for various types of patients, and staff rations for such operations (anon. 1954d: 20). These recommendations were implemented by a number of hospitals creating clothes centres in the attempt to meet the 'needs' of their patients on a more individual level, indicative of an increasingly individualised notion of self (Giddens 1991).

The efforts of the Committee and, in turn, the State hospitals were part of the discourse to humanise hospitals. Moreover, these "ethical" dress concerns were made more urgent by financial restraints on the one hand, forcing hospitals to ask for help from both families and local communities; and greater visibility and increased activity of patients through open-door policies on the other. As a result, more attention was paid to what patients were wearing, reflected in a series of articles on dress-related subjects, for example concerning: personal dress in the admission procedures (Tarumianz 1957), fabric considerations for mental hospital clothing (Osmond 1956), garment care as 'social adjustment' (Evans 1956), and the de-institutionalisation of patients' appearance (Goodman 1961). The following extract written by a hospital superintendent is indicative of their predominant rationale and tone:

> There is no reason why the mentally ill should not be attractively dressed, however ill they may be. While this might not in itself prevent grave regression and disorganization, the fact that fine clothing is provided regardless of the patient's anti-social ways symbolizes a kindly outlook and awareness of his needs. […] Cheap, ugly, ill-designed stuff harms our patients and is a waste of money. We must banish drab institutional clothing and introduce specially designed dresses, suits, shirts, ties, socks, stockings, underwear, etc., which, while meeting the needs of our patients, will remain good to look at and pleasant to touch. […] I do not suggest that better clothing alone will change mental hospitals. Properly planned treatment and re-ablement programs are essential. Here, however, is one way in which improvement in our patients' well-being and self-respect can be made quickly and cheaply with no more effort than a little imaginative understanding. (Osmond 1956: 18)

In addition to the increased significance granted to dress, there was a change in the perception of dress itself, and a rising belief in its therapeutic effect, described in a contemporary article on suitable clothes for "mental" patients by a hospital laundry manager:

occur. Also our hospital dress test is producing some evidence that even destructive patients will try to take better care of garments which are attractive and comfortable and which are marked with their own names' (anon. 1954c: 19).

> Mental hospitals formerly considered patient clothing as a low-budget item able to meet, but not exceed, the minimum requirements of common decency. If the institutional budget has only $15 a year for clothing purchases for each patient, then it is difficult to improve standards. Happily, this is changing. Already in Delaware, Maryland, New York, Ohio, South Carolina, Connecticut, New Jersey, Kentucky, and other forward-looking states, authorities are beginning to consider patient clothing at least in part a therapeutic issue. (Goodman 1961: 33)

Throughout the US, mental hospitals were opening clothing centres and launching dress programmes. A "dress-therapeutic discourse" was being constructed that ultimately enabled "Therapy of Fashion" as a treatment approach.

4.2.3.2 Clothing Centers



figure 37: The Clothing Center at Glenwood State School, Glenwood (Iowa), where patients can select garments and jewellery and each piece of clothing is then marked with the patient's name, building and ward, 1960

'In quite a few mental hospitals and schools for the deficient, "stores" have been established, where patients may select their own garments. These are stocked with various types of state-owned and donated clothing, both new and used,' observed one writer in 1961 and evaluated, 'Progress in clothing distribution is moving from the unsatisfactory central pool, with its "small, medium, large," through the ward as a unit, to full identification of each garment by individual patient's name' (Goodman 1961: 35).

Examples of such stores were the Clothing Center at Glenwood State School (Iowa) (figure 37), 'where patients can select garments and jewelry and each piece of clothing is then marked with patient's name, building and ward' (anon. 1960a: 43); the shoe shop at Metropolitan State Hospital, Norwalk (Calif.); and the clothing store at Larned State Hospital (Kans.), where the shoe department (figure 38) 'allows patients the pleasure of being fitted in shoe styles of their own choice' (anon. 1955: 18). At first glance, not much seems to distinguish these centres from any other clothes shop.



figure 38: The shoe department of the clothing store at Larned State Hospital's (Kans.), 1955



figure 39: The Clothing Center at Delaware State Hospital, Wilmington (Del.), 1956

The workings of such patient stores are illustrated by the following description of the clothing center at Delaware State Hospital in Wilmington (Del.) (figure 39), which opened in 1954 after a 'thorough overhaul of its clothing program, in accordance with the procedures recommended by the A.P.A.-M.H.S. Committee on Clothing' (Tarumianz 1956: 3):

> Patients are brought to the clothing center showroom to select and be fitted with the items they need. […] Twice a year the supervisor surveys the clothing requirements of all patients who receive clothing from private sources, and notifies their relatives or guardians accordingly. All such clothing is sent to the clothing room upon receipt so that it may be acknowledged, recorded and marked. […] The new program costs about $3000 a year more, including salaries and clothing purchases, but we have found the results well worth it. […] We are very pleased with the way the new clothing system is working out. Everyone has noticed a decided improvement in the appearance of patients, particularly the chronic ones, and the patients themselves appreciate having apparel which they chose and which fits well. We find also by having the clothes properly marked, less time is being required for sorting it in the laundry.



figure 40: "The Wardrobe", Hudson River State Hospital, Poughkeepsie (N.Y.), 1960



figure 41: "The Wardrobe", 'Clothes may make the man, but it's having a choice that makes the difference.' (Cartmell & Quinlan 1960: 40)

Apart from 'improving the dress provision' for patients by simultaneously individualising and rationalising their garments, some of these new clothing centres also developed educational objectives. "The Wardrobe" (figure 40 and 41), the clothing centre at Hudson River State Hospital in Poughkeepsie (N.Y.), for example, was launched in order to 'upgrade the dignity of the patients' after the introduction of mirrors to every ward had resulted in very negative patient perceptions (Cartmell & Quinlan 1960: 40). This forced form of self-reflection, which was also instigated at Napa State Hospital, where full-length mirrors were installed on the wards (Thompson 1962b: 836), is indicative of the non-coercive yet disciplinary techniques employed as part of the humanisation of hospitals, prompting patients to reflect on and consequently take care of themselves.

Conceived as an informal volunteer project of second hand donations, the response to "The Wardrobe" by both the local community and the patients, was said to have been so positive that the centre had to expand and was turned into an official hospital programme with didactic aims: 'Patients are now assuming responsibility for the

care of their clothing, and making use of the irons and repair facilities available on all wards' (Cartmell & Quinlan 1960: 40–1). This educational purpose of patients' clothes shops was made explicit at the mental institution Fort Wayne School (Ind.) (figure 42), where a shop was opened in 1955 to 'be used in the training program for patients' (Dolnick 1960: 41). Not only was 'the old system of mass distribution of uniform-type clothing […] replaced by a highly individualized clothing program,' the shop was also intended as a 'real-life simulation', where the "mentally ill" could "purchase" garments for themselves, an opportunity to 'train' patients for their 'readjustment to home' (41). 'A teacher of social competence in the training department presents an intensive course each week in wardrobe planning for selected educable patients [and addressed] clothing needs, suitability, [cost and the] handling of money. […] This is climaxed by a […] visit to the clothing shop' (42). Evaluative feedback praises 'improvements' in patients' appearance and behaviour, but equally highlights the shop as an 'excellent source for the betterment of hospital-community relations' (41):

> The clothing shop also serves a valuable purpose in community education, primarily due to the efforts of the volunteers who work in the shop and help with donations. The community has begun to learn about the inner workings of the school and to accept it as an intensive training center. (Dolnick 1960: 42).



figure 42: The Clothing Shop in Fort Wayne State School (Ind.), 1960

The clothing centres for patients, opened in mental hospitals in the US from the mid-1950s, implemented the 'Basic Principles' published by The Committee on Clothing, and thus reflected and were part of the dominant ideology of humanisation and de-institutionalisation. These dress shop examples further illustrate the complexity of dress concerns at that time: managing the dress needs of patients on a low budget while also 'improving' their appearance and thus, it was hoped, the image of the institutions

themselves, as well as utilising the assumed didactic and increasingly therapeutic qualities of dress.[132] This latter objective was indicative of the underlying ideology of normalising patients' behaviour through dress which underpinned and determined a series of dress programmes created in mental hospitals at that period.

[132] Writing about the deinstitutionalisation of dress in British women prisons, another form of 'total institution', Wilson (1992: 10–1) notes that the change to inmates wearing their personal dress which took place in the 1960s, was welcomed by prison officials, because, it was argued that the women would 'reveal' their personalities more fully. While this confessional aspect was arguably part of the humanisation of hospital dress in the US, it is not thematised and emphasis was placed on clean, appropriate and individual dress rather than personal clothing. Nonetheless, Wilson's comments are of relevance in their common concern with humanising dress in 'total institutions' of the 1960s, moreover in their historical reference to the classification of women: 'In the modern British prison system, women inmates now wear their own clothes instead of a uniform. This change, made in the 1960s, was interpreted as liberal and progressive, yet, it has another side to it. As early as 1836, a Frenchman, Dr Parent-Duchatêl, who published a pioneering investigation of prostitution, was arguing that the registration of prostitutes was necessary as part of their 'individualisation'. Every prostitute must have her own dossier, because [11] the better the authorities know the individual woman in question the more successful their surveillance of her world would be. Parent-Duchatêl's argument seems almost to anticipate Foucault, while prison reformers gave very similar reasons for the doing away with uniforms in British women's prisons – if female prisoners dressed as they pleased they would 'reveal' their personalities more fully than had been possible in a uniform intended to degrade and to reduce the personality of the prisoner. (The male prison governors of women's prisons have also seen fashion as promoting a more acceptably heterosexual culture in women's prisons.)'.

4.2.3.3 Dress Programs

'To take advantage of the therapeutic potential of clothing, the Arkansas State Hospital at Little Rock, has revised its procedure for issuing clothing to female patients,' stated its assistant manager as early as 1954 and went on to praise their individualised dress-making service (Wilbur 1954: 20). Although a mental institution for veterans, the Lyons VA Hospital (N.J.), described its goal of 'dressing all patients in personally owned clothing' as 'an integral part of treatment of hospitalized psychiatric patients, for it actuates their own self-respect and encourages ward personnel to aid them in their rehabilitation' (Weitz 1954: 6). Another VA mental institution, this time in Tuskegee (Ala.), outlined the rationale behind its "Good Grooming Programme" (figure 43 and 44):

> Realizing that there is a direct relationship between the patient's adjustment and the way in which he is clothed, this section set up the project to promote habits of good grooming and personal hygiene, and the maintenance of continued interest, pride, enthusiasm and participation. We feel that by providing not only interesting information on clothing and the accepted use of combinations and accessories, but also a selection of decent clothing, we may be able to motivate and stimulate the patients to take more interest and pride in their personal appearance. (Ashley 1960: 45)

In addition to the clothing centres, a series of dress-related therapeutic programmes, evidently for women and men, were launched in mental hospitals in the US from the mid-1950s, indicative of a shifting discourse concerning a "dress-therapeutable" self. These programmes featured some of the elements included in "Therapy of Fashion" and suggest that this pilot study rather than constituting a 'new' treatment, evolved amidst existing dress-related therapeutic practices.



figure 43: "Good Grooming Programme" at VA Hospital in Tuskegee (Ala.), 'Summer suit is modeled by a patient from the continued treatment service.' (Ashley 1960: 45)



figure 44: "Good Grooming Programme" at VA Hospital in Tuskegee (Ala.), 'Patient who was named "Mr. VA" in the Good Grooming Project, displays the new fall suit as he accepts his trophy.' (Ashley 1960: 45)

The "Good Grooming Programme" at VA Hospital in Tuskegee (Ala.) is a case in point, following a similar process to that of "Therapy of Fashion", albeit with male patients and on a smaller scale. It was first established in March of 1959, some six months before the pilot study at Napa. The programme was inspired by the recommendations of the A.P.A.-M.H.S. Committee on Clothing (Ashley 1960: 45) and included a fashion show, sessions on style guidance and dress advice, and a display by the patients (figure 43 and 44)[133].

Although it is noteworthy that this programme was undertaken with men at that period, it constituted an exception, as the majority of dress-related therapeutic initiatives in the US at this time were aimed at women. Moreover, they emphasised a "special" relationship between women and dress, as was done in the context of "Therapy of Fashion". Equally, these programmes posited a particular rehabilitative power of dress on women "mental patients", as reiterated in the following comment by a hospital laundry manager:

> We all know that the question of dress and adornment is of particular importance to women. The fact, that a woman happens to be a mental patient does not immunize her to this aspect of her personality. Quite the contrary, concern about her appearance might very well be one of the bridges to reality and self-respect, which the therapist can use more helpfully in treatment. This would appear to be especially true of convalescent women. (Goodman 1961: 33)

This statement illustrates the way the relationship between dress, self and sanity is discursively constructed in these dress practices, placing particular emphasis on a gendered self. It reveals a belief not only that the self is immanent in appearance, but also in the moral obligation to care for that self, and do so correctly. In the case of women, particularly, it included the act of dressing "appropriately". This is also exemplified in the Home Arts Workshops offered within Occupational Treatment to encourage women 'to maintain good grooming and to carry out the responsibilities they will have to assume at home' (Stumpf 1957: 20), or the increasing Home Economics teaching in mental hospitals, a quintessentially US-American educational programme that focused very much on 'women's primary role in the home and family' (Helvenston & Bubolz 1999: 319).

The so-called charm classes held at several hospitals around that time constituted another example. Taught at Metropolitan State Hospital in Norwalk (Cal.), they were 'covering fundamentals of speech, posture and poise, as well as good taste in make-up and dress' (McKeehan 1957: 1) and saw the 'charm class members […] serve as models [in the] gala annual event [of a fashion show]' (1). Moreover, the charm class at St Elizabeths Hospital, Washington, D.C. (figure 45) was officially based on the 'theory that every woman feels better if she knows she looks well' (Miller 1956: 8), a belief fundamental to "Therapy of Fashion". It followed 'a course outline developed by the

[133] The black male patients depicted in the photographs of this clothing programme highlight the exclusively white and female context of "Therapy of Fashion". As previously mentioned, the images included provoke more questions than can be answered within the parameters of this thesis.

volunteer instructor [a former model] and approved by the physician in charge, the women study correct posture in standing, sitting and walking; exercises individually prescribed to correct postural and weight distribution faults; the selection and application of make-up; care of the hair, skin and nails; and selection of becoming styles and colors in clothing' (8).



figure 45: The charm class at St Elizabeths Hospital Washington, D.C., 'Mrs. Marcella Blaetus, the volunteer who conducts the charm class, shows […] how to apply lipstick properly.' (Miller 1956: 8)

'Correct' posture and 'weight distribution faults' speak not only of normative notions of physical beauty inherent in this therapeutic approach, but also illustrate the knowledge/power correlation at work in the classes. The bodies of participating patients were to be improved and transformed through dress and under the direct authority of a 'knowledgeable' fashion 'expert' taking on the role of an 'assistant therapist' (Hellerich 1985: 119). Moreover, these regularising terms illustrate how dress was employed as both a normalising and disciplining technology of the self.

These charm classes were taught at the hospital in which Erving Goffman undertook his long term observational research for *Asylums*. The dress practices and treatment of patients communicated here five years before Goffman published his research are very different[134]. Yet, there is a disciplining core to both: stripping patients

[134] It remains unknown whether the charm classes had been terminated when Goffman was undertaking his observational study at the hospital, whether they constituted too small a project in an institution of 7000 patients to be included, or, indeed if they were excluded for a reason. According to Gambino (2013: 5) Goffman's account of the institution was somewhat reductive. Gambino (2013: 5) argues: 'A closer look at the changes transforming St. Elizabeths around the time of Goffman's research reveals a far richer portrait of institutional culture. Group therapy, psychodrama, art and dance therapy, patient newspapers, and patient self-government – each of which debuted at the hospital in the 1940s and 1950s – provided novel opportunities for men and women to make themselves heard and to take their fate into their own hands. While these initiatives did not reach all of the patients at St. Elizabeths, surviving documentation suggests that those who participated found their involvement rewarding and empowering'. While such a re-reading of Goffman's *Asylums* lies outside the parameters of this thesis, his in-depth descriptions and meticulous detail speak of a carefully conceived and executed study, which this research thus draws on.

of their 'identity kits' and teaching them 'proper' make-up and correcting their 'weight distribution faults'. Moreover, these two accounts from the same hospital are reminders of the fact that dress practices varied within and among the different mental institutions at that period, and did not preclude the employment of 'coercive' dress, such as straightjackets, which were still commonly used at the time (Ch.3). Thus the dress of "mental" patients cannot be generalised as it included a variety of simultaneous practices.

What united these institutions and indeed enabled their different dress-related therapeutic initiatives, however, was, firstly, a notion of dress or dress-related activities as educational opportunities and a therapeutic tool for the "mentally ill", and secondly a growing discourse of humanisation of both hospitals and the everyday dress provided for patients, and therapeutisation (1.4), where patients' activities were re-inscribed therapeutically. As such, "Therapy of Fashion", in its conception, principles and execution, could be seen as the logic of its time. The pilot study at Napa State Hospital in October of 1959 combined features from different clothing programmes (although their level of contact is unknown), adding the defining element of fashion in order to test and develop a therapeutic approach: not just a therapy of dress, but a therapy of fashion that was evaluated, widely publicised, and supported by dedicated organisations that introduced the treatment to a series of hospitals throughout the country, turning it into something approximating a national volunteer service in the 1960s.

4.3 From pilot project to national volunteer service

4.3.1 The dissemination of "Therapy of Fashion"

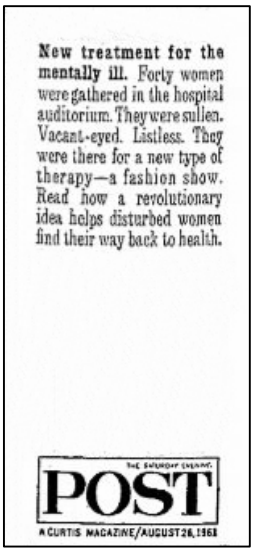


figure 46: 'New treatment for the mentally ill. Forty women were gathered in the hospital auditorium. They were sullen. Vacant-eyed. Listless. They were there for a new type of therapy – a fashion show. Read how a revolutionary idea helps disturbed women find their way back to health.' advertisement for *The Saturday Evening Post.* (anon. 1961a: 4)

Figure 46 shows the announcement of an article on "Therapy of Fashion" used to advertise *The Saturday Evening Post*, published in Philadelphia, but read nationwide. As 'the preeminent medium of its day' (Cohn 1989: 6), this weekly magazine reached a mass audience of millions for much of the twentieth century (Cohn 1989). This advertisement ran in several local newspapers in August of 1961 (e.g. anon. 1961a, anon. 1961b), announcing a four-page in-depth report on the 'new' treatment by aforementioned science journalist Milton Silverman and his wife Margaret (1961: 22–3 & 79–80): 'Glamour Treatment for the Mentally Ill', complete with statements and images of both volunteers and participating patients.[135] The fact that the 'institution' (Mott 1957: 716) that was *The Saturday Evening Post* featured such a prominent piece on "Therapy of Fashion" indicates the potential reach of this 'revolutionary idea', as it was referred to, and aided its development from pilot project to national volunteer service. Moreover, the Silvermans (1961: 80) were already reporting the growing dimensions of the therapy:

[135] The ethical implications of this "show all" sensationalist approach seem to have gone unconsidered.

> After the successful trials at Napa, the San Francisco Fashion Group and the San Francisco Association for Mental Health introduced their programs at other California hospitals. By this summer nearly 400 women had gone through either the full three-day course or abbreviated one-day versions. […] Similar programs have already been conducted by local fashion groups and mental health associations at hospitals in Los Angeles and Minneapolis, and still others are being developed in New York, Houston, Toronto and Montreal. Other hospitals can undertake similar programs, claims Jane Winthrop, wherever interested groups are willing to set up courses based on some fashion and much close "woman-to-woman" contact.

Fashion Group member Thelma Thompson (1962b: 835) confirmed this popularisation:

> Doctors and personnel of mental hospitals are recognizing that personal appearance is one of the clues to mental health. […] Fashion therapy has developed so successfully that it has been used as a guide for Fashion Groups across the country in bringing Fashion Therapy to their local state hospitals. Following the footsteps of this pioneering San Francisco group, Fashion Therapy has been introduced in 11 major United States cities and in Paris.

While details of the international scope of "Therapy of Fashion" remain vague, its national expansion has been established.[136] It was actively promoted by Napa Hospital staff and the press they invited, as well as the volunteer organisations sponsoring and carrying out the programme. Dr Miller and his colleagues (et al. 1960) had an interest in publicising their 'new treatment', as confirmed by the access they granted to local and national newspapers. In turn Margaret Kuhns of the MHASF called upon its members to popularise the approach: 'Mental health associations should make efforts to find ways to "spread this fashion therapy plan" in their cities. Mental health volunteers "ought to contact mental hospitals and get permission to help teach patients 'how to look, how to walk, how to dress, but mostly how to become human beings again'" (anon. 1962i: 50), illustrating inadvertently some of the naturalisation brought to the programme by volunteers (4.4.2).

The Fashion Group promoted "Therapy of Fashion" with equal engagement throughout the 1960s: it organised annual fundraiser fashion shows (figure 47 and 48), arranged sponsorship deals with local fashion and cosmetics companies, advocated the programme to fashion professionals nationwide, and planned volunteer training. 'It is planned that in the fall, five or six carefully screened volunteers with fashion background, from various hospital towns, will come to San Francisco and that we will give six seminar sessions so that these volunteers will learn our techniques. These people will return to their local town, recruit, screen, and train volunteer help' (Thompson 1962b: 836). As a result of this collective effort, "Therapy of Fashion" was established at several mental hospitals, following the same principle, but implemented according to local circumstance.

[136] The expansion of "Therapy of Fashion" can only be traced to some other mental hospitals in the US, such as the Californian Metropolitan State Hospital in Norwalk and Mendocino State Hospital in Talmage, as well as mental institutions in Wisconsin, Maryland, Indiana, Illinois and New York. The international proliferation, however, was confirmed by an article in the Californian *The Times* in 1965, which stated that this idea 'has been so successfully carried on in mental hospitals in this area by the San Francisco Association for Mental Health [sic] that it has been emulated in other parts of the country, in Europe and in the Orient' (anon. 1965b: 6). For an overview of "Therapy of Fashion", see appendix 1.



figure 47: '1,100 attend the Therapy of Fashion show to benefit Therapy of Fashion Program' (MHASF 2008), 1968



figure 48: 'Annual fashion show at the Hotel Mark Hopkins benefiting the Association's "Therapy of Fashion" program' (MHASF 2008), 1965

4.3.2 "Fashion Horizons" and beyond

In May of 1962 the Fashion Group and the MHASF launched a new "Fashion Therapy" programme in California at Mendocino State Hospital in Talmage near Ukiah (elena 1962: 3). It was conceived on the familiar premise 'that if a woman can be motivated into caring about her appearance and her clothes, she has an excellent chance of regaining her mental health' (Tucker Neep 1962: 6), yet the structure had been altered somewhat[137]. Mirroring the educational ethos of mental hospitals at that time, the programme was now carried out as a 'curriculum' culminating in a 'graduation ceremony' (figure 49), which was attended by hospital staff, donors and volunteers, and saw the 'graduates' walking to a raised platform in the centre of the auditorium were they received a diploma and a special gift (6). By mobilising the rhetoric and rituals of educational examinations, this edition of "Therapy of Fashion" legitimated itself and highlights the production of expert fashion knowledge involved in its construction.



figure 49: 'After graduation – Ukiah's Beta Sigma Phi chapters hostessed a "tea" for the graduates and the "faculty" of the Fashion therapy program.' (Tucker Neep 1962: 6)



figure 50: 'Fashion Therapy Planners' including designer Irina Roublon, second from the right (Tucker Neep 1963: 6)

The programme was initially run by members of the Fashion Group, but eventually a locally run project was organised (figure 50), which was to 'concentrate on make-up, hair-styling, posture and learning how to choose what is most becoming' (6). While the design of individual dresses for each patient was a central feature at Napa, it was abolished, as one journalist explained: 'The Fashion Group has dropped the making of dresses because they found it was a hindrance in that it delayed the program and entailed an investment of extra funds. There is, however, the possibility of re-styling dresses which are out-dated' (6). The cost factor was addressed in several accounts of "Therapy of Fashion" (e.g. Meek-Barker, AI, 17.11.2015; Thompson 1962b, Tucker Neep 1962) and contributed to its decline at the end of the decade. As the design and making

[137] The programme was described by a journalist in the following terms: 'During three visits to the hospital, the chosen students were given individual make-up kits and were taught how to apply the cosmetics. They also were shown how to walk and how to sit down; their figures were analysed and a foundation garment ordered for them; in some instances their hair was completely re-styled. In all instances, a dress was designed to suit the students likes and to accentuate her best features. […] Friday, June 1, was graduation day for 38 patients (Tucker Neep 1962: 6).

of individual dresses for each patient constituted the most expensive element in the programme, its cutting was an economy measure. Nevertheless, at Metropolitan State Hospital in Norwalk, another Californian mental institution, where "Therapy of Fashion" had been launched in 1963, dress-making was introduced, with ready dress patterns chosen and sewn by the patients to minimise time and cost (Sweeney 1963a: 18). "Fashion Horizons", as the programme was called, equally received enthusiastic feedback from hospital officials, one of whom was quoted as saying: 'in some instances [it] has been a major aid in hastening a patient's release' (18). In the numerous articles two cases were repeatedly reported, first of all: 'Mary K., a college graduate who once had been a teacher. She entered the hospital haunted by feelings of rejection and suspicion, but they disappeared during the course as she found herself helping other patients with their sewing. She has returned to her family, and is once again teaching' (18). And secondly:

> Linda S., a 32-year-old laboratory assistant, was easily frightened, depressed and often considered suicidal. When she started the program, she would not speak to other persons and seldom raised her head. But during the course she began to talk to others. Gradually, she conversed more easily, improved her appearance and took a greater interest in the world about her. She was discharged and has adjusted to life in the community, case workers say. (18)

The evaluative comments and examples highlight a common perception of three elements of this therapeutic approach: the employment of dress as a normalising technology of a gendered self, and of the 'feminine adjustment' the treatment aimed for; the approval given to "successful" transformations, and to 'improved' and 'tasteful' appearances; and finally, the social role that dress and dress-related activities, such as sewing and fitting, were seen to fulfil in the psycho-medical setting. These cases also illustrate the gendered nature of technologies of the self an aspect neglected by Foucault, as previously discussed (1.2). They show how dress, and in turn "dress therapy", are constructed as gendering practices, to fashion well-socialised women though fashionable dress. This was reiterated in the feedback on the programme from Spring Grove Hospital in Baltimore, where the Fashion Group and The Mental Health Association of Maryland had started "Therapy of Fashion" in October 1962. After working with a smaller group of twenty-five women (anon. 1962j: 4) on a nine-week programme (anon. 1962d: 15), hospital authorities were reported as saying: 'Making a woman mental patient feel attractive and feminine again has a great therapeutic effect […]. Patients ready for release from hospital gained confidence in their appearance and reassurance in their personal contact with fashion volunteers' (anon. 1962j: 4).

Apart from their volunteer work at Spring Grove Hospital, The Maryland Association for Mental Health was also 'making arrangements for the Fashion Therapy Program in Springfield, Crownsville and the Eastern Shore State Hospitals' (anon. 1962j: 4). In

California the programme had been introduced to the San Francisco County Hospital (anon. 1963b) and Agnews State Hospital in Santa Clara (anon. 1968b), in addition to Napa and the two launches mentioned above. Similarly, in Illinois, the Mental Health Association of Greater Chicago was disseminating the treatment (anon. 1971), which had already been established at Logansport State Hospital (Ind.) (anon. 1965a) and Rochester State Hospital (N.Y.) (anon. 1967a), thus covering a range of states.



figure 51: 'Gail McKy, Jaycette "Fashion Therapy" chairman, shows the new "Cleopatra Look", 1962.' (Andresen 1962: S5 p5)

While local fashion groups and mental health associations were mostly promoting and executing "Therapy of Fashion" throughout the different US states; in Wisconsin it was the Jaycettes, the auxiliary to the Madison Junior Chamber of Commerce, who ran the sessions at Mendota State Hospital, together with the recreational therapy department as of March 1962 (Andresen 1962: S5 p5). They offered a programme of eight weekly meetings that 'covered various aspects of good grooming and fashion, including an opening style show by Jaycettes using their own clothes, hair styling and setting, color and accessory choice, and cosmetics' (S5 p5). Their guiding principles were similar, yet the execution was more improvised (figure 51). A session on hair care, for example, was described as follows: 'There were cardboard cutouts so that patients could judge their face shapes, paper hairstyles to frame their faces, and wigs, so they "could see how they would look as blondes"' (Andresen 1962: S5 p5). The idea of the blonde evidently conjured up a prevalent beauty ideal which was part of the "feminine mystique".

Evaluations of the programme were comparable to those of other settings in their enthusiasm and approval. The assistant superintendent, Dr Sonja Muson, praised the project's 'great therapeutic potential,' and observed that 'the patients have been very enthusiastic and have benefited greatly' (S5 p5), while recreational therapist Judith Teufel (in Andresen 1962: S5 p5) summarised the project as follows:

> Most of the twelve patients in this group had lost interest in personal care […] . Their doctors prescribed fashion therapy for them to try to reawaken their social awareness. Hopefully, we've helped them. Out of [the] original group […] four have been progressed to the open convalescent ward, two are on "home visits," and another has been discharged […] The fact that they even begun to care about themselves is significant. Just having someone from the community show their interest and saying 'I like you' by working with them is the really important thing.

These statements reiterate the normalising and socialising potential attributed to "Therapy of Fashion" as a form of social therapy, reminiscent of the jargon used to advertise psychotropic drugs as aids to 'social rehabilitation' (figure 32) or 'social recovery' (figure 33) (4.2.2). Moreover, they highlight the obligation to care for the self (Foucault 1984b/1988) which underpins this approach.

"Therapy of Fashion" grew significantly in scope throughout the 1960s in the US, potentially reaching hundreds, if not thousands of women, if one multiplied the 400 patients reported by the summer of 1961 (Silverman & Silverman 1961: 80). Back at Napa State Hospital the pilot study was instituted as part of the treatment programme and ran regularly until at least 1970.[138] Alongside it, a similar therapeutic approach for teenage girls entitled "Groom-Up", was established (figure 52 and 53). It had been piloted alongside its adult counterpart in the late 1950s: 'At the same time, at the Napa State Hospital, an experimental fashion-therapy program was being tested on teen-aged girls who had been brought into the hospital for emotional problems' (Silverman & Silverman 1961: 80).



figure 52: 'The Groom-Up program helped young patients hospitalized at Napa Sate Hospital.' (MHASF 2008), 1958



figure 53: The Groom-Up program at Napa Sate Hospital, 1967

According to visual evidence this teenage programme also ran throughout the 1960s (figure 53), yet no further documentation could be found. The very idea of under-aged patients being subjected to an appearance-based treatment for 'emotional problems' during the transitional period of adolescence raises considerable ethical questions. Its imperative title 'Groom-Up' is indicative of the transformation asked of its participants, and, of the gendered, normalising transformative performance expected from all the female patients undergoing "Therapy of Fashion", as I discuss below.

[138] Evidence of annual fashion luncheons to benefit "Therapy of Fashion" can be found until 1970, see the overview of "Therapy of Fashion" in appendix 1.

4.4 Gendering practices and relations of power

4.4.1 'I feel like a woman for the first time.': The performance of femininity

By the early 1960s "Therapy of Fashion" was fully integrated into the treatment plan at Napa State Hospital. 'The standard fashion therapy course at Napa – financed largely by Fashion Group itself – now consists of three sessions, held a week apart, followed by a formal fashion show,' the Silvermans (1961: 80) described its established procedure. They also detailed a make-over performance as a customary feature of the professional fashion show that opened each therapy course and which was paradigmatic of the gender performance at the heart of this treatment approach, as analysed below:

> In what has now become a standard routine, Vivien Thorne, a talented young San Francisco fashion artist, appears barefoot in a slip, with hair dangling and bedraggled, no lipstick, no make-up, no nail polish. "She represents the absolute nothing, the small sad sack," explains Jane Winthrop. "We call her Basic Girl." Patients generally exclaim, "She looks like she's just had a shock treatment," or even "Good Gawd, she looks like me!" Then in the next half hour, while the show goes on, Miss Thorne sits before a mirror at an improvised dressing table, does her hair, applies her make-up and finally appears, sleek and modish, in a handsome and apparently priceless golden-brown opera gown and miniature hat – actually concocted from an old Army blanket and a sample length of drapery fabric. "The whole cost was three dollars and fifty cents," says Mrs. Winthrop. "You see? Fashion is just tricks." (Silverman & Silverman 1961: 80)[139]

This fashion show set the aesthetic standard for the programme to follow and the makeover feature of 'the basic girl' specified the type of gender performance expected of the women in the audience. It reiterated what Tynan (2016: 197) has termed more generally 'the censure of a society that demands the concealment of an unfinished and chaotic femininity'. A clearly defined aesthetic value judgement was imposed at the beginning of every course of "Therapy of Fashion", embodied by the models and exemplified in the makeover. It visualised the official aim of the treatment, the 'healthy feminine characteristics' (Miller et al. 1960: 42) to be recreated. This value judgement also implied a woman's obligation to beautify and care for herself, that she should make an "effort" or else she 'stands for nothing' as Winthrop put it. 'The program attempts to re-awaken self-interest and self-confidence in the patients by appealing to the feminine instinct of pride in appearance' one journalist (Sweeney 1963a: 18) reiterated the premise of "Therapy of Fashion". It was this largely naturalised discourse, constructed by medical staff, volunteers and journalists alike, which engendered the treatment in general and the make-over feature in particular in its suggestion of the female "mental"

[139] This regular feature of the makeover was confirmed by my interviewee Jane Meek-Barker, who remembers Vivien Thorne as follows: 'Vivien Thorne, she was a pretty little blond, artistic, very talented and very endearing and very giving… she was an artist and she worked for one of the stores 'City of Paris' or 'The White House' [department stores in San Francisco]. Anyway, she had made herself a fabulous coat with a hood… out of an army blanket. You know the blankets that were issued to service men during the Second World War. […] this fabulous looking coat, a cape coat and wore that in the initial fashion show.' (AI, 17.11.2015)

patient as the 'Basic Girl' to be made over into the normative ideal: well-dressed and well-socialised.

'She looks like me!' exclaimed some of the patients allegedly, and their portrayal by the Silvermans (1961: 22) confirms the recognition:

> Nearly all the women were bedraggled and unkempt, their hair untidy or pulled into a severe bun, their lips pale, their faces untouched by make-up or carelessly overrouged, and their clothes – everything from robes and blue jeans to drab house dresses – clean but rumpled and dowdy. […] Most of the others sat silent and motionless, as unanimated as so many sacks of vegetables. […] "They were dressed sick." (79)

This description of the "mental" patients prior to undergoing "Therapy of Fashion" is reminiscent of Andrews' (2007a: 5) discussion of representations of the 'mad poor' up to the nineteenth century: an 'agglomerated mass,' degraded in appearance, 'incapable of dressing themselves appropriately,' (17) whose 'tatty' dress implied 'mental degradation' (10) (Ch.3). '[F]orms of flouting dress norms were significant constituents of madness' writes Andrews (2007a: 18) of that period and continues that they 'marked these women out as crazy contradictions of the codes of contemporary culture and fashion – for women were expected to take especial pride in their dress and coiffure' (Andrews 2007a: 10). Both assumptions evidently persisted into the second half of the twentieth century. And both determined this therapeutic approach and its programme of style guidance, hair- and make-up lessons, advice on 'correct' undergarments and comportment intended to transform "mental" patients into healthy feminine subjects (figure 54 and 55).



figure 54: 'Charlotte Swartz […] member of the Fashion Group of San Francisco aid[s] patients on the way back to health through the motivation of the urge of self-adornment.' (Thompson 1962b: 836)

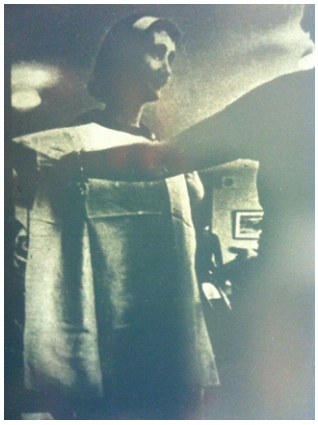


figure 55: 'At Napa State Hospital, in northern California and elated patient selects the material for a fashionable dress which will be designed especially for her.' (Silverman & Silverman 1961: 22)

The transformation was to be achieved through the process of re-fashioning female patients, depicted in these images and detailed at the beginning of this chapter. This process is reminiscent of a masquerade, a masquerade of womanliness, as the psychoanalyst Joan Riviere puts it in her seminal study of successful working women in

1929. She analysed the ways in which these women were hiding behind a façade of 'femininity' so as to avoid retribution by men, womanliness thus becoming a masquerade, a theatrical playing out of particular styles and codes of the body. 'Womanliness therefore could be assumed and worn as a mask,' she states, 'both to hide the possession of masculinity and to avert the reprisals expected if she was found to possess it' (1929: 306). Riviere argues for the congruency of womanliness and masquerade: 'The reader may now ask how I define womanliness or where I draw the line between womanliness and the 'masquerade'. My suggestion is not, however, that there is any such difference; whether radical or superficial, they are the same thing' (306).

What the treatment at Napa, and all the other hospitals, offered its participants were props and 'tricks' (Winthrop in Silverman & Silverman: 80) for a masquerade of 'womanliness' in its aim to 'recreate' a convincing gender performance. The female patients undergoing "Therapy of Fashion" were supposed to perform "normality", as defined by male 'medical authorities' and female 'fashion experts'. The proposed recitation of gender norms, and their ritualised enactment through dress, in the full sense of the word, underpins this therapeutic approach and in turn illustrates the constructedness of gender, the way in which we all continually produce or construct our gender (and other) identities, the deep-seated role play repeated on a daily basis, its performativity.

The anti-essentialist notion of gender as 'performative' has been most prominently conceptualised in the work of literary theorist Judith Butler (1990 & 1993). It takes gender as a set of styles of the body, which are constructed, replayed and performed through our everyday actions as gendered subjects. 'Gender is neither a purely psychic truth, conceived as "internal" and "hidden", nor is it reducible to a surface appearance,' argues Butler (1993: 234), 'On the contrary, its undecidability is to be traced as the play *between* psyche and appearance'. While gender cannot be reduced to dress, its performance relies heavily on it. The daily construction of gender identities makes use of codified dress- and body styles. In "Therapy of Fashion" this largely naturalised process became explicit in the way the patients were made to perform gender through make-up, clothing, hairstyling and comportment – a series of gendered and intentionally gendering performances. The terms 'performance' and 'performativity' should be distinguished, however, as Butler (1994: 3) specifies: 'the former presumes a subject, but the latter contests the very notion of the subject'. She adds: 'Performativity is the discursive mode by which ontological effects are installed' (3). The difference between ontology and performance is also emphasized by literary theorist Peggy Phelan, who argues that women in particular have been encouraged to mistake performance for

ontology. However, she notes, 'precisely what motivates the performance is that which ontology – the question of being itself – will not and cannot answer'.[140]

In her conceptualisation of performativity Butler was influenced by the social constructivism of Foucault and his notion of discourse:

> I begin with the Foucauldian premise that power works in part through discourse and it works in part to produce and destabilise subjects. But then, when one starts to think carefully about how discourse might be said to produce a subject, it's clear that one's already talking about a certain figure or trope of production. It is at this point that it's useful to turn to the notion of performativity, and performative speech acts in particular – understood as those speech acts that bring into being that which they name. This is the moment in which discourse becomes productive in a fairly specific way. So what I'm trying to do is think about the performativity as *that aspect of discourse that has the capacity to produce what it names.* (1994: 3)

Butler maintains that this production of subjectivity takes place through repetition, a performance which is recited continuously. This process is illustrated in "Therapy of Fashion" where female patients are asked to recite gender norms concerning both dress and behaviour in order to 'recreate healthy feminine characteristics' (Miller et al. 1960: 42) in themselves, effectively.

"Therapy of Fashion's" goal of producing 'healthy' feminine subjects by making the patients "look like" women and "act like" women was naturalised, its aesthetic norms internalised so thoroughly that in their feedback (or in what was transmitted of it) patients described 'feeling like a woman' in terms of an achievement. As one journalist reported: 'The value of the project was summed up, [Margaret Kuhns] said, by a patient who told her: "Until I took this course, I knew I was a woman, but I had forgotten what it felt like to be one"' (Willis 1962: 15). And another source claimed: 'Perhaps the most significant comment was provided by a farmer's wife who had been hospitalised for years with severe schizophrenia, and then recovered remarkably after the fashion therapy. "All my life," she said as she left the hospital to return to her home, "I suppose I knew I was a woman. But now, for the first time, I feel like a woman"' (Silverman & Silverman 1961: 23).

This thesis does not aim to and cannot delineate the effect of therapeutic practices on its participants. Moreover, whether or not the participating patients actually enjoyed this treatment cannot be determined. Nor can it be said whether or not they welcomed the social interaction or approval it granted. However, it is worth considering

[140] Phelan (1993: 105) develops this argument in the context of her analysis of Jennie Livingston's 1990 documentary *Paris is Burning*: 'White women like myself have been encouraged to mistake performance for ontology – to believe that the role is real, and thus sufficient to constitute an identity, a sense of purpose, a reason for being. If performance can provide a substitute real then "identity" can truly be an invention – not something susceptible to some external facts (biological, sexual, economic) which prohibit our access to "femininity," "beauty," "glamour," "power," "wealth," or whatever it is we desire. But the only way we can see if performance is an adequate substitute for ontology is through the staging of performances. In that enactment, however, we make conscious again the difference between performance and ontology: precisely what motivates the performance is that which ontology […] will not and cannot answer.'

the capacity of the women involved in the treatment to appropriate it, to use its potentially creative and playful aspects, or even to subvert its official aims.

Fashion, the concept at the core of this treatment, is said to constitute not only a disciplinary power, but also a creative one. Fashion is the only possibility to recreate oneself, to put on a new skin – every day, maintains fashion theorist Valerie Steele (in Mortag 2002: 24), for example. Moreover, fashion scholar Leslie Rabine (1964: 64) describes the act of dressing as entailing a 'mythical moment' and the clothed body as 'symbolizing a self-produced coherent subject'. According to her: 'the pleasures of fashion include the symbolic replay of this profoundly productive moment when subjectivity emerges'.

Thus, the promise of fashion, one could argue, lies precisely in this possibility of a playful performance of the self, the promise of dress in representing a multi-sensorial, embodied creative practice. At the same time, and underlining its complex and paradoxical nature, fashion also constitutes a disciplinary measure. These opposing dynamics are described by Wilson (1992: 14) in the following way: 'We can still acknowledge that dress is a powerful weapon of control and dominance, while widening our view to encompass an understanding of its *simultaneously* subversive qualities,' or indeed creative ones. Writing in relation to asylum dress, Wynter (2011: 41) reiterates and exemplifies that dress in this setting 'could also serve as a means with which patients could undermine therapeutic intentions and even claim control of their own lives'.

It could thus be argued that, just as fashion does not only consist of disciplinary power, so "Therapy of Fashion" did not only amount to a technique of social control. Arguably, it also tapped into the primary motivation in dress, adornment (Kaiser 1997), thus potentially opening up a space for a playful and creative process of self-realisation, even if limited and governed by rules, by standardised notions of gender and mental health, and by an expert authority that controlled any creative potential. However, it is worth acknowledging the capacity of these women to make even small parts of this prescriptive treatment programme their own.

The makeover feature which stood at the beginning of every course of treatment exemplified the performance expected from patients. Based on the correlation between looking, acting and feeling like a woman, it also established the female volunteers as figures of authority. Moreover, these 'key fashion professionals' (Miller et al. 1960: 42) also demonstrated their ability, self-discipline and capacity to make themselves over into successful professional women, whereas the patients needed help. The 'Basic Girl' had the capacity to transform herself, doing her own hair and make-up, designing her own garments, whereas the patients were transformed by the expert volunteers. The rhetoric of help underpinned "Therapy of Fashion", its prescriptive and even disciplinary connotations underlying, as I discuss in the final section of this chapter.

4.4.2 'We tell them to wear girdles, too, we help them with their whole general appearance.': Volunteer help and the exertion of power

'We help them with their whole appearance' stated one volunteer of "Therapy of Fashion" (anon. 1962i: 50). 'Hopefully, we've helped' said another (Andresen 1962: S5 p5) at Mendota State Hospital. The notion of help, the charitable act of giving either time, expertise or means, permeates numerous articles written on "Therapy of Fashion". 'How expert hair stylists, clothes designers and beautiful young models are helping women in mental hospitals' read the title of the Silvermans' report on the treatment. They highlighted the volunteer commitment throughout:

> To Mrs. Winthrop the programs in the San Francisco area have more than warranted the time, effort and money involved. "To a lot of us," she says, "the fashion business sometimes seems futile and ridiculous. You get the idea that you're just selling more things costing more money to more women who've already got more things than they need. You begin to feel a little ill. And then suddenly a door opens – you find a way you can take your knowledge and use it to help women who desperately need help." (Silverman & Silverman 1961: 80)

Besides being a comment on the fashion business from an advertising executive, Winthrop's reflection captures the two sides of the process, helping and being helped, being able to help and 'desperately need[ing] help'. In the case of "Therapy of Fashion" this dichotomy was set up between volunteer 'fashion experts' and 'patients', between 'well groomed and cultured professionals' and 'chronic and acute' patients, as Dr Miller described it (et al. 1960: 42), effectively between the 'knowing' and the ones needing advice, indicative of the rising therapy and advice culture at that time mediated through 'expert knowledges' (Giddens 1991: 5) (1.4).

Most of the dress-related programmes introduced in this chapter, from clothing centres to the different therapy settings, were run by female volunteers, invited into mental institutions in line with new open-door thinking, which coincided with under-staffing. The amount of volunteer time invested in developing and running "Therapy of Fashion" is noteworthy, as Jean Meek-Barker, volunteer at Napa, remarked: 'don't forget, you are talking about women giving up their own time. […] There were between ten and twenty of us [each session]. We were all working people, working stiffs' (AI, 17.11.2015). Many of them were working mothers, giving up their time to help. 'It was terrific,' she reminisced and explained her motivation, 'if you don't do anything for other people, why are you around. What's the point of being alive?' (AI, 17.11.2015).



figure 56: 'Fashion experts volunteered to provide advice on cosmetics for the Therapy of Fashion program.' (MHASF 2008), 1969

As the volunteers were largely untrained, what qualified them for the treatment of "mentally ill" women was their expertise in fashion (figure 56), which is emphasised in many accounts, constructing them as 'fashion experts'. Moreover, they did not receive any psycho-medical training prior to the treatment. 'None of the Fashion Group members had been given any preliminary coaching. "Just treat the patients as you'd treat old friends," they were advised. They did precisely that and discovered that the patients became friends' (Silvermans 1961: 79–80). The 'informal' and 'friendly' atmosphere of therapy sessions is a feature repeatedly mentioned in newspaper articles. One volunteer praised the 'conversational woman-to-woman basis' of classes (Andresen 1962: S5 p5). The Silvermans (1961: 79–80) documented the interaction as follows:

> Even when they relaxed and used such normal fashion jargon as "crazy costume jewelry" or "an insane little hat," they found the patients did not swoon or take offence. One model, for example, told a patient, "If you think you need that much rouge, you must have a hole in your head." Immediately she added, "Oops! I shouldn't have said that!" But the patient reassured her, "That's all right, dearie. I do have a hole in my head. That's why I'm here."

If this journalistic account can be taken as a record of events, it gives an impression of the tone and treatment, which in this case might be interpreted as insensitive, or unbiasedly direct, unaware of diagnoses or medical history. Moreover, it illustrates the persistent equation of appearance and mental health (Goffman 1963: 27) (1.3.2.1), and, finally conveys that each of the volunteers would bring their own mannerisms, approach and values into the therapeutic setting, as well as their personal motivation to help.

Helping to teach patients 'how to look, how to walk, how to dress, but mostly how to become human beings again' was how Margaret Kuhns (in anon. 1962i: 50) described "Therapy of Fashion". She explained the principle as follows: 'We tell them to wear girdles, too, we help them with their whole general appearance' (50). Speaking not only as a volunteer and member of MHASF, but also as its vice president, her words are indicative of the perceived volunteer-patient relationship and the underlying approach, which was arguably amicable and well-intended, but essentially prescriptive. Giving her perspective on the treatment, Jean Meek-Barker made the following remark: 'If you are

talking about fashion as therapy, you want to consider bodily health – a certain amount of it, you know. How is the weight? Do they stand up right? Do they walk right? Because walking on the runway is one of the things we did in fashion therapy. And you know, they couldn't crouch and fall off the runway' (AI, 17.11.2015).

'We tell them to wear girdles', 'experts advising' patients as to the 'proper' way to dress, the 'correct' make-up, the 'right' way to walk. These statements by volunteers illustrate the production of truth in the context of "Therapy of Fashion" as a basis for the legitimisation of their status as experts. Moreover, they indicate how, in the process of 'helping' patients, the volunteers were also imposing their own beauty ideals, their taste preferences on them and setting a particular aesthetic standard to be attained to. The volunteers of "Therapy of Fashion", all of them women, were put, and put themselves in a position of authority to dress other women. Yet, they did not just hold power by being in charge, as 'assistant therapists' (Hellerich 1985: 119), alongside the medical staff, but by the truths they held, by what they knew and what they did with that 'expert' knowledge. These 'fashion experts' imposed their aesthetic value judgement by demonstrating what was fashionable, beautiful and feminine, not as a personal opinion, but the truth. Holding the power over the definition of these terms, the volunteers thus constructed a 'regime of truth' (Foucault 1984d: 73) which institutionalised and legitimated their vision of fashion, femininity and normality. Their authority was legitimated by these truths and exerted through words: telling patients what to wear, what was allegedly fashionable, granting their approval or disapproval (figure 57). It was legitimated in gestures and practices, as they analysed their figures, styled them, did their make-up and dressed them.

Yet, the act of telling someone what to wear is highly intimate, the act of dressing someone else, as was the case in styling sessions and fittings, even more so. The act of dressing presumes the act of undressing, as does the analysis of patients' 'figures' (Tucker Neep 1962: 6) or their 'weight distribution faults' (Miller 1956: 8), common elements in "Therapy of Fashion". Undergarments are repeatedly mentioned as a distinct feature of the programme: 'the importance of undergarments' (Clinton 1960b: 11), 'being fitted with proper foundation garments' (Miller et al. 1960: 42), 'a foundation garment ordered for [patients]' (Tucker Neep 1962: 6), suggestive of a degree of exposure for the patients. The act of dressing someone else is very personal. It is what we do with our loved ones, most commonly our children. Dressing adult women, however, runs danger of infantilising them, regardless of their "mental capacity", because it alludes to the unreasonable child. The "madman", writes Foucault (1954/1987: 24) about the myth of their regression, 'relapses and can fall back, through illness, to an earlier state; the myth, too, of an identity between the mentally ill person, the primitive, and the child'. Furthermore in *Madness and Civilization:* 'Madness is childhood. Everything at the

Retreat is organized so that the insane are transformed into minors' (1961/2001: 239). It could thus be argued that these adult "mental" patients were treated like children, dressed to behave consistent with and to display 'healthy feminine characteristics' (Miller et al. 1960: 42).



figure 57: 'Madame Irina Roublon, one of California's most successful designers, has a special knack for making the patients feel attractive. For this older patient she designed a frothy hat. […] "Darling, you will be so pretty. I will be so happy with you."' (Silverman & Silverman 1961: 22)

The productive forces of "Therapy of Fashion" were such that it did not just produce gendered subjects or re-produce normative notions of behaviour and appearance, but also power structures. Considering Foucault's conception of power as multi-directional, these power relations, although arguably largely hierarchical in nature were not exclusively so, as touched on at the beginning of this chapter which considered some of the volunteers' fear of contact with "mentally ill" but also the capacity of patients to resist treatment or even possibly to subvert official aims, however limited that potential.

Nevertheless, "Therapy of Fashion" was a means of social management, as this chapter argues, although couched in the discourse of the humanisation of hospitals. 'The fashion-therapy program fits logically into the modern total-push attack against mental disease and the treatment of each individual as a person rather than a patient,' Dr Miller (in Silverman & Silverman 1961: 80) explains the humanising mission of this treatment approach. However, as Foucault forcefully demonstrates in relation to modern institutions, the replacement of coercive techniques with non-coercive ones under a humanising ideology of care does not mean these new measures are less controlling, disciplining, or indeed subjectifying. Foucault's notion of biopower (1975/1995) in particular is pertinent to "Therapy of Fashion" which aimed to transform, improve, and to fashion women's minds and bodies through fashionable dress. Concerned with the dress provisions and prospects of patients, this treatment approach wanted to 'help' them to 'look good and feel better' all the while disciplining its participants and impelling them to discipline themselves.

4.5 Conclusion

'What about the future of Fashion Therapy?' asked one of its volunteers in an article she wrote on the treatment in 1962:

> I can speak for the San Francisco group only. The requests from mental hospitals are overwhelming. After eight courses, four meetings each, and twenty one-night stands in less than three years, The Fashion Therapy team is weary. The time required has cut heavily into the regular job. To carry on, revisions must be made. (Thompson 1962b: 836)

Some changes were made, such as recruiting other volunteer services like the Jaycettes or reducing the individual dress design service, and even abandoning dress-making altogether in some settings. Nonetheless, the termination of this dress-related therapeutic approach by the mid-1970s[141] was arguably related to a lack of resources both concerning money and volunteer time. Whether or not a changed image of women and shifting gender roles contributed to its cessation remains unclear.



figure 58: 'Fashion helps therapy', advertisement for Blue Ridge Textile Company, 1961, 'Clothes really help the patient. Hospital experience has definitely demonstrated how the judicious use of fashions, fabrics, and colors will help the female patient regain her femininity … improving attitude and more favorable response. […] Blue Ridge Textile Co., Inc., famous for "engineered fabrics to answer the problem" has, in the past eighteen months, set up a special division to construct and produce specific fabrics, expressly for mental patients…fabrics that are soft, smooth, comfortable…fabrics that will take repeated launderings and stand up to most rugged treatment. In these knitted nylon fabrics "with a memory", Blue Ridge designers have created smartly styled dresses, slippers and lingerie in colors and designs that make the patient feel and look like women again.'

[141] The last reference found in relation to "Therapy of Fashion", albeit in the area of Greater Chicago, dates back to December of 1974 (anon. 1974), whereas in San Francisco it dates back to 1970 (Logrippo 1970).

'Fashion helps therapy', read the copy of an advertisement by Blue Ridge Textile, for fabrics 'engineered […] expressly for mental patients' in 1961 (figure 58). It was placed in the same medical journal where Dr Miller (et al. 1960) had published the results of the pilot study of "Therapy of Fashion". While it remains unclear if the two were connected[142], this commercial constitutes further evidence of a rising "dress-therapeutic" discourse in the US of the 1960s, as this chapter demonstrates. This discourse was co-constructed by mental hospitals, mental health associations and volunteer organisations, the Fashion Group, the press, and advertisers of psychotropic drugs and specialised fabrics. The proliferation of discursive and non-discursive practices around dress and mental hospitals was evident in different dress-related therapeutic initiatives established from the mid-1950s and the formation of a designated therapeutic approach centred on fashionable dress in 1959. "Therapy of Fashion" grew from a local pilot project to a national volunteer service throughout the 1960s. This chapter argues that a renewed discourse of the humanisation of hospitals in general and the treatment of the "mentally ill" in particular, as well as the advent of psychotropic drugs (4.2.2), further enabled this programme of grooming, dress-design and self-presentation classes, which was underpinned by a strong belief in the rehabilitative effect of dress.

'[T]he judicious use of fashions, fabrics and colors will help the female patient regain her femininity' continued the advertisement copy. In the way women were singled out, this statement illustrates the gendered nature of both the discourse and the therapeutic practice it generated. Moreover, these words read like a re-formulation of the official aim of "Therapy of Fashion" which was premised on an essentialist perception of the relationship between women, dress and fashion, and a perceived obligation concerning their appearance management and behaviour.

As such, "Therapy of Fashion" constitutes a complex cultural practice. The role and use of dress in relation to the self within this treatment approach was determined by notions of pedagogy, pragmatism, power and possibly play, reminiscent of early institutionalised psycho-medical history (Ch.3). Thus, "Therapy of Fashion" does not constitute a break with the past, but brings together and combines different uses of dress. Enabled by a contemporary notion of an individualised, fashion-able and therapeutable self, this treatment aimed to transform and normalise the bodies and minds of "mentally ill" women in the US of the 1960s.

[142] Whether or not the 'hospital experience' mentioned in the advertisement refers to "Therapy of Fashion" or which hospital the fabrics by the Blue Ridge Textile Company were tested at could not be established.

chapter five
La vêtothèque:
Dress and fashion therapy in France

Introduction



figure 59: The original setting of the *vêtothèque* at Hôpital La Timone in Marseille, 1999

A large, light-flooded room, white walls, parquet floor, furnished with twelve wooden wardrobes on wheels[143] (figure 59). '*Créateurs de Passions'* is printed on the outside of their doors, full-length glossy photographs cover the inside: a taped mannequin, a magnified safety pin, the lower side of a surfboard, a glass chair, a torrent. The wardrobes are filled with garments, around 250 pieces arranged on hangers and in drawers: agnès b, Doctor Jekyll, Les Gens, Manon Martin, Sessun, Tcheka by Nico, Tectus, Aviatic, Captain Tortue, Honoré, Poivre Blanc – fashionable clothes, mainly by young local designers and labels (IMM 2000).

The original setting of the first *vêtothèque*, the first dress library in France, could be mistaken for a movable clothes shop. It was inaugurated at *Espace Arthur*, a newly opened psychiatric unit for adolescents at Hôpital La Timone in Marseille by Maryline Bellieud-Vigouroux[144], president of the local fashion institute, the *Institut Mode*

[143] The wardrobes were custom made by designers Paul Mathieu and Nicole Dellatana (IMM 2000).
[144] Maryline Bellieud-Vigouroux changed her name from Vigouroux to Bellieud-Vigouroux in 2001/2. Hence, in articles published until 2001 she is referred to as Vigouroux.

Méditerranée et des Jeunes Créateurs (IMM) on 12 October 1999 (figure 60). The head of the unit, eminent French child psychiatrist Marcel Rufo had contacted her in July of that year, concerned with patients' reactions to medical staff uniforms.[145] He was looking to eliminate the prevalent white coat, with the outcome that his staff began wearing their own clothes and a badge (Vigouroux in Rault 2001: 76). A collaboration came into being and attention was drawn to patients' dress, to the incorporation of fashionable dress in the therapy process, of creating a *vêtothèque*, a biannually changing dress library, where therapeutic sessions would take place and the youths could borrow garments (Bellieud-Vigouroux, AI, 18.9.2013).



figure 60: The inauguration of *Espace Arthur* and its *vêtothèque* at Hôpital La Timone in Marseille, Maryline Bellieud-Vigouroux (right) with First Lady Bernadette Chirac (centre) and hospital as well as IMM staff, 12 October 1999

'The *vêtothèque* offers a space of expression to the adolescents, a space of discovery, of research, from choice to appropriation, recognition, acceptance and participation – by way of a concept, which is highly present in our society: fashion,'[146] reads one of the rare official documents on this treatment approach, an internal manuscript written by medical staff (Descloux et al 2001). Emphasis is being put on fashion, on changing the garments every six months, on modelling the outside world, what the youths that have been taken out of their normal settings would find in the shops at their budget (Bellieud-Vigouroux, AI, 18.9.2013).

Vêtothérapie[147] – 'C'est un concept made in Marseille,' remarks Bellieud-Vigouroux (in Hello 2005), which has since been implemented at the children's psychiatric hospital in

[145] According to the IMM (2000), Rufo presented research that he had conducted together with his team into 'Le malade et vêture' ('The patient and dress') in the hospital environment.
[146] 'L'atelier vétôthèque propose aux adolescents un espace d'expression allant de la découverte, de la recherche, du choix jusqu'à l'appropriation, la reconnaissance, l'acceptation, l'appartenance, au travers d'un concept très présent dans notre société: la mode.' (Descloux et al. 2001)
[147] While different spellings exist of this term, as evident in the sources (e.g. Kagan 2008, Rufo 2007), in the context of this thesis *vêtothérapie* will be used, following the lead of one of its initiators Professor Rufo (e.g. 2007: 86).

Fréjus and, most prominently, at *Maison de Solenn* in Paris*,* a purpose-built psychiatric unit for adolescents since November 2004.

The present chapter documents the development and different applications of this, rather closed setup of a dress-related therapy and analyses it in relation to the underlying cultural therapy approach of *soins culturels*, advocated by Rufo for the psycho-medical treatment of adolescents and essentially determined by a growing discourse of 'humanisation' of hospitals in France throughout the twentieth century, which increasingly emphasised the role of culture in the process of convalescence.

While fashionable dress is suggested in this context as a tool for relationships, self-acceptance and discovery (Descloux et al. 2001), this chapter argues that in its socialising and self-revelatory employment, it is also regarded as a normalising and disciplining technology of the adolescent self. Moreover, it maintains, that dress within *vêtothérapie* is not only utilised as a social tool and form of diversion or occupational treatment, but also as a diagnostic indicator and regulating force. As such, this therapeutic approach is directly implicated in what has been described as our confessional culture (1.4).

Far from being the value-free and neutral therapeutic tool it is mostly portrayed as in the context of *vêtothérapie*, dress is inscribed with markers of age, gender, social, economic and cultural contexts, imbued with normative and highly subjective notions of aesthetic and physical beauty which remain, however, largely unacknowledged. This chapter, thus, also analyses the theoretical underpinnings – or lack thereof, as well as underlying discourses on self, body, fashion, culture and treatment in relation to arising therapeutic practices. Moreover, it acknowledges the fact that the discursive constructions of the relationships between fashionable dress and the gendered, adolescent, "disordered" self being treated vary considerably among the different parties involved in organising, sponsoring and practicing *vêtothérapie,* and are, in turn, underpinning and, indeed, formative of highly individual therapeutic approaches. Consequently, this chapter is structured along the respective settings and opens with a discussion of the original concept and its cultural context.

5.1 *Espace Arthur* & *soins culturels*: Cultural therapy and the role of fashionable dress within it

5.1.1 *Espace Arthur*: 'The first building block of an adolescent medicine'[148]



figure 61: *Espace Arthur – Unité d'Adolescents*, plaque featuring a drawing of Arthur Rimbaud, the eponym of this unit. The plaque was first installed at Hôpital La Timone in 1999, moved to Hôpital Sainte-Marguerite in 2008 and is now hanging at *Espace Méditerranéen de l'Adolescent* (E.M.A), where the unit was moved to in June of 2012.

Under the premise that 'illness isolates and excludes' human beings, the idea behind *Espace Arthur* was to create a secure medical area, yet, with an atmosphere similar to that of the outside world, explains Professor Rufo (in Righini 1999). He adds: 'The solution is to create an intermediate area between inside and outside […] to avoid the sealing off and chronicisation of illness'[149] (Rufo in Righini 1999). First opened in May of 1999, the unit, which is named after poet Arthur Rimbaud[150] (figure 61), houses approximately a dozen adolescents at a time, aged twelve to twenty.[151] According to its official brochure[152], *Espace Arthur* treats young women and men who show:

> pathologies specific to adolescence. Intense crisis expressed through:
> • conflicts with parents
> • suicide attempts and depressions of all forms
> • body related pathologies and addiction behaviours
> • social pathologies
> • cognitive pathologies
> • pathological crises connected to personality disorders[153] (APHM 1999: 4).

[148] 'La première pierre d'une médecine d'adolescent.' (Rufo in INJEP 2001)
[149] 'La maladie isole et exclut. La solution est de créer des espaces intermédiaires entre le dedans et le dehors, telle la mode, pour éviter l'étanchéité et la chronicisation de la maladie.' (Rufo in Righini 1999)
[150] The name is generally attributed to French poet Arthur Rimbaud (1854–1891) (e.g. Maziers 2001). Some sources state it was also named after the psychiatrist Arthur Tatossian, who advanced the idea of adolescent psychiatry as a distinct discipline (e.g. Hello 2005).
[151] *Espace Arthur* is both a live-in unit and a day clinic. (APHM 1999: 3)
[152] This brochure was published when *Espace Arthur* was first opened in 1999. It has not been republished since the unit moved to Hôpital Sainte-Marguerite in January 2008 and finally into *Espace Méditerranéen de l'Adolescent* (E.M.A) in June 2012.
[153] 'L'Espace Arthur traite les jeunes de 12 à 20 ans, présentant des pathologies spécifique de l'Adolescence:

The aim of the unit is defined as 'helping the young to cross a difficult moment, the bridge between childhood and adulthood, without stigmatisation through their pathology, by taking account of the individual under construction in her or his entirety'[154] (APHM 1999: 5). These statements illustrate the way 'the adolescent' is discursively constructed, and the way 'adolescence' is a constructed 'social, institutionalised' 'phenomenon' (Schäfers & Scherr 2005: 20–3). While the 'teenager' was very much a marketing creation in the US of the 1940s (Savage 2007), the concept of adolescence can be traced back to the second half of the eighteenth century which saw a rising concern with particular educational requirements (Schäfers & Scherr 2005: 18). In France this understanding was lastingly determined by Jean-Jacques Rousseau's *Emile, or on Education* originally published in 1762, outlining an educational philosophy for the phase of the 'second birth' (Schäfers & Scherr 2005: 19).

Moreover, these statements are indicative of a particular notion of self underpinning the therapeutic approach of *Espace Arthur* and thus *vêtothérapie*: a notion of an individual self in transition, in crisis and in need of help. In order to do so this unit was set up to provide individualised treatment specifically for adolescents (APHM 1999) and proposes a cultural therapeutic approach (*soins culturels*) (5.1.2), exemplifying, in turn, the real effect of discourse, constitutive, in this case, of a designated therapeutic practice and location (figure 62).



figure 62: *Espace Arthur – Unité d'Accueil et de Soins pour Adolescents et Jeunes Adultes*, entrance at Hôpital La Timone in Marseille, 1999

Crise aiguë s'exprimant par: Conflits avec parents, Tentatives de suicide et dépressions sous toutes leurs formes, Pathologies centrées sur leur corps et les conduites de dépendance, Pathologies de l'intégration socioculturelle, Pathologies cognitives, Crises pathologiques inaugurales d'un trouble de personnalité.' (APHM 1999: 4)

[154] 'L'objectif est d'aider le jeune à traverser un moment difficile, passerelle entre l'Enfance et l'Âge adulte, sans stigmatisation de la pathologie, en prenant compte de l'individu en construction dans sa globalité.' (APHM 1999: 5)

Espace Arthur does not only offer separate rooms for each of the patients, but also a common room; a media library *"Louis Hachette"*[155]*,* named after the founder of its sponsoring company; a classroom; spaces for balneotherapy and occupational therapy; a room dedicated to psychomotricity called *"Blé de l'Espérance"*[156]*;* a dining area with cooking facilities (APHM 1999: 6); as well as a multipurpose room which houses the *vêtothèque*. The unit was financed through a collaboration between *Assistance Publique de Marseille,* the public health care organisation, and private sponsorship from companies, banks and individual donors.[157]

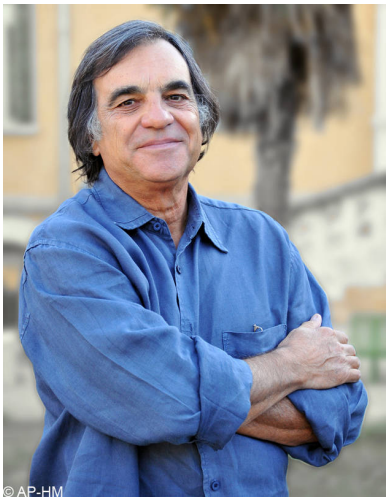


figure 63: Professor Marcel Rufo, 2012



figure 64: Dr Michèle Battista, 2008

The realisation of this showcase of a medical centre took several years of fundraising and organisation. 'This unit, that's fifteen years of work for Professor Rufo [figure 63] and five years for me,' explains Michèle Battista (in Arnoult 2001) (figure 64), its former head psychiatrist and fervent advocate of *vêtothérapie*, 'When it opened its doors […] I felt as though I had given birth'[158]. Rufo (in Fau 1999) describes the rationale and ultimately his vision of *Espace Arthur* as 'the first building block of a future hospital for adolescents, which responds to a need. There are six million eleven- to nineteen-year-olds in France today, who do not have appropriate structures at their proposal'[159]. French adolescent patients are normally treated in either children's hospitals or adult psychiatric units (Dollfus in Sultan 2001a: 77). Rufo (in Fau 1999) adds: 'There are about a dozen "ado"

[155] The media library was sponsored by "Fondation Hachette" of the French publishing house (renamed "Fondation Lagardère" since, after its president), who equipped it for a total of 250 000F (Fau 1999), an equivalent of approximately £32000.
[156] 'grain of hope'
[157] The private sponsorship is described by Rose and Allen (2001) as follows: 'The unit is being supported with donations from local banks and also from one of the world's most famous fashion victims, multi-millionaire divorcée Mouna Ayoub, who spends more than £500,000 a year on clothes by designers such as John Galliano and Karl Lagerfeld. Ms Ayoub, who wed billionaire Nasser Al-Rashid in 1979, herself used clothes as a form of therapy during her years living in the isolated environment of a Saudi Arabian marriage. She once said: 'Fashion became a medicine - my only way out of a very restricted life'.
[158] 'Cette unité, c'est 15 ans de travail pour Pr Rufo, 5 ans pour moi. Quand la structure a ouvert ses portes en mai 1999, j'ai eu un peu l'impression d'avoir accouché.' (Battista in Arnoult 2001)
[159] 'L'Espace Arthur est la première pierre d'un future hôpital pour adolescents, qui répond à une nécessité. Il y a aujourd'hui 6 million de français entre 11 et 19 ans qui ne disposent pas de structures appropriées.' (Rufo in Fau 1999)

units in France, but the one in Marseille is particular. It marks the beginning of a reflection on adolescent medicine which is neither that of children, nor that of adults'[160].

Given Rufo's reported status of 'France's most famous, most publicised and most widely read child psychiatrist'[161] (Vincent 2004) specialising in the treatment of adolescents, his comments can be taken as part of a discourse constructed by Rufo to legitimise his own profession, his specialised treatment approach, and future projects, such as a designated psychiatric hospital for adolescents, which was eventually created in Marseille in 2012 (E.M.A). It is part of a therapeutic discourse which legitimises the creation of 'appropriate' psycho-medical 'structures' for treating adolescents. As such, this statement has to be read in relation to the parameters of psycho-medical care in France, which is the country with 'the highest density of psychiatrists in the world (13,600 [in 2005])' (Lézé 2014: 316). Psychiatry, in turn, constitutes its 'most frequent medical specialization (13 percent)' (316). It is a country deeply implicated in contemporary therapy culture (1.4). Almost one-sixth of its current population of 66.8 million (INSEE 2016) are said to be affected by a 'mental disorder' according to Lézé (2014: 317):

> Mental disorders are the second most frequently attributed diagnostic category in France. Ranging from distress to psychiatric pathologies, mental disorders are estimated to affect 10 million people. In 2005, they represented 10.6 percent of health care expenditure (11.4 billion euros). France is one of the countries in Europe with the greatest incidence of depressive disorders and has a very high suicide rate. (17 in 100,000). […] France is the greatest consumer of antidepressants in Europe and the second-greatest consumer of alcohol. Tobacco and cannabis are also very prevalent among 18- to 25-year olds.

The high suicide rate of French teenagers is referred to by most of my interviewees in explanations of the need for designated and different treatment approaches for adolescents, such as a cultural approach (*soins culturels*). 'Depression is on the increase among youngsters,' details Dr Battista (in Fau 1999) shortly after the inauguration of *Espace Arthur* 'there were 45000 suicide attempts among eleven to twenty-year-olds last year and 2500 deaths'[162]. Professor Rufo (AI, 3.4.2008) told me that 'high risk behaviour constitutes the first cause of death among adolescents'. He argues that this high risk behaviour, that the suicides determine their work and impose a specialised treatment approach of *soins culturel* including *vêtothérapie*:

> All the staff at *Espace Arthur* work upstream of suicide, of depression. Adolescent psychiatry is a cross-discipline. Taking care of teenagers imposes *soins culturels* besides medical and psychological therapies. Street fashion is part of their culture. This fashion space [*vêtothèque*] brings the city into the hospital. In our treatment we use tools from outside of the hospital.[163] (Rufo in Revilla 2001: 16)

[160] 'Une quinzaine d'unités pour "ados" existent en France, mais celle de Marseille est spécifique. C'est le début d'une réflexion sur la médicine de l'adolescent, qui n'est ni celle de l'enfant, ni celle de adulte.' (Rufo in Fau 1999)
[161] 'Il est, sans conteste, le pédopsychiatre le plus célèbre de France. Le plus lu, le plus médiatisé. […]: le professeur Marcel Rufo.' (Vincent 2004)
[162] 'La dépression est en progression chez les jeunes: il y a eu 45000 tentatives de suicides chez les 11-20 ans l'an dernier et 2500 morts.' (Battista in Fau 1999)
[163] 'Tout le personnel de l'Espace Arthur travaille en amont du suicide, de la dépression. La psychiatrie de l'adolescent est une discipline métisse. S'occuper des adolescents impose des soins culturels en plus des soins médicaux et psychologiques. La mode de la rue fait partie de leur culture. Cet espace mode fait revenir la ville dans l'hôpital. Nous soignons avec des outils venus de l'extérieurs de l'hôpital.' (Rufo in Revilla 2001: 16)

While it cannot be ascertained in how far the threat of suicide impacts on the daily work of staff, or in how far it determines power relations, this statement illustrates the significance this threat is granted in this setting. Moreover, it exemplifies the understanding of fashionable dress as part of teenage culture, and the notion of culture in general as part of their frame of reference, both underpinning therapeutic practice. It is in this respect that *Espace Arthur* does not only constitute the first building block of a designated hospital for adolescents, but of a specialised medical approach, as Rufo (in INJEP 2001) argues: '*L'Espace Arthur* constitutes the first building block of an adolescent medicine, which includes *soins culturels* in the set of problems concerning adolescents'[164].

[164] 'L'Espace Arthur est la première pierre d'une médecine d'adolescent incluant les soins culturels dans la problématique de jeunes.' (Rufo in INJEP 2001)

5.1.2 'Culture is a therapy.'[165]

5.1.2.1 *Soins culturels*

> I insist on the term "*soins culturels"*. It expresses well that culture, the cultural activities represent a therapy in their own right, in the same way as psychotherapy. It goes without saying that one does not exclude the other. Moreover, they are prescribed by doctors and take place under the direction of a professional carer and with a therapist: psychologist, nurse or doctor, whose presence reassures that it effectively constitutes a therapy not a sponsored activity intended to kill time. In order to relaunch the psychic game we need cultural aids that provide so many possibilities of opening up and getting to know oneself and others: theatre, music, internet, cooking, radio, dance… everything that constitutes life, as a matter of fact, and constitutes the life of teenagers in particular. (Rufo 2007: 83)[166]

The concept of *soins culturels* was first developed in the context of *Espace Arthur* at Hôpital La Timone in Marseille in 1999. It was maintained when the unit moved first to Hôpital Sainte-Marguerite in 2008 and eventually to the designated hospital for teenagers *Espace Méditerranéen de l'Adolescent* (E.M.A) in 2012. Here the cultural approach was extended following the lead of its Paris counterpart *Maison de Solenn*, also headed by Rufo between 2004 and 2007. What started as a small idea at *Espace Arthur* with a library, a media library, occupational treatment and the *vêtothèque* was developed into a fully formulated therapeutic approach with an entire floor of the modern, purpose-built *Maison des Adolescents* in Paris dedicated to it (5.5). 'The third floor is my favourite one,'[167] remarks Rufo (2007: 83) correspondingly.

The cultural activities on offer at *Maison de Solenn* have expanded significantly. When it first opened the teenagers could play theatre, make art, sculpture, music or radio, cook, dance or visit a media library and the *vêtothèque*. Whereas the current list of cultural workshops (*atelier culturels*[168]) at *Maison de Solenn* reads as follows: Sculpture, Hairdressing, Audio-visual design, Five Senses, Kitchen, Dance, Writing, Physical education, Fashion space, Gardening, Video games, Journalism and multimedia, French, Media library, Music, Perfume, Philosophy, Radio, Re-schooling, Cosmetotherapy, Beauty therapy, Theatre.[169]

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[165] 'La culture est un soin,' reads the title of a subchapter in: Rufo, Marcel (2007) *La Vie en Désordre: Voyage en Adolescence.* Paris: Éditions Anne Carrière, pp. 81–95.

[166] 'J'insiste sur l'expression "soins culturels": elle dit bien que la culture, les activités culturelles représentent un soin à part entière, au même titre que la psychothérapie - les uns ne dispensant pas de l'autre, cela va de soi. D'ailleurs, ils sont prescrits par les médecins et se déroulent sous la houlette d'un animateur professionnel et avec un soignant: psychologue, infirmière ou médecin, dont la présence valide qu'il s'agit effectivement d'un soin et non d'une activité de patronage destinée à tuer le temps. Pour relancer le jeu psychique, on a besoin de supports culturels qui sont autant de possibilités d'ouverture et de rencontre, avec soi-même et avec les autres: de théâtre, de musique, de séances sur Internet, de cuisine, de radio, de danse... de tout ce qui fait la vie, en somme, et plus particulièrement la vie des adolescents.' (Rufo 2007: 83)

[167] 'À la Maison de Solenn, c'est le troisième étage que je préfère.' (Rufo 2007: 83)

[168] It is noteworthy that by 2012 the term *soins culturels* had been abandoned, *atelier culturels* is now used to describe the different activities. Moreover, what was formerly the *vêtothèque* is called *espace mode*. Whether or not this change in terminology was to mark a new leadership after Rufo departed, or how it was otherwise motivated could not be established.

[169] *Arts plastiques, Coiffure, Création audio-visuelle, Cinq sens, Cuisine, Danse, Ecriture, Education physique et médiations corporelles, Espace mode, Jardinage, Jeux vidéos, Journalisme et multimédia, Français, Médiathèque, Musique, Parfums, Philosophie, Radio, Rescolarisation, Socio-esthétique, Soins esthétiques, Théâtre.* (http://www.mda.aphp.fr/structures/ateliers-culturels/) (6.12.2016)

'The more I get on, the more I believe that the hospital has to adapt to the adolescents, to their rhythm, their needs,'[170] Rufo (2007: 144) reflects in his book *La Vie en Désordre* on the development of his approach and the institutions dedicated to it. He outlines his thinking, as illustrated in the opening quotation, and argues that *soins culturels* constitute a distinct form of therapy, however, one that is meant to complement rather than replace more conventional methods, such as psychotherapy. Effectively, Rufo (2007: 83) discursively constructs culture as a therapy. Although the term remains undefined by him, a particular French aesthetic understanding of culture underpins this approach, as addressed below (5.1.3). Rufo constructs the approach of *soins culturels* in general and cultural activities in particular as "proper" therapy by arguing that they are 'prescribed' and supervised by 'doctors'. He maintains that they constitute not just 'sponsored activities' but a form of therapy, legitimised by the presence of a medical professional, who directs the activity. Yet, by directing the activity that professional also directs the patients themselves. *Soins culturels* can thus be understood as constituting both technologies of self as well as 'technologies for the direction of others' (Foucault 1983: 369–70). Moreover, they are intended as a technology of knowledge and a social technique, as Rufo (2007: 83) describes the 'opening up and getting to know oneself and others'. The professional in charge of such sessions fulfils both the role of the therapist and that of a teacher directing the adolescents to direct themselves – in relation to others, as will be explored in relation to *vêtothérapie*.



figure 65: *Les soins culturels* – The main aims of the cultural therapeutic approach explained in the brochure of *Maison de Solenn* in Paris: 'to let life enter into the hospital, to integrate culture in the medical process, to propose themes for activities and reflection' (APHP 2005)

[170] 'Plus j'avance plus que je crois que l'hôpital doit s'adapter aux adolescents, à leur rythmes, à leur exigences.' (Rufo 2007: 144)

The thin brochure of *Maison de Solenn* dedicates an entire page to *soins culturels* (APHP 2005) (figure 65), indicative of the central role this therapeutic approach is granted here. Three main aims are listed as follows: 'to let life enter into the hospital, to integrate culture in the medical process, to propose themes for activities and reflection' (APHP 2005). While the last two aims outline the idea and possible applications of *soins culturels*, the first one, 'to let life enter', describes a fundamental principle said to underpin this treatment approach and the psycho-medical institutions in which it is practiced. '[T]o create intermediate areas between outside and inside,' Rufo (in Righini 1999) explains this principle, as quoted at the beginning of this section. The notion of bridging "outside" and "inside" is prevalent in the discourse of *soins culturels*. 'To not let the adolescent be disconnected from his or her daily world,' the brochure details this objective. 'To not end the reality of the outside, but, on the contrary, construct it'[171] (APHP 2005). This dichotomy between the exterior and interior of the hospital, but also the patient is reiterated by most of the practitioners I interviewed. 'Psychiatry is something which really has to mix with outside and inside'[172] maintained Rufo (AI, 3.4.2008), for example. To illustrate his point, Rufo told me that all of the teen-psychiatric *services* he directs must have a bar, a bistro, a place to have a coffee or hot chocolate, in order for 'people from the outside' to mingle with 'adolescents from the inside'[173].

In relation to the *vêtothèque*, Battista (Righini 1999) observes that it 'lets life enter into the hospital, but in a minor key'[174]. She explains elsewhere: 'The outside must help the inside'[175] (Battista in Monnier 2000). *Soins culturels* are seen to be able to bridge the outside/inside dichotomy. They are regarded as an 'intermediate area', as Rufo terms it above. In this context the relational concepts of the 'intermediate' and the 'transitional' by English paediatrician and psychoanalyst Donald Winnicott (1896–1971) are frequently referred to (e.g. AI, Rufo, Battista, Kagan)[176]. Dress, for example constitutes 'an intermediate area between the self and the other'[177] according to Rufo (AI, 3.4.2008), so does the *vêtothèque* (Rufo in Righini 1999) and other cultural activities. While these terms remain somewhat vague in relation to the different therapeutic contexts they are meant to describe, Winnicott (1953: 89) himself defines them as follows:

> I have introduced the terms 'transitional object' and 'transitional phenomena' for designation of the intermediate area of experience, between the thumb and the teddy bear, between the oral erotism and true object-relationship, between primary creative activity and projection of what has already been introjected […] .

[171] 'Une hospitalisation, qu'elle qu'en soit la durée, ne doit pas déconnecter l'adolescent de son univers quotidien. Il ne s'agit pas d'en finir avec la réalité extérieure mais bien au contraire de la construire. C'est tout l'objet des soins culturels.' (APHP 2005)
[172] '[L]a psychiatrie est quelque chose qui doit vraiment se métisser avec dedans et dehors.' (Rufo, AI, 3.4.2008)
[173] 'Par exemple, notre exemple, un truc qui est essentiel: je ne peux pas avoir un service moins un bar, un bistro pour boire du thé, du café, du coca et - dans le service, pour que les autres, les gens, les adolescents du dehors viennent aussi, se mélangent aussi avec des adolescents de dedans.' (Rufo, AI, 3.4.2008)
[174] '[La vêtothèque] fait entrer la vie à l'hôpital, mais de façon tamisée.' (Battista in Righini 1999)
[175] 'Le dehors doit aider le dedans.' (Battista in Monnier 2000)
[176] Rufo has been quoted as saying that it was one of his missions to "translate" Winnicott, Freud and Spitz into Marseillais (Rufo in Vincent 2004).
[177] 'd'espace intermédiaire entre le soi et l'autre' (Rufo 3.4.2008)

If *vêtothérapie* in general and dress in particular are understood as an 'intermediate area' in a Winnicotian sense, then they are also supposed to constitute a developmental experience, a psychologising and didactic technology of self, as will be explored in more detail later on (5.2).

In the brochure of *Maison de Solenn* the aims of *soins culturels* are juxtaposed with a direct quotation from Rufo (in APHP 2005):

> When you dance you heal yourself! *Soins culturels* contribute to an improvement of morale and mind: we feel better when we want to learn. Teachers from schools and associations help the young hospitalised to work, through dance in connection with theatre, fashion, drawing; in creative chaos, changing, innovative and playful. Everything can be invented in this place.[178]

Rufo's statement reiterates the different roles *soins culturels* is seen to perform: therapy, education, creative outlet and motivator to work. Effectively, they are also seen as constituting a form of self work, self management, not just a didactic but also a disciplinary technology of self. Moreover, his words illustrate an understanding of self which integrates mind and body. Physical activities, such as dance are seen as having a direct effect on the mind. Governing his work, according to Rufo (2007: 90), is a notion of health as defined by the World Health Organisation (WHO): 'not only the absence of illness, but a good balance between mind, body and the social'. 'In that sense,' he adds 'one needs to admit that there is no split between the head and the body, but that the two form a whole: the subject'[179] (90). In assessing the value of *soins culturels* Rufo (2007: 86) equally asserts the human-centred nature of this therapeutic approach and his work:

> These activities are valuable because they demonstrate that however intense and pervasive the suffering might be at times, everyone retains elements that are "sane" and intact, on which one can lean in order to recover a little self-confidence and joy in functioning. Once again, it is a question of not losing sight of the subject, of not reducing it to its disorder. That's why I get annoyed with people who dare to call *soins culturels* a "gadget".[180]

While Rufo's words allude to his way of dealing with his critics, they also illustrate what Foucault (1969/2002: 25) terms the 'principles of classification, normative rules, institutionalized types' that constitutes 'facts of discourse': "sane" (even when used with double quotation marks), intact, recover, disorder. They speak of a normative, healthy state to reach or to return to. However, Rufo also reiterates his 'fundamental principle':

[178] 'Quand tu danses tu te soignes! Les soins culturels contribuent à amélioration du morale et du psychisme: on va mieux quand on a envie d'apprendre. Des enseignants de collège et des associations aident les jeunes hospitalisés à travailler, par la danse associée au théâtre, à la mode, au dessin, dans un désordre créatif changeant, innovant et ludique. Tout est à inventer dans cet endroit.' (Rufo in APHP 2005)

[179] 'La santé, telle que la définit l'Organisation mondiale de la santé (OMS), n'est pas seulement l'absence de maladie, mais un bon équilibre entre le psychisme, le physique et le social. En ce sens, il faut admettre qu'il n'y a pas de division entre la tête et le corps mais que les deux forment un tout: le sujet.' (Rufo 2007: 90)

[180] 'Ces activités sont précieuses parce qu'elles viennent signifier que, malgré sa souffrance parfois intense et envahissante, il subsiste en chacun des parties "saines", intactes, sur lesquelles il doit s'appuyer pour retrouver un peu de confiance en soi et de plaisir à fonctionner. Encore une fois, il s'agit de ne pas perdre le sujet de vue, de ne pas le réduire à son trouble. C'est pourquoi je m'agace de ceux qui osent parler de "gadget" à propos des soins culturels.' (Rufo 2007: 86)

'it is not the illness that counts, but the subject'[181] (2007: 246). Thus, the notion of self underpinning his work and the treatment approach of *soins culturels* is communicated as being individual, social, cultural and humanised. As such this approach is determined by and forms part of the modern-day movement of humanisation of hospitals in France, which centres not only on the human subject but also on the role of culture in medical treatment.

[181] 'Toujours revenir à ce principe fondamental: ce n'est pas la maladie qui compte, mais le sujet.' (Rufo 2007: 246)

5.1.2.2 'What to humanise in the hospital? To humanise everything!'[182]: The humanisation of hospitals in France

A discourse of humanisation of hospitals developed in France in the late 1920s, when, as a result of new social insurance laws, the middle classes were admitted to hospitals alongside the poor (Nardin 2009: 25). This discourse gained urgency after World War II as hospitals acquired the status of a public service (*Assistance Publique* – AP), but had since Word War I turned into 'veritable treatment factories'[183] (Ngo Ba Tay 1963: 22). The humanisation of hospitals became 'above all a question of medical ethics'[184] (80), one that was widely agreed on (Nardin ed. 2009). The movement was endorsed by an increasingly global humanising discourse, not only concerning medicine, as previously discussed in relation to the humanisation of hospitals in the US (4.2.2)[185]. In France it gained programmatic status in 1958 when the health minister published a 'bulletin regarding the humanisation at the hospital'[186] (Nardin 2009: 23). 'What to humanise in the hospital? To humanise everything! At least everything we can,'[187] proclaimed Paul Aurousseau (in MAP-HP 2009), the principle inspector of AP shortly after. What followed was a discursive explosion around the subject, which persists until the present day (Nardin 2009).

The programme of medical humanisation in France involved all aspects of hospitalisation: from architecture, including the abolition of communal halls to the decoration of wards; from food to the dress of staff and patients; from cultural activities to staff training, and the promotion of different approaches to medicine in general (MAP-HP 2009). The role of culture in the recovery and well-being of patients was foregrounded, indicative of a particular understanding of culture, as addressed below.

In how far these measures made for "more humane" hospitals lies outside the parameters of this thesis, however, a shifting discourse concerning hospital care was intended to lead to different treatment practices. This shifting discourse is also evident in the evolution of medical terminology, as previously discussed in relation to the early institutionalised treatment of the "mad" (Ch.3). The French patient charter, for example, originally referred to 'the sick'[188] when it was first published in 1974, then 'the patient'[189]

[182] 'Dans l'hôpital, humaniser quoi? Humaniser tout!' (Aurousseau in MAP-HP 2009)
[183] 'Depuis la première guerre mondiale de véritables "usines de soins".' (Ngo Ba Tay 1963: 22)
[184] 'L'humanisation de l'hôpital est avant tout une question d'ethique médicale.' (Ngo Ba Tay 1963: 80)
[185] As in the US, the increase in the discourse of humanisation of hospitals involved a debate concerning de-institutionalisation, particularly in the psycho-medical context, which, in turn, coincided with the rise of psychotropic drugs. The role of France in this development is summarised by Lézé (2014: 316) as follows: 'After liberation, the French *désaliéniste* movement of deinstitutionalization sought to bring both patient and treatment back into society. In 1952, at the Hôpital Sainte-Anne in Paris, Jean Delayand Pierre Deniker showed that chlor-promazine (Largacril or Thorazine) was efficient in schizophrenic patients. This therapeutic revolution of international scale launched the psychopharmacology of neuroleptics (1955) and provided support for the deinstitutionalization movement'.
[186] 'Circulaire relative à l'humanisation à l'hôpital' (Nardin 2009: 23)
[187] 'Dans l'hôpital, humaniser quoi? Humaniser tout! Du moins tout ce que nous pourrons.' (Aurousseau in MAP-HP 2009)
[188] 'Chartre du malade hospitalisé' (1974)
[189] 'Chartre du patient hospitalisé' (1995)

in 1995 (UNAF 2007), while its latest edition of 2006 refers to 'persons hospitalised'[190] (Ministère de la Santé 2006). Moreover, the term 'humanisation' itself denotes an anticipated shift in focus away from the sick/ness to the individual human being. Equally, current hospital terms like 'service', 'reception', 'well-being', 'quality', 'rights' are indicative of an intended change in hospital culture.

It is this intended change which is evident in the conceptualisations of *Espace Arthur*, *Maison de Solenn* in Paris and E.M.A in Marseille, in their reiteration that it is the 'subject' that counts, not the illness (Rufo 2007: 246). The aforementioned brochure of *Arthur Espace* emphasises the 'individual' 'without pathological stigmatisation'[191]. While it employs terms such as '*jeune*', '*adolescent'* but also '*patient*'[192] (APHM 1999) to address its subjects, the brochure of *Maison de Solenn* only resorts to expressions such as *'les adolescents hospitalisés'*[193] (APHP 2005) or *'les jeunes hospitalisés'*[194] (Rufo quoted in APHP 2005), arguably indicative of a further shift in humanising discourse. Similarly the official term used to describe both *Maison de Solenn* and E.M.A is *Maison des adolescents*[195] rather than the German equivalent of *Klinik für Jugendpsychatrie* (hospital for adolescent psychiatry) or the British and American one of *Adolescent Mental Health Centre.* Rufo (2007: 94) explains the rationale behind this expression: '*Maison des adolescents*, the word has a meaning. It says that they should make these places their own, they should not feel like being in a hospital but at home to some degree, and finally, they should not feel embarrassed or ashamed to be visited by their loved ones'[196].

Not having the impression of being hospitalised, feeling at home, letting life in - these are principles said to be not just at the heart of the *Maison des adolescents* and *soins culturels*, but also the movement of humanisation of hospitals in general, which equally foregrounds the role of culture in the treatment of illness or rather human beings.

Culture in the form of literature, fine art and music was granted an important role in the French discourse of medical humanisation (MAP-HP 2009). Hospitals were fitted with libraries (figure 66), for example, art works were installed in public areas, music and theatre workshops organised, art-based occupational treatment offered (MAP-HP 2009). While these measures are reminiscent of some of the cultural activities propagated by asylum reformers during nineteenth century moral treatment of the "insane" (3.2), in centralised France with its 'unified health care policy' (Pietikainen 2015: 95) they were

[190] 'Chartre de la personne hospitalisée' (2006)
[191] 'L'objectif est d'aider le jeune à traverser un moment difficile, passerelle entre l'Enfance et l'Âge adulte, sans stigmatisation de la pathologie, en prenant compte de l'individu en construction dans sa globalité.' (APHM 1999:5)
[192] 'young', 'adolescent', 'patient' (APHM 1999)
[193] 'the adolescents hospitalised' (APHP 2005)
[194] 'the young hospitalised' (Rufo quoted in APHP 2005)
[195] House of adolescents
[196] 'Maison des adolescents, le mot a un sens. Il dit qu'ils doivent pouvoir s'approprier les lieux, ne pas avoir l'impression d'être à l'hôpital, se sentir un peu chez eux, afin de n'éprouver ni honte ni gêne à recevoir la visite de ceux qu'ils aiment'. (Rufo 2007: 94)

coordinated and funded by the state. In 1971, for example, the 'Committee of hospital arts and aesthetics'[197] (CAEH) was founded. Its role was 'to establish a collection of contemporary art for the public spaces of hospitals, and to develop proposals concerning the architecture, the design and the colour scheme in the process of renovations of the hospital services'[198] (Nardin ed. 2009: 200).



figure 66: A French hospital library, 1937

Part of this cultural humanising discourse in relation to hospitals was also a consideration of ways to make the dress worn by both medical staff and patients more individual and fashionable (MAP-HP 2009). Accordingly, in 1990 *Assistance Publique – Hôpitaux de Paris* (AP-HP) launched a competition among the *grands couturiers*, the established French fashion designers, to modernise the uniforms of hospital receptionists (MAP-HP 2009). The houses of Balenciaga, Guy Laroche and Jacques Esterel took part. While the results were not put into practice, this competition exemplifies the nature of the French discourse of humanisation in hospitals which incorporated culture in general and (fashionable) dress in particular, thus constituting part of the conditions of possibility enabling psycho-medical therapeutic practices like *vêtothérapie.*

[197] La Commission des arts et de l'esthétique hospitalière (CAEH)
[198] 'Cette commission a pour objectifs de constituer un fonds d'art contemporain destiné aux espaces publics des hôpitaux, et de formuler des propositions touchant l'architecture, le design et le choix des couleurs dans les opérations de rénovation des services hospitaliers.' (Nardin ed. 2009: 200)

5.1.3 '*La mode, c'est la culture.*'[199]: 'Fashion is culture,' Fashion is French culture – *vêtothérapie* as part of *soins culturels*

> Dr. Webster, in his notes on foreign lunatic asylums, published in the 'Psychological Journal of Medicine,' speaks of the bright head-dresses and vivid shawls used in France, as giving a cheerful appearance to the assembled inmates. Nothing less could be expected from the known disposition of a people of whom it has been said, that if any man among them was thrown naked into the sea, he would rise up clothed from head to foot with a sword, bag-wig, and ruffles to boot. In the present matter they have been wiser in their generation than ourselves; and we can imagine with what surprise they would learn that at Hanwell, the most celebrated English establishment for the treatment of the insane, patients are rewarded for good conduct by allowing them to wear a fancy waistcoat. (anon. 1857: 365–6)

The above observation by English asylum inspector Andrew Wynter[200] is a reminder that modern day dress-related therapeutic practices such as *vêtothérapie* follow a long tradition of employing dress in the psycho-medical setting to work on the self (Ch.3). Moreover, it illustrates the existence of a naturalised association of fashion with France in the mid-nineteenth century. In fact, in as early as 'the late seventeenth century across Europe 'fashion began to be referred to by its French name, *la mode*, and to be considered something inherently and indisputably French' (DeJean in Rocamora 2009: 25). In turn, '[t]he eighteenth century,' according to Jones (2004: 211) 'was a particularly significant moment […] French society witnessed the emergence of a new fashion culture [one that forged] an intrinsic link between fashion, frivolity, Frenchness and femininity' (3). The enduring discursive construction of fashion as intrinsically French, as intrinsically Parisian, because French fashion is centralised in the capital, is forcefully demonstrated by Rocamora (2009). 'French fashion is conflated' with Paris, she argues (33) and, correspondingly, French fashionable femininity with '*la Parisienne'* (99).[201]

As such, fashion forms part of the French cultural discourse. 'A national culture is a discourse,' explains Hall (1992: 292–3), 'a way of constructing meanings which influences and organises both our action and our conception of ourselves'. Thus, when Rufo (AI, 3.4.2008) told me: '*La mode, c'est la culture*,' 'Fashion is culture,' he refered to French culture. 'Because in France the notion of fashion is a cultural notion,'[202] he specified (Rufo, AI, 3.4.2008). In his case this notion is not restricted to women. He highlights the value of fashionable dress and *vêtothérapie* for both female and male patients. However, in how far it constitutes a gendering technique will be touched on below (5.3).

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[199] 'Fashion is culture.' (Rufo, AI, 3.4.2008)

[200] As previously mentioned (3.2.2), although published anonymously his authorship can de deduced from a reprint of the essay.

[201] This discursive construction of the link between France and female fashion in particular is also evident in the multitude of articles and style guides giving advice on how to dress like a Frenchwoman or a Parisian (e.g. de la Fressange 2011, Berest et al. 2011, Doré 2015, Lecoeur 2013, Martine 2015, Scott 2012, Sommers 1988) in contrast to very limited writings on how to dress like a German woman, for example, or an American one.

[202] 'Parce que, par exemple, si on dit la France, vous voyez, parti sur la notion de mode, la notion de mode est une notion culturelle en France.' (Rufo, AI, 3.4.2008)

As argued above, the treatment approach of *soins culturels* is based on a particular notion of culture, even if not explicitly defined. 'Culture', in a general sense, has been fruitfully described by cultural theorist Grant McCracken (1990: XI) as 'the ideas and activities by which we construe and construct our world'. More specifically, the prevailing notion of culture in France has been portrayed as follows:

> The text- and media-based, aesthetic notion of culture […] constitutes the dominant notion of culture in […] France nowadays, found in terms and institutions such as *Ministère de la Culture*, *Centre culturel*, *biens culturels* […] or *Maison de la Culture*. On the one hand [it] is connected to the idea of a limited sphere of cultural production, which is aesthetically valorised; on the other, to the idea of a canon of texts, monuments or works of art that are of enduring character, that embody collective or universal and moral aesthetic value, and are present in cultural media and institutions, and get passed on for those reasons.[203] (Lüsenbrink 2004: 11)

The 'ideas and activities' McCracken invokes are aesthetically underwritten in France, according to Lüsenbrink. Thus, the notion of the cultural in *soins culturels* is an aesthetic one. It is also connected although not reduced to high culture, to 'haute culture' as Bourdieu (1993: 132) terms 'goods of legitimate culture' in a talk aptly connecting French 'haute couture' to (high) culture. Fashion in France is not only considered to be part of the *biens culturels*, the national heritage which has for centuries been endorsed by the state[204], but it is culture in itself, as Rufo asserted. As such, fashionable dress can be incorporated into a medical discourse on humanisation of hospitals as well as a cultural therapeutic psycho-medical approach. The conditions of possibility of the therapeutic practice of *vêtothérapie* not only include its embeddedness in the concept of *soins culturels* and in turn the underlying discourse on the humanisation of hospitals which foregrounds culture, but also a particular aesthetic notion of culture in France, which includes fashion, a culturally specific understanding of fashion itself. Thus, in the form of *vêtothérapie* fashion is said to be able to become a treatment, endorsed municipally and federally[205], and regarded by some as 'the culmination of all treatments' (Battista in Sage 2001: 18), as I discuss below.

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[203] '*Der text-und medienbezogene, ästhetische Kulturbegriff* […] repräsentiert den heute in […] Frankreich dominierenden Kulturbegriff, der sich in Bezeichnungen und Institutionen wie *Ministère de la Culture*, *Centre culturel*, *biens culturels* […] oder *Maison de la Culture* findet. Mit diesem text-und medienbezogene, ästhetische Kulturbegriff ist zum einen die Vorstellung einer begrenzten Sphäre der kulturellen Produktion verbunden, die ästhetisch valorisiert wird; und zum anderen die Vorstellung einen *Kanons* von Texten, Monumenten oder Kunstwerken, die einen zeitüberdauernden Charakter aufweisen, kollektive oder universelle ästhetische und moralische Werte verkörpern und aus diesen Gründen in kulturellen Medien (wie Schulbüchern) und Institutionen (wie Kulturinstitutionen, Schulen, Akademien) present sind und tradiert werden.' (Lüsebrink 2004: 11)

[204] The endorsement of fashion through the French state dates back to the reign of Louis XIV. His finance minister Jean-Baptiste Colbert (1619–1683) began to actively promote French fashion and luxury goods (Rocamora 2009, Steele 1988). Moreover, several government-funded professional bodies have been active in supporting fashion in France, most importantly the *Chambre Syndicale de la Haute Couture* which turned into today's *Fédération Française de la Couture du Prêt-à-Porter des Couturiers et des Créateurs de Mode*, whose primary mission is: **'**To preserve Paris' position as the world Capital of Fashion Design' (http://www.modeaparis.com/2/federation/Missions-actions-goals 9.12.2016)**.** More recently government-allied and co-funded organisations such as *Association Nationale de Développement des Arts de la Mode* (ANDAM) or *l'Institut pour le Financement du Cinéma et des Industries Culturelles* (IFCIC) have focused on supporting young fashion designers. While the state owned investment bank BPI launched a fashion funding programme *Mode et Finance* to support small to medium fashion businesses.

[205] On a municipal level *vêtothérapie* is supported through the IMM, now MMMM, on a state level through the *Fédération Française du Prêt-à-Porter Féminin* (FFPPF) as will be addressed later on (5.5).

5.2 'The culmination of all treatments': *Vêtothérapie* at *Espace Arthur*

> The vétotèque offers a space of expression to the adolescents, a space of discovery, of research, from choice to appropriation, recognition, acceptance and participation – by way of a concept, which is highly present in our society: fashion.'[206]
> Roselyne Descloux (et al. 2001), head nurse

> The scheme isn't really about fashion: it's about self-confidence and using clothes as a way to express yourself. It shows clothes can be therapeutic.
> agnès b. (in Groskop 2001b: 63), fashion designer and sponsor of *vêtothérapie* since its foundation

> Clothes shopping for adolescents.[207]
> Christian Guirlinger (2000), CEO of *Caisse d'Epargne Provence Alpes Corse*, one of the sponsors of the *vêtothèque*

> [A] clothing store.[208]
> Bernadette Chirac (in Sultan 2001b), president of *Fondation Hôpitaux de Paris-Hôpitaux de France*

> [S]ome people think we have a fashion boutique here – that's rubbish. This is not Club Med for troubled teenagers. We use clothes in a very specific way to make them confront things they would rather not think about.
> Dr Michèle Battista (in Groskop 2001a: 49), head psychiatrist

> Many girls are reluctant to get in front of the mirror, so often I will put on something and say, "Well, how does it look on me?" It makes some less afraid of other people's bodies and of comparisons. It becomes a game.
> Martine (in Groskop 2001b: 62), psychiatric nurse 'supervising 'trying-on sessions''

> Not forgetting that putting on a garment enables you to reclaim your body and regain self-respect.[209]
> Sandrine (in Gerez 2002), psychiatric nurse 'animating the *vêtothèque'*

> Even though I'm not a doctor, this project is the most rewarding since the foundation of the *Institut de la Mode*. I was able see how dress and the other *soins culturels* can be a source of pleasure. Like a ray of sunshine on the haggard skin of an anorectic.[210]
> Maryline Bellieud-Vigouroux (in Maziers 2001), co-founder of the *vêtothèque* and former president of the *Institut Mode Méditerranée* (IMM)

> Dress does not cure.[211]
> unnamed nurse (in Rotman 2001)

> In all civilisations dress is the first element, the first cultural sign. If we advocate the idea of *soins culturels*, if we don't hesitate to let music, art and sport enter into the hospital, then dress also has a legitimate therapeutic position there. Getting dressed is everywhere and has forever been a sign of respect towards oneself and others. Is it not terrible to see a loved one, on a drip, always dressed in a hospital night gown?[212]
> Professor Rufo (in Rachline 2000: 133), head of unit

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[206] 'L'atelier vétôthèque propose aux adolescents un espace d'expression allant la découverte, de la recherche, du choix jusqu'à l'appropriation, la reconnaissance, l'acceptation, l'appartenance, au travers d'un concept très présent dans notre société: la mode.' (Descloux et al. 2001)

[207] '[U]n "Shopping" de vêtement pour adolescent.' (Guirlinger 2001)

[208] 'Comme à l'hôpital de la Timone, à Marseille, une boutique de vêtements.' (Chirac in Sultan 2001b)

[209] 'Sans oublier, qu'enfiler un vêtement permet de se réapproprier son corps. Et retrouver le respect de soi-même.' (Sandrine in Gerez 2002)

[210] 'Même si je ne suis pas médecin, ce projet est le plus gratifiant depuis la création de l'Institut de la Mode. J'ai pu voir combien le vêtement et les autres soins culturels pouvaient être sources de plaisir. Comme un rayon de soleil sur le peau décharnée d'une anorexique.' Bellieud-Vigouroux (in Maziers 2001)

[211] 'Le vêtement ne guérit pas.' (in Rotman 2001)

[212] 'Dans toutes les civilisations, l'habit est le premier élément, le premier signe culturel. Si l'on défend la notion de "soins culturels", si l'on hésite pas à faire entrer la musique, l'art, le sport à l'hôpital, alors les vêtements y ont eux aussi une place thérapeutique légitime. S'habiller est partout et depuis toujours une marque de respect à l'égard de soi-même et des autres. N'est-ce pas terrible de voir quelqu'un de proche les bras perfusés, vêtu à toute heure d'une chemise de nuit de l'Assistance publique?' (Rufo in Rachline 2000: 133)

A space of expression and self-discovery through fashion, not about fashion, a clothes shop, not at all a clothes shop, a game, a form of therapy, no therapy, a source of pleasure, a humanising agent – according to the various people involved in developing, sponsoring and practicing *vêtothérapie*, this therapy constitutes or is aimed at very different things. Contradictory descriptions are given that are, in turn, indicative of distinct notions of dress and fashion, their relationship to the self, and indeed therapy. The above statements, made in the first two years after the inauguration of the *vêtothèque* at *Espace Arthur,* exemplify the variety of competing 'discursive elements' (Foucault 1976/1990: 100) that exist in relation to this treatment approach. Consequently, *vêtothérapie* neither constitutes a coherent discourse nor a clearly defined practice. Amplified by the fact that there are no treatment manual or therapeutic guidelines, it is better understood as an umbrella term for different dress-related practices undertaken in the *vêtothèque*.

This section explores some of these 'discursive elements' that make up *vêtothérapie* as it was first developed in 1999 in Marseille. It investigates the notions of dress, fashion, self and therapy underpinning this treatment approach but also the naturalisations involved. Focusing predominantly on what was said and written by the people in charge at the time, and on what has been passed on in the form of direct quotations in articles published in the press or as reconstructions in the interviews I conducted, this section analyses the thinking behind *vêtothérapie.* In doing so it centres on the key people involved in the development of this treatment approach: Rufo, Bellieud-Vigouroux, Battista, as well as nursing staff. The following section (5.3), in turn, examines some of the different ways in which these were put into practice in the three hospitals that have housed *Espace Arthur* to date.

In the autumn of 1999, shortly before the inauguration of the *vêtothèque* Marcel Rufo (1999) gave a conference paper entitled 'The habit makes the monk'[213], a play on the French allegory which normally signifies that 'clothes do not make the man'. He outlines his understanding of the role of dress in the hospital context and asks if patients' gowns, as a vestimentary manifestation of their illness, do not run the risk of further excluding them from the world, of making them feel inferior (Rufo 1999: 8–9). 'The respect of patients and their integration into the world doubtlessly passes through their self-presentation,'[214] Rufo (9) maintains and reasons: 'Is not the way we dress symptomatic of being well and in good spirits? To present oneself in the most suitable, pleasant and beautiful way constitutes one of the first signs of a good psychological and social life'[215].

[213] 'L'habit fait le moine.' (Rufo 1999) Normally the French saying goes: 'L'habit ne fait pas le moine.'
[214] 'Le respect des patients et leur intégration au monde passe sans doute par leur présentation.' (Rufo 1999: 9)
[215] '[L]a façon dont on s'habille n'est-elle pas significative d'un bien-être, d'un bon moral? Se présenter à autrui sous des dehors les plus adaptés, les plus agréables et les plus esthétiques est un des premiers signes d'une vie psychologique et sociale de bonne qualité.' (Rufo 1999: 9)

In our interview Rufo (AI, 3.4.2008) reiterated the title of his paper, this time in relation to adolescents: 'Clothes make the man, certainly during adolescence'[216]. He added: 'Particularly to the teenager, dress matters a lot,'[217] fashionable dress, that is, because they live in the moment, Rufo (2007: 248) argues elsewhere. What emerges from Rufo's various dress-related statements is that he deems dress important enough to integrate it into his therapeutic approach, not only because it is part of culture or because his patients are interested in it, but because he sees it as an 'indicator'[218] (Rufo 2003: 64), a form of 'self-construction'[219] thus self-revelation (in Kerchouche 2011), and as an 'antidepressant'[220] (Rufo, AI, 3.4.2008).

'Because psychologists don't examine bodies, they have to examine dress,'[221] Rufo (2003: 69) maintains in an article about *vêtothérapie*, indicative of the diagnostic role dress is seen to play in it. He also told me: in the interest of a human-centred approach to medicine, 'if you are interested in the human subject, you have to be interested in dress'[222] (Rufo, AI, 3.4.2008). Moreover, as he argues above, Rufo sees 'suitable', 'beautiful' dress as a sign of good mental and physical health, and as having a positive (or potentially negative) effect on the wearer. He thus shares both the previously discussed modern belief of the self as immanent in appearance (1.3.1) as well as the literal approach to its interpretation found in some earlier psycho-medical texts (1.3.2). 'In fact, I believe the idea is very simple,' remarked Rufo (AI, 3.4.2008) 'you dress how you feel. You feel how you dress and if you dress well then you are well in your head,'[223] reminiscent of the principle of 'Look good, feel better' propagated as part of "Therapy of Fashion" in the US in the 1960s (Ch.4). Consequently, a particular notion of dress as self-revealing, social, encouraging and humanising, is underpinning Rufo's concept of *vêtothérapie*. The relationship between dress and the self is constructed so as to legitimise this therapeutic approach: '"Taking care of oneself": the expression is self-explanatory. It is important to make yourself look good: you don't feel as bad if you succeed in pleasing yourself,'[224] maintains Rufo (2007: 88) in writing about the *vêtothèque.* Silenced in this understanding of dress is its disciplinary dimension, the obligation to take care of the self (Foucault 1984b/1988), to "be well" and "look good" – a feature of our therapy culture (1.4). Dress is naturalised as 'harmless' (Rufo 2007: 87),

[216] 'Pourtant l'habit fait le moine en tout cas en adolescence.' (Rufo, AI, 3.4.2008)
[217] 'Notamment, à l'adolescent les habits comptent beaucoup.' (Rufo, AI, 3.4.2008)
[218] 'Les habits sont révélateurs.' (Rufo 2003: 64)
[219] 'La mode est une construction de soi.' (Rufo in Kerchouche 2011)
[220] 'Je trouve que l'habit est un antidépresseur.' (Rufo, AI, 3.4.2008)
[221] 'Vous savez bien, que les "psy" n'examinent pas les corps, il faut donc bien qu'ils examinent les habits.' (Rufo 2003: 69)
[222] 'Si on s'intéresse au sujet, on est obligé de s'intéresser à l'habit.' (Rufo, AI, 3.4.2008)
[223] 'Je croix en fait, que c'est une idée très, très simple, que on s'habille comme on va quoi. On est bien comme on s'habille et quand on s'habille bien c'est quand va bien dans la tête.' (Rufo, AI, 3.4.2008)
[224] 'Prendre soin de soi, l'expression est explicite. Se faire beau, c'est important: on va moins mal si on réussit à se plaire.' (Rufo 2007: 88)

and if 'suitably' employed positive – 'an antidepressant' whose potential side-effects or differing perceptions of remain unacknowledged.

In formulating the aims of *vêtothérapie* Bellieud-Vigouroux (in Groskop 2001a: 48), who is referred to as its key initiator by all my interviewees, shares much of Rufo's thinking but foregrounds the role of beauty and pleasure in relation to fashion:

> We began to think that clothes could be used as a form of behavioural therapy. We wanted to get away from the impersonal. After all, regulation hospital pyjamas and beige walls are depressing. The idea is that the patient should see that life can be beautiful. It is about treating the person as an individual.

Elsewhere she details:

> We want to discourage girls from wearing the clothes they wore when they were ill and start seeing themselves as someone who enjoys their appearance. […] We see fashion as a positive thing. Clothes should be used to enhance your mood. The idea that clothes could be a medicine for the body is something very exciting. (Vigouroux in Groskop 2001b: 61)

Fashion is 'useful not futile'[225] maintains Vigouroux (in Rault 2001: 76). She insists on its direct 'therapeutic benefits,' described by her as follows: 'Even the anorectics, who cannot stand to look at themselves finally take pleasure in liking themselves. When they drown in a size XS they realise that they are not fat. And the second skin of the garment reconciles with the first'[226] (Bellieud-Vigouroux in Maziers 2001). Bellieud-Vigouroux's unquestioningly positive take on fashion and the effect she thinks it can have on people extends beyond the hospitalised, as she explained in our interview: 'Everything that concerns dress can only be of benefit to the patient or the healthy individual. […] Dress is important and it is an opportunity that we all have even without it being a therapeutic element'[227] (Bellieud-Vigouroux, AI, 18.8.2013). Fashionable dress is naturalised as pleasurable, positive and useful by Bellieud-Vigouroux, as by Rufo. That it might be seen as normative, prescriptive, constricting, or 'a sight of struggle' (Wilson 1992: 14) does not find acknowledgement. 'Fashion, that's my metier, that's a passion for me and not a pain,'[228] Bellieud-Vigouroux rationalised (AI, 18.8.2013). However, the opportunity she portrays fashion as is also connected to a responsibility: 'Dress is really a tool for communication. […] You have to present yourself well. Dress is tremendously important. It is major, I think!'[229] (Bellieud-Vigouroux, AI, 18.8.2013). Thus, fashion, which is mostly equated with dress by Bellieud-Vigouroux and the other persons involved in

[225] 'J'ai toujours pensé que la mode n'est pas si futile mais quelle doit être utile.' (Vigouroux in Rault 2001: 76)
[226] 'Même les anorexiques qui ne supportent pas de croiser leur regard prennent enfin plaisir à se plaire. Quand elles flottent dans une taille XS, elles réalisent qu'elles ne sont pas grosses. Et la deuxième peau qu'est le vêtement réconcilie avec la première.' (Bellieud-Vigouroux in Maziers 2001)
[227] 'Mais, personnellement, au contraire, tous qui peut toucher aux vêtements ne peut être que gagnant pour le patient ou l'individu bien portant. […] C'est important les vêtements et c'est une chance que nous avons nous, de pouvoir utiliser sans ça soit une élément thérapeutique.' (Bellieud-Vigouroux, AI, 18.8.2013)
[228] 'La mode, c'est mon métier, c'est une passion pour moi et ce n'est pas une souffrance.' (Bellieud-Vigouroux, AI, 18.8.2013)
[229] 'Le vêtement c'est vraiment un outil de communication. […] Il faut bien se présenter. Le vêtement c'est vachement important. Je trouve, pour moi, c'est capital!' (Bellieud-Vigouroux, AI, 18.8.2013)

vêtothérapie, constitutes not only an opportunity to re/create the self but also an obligation to care for the self according to her, as for Rufo. In relation to *vêtothérapie* this means that patients are not only 'invited' to find pleasure in fashion and to beautify themselves, they are also obliged to do so. Beauty is their duty, as it was for the patients of "Therapy of Fashion" (Ch.4). Their appearance is seen as part of the contemporary project of a changeable and perfectible self (1.4.2).

According to Bellieud-Vigouroux (AI, 18.8.2013) it is Michèle Battista who has to be credited with the realisation of her idea of the *vêtothèque*, who took it into her hands and brought it to life. During her time as head psychiatrist at *Espace Arthur*, between 1999 and 2003, Battista was most directly involved in the treatment, as evidenced in many of the press articles. She expresses her understanding of *vêtothérapie* as follows:

> This is only one activity among many, but it is, in a sense, the culmination of all others. Our idea is to create an intermediary space, such as the fashion library that breaks down the barriers. […] We are asking [the adolescents] to come to terms with themselves and their own bodies and to find their own image. […] Here we are inviting them to develop their own identity. (Battista in Sage 2001: 18–9)

This statement conveys not only her enthusiasm for this treatment approach, but also three of her priorities in its application: breaking barriers, acknowledging one's body and constructing an identity. One of the key functions Battista (in Revilla 2001: 16) attributes to *vêtothérapie* is 'to help [the adolescents] to get going again'[230]. She explains: 'Because they are depressed and focused on themselves, nothing is of importance, neither their existence, nor their appearance'[231] (Battista in Rault 2001: 77). Battista (in Revilla 2001: 16) maintains that 'You have to reignite their appetite and dress is a good tool. The fitting can be considered as a game, the kids talk among themselves, try on, search for themselves. It is a first sign of the road to recovery'[232]. Underpinning her understanding of *vêtothérapie* is also a belief that looking "good" makes one feel "good", already voiced by Rufo and Bellieud-Vigouroux: 'The idea is that being beautiful is part of the well-being of adolescents. Beauty heals and creates the desire to beautify yourself' (16). Battista (in Revilla 2001: 16–7) adds: 'Dress is a means of communication with others. It is like a remedy that facilitates words and that enables desire to emerge'[233]. While Rufo emphasises dress in this context as revealing and conceptualises *vêtothérapie* as a diagnostic indicator, Battista (AI, 2.4.2008) insists on its social function: 'first and foremost it is about establishing contact with the adolescents'[234].

[230] '[C]'est les aider à redémarrer.' (Battista in Revilla 2001: 16)
[231] '[P]arce qu'ils sont déprimés, recentrés sur eux-mêmes, que rien n'a d'importance, ni leur existence, ni leur apparence.' (Battista in Rault 2001: 77)
[232] '[C]'est les aider à redémarrer. […] Il faut lui donner envie à nouveau, et le vêtement est un bon outil. L'essayage peut être considéré comme un jeu, les enfants se parlent entre eux, essayent, se cherchent. C'est une premier signe que le chemin de la guérison est pris.' (Battista in Revilla 2001: 16)
[233] 'L'idée, c'est qu'être beau participe au bien être des adolescents. Le beau soigne et donne envie de se l'approprier. Le vêtement est un moyen de communication avec l'autre. C'est une sorte de médicament qui facilite les mots et qui permet l'émergence d'un désir.' (Battista in Revilla 2001: 16–7)
[234] 'Non, c'est un prise de contact tout d'abord.' (Battista, AI, 2.4.2008)

Another element repeatedly emphasised by Battista (in Groskop 2001a: 48) in explanations of *vêtothérapie* is the body:

> All the teenagers we treat have one thing in common: they hate their bodies. Fashion therapy is just part of the process we take them through: it is about learning to accept their appearance and the image that they show to the world.

Battista (2000) situates the body 'at the centre of the process of adolescence,' and maintains: 'It is through the body that the suffering is expressed'[235]. She told me: 'It is the body that speaks, because if they could put it into words, well, they wouldn't be adolescents'[236] (Battista, AI, 2.4.2008). The 'suffering' articulated through the body refers to 'scarification, food deprivation or excess, even suicide attempts,' according to Battista (in Sultan 2001a: 77), who perceives the role of dress in this context as follows: 'Dress helps [the adolescents] to become reconciled with themselves. It constitutes a second skin that enables you to better accept the first one'[237]. Moreover, she considers fashionable dress to be of particular relevance in the treatment of adolescents, as 'the idea of change'[238] (Battista, AI, 2.4.2008) is inherent to both. 'By changing every six months, fashion perfectly accompanies adolescence,' Battista (in Jacquier 2004: 404) maintains 'which is characterised by metamorphoses of the body'[239]. Fashion is naturalised by Battista as being transient, as changing twice a year, regardless of the artificial acceleration constructed discursively by the fashion media and industry. She regards fashionable dress as 'an intermediate area between the body of the adolescent and the exterior world. It is an expression of the changing body' (in Gerez 2002). Battista adds in relation to identity construction, another of her priorities in *vêtothérapie*: 'It allows teenagers to imagine themselves differently and offers them the possibility to be someone else. Being someone else in order to become oneself'[240]. Throughout her years of employing *vêtothérapie,* first with adolescents at *Espace Arthur* then with children at a day clinic in Fréjus, she reiterates that it constitutes an opportunity for the kids to 'try on different identities[241]' (AI, 2.4.2008), to 'develop their own identity' (in Sage 2001: 19), to 'reconstruct an identity for themselves through dress'[242] (2004). Thus, the notion of self conveyed in Battista's verbal and written statements is not only embodied, dressed and social, but also one that can and should be remade – through dress. Fashionable dress, in turn, is seen as unreservedly positive in its effect, empowering not prescriptive,

[235] 'Le corps est au centre du processus adolescent. […] c'est par là que la souffrance s'exprime.' (Battista 2000)
[236] 'C'est le corps qui parle parce que s'ils pouvaient mettre des mots, eh ben, ils ne seraient pas adolescents.' (Battista, AI, 2.4.2008)
[237] 'C'est avec son corps qu'un adolescent exprime sa souffrance – via des scarifications, des privations ou des excès alimentaires, voire des tentatives de suicide. Le vêtement l'aide à se réconcilier avec lui-même, il agit comme une seconde peau qui permet de mieux accepter la première.' (Battista in Sultan 2001a: 77)
[238] 'Parce que la notion de changement va avec l'adolescence.' (Battista, AI, 2.4.2008)
[239] 'En changeant tous les six mois, la mode accompagne parfaitement le temps de l'adolescence caractérisé par les métamorphoses du corps.' (Battista in Jacquier 2004: 404)
[240] 'Le vêtement est un espace intermédiaire entre le corps de l'adolescent et le monde extérieur. C'est l'expression de l'évolution du corps. Il permet aux adolescents de s'imaginer autrement et leur offre la possibilité d'être autre. D'être autre pour devenir soi.' (Battista in Gerez 2002)
[241] 'd'essayer des identités proposées' (Battista, AI, 2.4.2008)
[242] 'se reconstruire ainsi une identité' (Battista 2004: 24)

naturalised as a tool for self-discovery and reconstruction. It is granted a central role in enabling both the communication with and among adolescents, and an approach to and reconciliation with the body of adolescents on the basis of their common changeability, according to Battista.

One of the most valuable sources on the concept of *vêtothérapie* takes the form of a short unpublished manuscript written by the head nurse of *Espace Arthur* together with three other nurses and intended for internal use only (Descloux et al. 2001). 'And if clothes made the man, Fashion as therapy'[243] the title reads. While it appears to collate some of the central ideas common to the practitioners in charge, it is the only document to explicitly put into writing the main concept and objectives of *vêtothérapie.* As such it forms part of what Foucault (1976/1990: 28) terms the 'internal discourse of the institution', defined as 'the one it employed to address itself, and which circulated among those who made it function'. In this paper, as quoted at the beginning, the *vêtothèque* is presented as a space of 'expression', 'discovery', 'research', 'recognition', 'acceptance' and 'participation' through fashion, 'a concept, which is highly present in our society,' as they put it. The main aims are summarised as follows:

> To build a relationship with oneself: regaining self-respect by way of accepting one's body. To build a relationship with one's peers: allowing group belonging, the opportunity for mutual recognition and acceptance. The aim being to help the adolescent construct some sort of self-image in accordance with his personality and taste.[244] (Descloux et al. 2001)

Fashion is put forward as a prevalent form of self-awareness and self-knowledge, a tool to express, recognise, respect and accept oneself, as done by Rufo and Battista. Linked to such a claim is the naturalised assumption that one should know oneself, an obligation to express the self and the process of confessional self-revelation that goes along with discovery and recognition. Moreover, fashion, in the form of *vêtothérapie* is seen to have a positive impact on the bodies of patients, to aid their physical self-acceptance. This naturalised belief is re-iterated as follows: 'The hospitalised adolescents […] have difficulties in existing in their bodies, hence dress can act as a therapeutic tool'[245] (Descloux et al. 2001).

In this manuscript fashion in general and the *vêtothèque* in particular are portrayed as a 'means of communication'[246] (Descloux et al. 2001) and a social tool. The authors include the following citation: "Tell me how you dress and I will tell you which

[243] 'Et si l'habit faisait le moine, La mode en tant que soin' (Descloux et al. 2001)
[244] 'Les objectifs thérapeutiques de cet atelier: Créer un lien avec soi même: restaurer l'estime de soi par l'acceptation de son corps. Créer un lien avec se pairs: permettre l'appartenance à un groupe, la possibilité d'une reconnaissance et d'une tolérance mutuelle. Le but étant d'aider l'adolescent à se construire une sorte de look intérieur en respectant sa personnalité et ses goûts.' (Descloux et al. 2001)
[245] 'Les adolescents hospitalisés […] ont de fait une difficulté à exister dans leur corps, le vêtement peut alors apparaitre comme un outil thérapeutique.' (Descloux et al. 2001)
[246] 'un moyen de communication' (Descloux et al. 2001)

group you belong to,"[247] indicative of a literal interpretation of dress, similar to the one expressed by Rufo. Moreover, through *vêtothérapie* the adolescents are meant to 'build relationships' with other patients, 'to find their place in the group'[248]. Evidently conceived as a group therapy, fashion and the act of dressing are naturalised by all the practitioners considered here as positive, socialising phenomena. They are also conveyed as opportunities to 'imagine oneself differently'[249] (Decloux in Gerez 2002), to 'adapt to beauty', because 'beauty heals'[250] – two further common key naturalisations. Moreover, what remains unacknowledged throughout these accounts is the aspect that underpinning the notion of re-imagining the self, of restyling one's self-image, lies a duty to care for the self in terms of appearance, as mentioned above, to perfect and beautify oneself. In how far such naturalisations leave room for alternative perceptions, possible apprehensions and resistance will be discussed below (5.3).

Among the different practitioners involved in *vêtothérapie*, Michèle Battista is the only one found to reflect on principles for selecting patients to participate in this therapeutic approach, the only one to suggest that it might not be suitable for everyone.

> We have very strict criteria on who this treatment is appropriate for. Very often we are talking about children who have not laughed about anything for a long time. Their family lives revolve around conflict and around their illness. Life is no longer fun for them. A therapy like this makes them laugh – dressing up is something inconsequential, something fun. It takes them out of themselves. (Battista in Groskop 2001a: 49)

In this statement Battista not only draws attention to the criteria and care applied to *vêtothérapie*, but also highlights the playfulness of the treatment, its "fun factor", commented on by most of its practitioners. Thereby it illustrates the complexity of the role fashion is seen as playing in this treatment approach, as do the different 'discursive elements' (Foucault 1976/1990: 100) brought together here that form part of its conditions of possibility. *Vêtothérapie* in turn signifies slightly different things to the various practitioners involved, who, however, hold in common an invariably positive notion of fashion, as well as the view that it is of particular relevance to teenagers. Consequently, the inclusion of fashionable dress in the psycho-medical treatment of adolescents is justified by all, but it is also relativised by most, making for a multi-layered if slightly contradictory ground on which the treatment is built. Said to be the 'culmination', to be impactful, it is also described as 'harmless' fun, its core activity as 'inconsequential'. Some of the therapeutic practices that have emerged from this somewhat elusive discourse will be analysed in the following section.

[247] "[D]is-moi comment tu t'habilles, je te dirai à quel groupe tu appartiens." (Descloux et al. 2001)
[248] 'trouver leur place au sein d'un groupe' (Descloux et al. 2001)
[249] 'Le vêtement permet aux adolescents de s'imaginer autrement.' (Decloux in Gerez 2002)
[250] 'Le beau soigne et donne envie de se l'approprier.' (Descloux et al. 2001)

5.3 *Espace Arthur*: From Hôpital La Timone to *Espace Méditerranéen de l'Adolescent* (E.M.A) – the practice of *vêtothérapie* in Marseille

5.3.1 'A remedy that facilitates words': *Vêtothérapie* at *Espace Arthur,* Hôpital La Timone



figure 67: Maryline Bellieud-Vigouroux with designer 'Dr Jekyll' and patient choosing garments at the *vêtothèque*, *Espace Arthur* at Hôpital La Timone in Marseille, December 2000 (censor bar added)

> But the adolescent finds it difficult to take the first step to make a choice, he is depressed, self-centred, nothing is of importance, neither his existence, nor his appearance. Assisted by a member of staff he enters the [*vêtothèque*], he touches the garments in the wardrobes. He is not bothered. The suggestions given by the therapeutic team help the adolescent to access his concerns. It is necessary to desire for him. He undresses, dresses himself up in a corner. His gaze gets hooked on his image in the mirror. He agrees to leave the room with a new appearance… The others, peers give their views on this *New Other*.[251] (Battista 2000)

The *vêtothèque* at *Espace Arthur*: a table covered in clothes. Maryline Bellieud-Vigouroux holds up a jumper, black body, colourful striped sleeves, her eyes fixed on the garment. On her left a young woman, a patient with long black hair, black bomber jacket with white sleeves, a thin silver bracelet. On Bellieud-Vigouroux's right the designer 'Dr Jekyll', one of the sponsors of *vêtothérapie*. He holds up one of the jumper sleeves and smiles encouragingly at the patient. She looks sceptical. The scene is set against some wardrobes full of garments. This photograph (figure 67) was taken in December 2000,

[251] 'Mais l'adolescent a du mal à faire la démarche d'aller choisir, il est déprimé, recentré sur lui-même, rien n'a d'importance, ni son existence, ni son apparence. Aidé d'un membre de l'équipe il pénètre la salle de "psychomot'", il effleure les vêtements dans les malles. Il n'est pas concerné, les suggestions, soutenues par alliance thérapeutique, aident l'adolescent à accéder à sa demande. Il est nécessaire de désirer pour lui. Il se dévêt, se transvêt dans un coin. Son regard accroche son image dans le miroir. Il accepte de sortir de la salle dans un nouvel aspect... Les autres, les pairs donnent leurs avis sur ce *Nouvel Autre.*' (Battista 2000)

published on a local news website in 2005, in how far it was staged cannot be determined.

Juxtaposed with Battista's description of the beginnings of the process of *vêtothérapie*, it could be read as an illustration of her words of the teenager who is 'not bothered' and the 'necessity to desire for' him or her, although that 'necessity' could be regarded as a discursive construction legitimising the role of the therapist. However, in December 2000 a very similar photograph (figure 68), evidently taken at the same session was published in *La Provence*, a local newspaper. The image together with the original caption, conveys a very different atmosphere at the *vêtothèque*, one of friendly collaborative exchange, or as the article interprets it: 'Lucille, Maryline Vigouroux and Docteur Jekyll in front of the creations of the latter: their smiles show that the outcome of the *vêtothèque* of *Espace Arthur* at la Timone is a success'[252] (François 2000). In essence, the way *vêtothérapie* was practiced in the early years at *Espace Arthur* can only be vaguely reconstructed from a limited number of sources: direct quotations from practitioners and patients as rendered in press articles, some of which also include photographs (figures 68–74); memories of the practitioners recorded in their own rare writings or my interviews. Moreover, as previously addressed (Ch.2), reconstructions of any of the therapeutic settings or practices, even to some extent, the ones observed, can only ever be partial impressions of what was going on and why. In the case of early *vêtothérapie* practice press articles constitute the key source that make up this impression, although their accuracy cannot be ascertained.



figure 68: 'Lucille, Maryline Vigouroux and Docteur Jekyll in front of the creations of the latter: their smiles show that the outcome of the *vêtothèque* of *Espace Arthur* at la Timone is a success.' (Francois 2000) (censor bar added)

[252] 'Lucille, Maryline Vigouroux et Docteur Jekyll devant les créations de ce dernier: leur sourire montre que le bilan de la vêtothèque de l'espace Arthur à la Timone est une réussite.' (François 2000)

In the first two years following its inauguration *Espace Arthur* was reported on in local, national and even international press[253]. While the articles introduce the new treatment unit in general, most of them focus on the *vêtothèque*, on fashion and anorexia. Moreover, the articles published in the British press mobilise a somewhat reductive discourse that connects France to fashion and fashion to anorexia in naturalised ways, as the following headlines exemplify: 'Now French fashion has designs on teen therapy' (Rose & Allen 2001), 'Why 'fashion' therapy works for anorexics' (Goodchild & Sheppard 2001), 'Designer way to treat anorexia' (Sage 2001), 'The clinic where couture is the cure' (Groskop 2001a), 'The fashion designers who cure anorexia' (Groskop 2001b).

Although Battista (AI, 2.4.2008) remembered the comments in the press as 'very, very negative'[254], at the time she told one journalist: 'I am pleased with the attention, because it is good for us to examine what we're doing and to discuss it' (Battista in Groskop 2001a: 49). She maintained: 'The media coverage, it has to work,'[255] and argued that it was the media attention that helped to develop and spread the treatment approach, at least to Fréjus and Paris (AI, 2.4.2008).[256]

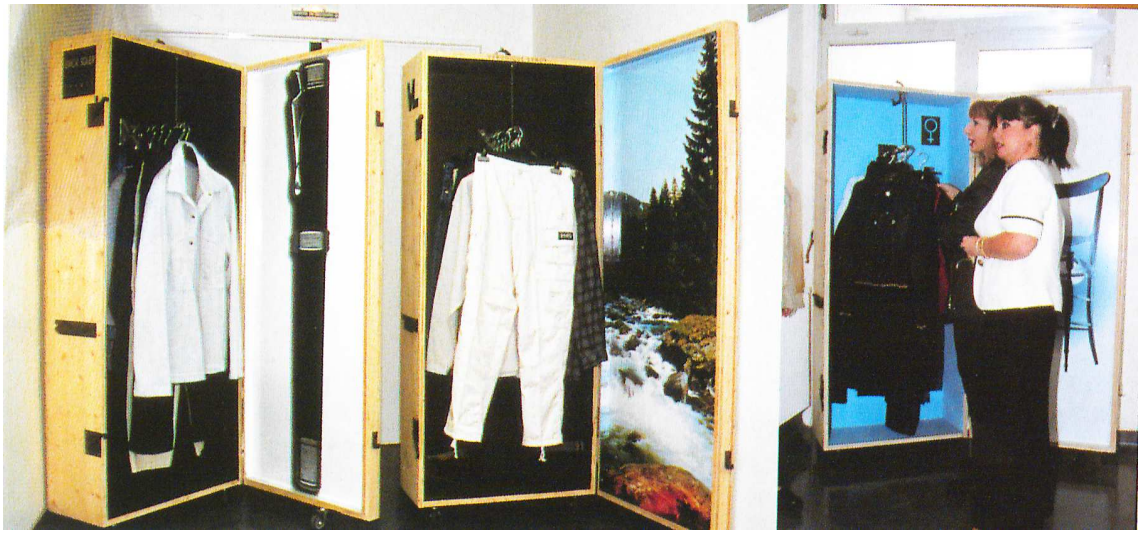


figure 69: Photographs of a *vêtothérapie* session at *Espace Arthur,* Hôpital La Timone in Marseille, published in *Vogue Paris* in May 2000

[253] The press coverage included daily newspapers (Carquain 1999, Rotman 2001, Saint-Jean 2001), weekly and monthly magazines (Gaulme 2001, Rachline 2000, Rault 2001, Sultan 2001a&b), radio programmes (Banoun 1999, Baudu 1999, Chimot 1999, Loriol 1999), and television broadcasts (France 3 2000a&b, Lacombe 1999, Leymergie 2001, Pallet 2000, Purdon 2000). Some articles featured in the British press in 2001 (Goodchild & Sheppard 2001, Groskop 2001a&b, Rose & Allan 2001, Sage 2001).

[254] 'Très, très négative.' (Battista, AI, 2.4.2008)

[255] 'La médiatisation, il faudra que ça marche.' (Battista, AI, 2.4.2008)

[256] The ethical implications of the media coverage remain unaddressed, however. As previously mentioned in the photographs which accompany the articles patients are not anonymised. The following extract published in *The Times* gives an impression of the presentation of the treatment in front of the press. It describes how *Times* photographer Alastair Miller took pictures of one patient, named here as Julie, a former model being treated for anorexia: 'Her tension was understandable. Here she was again, after two years of severe anorexia, facing a camera and being asked to try on trendy, new clothes. […] to demonstrate a new type of therapy at a unit for adolescents at La Timone University Hospital in Marseille. […] Warily, she held up a bright red top and turned to the photographer. But then, suddenly, as the camera clicked, her attitude changed. […] "Being photographed like that is a big step forward for Julie," says Dr Michele Battista. "It's difficult for anorexics to except their own image in the mirror"' (Sage 2001: 18).



figure 70: One patient and two therapists, photographs of *vêtothérapie* session at *Espace Arthur,* Hôpital La Timone in Marseille, published in *Vogue Paris* in May 2000 (censor bar added)

Returning to the way *vêtothérapie* was originally practiced at *Espace Arthur*, Battista (2000), in the opening quotation, describes the process of getting adolescents involved in the therapy: 'assisted by a member of staff he enters the [*vêtothèque*], he touches the garments in the wardrobes'. The head nurse portrays this process of initiation in similar terms: 'With the help of a member of staff, the adolescents look, touch, try on the garments. The suggestions are supported by the therapeutic team with the nurse'[257] (Descloux et al. 2001). This approach is indicative of the embodied notion of self underpinning *vêtothérapie,* as evidenced in the practitioners' conceptualisations of the treatment. Battista (AI, 2.4.2008), in particular, stressed the role of the senses: 'the interesting thing about *vêtothérapie* is that it stimulates all the senses. All of them: eyes, touch, nose. [The adolescents] even smell the garments. There have been some who put the fabrics into their mouths, sucking them'[258]. Shortly after the opening of the unit she described her approach of working with dress together with the adolescents as follows: 'We help them to get in touch with the garment, to love its shape. And by way of doing that to reclaim their bodies'[259] (Battista in Carquain 1999: 24). Battista (AI, 2.4.2008) explained that for the adolescents 'to put on a garment that's difficult'[260], but insisted that it helps them 'reclaim' their bodies, which she regards as the centre of the adolescent process, as discussed above. To 'reclaim' their bodies speaks of the kind of physical self-monitoring and work identified by Orbach (2009) as part of a contemporary discourse which holds the individual responsible for their health and well-being and sees the body as a form of project: to be known and to be improved (1.4.2) – to be achieved in this context through dress.

[257] 'Les adolescents aidés par un membre de l'équipe, regardent, touchent, essaient les vêtements, les suggestions sont soutenues par l'alliance thérapeutique avec le soignant.' (Descloux et al. 2001)
[258] 'Il faut appel, ce qui est intéressant dans la *vêtothérapie*, c'est que tous les sens sont stimulés. Tous, les yeux, le nez, la touche […] Ils les sentent même, les vêtements. Il y en a même qui se mettent à tétine, avec les tissus.' (Battista, AI, 2.4.2008)
[259] 'Nous les aidons à entrer en contact avec le vêtement, à aimer sa forme. Et par ce biais, à se réapproprier leur corps.' (Battista in Carquain 1999: 24)
[260] 'Puis se mettre en vêtement sur le corps, c'est difficile, hein?' (Battista, AI, 2.4.2008)

Battista also mentioned the role of the peers in 'breaking down barriers', reiterating the importance she grants to the social aspect of the treatment as a socialising thus normalising technology of the self. Essentially conceived as a group activity, *vêtothérapie* is based on the principle of what Battista (AI, 2.4.2008) referred to as 'narcissistic triangulation' which describes a process of imitation and indirect communication through someone relatable, in this case other adolescents. One journalist observes the interaction between participants as follows: 'A great complicity reigns among the kids, who give their views on the outfit of the other, from "you are ugly" to "that's super"'[261] (Gaulme 2001: 37). The opening times of the *vêtothèque*, when the wardrobes are moved into the centre of the *salle polyvalente* and symbolically unlocked, is divided into 'formal' and 'informal' moments (Battista, AI, 2.4.2008). Battista explained that each patient is given a personalised schedule for the different activities. However, after about ten sessions of *vêtothérapie*, the wardrobes stay open and the teenagers can use it during the designated 'informal moments' (figure 71). And they do, as Battista (in Groskop 2001b: 63) told one journalist: 'One of our biggest successes was when some of the girls organised a fashion show among themselves. I was really proud of that'.



figure 71: 'Informal' time amongst adolescents at the *vêtothèque*, Hôpital La Timone, Marseille, 2002 (censor bars added)

Another element in trying to involve the adolescents in *vêtothérapie*, according to Battista (in Rault 2001: 78), is to get them to critique what the staff are wearing, or how they dress up in the *vêtothèque*, or indeed, by letting the kids dress up the therapists: 'Because there are no uniforms in our unit, the teens can identify or reject the way in which the staff dress themselves, so they construct themselves through critiquing. We only advance through the criticism'[262]. She told another journalist:

> The other day the teens dressed me up in two different styles. The first, what the staff called "*Zézette*"[263]: micro-mini, 20cm high heels, feather boa and crop top. The other was streetwear: baggy trousers, trainers and fag, me, who never smokes… . They needed to assault me in the way I represent conformity.[264]

[261] 'Une grande complicité règne entre les enfants, qui donnent leur avis sur la tenue de l'autre, du « t'es moche » à « c'est super ».' (Gaulme 2001: 37)
[262] 'D'autre part, il n'y a pas d'uniforme dans notre unité. Les ados peuvent donc s'identifier ou rejeter la manière dont le personnel s'habille, ils se construisent ainsi en critiquant. On n'avance que par la critique.' (Battista in Rault 2001: 78)
[263] Zézette is a character from the 1982 film *Le Père Noël est une ordure!* by Jean-Marie Poiré.
[264] 'L'autre jour, les ados m'ont travestie en deux styles. Le premier, que le personnel a appelé "Zézette" (en référence au film "Le Père Noël est une ordure"): jupe au ras des fesses, talons de 20 centimètres, boa et tee-shirt qui découvre le

The process of role play and dressing up in general is regarded by Battista (in Sage 2001: 18) as central in 'breaking down the barriers' one of her main objectives concerning *vêtothérapie*, as previously discussed (5.2). She details: 'Under the pretext of dressing up, the kids let go, put on garments they would normally never dare to wear and sometimes undergo surprising transformations. This way some of them express their hidden sexuality for the first time'[265] (Battista in L'Agence MP 2001: 39).



figure 72: *Vêtothérapie* session at *Espace Arthur,* Hôpital La Timone in Marseille, 2001 (censor bar added)

While dressing up is portrayed in this context as a light form of diversion for the hospitalised teenagers, as suggested in figure 72, Battista's statement also reiterates its confessional nature, the way the adolescents are seen and watched to 'express' themselves through their dress choices. Thus dress was not only thought of as an 'indicator' (Rufo 2003: 64) and 'a remedy that facilitates words'[266] (Battista in Revilla 2001: 17) in the process of conceptualising *vêtothérapie* (5.2), but it is interpreted as such in practice. It 'helps them to communicate non-verbally'[267] maintains Battista (in Jacquier 2004: 404). This guiding principle and practice is reiterated by the head nurse Descloux (et al. 2001):

nombril. L'autre, c'était streetwear: baggy, baskets et clope, moi qui ne fume jamais... Ils avaient besoin de m'agresser dans ce que je représente de conformisme.' (Battista in Gaulme 2001: 36)

[265] 'Sous le prétexte du déguisement, les enfants se lâchent, mettent des vêtements que normalement, ils n'auraient jamais osé porter et réalisent parfois des transformations étonnantes. Certains d'entre eux expriment ainsi pour la première fois leur sexualité cachée.' (Battista in L'Agence MP 2001: 39)

[266] 'une sorte de médicament qui facilite les mots' (Battista in Revilla 2001: 17)

[267] 'en les aidant à communiquer non verbalement' (Battista in Jacquier 2004: 404)

> This activity has a real therapeutic interest provided that it responds to a precise indication. It demands an involvement and increased vigilance of the team to avoid the *vêtothèque* being just a wardrobe that is available, but instead an initiative to put things into words.[268]

It is noteworthy, that while the adolescents in their psycho-medical care are being presented to the press and are photographed without anonymisation, the authors caution that *vêtothérapie* as an activity necessitates particular attention from its staff to ensure it is an activity of self-verbalisation not just of dressing up. The above statement thus reiterates how central a function the process of self-disclosure is to this treatment approach. Moreover, one of the nurses running the *vêtothèque*, Marie-Dominique Carli (in Sultan 2001a: 77) describes how this is put into practice: 'All their gestures are analysed. Dress is a support which facilitates the dialogue with the psychologist ("Have you seen doctor, I dressed up as a girl"). It is also a way for them to express their feelings and look at themselves as who they are'[269]. Consequently, within *vêtothérapie*, dress is perceived and employed as a technology for the adolescents to 'express', reveal and know themselves. It is seen as a facilitator of self-verbalisation, regarded as an 'indicator' of 'hidden sexuality', 'desires', of 'who they are'. By being regarded as a diagnostic tool, dress takes on the role of a 'technique for producing the truth', as Foucault (1976/1990: 59) puts it in relation to confession in general. Moreover, to adapt the aforementioned words of Armstrong (1994: 25) (1.4.2): dress, as a humanising agent, is seen to offer liberation through a discourse of self-expression and self-discovery. By way of this confessional approach, however, it 'succeed[s] in fashioning subjectivity itself' (25). While it cannot be determined how the different patients perceive this treatment or how it impacts on them, *vêtothérapie*, as evidenced here, constitutes not only a kind of occupational treatment or diversion, but also an intended and essentially forced form of non-verbal and verbal confession. The adolescents are obliged to look at themselves, to show themselves, to be seen by others, as also illustrated in some of the photographs published in the press articles (figures 69–74). Most of these depict patients looking at themselves and being looked at by therapeutic staff. Several of these images contain a mirror reflecting the patients and revealing, in turn, how they are being observed by a therapist or nurse, somewhat symbolic of the omnipresent (psycho)medical gaze. This pervasive process of reflection will be addressed in more detail in the context of *Maison de Solenn* (5.5).

[268] 'Cette activité a un réel intérêt thérapeutique à condition qu'elle répond à une indication précise. Elle nécessite une implication et une vigilance accrue de la part de l'équipe afin que la vêtothèque ne soit pas une simple garde robe à disposition, et qu'elle soit à l'initiative d'une mise en mots.' (Descloux et al. 2001)

[269] 'Tous leurs gestes sont analysés. Le vêtement est un support qui facilite le dialogue avec le psychologue ("Vous avez vu, docteur, je me suis déguisée en fille."). C'est aussi un biais pour qu'ils expriment leur sentiments ou se regardent tels qu'ils sont.' (Carli in Sultan 2001a: 77)

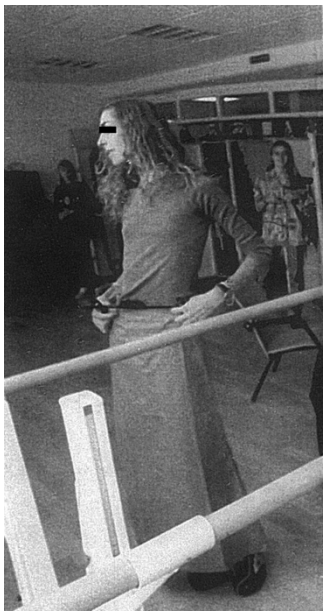


figure 73: 'Julie, a former model, tried on designer clothes and…' (Sage 2001: 18) (censor bar added)

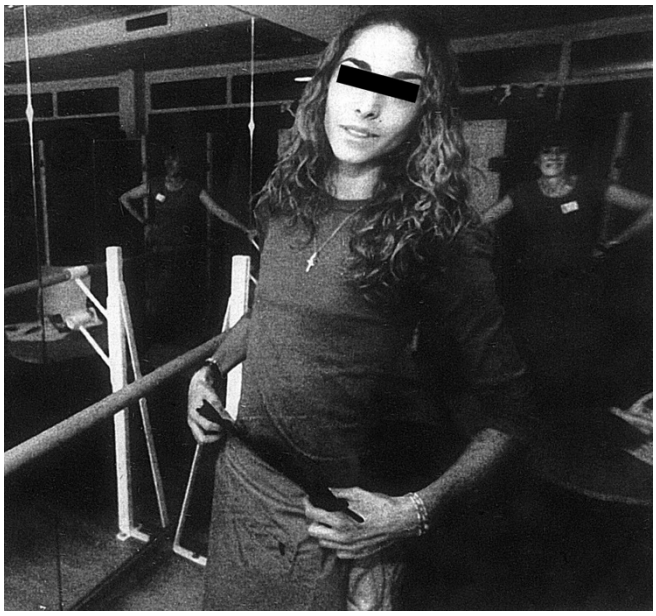


figure 74: '…prepares to face the mirror as part of her treatment for anorexia at L'Espace Arthur therapy unit in Marseille.' (Sage 2001: 19) (censor bar added)

While *vêtothérapie* as practiced at *Espace Arthur* at Hôpital La Timone is evidently embedded in Western confessional culture, part of our 'confessing society' (Foucault 1976/1990: 59), it cannot be determined in how far it was perceived by the adolescents as revelatory, intrusive, entertaining, or irrelevant. The feedback from patient recorded in the press ranges from 'It's fun' to annoyance, from 'the garments are too beautiful for me'[270] (patient in Rault 2001: 77), or 'not my style' (patient Maila in: Rose & Allen 2001) to 'If I entered the *vêtothèque*, I would rip up the clothes'[271] (patient in Rault 2001: 77). One sixteen-year-old patient, Sylvie (in Groskop 2001a: 48) is quoted as saying: 'It's fun to try something different and you don't feel weird doing it because you know that everyone else here has problems accepting the way they look too'. Another patient is cited as stating: 'It is completely illusory to think one can change the inside through appearance. *Espace Arthur* is not only the *vêtothèque*, it's the nurses, the dialogue'[272] (patient in Rault 2001: 77). In how far these differing opinions are indicative of the level of implication of the respective patient in the therapeutic ethos, or in how far they were quoted to drive the argument of the journalist cannot be determined. Nonetheless they give an impression of the diverse perceptions of patients.

'I get a bit annoyed about this fashion stuff,' sixteen-year-old patient Anne (in Groskop 2001b: 62) is quoted as saying 'I mean wearing a designer T-shirt isn't going to make me better, is it? I've seen it work for the girls, but personally I can't really see the point, I'd rather keep wearing my own clothes, to be honest'. Battista (in Groskop 2001b:

[270] 'Les vêtements sont trop beaux pour moi.' (patient in Rault 2001: 77)
[271] 'Si j'entre dans la vêtothèque, les vêtements, je les déchire.' (patient in Rault 2001: 77)
[272] '[Il est complètement] illusoire de penser qu'on puisse changer l'intérieur par l'apparence. L'espace Arthur ce n'est pas que la vêtothèque, c'est les infirmiers, le dialogue.' (patient in Rault 2001: 77)

62), her doctor, is quoted in reaction: 'Anne's dress sense has changed a lot since she first arrived, even if she won't admit it: "She dressed very provocatively – without meaning to – and then wasn't prepared to deal with the attention. Now she feels more comfortable with herself, it's toned down a bit"'. This example illustrates not only the differing readings by doctor and patient of the same process, but also the way the dress of patients is being observed in this setup, the way changes in dress behaviour are diagnostically interpreted and welcomed as changes of the self. In turn, the following, final example of patient feedback is indicative not only of the positive reactions of some of the patients, but also of the validation of certain behaviour within *vêtothérapie*:

> I have been very ill and haven't been to school for several months. When I first heard about this idea, I thought: 'Wearing an Agnès B T-shirt is not going to make me better.' I though it was pathetic, I tried it, though, and realised it can really help girls like me who have anorexia. I was frightened of my own clothes because I had become obsessed with what I fitted into, so it was good to mess around with some new things. I looked at myself in the mirror for the first time in months. If it can make girls like me feel better about themselves it must be a good thing. (patient Marie in Groskop 2001a: 49)

Both the process of self-acknowledgement and reflection, of looking at oneself in the mirror, and the connection between looking and feeling good are central elements in the conceptualisation of *vêtothérapie*, as argued above (5.2). That they should be addressed in both patient and staff feedback on the treatment only further exemplifies the way that therapeutic discourse is formative of therapeutic practice in this context, as corroborated by Battista's (in Groskop 2001a: 49) evaluative comments:

> It is hard to gauge the success, but I consider it a triumph that none of the patients we have treated have made another suicide attempt. When you are working with teenagers this ill, that is hugely significant. If it makes one anorexic girl look in the mirror, then it's working.

Moreover, her words are suggestive of the pressure on the staff, working as Rufo (in Revilla 2001: 16) put it earlier 'on the upstream of suicide', under circumstances that are said to justify unconventional means, such as the integration of dress into psycho-medical treatment of adolescents. While no formal evaluation was undertaken of *vêtothérapie*, the evaluative comments of staff and volunteers that have been passed on are largely positive. Bellieud-Vigouroux (in Groskop 2001a: 48), for example, gives the following assessment: 'The effect on some of [the adolescents] is extraordinarily positive. They learn to compliment each other. It gives them a sense of humour about what they're wearing'. In the context of an academic journal article, Rufo (2003: 68) reflects on the *vêtothèque* by identifying three phases in its utilisation: The first one, he says, is marked by the sceptical reactions of medical staff, who regard it as a "gadget". The 'more interesting' second phase sees the adolescents being treated and 'looking at themselves again' because of *vêtothérapie* whose success he illustrates by recounting the case of one patient, who was able to leave the unit due to her particular engagement with it. 'Now,' comments Rufo (2003: 69) on the third phase, 'the team asks me for financial

means to continue to experience'[273]. However, not all members of Rufo's pedo-psychiatric unit are convinced by this treatment or willing to practice it, as Battista (AI, 2.4.2008) told me about her departure from *Espace Arthur* in 2003:

> The colleague with whom I worked, who is now in charge of *l'Espace Arthur* hated it. The garments, the mediatisation, considering that it is completely stupid, that it is useless, that it is futile. "That's not what taking care of adolescents is about." It is like all treatments, you have to believe in it.[274]

Consequently, when Battista left Marseille to head a pedo-psychiatric day clinic in Fréjus (5.4), the practice of *vêtothérapie* was much less promoted internally and externally. Although the *vêtothèque* was still restocked twice a year[275] the way it was run changed considerably, due to its reliance on the individual conceptualisations of staff as demonstrated here.

[273] 'L'équipe me demande maintenant des moyens budgétaires pour continuer l'expérience.' (Rufo 2003: 69)
[274] 'La collègue avec qui elle je travaillais, qui est maintenant responsable de l'Espace Arthur détestait ca. Les vêtements, la médiatisation, considérant que c'est une grande bêtise, que ça sert a rien, que c'était la futilité. "C'est pas ça s'occuper des adolescents." C'est comme tous les soins. Il faut y croire aussi.' (Battista, AI, 2.4.2008)
[275] In April 2005, for example, donations from the following brands were received at *Espace Arthur*: Aigle, La Fée Victoire, Le Marseillais, Les P'tites Bombes, Make, Sandrine Leonard, Sessun, Petit Bateau, Kulte, La Redoute, Tcheka, Volcom. In addition to these donations, Maryline Bellieud-Vigouroux and medical staff made purchases from the following local brands: A Boréalis, Cabaz, Cobaye, Drolatic, Dvil, Inari, Line Kae, Too Kisses, Warda Women (Hello 2005).

5.3.2 'It started in Marseille, but we dropped it.'[276]: Espace *Arthur* at Hôpital Sainte-Marguerite



figure 75: Sign pointing to *Espace Arthur* situated on the first floor of Pavillon 5 at Hôpital Sainte-Marguerite in Marseille between January 2008 and June 2012



figure 76: *Vêtothèque*, a sign on the door of the small room where *vêtothérapie* sessions were supposed to take place at Hôpital Sainte-Marguerite after *Espace Arthur* had been moved there in January of 2008

In January of 2008 Professor Rufo took up a new post at Hôpital Sainte-Marguerite in Marseille and took *Espace Arthur* with him, an interim stop on the way to a designated psychiatric hospital for adolescents, which opened in 2012 (5.3.3). It was moved to the first floor of one of the pavilions of the main hospital building (figure 75), originally built at the end of the nineteenth century. When I visited in April of 2008 the *vêtothèque* was situated in a small room of no more than twelve square metres (figures 76–78). Ten of the originally twelve wardrobes were squeezed into the space, partially obstructing the window. Other than that the room contained two chairs and a small round table with an empty diary. There were no mirrors, not even in the small adjacent bathroom. The wardrobes were filled with clothes, some with their original labels (figure 79), some with handwritten price tags (figure 81 and 82), others torn, untidy shelves stuffed full of garments and accessories (figure 80). Jean Goedertier, one of the male nurses at *Espace Arthur*, could not remember the last time the *vêtothèque* was used (Goedertier, AI, 3.4.2008). No-one was in charge, yet garments were still being delivered twice a year.

[276] 'Ca commencé ici [Marseille], mais on a laissé tombé.' (Burki, AI, 3.4.2008)

The old ones are sold to patients at a fraction of the original price, hence the tags, in order to raise money for other activities, he told me and asked if I would be interested in doing a project with the kids. The female patient who was requested by Rufo to show me around said she had only visited the *vêtothèque* twice during her stay of several weeks. Looking at the clothes with contempt, she added: 'That doesn't interest me at all' (patient, AI, 3.4.2008). One of the psychologists, Michèle Burki (AI, 3.4.2008) explained: 'Well, Marseille. Marseille is not very much. It started here, but we dropped it'[277] – without going into further detail.



figure 77: The *vêtothèque*, *Espace Arthur* at Hôpital Sainte-Marguerite. The twelve wardrobes are squeezed into a small room with a tiled floor, lit only by one window in the corner, partially obstructed by the furniture. 3.4.2008



figure 78: *'Créateurs de Passion'*: the wardrobes remain the same while the whole setting has changed for the *vêtothèque* at Hôpital Sainte-Marguerite.



figure 79: Some of the garments still carry their original labels and seem untouched.



figure 80: *Vêtothèque* wardrobes stuffed with garments

[277] 'Donc Marseille. Marseille, n'est pas beaucoup. Ca a commencé ici, mais on a laissé tombé.' (Burki, AI, 3.4.2008)



figure 81: The wardrobes are full, new garments are delivered every season, but the *vêtothèque* is largely inactive.



figure 82: Some of garments carry a handwritten price tag. The garments are sold at the end of the year to finance other projects.

The 'discursive explosion' (Foucault 1976/1990: 17) around *vêtothérapie* in the first years following its inauguration at *La Timone* hospital in 1999 had evidently come to a halt when *Espace Arthur* moved in 2008, also determined by the departure of Dr Battista in 2003. It is thus noteworthy that a treatment approach as subjective as *vêtothérapie* is entirely predicated on its construction by the therapeutic staff in charge.

Moreover, what was also interesting to observe for me in this setting were the original *vêtothèque* wardrobes: carrying a sign with the brand whose clothes they contained (e.g. La Redoute, figure 80); marked with sizes 'small', 'medium', 'large' (figures 83–85); labelled with the astronomical gender symbols designating their content to be either male or female dress (figures 86–88). Additionally, all garments included their original labels and dress sizes (figure 84). The question of normative body ideals and notions of aesthetic preferences transported through this approach poses itself strongly. How did the displayed sizes determine dress choices of the adolescents in the *vêtothèque* at La Timone? As this treatment approach set out to address self perception, how did the categories of 'small' or 'large' make the patients with or without eating disorders see themselves? With regards to these dress sizes Rufo (AI, 3.4.2008) made the following remark: 'What is fascinating about this story of dress and the teenagers who are hospitalised, especially the anorectics, is that they spend their time masking their bodies, yet thanks to '38', '34', '32', thanks to the sizes you find in fashion, they realise that they are skinny'[278]. This claim seems contentious in the light of the body perception disorder anorexia is said to be, as will be addressed in Chapter Six, which analyses a dress-related therapeutic approach that focuses on the illness. Moreover, it subsumes the behaviour and assumes the experience of a diverse set of patients.

[278] 'Là où c'est passionnant, cette histoire d'habit et d'adolescents hospitalisés, notamment des anorexiques, c'est que, elles passent son [sic] temps à masquer leurs corps et pourtant grâce au 38, 34, 32, grâce aux tailles qu'on trouve dans la mode, elles se rendent compte qu'elles sont maigres.' (Rufo, AI, 3.4.2008) It is noteworthy that Rufo passes from the masculine to the feminine in his statement, referring first to the male teenager and then to female 'anorectics', indicative of a naturalisation of anorexia as a predominantly female disease in its perception.

Nonetheless it is reiterated, somewhat more differentiatedly, by one the psychiatric nurses, Martine (in Groskop 2001b: 62), who was supervising *vêtothérapie* sessions:

> The sizes start at extra small, and they're really meant for children. Some of the older girls have two admit that even the tiniest clothes are too big for them, and this can be an important first step in helping them realise that they are not as 'enormous' as they think they are. The aim is to make the girls feel good in their own bodies, with a view to feeling even better when there're 100% healthy.

As evidenced in these comments by practitioners, the size of the garments in the *vêtothèque* was of concern, also with a view to selecting them, as Vigouroux (in L'Agence MP 2001: 39) explains:

> The selection of clothes is made according to the lifestyle of those twenty teenagers and their wishes. This task demands the greatest care, particularly with regards to the sizes. Sometimes, we are obliged to buy a custom-made garment for the bulimics, for example, or children's sizes for the anorectics, so that they find themselves beautiful in the mirror.[279]



figure 83: 'Small, Medium, Large' – the shelves of the wardrobes are marked with size categories.



figure 84: agnès b., size 36 - all garments carry their original labels and dress size labels.



figure 85: 'Large, Medium'

This type of categorisation was also employed in relation to gender. By marking the wardrobes and shelves with the Venus and/or Mars symbol, by reiterating the gender binary *vêtothérapie* participated in the construction of gender differences. It predetermined the way the garments are supposed to act as 'signifiers of sexual difference' (Entwistle 2000: 141). While the treatment officially 'offers a space of discovery' (Descloux et al. 2001) to the adolescents and 'invite[s] them to develop their own identity' (Battista in Sage 2001: 18–9), it is prescriptive in this 'offer'. By imposing this type of knowledge, this 'regimen of truth' (Foucault 1984d: 73) about gender and fashion, *vêtothérapie* constitutes a gendering practice, although largely naturalised by its practitioners. These marked wardrobes illustrate the meaningfulness of gender in this

[279] 'La sélection de vêtements se fait en fonction du mode de vie de cette vingtaine d'adolescents et de leur envies. Cette tâche exige la plus grande prudence, notamment en ce qui concerne le choix des tailles. Parfois, nous sommes obligés d'acheter des vêtements sur mesure pour les boulimiques par exemple, ou bien des tailles d'enfants pour les anorexiques, afin qu'ils se voient beaux dans le miroir.' (Vigouroux in L'Agence MP 2001: 39)

setting and act as a reminder that *Espace Arthur* comprises a 'gendered landscape' as MacKinnon (2011: 84) describes nineteenth-century asylums. Thus, the practice of gender-marking underlines that *vêtothérapie* not unlike "Therapy of Fashion" was proposed as a gendering technology of the self (4.4.1). However, in how far the gender performances were normalised in the course of the therapeutic practice at La Timone cannot be determined.



figure 86: The *vêtothèque* wardrobes are marked with astrological gender symbols.



figure 87: Mars – designated wardrobe for men's clothing



figure 88: Venus – designated wardrobe for women's clothing

The categorisation employed at the *vêtothèque* in relation to both dress size and gender is not 'intrinsic' as Foucault (1969/2002: 25) argues in relation to classifications of 'fields of discourses' in general. While they present themselves as naturalised divisions, every garment contains a size and has gender connotations, they constitute 'normative rules'. Thus *vêtothérapie* aims to participate in the normalising production of body and beauty stereotypes, and of gendered identities, emphasised by the way in which garments are treated as neutral materials, as previously discussed.

Although I came across a dormant *vêtothèque* at Hôpital Sainte-Marguerite, my visit enabled the reflection of its past practice. In how far the move of *Espace Arthur* to its intended destination at *Espace Méditerranéen de l'Adolescent* (E.M.A) in 2012 has determined *vêtothérapie* will be discussed below.

5.3.3 'I don't pay special attention to what the kids are wearing. I don't care.': *Espace Arthur* at *Espace Méditerranéen de l'Adolescent* (E.M.A)



figure 89: Hôpital Salvator, Marseille, home to E.M.A and *Espace Arthur* since 2012



figure 90: Hôpital Salvator, entrance, 19.9.2013



figure 91: Marcel Rufo at the inauguration of E.M.A with Bernadette Chirac, 28 June 2012

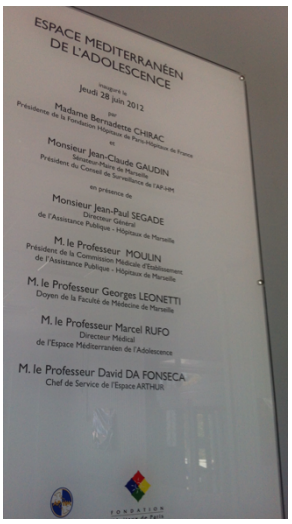


figure 92: *Espace Méditerranéen de l'Adolescent* (E.M.A), the inauguration plaque

On the 28 June 2012 *Espace Méditerranéen de l'Adolescent* (E.M.A) was inaugurated at Hôpital Salvator in Marseille, which had been a hospital since the early twentieth century (figures 89–92). The designated psycho-medical institution for adolescents offers three levels of care for patients and their families, explains child psychiatrist Professor David Da Fonseca (in APHM 2012b), head of *Espace Arthur* at E.M.A: a walk-in service, the day clinic for forty-five teenagers and full-time hospitalisation for about twenty-five. With a planned surface area of 6500 square metres including vast gardens, the cost for the complete refurbishment project was estimated at €16 million (APHM 2010: 8). 'Precious materials' were used, according to the head engineer Philippe

Aramini (in APHM 2012b), 'so that the adolescents feel at home'[280]. The colour scheme was chosen with similar intent, and magnified words are written anamorphically in capital letters and bright colours across the ceilings and walls: *Cool, Rire, Fun, Rêve, Oui, Zen, Ecole, Danse, Art*[281] (figures 93–95).



figure 93: *Lire* 'Read' – E.M.A was designed 'so that the adolescents feel at home'. (Aramini in APHM 2012b)
figure 94: *Rêve* 'Dream' – the magnified, anamorphical words written across ceilings and walls run through E.M.A.
figure 95: *Danse* 'Dance' – the words refer to the content of rooms or the concept of E.M.A.

Funded through a public private partnership, E.M.A was conceived as a comprehensive clinic, which takes culture as its starting point, as the press release details:

> Since 2012 l'EMA, an innovative structure that is unique in France, proposes a model of complete care for suffering teenagers, from crisis to after care, integrating somatic and psychological care, rehabilitation, cultural mediation, and scholastic support. This new hospital, piloted by the APHM with different partners in the medical and social sector, as well as the Department of Education and the local community ensures a complete medical approach and grants culture an essential role in the application of treatments.[282] (APHM 2016)

According to Marcel Rufo (in APHM 2012b), who initiated the project and acts as its medical director, the idea behind E.M.A was to create: 'a hospital in the city, outside the city […] centred on the notion of *soins culturels*'[283]. Correspondingly, the press pack speaks of wanting 'to build a hospital "differently" by joining care, culture and education'[284] (APHM 2012a: 4), of 'a made-to-measure' hospital […], open to the city […], a resource- and research centre'[285] (3). All of the partnering institutions are said to 'participate' in the *soins culturels*, which have been granted a 'dedicated space' with 'a library, music and dance studio, *vêtothèque*, drawing and fine art studio, radio station'[286] (5) (figure 96).

[280] 'des matières nobles […] que les adolescents se sentent comme chez eux' (Aramini in APHM 2012b)
[281] Cool, Laugh, Fun, Dream, Yes, Zen, School, Dance, Art
[282] 'Depuis 2012, l'EMA, structure novatrice unique en France, propose une prise en charge complète des adolescents en souffrance, de la crise aux soins de suite, intégrant les soins somatiques, psychiques, de réadaptation, la médiation culturelle et l'accompagnement scolaire. Ce nouvel hôpital, piloté par l'AP-HM avec différents partenaires de santé et médico-sociaux, ainsi que l'Education Nationale et les collectivités territoriales permettra d'assurer un suivi médical complet et d'accorder à la culture une place essentielle dans l'application des soins.' (APHM 2016)
[283] 'un hôpital dans la ville et hors de la ville […] centré sur un notion de soins culturels' (Rufo in APHM 2012b)
[284] 'construire un hôpital "autrement" en associant soins, culture et éducation' (APHM 2012a: 4)
[285] 'Un hôpital "sur mesure"[…], ouvert sur la cité […], centre de ressources et de recherche' (APHM 2012a: 3)
[286] 'Les soins culturels auxquels participent toutes les institutions et qui, au sein d'un espace dédié, regroupent bibliothèque, salle de musique, salle de sport et de danse, vétothèque, salle de dessin et d'arts plastiques, station de radiophone.' (APHM 2012a: 5)



figure 96: *Radio EMA*, Marcel Rufo at the radio facilities at E.M.A on the day of its inauguration, 28.6.2012



figure 97: *Espace Arthur* at E.M.A, 19.9.2013

While the *vêtothèque* was moved as part of *Espace Arthur* from Hôpital Sainte-Marguerite to E.M.A (figure 97), while it is officially listed as one of the *soins culturels* on offer, it remains inactive. The wardrobes and what is left of the garments have been installed in the dance studio (figure 98 and 99), but there is no one in charge. No new garments are delivered. 'I don't know who to give them to,'[287] explained Bellieud-Vigouroux (AI, 18.9.2013). The Marseille fashion institute is still named as the official partner for the *vêtothèque* in the press release (APHM 2012a: 8), yet, according to Bellieud-Vigouroux (AI, 18.9.2013), the therapeutic team in Marseille lost interest in the project: 'There were other things to do'[288]. Moreover, she added, Rufo had still not fully returned from Paris, where he headed *Maison de Solenn* between 2004 and 2007 (5.5) and as a result the collaboration came to a halt:

> I called them again and again to say I am at your disposal, but things have to be organised. […] I have no time to lose. I have given a lot of time, but nothing. Either there is an aim and we relaunch *espace mode* or not. Today, there is more fine arts, I believe, they rather want to customise the clothes. I believe there is a studio, a woman, quite good, that runs it and with regards to the clothes, they want to paint them, want to transform them. But that's not at all the same orientation that I had chosen. That worked very, very well.[289] (Bellieud-Vigouroux, AI, 18.9.2013)

[287] 'Je sais pas à qui les donner.' (Bellieud-Vigouroux, AI, 18.9.2013)
[288] 'Il y avait autres choses à faire.' (Bellieud-Vigouroux, AI, 18.9.2013)
[289] '[V]ingt fois je relance, en disant, je suis à votre disposition, mais il faut que les choses soient organisées. […] J'ai pas de temps à perdre. J'ai bien donné du temps, mais rien. Soit il y a une finalité et on recommence l'espace mode, soit il n'y en pas. Aujourd'hui il y a plutôt le centre, il y a des arts plastiques, je crois, plutôt ils customisent des vêtements. Je crois qu'il y un atelier un peu arts plastiques, une femme, assez bien, qui l'anime et à partir des vêtements, ils vont les peindre, ils vont les transformer Mais c'est pas du tout la même orientation que j'avais choisie, moi. Ça a très, très bien fonctionné.' (Bellieud-Vigouroux, AI, 18.9.2013)



figure 98: The original *vêtothèque* wardrobes located in the multi-purpose space at E.M.A, 19.9.2013



figure 99: The *vêtothèque* at E.M.A remains inactive. Only partially filled with garments, the wardrobes are rarely opened for theatre projects.



figure 100: *Atelier arts plastiques* – the art studio at E.M.A, 19.9.2013



figure 101: Dress project as part of applied arts course at E.M.A: the adolescents choose an artist and interpret garments and accessories accordingly.

The woman Bellieud-Vigouroux refers to is Sidonie Fouquet, an art teacher, employed at E.M.A as *éducatrice spécialisée*, a specialist educator not a therapist. She has been put in charge of the art studio and works with dress in the context of the arts classes or the more informal art-based activities she runs in the afternoons. They paint on the garments, customise them, 'make them their own'[290] (Fouquet, AI, 19.9.2013) (figures 100–109). Fouquet (AI, 19.9.2013) is not interested in working with the *vêtothèque*, because, she said, fashion is not of interest to her: 'I don't pay special attention to what the kids are wearing, because that's me... . Even my friends, even adults, I don't care. I shouldn't, because that's a language, but well, that's how it is'[291]. Moreover, Fouquet (AI, 19.9.2013) does not grant particular significance to fashion in the context of her job, because she does not think it is of particular relevance to the teenagers she works with:

[290] 's'approprier les vêtements' (Bellieud-Vigouroux, AI, 18.9.2013)
[291] 'Moi, je fais pas spécialement attention aux vêtements que les enfants portent, parce que c'est moi… même mes amis, les adultes, je m'en fous. Je devrais pas, parce que ces un langage, mais ben, c'est comme ça.' (Sidonie Fouquet, AI, 19.9.2013)

'The adolescents that we have, are they adolescents who follow fashion much? I don't think so. That is to say they are detached from that. I think there are other, more important issues that overwhelm them in fact. So they don't care'[292]. She reiterated that *vêtothérapie* has been disregarded as a therapeutic approach:

> Honestly, when I first started here, I remember Dr Campredon, who welcomed me, saying that it wasn't being pursued at all. That nobody used it. Nobody used the garments, very little. There are two nurses here […] two women who love fashion. So, from time to time, they take the kids to try on clothes. But it is not something that is at all pursued. I have been working with those two for years and haven't seen it.[293] (Fouquet, AI, 19.9.2013)

Another specialist educator, Bernard Grangeon (AI, 19.9.2013), confirmed that the original purpose of the *vêtothèque* has been abandoned and told me that he sometimes uses the garments as costumes in one of his theatre projects.

Fouquet, meanwhile, works with second-hand clothes, discarded personal pieces or garments given to her by colleagues, because, she said, it would be a shame to paint on the clothes in the *vêtothèque*, but you need different sizes (Fouquet, AI, 19.9.2013).

> What I do is something which is much simpler in approach. So the idea was either an individual or a group activity to change the medium. Because most of the adolescents paint on paper or in sketchbooks. And already to work on fabric meant the movement was not the same. You are not necessarily seated. You can be standing, above the garment. You also have to work with the idea of three dimensions, because finally it has to be worn. […] Then, the idea of painting a garment is something that's really unifying, even just to get to know each other, to have an exchange. […] Because if you don't do anything, if you wear the garments and don't do anything with them […] that's a shame.[294] (Sidonie Fouquet, AI, 19.9.2013)

Fouquet (AI, 19.9.2013) detailed that she works with different themes, such as Africa (in collaboration with the dance instructor, figure 100), interpretation of an artist chosen by the adolescents (figure 101), a staged wedding (figures 102–104), customisation (figure 105 and 106), or the question of what to hide and what to exaggerate through dress (figures 107–109). 'It is really a medium they adore,'[295] she evaluated and added: 'Then it becomes their very own garment'[296] (Fouquet, AI, 19.9.2013). At the end of a project she takes the teenagers to the park, as a 'continuation of painting, of wearing a garment,

[292] 'Les adolescents qu'on a, est-ce que ce sont des adolescents qui suivent beaucoup la mode? Je crois pas. Sois sont détachés de ca. Il y a d'autres problématiques plus importantes je crois, qui les envahissent en fait. Donc, ils sont foutes.' (Sidonie Fouquet, AI, 19.9.2013)

[293] 'Très honnêtement, quand je suis arrivé dans service de Monsieur Rufo, quand il était sur Paris, je sais que Docteur Campredon, qui m'a accueilli me disait, en fait, c'était pas du tout investi. C'est que personne utilisait, très honnêtement. Personne utilisait les vêtements, très peu. Il y a deux infirmières ici […]. Elles sont deux femmes qui aiment la mode. Donc, de temps en temps elles amènent les enfants, les ados essayer des vêtements. Mais c'est pas quelque chose qu'était investi du tout. Moi, je travaillais pendant des années avec eux et j'ai pas vu.' (Sidonie Fouquet, AI, 19.9.2013)

[294] 'Moi, c'est quelque chose qui est beaucoup plus simple dans l'approche. Et donc l'idée était un travail, soit individuel, soit collectif pour changer de support. Parce que la plupart des adolescents peignent sur des papiers ou des carnets. Et là le fait de travailler sur de la toile, déjà, ça le geste n'est pas le même. Déjà au niveau de corps, de son propre corps on n'a pas la même approche. On n'est pas forcément assis. On peut être debout, au dessus du vêtement. Il faut travailler aussi dans l'idée de la trois dimensions, parce que du coup, comme ça doit être porté. […] Alors, que l'idée de peindre le vêtement, ça c'est quelque chose qu'était vraiment fédérateur, qu'était même pour se rencontrer entre eux, pour s'échanger. […] Parce que si on ne fait rien, si on porte des vêtements et on fait rien avec […], c'est dommage.' (Sidonie Fouquet, AI, 19.9.2013)

[295] 'C'est vraiment un support qu'elles adorent.' (Sidonie Fouquet, AI, 19.9.2013) Fouquet explains that she uses the female pronoun 'elles' because at the beginning she mainly worked with girls.

[296] 'Après, ça fait leur propre vêtement à eux.' (Sidonie Fouquet, AI, 19.9.2013)

it would be interesting to enhance it outside in the park,' Fouquet (AI, 19.9.2013) explained, 'So, to change the location, the space which is perceived differently than in the mirror. And all of a sudden, everyone saw themselves, everyone saw the other, the garments were arranged and so on'[297]. She regards the staging, including accessories and make-up as part of the process and if the teenagers are interested she organises a photo session, explaining to them: 'that these photos would under no circumstances be used outside, that they won't be published, that it stays here' (Fouquet, AI, 19.9.2013). In relation to a recent group project, which saw the teenagers communally paint, wear and stage a skirt (figures 107–109), she commented on the phase of representation as follows: 'And they loved seeing themselves. When I put up the photographs, they really liked it. To see themselves again, to look at themselves. That's important for their image'[298]. Thus, Fouquet also works with self-reflection, but said she does not draw diagnostic or therapeutic conclusions from it. The way she uses dress within arts education differs substantially from *vêtothérapie* as it was originally conceptualised. The discourse she constructs around dress diverges: fashionable dress is neither described as important and positive, nor is it seen to be of particular relevance to the adolescents in treatment; it is not seen as a key communicator or diagnostic indicator; its representation not linked to the mirror and regarded as a private matter of the participants, not to be publicised. The dress-related discourse constructed engenders distinct practices, highlighting both, the way *vêtothérapie* is constructed as a therapeutic practice by the different practitioners involved and the intrinsic relationship between what is thought and said, and what is done.

[297] 'La suite, en faite de la peinture, de l'acte de peindre, de porter le vêtement, ça serait intéressant de le mettre en valeur à l'extérieur, dans le parc. Donc pour changer d'endroit, l'espace qui se voit autrement que dans un miroir. Et tout un coup chacun se voyait, chacun voyait l'autre, arranger les vêtements etc.' (Sidonie Fouquet, AI, 19.9.2013)

[298] 'Je leur explique bien, que c'est des photos qui serons absolument jamais utiliser a l'extérieur. C'est pas diffuse. Ca reste la. Et ils adorent de se voir. Quand j'ai accrochait des photos, ils ont adore ca. Se retrouver, se voir. Ca c'est important pour leur images.' (Sidonie Fouquet, AI, 19.9.2013)







figure 102 & 103 & 104: The wedding dress project, E.M.A, 19.9.2013



figure 105: Individual customisation project, dress front, E.M.A



figure 106: Individual customisation project, dress back, E.M.A



figure 107: Group project, painting on a skirt what to reveal, hide and exaggerate in dress, front, E.M.A



figure 108: Group project, painting on a skirt what to reveal, hide and exaggerate in dress, back, E.M.A



figure 109: The staging of the finished project with a photographer, E.M.A

5.4 Princesses and pistols: *Vêtothérapie* or dressing up with children in Fréjus

When Michèle Battista left *Espace Arthur* in 2003 to take up her new post as head of the pedo-psychiatric unit at Centre hospitalier intercommunal in Fréjus, she wanted to recreate the *vêtothèque*, this time for children. 'We had to. We couldn't not take up this project. Except we didn't have the means. […] We did not have the *Institut Mode Méditerrannée*. That was a coup after all. It's a question of money. […] We had to make do,'[299] she told me (Battista, AI, 2.4.2008). The head nurse at Fréjus, Catherine Muolo, had already used fancy dress costumes in her work with the five to nine- year old children that make up the patients here. Once a week they all used to dress up as princesses, fairies, or cowboys. She was interested in developing that practice (Muolo, AI, 2.4.2008). Together they created a small *vêtothèque* (figures 110–114): five lockers with costumes; a shelving unit for more than twenty boxes filled with accessories: scarves, hats, necklaces and pistols; and a large basket overflowing with adult clothes. 'Costumes need to be kept separate from garments,'[300] remarked Muolo (AI, 2.4.2008). This separation concerns the imagination of children, as addressed below.



figure 110: The *vêtothèque* for children at the Psychiatrie infant-juvénile, Centre hospitalier intercommunal Fréjus - Saint-Raphaël in Fréjus, 2.4.2008

[299] 'Et je me suis dit qu'il fallait, on ne pouvait pas, on ne pouvait pas ne pas reprendre ce projet. Sauf qu'ici on n'avait pas de moyen. […] On n'a pas eu un Espace Mode Méditerranée. Je vous ai dit qu'on voit des créateurs qui vous donnent des vêtements, c'est un coup quand-même, c'est une histoire d'argent aussi. […] Donc on a fait avec les moyens du bord.' (Battista, AI, 2.4.2008)
[300] 'que les déguisements sont à part des vêtements' (Muolo, AI, 2.4.2008)



figure 111: Boxes filled with different accessories for dressing up at the *vêtothèque* for children in Fréjus



figure 112: *'Pistolets'*, a box filled with toy guns

While the present chapter focuses on *vêtothérapie* for adolescents, as practiced at *Espace Arthur* and *Maison de Solenn*, this section briefly documents its application at the pedo-psychiatric unit in Fréjus and draws out the main conceptual differences, which in turn can pull further focus on the dress work undertaken with teenagers.

Given that the patients at Fréjus are 'children with issues concerning boundaries, social relations and contact,' as Battista (AI, 2.4.2008) described them, 'again reminiscent of the intermediate area'[301], made her want to develop *vêtothérapie* specifically for children. Two of the main differences between the dress-related therapeutic approaches for children in Fréjus and adolescents in Marseille that emerged from my interview with Battista and Muolo, can be summarised as: projection versus verbalisation, and *vêtothérapie* versus "*modotherapie*".

One of the key principles of *vêtothérapie* with children as practiced in Fréjus is that it focuses on projection rather than verbalisation. In small groups of about four children, they work towards the body in stages, starting with drawings and other forms of representing the body, as Battista (AI, 2.4.2008) described: 'You also project in the drawing. Thus, contrary to the adolescent, one does not verbalise, but project the *vêtothérapie* session through the drawing, cutting out, collages, cutting up garments, customisation'[302]. Muolo (AI, 2.4.2008) detailed:

> And then we have to proceed in stages, we cannot work on the body at once. Voilà, you had to go through dressing cardboard cut-out figures using magazines, then small bits of fabric. Then the choice of fabrics, what are they, why is this fabric soft, is it beautiful, it has colours, the touch, all that. So we had the little character. And later you dress yourself and you dress the other person.[303]

[301] 'Donc, l'idée que nous avions des enfants en difficulté de limites, de relations sociales, de contact. Donc, autre chose. Mais qui à nouveau faisait appelle à l'espace intermédiaire.' (Battista, AI, 2.4.2008)
[302] 'Et, on projette aussi dans le dessin. Donc, on ne met pas un mot contrairement aux adolescents, mais on projette par le dessin, la séance de *vêtothérapie*. Avec du découpage, avec des collages, avec du découpage de vêtements, avec de la customisation, si on utilise le mot, voilà.' (Battista, AI, 2.4.2008)
[303] 'Et puis on est obligé de passer par des étapes, on ne peut pas travailler sur leurs propres corps tout de suite. Voilà, il a fallu passer par des découpages habillés, des petits personnages en carton. Donc avec déjà, donc, avec des revues, après des petits tissus. Alors dans le choix des tissus, qu'est-ce qui, pourquoi ce tissu il est doux, il est beau, il a des couleurs, le touché, tout ça. On avait le petit personnage, voila. Et après, on s'habille et on habille l'autre. Voila.' (Muolo, AI, 2.4.2008)

Thus the process of verbalisation of the self which is central to *vêtothérapie* with teenagers is substituted by a process of visualisation, of 'projection' of self according to Battista. Moreover, the body is approached much more slowly, as she explained: 'One goes through something that is completely projected in order to come back to the self'[304] (Battista, AI, 2.4.2008).

The way in which *vêtothérapie* with children is described as structured along different stages is indicative of its slower pace. It is supposed to take account of the distinctive temporal dimensions in the respective stages of development, as Battista highlighted: 'The difference between the adolescent crisis, which is a phase for the individual, and the construction of an individual, like the construction of a child, which is much slower. We acknowledge that in the pace with which we use dress'[305]. Thus the therapeutic practice in Fréjus can be described as *vêtothérapie*, in the true sense of the word, whereas "*modothérapie*" is more fitting for what is done with the adolescents in Marseille. 'Fashion therapy in the sense that designer clothes are used and the clothes change every six months,'[306] Battista (AI, 2.4.2008) confirmed 'because the notion of change fits adolescence. Yet, the pace at which a child constructs itself is much slower. He needs repetition'[307]. Moreover, Muolo adds that a child does not have the same understanding of fashion as a teenager. Referring to her patients, she maintained: 'They are six or seven-year-old children, but they don't have a notion of fashion. That will be an identification with the mother'[308] (Muolo, AI, 2.4.2008). This unquestioned association between dressing up and the mother speaks of a naturalisation of feminine fashionability.

Within the dress they utilise Battista and Muolo insist on the distinction between garments and 'ready-made' fancy dress costumes, and that the children are not shown off. They do not leave the room dressed up: 'This is not a carnival!' (Muolo, AI, 2.4.2008). The distinction between costume and dress is one of the few parameters about the treatment clearly communicated to the children:

> Here, then, we wanted to make the difference between costume which is part of the imaginary, after all there are children who find it difficult to enter the imaginary; and dress which is part of reality. So we always check: what are the differences between costume and dress? Every time we come back to this understanding.[309] (Muolo, AI, 2.4.2008)

[304] 'On passe par quelque chose de complètement projeté, d'accord? Pour un revenir à soi.' (Battista, AI, 2.4.2008)
[305] '[L]a différence entre la crise d'adolescence qui est un temps de l'individu, alors que la structuration de l'individu, comme la structuration d'un enfant, c'est beaucoup plus lent. Donc, et on respecte dans la vitesse d'utilisation du vêtement.' (Battista, AI, 2.4.2008)
[306] 'Modo-therapie dans le sens où on utilise des vêtements de créateurs qui changent tous les six mois.' (Battista, AI, 2.4.2008)
[307] 'Parce que la notion de changement va avec l'adolescence. Alors l'enfant, la vitesse de construction d'un enfant est beaucoup plus lente. Il a besoin de répéter.' (Battista, AI, 2.4.2008)
[308] 'C'est des enfants de six/sept ans, mais il n'y a pas la notion de mode. Ce serait une identification à la mère.' (Muolo, AI, 2.4.2008)
[309] 'Alors, ici on a voulait faire la part de chose entre le déguisement, qui fait partie de l'imaginaire, donc il y a des enfants qui ont du mal à entrer dans l'imaginaire; et le vêtement, qui fait partie de la réalité. Donc toujours on y régule: quelle différences entre déguisement et vêtement? Chaque fois revenir sur cette notion.' (Muolo, AI, 2.4.2008)

Muolo pointed out that costumes and dress are stored separately to underline this distinction, as evidenced in the figures. Moreover, at the end of each session, having reiterated the difference between the two, they make sure to finish this 'game of imagination': 'We play with the imagination but at the end of the therapy session it is necessary to stop the imagination, because otherwise, if taken to an extreme, you could go mad' (Battista, AI, 2.4.2008)[310].



figure 113: Lookers with costumes for children at the *vêtothèque* in Fréjus, 2008



figure 114: A big dressing up basket filled with adult garments brought in by staff

Other than the costumes, the garments they work with were donated by the staff of the unit and are described by Battista (AI, 2.4.2008) as: 'adult clothes to play grown up, as all young girls do who nick their mothers' shoes, or the boy who nicks the tie from his dad's suit'[311] (figure 114). Her comments illustrate that *vêtothérapie* as undertaken here with children is also constructed as a gendering practice. Given the level of reflection on the various aspects of this therapeutic approach as indicated above, it is noteworthy that the gendered nature of the ready-made costumes is not acknowledged, the normative gender notions inherent in both costumes and adult garments not addressed. Despite the key differences between *vêtothérapie* for children and adolescents, this naturalisation of gendered dress practices, even its silencing is a common feature to both. Moreover, dress in both is regarded as a tool for contact and communication, as well as a diagnostic indicator. In both setups it is constructed as a neutral, embodied, multi-sensory and playful technology of the self, employed to reveal and normalise the self.

[310] 'On joue avec l'imagination mais en fin de séance il faut toujours arrêter l'imagination, parce que sinon ça veut dire, à l'extrême on devient fou.' (Battista, AI, 2.4.2008)
[311] 'Des vêtements d'adultes pour faire le grand, comme font toutes les petites filles qui piquent les chaussures des mamans, le garçon qui pique la cravate du costard de papa, voilà.' (Battista, AI, 2.4.2008)

5.5 'In the land of mirrors: To heal oneself through dress'[312]: *Vêtothérapie* at *Maison de Solenn*, Paris

5.5.1 *Maison de Solenn*: 'A pedopsychiatrist's dream'[313]



figure 115: *Maison de Solenn*, Paris, 10.4.2008

> Conceive a spacious building resembling the palace of a peer, airy, and elevated, and elegant, surrounded by extensive and swelling grounds and gardens. The interior is fitted up with galleries, and workshops, and music-rooms. The sun and the air are allowed to enter at every window, the view of the shrubberies and the fields and groups of labourers, is unobstructed by shutters or bars; all is clean, quiet and attractive. (Browne 1837 in Porter 2002: 117–8)

> Clear, open to the city, surrounded by greenery, the building of Maison de Solenn […] invites to pass its threshold without prejudice and without apprehension. It was designed to let in as much light as possible and spaces are vast to banish any feeling of confinement.[314] (APHP 2005)

Maison de Solenn (figure 115), 'the house of Solenn', opened its wide glass doors onto the Boulevard de Port-Royal, just south of Paris' city centre in November of 2004. Named after the late daughter of French television journalist Poivre-d'Arvor (figure 116), the *Maison des Adolescents,* which forms part of Hôpital Cochin, is conceived as an '*Espace Santé*', a 'health space' for teenagers. Just as E.M.A in Marseille it comprises a walk-in

[312] 'Au pays des miroirs – Se soigner par le vêtement' – reads the title of an article on the *vêtothèque* at *Maison de Solenn* published by Martine Kagan, Eugénie de Mortemart, Maryline Bellieud-Vigouroux and Marie Rose Moro (2012).
[313] '[L]a Maison de Solenn est un rêve de pédopsychiatre.' (Rufo 2007: 27)
[314] 'Clair, ouvert sur la ville, entouré de verdure, le bâtiment de Maison de Solenn […] invite à franchir son seuil sans a priori et sans appréhension. Il a été conçu pour que la lumière y entre le plus largement que possible et les espaces sont vastes pour bannir tous sentiment d'enfermement.' (APHP 2005)

service, a day clinic and full-time hospitalisation with twenty beds for eleven to eighteen-year-olds (APHP 2005). Initiated by Bernadette Chirac and headed by Marcel Rufo for the first three years until 2007, *Maison de Solenn* was to be the blueprint for E.M.A, and, according to Rufo (in APHP 2005) 'a large national future network'[315] of psycho-medical provision tailored to adolescents.



figure 116: *Maison de Solenn* – a large portrait of the late Solenn Poivre d'Arvor above the reception in the entrance hall. The daughter of Véronique and Patrick Poivre d'Arvor committed suicide in 1995 aged nineteen, after what her mother called 'the drama of anorexia' (Poivre d'Arvor 2005). Paris, 10.4.2008

With an estimated cost of €11 million (Chirac in Sultan 2001b) *Maison de Solenn* extends over 600 square metres across four floors (figure 117 and 118). The ground floor comprises a vast reception area and consultation rooms, the first and second floors house the research unit and area of hospitalisation respectively, while the third floor is dedicated to *soins culturels*, which lies at the heart of this unit, and contains many different workshops, as previously discussed (5.1.2.1). It is here that the *espace mode*[316] is situated, the 'fashion space' as it is termed in Paris.

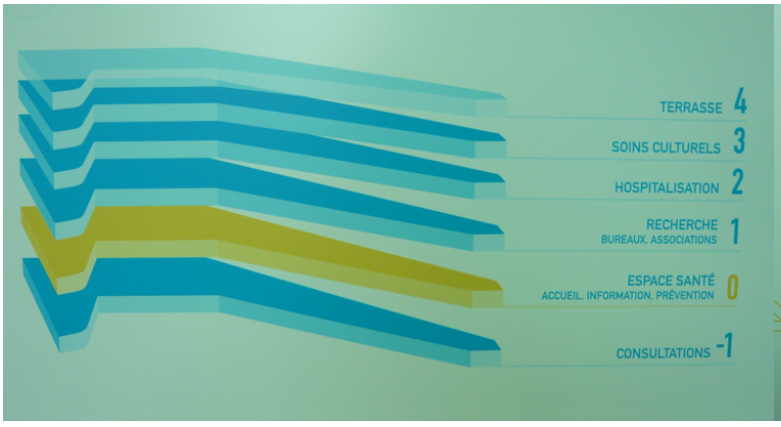


figure 117: Floor plan of *Maison de Solenn*, Paris, 10.4.2008

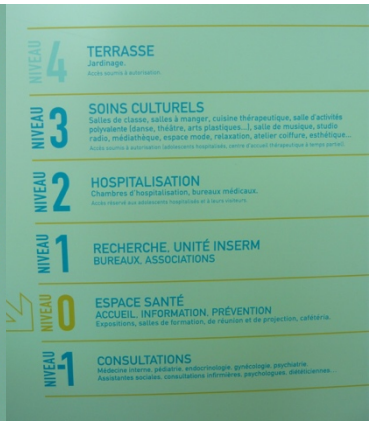


figure 118: Floor plan descriptions

[315] '[I]l est sans doute le premier d'un futur grand réseau national.' (Rufo in APHP 2005)
[316] While the terms *espace mode* is used on the website of *Maison de Solenn*, Martine Kagan, the *educatrice specialisée* in charge, refers to *vêtothèque* in writing (Kagan 2008 & Kagan et al. 2012) and in our interviews.

Maison de Solenn is described in its brochure as: 'An open door to the small and big problems of adolescents. […] to welcome, listen, inform, reassure, prevent and guide […] a comprehensive and multi-disciplinary approach to adolescence'[317] (APHP 2005). Openness is not only defined as one of its key principles, alongside overcoming the aforementioned inside/outside dichotomy (5.1.2.1), but also a central element of the architectural concept, as Jean-Marc Ibos and Myrto Vitart, the architects explain:

> The aim, here, was to offer a place which allows the young mental health patients to stay in touch with the outside, whilst taking advantage of this truly exceptional site, its 120 metres of facing onto the boulevard. […] The hall prolongs the promenade. An invitation to enter. One takes in a garden beyond that. […] The transparency and the reflection create a constant ambiguity concerning the boundaries. […] One feels safe there, at once free and protected.[318] (Ibos-Vitart 2012)



figure 119: 'Maison de Solenn endlessly plays on openness, and the walls have been replaced by window panes.' (Rufo 2007: 23)

The long glass-fronted building is reminiscent of what one of Esquirol's pupils, asylum doctor Browne, quoted above, described in his *What Asylums Were, Are, and Ought to Be* in 1837: 'spacious', 'airy', 'elegant', 'surrounded by gardens', 'fitted with workshops', 'all is clean, quiet, and attractive' (figure 119). He, alongside many other nineteenth century asylum reformers held architecture 'of cardinal importance' (Porter 2002: 116) (Ch.3) within psycho-medical treatment, a belief that is reiterated in the context of *Maison*

[317] 'Une porte ouverte sur les petits et grands problèmes des adolescents. […] L'Espace Santé – accueillir, écouter, informer, rassurer, prévenir et orienter. […] Maison de Solenn – une approche globale et pluridisciplinaire de l'adolescence.' (APHP 2005)

[318] 'L'objectif, ici, était d'offrir un lieu qui, tirant parti du site en ce qu'il a de proprement exceptionnel, ses 120 mètres de linéaire sur le boulevard, permette aux jeunes internés de rester en contact avec l'extérieur. […] Le hall prolonge l'esplanade. Il est invitation à entrer. On y lit un jardin, au-delà. C'est un espace ouvert, transparent, aux premières loges par rapport à la scène urbaine. […] La transparence et le reflet créent une constante ambigüité sur les limites. […] On se sent là en sécurité, libre et protégé à la fois.' (Ibos-Vitart 2012)

de Solenn, as its brochure details above (APHP 2005) and Rufo (2007: 23) outlines in *La Vie en Désordre*:

> Asylums appeared to be the architectural representation of psychosis, the sick being locked between walls as he was locked in his frenzy, which created a separate world. He was immured, psychologically and physically. The hospital became a kind of sarcophagus. In contrast, *Maison de Solenn* endlessly plays on openness, and the walls have been replaced by window panes, that didn't please everyone.[319]

The transparency of the building of *Maison de Solenn* is proposed by the architect and the medical management, including Professor Rufo as a metaphor for its treatment approach. It is equated with the participation in and affirmation of life. Contrasted with past asylum practices, which are said to 'lock' the sick away, to 'immure' them in body and mind, as Rufo puts it[320], openness and transparency are represented as liberating, humane and progressive.

> The seeing machine was once a sort of dark room into which individuals spied; it has become a transparent building in which the exercise of power may be supervised by society as a whole. (Foucault 1975/1995: 207)

In *Discipline and Punish* Foucault makes the above statement, not just in relation to Jeremy Bentham's model prison the Panopticon, but 'any panoptic institution'. 'The panoptic schema,' he adds 'was destined to spread throughout the social body' (207). The surveillance, or observation in the context of the psycho-medical treatment of adolescents spread outward and inward. In the case of *vêtothérapie* the staff were watching patients who were 'invited' to watch themselves, to reflect on themselves (5.2). The transparency of the building, its glass walls not only enable looking out or in, but also encourage self-reflection. Thus, the spacious dance studio which houses the *vêtothèque* at *Maison de Solenn* is encircled with mirrors or glass (figure 120). Three out of four walls send one's image back. Self-reflection, as previously discussed, is regarded as an attainable form of self-discovery and knowledge. One of the key objectives of *vêtothérapie* is the reflection of the self: 'it is not so much the garment, as it is recapturing one's self-image,'[321] maintained Rufo (AI, 3.4.2008); 'the mirror is essential'[322] insists nurse Cardi (in François 2000); and Battista (in Groskop 2001a: 49) evaluates 'If it makes one anorexic girl look in the mirror, then it's working'.

[319] 'Les asiles paraissaient être la représentation architecturale de la psychose, le malade étant enfermé entre des murs comme il était enfermé dans son délire qui recréait un monde à part. Il était emmuré, psychiquement et physiquement, l'hôpital devenant une espèce de sarcophage. À l'opposé, la Maison de Solenn ne cesse de jouer l'ouverture, et les murs ont été remplacés par des vitres, ce qui n'a pas plu à tout le monde.' (Rufo 2007: 23)

[320] While the "mad" were secluded during the time of their early institutional treatment, there was also a tradition of putting them on display, as previously addressed (3.2.3.2).

[321] 'C'est pas tant l'habit, que la reconquête de l'image de soi.' (Rufo, AI, 3.4.2008)

[322] 'Le miroir est essentiel.' (Cardi in François 2000)



figure 120: The dance studio, a multi-purpose hall at *Maison de Solenn*, which houses the *espace mode*, as the *vêtothèque* is called here, Paris, 10.4.2008

In response to Rufo's (2007: 23) critics, the ones that were not 'pleased' about the replacement of walls with windows, according to him, the ones speaking for 'these poor adolescents that are forced to show themselves when they want to hide'[323], he retorts:

> To show oneself, to be seen, is much less serious than to remain isolated, to hide, especially during adolescence when extraversion is neurotically less worrying than inhibition, withdrawal. To catch sight of one's reflection might be a way to again apprehend a corporeality that one does not see any more by oneself.[324] (Rufo 2007: 24)

Moreover, he rebukes 'these detractors'[325] (Rufo 2007: 23) for speaking in the name of the adolescents, although many of the naturalisations underpinning *vêtothérapie* assume their perspective, think and speak for the teenagers, as previously discussed (5.2). With regards to the omnipresence of reflection at *Maison de Solenn*, Rufo (2007: 24) states that he had only heard one remark from a patient, 'an anorectic' who commented: '"One is reflected a lot here… . – Does it bother you? – No. Anyway, I don't look at myself"'[326]. Thus, in how far the adolescents reflect or resist cannot be determined. While the discourse constructed by the different practitioners and stakeholders can be analysed, their effects on the various patients remain unknown, which also becomes apparent in the v*êtothérapie* session observed at *Maison de Solenn*.

[323] 'ces pauvres adolescents que l'on contraint à s'exhiber quand ils veulent se cacher' (Rufo 2007: 23)
[324] 'Se montrer, être vu, est beaucoup moins grave que de rester isolé, se cacher, surtout à l'adolescence où l'extroversion est névrotiquement moins inquiétante que l'inhibition, le repli. Apercevoir des reflets de soi peut être un moyen d'appréhender à nouveau une corporalité qu'on ne voit plus soi-même.' (Rufo 2007: 24)
[325] 'ces détracteurs' (Rufo 2007: 23)
[326] '[U]ne anorexique qui a dit un jour: "On se reflète beaucoup ici... . – Ça te dérange? – Non, de toute façon, je ne me regarde pas."' (Rufo 2007: 24)

5.5.2 Style guidance, occupation, play, self-discovery, identity work, tool for relationships: A *vêtothérapie* session at *Maison de Solenn*

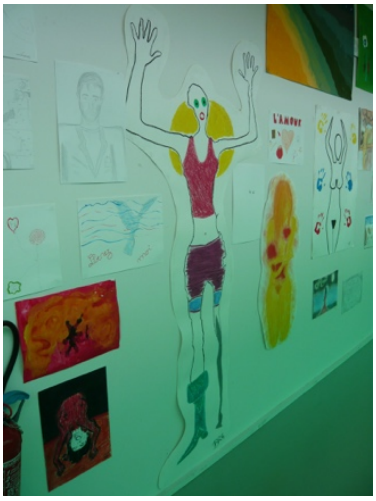


figure 121: On the way to the *vêtothèque* on the third floor of *Maison de Solenn* which is dedicated to *soins culturels,* one passes the art studio, where patients' drawings have been put up. Paris, 10.4.2008



figure 122: *Espace mode* – this symbol by the entrance to the dance studio designates the *vêtothèque* at *Maison de Solenn*.



figure 123: Martine Kagan, *educatrice specialisée* at *Maison de Solenn* and in charge of the *vêtothèque* since its inauguration in 2004 until 2015, Paris, 23.1.2009



figure 124: *Espace mode* – the *vêtothèque* at *Maison de Solenn* located in a large, glass-fronted and mirror-lined multi-purpose space which is also the dance studio. The wardrobes on wheels have been modelled on the ones in Marseille but remain undecorated. Paris, 10.4.2008

Twice a week Martine Kagan (figure 123) opens the *espace mode* for one hour. The *éducatrice specialisée*, who has been in charge of the *vêtothèque* at *Maison de Solenn* since its inauguration when Professor Rufo 'threw the garments into [her] arms' (Kagan, AI, 10.4.2008), prepares the room. She opens the fifteen wardrobes, puts on music and arranges some of the clothes, puts outfits together (figure 124). Kagan wants to create a pleasant atmosphere, a shop atmosphere, she said (AI, 10.4.2008). On the basis of a

contractual arrangement with the *Fédération Française du Prêt-à-Porter Féminin* (appendix 2), which was supported by Bernadette Chirac and organised by Maryline Bellieud-Vigouroux[327], *Maison de Solenn* receives donations from more than a dozen brands twice a year, in April and September: agnès b, Antik Batik, IKKS, Naf Naf, Kulte, Lacoste, Petit Bateau, Psy Monte-Carlo, Sessun (appendix 3 and 4) (figures 125–127). Kagan unpacks about three-hundred garments every season: indoor only, accessible and washable, sizes 34-44, no underwear (Kagan, AI, 10.4.2008).[328] She sorts them by labels, colours, materials and designates five wardrobes for men's garments, the other ten for women's (figure 128 and 129), unlike in Marseille, however, they are unmarked.



figure 125: A delivery for *espace mode* from agnès b., Paris, 10.4.2008

[327] Bellieud-Vigouroux (AI, 18.9.2013) recounted the beginnings of the collaboration with Chirac as follows: 'Madame Chirac attended the inauguration of *Espace Arthur* in 1999. She was already the wife of the head of state and the president of *pièces jaunes* and the *Fondation APHP* at that point, and very much "in love" with Marcel Rufo. In any case, Monsieur Rufo, either you love him or hate him. There is no in between. We love him. We are real groupies. I think Madame Chirac was the first to succumb to his charm, as she tested *L'Espace Arthur* at Marseille for her project at Hôpital Cochin. It was her ambition to build a big hospital for the kids and she wanted Marcel Rufo to be the director of this institution. So, Marseille was a test. She saw the fashion programme and was very enthusiastic. She said: "Listen, I am very interested in introducing this fashion space into my new project. See how you get on with it, if it is a failure or success. Let me know and if it is a success we shall do things together"'. // 'A l'inauguration [de *l'Espace Arthur*] en 1999 est venue Madame Chirac qui était déjà à la fois l'épouse du chef de l'Etat et aussi la présidente des pièces jaunes et de la Fondation APHP, qui était déjà très amoureuse entre guillemets de Marcel Rufo. De toute façon, M. Rufo, on aime ou on déteste, y a pas de sentiment tiède. Nous, on aime vraiment; on est vraiment des groupies. Madame Chirac, je pense que c'est la première qui ait subi le charme du Professeur Rufo, comme elle testait *l'Espace Arthur* à Marseille pour son projet à l'hôpital Cochin […]. Elle avait l'ambition de construire un grand hôpital pour les enfants et elle voulait que Marcel Rufo soit le directeur de cet établissement. Donc c'était un test, Marseille. Elle a vu le programme de la mode, elle était d'un grand enthousiasme, elle a dit "Ecoutez, ça m'intéresse énormément d'introduire cet espace mode dans mon nouveau projet. Menez-le, voyez si c'est réalisable, ça peut être un échec comme un succès, tenez-moi au courant, et si c'est un succès, revenez vers moi, et on fera des choses ensemble'. (Bellieud-Vigouroux, AI, 18.9.2013)

[328] The garments from the previous season are sold in a jumble sale twice a year.



figure 126: A wardrobe filled with garments donated by Antik Batik



figure 127: The Italian-born designer of Antik Batik, Gabriella Cortese, has been a supporter of *vêtothérapie* from the beginning.



figure 128: Set up to create a shop atmosphere - *espace mode* at *Maison de Solenn*

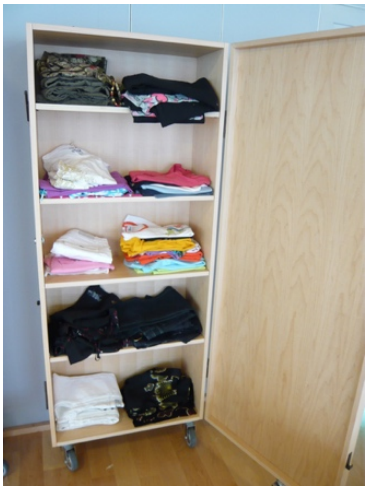


figure 129: Garments are sorted by type, colour, label or material.

Kagan was not given instructions on how to operate the *vêtothèque*. She has never visited *Espace Arthur*, nor has she met the therapeutic staff running *vêtothérapie* in Marseille, apart from Michèle Battista who came to visit a couple of times. It was Maryline Bellieud-Vigouroux who helped Kagan to get organised and unpack the garments for the first three seasons. 'It was a little like plunging into the unknown,'[329] Kagan (AI, 10.4.2008) recounted. She had been working with adolescents within social services for many years, had worked with dance before. 'It just came about like that' (Kagan, AI, 10.4.2008)[330]. Kagan (AI, 10.4.2008) cited her love of fashion and her 'genuine interest in dress in general' as a fitting basis for her work, adding 'it is part of my life and I have fun with it in the mornings before I leave. I play around with dress every day'[331].

Within the first year of working with *vêtothérapie* at *Maison de Solenn*, Kagan enlisted the help of a stylist because she wanted someone with more experience in

[329] 'C'était un peu plonger dans l'inconnu.' (Kagan, AI, 10.4.2008)
[330] 'Ça se fait comme ça.' (Kagan, AI, 10.4.2008)
[331] 'J'ai un intérêt réel pour les vêtements en général, ça fait partie de ma vie et de ce qui m'amuse le matin avant de sortir. Je joue avec le vêtement tous les jours.' (Kagan, AI, 10.4.2008)

fashion by her side. 'She has got a professional eye, so she'll know how to put together shapes and colours that I wouldn't necessarily think of,'[332] explained Kagan (AI, 10.4.2008). Eugénie de Mortemart (AI, 27.6.2014), who has been volunteering at the *vêtothèque* since 2005, described herself as a style advisor to persons in particular life situations, be that age, illness or morphological idiosyncrasies. When I observed a *vêtothérapie* session de Mortemart is on maternity leave and is substituted by Maï Pietri, a stylist who works in the fashion industry. Neither have received any training prior to working with the adolescents at the *vêtothèque.*

Espace mode, Friday, 23 January 2009, 10am: a small group of girls arrive, five in total, accompanied by two nurses. Aged between thirteen and sixteen, some of the girls have been hospitalised for months and evidently know the *vêtothèque* well. They briefly greet Kagan and move towards the wardrobes. According to Kagan (AI, 23.1.2009), the adolescents regard this time as a welcome break from the hospital floor. 'Well, you go there, go over there. I have received things, have a look through and I will be with you later,'[333] she tells them. Kagan has a brief exchange with the nurses, who leave and greets two girls she has not met before. The teenagers start looking through the wardrobes, touching the clothes, pulling out something, trying it on in a small adjacent room (figure 130), coming back to look at themselves in the wall-sized mirror (figure 131), 'a central moment of the session'[334] (Kagan et al. 2012: 403). Kagan tells them: 'This suits you,' but also: 'I don't like this on you, try that'. She points to new garments that have arrived: 'You will love this,' she says. Two very thin girls are clearly excited about the session: chatting, trying on garments, commenting on each other's outfits. Everything fits them, even if most of the clothes are too big, with belts and tucking. These two get most of the attention of both Kagan and the stylist Maï Pietri, who keeps saying: 'that's great on you!', but also: 'Next time I would like you to have breasts to fill this T-shirt'. One larger girl walks along the row of wardrobes, looking at garments, touching them and trying some on to find that most are too small. She is having difficulties to find something that fits. She does not engage with the other girls and does not get much attention.

Suddenly Kagan emerges from the changing room with a pair of scissors that have been left there when a new delivery was unpacked. Her and Pietri exchange an alarmed look. Halfway through the session the stylist pulls out a number of current fashion magazines, *Cosmopolitan*, *Vogue* and *Elle*: 'Lets look at the trends for this season'. The girls gather round and start discussing prints, dress shapes and 'the right way to wear jeans now'. Then Pietri starts explaining how a photographic fashion image

[332] 'Elle a le regard de sa profession, donc elle va savoir faire des accords de formes et de couleurs auxquels j'aurais pas forcement pensé.' (Kagan, AI, 10.4.2008)
[333] 'Bien, tu y vas, vas par là. J'ai reçu des choses, tu peux les fouiller et je viens te voir après.' (Kagan, observation, 23.1.2009)
[334] 'un moment central de la séance' (Kagan et al. 2012: 403)

is produced. She talks about styling and make-up, about lighting, angles and retouching. They go through the magazines pointing to signs of artifice, to models that are too thin: 'She looks far too thin,' they all agree. 'But you are even thinner than that,' Pietri addresses two of the girls. At the end of the session, Kagan gets out her log book and the girls return the washed and ironed garments they no longer want and choose up to three items of clothing they would like to borrow until the next session.[335]



figure 130: The changing room – a small adjacent space



figure 131: Surrounded by mirrors and glass – *espace mode* at *Maison de Solenn*, Paris, 10.4.2008

The official treatment description of *espace mode* on the website of *Maison de Solenn* reads as follows:

> Through dress and fashion the female adolescent and sometimes the male, seeks to tame her body which is changing, to enhance it, to embellish it, to love it, and to clothe it. The beautiful garments that are donated each season by fashion designers are made available to the adolescents during their hospitalisation to learn to find her or his style and own way of dressing […] to reconnect with their body, their image and self-esteem.[336] (Maison des Adolescents 2016)

Fashion is foregrounded, as is the function of finding one's own style. According to Kagan (AI, 23.1.2009) 'there are several levels of use of the *vêtothèque*'[337]. Apart from style guidance ('One leads the teenager to find his style.'[338]), she cited: occupation ('the occupation of time […] getting out of the second floor, the hospitalisation'[339]); play ('a game space'[340]); self-discovery ('To find one's own skin through the garments. […] That's finding yourself.'[341]); identity work ('There is something around identity that has to be

[335] The adolescents are responsible for the borrowed garments and have to wash and iron them before they are returned the following week. Laundry facilities are provided on the second floor for that purpose (Kagan 2008: 2).
[336] 'Par le vêtement et la mode, l'adolescente, et parfois l'adolescent, cherchent à apprivoiser son corps qui se transforme, à le mettre en valeur, à l'embellir, à l'aimer et à le vêtir. De beaux vêtements offerts chaque saison par des créateurs sont mis à la disposition des adolescents au cours de l'hospitalisation pour apprendre à trouver son style et sa propre manière de se vêtir […] pourront renouer avec leur corps, leur image et l'estime de soi.' (Maison des Adolescents 2016)
[337] 'Il y a plusieurs niveaux d'utilisation de la vêtothèque.' (Kagan, AI, 23.1.2009)
[338] 'On amène l'adolescent à trouver son style.' (Kagan, AI, 10.4.2008)
[339] 'l'occupation du temps […] sortir des murs du deuxième, de l'hospitalisation' (Kagan, AI, 23.1.2009)
[340] 'Un espace de jeu.' (Kagan, AI, 10.4.2008)
[341] 'Trouver sa propre peau par des vêtements. […] C'est se trouver soi-même.' (Kagan, AI, 10.4.2008)

worked on.'[342]); body image work ('One works a lot on body image and its acceptance.'[343]); and tool for relationships, a socialising activity – albeit with therapeutic and educational intent ('This is just a tool for relationships, *voilà*. It has to become therapeutic. It has to become educational or pedagogic. But it is a tool – for me.'[344]). Kagan (AI, 10.4.2008) emphasised the relational aspect of *vêtothérapie* by arguing that it enables links between the teenagers and their therapists, doctors, peers and even their families. However, while she repeatedly referred to the 'socialising' function of the *vêtothèque* and maintained that it 'provides the young with the possibility to be in relation with us (institution), and to be in relation between themselves'[345] (Kagan 2008: 2), Kagan always returns to the aim of style guidance. She described her role as 'leading the teenagers' to find 'their style'[346] (AI, 10.4.2008). This prioritisation of styling is also evident in Kagan's practice (from what I could gather from the one session I observed) and her comments to the adolescents: telling them what suits and what does not, making suggestions, proposing combinations, looking approvingly and disapprovingly at what the girls are wearing. This prioritisation is reiterated in the reflection and short interview following the session.

Once the girls have been picked up by the nurses again, Kagan and Pietri exchanged their views on the past hour, the styling, dress choices and behaviour of some of the girls whilst clearing the garments away and closing the wardrobes. Pietri (AI, 23.1.2009) explained why she brought in the magazines:

> The first time here that someone brings magazines. I want them to choose some pieces and afterwards we are going to find their look. I am going to ask them to draw them with an outfit and to find colour. I would like them to be aware of the quality, the colours and how things fit. I also want them to know that they have been photoshopped, to know that these are not real legs. […] And that their legs are much skinnier than that. So I also want them to realise that. They didn't realise, but I want to show it. And I think to find them their own style, it can be a plus. We could also do different specials, an accessories special and so on.

Pietri added that she sometimes does not know how far she can go in her comments. Repeating what she said to one of the girls about having breasts next time, she asked: 'Have I gone too far?' (Pietri, AI, 23.1.2009). Kagan (AI, 23.1.2009) jumped in: 'No. It's the reason why for every atelier, we work as a couple with a professional and a therapist[347]. There is a professional stylist here. That's you. So, there is no reason to be embarrassed because you gave your opinion'[348]. The reasons why Kagan enlisted the help of a fashion stylist was for her professional eye and opinion. Maryline Bellieud-

[342] 'Il y a quelque chose autour de l'identité qui se travaille.' (Kagan, AI, 10.4.2008)
[343] 'On travaille beaucoup sur l'image du corps et s'accepter.' (Kagan, AI, 23.1.2009)
[344] 'C'est qu'un outil de relation, voilà. Il va falloir que ça devienne thérapeutique. Il va falloir que ça devienne éducatif ou pédagogique, mais c'est un outil - pour moi.' (Kagan, AI, 10.4.2008)
[345] 'offrir la possibilité à un jeune d'être en relation avec nous (institution), d'être en relation entre eux' (Kagan 2008: 2)
[346] 'On amène l'adolescent à trouver son style.' (Kagan, AI, 10.4.2008)
[347] The interview with Pietri and Kagan moved between English and French, hence the original French language version is only given for some quotations.
[348] 'Il y'a une professionnelle du stylisme ici. C'est toi. Donc, il n'y a pas de raison de se gêner pour donner ton avis.' (Kagan, AI, 23.1.2009)

Vigouroux (AI, 18.9.2013), with whom Kagan developed her practice, equally regards the presence of an 'outside fashion professional' as 'very important' in *vêtothérapie*, someone who does not take account of the teenagers' illness, or will tell them that they are beautiful like their families might, but has, what she termed, a 'natural dialogue' with them, described by her as follows:

> "Ah, that doesn't suit you at all. You are too skinny." But I don't enter into their pathology. […] From the moment she is in front of me and wants to get dressed, I treat her like any other person, that doesn't bother me. And if she puts on a t-shirt that is too large, I say "no". "And then this colour, honestly with your complexion, it doesn't suit you at all. It would be better if you wore orange or pink. Or these trousers, well, you are pleased because your are drowning in them, but put a belt on then." And, so to have this natural dialogue, it makes them think.[349]

The act of telling other people what suits them and what does not, of telling them what to wear, of dressing other people is not only highly personal and intimate, but is also reliant on a knowledge-power relationship, as addressed in the context of "Therapy of Fashion" (4.4.2). The stylists and therapists involved in *vêtothérapie* hold certain truths about fashion, not just that it is positive and will make you 'feel good' (5.2), but also that 'finding one's style' is a desirable goal, that certain cuts and colours suit certain complexions and body shapes. These truths, which are largely naturalised, determine their practice, their way of talking and acting around the adolescents and grant them the authority to tell other people what (not) to wear.

In how far then does *vêtothérapie*, as it is practiced here differ from the aforementioned field of style advice and marketing which forms part of the fashion industry? While the *vêtothèque* is psycho-medically underwritten and said to be legitimated by the presence of a therapist (Rufo 2007: 83), its trend-based, fashion-sponsored approach and recurrent comparison to a clothing store, as well as comments of wanting to create a shop atmosphere, of the 'contemporary' nature of the garments that are 'of average price and can thus be bought by the parents'[350] (Kagan 2008: 3), all make for a commercial underpinning. In describing how she 'leads' the teenagers to 'find their own style' Kagan (AI, 10.4.2008) reiterated the parallel to commercial fashion:

> That happens over time. But as it would happen in a clothes store, if there is a good relation between the saleswoman and her client, who comes looking for love, comes looking for how I will love myself. And gradually she will be able to find what suits me better. That's work. It takes time.[351]

[349] '"Ah, no. Ça, ça te flatte pas du tout. Tu es trop maigre." Mais je rentre pas dans sa pathologie. […] A part du moment où elle est face à moi et qu'elle veut s'habiller, moi, je la traite comme n'importe quelle personne, ça ne me dérange pas. Et si elle se met un T-shirt trop grand, je lui dit "non". "Et puis cette couleur, franchement avec ton teint, ça te va pas du tout. Il vaut mieux que tu mettes de l'orange ou du rose. Ou ce pantalon, bien, t'es contente parce que tu flottes dedans, mais tu mets un ceinture alors." Et donc d'avoir ce dialogue naturel, ça les fait réfléchir.' (Bellieud-Vigouroux, AI, 18.9.2013)

[350] 'Ils sont donc contemporains, à prix moyen, et donc achetables par les parents.' (Kagan 2008: 3)

[351] 'On amène l'adolescent à trouver son style. Ca se fait sur la durée, ça. Mais comme ça se ferrait dans un magasin de fringues, si il y a un bon lien qui se met en place entre la marchande de vêtement et sa cliente qui vient chercher l'amour, qui vient chercher comment je vais m'aimer. Et progressivement elle va pouvoir trouver ce qui me convient mieux. C'est un travail, ça. Ca prend du temps.' (Kagan, AI, 10.4.2008)

With regards to her work with the adolescents Kagan added: 'And it shouldn't be our own responses. Everyone is free'[352]. Asked about this notion of freedom in dress and whether she thought *vêtothérapie* in particular and fashion in general carried, certain normative ideals, Kagan (AI, 10.4.2008) negated:

> No. What is proposed, is completely heterogeneous. In any case it is part of a trend. We receive the garment the moment the collections hit the shops. But everything is heterogeneous. There is something for everyone… . The work we're doing here is not about suggestion. There may be a proposition. […] But the patient leaves with whatever he has chosen. I would like to believe that there is a certain freedom after all. I don't confine anyone.[353]

Dress is regarded as a neutral tool by Kagan, just as it is by most of her colleagues at *Espace Arthur* (5.2 & 5.3). The prescriptive nature of dress remains unacknowledged, so does the authority of the therapist and stylist, their power over definitions of what is suitable thus beautiful. While Kagan argued that there is a choice of garments for everyone, the girl who could not find many clothes that fitted her during the observed session suggested otherwise. With regards to dress sizes Kagan (AI, 10.4.2008) told me that she never talks in sizes, that she 'hides them', that 'there is no 34, 36, 38'[354]. Asked whether or not the size labels are left in the garments at the *vêtothèque* in Paris, she replied: 'Yes, of course. That's the reality'[355] (Kagan, AI, 10.4.2008). Dress categorises, as discussed in relation to the sizing practices at *Espace Arthur* (5.3.2). Fashionable dress in particular is inscribed with normative notions of physical and aesthetic beauty that are largely naturalised in this setting. Thus to speak of freedom in relation *vêtothérapie* appears to be an illusion, as it negates its own impact, negates that dress is regarded as a socialising thus normalising and a disciplining technology of the fashionable adolescent self. 'A dangerous illusion of freedom' Tomlinson (1990: 13) terms the notion of commodity-based identity construction in our consumer culture, whose description shares elements of *vêtothérapie*:

> Our personal identity is created out of elements created by others and marketed aggressively and seductively. This is the key to what have emerged as the dominant modes of consumption, based upon an individualized sense of selfhood and well-being and the notion of free choice. But if we think we are free when our choices have in fact been consciously constructed for us, then this is a dangerous illusion of freedom.

Running through *vêtothérapie* is a discrepancy between what is said about the treatment by its practitioners and what is done. Dress is regarded as a neutral and positive tool, yet it is employed in a normative and prescriptive way. The patients are said to be free, yet they are being told what suits them. They are meant to 'discover themselves' and

[352] 'Et il ne faut pas que ce soit nos réponses à nous. Chacun est libre.' (Kagan, AI, 10.4.2008)
[353] 'Non. Non, c'est complètement hétérogène, ce qui est proposé. De toute façon, ça s'inscrit dans un courant. On reçoit des choses au moment où des collections tombent dans les magasins. Mais tout est hétérogène. Il y en a pour tout les… . Le travail qu'on fait là, n'est pas de la suggestion. Il peut y avoir une proposition. […] Mais le patient part avec ce qu'il a choisi. J'ai envie de croire qu'il y a quand même une certaine liberté. Je n'enferme personne.' (Kagan, AI, 10.4.2008)
[354] 'Il y a pas de taille de vêtement, je les cache. […] Il y a pas 34, 36, 38.' (Kagan, AI, 10.4.2008)
[355] 'Oui, bien sûr. C'est la réalité.' (Kagan, AI, 10.4.2008)

'find their own style', yet there is a stylist who suggests how they should look, who approves or disapproves their dress choices. 'That's very difficult for the therapeutic staff to know how to remain in the background. Not give or be, not to impose something of ourselves. We are not here to express ourselves,'[356] Kagan (AI, 10.4.2008) remarked at the end of our interview as I am about to leave. Writing about the *vêtothèque* at *Maison de Solenn* in 2012, Kagan together with de Mortemart and Bellieud-Vigouroux include the following comment:

> The therapeutic relationship in this workshop on dress and the body, authorises the *educatrice* and the stylist to perform a certain number of gestures or words that are normally prohibited between strangers. These situations carry a risk and the respect of the person should be foregrounded.[357] (Kagan et al. 2012: 403)

While this statement constitutes a legitimisation of the action of *vêtothèque* staff in the name of therapy, a sanctioning of some of the practices documented in this chapter, it also draws attention to the ethical implications, to 'a risk' involved, albeit without further specification. Moreover, this statement points to the inherent contradiction of *vêtothérapie,* as previously addressed (5.2). Working with something as value-laden as fashionable dress in a context that is deeply implicated in therapy culture by people whose tastes, words and gesture are highly subjective makes it impossible to 'remain in the background' to abstain from 'imposing' the own self on that of others. It makes for the construction of highly individual, complex and contradictory practices related to the term *vêtothèque*[358].

[356] 'C'est une grande difficulté pour les soignant de savoir être suffisamment en retrait, de pas donner ou de pas être, de pas imposer quelque chose de même. C'est pas nous qui sommes là pour exprimer.' (Kagan, AI, 10.4.2008)
[357] 'La relation de soin, dans cet atelier autour du vêtement et du corps, autorise l'éducatrice et la styliste à un certain nombre de gestes ou de paroles qui sont habituellement interdits entre étrangers. Ce sont autant de situations à risque où le respect de la personne doit être au premier plan.' (Kagan et al. 2012: 403)
[358] Martine Kagan stopped working at *espace mode* in January 2015. Brigitte Persello, who is currently in charge of *vêtothérapie* at *Maison de Solenn* did not wish to be interviewed about her work. (Moro, personal correspondence, 17.1.2017)

5.6 Conclusion

'Today, we even notice a transformation in the therapeutic staff, more attention is paid to their appearance,'[359] Michèle Battista (in Rachline 2000: 134) remarked one year after the *vêtothèque* was inaugurated at *Espace Arthur*. Her comment is reminiscent of an observation made by Dr Miller (et al. 1960: 43) at Napa State Hospital forty years earlier about a 'noteworthy improvement' in the 'appearance' of 'ward staff' following the pilot of "Therapy of Fashion" (Ch.4). Four decades lie between these two dress-related therapeutic practices on either side of the Atlantic. While it is not the aim of this thesis to compare the different settings, some elements of their discursive construction are strikingly similar: an uncritical and neutral understanding of fashionable dress, a belief that 'looking good' will make one 'feel better', the implication in therapy culture and the resultant obligation to dress 'well' and 'look after' one's appearance which explain the positive evaluations of changes in staff appearance above. However, the cultural underpinnings of *vêtothérapie* as well as its federal programmatic support are unique features, as are the different practices it entails.

La vêtothèque is a collective term. Under its umbrella different therapeutic applications are undertaken: dress and costume therapy with children in Fréjus and diverse forms of fashion therapy at *Espace Arthur* and *Maison de Solenn*. These practices are discursively constructed in distinct ways by the respective parties involved in *vêtothérapie*, as this chapter documents in detail. However, while fashionable dress is commonly said to be a neutral cultural tool, it is seen to reflect and disclose the self. Consequently, as I argue in this chapter, the dress used within the *vêtothèque* in general and *vêtothérapie* in particular are regarded as a cultivating and socialising thus normalising and disciplining technology of the adolescent self.

[359] 'Aujourd'hui, on constate même une évolution chez les soignants, plus d'attention portée à leur allure.' (Battista in Rachline 2000: 134)

chapter six
The haptic suit:
Sensory stimulation treatment

Introduction



figure 132: The haptic suit, a neoprene diving suit by Barakuda, a German company who produce the made-to-measure suits currently used in sensory stimulation treatment as part of body therapy at the Clinic for Child- and Adolescent Psychiatry at Charité hospital Berlin

Sensory stimulation treatment proposes the prolonged wearing of a diving suit to target the body schema disorder argued to be involved in anorexia nervosa. Piloted by German haptologist Martin Grunwald in 2003, this suit is supposed to remap the body schema of patients and result in a more realistic physical self-perception. As a touch-based approach, it is said to stand in opposition to the largely visual-centred cognitive behavioural therapies employed predominantly in the treatment of this prevalent yet unresolved eating disorder. Since its pilot study, it has been applied at a small number of hospitals in Germany and Austria.

One garment: a neoprene diving suit, the haptic suit. Only one item of clothing is used in sensory stimulation treatment. Unlike both "Therapy of Fashion" and *vêtothérapie* it does not take dress as a starting point. Its founder did not consider the clothing of the patients he was aiming to treat, nor was he interested in fashion. As such, this therapeutic approach seems to stand in contrast to the other dress-related therapeutic practices, only incorporating a garment because it could simulate the sense of touch most effectively. However, this garment is constructed as a technology of the self in similar ways as in the other two therapeutic practices. The diving suit is therapeutically re-appropriated as the "haptic suit".[360] It is employed to normalise the self-perception, and thus the body weight, of patients with anorexia. Consequently, as this chapter demonstrates, dress is psycho-medically re-inscribed and discursively constructed as a form of self-work just as much as the other two treatments.

The present chapter analyses the discursive construction of sensory stimulation treatment. This little-known dress-related therapeutic approach is explored in its development, scientific underpinnings and current applications. Moreover, I investigate the conditions of possibility, the discourse of haptics and of tactile[361] aspects of the self that underpin, and in turn engender this body-centred treatment.

This chapter argues that sensory stimulation treatment, in its prioritisation of touch in relation to the self and dress, constructs itself as a 'counter-discourse' (Foucault 1972: 209). I analyse the underlying discourse of the importance of touch to the self, the resulting treatment approach, and indeed, the haptic suit itself, as a counter-discourse to largely ocularcentric notions of self in general (6.2.3), and to a cognition-based understanding and treatment of anorexia in particular (6.1.2). Moreover, this chapter maintains that sensory stimulation treatment, whilst not aimed at fashioning patients through the use of fashionable dress, is equally concerned with transforming and normalising their self-perception and thus their bodies and selves.

[360] It should be noted that the term "haptic suit" is not used by Grunwald himself, but was coined in the context of the application of sensory stimulation treatment at the University hospital Salzburg (ÖGKJP 2015). Grunwald refers to a 'diving suit' or 'neoprene suit'.

[361] The term tactile denotes touch-based. As Grunwald (2004: 18) explains: 'One speaks of tactile perception, when pressure-, pain- or temperature stimuli meet motionless body regions.' // 'Von taktiler Wahrnehmung spricht man, wenn Druck-, Schmerz- oder Temperaturreize auf eine selbst unbewegte Körperregionen treffen.' (Grunwald 2004: 18) // Tactile perception thus forms part of our haptic perception, which refers to both tactile and kinaesthetic aspects, the latter representing what we feel in our muscles, joints or tendons – the moving sensory feedback.

6.1 Sensory stimulation treatment: The development of a treatment approach

6.1.1 The exploration of anorexia nervosa in relation to haptic perception: The construction of a scientific discourse

> In societies like ours, the "political economy" of truth is characterized by five important traits. "Truth" is centered on the form of scientific discourse and the institutions which produce it; it is subject to constant economic and political incitement (the demand for truth, as much for economic production as for political power); it is the object, under diverse forms, of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body, notwithstanding certain strict limitations); it is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media); lastly, it is the issue of a whole political debate and social confrontation ("ideological struggles"). (Foucault 1984d: 73)

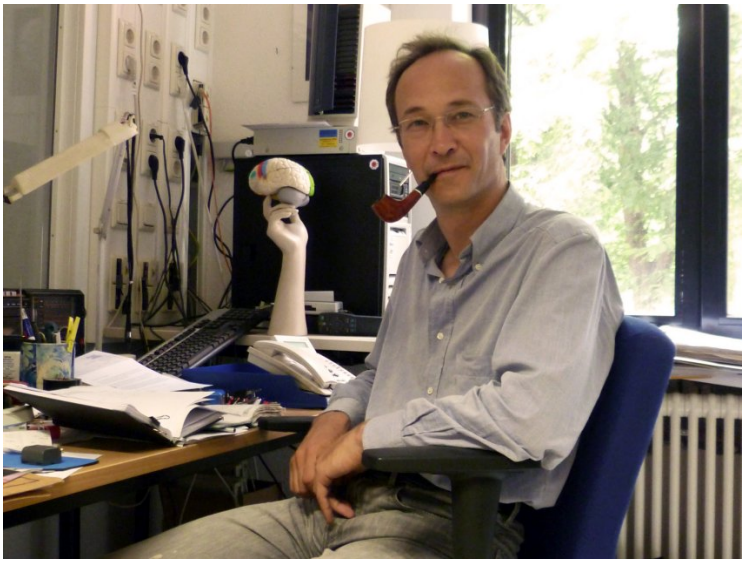


figure 133: Martin Grunwald in his office, Haptic Laboratory, University of Leipzig, Germany, 24.4.2013

Dr Martin Grunwald (figure 133) is the head of the Haptic Research Laboratory at the Paul Flechsig Institute for Brain Research at the University of Leipzig. He defines haptics as 'the science of the human sense of touch' (Grunwald & John 2008: 15) and focuses on the research and analysis of haptic perception, 'which does not only consist of the sensing of the surface, size, and contour of objects via cutaneous receptors, but also deep sensibility, which conveys the position of our bodies to consciousness by means of sensors in joints, muscles and tendons'[362] (Mazhar 2013).

Trained as a psychologist he founded the Laboratory, the only one of its kind in Germany, in 1996, specialising in basic haptic research as well as applied clinical and industrial research. Grunwald thus continues a long experimental psychological research

[362] '[Die haptische Wahrnehmung], wozu nicht nur das Erfühlen von Oberfläche, Größe und Kontur von Gegenständen mithilfe der Hautrezeptoren zählt, sondern auch die Tiefensensibilität, die dem Bewusstsein mittels Sensoren in Gelenken, Muskeln und Sehnen die Lage unseres Körpers im Raum vermittelt.' (Mazhar 2013)

tradition at the University of Leipzig, where physician Johann Heinroth (1773–1843) held the first chair in *'Psychische Heilkunde'* (psycho-medical science) (Kreuter 1996–II: 537) and where physiologist Wilhelm Wundt (1832–1920) founded the first psychological laboratory in 1879 (Kreuter 1996–III: 1604).[363] Among Grunwald's academic ancestors Wundt, in particular, was 'instrumental in establishing psychology as an experimental science dealing with observable, measurable effects' (Boslaugh 2014: 332). It is on the basis of his work, that the University is regarded as 'the birthplace of modern psychology'[364] (Huster 2016) and thus constructed as what Foucault above terms an 'apparatus of scientific truth'.

Grunwald's research has also been directly influenced by another of his predecessors, an early pioneer of experimental psychology, the anatomist and physiologist Ernst Heinrich Weber (1795–1878) (Boslaugh 2014: 331). Grunwald argues that the 'scientific and systematic examination of the human sense of touch' began with Weber (Grunwald & John 2008: 15), whose studies were published in two seminal texts on the subject (1835 & 1846). His work marked the beginnings of a long and rich tradition of haptics in Germany (Grunwald & John 2008: 15), which constitutes part of the conditions of possibility for Grunwald's research in general, and sensory stimulation treatment in particular. This haptic tradition came to a halt, however, with World War II when scientific psychology took a cognitive turn, according to Grunwald (et al. 2008: 15), a development he aims to challenge, as evidenced in the haptic suit. Grunwald thus puts forward another 'regime of truth' (Foucault 1984d: 73), and engages in a struggle for truth, in the construction of an alternative scientific discourse for the development of sensory stimulation treatment, as this sub-section explores.

In 2003 Grunwald undertook a pilot study termed 'Inducing sensory stimulation in treatment of anorexia nervosa', which saw the therapeutic re-inscription of a diving suit (6.1.3). The results were published, after numerous editorial rejections, in a medical journal as a short article in 2005 (Grunwald & Weiss), and in much more detail in a chapter of a book edited by Grunwald (ed. 2008). The majority of his chapter, entitled 'Haptic perception in anorexia nervosa', is dedicated to the background research and ten-year-long scientific journey towards the pilot study, a detailed production of 'truth

[363] At that period, shortly after the establishment of the German Empire, 'mental health care entered a new phase' in Germany, 'with the introduction of the academic system of university clinics, […] designed to be elite institutions, where the most up-to-date medical methods and techniques would be developed and applied to solve the persistent problem of madness' (Pietikainen 2015: 95–6). The 'continuous and systematic research on mental disorders' (Pietikainen 2015: 97) undertaken in these academic and research-oriented clinics, affiliated to medical faculties, established Germany as a 'leader in the development of scientific psychology and psychiatry' (Boslaugh 2014: 331). In 1880, for example, 'there were no fewer than 21 chairs in psychiatry in the German Empire – more than anywhere else in the world' (Pietikainen 2015: 116), some of these and their teachers have been discussed earlier (Ch.3). To this day, university clinics play a vital scientific and academic role due to their 'unique feature' of providing both research and teaching in all areas of patient care, according to Ralf Heyder (2015: 99), general secretary of the Association of University Hospitals in Germany. Accordingly, Grunwald's own research was enabled precisely through this collaborative setup in Leipzig.

[364] 'Psychologie in Leipzig – Geburt einer Wissenschaft' (Huster 2016)

through scientific knowledge' (Foucault in Martin 1982: 15) that includes research data and visual documentation (reproduced here as figures 134–137). This trajectory is reiterated and 'circulated' (Foucault 1984d: 73) in articles on Grunwald (e.g. Blakeslee 2007, Henschel 2004, Stoll 2014) and in interviews given by him (3sat 2010; mdr 2010; Grunwald, AI, 24.8.2007) as an essential scientific basis on which sensory stimulation treatment was developed. Grunwald (2008: 335) describes that he began conducting 'psycho-physiological trials into brain electrical changes during haptic perception', as part of his doctoral research at the University of Jena in the mid-1990s (figure 134).[365]

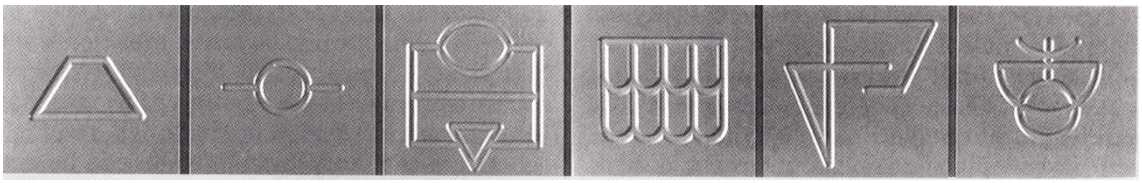


figure 134: The haptic task: 'Six haptic sunken reliefs of varying degrees of complexity made of hard plastic. The engraving design is 7mm wide and 3mm deep.' (Grunwald 2008: 340)

The haptic task, as this test became known as later on, 'consisted of having subjects haptically explore sunken reliefs [figure 134] with closed eyes [figure 135] and then reproduce the image presented upon them afterwards with their eyes open' Grunwald (2008: 335) details. 'The aim was to analyse the stimuli-dependant changes in the subjects EEG'.

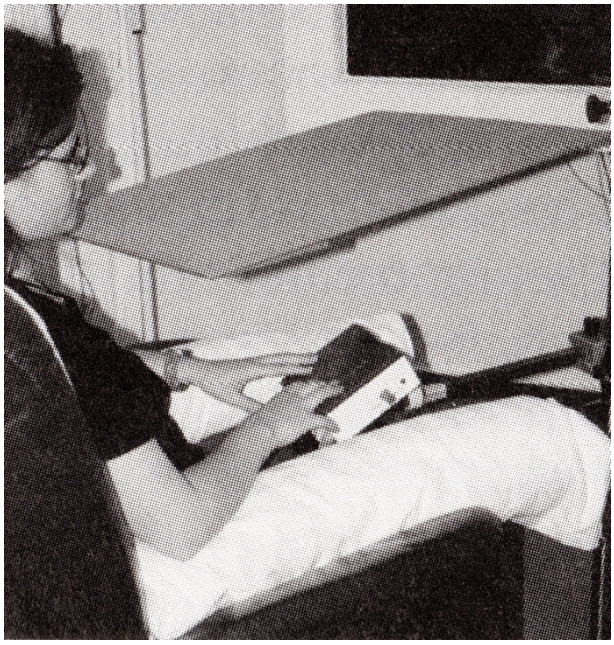


figure 135: The haptic task: 'Position of the test subject during haptic exploration of one sunken relief. […] With the help of a strategically placed screen the participants were prevented from gathering visual information about the stimuli.' (Grunwald 2008: 340)

[365] While Grunwald's account rationalises his academic journey, in our first interview he spoke in detail about scientific arbitrariness, as mentioned earlier (2.4) and the many coincidences involved in the development of this treatment approach concerning his specialisation in haptics, the focus of his doctoral research, coincidental meetings and findings (Grunwald, AI, 24.8.2007).

Grunwald describes this task as an extremely easy one: 'You simply have to transform what you feel into what you see. You do this all the time without thinking, as when plunging your hand into your car's glove compartment in search of a hairbrush or sunglasses. A quick slide of the fingertips usually identifies objects immediately' (Blakeslee 2007: 49). Consequently, when eventually 'one test subject was completely unable to perform the task' Grunwald (2008: 335) 'wanted to explain these unexpected individual findings'. He recounts how this young woman required 'much longer exploration times' for 'reproductions that […] showed that her perception of the stimuli's entire structure was completely false and distorted' (335). And he adds that: 'a series of theoretical considerations and experimental studies […] led us to the field of clinical-experimental psychology and an extreme mental disorder – anorexia nervosa' (335).

Even though Grunwald only happened upon this illness by chance, as he put it (AI, 24.8.2007), and it was effectively a data-driven by-product of his core research, the psychologist decided to continue the exploration of his 'hypothesis that anorectic patients have a perception disorder'[366] at the Haptic Research Laboratory at the University of Leipzig, making the eating disorder one of his fields of professional activity:

> I once said: I want to crack anorexia. To me it was like a game of chess. I really wanted to find an approach… You know, fifteen percent die! Ten to fifteen percent of girls die in the course of the disease. They went through ten, twenty therapies. They've seen every hospital in the field. They die of kidney failure, heart failure… . That was my ambition. In all honesty. Once you have seen these girls… they don't want to die. They want to live. They want to have fun, too. But they are unhappy, anorectic, have a body schema disorder and can't eat. And there are two patients I had seen who died in the course. It spurs you on.[367] Grunwald (AI, 24.8.2007)

In his account of the development of sensory stimulation treatment, Grunwald (2008: 335) terms anorexia nervosa 'one of the most severe mental disorders' and defines it as an illness 'characterised by extremely low body weight and with an obsessive fear of gaining weight', an illness affecting predominantly 'young girls'. *Magersucht*, the German term, literally means addiction to skinniness. Accordingly, Grunwald (335) describes that patients affected by anorexia 'often control body weight by voluntary starvation, vomiting, purging, excessive exercise, sports or other weight control measures'.

While different types of eating disorders often overlap, somewhat qualifying existing statistics, it is assumed that one in six adolescents between the ages of eleven

[366] 'Denn anhand dieses Falles entstand dann die Hypothese, ja, möglicherweise haben anorektische Patienten eine Wahrnehmungsstörung.' (Grunwald, AI, 24.8.2007)

[367] 'Ich will die Anorexia knacken. Das ist für mich wie so ein Schachspiel gewesen. Ich wollte das wirklich knacken, ich wollte irgendeinen Zugang finden, wo diese… . Verstehen Sie, es sterben 15%. 10-15% der Mädels sterben im Verlauf der Erkrankung. Die haben zehn, zwanzig Therapien hinter sich. Die haben jedes Krankenhaus gesehen, was es im Bereich gibt. Die sterben Ihnen an Leberversagen, Herzversagen… . Das war dann schon mein Ehrgeiz. Das muss ich ehrlich sagen. Also, wenn Sie das einmal gesehen haben, dass da Mädels… . Die wollen nicht sterben, nur die sind nicht bei sich. Sie wollen aber nicht sterben. Die wollen leben. Die wollen auch Spass haben. Nur sind sie unglücklich, magersüchtig, körperschemagestört und können keine Nahrung zu sich nehmen. Und dann sind eben auch zwei Patienten, die ich schon untersucht habe, sind auch gestorben, im Verlauf. Das stachelt auch einen Ehrgeiz an.' (Grunwald, AI, 24.8.2007)

and seventeen is currently suffering from an eating disorder in Germany (Kramer-Förster 2009: 100). More specifically, according to a recent study by the federal Robert Koch Institute, 1.1% of women and 0.3% of men are affected by anorexia nervosa (Hilgemeier 2016), whose long-term effects include osteoporosis, hair loss, or infertility, and which is considered the 'mental illness' with the highest death rate (Kramer-Förster 2009: 100 & Brumberg 2006: 17). Approximately 15% of patients die, because of related side effects or suicide (Cecere 2012: 182).

Although 'cases of female anorexia were documented as early as the thirteenth century' (Kaiser 1997: 104), and the illness was named and identified in English-language medicine by the 1870s (Brumberg 2006: 15) and has since been widely accepted as a medical condition, to this day a cure 'is not easily accomplished and recidivism rates are high' (17). This lack of reliable methods of treatment was reiterated by Grunwald (AI, 24.8.2007) as a justification for the development of sensory stimulation treatment. He described an inconsistency between the current capacity and achievements of science, as he put it, and the persistently unresolved nature of anorexia, between a scientific discourse of discovery and the situation of patients:

> There is a certain discrepancy. Mars has a beautiful surface – I think that's great. I also find it amazing that we are able to perform heart transplantations, kidney transplantations by now. We are capable of so many great things. Yet, in relation to the psychological disorder of anorexia ten percent go to heaven. Long before their time! Long before their time. […] Somehow, I think, there is a discrepancy between our technical industrial possibilities and our possibilities to really help in the field of psychology.[368] (AI, 24.8.2007)

To this day, the cause and treatment of anorexia remain unresolved. 'Complex' is a term that is repeatedly used (e.g. Brumberg 2006: 15, Cecere 2012: 182, Strober 2006: 159) as is the notion that it is precipitated 'out of a mix of psychological and biological vulnerabilities' (159). In his writings, Grunwald (2008: 335) summarises the current state of research: 'The reasons for the development of anorexia nervosa are still not fully explained. It is unanimously agreed that multi-factorial conditions are responsible. Alongside psychological and social factors, genetic and patho-physiological processes are being discussed'. Moreover, according to Grunwald (2008) there is also a general agreement in this otherwise uncertain field concerning the crucial role of body image in both the onset and development of the illness. In 1978 the German-American doctor and psychoanalyst Hilde Bruch had described a distorted body image as a key feature of anorexia nervosa in her seminal work *The Golden Cage*[369]. Not only do the majority of

[368] 'Und es gibt eine gewisse Diskrepanz. Schön Marsoberfläche, finde ich ganz große Klasse. Ich finde es auch ganz toll, dass man Herzen transplantieren kann und Lungen mittlerweile. Wir können so viele tolle Sachen. Aber bei der psychischen Störung der Magersucht gehen uns da 10% Richtung Himmel. Lange vor der Zeit. Lange vor der Zeit. [...] Und irgendwie finde ich, da gibt es so ein Missverhältnis zwischen unseren anderen technischen industriellen Möglichkeiten und unseren Möglichkeiten im psychischen Bereich wirklich zu helfen.' (Grunwald, AI, 24.8.2007)

[369] The title of Bruch's book implies anorexia nervosa to be an illness affecting predominantly girls from affluent families, as she had witnessed and treated the eating disorder in mid-twentieth-century US. Whether or not the illness was brought to the attention of doctors by affluent families more frequently, thus determining this perceived class-relation remains unclear. However, since then, the demographics of anorexia nervosa have changed significantly, according to Cecere (2012: 181) who argues: 'If Hilde Bruch (1978) could say in the mid-twentieth century that anorexia appeared to be a

patients believe they are well, in spite of being clinically underweight, they also tend to overestimate their body size, often dramatically, asserts Grunwald (2008: 335) in his account of the treatment development with reference to a series of experimental studies. Yet, Grunwald (2008: 337) adds, the reasons behind the prevalent body image distortion remain largely unexplored, which is where he positions his research, questioning the implications of a possible perception disorder for someone's physical self-perception. In the description of his research journey, he details that the repetition of the haptic task with a bigger sample (figure 136) confirmed his hypothesis about distorted haptic perception in patients with anorexia on the basis of 'significant differences between the two groups' concerning both quality of reproductions (figure 136) and EEG data (342).

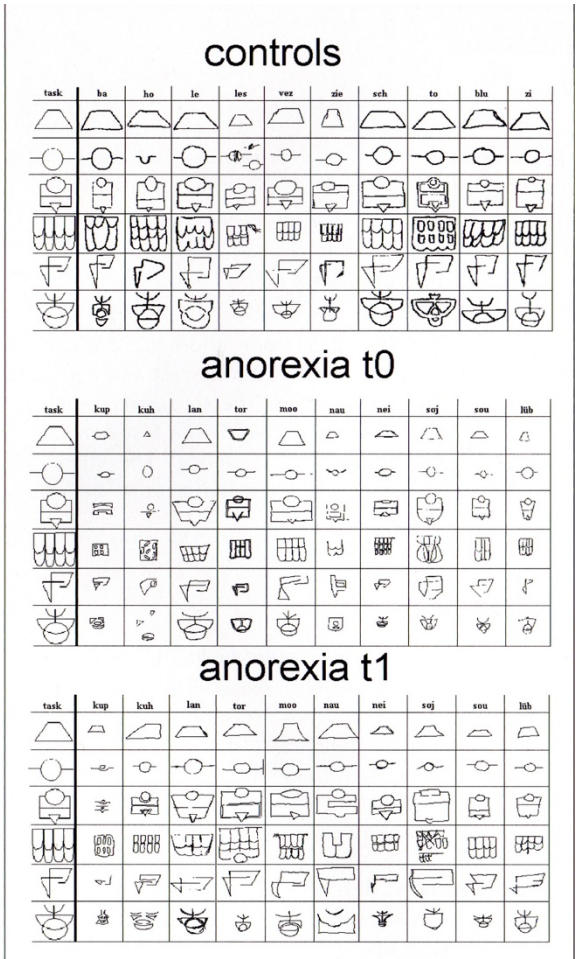


figure 136: The haptic task: 'Reproductions submitted by healthy controls and by patients with anorexia nervosa' (Grunwald 2008: 342)

strange disease affecting upper-class, well-educated young girls, now we find ED patients in all social classes. In recent years, the epidemiological data related to these diseases have shown worrying global increase'.

Moreover, Grunwald's research concludes a dysfunction of the 'right parietal cortex' in 'AN patients', including 'an altered ability in processing perceptions and somatosensorical integrations' (343). And he describes the development of another neuro-psychological test, the *Haptimeter* (figure 137) for further investigation.

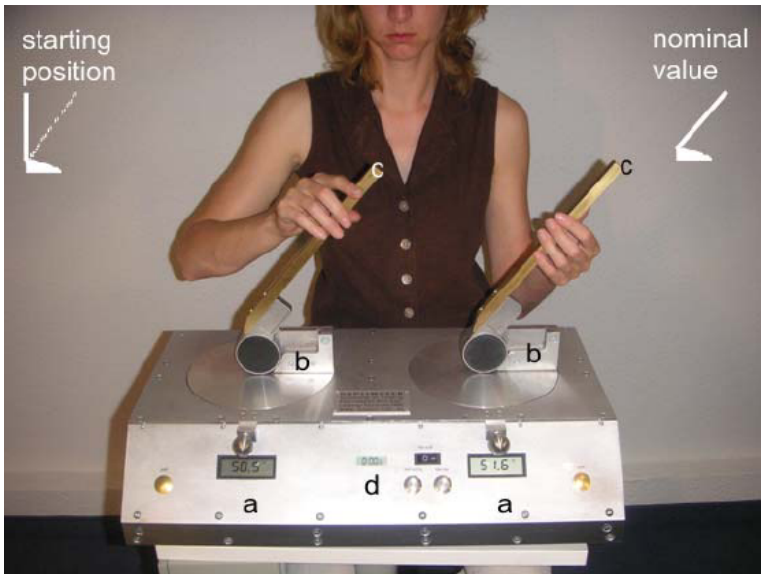


figure 137: The haptimeter, featuring 'two adjustable, digital angle legs. The investigator set one of these legs to a defined position and the test subject was to reproduce this angle on the second leg (with closed eyes)' (Grunwald 2008: 344). According to Grunwald (2008: 344), 'clear differences between AN group and healthy controls' were the results of this test and confirmed a dysfunction of the right parietal lobe in anorectics, that area of the brain responsible for the production of spatial percepts, for the perception of our bodies in space, for the correlation of 'multisensory information to maintain a bodily sense of self' (337).

After detailing 'clear differences between AN group and healthy controls' concerning spatial perception[370], Grunwald (2008: 344) presents his final conclusion as follows: 'Our results support the presumption that not only a distortion of body image exists in cases of anorexia nervosa but, rather, of body schema as well' (348).[371] As previously discussed (1.1), body image refers to a conscious visual self-representation (Haggard & Wolpert 2005: 1). Body schema, in contrast, denotes an unconscious form of self-representation (Haggard et al 2003: R171)[372] or as Grunwald explains: 'a real-time

[370] Grunwald (2008: 347) explains: 'Particularly the right posterior parietal lobe organises multisensory integration and is responsible for the production of spatial percepts. This warrants the assumption that the right posterior parietal lobe plays a crucial role in the comparison of nominal and actual values. […] a functionally disturbed right parietal lobe does not provide enough processing resources. Thus, the distinctively increased angle differences as shown in the AN group can be interpreted as a consequence of this disturbance'.

[371] Grunwald (2008: 348) details: 'The notable EEG changes in the parietal cortex during haptic demands, the poorer reproduction performances with the sunken reliefs and also the large deviations in the angle paradigm suggest that the multi-sensory integration is disturbed in patients with anorexia nervosa. This impairment of multi-sensory integration is probably a direct result of a functional disturbance in the right parietal cortex. […] If one follows this hypothesis then, in anorexia nervosa, a body schema distortion exists based on a functional deficit of the right parietal region'.

[372] The term schema in relation to the body was proposed by British neurologists Head and Holmes (1911: 187) to imply 'an unconscious and passively updated representation of the position of the body in space, often identified with the parietal lobes' (Haggard et al 2003: R171). The Austrian psychiatrist Paul Schilder (1923: 2) adapted it from them as *Körperschema*, which he defines as 'the spatial perception everyone has of oneself' // 'Als Körperschema bezeichne ich das Raumbild, das jeder von sich selber hat.' (Schilder 1923: 2) //. However, Schilder simultaneously uses *Körperbild* (body image) to describe the mental representation of one's own body (1.1), leaving it unclear if either term is 'meant to describe processes that are available to the conscious mind' (Grunwald 2008: 336). According to Grunwald (2008: 336) the confusion between body image and body schema has only been addressed in recent years. Generally speaking, he

abstract, internal representation of one's own body in space which is derived from sensory input'.[373]

One of the key features of the scientific discourse constructed by Grunwald is his argument that anorexia nervosa essentially constitutes a body schema disorder, his assertion that it is our body schema which comprises the basis for our body image in the first place as 'an absolutely central and basal aspect of one's mental bodily representation' (Grunwald 2008: 335). Moreover, Grunwald (335) insists that current therapies are 'relatively inefficient' because they are based on cognition, which cannot impact on body schema. He thus competes in a 'truth game' (Foucault in Martin 1982: 15) by constructing a scientific discourse intended to counter what he regards as the dominant cognitive discourse of anorexia, one that could form a distinct treatment practice, as I discuss below.

argues that 'the scientific attempt to describe mental representation, the conscious and unconscious depiction and perception of one's own body, has a long history' in a number of academic disciplines, which have developed 'a variety of concepts, and accordingly, terminologies […] which are not used uniformly' (336). 'This is especially true of 'body image' and 'body schema', he states, 'which are used differently not only in the German speaking world but also in English speaking circles' resulting in a confusion over key terminology that 'only in the last few years, led to an effort to create a uniform terminology to be used in all of these fields' (Grunwald 2008: 336).

[373] Grunwald himself used to refer to 'body image' when he first published the above research together with a colleague in 2005 (Grunwald & Weiss) but has since been much more precise about the distinction. In his account of the development of sensory stimulation treatment he details: '[O]ne can use the term *body schema* to refer to an on line, real-time abstract, internal representation of one's own body in space which is derived from sensory input (including muscle, haptic, cutaneous, vestibular, tactile, visual, and auditory). This representation provides a three-dimensional, temporal, dynamic representation of the body in space and biomechanical properties of one's body, which articulates with motor systems in the genesis of action. The term *body image*, in contrast, refers to a conscious representation of the body; the private body-related concepts of oneself (attitudes, thoughts about and feelings towards one's own body) as well as conceptual knowledge about the body. Aspects of body image can be represented verbally or cognitively. The two terms, therefore, essentially differentiate themselves in purpose and content of that which they are meant to describe' (Grunwald 2008: 336).

6.1.2 'All this psychodynamic jabbering that is fruitless and misses these women and girls completely. They continue to be ill.': The construction of a counter-discourse

> With regards to eating disorders, I think, too little neuro-biological research has been undertaken in the many years previously, let alone brain research. One just believed in the psychoanalytic interpretation. Identity problems, relationship conflicts between the parents – these classic concepts of psychoanalysis then – conflicts regarding the self, gender identity and so forth. Many "plastic" words, too. And that is not enough. It is simply not enough.[374] (Grunwald, AI, 24.8.2007)

In both his written work and interviews Grunwald constructs a scientific discourse which not only criticises what he portrays as a general and dominant approach to researching and treating anorexia, but which also justifies his own work. This 'battle "for truth", or at least "around truth"' (Foucault 1984d: 74), is standard academic procedure in the production and validation of knowledge. This sub-section analyses the way Grunwald constructs a 'counter-discourse' (Foucault 1972: 209) in the development of sensory stimulation treatment, and it discusses this Foucauldian term and how I re-appropriate it.

According to Grunwald 'too little neuro-biological research' has been undertaken with regards to anorexia nervosa, and the role of body schema, designated by him as the 'central element' (2008: 335), remains largely unexplored. Grunwald (2008 & AI, 24.8.2007) identifies two main reasons for what he regards as a gap in existing research: firstly, the complexity of researching an entity which is linguistically not accessible; and, secondly, the predominance of largely visual-centred and language-based approaches in both the research and treatment of anorexia nervosa. These approaches are related to a wider psycho-medical discourse of the 'verbalisation of self' (1.4) as well as to underlying ocular- and logo-centric cultural parameters, which will be addressed later on (6.2).

Regarding the scientific research, Grunwald (2008: 337) maintains: 'The analysis of body schema distortions is much more difficult, as this concept describes the internal, mental aspect of bodily representation and this is not consciously accessible by the examined person'. The fact that we cannot talk about the 'neuronal correlate or construct'[375] that is our body schema, according to Grunwald (AI, 24.8.2007), complicates its research considerably. Our body image, in contrast, is linguistically accessible to us because our attitudes and feelings towards our body can be verbalised, they can also be examined and addressed. Grunwald (2008: 338) maintains that as a

[374] 'Und bei den Essstörung ist, glaube ich, in den vielen Jahren vorher einfach zu wenig Neurobiologie betrieben worden. Ganz klar. Hirnforschung schon gar nicht. Man hat halt dieser psychoanalytischen Interpretation geglaubt. Das halt, sozusagen, Identitätsprobleme, Beziehungskonflikte zwischen den Eltern – also diese klassischen Konzepte der Psychoanalyse - Konflikte mit dem Selbst, mit der Geschlechtsidentität und so. Also viele Plastikwörter auch. Und das ist aber zu wenig. Es ist einfach zu wenig.' (Grunwald, AI, 24.8.2007)
[375] 'neuronales Korrelat oder Konstrukt' (Grunwald, AI, 24.8.2007)

result 'scientists researching clinical anorexia nervosa have predominantly concentrated on the research of body image disturbance, as it was possible to fall back on accordant methods of examination'. According to him, both the research and treatment of anorexia nervosa are currently dominated by a linguistic model based on cognition. A recent study summarising the field states: 'It is widely accepted that Cognitive Behavioural Therapies is the treatment of choice' (Murphy et al. 2010: 611). Grunwald (AI, 8.7.2016) described the circulation and validation of a cognition-based 'regime of truth' (Foucault 1984d: 73, cited at the beginning of 6.1.1 above), of what he regards as a dominant discourse as follows:

> Cognitive behavioural therapy focuses entirely on the „restructuring" of wrong cognitive processes into right ones – a very mechanistic model, which is, however, taught at 97% of all German universities. Equally, most German hospitals only use CBT in their treatment, [which] wants to hold on to the approach that anorexia nervosa is treatable through language and cognition. While this might be the case for certain aspects of the disease, it is certainly not for the disordered body schema. If at all, this level of the disease can only be treated with physical therapy, [which is, however] not covered by health insurance, neither is it researched at universities, precisely because the behaviour therapy lobby looks out for itself. Not a good development![376] (Grunwald, AI, 8.7.2016)

In his writing Grunwald (2008: 335) maintains that 'current therapeutic approaches are relatively inefficient' because the body schema disorder of patients with anorexia cannot be addressed linguistically. He makes this point much more directly in our interview. His choice of language and tone are indicative of the way scientific knowledge is presented in more neutral and rational terms in its published form, as Grunwald (AI, 24.8.2007) told me: 'All this psychodynamic jabbering that is fruitless and misses these women and girls completely. They continue to be ill. I find this situation unacceptable'[377]. Elsewhere Grunwald (in 3sat 2010: 4') insisted: 'You cannot convey to someone with such a distorted perception of their body why they should eat,'[378] and likened anorexia to a distortion of reality found in schizophrenia[379] (Grunwald, AI, 24.8.2007).

In the development of sensory stimulation treatment, Grunwald presents two conflicting scientific discourses in relation to the eating disorder: one, the dominant, informed by psychoanalysis and another by neurobiology.[380] One is reductive, according to him, the

[376] 'Verhaltenstherapie, dieses Verfahren setzt zu 100% auf der "Umstrukturierung" falscher kognitiver Prozesse in richtige - sehr mechanistisches Konzept, das aber zu 97% an allen deutschen Universitäten gelehrt wird. Und auch in den meisten deutschen Kliniken wird nur nach VT behandelt. Diese Bewegung will einfach weiter daran festhalten, dass via Sprache und Kognition die AN behandelbar sei. Das mag ja für einige Aspekte der Erkrankung zutreffen, aber nicht für das gestörte Körperschema. Diese ebene der Erkrankung kann wenn überhaupt nur körpertherapeutisch behandelt werden. Körpertherapeutische Verfahren werden einerseits nicht von den Kassen bezahlt und andererseits wird dazu eben auch nicht an den Unis geforscht, weil eben die VT-lobby auf ihre Pfunde achtet. Das ist keine gute Entwicklung!' (Grunwald, AI, 8.7.2016)

[377] 'Und dieses ganze psychodynamische Gelaber, was funktionslos an den Frauen und Mädchen vorbeigeht. Die bleiben weiter krank. Ich finde das eigentlich unannehmbar so eine Situation.' (Grunwald, AI, 24.8.2007)

[378] 'Wenn jemand ein derartig verzerrtes Körperempfinden von sich selbst hat, dann ist ihm auch nicht beizubieten, warum er jetzt essen soll.' (Grunwald in 3sat 2010: 4')

[379] 'Das gleiche Phänomen finden Sie bei der Schizophrenie.' (Grunwald, AI, 24.8.2007)

[380] Grunwald (2008: 338) criticises that examinations into the neuro-biological and neuro-physiological basis of anorexia have only just begun. Among others, he refers to the work of British neurophysiologist Patrick Haggard (e.g. et al. 2003 & 2005) whose research at University College London partially focuses on the representation of one's own body.

other more true. Correspondingly, in both his writings and our interviews Grunwald presents his work as departing from mainstream research approaches to the illness, even as opposing them. He thus constructs a 'counter-discourse' (Foucault 1972: 209), to what he regards as the dominant, most widely accepted, institutionally validated and financially supported discourse. Grunwald puts forward another 'regime of truth' (Foucault 1984d: 73) based on the presentation of new scientific knowledge, with the aim of developing a 'more effective' therapeutic treatment practice.

Just as the notion of discourse is not clearly or permanently defined in the work of Foucault, as previously discussed (1.2.2), nor is the term counter-discourse. He refers to it when he describes prisoners talking about their experience as part of the *Groupe d'Information sur les Prisons (GIP)* co-founded by him in 1971 in an effort to make known 'what the prison is' (Foucault 1971: 175).[381] 'And when the prisoners began to speak, they possessed an individual theory of prisons, the penal system, and justice. It is this form of discourse which ultimately matters, a discourse against power, the counter-discourse of prisoners and those we call delinquents – and not a theory *about* delinquency' (Foucault 1972: 209). He thus defines counter-discourse as a 'discourse against power'. Moreover, in *History of Sexuality Vol. 1.* Foucault (1976/1990: 101) employs the term 'reverse discourse' when referring to the way 'homosexuality began to speak on its own behalf'. Here he argues that 'power and knowledge are joined together' in discourse:

> And for this very reason, we must conceive discourse as a series of discontinuous segments whose tactical function is neither uniform nor stable. To be more precise, we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies. […] There is not, on the one side, a discourse of power, and opposite it, another discourse that runs counter to it. Discourses are tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy; they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy. (100 & 101-2)

'[D]iscontinuous segments', 'a multiplicity of discursive elements', 'tactical blocks': Foucault offers a variety of formulations for different and differing discourses, or 'contradictory discourses', as he terms them. While he describes their dynamic as other than 'accepted' and 'excluded', or 'dominant' and 'dominated', it remains unclear how they are related and how they are constructed in relation to each other. Consequently, I would argue that discourses are also produced in reaction to other discourses and that Foucault's earlier use of the term 'counter-discourse' captures this dynamic well, without

[381] 'ce qu'est la prison' (Foucault 1971: 175) asks the manifesto of the GIP entitled 'Création d'un groupe d'information sur les prisons'. It was introduced at a press conference by Foucault alongside Jean-Marie Domenach and Pierre Vidal-Naquet on 8 February 1971, announcing the creation of the GIP in order to make known 'what the prison is'. The GIP was dissolved again in December of 1972. For a detailed discussion of the GIP and Foucault's role within it see: Zurn, Perry & Dilts, Andrew (eds.) (2016) *Active Intolerance: Michel Foucault, The Prisons Information Group and the Future of Abolition.* Houndmills, Basingstoke: Palgrave Macmillan.

marking it as lacking in power. Seeing that Foucault (1976/1990: 93) firstly defines power as being ‘everywhere […] because it come from everywhere’, and secondly conceives a ‘plurality of resistances’ (96) as an inherent part of power, I argue that counter-discourses form part of the logic of discourses. However, they distinguish themselves in their reaction to, and resistance against, more validated discourses. In relation to truth Foucault (1984d: 73) argues, as mentioned above (1.2.2 & 6.1.1), that ‘each society has its regime of truth, its “general politics” of truth: that is, the types of discourse which it accepts and makes function as true’. I thus employ the term ‘counter-discourse’ to refer to those discourses that are not generally accepted and made to function as true, in both society and academic disciplines, including science. Thus, when Grunwald constructs a scientific discourse in reaction to what he describes as a generally accepted discursive construction of, and practices around, anorexia nervosa, he constructs a counter-discourse. Not only does Grunwald critique what he presents as the dominant cognition-based treatment of anorexia nervosa, he also constructs a counter argument which questions the very basis of such an approach, a counter-discourse to generate a counter-therapy.

6.1.3 The therapeutic re-inscription of the diving suit

> Regardless of the reasons for the described, multi-sensory integration disturbances in AN, one must ask the question of how body schema distortion may be positively adjusted. As this basal structure of our bodily self is not linguistically or cognitively accessible, an intervention strategy which uses another form of stimulation must be used in order to re-organise the body schema distortion. The aim of this should be to recreate an entire-body, sensory stimulation which is above threshold. This stimulation would not be generated passively (e.g. massage) but rather should be generated by the patients themselves through movement. The decisive and functional point is the direct dependence of the bodily stimulation on the physical movements of the patient. This above-threshold bodily stimulation should be temporally and spatially coherent (agree with) the movements made by the patient. […] To achieve a similarly intense form of bodily stimulation we conducted a pilot study in which we used a conventional custom-made neoprene diving suit. (Grunwald 2008: 348)

In December of 2002 the sensory stimulation treatment pilot project was launched at the University of Leipzig, as Grunwald describes above from, what Foucault (1976/1990: 53) terms 'the rarefied and neutral viewpoint of a science' (though Foucault is referring in this instance to the discourse of sexuality not medicine). Grunwald re-iterates his counter-argument to a cognitive approach and goes on to detail the design and results of the study, supported by a graphic representation of the results including an anonymised photograph of the proband (reproduced in figure 138). This pilot study consisted of a young woman 'suffering from anorexia nervosa' since the age of fourteen, as Grunwald (2008: 349) puts it, who wore a custom-made neoprene diving suit for one hour three times per day over a period of three months[382]. The suit had been chosen because, Grunwald told me (AI, 24.8.2007), he had noticed a particular physical perception whilst wearing it himself. He also thought it could easily be integrated into patients' lives, worn underneath their clothes, not limiting daily activities. Moreover, it was chosen, as he writes, to achieve 'an intense form of bodily stimulation' (Grunwald 2008: 348). A neoprene diving suit was thus discursively re-constructed as a psycho-medical, and neuro-biological treatment. Although worn by the patient at home, the clinical context of the study including regular weighings and EEG measurements as well as the diary the proband was asked to keep, re-appropriated the suit as a therapeutic treatment. Grunwald thus changed the meaning of the diving suit and re-inscribed it as the haptic suit.

[382] The length of the pilot treatment was ultimately determined by the seasons, as Grunwald (AI, 24.8.2007) explained in our interview: 'The proband arrived in December and we started testing the diving suit in February, when it was getting warmer outside. It was clear that you couldn't survive with the diving suit during summer. It doesn't work. That was the real reason why we stopped after fifteen weeks.' // 'Sie kam ja im Dezember und wir haben im Februar oder so, oder März dann angefangen mit dem Neoprenanzug und dann wurde es ja auch immer wärmer. Also, es war mir ja auch klar, dass dann im Sommer kann man nicht mit dem Neoprenanzug überleben draußen. Das geht nicht. Und das war auch die eigentliche Basis dafür, dass wir dann nach fünfzehn Wochen bei ihr aufgehört haben.' (Grunwald, AI, 24.8.2007)

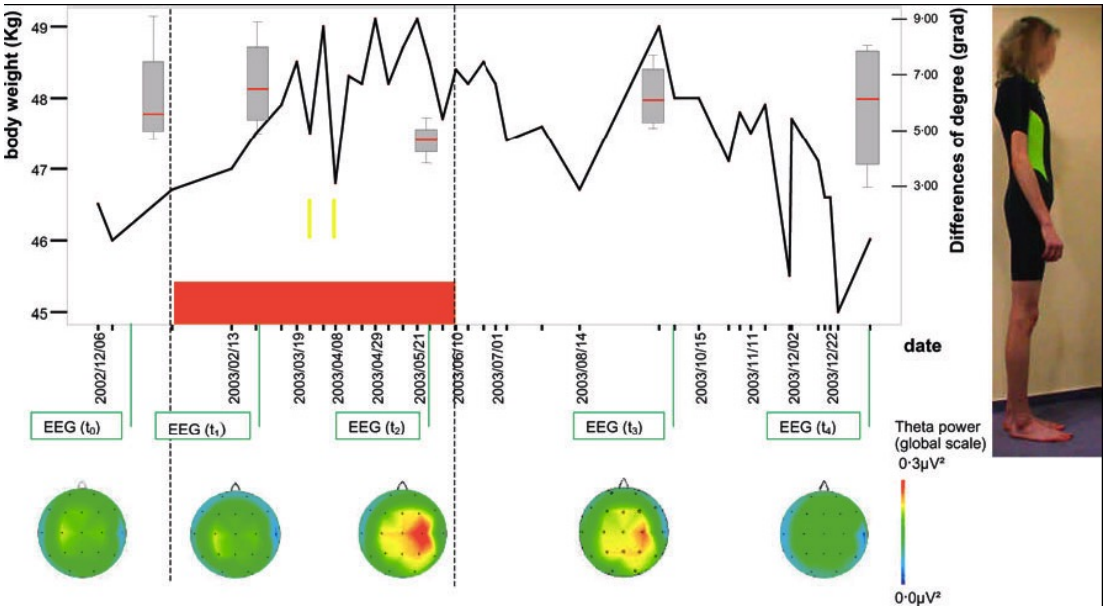


figure 138: The pilot study of sensory stimulation treatment in 2003: 'Body weight, differences in an angle paradigm, and EEG theta (3.5 Hz–7.5 Hz) activity of patient A.B. during 14 months. […] The red bar indicates the time during which the patient used the diving suit (for one hour three times per day)' (Grunwald & Weiss 2005: 380). The course of the pilot study is described by Grunwald (2008: 348–9) as follows: 'A female long-term anorectic patient (19 years old) wore the diving suit over her underclothes for 1 hour, three times per day. Body temperature was measured auxiliary before and after wearing the diving suit. The patient kept a diary to record events of the day and specific body feelings while she was wearing the suit. The pilot treatment lasted 15 weeks with the whole project lasting 14 months. During this time, body weight was recorded 39 times. Background EEG (eyes closed, everyday clothes on without diving suit) was recorded 5 times to evaluate EEG theta power. Quality of body representation was assessed repeatedly using the 'angle paradigm'. Standardised clinical questionnaires focusing on eating disorders were carried out at the beginning and the end of the project. Since the age of 14, she has been suffering from anorexia nervosa. Before our treatment, she underwent two in-patient and three ambulatory psychotherapies. […] During the time of investigation the patient was actively taking part in her arts and media classes at university'.

In spite of the small scale of the pilot study, Grunwald (2008: 350) evaluates sensory stimulation treatment as effective in remapping and correcting a distorted body schema[383]: 'Although this case only involved one patient, the data collected supports the belief that it is possible, with this treatment, to positively change the body schema disturbance without medication or side effects'[384]. According to Grunwald (2008: 349),

[383] Grunwald (2008: 348–9 & 50) summarises the overall findings of the pilot study with reference to the table of measurements taken in its duration (figure 138): 'The patient described no mental or physical side effects from wearing the diving suit. Body weight increased significantly during the period in which she wore the diving suit. EEG theta activity showed low activity, with left-hemispheric dominance at the beginning of investigation (T0 and T1). At the end of pilot treatment (T2), theta activity showed a remarkable enhancement, including a shift to the right hemisphere. This change reversed at the end of the project (T4). Analysis of the angle deviations revealed strong deviations at T0, smallest deviations at T2, and reversing deviations at T3–T4. […] We assume that significantly gained body weight and smaller angle deviations at T2 are consequences of an improved body schema representation due to an activation of the right hemisphere by the increased somatosensory stimulation while wearing the diving suit'.

[384] At the end of the pilot study, the proband continued to wear the suit for another three months and agreed to be interviewed for an in-depth magazine report on the sense of touch (Henschel 2004), which describes the results on a more personal level, also quoting from the diary kept by the patient as part of the study. In recounting the outcome of the pilot study in a journalistic context, the following account also illustrates the discursive construction of scientific knowledge, as presented by Grunwald above: 'The young woman has gained weight. Once a week she visits the laboratory to be weighed. Her temperature, at 36 °C and less at the beginning of the treatment, has returned to normal. Her hands and feet are no longer as cold. In her diary she describes how the "straitjacket" turned into a form of support, without which her body seemed to melt. […] Instead of wanting to control the body with her overly sharp intellect, she frequently catches herself sensing it, acknowledging it, following its desires. She gives into the appetite for food, wanting to be close to other people, for friendship and occasionally sex, without hating herself afterwards, as she used to. She thinks it possible that others are fond of her. "All the people who called today or came to see me, wanted to talk to me, they were like messengers from heaven." She slips into their images of herself, like a new dress she feel comfortable in. "Already looked better in the mirror today." Since holidaying in Turkey, she has slipped off the cocoon, in which she caught up with a phase in her development. She now dares to live without the suit' (Henschel 2004: 139). // Die junge Frau hat zugenommen. Einmal pro Woche kommt sie zum Wiegen ins Labor. Ihre Temperatur hat sich von 36 °C und weniger, zu Anfang der Behandlung, auf normale Werte eingependelt. Hände und Füße sind nicht mehr so kalt. In ihrem Tagebuch beschreibt sie, wie aus der

one of the most immediately visible results was the weight gained by the proband.[385] Grunwald (in Hilgemeier 2016) explains elsewhere that it is through consistent haptic stimulation, and the pressure 'which this tight garment applies to the skin and joints [that] the brain learns to perceive the body more realistically'[386]. Moreover, as a consequence of wearing the suit regularly, he maintains that the 'brain begins to process truly adequate information concerning the dimensions of the body'[387], resulting in a 'more adequate' body image (Grunwald in 3sat 2010: 3'10). Grunwald's scientific basis for sensory stimulation treatment, including his description and evaluation of the pilot study, exemplify Foucault's notion of discourse as having real effects (1.2.2), in this case as resulting in a particular therapeutic practice.

Essentially, the diving suit is employed as a technology of the self. Therapeutically re-inscribed as the haptic suit it is used as a technology to normalise both body schema and body image, the physical self-perception of anorexia patients and ultimately their weight. The normalisation of these parameters is not, however, reliant on particular ideals of physical beauty, as was the case in "Therapy of Fashion" (Ch.4), but rather, according to Grunwald (AI, 24.8.2007), defined by 'adequacy', and the 'objective physiological deficiency of an organism'[388]. Questioned about the normative, even problematic, nature of "ideal" or "healthy" physical self-perception, he maintained that 'an organism is healthy or adequately grounded in the world if it can survive. The problem with anorexia is that you are not capable of surviving if it goes on for a long period of time. The organism ceases to exist'[389] (Grunwald, AI, 24.8.2007). Grunwald explains the aim of sensory stimulation treatment as the desire to restore an 'adequate' body schema as a basis for a 'survivable' body image. In this way he constructs the haptic suit as a medically and scientifically underwritten technology of the self.

It is noteworthy that the method behind this treatment approach stands in direct contrast to the concept of 'sensory deprivation' governing another dress-related technology of the self within the psycho-medical realm, albeit an overtly coercive one:

„Zwangsjacke" allmählich eine Stütze geworden ist, ohne die ihr Körper zu zerfließen scheint. [...] Statt den Körper mit ihrem überscharfen Intellekt kontrollieren zu wollen, ertappt sie sich häufig dabei, wie sie in ihn hineinfühlt, ihn beachtet, seinen Wünschen folgt. Dem Appetit auf Essen, auf Nähe zu anderen Menschen, auf Freundschaften und gelegentlich auf Sex gibt sie nach, ohne sich – wie früher – hinterher dafür zu hassen. Hält es für möglich, dass andere sie mögen. „All die Menschen heute, die anriefen oder vorbeikamen, Lust hatten mit mir zu reden, waren wie Himmelsboten." In deren Bild von ihr schlüpft sie wie in ein neues Kleid, in dem sie sich wohl fühlt. „Sah heute im Spiegel schon besser aus." Seit einem Türkei Urlaub hat sie den Kokon abgestreift, in dem sie eine Phase ihrer Entwicklung hat nachholen können. Sie traut sich zu, ohne Anzug weiter zu leben.' (Henschel 2004: 139)

[385] Given her initial measurements of 46.50kg, 179cm, BMI 14.5 (Grunwald & Weiss 2005: 379) the increase to 49kg was seen as 'significant', as Grunwald (in Niemann 2009) explains: 'While this might not seem very much, in the case of anorexia patients it is a new dimension. Normally you fight for 100g'. // 'Das klingt nicht viel, ist aber bei Anorexie-Patienten eine neue Dimension. Denn sonst kämpft man um 100 Gramm' (Grunwald in Niemann 2009).

[386] 'Durch den Druck, den das enge Kleidungsstück auf die Haut und die Gelenke ausübt, lernt das Gehirn, den Körper wieder realer wahrzunehmen.' (Grunwald in Hilgemeier 2016)

[387] 'Das Gehirn fängt an wirklich adäquate Informationen über die Körperdimensionen zu verarbeiten.' (Grunwald in 3sat 2010: 3'10)

[388] 'objektiv physiologischer Mangelzustand für den Organismus' (Grunwald, AI, 24.8.2007)

[389] 'Der Organismus ist dann gesund oder adäquat verortet in der Welt, wenn er überleben kann und das Problem mit der Anorexia ist, dass wenn sich das über einen längeren Zeitraum zieht, sind Sie nicht überlebensfähig. Der Organismus hört auf zu existieren.' (Grunwald, AI, 24.8.2007)

the straitjacket (Ch.3).[390] While both can be considered as forms of normalisation and even disciplining, sensory stimulation treatment aims to animate the sense of touch rather than extinguish it, and, to provide flexibility rather than render the patient immobile, according to Grunwald (AI, 24.8.2007). From his comments it can be concluded that he regards the diving suit as a neutral garment, one without side effects. As such he shares with the practitioners of both "Therapy of Fashion" and *vêtothérapie* an understanding of dress, in his case the suit, as a neutral entity with a positive effect on the wearer. Moreover, common to these three dress-related therapeutic approaches is the employment of dress as a confessional technology of the self. While sensory stimulation treatment, unlike the other two approaches, is explicitly not accompanied by psycho-therapeutic practices of verbalisation, as Grunwald insisted (AI, 24.8.2007), the diary writing of the proband constitutes a form of self-monitoring, self-verbalisation, and thus revelation, also found in other dress-related settings.

With regards to gender, it should be noted that sensory stimulation treatment, although piloted on a female proband, was not designed for women exclusively and is used with both male and female patients, as will be addressed later on. The diving suit, whilst initially devised as a garment for men (Acott 1999), is commercially available in male, female or unisex versions. As the "psycho-medical" haptic suits are custom-made for each patient, they take into account the individual shape of the wearer (Riess, AI, 11.9.2013). In relation to "Therapy of Fashion" and *vêtothérapie* that both work with clearly gendered garments which, in the case of the former, are overtly intended to feminise patients, sensory stimulation treatment appears to be less of a gendering technique of the self. Concerned with patients' own physical self-perception, it does not focus on how they are perceived by other people. In its attempt to eliminate human interaction, it does not aim to be a social therapy unlike the other dress-related therapeutic practices under review in this thesis. These also present themselves as forms of occupational treatment, as opposed to the neuro-biological treatment sensory stimulation treatment aims to be. It thus also stands in contrast to the other practices, employing only one, rather functional, garment, although, to a similar end: as a normalising technology of the "disordered" self. The notion of self underpinning this treatment approach, however, is not so much a social self, based on outer appearance, as it is a touch-based individual self, as will be addressed in detail below.

In conclusion, the haptic suit is constructed as a counter-treatment, conceived in opposition to prevailing cognition-based therapies. Grunwald's work in general can be

[390] Another historical precursor in working with the senses within psycho-medical treatment is to be found in the work of French psychiatrist Louis Delasiauve (1804–1893), who foregrounds the senses in the treatment of 'idiots', arguing in his *Des Principes Qui Doivent Présider à L'éducation des Idiots* that 'senses are really the entrance gate for intelligence; consequently, they had to be used in order to bring in information and to educate the idiots (1859: 40 in Sueur 1997: 46).

analysed in its construction as a counter-discourse, aiming to counter not only the "cognitive turn" within psychiatry (Grunwald 2012) but challenge the ocularcentrism within his discipline and emphasise the importance of touch, both in relation to prevalent notions of the self and in the research and treatment of anorexia nervosa. The following section will explore the sensory discursive context of his work accordingly in more detail.

6.2 The counter-discourse of the haptic suit: Countering the 'cognitive turn' – challenging ocularcentrism

6.2.1 The 'cognitive turn' within ocularcentric culture

As touched on at the beginning of this chapter, Grunwald's work follows a long tradition of the science of the human sense of touch in Germany before World War II (Grunwald & John 2008: 15). Apart from the aforementioned founding father of haptics Weber, other important scientists of the field are the philosopher and psychologist Max Dessoir (1867–1947) who coined the term 'Haptik' in his 'Über den Hautsinn' ('On the skin sense') in 1892 (Grunwald & John 2008: 39), the psychologist David Katz (1884–1953), the experimental psychologist Géza Révész (1878–1955), and physiologist Emil von Skramlik (1886–1970), who argued that the whole body is a tactile sensory system (1937).

These researchers' publications on haptic perception (Weber 1835 & 1846, Dessoir 1892, Katz 1925, von Skramlik 1937, Révész 1938) have helped to establish an independent subject area located between psychology and physiology (Grunwald 2012). However, this rich tradition in haptics was interrupted by World War II and was not resumed afterwards due to 'thematic and staffing changes'[391] according to Grunwald (2012). 'The sensory system of touch and its functional role for perceptual-cognitive processes were forgotten in the course of the "cognitive turn" within scientific psychology!'[392] he decries (Grunwald 2012). Grunwald continues this tradition which he regularly references (e.g. Grunwald 2012, Grunwald & John 2008) and it constitutes part of the conditions of possibility of his research.

This repudiation of the sense of touch was further enabled by the ocularcentrism which defines Western culture, interpreting the sense of sight 'as the reigning modality'[393] as Grunwald (AI, 24.8.2007) put it, adding: 'That's Plato and his unspeakable description of the sense of sight as the divine sensory system'[394]. Sight has 'historically been regarded as the noblest of the senses, and thinking itself thought of in terms of seeing,' observes Finish architect Juhani Pallasmaa (2005: 15) in his influential book *The Eyes of the Skin.* Accordingly, the sensory systems are organised in a hierarchical structure headed by vision. The 'classical hierarchy' of the senses 'is arranged as follows: *visus* (sight), *auditus* (hearing), *odoratus* (smell), *gustus* (taste), *tactus* (touch),' the German medical historian Robert Jütte (2005: 61) argues.

[391] 'thematische und personelle Umwälzungen' (Grunwald 2012)
[392] 'Das Tastsinnessystem und seine funktionale Rolle für perzeptiv-kognitive Prozesse wird im Zuge der „kognitiven Wende" innerhalb der wissenschaftlichen Psychologie vergessen!' (Grunwald 2012)
[393] 'als regierende Modalität' (Grunwald, AI, 24.8.2007)
[394] 'Das ist Platon, Platon. Platon und seine unsägliche Beschreibung, dass der visuelle Sinn, der Sehsinn das göttliche Sinnessystem ist.' (Grunwald, AI, 24.8.2007)

Thus the optical sense has been at the top of the hierarchy since antiquity. In *Modernity and the Hegemony of Vision* philosopher David Michael Levin (1993: 2) maintains that 'beginning with the ancient Greeks, Western culture has been dominated by an ocularcentric paradigm, a vision-generated, vision-centred interpretation of knowledge, truth, and reality'. Of course, ocularcentrism has not been uncritically accepted. While the existence of a scopic regime is generally regarded as a characteristic of our culture, it continues to be the point of both philosophical and scientific criticism. Particularly among twentieth-century French thinkers[395] has the hegemony of sight been criticised and vision 'denigrated', as historian Martin Jay (1994) explores in his seminal work.

At the same time, it has been argued that the Western ocularcentric tradition has been reinforced, for example, by what the German philosopher Martin Heidegger (1889-1976) (1977: 134) terms 'the conquest of the world as picture,' which he regards as '[t]he fundamental event of the modern age'. The lessons of the senses have been overtaken by the dominance of language and the information revolution, according to French philosopher Michel Serres (2009).[396] And Pallasmaa (2005: 16) assesses recent developments along similar lines:

> There is no doubt that our technological culture has ordered and separated the senses even more distinctively. Vision and hearing are now the privileged sociable senses, whereas the other three are considered as archaic sensory remnants with a merely private function, and they are usually suppressed by the code of culture. Only sensations such as the olfactory enjoyment of a meal, fragrance of flowers and responses to temperature are allowed to draw collective awareness in our ocularcentric and obsessively hygienic code of culture.

Thus, the 'cognitive turn' as described above by Grunwald not only fell on fertile ground, but was continually fortified by the underlying ocularcentric culture, which side-lines the sense of touch – reinforcing, in turn, the prevalent dichotomies of touch/sight and body/mind. Within the psycho-medical disciplines this led to cognitive behavioural approaches dominating therapy in general, and the treatment of anorexia nervosa in particular, according to Grunwald. The way that logo- and ocularcentric discourses underpin and generate, in this case, cognitive and language-based therapeutic practices, illustrates how discourses are constitutive of reality (1.2.2). Moreover, underlying notions of self are formative of practices of the self – therapeutic or other – as this thesis explores, and as I will address in more detail below in relation to sensory stimulation treatment.

[395] The phenomenological philosopher Maurice Merleau-Ponty (1908-1961) constitutes one of the central figures in this critique of the 'Cartesian perspectivalist scopic regime', of what he terms 'a sort of madness in vision' (Merleau-Ponty 1968: 75).

[396] Accordingly, Serres (with Latour 1995: 132) notes that his book *Les cinq sens*, originally published in 1985 was written in reaction to the sensorial poverty of contemporary theory: it 'cries out at the empire of signs'.

6.2.2 The cloth mother and a touch-based concept of self: The influence of Harry Harlow

Given the lack of other contemporary haptic research in Germany, according to Grunwald (AI, 24.8.2007), he turned to the work of American developmental psychologist Harry Harlow (1905–1981) for inspiration (figure 139–142). Grunwald has been heavily influenced by Harlow's experiments and findings, particularly Harlow's touch-based notion of self, and repeatedly refers to him in his writings and interviews, even arranging for his biography to be translated into German (Blum 2010).[397]

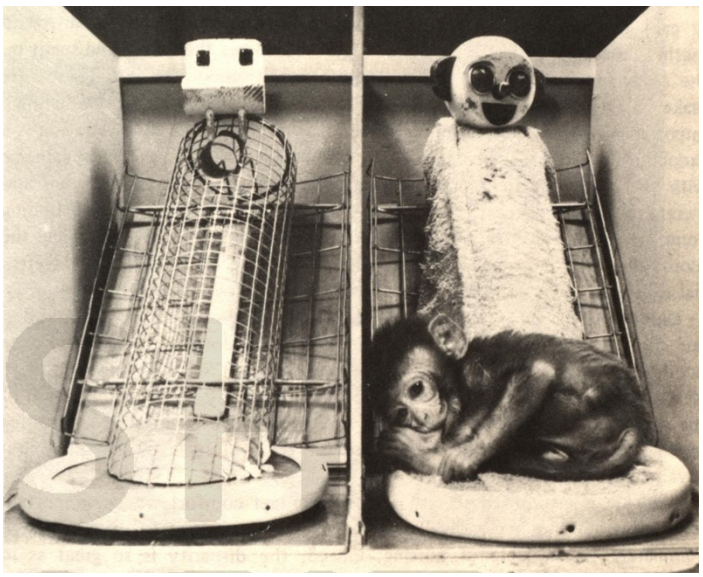


figure 139: The experiments of Harry Harlow: a monkey with wire and cloth mother surrogates



figure 140: Harry Harlow with monkey clinging on to the cloth mother, 1959

Much of Harlow's research and writing focuses on the significance of physical touch to human development, on 'love', as he puts it (1974 & et al. 1979). Harlow researched the role of attachment in the mother-baby relationship[398] in his ethically controversial experiments with monkeys, where a surrogate 'cloth mother' (figure 139), a wire figure, 'covered by soft, resilient terrycloth sheaths' (1974: 28) was used to give the sensation of touch. Given the choice between a wire mother and a cloth mother, the monkeys would overwhelmingly choose the cloth surrogate, even if the wire mother had the capacity to nurse them (figure 141). They would choose nurturing over sustenance according to Harlow (1974 & et al. 1979).

[397] Incidentally the translation of Harlow's biography was done by Martin Grunwald's former wife Sabine Grunwald.

[398] While Harlow focused on the infant-mother relationship in his experiments, he addressed the importance of researching the infant-father relationship during his presentation of the results in 1958, closing with the following words: 'The socioeconomic demands of the present and the threatened socioeconomic demands of the future have led the American woman to displace, or threaten to displace, the American man in science and industry. If this process continues, the problem of proper child-rearing practices faces us with startling clarity. It is cheering in view of this trend to realize that the American male is physically endowed with all the really essential equipment to compete with the American female on equal terms in one essential activity: the rearing of infants. We now know that women in the working classes are not needed in the home because of their primary mammalian capabilities; and it is possible that in the foreseeable future neonatal nursing will not be regarded as a necessity, but as a luxury ---to use Veblen's term -- a form of conspicuous consumption limited perhaps to the upper classes. But whatever course history may take, it is comforting to know that we are now in contact with the nature of love' (Harlow 1958: 685). Harlow was criticised by American feminists at the time, who saw his research as essentialising, which contributed to his reputation as a politically incorrect scientist (Blum 2003) and influenced his legacy lastingly.

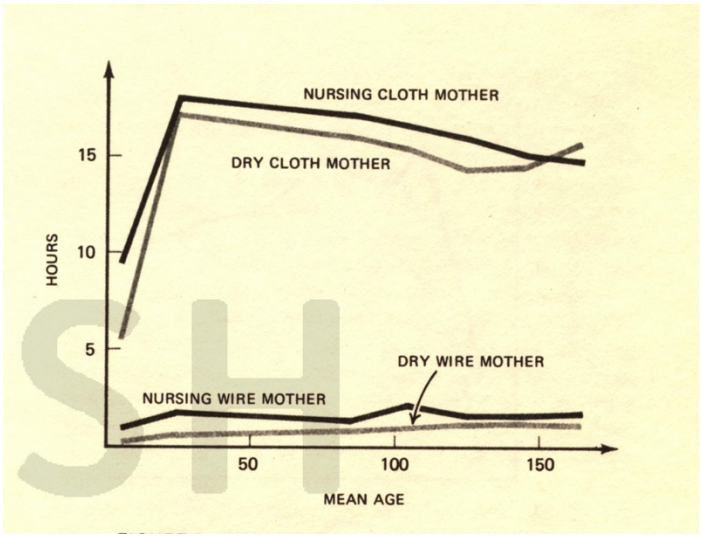


figure 141: The results of Harlow's "cloth mother" study: 'Time spent on cloth and wire surrogate.' (Harlow 1974: 29)



figure 142: 'Typical response to cloth mother in fear situations' (Harlow & Mears 1979: 112)

In summary, Harlow (1974: 26) concluded that it was 'contact' rather than the hunger drive which was 'the primary factor in this relationship', that attachment or love in the form of touch and physical interaction were vital for an early and developing sense of self.

According to Grunwald (2004), the vital role of affection and indeed touch in infant development is now widely accepted as a result of Harlow's work and informs the treatment of, for example, premature babies (Blum 2003).[399] Moreover, Harlow is said to have contributed lastingly to the growing perception of the importance of touch to human health (Field 2000), supported by a series of more recent studies demonstrating that 'touch is good for your health, your immune system, your sleep, your anxiety level' (Blum 2003: 282). Yet, when conducting his research in the 'minimal touch policy' US (Henschel 2004: 125) of the 1950s and 1960s it was highly contested (Blum 2003), making him an academic outsider, not unlike Grunwald in his own estimation. Grunwald also mobilises the narrative and findings of Harlow to construct a counter-discourse to the ocularcentric psycho-medical disciplines and validate his own work as part of a scientific trajectory. Moreover, Harlow's conception of a touch-based notion of self underpins much of Grunwald's research. In relation to the haptic suit, it is Harlow's demonstration that touch can be equated with or even substituted by cloth which inspired Grunwald to think about cloth and clothing when contemplating ways of simulating human touch in order to stimulate the 'disordered body schema' in anorectics (Grunwald, AI, 24.8.2007). As an important influence on several levels, it can thus be argued that the work of Harlow forms part of the conditions of possibility of sensory stimulation treatment.

[399] In this context Henschel (2004: 125) reports the following phenomenon: some children from emotionally destructive homes or in orphanages stop growing and research in Rumania has shown that they could only be cured through what was termed 'loving treatment'. // 'Einzig liebevolle Behandlung löst sie aus ihre Erstarrung.' (Henschel 2004: 125)

6.2.3 The self in the mirror: Challenging vision-based concepts of self

It is noteworthy that Harlow advocated the importance of the role of touch in the development of self at a time when the hegemony of vision was largely unchallenged. Consequently, he was himself participating in the construction of a counter-discourse against the dominance of vision-based theories of the development and maintenance of self, not unlike Grunwald today, when the eye is still said to be perceived as 'the centre point of the concept of the self' (Pallasmaa 2005: 16). In his research and through the therapeutic practice it generated, Grunwald (AI, 8.7.2016) criticises the vision-based and essentially disembodied notion of self prevalent in both his discipline and also in Western thought. Accordingly, this section outlines the ocularcentric notion of self against which Grunwald proposes sensory stimulation treatment in particular.

With regards to these vision-based concepts of self, it is telling that the metaphor of the mirror is used in different disciplines to explain the emergence of subjectivity as well as subsequent stages of developing and maintaining the self. Within sociology, for example, the American Charles Cooley (1864–1929) formulated the theory of the 'looking glass self': 'Each to each a looking glass, reflects the other that doth pass' (1902: 152). It describes the process whereby we see ourselves in the mirror and perceive in someone else's mind some thought of our appearance. Individuals thus form their self-image by imagining how they appear to others. Or, what becomes the self is what we imagine others think of our appearance, motives, deeds, and character. Two decades later, George Herbert Mead (1925: 270) elaborated on the themes identified by Cooley with greater insistence on the part of social interaction, as previously discussed (1.1), on the process of taking the role of the other. Imitation is vital to Mead's formulation of the developmental process, in which an individual comes to adopt the perspective of a more generalised group sharing a particular societal perspective on the self. Mead's theory was later formulated as 'Symbolic Interactionism' (Mead 1934) by Herbert Blumer, a student of his. This cognition-based theoretical approach has also been taken up in analyses of dress, where Gregory P. Stone (1962: 86), for example, highlights 'the role of appearance in interactions and of its effect through the reflected image of others back on the self'. Both the material and metaphorical mirror continue to inform accounts of dress and the self (e.g. Finkelstein 1991, Holderman 2003, Stone 1962, Woodward 2007).

Similarly in psychoanalysis, the formation of the self has traditionally been formulated as a process which relies on seeing: seeing the self in relation to an "other". The ego is articulated as image-based, solidified particularly by Jacques Lacan's (1901–1981) influential lecture on the 'Mirror Stage' (1949/1977). Like the sociological sources

cited above, Lacanian psychoanalysis postulates that an original sense of self is based on seeing oneself in relation to others. Central to the process of self-formation is the infant's growing visual perception of its body as separate from the mother's. Thus the ego is constituted in the visual field, as validated by the mother's gaze. He also draws on the paradigm of the mirror, actual or imagined, in his account of the formation of self-identity within early childhood, which is based on seeing oneself as separate from the mother.[400] The other senses are not considered to be involved in the process of the formation of the self.[401]

The ocularcentrism of Lacan's theory in particular and psychoanalytic ideas of the self in general, have been usefully criticised by a number of writers (e.g. Jones 2006, Marks 2002, Sobchak 1999). Moreover, Jones (2006: 5) explains that a modernist discourse co-determined such notions: 'Psychoanalysis not incidentally, came to being with the rise of modernism and the concomitant development of new modes of visual representation based on photographic technologies. Psychoanalysis, then, offers a historically located model for understanding how these structures of subjectification work in relation to visual images and to the visual arts and their institutions'.

An important corrective to this dominant notion of an imagistic self is to be found in the work of French psychoanalyst Didier Anzieu (1923–1999) and his notion of the 'skin ego' (1989). Anzieu, who underwent analysis with Lacan (Jay 1994: 342n) and was one of his seminar members in the 1960s and 1970s, grounds the development of the ego in the body, opposing Lacan's notion of the ego as being structured like a language (Anzieu 1989). He defines the 'skin ego' and formulates his theory as follows:

> By Skin Ego, I mean a mental image of which the Ego of the child makes use during the early phases of its development to represent itself as an Ego containing psychical contents, on the basis of its experience of the surface of the body. This corresponds to the moment at which the psychical Ego differentiates itself from the bodily Ego at the operative level while remaining confused with it at the figurative level. (Anzieu 1989: 40)

[400] Lacan's conceptualisation of the self in how it broaches the issue of appearance in relation to the body and self, has been usefully employed by a number of fashion theorists (Bancroft 2006, Evans 1999, Silverman 1986).

[401] It should be noted that Mitchell & Rose's (1982) claim of 'The mirror stage' to be concerned with more senses than just sight, is flawed, as it is based on a mistranslation. They argue: 'Lacan is careful to stress, however, that this point is not restricted to the field of the visible alone: [quoting Lacan] 'the idea of the mirror should be understood as an object which reflects - not just the visible, but also what is heard, touched and willed by the child' (1982: 30). This assertion is supported by a quotation taken from the minutes of a meeting of the Société Psychanalytique de Paris (1949b), but is, however, based on a mistranslation, as it is in fact another psychoanalyst, Françoise Dolto, whose research is the subject of the meeting, that points to the extended sensory meaning of the mirror. The minutes of the meeting are published in the same edition of *Revue Française de Psychanalyse* as Lacan's (1949/1977) mirror stage lecture.

The meeting is based on Dolto's (1949) 'Cure psychanalytique à l'aide de la poupée-fleur' previously published in the *Revue*. In the essay, she outlines the case of Bernadette, a five year old girl, seemingly 'mentally retarded' (53), 'une anorexique mentale' (Société Psychanalytique de Paris 1949a: 548) who brings a teddy bear, a "poupée-fleur" as the girl refers to it, to one session (Dolto 1949: 59). The "doll" becomes a tool for analysis. At the 12th Conference of 'Psychanalystes de langue française' Dolto produced a prototype of the "Poupée-fleur" with the proposition to use this as part of child psychoanalysis. This "poupée-fleur" is also the subject of the meeting in question, at which Lacan is recorded as giving the following statement: 'Le Dr Lacan a le sentiment de plus en plus vif que la poupée-fleur de Mme DOLTO s'intègre dans ses recherches personnelles sur l'image du corps propre et le stade du miroir et du corps morcelé. Il trouve important que la poupée-fleur n'ait pas de bouche et après avoir fait remarquer qu'elle est un symbole sexuel et qu'elle masque le visage humain, il termine en disant qu'il espère apporter un jour un commentaire théorique à l'apport de Mme DOLTO' (Société Psychanalytique de Paris 1949b: 566). To which Mme Dolto replies: (Mme Dolto répond à ses interpellateurs [...] (566)) 'Au Dr Lacan: "Oui, la poupée-fleur s'intègre aux réactions du stade du miroir, mais il faut entendre l'idée du miroir comme objet de réflexion, - non seulement du visible, - mais de l'audible, du sensible, de l'intentionnel. La poupée n'a pas de visage, pas de mains ni de pieds, pas de face ni de dos, pas d'articulations, pas de cou."' (567). Consequently the citation referenced to Lacan in Mitchell & Rose (1982: 30), should in fact be referenced to Dolto.

Anzieu's concept of the skin ego grounds the development of a first sense of self not in the visual, as Lacan and the symbolic interactionists do, but in tactile experiences of the surrounding world. 'His concept of the 'skin ego',' Prosser (1998: 65) notes 'takes the body's physical skin as the primary organ underlying the formation of the ego, its handling, its touching, its holding – our experience of its feel – individualizing our psychic functioning, quite crucially making us who we are. […] It holds each of us together, quite literally contains us, protects us, keeps us discrete'. Anzieu thus outlines a thesis that goes 'against the grain of most popular post-structuralist theories of the body informed by psychoanalysis' (Prosser 1998: 65). The unconventional nature of his work is emphasised by the fact that both 'psychoanalytic theory and practice is quite removed from bodily experience' as Shapiro argues (1996: 297). Psychoanalysis remains the 'talking cure', she adds, in which the body is marginalised (297). As such it is very much part of our therapy culture (1.4), a confessional culture concerned with verbalising the self. Moreover, it has been highly influential in determining the linguistic and non-haptic orientation of psycho-medical therapies in general, as repeatedly argued by Grunwald (AI, 24.8.2007 & 8.7.2016).

While Anzieu does not mention dress in his work[402], even though tactile experiences of the world are essentially mediated through dress from the very beginning[403] (Entwistle 2000: 6), Grunwald's research culminates in a garment. By incorporating a physical item of clothing, he aims to challenge the ocular- and logocentrism within his discipline not only theoretically but also practically. Nonetheless, interesting parallels can be drawn between the work of Anzieu and Grunwald: both engage in the construction of a counter-discourse, working against the grain of their chosen disciplines and as a result at their margins, and both challenge the dominant ocularcentric notion of the self, which determines some of their respective resultant practices. The work of both sheds light on the under-analysed connection between self, body and the sense of touch, albeit from two different perspectives: neurobiology and humanities. And they both participate in a multisensory, tactile discursive re-conceptualisation of the self.[404]

[402] In the works of Anzieu's commentators (e.g. Connor 2002, Lafrance 2006, Prosser 1998), only one direct reference to dress can be found in Lafrance's doctoral thesis on Anzieu and the psychoanalysis of the skin. He notes: 'The skin can be shaped and re-shaped by a wide range of cosmetic practices such as tanning, piercing and make-up, and is made to mean – to a large extent – through the vast array of clothes and jewellery that protect and ornament it' (2006: 161). Although linking dress to the skin, Lafrance's work does not comment further on the role of dress in relation to the self.

[403] Taking this consideration further, future research could develop the concept of a "cloth ego" or "dress ego", exploring in how far an original sense of who we are is based on our first material and textile encounters, re-dressing the ocularcentric perspective of self-formation by adding the haptic dimension in relation to cloth/ing. Historically, the relationship between dress and the ego appears to have received little attention. The British experimental psychologist and practicing psychoanalyst John Carl Flugel (1884–1955) who went on to write *The Psychology of Clothing* (1930/1950), comments on this relationship by arguing clothing to be an advance of the inner ego, in his article 'De la valeur affective du vêtement' in 1929 in: *Revue Française de Psychanalyse*. Vol.3, pp. 509-23. Another comment comes from the Spanish Argentinian psychoanalyst Angel Garma (1904–1993) (1949: 184), connecting our ego to the conscious representation of our body and to dress – an under-analysed correlation to this day: 'We know that in the constitution of the ego, clothing is included in the body image'.

[404] In spite of a common concern in the work of Anzieu and Grunwald, Anzieu's writings were unknown to Grunwald (as were Pallasmaa's, for example – most likely a mutual unfamiliarity). Academic discourses are, evidently, still solidly grounded in distinct disciplines and one can just speculate what a common cross-disciplinary challenge of ocularcentrism might resemble or even generate.

6.2.4 'We experience the crucial relation to life and reality through the sense of touch not of sight.': A touch-based notion of self

What emerges from both the analysis of Grunwald's work and its sensory context, is the existence not only of conflicting discourses, but also of two competing schools of academic thought: ocularcentrism and what might be termed "haptocentrism". Since antiquity the two have been opposed, maintained Grunwald (AI, 24.8.2007), who also argued that the haptic side is conceptually superior although marginal in influence:

> Ever since then these two worlds have been fighting. One side argues that the visual sense is the most important, beautiful and central. The other, a small community, says "Open your eyes. Let's consider people who are blind or deaf-blind." We cannot detect any impairment of consciousness or higher cognitive abilities in people who are deaf-blind. None whatsoever. They know exactly that they are here and can distinguish inside and outside. […] The ones who can't exist are the ones without a sense of touch, but that's so fundamental…, nature doesn't allow it. There is no creature with a fundamental impairment of the sense of touch. It simply doesn't exist. It is neither born, nor would it be capable of surviving. Therefore, these discussions about dominance or hierarchy are still influenced by Plato and there are not enough people stating that we experience the crucial relation to life or reality through the sense of touch and not of sight.[405]

While ocularcentrism might still be regarded as the dominating paradigm in Western culture, recent decades have witnessed a rise in discourse criticising the 'scopic regime', as discussed above. Moreover, there is a current debate which propagates a consideration of the senses as inherently connected, as Bennett and Hill (eds. 2014: IX) describe: 'A flood of recent work in both philosophy and perception science has challenged widespread conceptions of the traditional sensory systems – sight, touch, and so on – as operating in isolation'. Consequently, Grunwald's dichotomous narrative, which puts sight and touch in opposition, could become obsolete in the future. That said, in order to challenge ocularcentrism within his discipline, Grunwald strategically foregrounds the importance of touch for human development (AI, 24.8.2007). His ideas contribute to a growing discourse which specifically emphasises the role of touch, as can be seen in the specialised works of a series of writers in the humanities and the natural sciences. Within the humanities and social sciences, for example, a growing body of literature highlights the importance of touch to human experience and knowledge (e.g. Classen 2003, Classen ed. 2005, Howes ed. 2005, Pallasmaa 2005, Paterson 2007).

Notwithstanding this increasing body of theory challenging ocularcentrism and even championing the sense of touch, the lived psycho-medical reality that Grunwald

[405] 'Und seitdem kloppen sich eigentlich diese beiden Welten. Die einen sagen, der visuelle Sinn, das ist das wichtigste und aller, aller, allerallerallerschönste und zentralste. Und dann die kleine Gemeinde, die sagt, hey komm, jetzt mach doch mal die Augen zu. Lass doch mal ein paar Blinde…guck Dir mal ein paar Blinde an. Und wie sieht es da aus. Ja, bei den Blinden und auch bei den Taubblinden. Wir können keinerlei Beeinträchtigungen der Bewusstseins- und höheren kognitiven Fähigkeiten bei taubblinden Menschen feststellen. Überhaupt nicht. Die wissen nämlich ganz genau, dass sie da sind, was innen uns was außen ist. [...] Wer nicht bestehen kann, ist, der keinen Tastsinn hat. Aber das ist so grundlegend, da hat die Natur…, da lässt die gar nichts ran. Das ist gar nicht lebensfähig. Es gibt kein Lebewesen, was eine grundlegende Störung des Tastsinnes hat. Das gibt es einfach nicht. Das wird weder geboren, noch kann es überleben. Also von daher, sind diese Dominanz- oder Hierarchiediskussionen eigentlich immer noch so Platon'sch geprägt und es gibt zu wenig Leute, die sagen die entscheidenden Lebensbezüge oder Realitätsbezüge erfahren wir durch den Tastsinn nicht durch den Sehsinn.' (Grunwald, AI, 24.8.2007)

describes and contests remains, according to him, largely logocentric and sidelines haptics. Hence, the haptologist is critical of what he regards as a contemporary psycho-medical discourse and psychotherapeutic culture that advocate therapy instead of physical contact:

> That's why you have to read Harlow, because we are currently witnessing another phase of medical reconstruction, of medico-scientific restauration. Nowadays, there is a counselling service for anything, a self-help book for absolutely anything. A parental group for anything, teaching parents how to be nice to their children. It really isn't healthy anymore. […] Scientists, doctors, are hugely important as conveyors, also of physical culture. If a doctor says your child is sick, keep your distance, that might already be enough. [...] This dominant culture that says: "Don't spoil your children". Any kind of extra physical contact means that you are spoiling your child. Very strange. […] [Moreover] this model of the nursery from day one determines our cycles of interaction […] without any physical contact whatsoever. […] We have a concept of individuality, of freedom, of self-dependence effectively. This is being sold to us as the most precious good. Yet, as a result, we make some of our children totally sick. Child psychiatric clinics are packed. The distribution of Ritalin has skyrocketed worldwide. [406] (Grunwald, AI, 24.8.2007)

Effectively, Grunwald criticises the medicalisation of everyday life, or as Furedi (2004: 10) puts it: 'the monumental increase in the psychologization of modern life', as detailed above (1.4). Essentially, he criticises therapy culture, marked not only by the 'hygienic code of culture' of ocularcentrism (Pallasmaa 2005: 16) but also by another discourse of verbalisation of the self, which together have downgraded the sense of touch. Moreover, Grunwald disparages a no-touch ideology, not unlike the one Harlow addressed when he was conducting his research in the US of the 1950s and 1960s, also a period of increased psychologisation of everyday life (4.2), the precursor of today's therapy culture (1.4). This therapy culture, in turn, is marked by scientific 'expert knowledges' (Giddens 1991: 5), that, according to Grunwald, can impact negatively on the development of the self.

In an almost Foucauldian sense, Grunwald points to the way particular psycho-medical discourses have produced particular therapeutic practices that, in turn, determine particular notions of self (1.2). He criticises what he regards as a prevalent individualised, self-reliant and thus disembodied notion of self. 'The overriding problem,' Grunwald reiterated (AI, 8.7.2016) '[is that] the disciplines of medicine and psychology conduct their research and think in concepts of cognition, and generally without the body. Psychology got rid of the body – or rather it never incorporated it'.[407] At the same time

[406] 'Deswegen müssen Sie sich diesen Harlow reinziehen, weil wir jetzt wieder so eine Medi-Rekonstruktion oder Restauration des medizinisch-wissenschaftlichen haben. Für jeden Mist gibt es eine Beratungsstelle, für jeden Mist gibt es einen Ratgeber. Was Sie auch vorhin gesagt haben. Für jeden Mist gibt es eine Gruppe, die den Eltern beibringen, wie man nett und lieb zu seinem Kind ist. Das ist doch alles nicht mehr gesund. [...] Wissenschaftler, Ärzte, sind ganz wichtige Transporteure auch, von Körperkultur halt. Wenn ein Arzt sagt, Ihr Kind hat, halten Sie mal so ein bisschen Abstand. Das kann ausreichen. [...] Diese dominante Kultur, die da heißt: „Du darfst es nicht verwöhnen." Jede Form von Mehrkontakt heißt, Sie verwöhnen das Kind. Ganz merkwürdig. [...] [Außerdem] dieses Modell des Kinderzimmers ab dem ersten Lebenstag, das prägt natürlich dann die Interaktionszyklen [...] ohne physischen Kontakt. [...] Wir haben ein Konzept von Individualität, von Freiheit, von Selbstständigkeit eben. Und das wird uns als höchstes Gut verkauft. Dass wir einen Teil unserer Nachkommen total krank machen dabei, dass... . Die Kinderpsychiatrien sind voll. Ritalinvergaben innerhalb von mehreren Jahren ist auf Tonnen angestiegen weltweit!' (Grunwald, AI, 24.8.2007)

[407] 'Das übergeordnete Problem ist, dass Medizin und Psychologie in Kognitionskonzepten denkt und forscht; ohne Körper in der Regel. Die Psychologie hat den Körper abgeschafft bzw. hat ihn nie integriert.' (Grunwald, AI, 8.7.2016)

Grunwald himself is part of the psycho-medical discipline and therapy culture. A psychologist by training, a psycho-medical researcher, albeit with a specialisation in haptics, he engages in therapeutic studies and their circulation. Nonetheless, he portrays himself as challenging his own discipline from the margins. Grunwald engages in the creation of another 'regime of truth' (Foucault 1984d: 73). He works on strengthening another discourse, including a touch-based notion of self aimed at generating different meanings and practices concerning the self – anorectic and other.

Concluding his research into anorexia, Grunwald (AI, 24.8.2007) maintained that its treatment needs to take the body as its starting point, an embodied notion of the self in its haptic perception[408]: 'I sincerely hope that anorexia will be regarded differently, hopefully that will be the legacy of our work: an arduous interplay between messed up or morbid physical interaction inside the family and a pronounced neuro-biological dysfunction'[409]. In the conclusion to his account of the development of sensory stimulation treatment Grunwald (2008: 350) reflects, in more neutral terms, on future research needs not without reproducing his counter-discourse, and refers to the continuation of his work at the University hospital in Berlin, which I discuss in the following section (6.3):

> In order to achieve stable effects it is surely necessary to generate the bodily stimulation in younger patients within the framework of a complex, clinical, therapeutic setting. Fortunately, our colleagues at the child and youth psychiatry department of the Charité (Berlin) have integrated the diving suit into their bodily-therapeutic program and report very positive effects. It must be left to future research to determine which role the bodily stimulation and which the psychotherapy plays in these effects. It is, however, hoped that future clinical-experimental research will look more closely at and take into account the various social and biological factors that influence the development of the body schema. A key to the complex origins of eating disorders and other physical disturbances undoubtedly lies within.

[408] Grunwald emphasises the importance of the role of touch not only for their recovery, but increasingly also for the prevention of the illness (3sat 2010, Segler 2011). In our interview Grunwald (AI, 24.8.2007) explained his hypothesis as follows: 'Full physical contact is nourishment. Physical contact is one of the central factors in the lives of men and women, I think. I would go so far as to say – and I've only said this once before – that the development of all mental disorders is based on a disorder of the body schema. Assuming that body schema is the first of all our systems of cognition, the very first we are born with, and that it is then developed through social interaction. If that is disturbed, then the very foundation, the basic matrix of a human being is disturbed. Someone with a dysfunctional body schema potentially develops problems in all kinds of areas. And the funny thing is, virtually all mental disorders involve problems concerning haptic stimuli'. // 'Vollkontakt, das ist ein Lebensmittel. Also für mich ist es eigentlich für Männer wie für Frauen eine der zentralen Lebensgrößen. Ich würde sogar so weit gehen, ich habe das bisher nur ein einziges Mal geäußert, ich würde glauben, dass die Entstehung aller psychischen Störungen auf einer Störung des Körperschemas basiert. Unter der Annahme, dass das Körperschema vor allen anderen Kognitionen das erste ist, womit wir auf die Welt kommen, das allerallererste. Und das wird sozusagen nachgeburtlich weiterentwickelt durch den sozialen Kontakt. Wenn es da Störungen gibt. Dann ist sozusagen, die Grundmauer, die Grundfeste, die Grundmatrix des Menschen gestört. Und wer dort ein Fehler hat, der entwickelt, oder hat sozusagen das Potential an allen möglichen anderen Ufern noch Probleme zu bekommen. Und der Witz ist ... das eigentlich alle psychiatrischen Erkrankungen auch damit einhergehen, dass die Leute mit haptischen Reizen nichts anfangen können.' (Grunwald, AI, 24.8.2007) // In relation to this hypothesis, American animal scientist Temple Grandin (2005), who is very outspoken about her autism, has written an interesting account of the way 'many autistic children crave pressure stimulation' (318) and how she, herself, constructed a 'squeeze machine' that would put pressure on her body, granting her increased sensory stimulation, which is, in principle, not unlike the haptic suit.

[409] 'Die Anorexia, denke ich, also das hoffe ich sehr, dass das von unserer Arbeit übrig bleibt. Es soll wenigstens anders gesehen werden. Also, so ein hartes Wechselspiel zwischen versauter oder kranker Körperinteraktion innerhalb der Familie und ausgeprägter neurobiologischer Dysfunktion.' (Grunwald, AI, 24.8.2007) // Grunwald (AI, 24.8.2007) qualified his comments by adding the following explanation: 'We are not a group who would say that it [AN] is functional neurological disorder, but think that one's psychological environment determines neuro-biological dysfunctions'. // 'Also, von daher sind wir jetzt keine Gruppe die sagen, ja das sind Hirnfunktionsstörung, sondern wir denken schon, dass das psychologische Umfeld, das psychische Umfeld des Menschen, neurobiologische Fehlfunktionen sozusagen, bedingen, verursachen kann.' (Grunwald, AI, 24.8.2007)

6.3 The therapist in the wardrobe: Applications of sensory stimulation treatment

6.3.1 The role of the haptic suit in body therapy at Charité hospital, Berlin



figure 143: Prototype neoprene diving suits used for sensory stimulation treatment as part of body therapy at Charité hospital, Berlin, 11.9.2013



figure 144: Diving suits employed as part of body therapy: the yellow one belongs to a seven-year-old boy, the red and black one to a nine-year-old girl.

Gabriele Riess spreads out several short-sleeved diving suits, some flesh coloured prototypes, others in red or neon yellow (figure 143 and 144). The floor of this bright room in a functional hospital building is covered in thick red rubber mats (figure 145 and 146). Two piles of coloured blankets are stacked on the wide window sills. Elsewhere there are pillows, ropes, wall bars, a blackboard and a large wall mirror which can be covered by a curtain. It is a space reminiscent of a Pilates studio. One of the suits looks very small, and belongs to a seven-year-old boy (figure 144).



figure 145: The space dedicated to body therapy at Charité hospital, Berlin



figure 146: A space reminiscent of a Pilates studio – body therapy at Charité hospital, Berlin

Riess (figure 147) has been working as a body therapist at the Charité hospital in Berlin, the largest university clinic in Europe (Charité 2016), since 2003. Shortly after setting up her own practice, she began her part-time engagement at the Clinic for Child- and

Adolescent Psychiatry[410] at Charité, where she sees both male and female patients with eating disorders three times a week. Riess (AI, 11.9.2013) first learned about Grunwald's research in a magazine article and contacted him because, she says, she 'had basically been working in a very similar way for a long time'[411]. Following her degree in physical education, she trained as a movement therapist, substance abuse and social counsellor, as well as an alternative practitioner in psychotherapy. According to Riess (AI, 11.9.2013) the notion of the body as a sensory organism stands at the centre of her practice and she thus felt that the concept of sensory stimulation treatment would complement her work very well. 'I decided to propose the approach of the diving suit to the hospital. […] Grunwald was thrilled that there was finally someone from clinical practice who was interested and dared to try this'[412] (Riess, AI, 11.9.2013). However, she recalled that this new and hitherto unapplied treatment was met with scepticism, regarded as too constricting, not only by the cognitive behavioural therapists in the department but also other colleagues (Riess, AI, 11.9.2013). Finally, the integration of the haptic suit into her practice was authorised by the head of the clinic 'who is a great supporter of body therapy for anorectics'[413] (Riess, AI, 11.9.2013).



figure 147: Gabriele Riess, body therapist

In her therapeutic practice Riess follows a particular sequence, starting with her own 'diagnosis on many levels'[414] (Riess, AI, 11.9.2013). Part of this diagnostic process is a so-called rope test (figures 148–150), developed together with other body therapists at the Charité (Riess, AI, 11.9.2013). It is supposed to visualise the distorted physical self-

[410] The full official German title defines its specialisation in more detail: *Klinik für Psychiatrie, Psychosomatik und Psychotherapie des Kindes- und Jugendalters*, which literally translated means: Clinic for psychiatry, psychosomatics and psychotherapy of the child and youth age.
[411] 'Ich fand dann, dass ich im Grunde genommen ähnlich schon längst arbeite.' (Riess, AI, 11.9.2013)
[412] 'Und habe dann mich entschieden, ok, dann traue ich mich das jetzt mal in der Klink vorzutragen, dass ich das für eine gute Idee halte. […] Grunwald war natürlich super begeistert, dass da endlich jemand aus der Praxis kommt, die sich traut.' (Riess, AI, 11.9.2013)
[413] 'ein sehr starker Befürworter der Körpertherapie für die Essgestörten' (Riess, AI, 11.9.2013)
[414] 'Diagnostik auf vielen Ebenen' (Riess, AI, 11.9.2013)

perception at the centre of Dr Grunwald research, Riess (AI, 11.9.2013) explained, making it visible to both the patient and the therapist.







figure 148: A patient with anorexia depicts her estimation of the circumference of her thigh with red string on the ground. film still, 2010

figure 149: Gabriele Riess measures the circumference of the patient's thigh with a yellow string.

figure 150: Comparison of the patient's estimation of the circumference of her thigh (red) and the measured one (yellow)

Another element of the diagnosis described by Riess (AI, 11.9.2013) is a visual comparison which asks patients to acknowledge the perception of their bodies in relation to that of the therapist in front of a mirror. Riess (AI, 11.9.2013) termed the physical self-perception of many patients 'dramatically unrealistic' and 'delusional': 'I compare it to schizophrenia, hearing voices and we don't hear them'[415]. At the end of her diagnostic process, '99% of patients are diagnosed with a body schema disorder,'[416] according to the body therapist (AI, 11.9.2013).[417] It is noteworthy that the mirror as a generator of

[415] 'Ich vergleiche das mit der Schizophrenie, die Stimmen hören und wir hören die nicht.' (Riess, AI, 11.9.2013)
[416] 'Und wenn die Diagnostik durch ist, ist bei 99% der Patienten eine Körperschemastörung diagnostiziert.' (Riess, AI, 11.9.2013)
[417] Riess (AI, 11.9.2013) explained: 'I apply different categories: normal range, salient behaviour, heavily salient and finally delusional. Unfortunately they are not rare. Out of the patients one or two will have a delusional perception of their body. They measure about 45cm, but think their stomach has a circumference of 1.40m. They overestimate their size by one meter! […] The number one problem area is the stomach. Thighs are the second one and for those with a severe disorder also the face, the whole body. Sometimes the arms, but the main focus of their body schema distortion lies in their stomach and thighs. It is truly alarming. Concerning the stomach, I could fill a whole book with everything I have heard throughout the many years of working here. It is frightening. The language you hear: masses of fat, being bloated, disgusting, dripping, the notion of melting, of floating away, to be without boundaries, the thought that when I touch them I would be diving into masses of fat. The body seems to have no firmness, no boundaries. And if the body has boundaries, they really lie there [she points far out]'. // 'Ich habe so die Kategorie: sie ist im Normalbereich, sie ist auffällig, sie ist schwer auffällig und dann gibt es die Wahnhaften. Und die sind leider gar nicht selten. Ich habe von zehn Patienten immer mindestens einen bis zwei dabei, die eine wahnhafte Vorstellung ihres Körpers haben. Die haben dann einen Umfang, wenn ich sie messe, von vielleicht 45 cm oder weniger oder mehr, ich hab das jetzt nicht genau im Kopf. Und die haben die Vorstellung, dass ihr Bauch einen Umfang von 1,40m hat. Sie überschätzen sich von einem Meter. [...] Die Problemzone Nummer eins ist der Bauch. Die zweite sind die Oberschenkel und bei den ganz krass Gestörten ist es auch das Gesicht, der ganz Körper. Manchmal ein bisschen auch die Arme, aber im Hauptfokus ihrer Körperschemastörung liegt der Bauch und die Oberschenkel. Und das ist wirklich gravierend. Also beim Bauch kann man wirklich so, was ich hier über die vielen Jahre, die ich hier bin, könnte ich so ein ganzes Buch füllen. Es ist erschreckend. Was man so für Begriffe hört, wie von so Fettmaßen und aufgedunsen, eklig, triefend, die Vorstellung, dass der Körper sich wie auflöst, wegschwimmt, ohne Grenzen ist, dass, wenn ich sie berühre, sie die Vorstellung haben, ich tauche in Fettmaßen ein. Und es hat so keine Festigkeit der Körper, keine Grenzen. Und wenn er Grenzen hat, dann liegen die in ihrer Wahrnehmung tatsächlich da.' (Riess, AI, 11.9.2013)

verbal and visual self-reflection runs through all the therapeutic approaches, even body therapy. The mirror thus becomes part of the confessional and/or disciplining institutional apparatus, as discussed in relation to *vêtothérapie* (5.5.1). Moreover, it is involved in the revelation of truth, the discursive construction of medical truth which such diagnostic sessions constitute.

Riess (AI, 11.9.2013) maintained that both the visualisations of the rope test and of the mirror comparison are helpful but fail to reach patients on any significant level, which is why she makes them 'feel the diagnosis':

> This overestimated measurement lies on the floor here and this is when the haptic perception effectively starts. I begin to let them feel the diagnosis. […] Using cushions and blankets I wrap them to their perception [figure 151]. I started with these cheap blankets, effectively the predecessor of the diving suit. […] And then I wrap them to that perceived size, to 1.30m. And they walk around like the Michelin man and stand and sense and look.[418]



figure 151: Gabriele Riess wraps a patient in blankets 'to begin to let her feel the diagnosis' (Riess, AI, 11.9.2013). film still, 2010

The body therapist said that she explains to her patients: 'There is a white spot up there – it is proven'[419] (Riess, AI, 11.9.2013) and talks to them about distorted spatial perception, about Grunwald's study and research into eating disorders conducted at the Charité. Riess (AI, 11.9.2013) tells the patients that she wraps them 'so you can make a connection again'[420], to give them feedback about their actual body boundaries. For about two weeks Riess works with blankets. She described a mixture of different techniques and exercises, wrapping them softly 'to sense'[421] (figure 152) or tightly 'to hold the body'[422] (figure 153) – all in order to 're-nurture'[423] the patients, as Riess (AI,

[418] 'Das liegt dann hier auf dem Boden und dann beginnt quasi auch die haptische Wahrnehmung. Das ich beginne sie die Diagnostik fühlen zu lassen, [...] Das können wir dann so machen, das wir die Patientin dann mit Kissen, wickele ich sie mal auf ihre Wahrnehmung. Und dazu gibt es diese billigen Decken mit denen habe ich begonnen. Das war sozusagen, der Vorläufer für den Neoprenanzug. [...] Und dann wickele ich sie einmal auf dieses Ausmaß, das sie sich fühlen, auf 1,30m. Und dann laufen die hier rum wie ein Michelinmännchen und stehen da und spüren und sehen.' (Riess, AI, 11.9.2013)
[419] 'Hier oben ist ja so ein weißer Fleck, ist nachgewiesen.' (Riess, AI, 11.9.2013)
[420] 'damit Du jetzt wieder eine Verbindung herstellst' (Riess, AI, 11.9.2013)
[421] 'Nachspüren' (Riess, AI, 11.9.2013)
[422] 'Sie brauchen Halt.' (Riess, AI, 11.9.2013)
[423] 'nachgenährt werden' (Riess, AI, 11.9.2013)

11.9.2013) put it. 'I work with hammocks, for example,' she detailed 'Yes, I rock them. With the very young ones I hum and I rock them and hold them and use a lot of touch'[424] (Riess, AI, 11.9.2013).

The way in which the therapeutic discourse is constructed authorises the therapist to use words and gestures, as Kagan (et al. 2012: 403) wrote in relation to *vêtothérapie* (5.5.2), normally prohibited between strangers. The discursive construction of diagnosis and treatment, which draws on scientific knowledge in its production of a therapeutic truth, legitimises the therapist to 'touch' patients, to 'hold' and 're-nurture' them. The employment of the term 're-nurture' signifies a maternal or parental relationship, but also a lack that the therapist is thus sanctioned to treat.



figure 152: Patient wrapped in blankets, lying down and touched by Riess in order to 'sense', film still, 2010

Riess summarised the initial stages of her treatment as follows: 'They are actually haptically convinced. And they start to realise that it makes sense […] what is a body schema disorder, saying: "I now feel that I am not like that." It's the beginning of different processes. […] We then unwrap them and then we sense […] And at that point I already have them on board'[425]. At this stage, Riess (AI, 11.9.2013) said she suggests the diving suit to the patients, because sensory stimulation in the form of the suit is able to act on the patient for several hours while they get on with their daily routine at the clinic, effectively continuing her body therapy.

[424] 'Ich habe hier Hängematten, zum Beispiel. Ja, ich wiege die. Mit den ganz Kleinen mit den summe ich und wieg die und halte die und berühre viel.' (Riess, AI, 11.9.2013)
[425] 'Und dass sie eben tatsächlich davon wirklich fühlend überzeugt sind. [...] Und wenn die dann sehen das macht Sinn, was ist denn eine Körperschemastörung. "Ich fühl das jetzt. Ich sehe, ja ich bin ja gar nicht so," dann passieren verschiedene Prozesse. [...] Dann wickeln wir das wieder ab und dann fühlen wir. [...] Und dann habe ich sie schon im Boot.' (Riess, AI, 11.9.2013)



figure 153: Gabrielle Riess demonstrates on a colleague how she wraps patients with blankets to put haptic pressure on large areas of their skin. 2011

> My colleague and I offer it to them, we can't force them, that doesn't work. But we do tell them that it has no side effects, unlike [medication]. [...] And with the desperate cases we sometimes get support from the doctors, because they are also at a loss. […] We say first of all try to wear it for half an hour, first of all only in this room with me. Then: "Do a somersault here on the ground in the suit. Try what is possible." […] I then work towards them wearing it at least twice a day, sometimes rather three times. And there were patients, and there still are, who sleep in it, because they notice – when they manage to express their emotionality: "I am melting." – and that it holds them, gives them stability.[426] (Riess, AI, 11.9.2013)

'We can't force them'[427] Riess maintained, yet the notion of free choice is somewhat compromised in a hospitalised, continuously monitored setting for under-aged patients, as previously addressed (Ch.5). By portraying the suit as having 'no side effects', as giving 'stability', by telling patients that there is a 'white spot up there', a 'regime of truth' (Foucault 1984d: 73) about the treatment is produced. When doctors 'support' the choice to wear the suit and when stories are told of other patients 'who sleep in it', because they 'notice' the stabilising effect, an idea of objectivity is constructed. As such, these statements indicate the way in which therapeutic staff hold the power over definitions of 'effective' treatments. Moreover, they illustrate the mutual dynamic between knowledge and power, the way they 'directly imply one another' (Foucault 1975/1995: 27). Indicative of the inherent 'points of resistance' (Foucault 1976/1990: 95) in that relationship, is the fact that half of the patients refuse to participate in the treatment, according to Riess (AI, 11.9.2013).

[426] 'Wir bieten ihnen den an und meine Kollegin und ich, wir zwingen sie nicht, das geht gar nicht, aber wir sagen, es hat keine Nebenwirkungen... [...] Und bei den verzweifelten Fällen kriegen wir dann auch mal Unterstützung von den Medizinern, ja, weil sie auch nicht mehr weiter wissen. [...] So dass wir gesagt haben, versuch ihn erst einmal eine halbe Stunde zu tragen, erst einmal nur im Raum mit mir zusammen. Das heißt: "Mach' mal Purzelbäume hier mit dem Anzug. Guck mal, was da alles geht." [...] Und dann arbeite ich darauf hin, dass sie ihn mindestens zweimal am Tag tragen, manchmal sogar eher dreimal. Und es gab welche, es gibt immer wieder welche, die schlafen sogar dann damit, weil sie merken, was ich vorhin angedeutet habe, wenn sie es schaffen ihre Emotionalität auszudrücken: "Ich zerfließe," - dass das etwas ist, was ihnen Halt gibt.' (Riess, AI, 11.9.2013)

[427] 'Wir zwingen sie nicht, das geht gar nicht.' (Riess, AI, 11.9.2013)

These treatment descriptions exemplify how the suit is employed not only as a normalising but also as a disciplining technology of the self. On a physical level the suit is conveyed as stabilising the self. Yet, psychologically it is used in order for the patients to know and reflect on themselves, to 'express their emotionality' – if not in words then in movements. The pilot study aimed to shift the focus of anorexia treatment away from language, visual reflection and social interaction; yet in this treatment the verbalisation and reflection of the self, as well as the interaction with the therapist, are conveyed as essential elements.[428] Inherent in this treatment is not only the necessity to get undressed and put on the suit in the presence of a therapist, but also the obligation to articulate the self, to express one's self-perception and 'emotionality' and to work on the self. As such, sensory stimulation treatment, whilst placing less emphasis on language, is still directly implicated in our confessional culture (1.4).

Finally, in the narratives constructed around the haptic suit both by Riess and Grunwald, anorexia nervosa becomes naturalised as a female illness. Given that the majority of patients affected are young women (Hilgemeier 2016), and that both Grunwald and Riess treat more women (Riess, AI, 11.9.2016), this gendered connotation evidently correlates to their common sense of the illness. Nonetheless, it is noteworthy that Riess does not comment on gender differences in her body therapy with the haptic suit. Given her highly reflective working approach, the lack of responsiveness to questions of gender surprised me, as it presumably determines her everyday therapeutic practice with individual patients. In our interview Riess mostly refers to *die Patientinnen*, the German term for female patients, in both the singular and the plural. Comments regarding differences in her treatment of male patients, or their take on the haptic suit could, however, not be elicited.

Following the initial trial session with the suit, patients are fitted with their personal short-sleeved model[429] and can select their own colour scheme, a vital aspect for their 'motivation', Riess (AI, 11.9.2016) argued.[430] Subsequently, patients wear the suit for

[428] Riess repeatedly pointed out that the suit only constitutes one element in inpatient treatment, that it does not replace a therapist and should only be used under therapeutic supervision. In a similar vein Grunwald (in Segler 2011: 38) cautions: 'Patients or their parents, should, under no circumstances, get a diving suit on their own. The treatment releases so much, which should absolutely be caught by a therapist'. // 'Deshalb sollte man sich auf keinen Fall auf eigene Faust einen solchen Anzug für sich oder sein Kind beschaffen. In der Therapie kommt so viel in Gang, das muss unbedingt durch einen Therapeuten aufgefangen werden.' (Grunwald in Segler 2011: 38)

[429] Riess (AI, 11.9.2013) described how she and her colleagues developed the suits to fit the specific needs of their patients: 'We experimented a little with long sleeves, long legs or not – where are the problem areas and have tried to combine that with our motivational work. And we arrived at colours and also at short sleeves, because the number one problem area is the stomach'. // 'Wir haben ein bisschen experimentiert mit langen Ärmeln, langen Beinen oder nicht, kurz - wo sind denn die Problembereiche und so und haben dann das versucht mit der Motivationsarbeit auch zu koppeln. Und sind dann auf Farben gekommen, auch teilweise auf kurz Ärmel, weil die Problemzone Nummer eins ist der Bauch.' (Riess, AI, 11.9.2013)

[430] As seen in both "Therapy of Fashion" and *vêtothérapie* dress or certain dress elements are employed as a tool for communication and motivation. In relation to sensory stimulation treatment, Riess (AI, 11.9.2016) explained: 'Of course, the colour is also important. We are dealing with children and adolescents and since they are wearing the suit like a garment, we have to motivate them through the individual colour choice among other things'. // 'Ja natürlich ist die Farbe auch wichtig. Wir haben es mit Kindern und Jugendlichen zu tun und da sie die Anzüge tragen wie ein Kleidungsstück müssen wir sie u.a. durch die individuelle Farbwahl motivieren.' (Riess, AI, 11.9.2016)

one hour up to three times a day for a period of six weeks, the time it takes for the body schema to begin to change and slowly 'match reality', according to Grunwald (Segler 2011: 38). This period is followed by a phase of dishabituation, including body-, occupational- and physiotherapy, which conclude this treatment (Hilgemeier 2016).

To this day no representative study on the effectiveness of the haptic suit has been undertaken at Charité. There is no official evaluation. Yet, summarising her experience of working with sensory stimulation treatment, Riess (AI, 11.9.2013) reflected:

> Looking back, I personally regard it as an important part of the treatment, though, it could never replace the personal therapist, all the other work we are doing here, psychotherapy, family therapy. But it is an important part, which can be developed. Through dress, certainly, a lot can still be developed.[431]

In another interview she evaluates: 'More than half of the patients agree to the therapy and approximately 80% of treated patients clearly felt better because of it'[432] (in Hilgemeier 2016). One such patient, "Julia", who 'has been wearing the suit for three months and where it has achieved the best treatment results'[433], is portrayed in a short television report (3sat, 2010, 1'15). Asked to demonstrate and effectively validate the approach she describes her experience as follows:

> The first days and weeks were really very exhausting. I felt an extreme sense of pressure in my head. By now, I regard wearing the suit as normal. It definitely calms me a great deal. It is a feeling of security. The constriction has definitely helped me cope with anxiety. […] It makes a huge difference. It is much more physical. I wear the diving suit, I engage with it. I feel the individual parts of my body, beginning with my thighs, especially when I walk.[434] ("Julia" in 3sat, 2010, 1'50)

Her comment 'It is much more physical,' is a fitting description of the haptic suit, and a suitable summary of sensory stimulation treatment. How far this treatment is welcomed by patients as an embodied technology of self that normalises their self-perception and disciplines their body, or merely accepted or endured by them, cannot be determined, and is not the aim of this thesis.

[431] 'Wenn ich persönlich jetzt auf die Erfahrung - sage ich, es ist ein wichtiger Bestandteil, der auf der Liste, ersetzt niemals den persönlichen Therapeuten, die ganze Arbeit, die wir hier machen und die Psychotherapie und die Familientherapie und so. Es ist aber ein wichtiger Bestandteil, der ausbaufähig ist. Über Kleidung, mit Sicherheit, kann man da noch vieles entwickeln.' (Riess, AI, 11.9.2013) // While the details of such a development remain unformulated, both Riess and Grunwald maintained that the diving suit is 'just a basic model of the principle' (Grunwald, AI, 24.8.2007), that other materials could be used, such as merino wool, for example (Riess, AI, 11.9.2013). However, Riess (AI, 11.9.2013) added: 'the neoprene suit, in terms of the material, considering dress, is fantastic because it is so firm and can counter this distortion'. // 'Ich finde, Neopren ist wirklich nur ein Grundmodell des Prinzips'. (Grunwald, AI, 24.8.2007) & 'Es muss nicht immer der Neopren sein, aber der Neopren ist eben von dem Material her, was ich so in Kleidung sehe, finde ich den fantastisch, weil der so stabil ist und dieser Störung etwas entgegensetzt.' (Riess, AI, 11.9.2013)

[432] 'Mehr als die Hälfte unserer Jugendlichen lässt sich auf die Therapie ein, und rund 80 Prozent der Behandelten fühlten sich durch den Neoprenanzug deutlich besser.' (Riess in Hilgemeier 2016)

[433] 'Sie trägt den Anzug seit drei Monaten. Sie hat damit den besten Behandlungserfolg.' (3sat, 2010, 1'15)

[434] 'Die ersten Tage und Wochen waren auf jeden Fall sehr anstrengend. Ich hatte ein extremes Druckgefühl im Kopf und mittlerweile ist es so, dass ich das Anzugtragen als völlige Normalität einstufe. Das beruhigt, auf jeden Fall, wahnsinnig. […] Das ist ein Geborgenheitsgefühl. Diese Enge hat auf jeden Fall bei Angstbewältigungen geholfen.' ("Julia" in 3sat, 2010, 1'50)

While Riess maintained that 'with the support of the head doctor, we have really advanced with the diving suits here'[435] (Riess, AI, 11.9.2013)[436], they are now being used less frequently, due to funding restrictions (Hilgemeier 2016). Health insurance does not cover the cost of customisation which means patients have to either pay the €200 themselves or their therapist needs to apply for funding, a bureaucratic and time-consuming process (Segler 2011). The psychotherapist in charge needs to support the treatment, yet the resistance from the cognitive behavioural school persist, according to Grunwald (AI, 8.7.2016).[437] At the same time, the idea of asking patients to return their customised garments for subsequent use by future patients has proved difficult, as Riess (AI, 11.9.2013) reported:

> Some of my patients, when I ask them whether they would be willing to donate their suit at the end of their therapy, they decline, saying that is has become a symbol, that it helped them so much. It is like a therapist for them. That might sound like an exaggeration, but they say that it hangs in their wardrobes as a reminder. They do not want to part with it – that's how it is.[438]

Although this statement conveys patients' positive experience and connotations concerning the diving suit, it might also point to the depth of their implication in the therapeutic ethos, to keep a 'therapist' 'hanging' in their wardrobes.

[435] 'Weil ich unter dem Schutze des Oberarztes stehe, aber dadurch sind wir mit den Neoprenanzügen sehr weit fortgeschritten.' (Riess, AI, 11.9.2013)

[436] During our interview Riess repeatedly expressed her gratitude for the support her work gets from the head doctor. She attributes her capacity for working with a large number of patients with anorexia to her supportive working conditions: 'This is not self-evident from the beginning and I have the great benefit of feeling at ease in my work here. Very few therapists want to work with as many anorectics as I do here'. (Riess, AI, 11.9.2013) // 'Das ist auch nicht von Anfang an selbstverständlich und ich habe den großen Bonus, dass ich mich hier in meiner Arbeit mich so wohl fühle. Die wenigsten Therapeuten wollen so viele Essgestörte haben, wie ich die hier habe.' (Riess, AI, 11.9.2013)

[437] In relation to the work at Charité hospital, Grunwald (AI, 8.7.2016) makes the following claim: 'Mrs Riess and her colleague have told me that the fast changes effected by the diving suit resulted in strong rejection among behaviour therapists at the hospital. Psychologists simply don't understand that there are processes outside of language that are more effective and work faster. They seem to have a fear of loss if another method leads to quicker and better results than the current doctrine of salvation'. // 'Von Frau Riess und ihrem Kollegen habe ich damals gelernt, dass die schnellen Veränderungen durch den Neoprenanzug bei den VT-leuten in der Klinik starke Ablehnung produziert haben. Die Psychologen verstehen einfach nicht, dass es außerhalb von Sprache Prozesse gibt, die schneller wirken und effizienter sind. Sie haben so etwas wie "Verlustängste" - wenn eine andere Methode zu besseren und schnelleren Resultaten führt als die aktuelle Heilslehre.' (Grunwald, AI, 8.7.2016) // While the intricacies of this local conflict remain obscure, it is indicative of what Grunwald repeatedly describes as the bigger picture: two competing discourses, generative of cognitive behavioural therapy and sensory stimulation treatment respectively.

[438] 'Und ich habe Patienten... die ich dann mal gefragt habe: "Mensch, Du bist doch jetzt fertig mit der Therapie, spende mal Deinen Anzug." Und da sagt sie: "Mm [schüttelt mit dem Kopf] – das ist für mich ein Symbol, das bleibt bei mir, das ist so, der hat mir so geholfen." Das ist wie ein Therapeut für sie. Das klingt vielleicht übertrieben, aber: "Der hängt so im Schrank und erinnert mich." Und den wollen sie nicht abgeben - ist so.' (Riess, AI, 11.9.2013)

6.3.2 'An important contribution to therapy', taking 200 years to establish

In recent years, the haptic suit has been trialled at two further hospitals, one in Germany, the other in Austria. Both of these give similar feedback to that of Riess at the Charité, a mixture of what they term 'successful application' and lack of financial and organisational support for further research and development of the treatment. At the Pfalzklinikum für Psychiatrie und Neurologie in Klingenmünster, a regional psychiatric hospital in south-west Germany that evolved from one of the aforementioned large mid-nineteenth century rural asylums (Beyer 2009) (Ch.3), the haptic suit was 'successfully introduced into the treatment of anorexia patients' (Löschner, personal correspondence, 25.8.2016) in 2013. Yet, this measure is currently 'dormant' because of a 'conceptual restructuring' and 'lack of support from the psychotherapist', as Gabriele Löschner (personal correspondence, 25.8.2016), the moto-therapist in charge, explained. 'I very much hope that we will be able to reintegrate this therapeutic element in our treatment concept in the near future, as about half the participating patients found the wearing of the diving suit helpful.'[439] During the first year approximately fifty patients had tested the haptic suit here, Löschner (in Stoll 2014) recounts 'and about half of them felt it to be positive. It made them realise that something was wrong with their body perception'[440]. However, according to her it did not trigger positive feelings in all patients, 'some of whom felt bigger because of it'[441] (Löschner in Stoll 2014) and wanted to end the trial. Similar experiences are recorded at the University Hospital Salzburg in Austria (figure 154), where the haptic suit has also been tested since 2013 (Mazhar 2013).



figure 154: University Hospital Salzburg: Landeskrankenhaus Salzburg – Universitätsklinikum der Paracelsus Medizinischen Privatuniversität

[439] 'Seit ca. einem Jahr "schläft" diese Maßnahme aufgrund von größeren personellen und konzeptionellen Umstrukturierungen [...]. Dadurch fehlt u.a. die Unterstützung durch den verantwortlichen Therapeuten [...] Ich hoffe doch sehr, dass wir diesen Therapiebaustein zukünftig wieder in unser Behandlungskonzept aufnehmen werden, denn ungefähr die Hälfte der Patientinnen die daran teilgenommen hatten das Tragen des Taucheranzuges als hilfreich bewerteten.' (Gabriele Löschner, personal correspondence, 25.8.2016)
[440] 'Von den etwa 50 Patienten, die hier den Anzug getestet haben, empfand ihn etwa die Hälfte als positiv. Ihnen wurde dadurch bewusst, dass ihre Körperwahrnehmung nicht stimmt.' (Löschner in Stoll 2014)
[441] 'Es gab aber auch Patienten, die sich im Anzug noch dicker fühlten.' (Löschner in Stoll 2014)

The head of the department of child and adolescent psychiatry, Professor Dr Thun-Hohenstein (AI, 6.9.2016), made the following observation:

> The feedback from patients is positive during the time of wearing the suit. It is useful in getting patients to deal with their body schema distortions. Generally speaking the feedback from patients differs quite a bit. Some are very positive and say that it feels like a second skin, that they can finally feel themselves through it. Others, however, find it too close, too tight, too hot, it forces them to deal with something they don't want to deal with.[442]

To 'make patients realise something is wrong', to 'force them to deal with something they don't want to deal with' – these statements are indicative of the way the haptic suit is regarded as a revelatory and disciplining technology of self in these settings, too. It is constructed equally as a form of therapeutic self-engagement, discovery and knowledge, of self-work – part of the discourse of psycho-medical treatments and therapy culture (1.4).

According to a conference paper written by staff who work with the suit (ÖGKJP 2015), sensory stimulation treatment in Salzburg is employed as an inpatient acute therapy. It is offered to both males and females between the ages of twelve and twenty-one (Thun-Hohenstein, AI, 6.9.2016). The treatment mirrors that of Riess' work at the Charité, and involves three phases: introduction, wearing and dis-habituation of the suit (ÖGKJP 2015). The haptic suit is equally psycho-medically contextualised and thus validated, as the staff detail: 'The treatment is accompanied by body-oriented therapies, such as occupational- or physiotherapy, doctor's visits, psychotherapy, and the recording of sensibilities and standardised psychological questionnaires'[443] (ÖGKJP 2015).

Moreover, the treatment is constructed as a clinical trial. Thus, the results are officially recorded in detail, including MRI scans to determine changes in the cortex of the brain which is responsible for body perception. 'It is only by means of this systematic approach that we can learn more about the effectiveness of this method,' argues Thun-Hohenstein (in Mazhar 2013), 'since this could turn out to be its Achilles heel'[444]. Although the hospitals' university provides the academic platform for clinical research, thus constituting the apparatus for this type of knowledge production, a lack of funding has meant that the work is officially being undertaken as a clinical trial. While no results have been published so far, Thun-Hohenstein (AI, 6.9.2016) maintained that there will be an evaluation after the trial period. Based on the largely positive empirical results, he terms the haptic suit 'an important contribution to therapy'[445] (in Stoll 2014).

[442] 'In der Situation gute Rückmeldung für die Patientinnen. Bringt viel Auseinandersetzung mit dem Körperschema und seinen Abweichungen. Sehr unterschiedlich: tw. sehr positiv, „ist wie eine zweite Haut", endlich spüre ich mich" u.ä.; aber auch es ist mir zu nahe, zu eng, zu heiß; bringt mich auf Thema mit dem ich mich eigentlich nicht beschäftigen will.' (Thun-Hohenstein, AI, 6.9.2016)

[443] 'Die Tragephase wird durch körperorientierte Therapien (Ergo-, Physiotherapie), ärztliche Visiten, Erhebung der Befindlichkeit und standardisierte psychologische Fragebögen begleitet und dokumentiert.' (ÖGKJP 2015).

[444] 'Nur mithilfe dieses systematischen Zugangs können wir mehr über die Nachhaltigkeit der Methode erfahren, denn dies könnte sich als Achillesferse der Behandlung entpuppen.' (Thun-Hohenstein in Mazhar 2013)

[445] 'Ich halte das für einen wichtigen Beitrag zur Therapie.' (Thun-Hohenstein in Stoll 2014)

Back at the haptic laboratory in Leipzig, Grunwald (AI, 8.7.2016) welcomes the clinical application of his work elsewhere. Yet, he also expressed his disappointment at the slow take-up and lack of further research[446] or structured evaluation, which he again put down to the dominant cognitive discourse, this time with reference to another counter-discourse:

> I estimate that it will take another two- to three-hundred years before this cognitive strategy opens up to physical processes and thereby the sensory system of touch. Until then people will continue to try and prove that they can treat and heal Anorexia nervosa by means of cognitive restructuring. It takes a very, very long time before a new perspective is accepted by science. Just look at the way plate tectonic theory became accepted… .[447] (Grunwald, AI, 8.7.2016) [448]

[446] Grunwald (AI, 8.7.2016) reasoned the lack of further studies as follows: 'When we published our data [in 2005], I naïvely assumed that other independent groups would take up the idea and continue the research. I overlooked, however, that there is a strong interest on the part of behaviour therapy to lead the field of eating disorders'. // 'Mit der Veröffentlichung unserer Daten hatte ich sehr naiv angenommen, dass nunmehr andere und unabhängige Gruppen, die Ideen aufgreifen und dazu forschen. Ich habe aber übersehen, das es auf Seiten der VT [Verhaltenstherapie] sehr starke Interessen gibt, das Feld der Essstörungen auch weiter anzuführen.' (Grunwald, AI, 8.7.2016)

[447] 'Nach meiner Schätzung dauert das ca. 200-300 Jahre bis diese kognitive Strategie offen wird für Körperprozesse - und damit auch für das Tastsinnessystem. Bis dahin wird man wohl immer wieder zu beweisen versuchen, dass es mit kognitiver Umstrukturierung doch gelingt AN zu heilen oder zu behandeln. Neue Perspektiven setzen sich eben gerade in den Wissenschaften nur sehr, sehr langsam durch. Lesen sie mal wie sich die Plattentektonik durchgesetzt hat.' (Grunwald, AI, 8.7.2016)

[448] Contributing to Grunwald's disillusionment concerning a shift in the treatment approach to anorexia nervosa, is a sense of hopelessness regarding the illness itself, as he explains: 'It is endlessly hopeless. So many doctors quit, therapists who don't want to do it anymore. When you see a female patient four times in five years in a completely unchanged life-threatening condition and you have worked your guts out in terms of therapy, you quit. Because these girls sit in front of you and say: "There is nothing wrong with me. I want to go home." Only skin and bones. "There is nothing wrong with me" (Grunwald, AI, 24.8.2007).' // 'Und das ist hoffnungslos ohne Ende. Also da gehen so viele Ärzte, Therapeuten wollen nicht mehr. Wenn Sie eine Patientin in fünf Jahren vier mal sehen in einem völlig unveränderten lebensbedrohlichen Zustand und Sie haben sich die Seele aus dem Leib therapiert, da hören Sie auf. Weil die Mädels sitzen vor Ihnen und sagen: „Ich hab' nichts. Ich will wieder nach Hause. Ich hab' nichts." Sind nur noch Haut und Knochen.' (Grunwald, AI, 24.8.2007) // The body schema disorder together with high recidivism rates are said to constitute a challenge in the treatment of anorexia nervosa, as other practitioners have pointed out (e.g. Riess, AI, 11.9.2013; Strober 2006). While Grunwald is still involved in the field of anorexia nervosa, his haptics research and writing focus lies elsewhere which he also reasons with a lack of financial support. Grunwald has, for example, edited two monographs on the sense of touch and haptics (et al. eds. 2001 & ed. 2008), the first since von Skramlik's in 1937 in German speaking countries, according to Grunwald (2012). Moreover, he is increasingly involved in industrial research in order to finance clinical research at the Haptic Research Laboratory in Leipzig (Grunwald, AI, 8.7.2016). With regards to the research of anorexia nervosa, Grunwald has participated in the creation of an 'independent online consulting service for persons affected with eating disorders and their relatives (http://www.ab-server.de) which was developed by physicians and psychologists in Germany' (Grunwald & Wesemann 2006a: 218) and has conducted contextualising research (e.g. Grunwald & Busse 2003; Grunwald & Wesemann 2006a&b & 2007).

6.4 Conclusion

Just one item of clothing is used in sensory stimulation treatment, a neoprene diving suit, and that only because it was thought the most effective way to simulate the sense of touch. While both "Therapy of Fashion" and *vêtothérapie* developed because the medical staff involved started thinking about the dress of patients and how to make or keep them "fashionable", sensory stimulation treatment did not take dress as its starting point but re-inscribed it as a therapeutic method, because of its functional qualities. Accordingly, the notions of self underpinning the three dress-related therapeutic approaches under review in this thesis differ noticeably, and engender diverse practices. "Therapy of Fashion" was founded on an individualised concept of self, one that is normatively gendered and thus appropriately styled, is largely based on appearance, and whose "disordered" nature could be normalised authoritatively through fashion. The notion of an adolescent self that underwrites *vêtothérapie,* whilst individualised, embodied and gendered, is regarded by its practitioners as decidedly social, cultural, largely vison-based, fashion-conscious and transient. As such it determines the treatment's emphasis on changing wardrobes and the therapeutic peer group experience. Sensory stimulation treatment, in contrast, is underpinned by a primarily embodied and haptic understanding of the self, an anorectic self determined and reliant on the sense of touch, yet in need of 're-nurturing'. Moreover, its discursive construction of the relationship between dress and the self is largely based on function, on the haptic qualities of a neoprene diving suit, thus giving rise to a neuro-biologically underwritten approach which is decidedly different to that of the other dress-related therapeutic approaches.

This chapter analyses the way in which sensory stimulation treatment is discursively constructed. Foucault's notion of discourse, regardless of its aforementioned limits (1.2.2), permits a critical analysis of the production of 'truth through scientific knowledge' (Foucault in Martin 1982: 15). Moreover, the concept of counter-discourse allows me to think through the way this treatment constructs itself in opposition to what its instigator sees as the dominant discourses of the research and treatment of anorexia nervosa. It enables a consideration of the dynamic of struggles for truth and the construction of alternative 'regime[s] of truth' (Foucault 1984d: 73). Accordingly, this chapter demonstrates how sensory stimulation treatment is constructed as a counter-discourse, which is a basis for a counter-treatment: the haptic suit. While this suit is neuro-biologically re-inscribed as a form of therapy and constructed as a counter-therapy, as this chapter argues, it is also employed as a technology of the self, concerned equally with transforming and improving bodies, making them 'more adequate' in a 'survivable' rather than an aesthetic sense, according to Grunwald. As such, sensory

stimulation treatment might seem more pertinent as a therapy, the scientific discourse it constructs might appear more plausible, more reflected than the discourses underpinning the other treatment approaches. Yet, it is not the aim of this thesis to determine the quality or credibility of dress-related therapeutic practices, but to determine what they are, how they have become what they are, and how they have been discursively constructed.[449]

[449] While this thesis does not aim to assess the plausibility, quality or relevance of the dress-related therapeutic treatments under review, it should be acknowledged that certain discourses had a greater impact on me as a researcher, felt more valid to my own work. I would argue, for example, that Grunwald's research into body schema can inform an understanding of the construction and maintenance of the self as embodied and multi-sensory processes, with a particular reliance on touch. Moreover, by "substituting" touch with cloth/ing, Grunwald draws connections between self, body, body schema, touch and dress, thus shedding new light on a largely under-analysed correlation, which hardly even features in research on the physical self nor, possibly more surprisingly, in research on dress. Writing from my personal standpoint, Grunwald's work certainly made me question my own understanding of 'self', and the dominant imagistic, language-based notions of the self in relation to the senses and dress in my field of dress and fashion theory. By definition, this fairly young field sits at the cross-roads of a number of disciplines, ranging, for example, from art/history and sociology to psychology and economics, brought to life by a rich variety of disciplinary representatives (before the arrival of dedicated academic courses in the early 2000s), whose output reflects this wealth of perspectives. However, despite the fact that it is difficult to generalise across such a remarkable and diverse body of work, much of its writing on dress in relation to the self is grounded in our ocularcentric culture. Dress is mostly understood as a visual phenomenon (sociology), as text (cultural studies) or sign (semiotics) – to be read. Two of the central analytical models frequently applied within dress and fashion studies, particularly when exploring the role of dress in the construction of self, are semiotics and symbolic interactionism, both, by their nature, visually focused (6.2.3). Consequently, the material presence of cloth, the ways in which it operates on our skin, the physical impact of dress on the wearer, remain under-analysed in accounts of dress and self identity. The connection between dress, body, the self and its perception and touch are largely unexplored. A contributing factor is constituted by the marginalisation of the body, as Entwistle (2000) argues, much like Grunwald in relation to his field (6.2.4). Moreover, visual conceptualisations of both body and self are as prevalent as in most other subject areas (6.2.3), and are as such underlying and reinforcing an imagistic understanding of dress in relation to the self. Of course, there are exceptions to these perspective tendencies within this field, which are, generally to be found in some anthropological writings and psychological discussions. Consequently, I would argue Grunwald's research on the haptic suit could be brought to this field in order to draw attention to dominant notions of self in relation to dress and to the multi-sensory qualities of dress, an aspect generally overlooked in analyses of the relationship between dress and the self. His work could fruitfully be brought to this field to call into question existing research and point to future research needs.

conclusion









figure 155: Straitjacket of a '*maniaque'*, engraving by Etienne Esquirol, 1837

figure 156: Robe presented in the fashion show inaugurating "Therapy of Fashion", 1959

figure 157: Dress by French label Kulte, donated to *vêtothérapie*, *Maison de Solenn*, 2008

figure 158: Diving suit used as a haptic suit in sensory stimulation treatment, 2013

From straitjackets and ball gowns to institutional wear, from 'corrective undergarments' and fashionable outfits to the diving suit, this thesis interrogates the different ways in which dress is used to work on the self in a number of psycho-medical therapeutic settings (figures 155–158). Informed by a Foucauldian analytical framework and aimed at both a thick description of specific therapeutic practices as well as their discursive

analysis, my research focuses on the following questions in particular: What are these practices? How have they become what they are? How have they been discursively constructed? And how do they mobilise dress in relation to the self? Accordingly, this study of "dress as therapy" explores the conceptual underpinnings and the naturalisations that are generative of the different dress-related therapeutic approaches. It argues that dress in general, and "dress therapy" in particular, are constructed as technologies of the self, which are ways of transforming, improving and, effectively, normalising the bodies and minds of patients, both male and female.

Particular notions of the self underlie the respective therapies. As this thesis demonstrates, such notions are part of the conditions of possibility of working with dress on the self in therapeutic settings. They are predicated on the idea of the self as therapeutable, specifically through dress, which is seen as capable of changing both body and self. Consequently, these therapies, in their explicit employment of mostly fashionable dress, are distinctly contemporary, not only because they are enabled by the rise of therapy culture in the 1960s, but also because they rely on the modern idea that our outer appearance is linked to the self. They are, as I argue, a feature of contemporary therapy culture which is characterised by an understanding of the self not only as therapeutable, but also as project: to be reflected on and known, to be taken care of and worked on (1.4.2). This largely naturalised obligation to optimise the self forms part of the psychologisation, therapeutisation and medicalisation of everyday life (1.4). The way we experience and come to understand our selves is essentially determined by the psy-disciplines, as Porter (2002: 217–8) outlines:

> [P]artly because of the proliferation of psychiatries, more people are said to be suffering – indeed *claiming* to be suffering – from a proliferation of psychiatric syndromes, in a 'victim culture' in which benefits may appear to lie in buying into psychiatric paradigms. More people than ever swallow the medications, and perhaps even the theories, which psychiatry prescribes, and attend various sorts of therapists, as the idioms of the psychological and psychiatric replace Christianity and humanism as the ways of making sense of the self-to oneself, one's peers, and the authorities.

Moreover, the obligation to optimise the self involves both mind and body (1.4.2). The self is to be fashioned psychologically and physically, as this thesis shows, and fashionable dress is regarded as part of the work we are expected to perform on our bodies. In turn, what makes the study of the dress-related therapeutic practices under review in this thesis so pertinent is the point that they bring together two central contemporary coordinates defining our experience and understanding of ourselves: fashionable dress and therapy. Consequently, the relevance and originality of this thesis also lies in the fact that it constitutes the first analytical study of "dress as therapy". Moreover, it not only documents and analyses these different dress-related therapeutic practices, but also represents a new investigation into the way discourses are formative of therapeutic practices.

This research also shows that, contrary to what popular representations and the current state of research might suggest, dress has been used in relation to the self in the institutionalised psycho-medical context for more than 250 years. It provides a detailed history of the present of contemporary dress-related therapeutic approaches, and a trajectory of some of their common conditions of possibility (Ch.3).

The dress-related therapeutic practices under review are explored as gendered and gendering practices, drawing attention to how women, in particular, were to be fashioned, and their femininity disciplined, most pertinently in the context of "Therapy of Fashion" (Ch.4).

One of the key naturalisations running through all three therapeutic settings under review in this thesis is the understanding of dress as neutral. Unlike many of the psychotropic drugs in use within psycho-medical treatment, dress is regarded as having no side effects, particularly in the context of the *vêtothèque* (Ch.5). Moreover, both "Therapy of Fashion" and *vêtothérapie* are underpinned by a belief in the positive nature and effect of fashionable dress on the wearer: humanising and socialising their patients and making them 'feel better'. While this thesis is not concerned with the effect of these treatments on the patients, and it does not preclude that these practices might constitute creative spaces or moments of resistance or subversion for the patients, my research demonstrates the different ways in which dress is naturalised as neutral and conveyed to its participants as positive in these settings. Moreover, this thesis argues that, far from being the value-free and neutral therapeutic tool it is mostly portrayed as, dress is inscribed with markers of age, gender, social, economic and cultural contexts, and imbued with normative and highly subjective notions of aesthetic and physical beauty. Although largely naturalised these markers determine the ground on which the therapies are constructed to fashion subjectivities. Lastly, dress-related therapeutic discourses are analysed in their production of psycho-medical knowledge and struggles for truth, constructing not only discourses but also, in the case of the haptic suit, counter-discourses (Ch.6).

Thus the contributions of my thesis can be summarised under three main headings: new knowledge, new connections, and the extension of theory. In the process of charting a new field of experience, that of "dress therapy", this thesis has opened up an archive, or indeed several archives, as outlined above. It has generated both valuable primary material as well as unearthed and collated a wealth of sources, some of which hitherto inaccessible, in a systematic way. By putting these into the public domain and employing them for a rich unpacking of the respective therapeutic practices, my thesis has contributed to the production of knowledge. Moreover, it has drawn a number of new connections, both major and minor, for example: between the three dress-related

therapeutic practices rooted in different medical disciplines and countries, or between history and present, but also between Foucault and this cultural phenomenon, or the different historical uses of dress in relation to self, between the straitjacket and "dress therapy", between conflicts and contradictions within psycho-medical treatment – such as the proximity between care and control, or between ocularcentric notions of self, the skin ego and the haptic suit. This thesis, finally, has engaged in the extension of theory through its systematic development of a Foucauldian framework which brings together Foucault's early and late work, critiques and expands aspects of cultural specificity, of gender as determinant of knowledge–power relations, of visual and spatial analysis, or of counter-discourse as a fruitful analytical concept. Methodologically, this thesis combines the archaeological and genealogical approaches of Foucault with micro-sociological qualitative methods and thick description to take account of the complexity and richness of my subject as well as the reflexivity of my role as a researcher.

By exploring dress as a normalising and disciplining, gendered technology of the self in the therapeutic realm, this thesis contributes most directly to fashion and dress studies as well as Foucauldian studies, as outlined above. However, it is also relevant for a number of other academic disciplines, such as: sociology (with regards to the social significance of dress in psycho-medical context, of the social significance of dress in normalising people), cultural studies (in its analysis of dress as a cultural phenomenon in its social and political context in relation to power), social psychology (concerning the role of dress in social interaction and how dress determines behaviour in the therapeutic settings), and finally psychology (in its analysis of dress as part of psycho-medical and therapy culture as well as the project of self).

While this thesis constitutes the first study of the hitherto unchartered field of "dress as therapy", it marks only the beginning of possible explorations. There is much scope to further investigate the historical role of dress in therapeutic settings, as my research identifies. For example, no detailed study of the straightjacket has been published to date, in spite of its central role in sartorial psycho-medical history. The three dress-related therapeutic practices under review in this thesis constitute key examples, but dress is employed in many different ways in therapeutic settings, as I have indicated. The detailed exploration of patients' uniforms or institutional dress in specific settings, as well as a study of cosmetotherapy, could be interesting follow-ons from this thesis. More generally, dress-related practices could be analysed from different perspectives to the ones proposed here, including non-Western practices, for example, or with a main focus on gender, class or ethnicity as determinants of the treatment. Since my thesis constitutes a study of discursive practices, of the way discourses are constructed in the

different therapeutic settings, I have focused on aspects that determined the respective discourses in their analysis. For example, I do not study gender in each setting per se, but whenever gender determined the therapeutic discourses it is analysed (e.g. Ch.4, 3.2.3.1, 3.2.3.3). However, future research could explore gender as a determinant of the dressed experience of psycho-medical treatment both historically and contemporaneously. Similarly, the subject of ethnicity in relation to dress-therapeutic practices constitutes an interesting area of enquiry, particularly in the context of US-American VA State hospitals that were segregated and desegregated within three decades. While it did not emerge as an aspect that shaped the discourse of "dress therapy" as analysed here, an investigation into the differences within therapeutic dress practices could potentially constitute a rich area of study.

In the course of exploring "dress as therapy" I identified another largely unchartered field of experience and theorisation: dress and the senses, which I would like to explore in future research, as previously outlined (Ch.6). Finally, while my thesis draws largely on a Foucauldian analytical framework, it has also been influenced by the work of Goffman and the sociological methods he employs in his investigation of the asylum. Both Foucault's notion of 'technologies of the self' and Goffman's concept of 'identity kit' have been useful in conceptualising the employment of dress in relation to the self in psycho-medical settings. As such, a comparative study of these two concepts could constitute a valuable continuation of my thesis.

In an interview not long before his death, Foucault (in Martin 1982: 11) summarised his work in the following terms:

> It is one of my targets to show people that a lot of things that are a part of their landscape – that people think are universal – are the result of some very precise historical changes. All my analyses are against the idea of universal necessities in human existence. They show the arbitrariness of institutions and show which space of freedom we can still enjoy and how many changes can still be made.

While my thesis is not so much concerned with the impact of historical changes on subjectification, it takes essential inspiration from Foucault's social constructivism in exploring the different dress-related therapies that came about at particular moments in history, and were discursively constructed on the basis of particular notions and naturalisations. My thesis, thus, analyses these therapies as contingent practices. It aims to show their arbitrariness and consequently points to the arbitrariness of working with dress on the self, of making sense of ourselves through fashionable dress and therapy.

appendix

appendix 1: “Therapy of Fashion”: An overview

appendix 2: *Implication de la Fédération Française du Prêt-à-Porter Feminin dans le Projet de Vêtothèque-Hôpital Cochin*
Involvement of the *Fédération Française du Prêt-à-Porter Feminin* in the project of the *vêtothèque* at Hôpital Cochin

appendix 3: *Bon de livraison Antik Batik*
Delivery note of Antik Batik

appendix 4: *Bon de livraison Psy Monte-Carlo*
Delivery note of Psy Monte-Carlo

appendix 5: Dress-related therapeutic settings: Analytical table (extract)

appendix 1

"Therapy of Fashion": An overview[450]

• 1958 'The Groom-Up program helped young patients hospitalized at Napa Sate Hospital'[451]

• 10/1959 "Therapy of Fashion" pilot at Napa State Hospital (Cal.)[452]

• 2 March 1960 'Edited Showing of American Spring Collections' by The Fashion Group of San Francisco to help finance more fashion therapy classes[453]

• 1 March 1961 'Edited Showing of American Spring Collections' by The Fashion Group of San Francisco to help finance more fashion therapy classes[454]

• 3/1962 Fashion Therapy sessions conducted at Mendota State Hospital, Madison (Wis.) by the Jaycettes, the auxiliary to the Madison Junior Chamber of Commerce and the recreational therapy department of the hospital[455]

• 5/1962 The Fashion Group and the Mental Health Association of San Francisco start a Fashion Therapy Programme at Mendocino State Hospital, Talmage near Ukiah (Cal.)[456]

• 1 June 1962 38 patients at Mendocino State Hospital graduated from Fashion Therapy Program with final show and diplomas[457] (image)

• 10/1962 Fashion therapy project starting for 25 women at Spring Grove State Hospital, Baltimore (Md.)[458] and 'the Maryland Association for Mental Health is making arrangements for the Fashion Therapy Program in Springfield, Crownsville and the Eastern Shore State Hospitals'[459]

• 5/1963 Representatives of the Fashion Group of San Francisco meet local representatives at Mendocino State Hospital to set up locally run Fashion Therapy program[460]

• 5/1963 'Fashion Horizons' fashion therapy program at Metropolitan State Hospital, Norwalk (Cal.), sponsored by LA Fashion Group[461]

• 11/1963 Mention of Fashion Therapy school at San Francisco County Hospital (Cal.)[462]

• 27 February 1964 Fashion show luncheon in San Francisco to benefit Fashion Therapy project, tickets $8.50[463]

• 11/1964 "Therapy of Fashion" luncheon at the 14th Annual Conference of the National Association for Mental Health in San Francisco with demonstration of how program works and what it does for patients[464]

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[450] This overview does not raise any claim of completeness. It is included to indicate the national scope of "Therapy of Fashion", this largely undocumented and under-analysed initiative. The information has been gathered from a series of original newspaper articles, as referenced below.

[451] http://www.slideshare.net/mhasf/mhasf-60th-anniversary-slideshow (13.8.2008)

[452] Thompson, Thelma (1962b) 'Fashion Therapy' in: *Journal of Home Economics.* Vol.54(10), p. 835.

[453] anon. (1960f) 'Women Mental Patients in California Hospital Improve with 'Fashion Therapy'' in: *The Tipton Daily Tribune.* (Tipton, Ind.), 26 February, p. 6. & Clinton, Mary Ann (1960d) 'Fashion Therapy Found Helpful to Women in Mental Hospitals' in: *Redlands Daily Facts.* (Redlands, Cal.), 23 February, p. 6.

[454] anon. (1960e) 'Fashionable Treatment Helps Women in Mental Hospital' in: *The Times Recorder.* (Zanesville, Ohio) 1 May, p. 6–C. & Clinton, Mary Ann (1960e) 'Fashionable Treatment Aids Women in Mental Hospital' in: *The Sunday Herald.* (Provo, Utah), 31 July, p. 2A.

[455] Andresen, Lea (1962) 'Fashion Therapy Can Work Wonders' in: *Wisconsin State Journal.* (Madison, Wis.), 4 March, p. S5 p5.

[456] elena (1962) 'At Random' in: *Ukiah Daily Journal.* (Ukiah, Cal.), 1 May, p. 3.

[457] Tucker Neep, Gay (1962) 'Patients Are Fashion 'Grads' in: *Ukiah Daily Journal.* (Ukiah, Cal.), 6 June, p. 6.

[458] anon. (1962d) 'Fashions Help with Therapy for Patients' in: *Cumberland Evening Times.* (Cumberland, Md.), 12 October, p. 15. & anon. (1962j) 'Women Mental Patients to Get Fashion Therapy' in: *The Cumberland News.* (Cumberland, Md.), 12 October, p. 4 & anon. (1962c) 'Fashion Therapy Project to Begin' in: *The Daily Times.* (Salisbury, Md.), 13 October, p. 8.

[459] anon. (1962j) 'Women Mental Patients to Get Fashion Therapy' in: *The Cumberland News.* (Cumberland, Md.), 12 October, p. 4.

[460] Tucker Neep, Gay (1963) 'Fashions Coming to Fore in State Hospital Program' in: *Ukiah Daily Journal.* (Ukiah, Cal.), 3 May, p. 6.

[461] Sweeney, Joan (1963e) 'Fashion Therapy Helps Mental Unit Patients' in: *Grand Prairie Daily News.* (Grand Prairie, Texas), 9 May, p. 8.

[462] anon. (1963b) 'Goals Explained Over Coffee' in: *The Times.* (San Mateo, Cal.) 11 March, p. 19.

[463] elena (1964) 'At Random' in: *Ukiah Daily Journal.* (Ukiah, Cal.), 2 March, p. 5.

[464] anon. (1964a) 'Binderman will Attend Mental Health Meeting' in: *The Raleigh Register.* (Beckley, W. Va.), 12 October, p. 3.

• 4 March 1965 Americana fashion show at Hotel Mark Hopkins, San Francisco to benefit Fashion Therapy project[465]

• 3/1965 'Easter Bonnet Project' sponsored by Mental Health Association in Indiana and Carroll County to enable Fashion Therapy at Logansport State Hospital, Logansport (Ind.)[466]

• 3/1966 'Easter Bonnet Project' sponsored by Mental Health Association in Indiana and Carroll County to enable Fashion Therapy at Logansport State Hospital, Logansport (Ind.) [467]

• 1967 Groom-Up Program Napa State Hospital[468]

• 9 March 1966 American fashion designer luncheon show in the Grand Ballroom at the Fairmont Hotel, San Francisco to benefit Fashion Therapy project[469]

• 15 March 1967 American designer fashion show at the Grand Ballroom of Fairmont Hotel, San Francisco to benefit Fashion Therapy project[470]

• 7/1967 The Fashion Therapy Group of Mental Health Chapter, Monroe County, Scottville wins Community Service Award for their Fashion Therapy Program at Rochester State Hospital, Rochester (N.Y.)[471]

• 13 March 1968 American spring collection fashion show at the Fairmont Hotel, San Francisco to benefit Fashion Therapy project[472]

• 4/1968 Fashion Therapy Program at Agnews State Hospital, San Mateo County Ward, Santa Clara (Cal.) looking for volunteers to assist on basic grooming from 10-12 on Tuesdays[473]

• 12 March 1970 'Style 70' fashion luncheon at San Francisco Hilton Hotel to benefit Fashion Therapy project[474]

• 6/1971 Bell Ringer campaign conducted by Mental Health Association of Greater Chicago to finance programs such as fashion therapy program [475]

• 12/1974 Mention of fashion therapy program being sponsored by Mental Health Association of Greater Chicago[476]

[465] Pauley, Gay (1965) 'Aldrich to Zuckerman Fashions to be Presented' in: *Daily Independent Journal.* (San Rafael, Cal.), 23 February, p. 21. & anon. (1965b) 'Parade of Couture From Aldrich to Zuckerman' in: *The Times.* (San Mateo, Cal.) 23 February, p. 6.
[466] anon. (1965a) 'Carroll County News' in: *The Kokomo Morning Times.* (Kokomo, Ind.), 23 February, p. 24.
[467] anon. (1966b) 'Mental Health group will Sponsor Easter project' in: *The Kokomo Morning Times.* (Kokomo, Ind.), 20 March, p. B9. & anon. (1966a) ''Bonnet Project' at Mental Hospital' in: *The Kokomo Morning Times.* (Kokomo, Ind.), 24 March, p. 4B.
[468] http://www.slideshare.net/mhasf/mhasf-60th-anniversary-slideshow (13.8.2008)
[469] McAdams, Emily (1965) 'Designers Set Luncheon Show For March Date' in: *The Times.* (San Mateo, Cal.) 18 December, p. 6.
[470] anon. (1967b) 'Fashion Show To Benefit Mental Health Patients' in: *The Times.* (San Mateo, Cal.), 14 March, p. 11.
[471] anon. (1967a) 'Community Service Awards: Top Winners Share Laurels' in: *The Post-Standard.* (Syracuse, N.Y.), 15 July, p. 8.
[472] anon. (1968a) 'Fashion Benefit for San Francisco Mental Health Program' in: *The Times.* (San Mateo, Cal.) 11 March, p. 9.
[473] anon. (1968b) 'Help Wanted: Volunteer' in: *The Times.* (San Mateo, Cal.), 25 April, p. 11.
[474] Logrippo, Ro (1970) 'Anything Goes in Spring Fashions' in: *The Times.* (San Mateo, Cal.), 14 March, p. 7.
[475] anon. (1971) 'Campaign For Mental Health' in: *The Elk Grove Herald.* (Chicago, Ill.), 7 June, p. 6.
[476] anon. (1974) 'Operation Snowball aids mentally ill' in: *Suburbanite Economist.* (Chicago, Ill.), 15 December, p. CSR 7.

appendix 2

Implication de la Fédération Française du Prêt-à-Porter Feminin dans le Projet de Vêtothèque-Hôpital Cochin

Involvement of the *Fédération Française du Prêt-à-Porter Feminin* in the project of the *vêtothèque* at Hôpital Cochin

IMPLICATION DE LA FÉDÉRATION FRANCAISE DU PRET-À-PORTER FEMININ DANS LE PROJET DE VETOTHEQUE-HOPITAL COCHIN
(ouverture septembre 2004)

le 08 janvier 2004,

Historique

Depuis 1999, dans le service de pédopsychiatrie du Professeur Marcel Rufo à la Timone-Marseille, a été mis en place un concept expérimental initié par l'Institut Mode Méditerranée. Sur le thème : le vêtement, soin culturel ».
Pour favoriser l'estime de soi auprès de ces adolescents hospitalisés confrontés à différentes pathologies liées à leur mal être (anorexie, tentatives de suicides, violences, boulimies… *Le suicide est la deuxième cause de mortalité en France chez les adolescents.*)

La cible :

Les adolescents hospitalisés dans la nouvelle unité de l'Hôpital Cochin : La Maison des Adolescents, projet financé et soutenu par la Fondation des Hôpitaux de Paris-Hôpitaux de France, Présidée par Madame Jacques Chirac.

Le partenariat Fédération :

15 entreprises, mode féminine et accessoires, adhérentes à la Fédération ou exposantes à PAP Paris dont les collections correspondent au mode vestimentaire de ces adolescents seront sollicitées deux fois par an pour offrir chacune entre 20 et 30 modèles de la saison en cours, qui auront été préalablement choisis par une équipe mode constituée d'un responsable Fédération et d'un responsable Hôpital Cochin.
Ces collections, environ 300 pièces par saison, comportent que des petites pièces : T-Shirt, Sweat, Chemisiers, jupes, robes, pantalons, accessoires, afin de constituer une vestiaire qui sera mis à la disposition des adolescents utilisateurs.

La Fédération s'engage à sélectionner ces entreprises à les mobiliser autour de ce projet caritatif, humanitaire, généreux et original.

Il n'y a donc aucun engagement financier.

Les retombées :

La Vétothèque de l'Espace Arthur à Marseille a bénéficié depuis quatre an d'une médiatisation française et européenne importante à laquelle les partenaires ont été associés et souvent cités. Aujourd'hui ces médias attendent avec impatience de reparler de cette deuxième vétothèque parisienne dont le porte parole sera Madame Bernadette Chirac qui nous

Proposition de convention de partenariat

ENTRE

La Fondation des Hôpitaux de Paris-Hôpitaux de France, dont le siège social est à Paris, …, Fondation…,représentée par sa Présidente Madame Bernadette Chirac,

ci-après dénommée « FHPHF »
D'UNE PART

ET

Le Fédération Française du Prêt-à-Porter Féminin, dont le siège social est à Paris, au 5, rue de Caumartin 75009, statuts…, représentée par son Président Monsieur Jean-Pierre Mocho,

ci-après dénommée « FFPAPF »

ET

L'Institut Mode Méditerranée, dont le siège social est à Marseille au 11, la Canebière 13001, association loi 1901, enregistrée à la Préfecture des Bouches du Rhône le …, sous le N°…, représentée par sa Présidente Madame Maryline Bellieud-Vigouroux

ci-après dénommée « IMM »
D'AUTRE PART

Les trois parties conviennent de ce qui suit :

Article 1 : Objet

La « FHPHF » confie à la « FFPAPF » et à « l'IMM » (initiateur de la première vêtothèque dans le service de pédopsychiatrie du Professeur Marcel Ruffo, l'Espace Arthur à l'Hôpital de la Timone à Marseille) l'organisation du contenu de la Vêtothèque située au sein de la Maison des Adolescents de l'Hôpital Cochin.

Article 2 : Modalités de la mission

La « FFPAPF » apportera son soutien et sollicitera un collectif d'entreprises de mode de Prêt-à-Porter féminin et d'accessoires. Elle sélectionnera aux côtés de « l'IMM » chaque saison environ 300 modèles déclinés en plusieurs tailles et couleurs (petites pièces : pantalons, jupes, Chemises, T-Shirt, pull, accessoires : chapeaux, bonnets, écharpes, bijoux fantaisies…)

Ces vêtements seront livrés aux responsables de la Vêtothèque en début de saison (les Collections Automne/Hiver, en septembre, les collections Printemps/Eté, en avril).

De plus la « FFPAPF » et « l'IMM » apporteront leur concours deux fois par an pour l'organisation d'expositions photos, liées aux activités de la mode. De même que des rencontres avec des professionnels de la mode : coiffeurs, maquilleurs, stylistes, journalistes, attachés de presse…

En contre partie, la « FHPHF » s'engage à gérer et animer la Vêtothèque.

Article 3 : Contrôle et bilan

La « FHPHF » s'engage à informer régulièrement, environ tous les deux mois, par des mails, des fax ou des réunions, la « FFFPAPF » et « l'IMM » de l'évolution de la Vêtothèque.

Article 4 : Communication

La « FFPAPF » et « l'IMM » devront figurer sur tous les supports de communication de la Maison des Adolescents de l'Hôpital Cochin, et plus particulièrement sur les supports annonçant les expositions organisées à l'Hôpital Cochin.

Article 5 : Litiges

Tout litige, après épuisement des voies de conciliation amiable, sera compétence du Tribunal de Paris.

Article 6 : Election de domicile

Les trois parties élisent domicile dans leurs sièges respectifs.

Cette convention engage les 3 parties sur une année, afin d'être renouvelé ce partenariat devra être confirmé trois mois avant la fin de la première année.

Fait à Paris, le.....
(en trois exemplaires originaux)

Pour la « FHPHF »	Pour la « FFPAPF »	Pour « IMM »
Bernadette Chirac Présidente	Jean-Pierre Mocho Président	Maryline Bellieud-Vigouroux Présidente

appendix 3

Bon de livraison Antik Batik

Delivery note of Antik Batik

FEDERATION FRANÇAISE DU PRET A PORTER FEMININ

Paris, 16 novembre 2004

MAISON DE SOLENN
Hôpital Cochin
27, rue du Fbg Saint Jacques

75014 PARIS

Bon de livraison

ANTIK BATIK

Nombre	Désignation	Prix H.T. unitaire	Prix total H.T.
5	Tunique longue	25,00 €	125,00 €
10	Echarpe foulard	15,00 €	150,00 €
8	Sweat/t.shirt manches longues	35,00 €	280,00 €
8	Sac	45,00 €	360,00 €
3	Casquette	30,00 €	90,00 €
2	Robe	60,00 €	120,00 €

TOTAL ..... 1.125,00 €

Nombre total d'articles livrés : 36

5, rue de Caumartin 75009 PARIS / TEL : +33 (0)1 44 94 70 00 / FAX : +33 (0)1 44 94 70 02
E-mail : diradm@pretparis.com / www.pretaporter.com
SIRET 784 204 919 00020 / CODE A.P.E. 911 A-MATRICULE N°4934 / N°INTRACOMMUNAUTAIRE FR 49 784 204 919

appendix 4

Bon de livraison Psy Monte-Carlo

Delivery note of Psy Monte-Carlo

FEDERATION FRANÇAISE DU PRET A PORTER FEMININ

Paris, 16 novembre 2004

MAISON DE SOLENN
Hôpital Cochin
27, rue du Fbg Saint Jacques

75014 PARIS

Bon de livraison

PSY MONTE-CARLO

Nombre	Désignation	Prix H.T. unitaire	Prix total H.T.
6	Jupe	114,00 €	684,00 €
3	Pantalon	126,00 €	378,00 €
9	Pull	98,00 €	882,00 €
3	Robes	112,00 €	336,00 €
6	Tee-shirt	72,00 €	432,00 €

TOTAL ..... 2.712,00 €

Nombre total d'articles livrés : 27

5, rue de Caumartin 75009 PARIS / TEL : +33 (0)1 44 94 70 00 / FAX : +33 (0)1 44 94 70 02
E-mail : diradm@pretparis.com / www.pretaporter.com
SIRET 784 204 919 00020 / CODE A.P.E. 911 A-MATRICULE N°4934 / N°INTRACOMMUNAUTAIRE FR 49 784 204 919

appendix 5

Dress-related therapeutic settings: Analytical table (extract[477])

	"Therapy of Fashion"	*Vêtothérapie*	Sensory Stimulation Treatment
setting (time & place)	• 10/1959 Napa State Hospital, Imola, California, US (pilot project) • a pilot study 'recently completed at Napa State Hospital' (Miller et al. 1960: 42) & (Silverman & Silverman 1961: 80) • 1959–69? at Napa State Hospital (according to visual evidence) • '...eight courses, four meetings each, and twenty one-night stands in less than three years...' (Thompson 1962b: 836) • 'Fashion Therapy has been introduced in 11 major United States cities and in Paris.' (Thompson 1962b: 835) – no further evidence etc.	• 5/1999 – *Espace Arthur*, Hôpital La Timone, Marseille, France (12.10.1999 inauguration with *vêtothèque*) • 1/2008 move to CHU Sainte-Marguerite, Marseille • 6/2012 move to & inauguration of *Espace Méditerranéen de l'Adolescent* (E.M.A), Marseille • 2003 – Psychiatrie infant-juvénile, Centre hospitalier intercommunal Fréjus Saint-Raphaël, France • 11/2004 – *Maison de Solenn*, l'Hôpital Cochin, Paris, France	• 12/2002–5/2003 pilot study, Haptic Laboratory, Department of Psychiatry, University of Leipzig, Germany • 2006– practiced as part of body therapy by Gabriele Riess at Klinik für Psychatrie, Psychsomatik und Psychotherapie des Kindes- und Jugendalters, Charité - Universitätsmedizin Berlin, • 2013–15 application at Pfalzklinikum für Psychiatrie und Neurologie in Klingenmünster (Rheinland-Pfalz) • 2013– application & planned effectiveness study at Universitätsklinik für Kinder- und Jugendpsychiatrie, Salzburg, Austria
project description / setup	• a programme of grooming, dress design and self-presentation classes practiced at a Californian mental hospital in the early 1960s etc.	• *vêtothèque* – dress library where therapeutic sessions take place • part of a 'therapy of culture' approach (*soin culturel*) etc.	• inducing sensory stimulation through the wearing of a neoprene diving suit / "haptic suit" in the treatment of anorexia nervosa etc.
target group / diagnoses	• 'forty selected women patients in both the chronic and the acute categories' (Miller et al. 1960: 42) • 'women in mental hospitals' (Silverman & Silverman 1961: 22)	• adolescents in psychiatric hospitals • '*Espace Arthur* treats young women and men between 12 and 20 years of age who show pathologies specific to adolescence. Intense crisis expressed through: • conflicts with parents • suicide attempts and depressions of all forms • body related pathologies and addiction behaviours • social pathologies • cognitive pathologies • pathological crises connected to personality disorders.' (APHM 1999: 4). etc.	• patients with anorexia nervosa • pilot study undertaken with one female proband • although not exclusively conceptualised for women, it is mainly used with girls and young women, but also some boys and young men (no exact figures given)

[477] This is an extract from the analytical table developed in the course of researching and writing this thesis. I have indicated abridged sections by including 'etc.' at the end of the section.

number of patients treated	• 40 women in pilot project (Miller et al. 1960: 42) • 'By this summer nearly 400 women had gone through either the full three-day course or abbreviated one-day versions.' (Silverman & Silverman 1961: 80)	• no counts kept *Espace Arthur*, Hôpital La Timone, Marseille (1999–2008) • numerous • since May 1999 more than 100 patients treated (Groskop 2001a: 48) *Espace Arthur*, CHU Sainte-Marguerite (2008–2012) • hardly practiced *Espace Arthur*, *Espace Méditerranéen de l'Adolescent* (E.M.A) (2012–) • non directly in the "classic" sense of the *vêtothèque* CHI Fréjus (2003–) • numerous children *Maison de Solenn*, l'Hôpital Cochin, Paris (2004–) • numerous adolescents	• one proband in pilot study & 3–4 patients treated, Leipzig • numerous patients in ongoing application at Charité, Berlin • 50 patients treated at Pfalzklinikum (Stoll 2014) • 20 patients as part of piloting the treatment in Salzburg (Thun-Hohenstein, AI, 6.9.2016)
aims	• '"Therapy of Fashion" is designed to 'recreate healthy feminine characteristics in a selected group of women patients.' (Miller at al. 1960: 42)	• 'The vêtotèque offers a space of expression to the adolescents, a space of discovery, of research, from choice to appropriation, recognition, acceptance and participation – by way of a concept, which is highly present in our society: fashion.' (Descloux et al. 2001) etc.	• remapping body schema to create a more realistic body schema and body image in patients with anorexia nervosa etc.
principles / approach / way of working	• 'It is the combined opinion of the authors that fashion as a therapy may well prove to be an additional tool in the reactivation of women patients, especially among those on the chronic group with long-term periods of hospitalization.' (Miller et al. 1960: 43) • '...members of the Fashion Group of San Francisco aid patients on the way back to health through the motivation of the urge of self-adornment.' (Thompson 1962b: 836) • 'slap 'em in the face with fashion' (Mrs. Winthrop quoted in: Silverman & Silverman 1961: 79) etc.	• 'L'habit sert comme moyenne thérapeutique.' (Rufo, AI, 3.4.2008) • 'La mode au travers du vêtement est considérée comme moyen d'expression une thérapie.' (IMM 2000) • 'We began to think that clothes could be used as a form of behavioural therapy. We wanted to get away from the impersonal. After all, regulation hospital pyjamas and beige walls are depressing. The idea is that the patient should see that life can be beautiful. It is about treating the person as an individual.' (Vigouroux in Groskop 2001a: 48) etc.	• humans comprehend their girth and body boundaries through the sense of touch • 'By means of the pressure, which is exerted on the body by the diving suit, the brain of the patient learns to perceive her own body realistically as extremely thin.' (Grunwald in Niemann 2009) • 'Through the pressure, which this tight garment applies to the skin and joints, the brain learns to perceive the body more realistically.' (Gunwald in Hilgemeier 2016) etc.
background & development	• pilot project, Napa State Hospital, 1959 (Miller et al. 1960: 42) • carried out as 'volunteer service project of The Fashion	• Prof Rufo research into patients' reactions to medical staff uniforms / consideration what should be worn by staff at *Espace Arthur*	• pilot study at the Haptic Laboratory, Leipzig University (Grunwald & Weiss 2005) etc.

	Group of San Francisco, Inc., the local branch of a national organization of key professionals in the fashion field' (Miller et al. 1960: 42) etc.	• approached *Institut Mode Méditerranée et des Jeunes Créateurs* & collaboration came into being etc.	
staff & their professional background & qualification	Napa State Hospital, Imola, California: • Theo K. Miller (–1964), Superintendent and Medical Director (1943–1963) • Lewis G. Carpenter, Clinical Psychologist • Robert B. Buckley, Assistant Superintendent – Psychiatric • Ruth Baham, head of volunteers • Evelyn Avera, nursing supervisor of the programme (Silverman & Silverman 1961: 80) Fashion Group of San Francisco: • Irina Belotelkin née Roudakoff (1913–2009), designer - label: Irene Roublon • Thelma L. Thompson, Extension Service clothing specialist, University of California / later University of Nebraska • Jane Winthrop (1919–1997), advertising executive, San Francisco Regional Director of the Fashion Group 1959–1961 • Charlotte Swartz • Jean Meek-Barker (1961/1962?), journalist *Herald Tribune*, *Harper's Bazaar*, fashion editor at *Redbook* • Vivien Thorne, fashion artist (Silverman & Silverman 1961: 80) models: • Henrietta Ledebur (Silverman & Silverman 1961: 23) Mental Health Association of San Francisco: • Hazel Holly (was contacted by Ruth Baham / contacted Fashion Group) • Margaret Kuhns, vice president of the San Francisco Association of Mental Health (Willis 1962: 15) • Mrs R Guy Jubitz Jr. coordinator of volunteers (Silverman & Silverman 1961: 79)	• Prof Marcel Rufo = *chef du service médico-psychologique de la famille et de l'enfant au CHU Sainte-Marguerite de Marseille* = child psychiatrist = author *Institut Mode Méditerranée et des Jeunes Créateurs* • Marylin Vigouroux, director/pr *Espace Arthur*, Hôpital La Timone, Marseille (1999–2008) • Dr Michèle Battista, *pédopsychiatre* (child psychiatrist), Responsable de l'Unité de Soins (1999–2003) *Espace Arthur*, CHU Sainte-Marguerite (2008–2012) • no one in particular responsible for *vêthotèque* *Espace Arthur*, *Espace Méditerranéen de l'Adolescent* (E.M.A) (2012–) • Sidonie Fouquet, *educatrice spécialisée*, art CHI Fréjus (2003–) • Dr Michèle Battista, *pédopsychiatre* (child psychiatrist), chef de service Psychiatrie infant-juvénile, Centre hospitalier intercommunal Fréjus Saint-Raphaël • Cathérine Muolo, nurse *Maison de Solenn*, l'Hôpital Cochin, Paris (2004–) • Martine Kagan, *éducatrice specialisée* • Maï Pietri, freelance stylist • Eugénie de Mortemart, freelance stylist	• Dr Phil Habil Martin Grunwald, psychologist / haptologist, head of the Haptic Research Laboratory at the Paul Flechsig Institute for Brain Research at the University of Leipzig, Germany • Gabriele Riess, body psychotherapist (*Körperpsychotherapeutin*), since 2006 three times per week at Klinik für Psychatrie, Psychsomatik und Psychotherapie des Kindes- und Jugendalters, Charité - Universitätsmedizin Berlin, Germany • Gabriele Löschner, mototherapist, Pfalzklinikum für Psychiatrie und Neurologie in Klingenmünster (Rheinland-Pfalz), Germany • Univ-Prof Dr Leonhard Thun-Hohenstein, Universitätsklinik für Kinder- und Jugendpsychiatrie Salzburg, Austria
staff training in context of dress-related therapeutic approach	• 'None of the Fashion Group members had been given any preliminary coaching. "Just treat the patients as you'd treat old friends," they were advised.' (Silverman & Silverman 1961: 79)	• *Espace Arthur*: none • CHI Fréjus: none • *Maison de Solenn*, Paris: none	• Dr Grunwald developed pilot study • Gabriele Riess & staff in Salzburg developed own method based on pilot study and in exchange with Dr Grunwald

dress used in therapeutic approach	• 'nine glamorous fashions that were colorful, impractical, for fun' for fashion show (Thompson 1960a: 2B) • 'stunning gowns' for fashion show (anon. 1960: 16) • 'what we had, what we owned, what we made, that looked great' (Meek-Barker, AI, 17.11.2015) • sewing own garment / garments being designed for patients • undergarments ('the importance of undergarments' (Clinton 1960b: 11), 'being fitted with proper foundation garments' (Miller et al. 1960: 42), 'a foundation garment ordered for them' (Tucker 1962: 6) • make-up & hair styling	Marseille: *Espace Arthur*, Hôpital La Timone Marseille (10/1999–1/2008): • biannual collection of local and national designers *Espace Arthur* at CHU Sainte-Marguerite (1/2008–6/2012) • biannual collection of local and national designers • *Espace Arthur* at *Espace Méditerranéen de l'Adolescent* (E.M.A) (6/2012–) • leftovers from previous collections • dress as costume • working with dress in art projects – painting etc Fréjus: • costume – dressing up box, staff bring discarded garments *Maison de Solenn,* Paris: • biannual collection of local and national designers etc.	• diving suit with short sleeves / half leg • = pressure suit • = 'haptic suit' (ÖGKJP 2015) • colour of suits chosen by patients (Riess)
dress worn by staff	• 'Some of the interesting sidelights as a result of the course […] uniforms are now taboo.' (Thompson 1962b: 836) • fashionable clothes worn by the volunteers of The Fashion Group, e.g. black dress, matching jewellery, costumes, hat (see images) etc.	• casual – own clothes (following an initiative of Prof Rufo and collaborative research into the effects of staff uniform on patients together with Institut Mode Mediterranée) • not medical gowns (Decloux in Gerez 2000) etc.	• casual – own clothes
dress worn by patients	• bathrobes, simple dresses, simple fabrics • '"But you didn't have to notice what they did or what they said to know they were mentally sick," said a visitor. "They were dressed sick."' (Silverman & Silverman 1961: 22) etc.	• casual – own clothes	• casual – own clothes
internal & external evaluation // outlook & legacy	• evaluation of pilot study published in: Miller et al. 1960: 42 • 'For some patients in the group, effects of the fashion project were dramatic and immediate. One woman in her early thirties had persistently refused to enter any socializing activities and had even been unwilling to use her privilege of going out on the grounds. She finally admitted that she was ashamed of her appearance and said that she	• no formal evaluation • 'The effect on some of them is extraordinarily positive. They learn to compliment each other. It gives them a sense of humour about what they're wearing.' (Vigouroux in Groskop 2001a: 48) • 'I can't promise a cure-all for every anorexic woman. But fashion therapy is a great way of getting some girls to appreciate their bodies again. Many women find another side	pilot study • 'Increased body weight, normalized theta activity, and improved body image were the apparent results of wearing a diving suit.' (Grunwald & Weiss 2005: 379) applications • no formal evaluations Charité • 'To work with the diving suit as part of body therapy is a great support

	never went to parties or dances because she "looked so terrible". After being fitted with proper foundation garments, she looked into a mirror and said, "My, I look so different." At the fashion show she went on stage clad in her new dress and looking confident and happy.' (Miller et al. 1960: 42) etc.	to themselves in our wardrobes. It's as if they start exist again in their own eyes. One of our biggest successes was been some of the girls organised a fashion show among themselves. I was really proud of that.' (Battista in Groskop 2001b: 63) etc.	and success in my opinion.' (Riess in mdr, 2010: 1'10) <u>Salzburg</u> • 'I regard this as an important contribution to therapy.' (Thun-Hohenstein in Stoll 2014) etc.
reasons for inclusion / contribution to my thesis	• "Therapy of Fashion", practiced in the US in the 1960s was chosen, as it constitutes such an explicit, intentional and clearly delineated attempt to integrate fashionable dress within the psycho-medical therapeutic process, to work on the self with fashion. etc.	• *Vêtothérapie* is currently the most established of the approaches, working with fashionable dress on the self of adolescents in a space set up specifically for that purpose, the *vêtothèque*.	Sensory stimulation treatment was chosen, as it constructs an altogether different, haptic-based (counter)discourse of the relationship between dress and the self, which is formative of a distinct therapeutic practice: the wearing of only one rather functional garment, a diving suit, to impact on the "anorectic" self. etc.
points of originality / contribution to knowledge	• early example of explicit dress-therapeutic approach • under-analysed • construction and mobilisation of the relationship between dress and mental health in psycho-medical setting	• most widely practiced dress-related therapeutic approach currently practiced • emphasis on fashion and change • no analysis so far – mainly only press articles • no internal or external evaluation • not very publicised outside France	• little-known research & dress-related therapeutic approach • exemplary of construction of scientific discourse and knowledge production to generate dress-related therapeutic approach • construction of counter-discourse
research textual research	key sources: • Miller, Theo K. & Carpenter, Lewis G. & Buckley, Robert B. (1960) 'Therapy of Fashion' in: *Mental Hospitals – Hospital Journal of the American Psychiatric Association*, Vol.11(8), October, pp. 42–3. • Silverman, Milton & Margaret (1961) 'Glamour Treatment for the Mentally Ill' in: *The Saturday Evening Post.* 26 August, pp. 22–3 & 79–80. etc.	key sources: • Descloux et al. 2001 • Prof Rufo publications 1999 & 2007 <u>*press:*</u> • e.g. Carquain 1999; Rotman 2001; Saint-Jean 2001), magazines (Gaulme 2001; Rachline 2000; Rault 2001; Sultan 2001a&b), on radio (Banoun 1999; Baudu 1999; Chimot 1999; Loriol 1999), tv (France 3 2000a&b; Lacombe 1999; Leymergie 2001; Pallet 2000; Purdon 2000). British press (Goodchild & Sheppard 2001; Groskop 2001a&b; Rose & Allan 2001; Sage 2001 etc.	key sources: • Grunwald, Martin (2008) 'Haptic perception in anorexia nervosa' in: Grunwald, Martin (ed.) (2008) *Human Haptic Perception: Basics and Applications.* Basel: Birkhäuser Verlag, pp. 335–51. • Grunwald, Martin & Weiss, T. (2005) 'Inducing sensory stimulation in treatment of anorexia nervosa' in: *QJM: An International Journal of Medicine*. Vol. 98(5), pp. 379–80. etc.
visual research	• some images of setting, fashion show, hair and make up practice, volunteers of the project • five images in Silverman & Silverman 1961 • three images in Miller et al. 1960	*Espace Arthur*, Hôpital La Timone, Marseille (1999–2008) • several photographs in press, evidently admitted to unit / *vêtothérapie* sessions – patients depicted without anonymisation! (e.g. Brunet 2001; François 2000; Gaulme	• table of pilot study results • images of research setup (Grunwald 2008) • photo of original proband wearing diving suit (Grunwald 2008)

	• two images in Thompson 1962b • three images in MHASF slide show • some further images in press articles	2001; Gerez 2002; Groskop 2001a&b; Hello 2005; Monnier 2000; Rachline 2000; Righini 1999; Sage 2001; Sultan 2001a) *Espace Arthur*, CHU Sainte-Marguerite (2008–2012) • personal photographs *Espace Arthur*, *Espace Méditerranéen de l'Adolescent* (E.M.A) (2012–) • personal photographs CHI Fréjus (2003–) • personal photographs *Maison de Solenn*, l'Hôpital Cochin, Paris (2004–) • personal photographs	• personal photos of setting and diving suits used at Charité, Berlin • film stills from body therapy session at Charité • one image in Segler (2011)
fieldwork: visits, interviews, participant observation	• author interview Jean Meek-Barker, member of Fashion Group, volunteer in "Therapy of Fashion" at Napa State Hospital New York, telephone interview, 17.11.2015	• author interview Dr Michèle Battista, child psychiatrist, Psychatrie Infanto-juvénile, Centre Hospitalier Intercommunal Fréjus Saint-Raphaël, Fréjus, France, 2.4.2008 • visit to the children's *vêtothèque*, Psychatrie Infanto-juvénile, Centre Hospitalier Intercommunal Fréjus Saint-Raphaël, France, 2.4.2008 • author interview Pr. Rufo, Hôpital Sainte Margarite, Marseille, France, 3.4.2008 etc.	• author interview Dr Grunwald, head of haptic laboratory, University of Leipzig, Germany, 24.8.2007 • author interview Gabriele Riess, body therapist, Charité Berlin, Germany, 11.9.2013 • author interview Dr Grunwald, University of Leipzig, Germany, email, 8.7.2016 • author interview Prof Dr Thun-Hohenstein, University Hospital for Child- and Adolescent Psychiatry, Salzburg, Austria, email, 6.9.2016 etc.
research to do			
analysis underlying notions / assumptions / discursive construction of (also differences between what is being said and what is being done): self (i.e. What notions of self are being worked with?)	• social & individualised self • normatively gendered (thus appropriately styled) • based on appearance etc.	• transient notion of adolescent self • individualised, embodied, gendered • social, cultural etc.	• touch-based notion of self • self starts with body – with all senses, but primarily touch • self is socially constructed, but biologically determined etc.

body	• normative standards of physical beauty • 'The series began with a professional fashion show. Afterward, fashion experts advised individual patients about type of clothes best suited to them. In subsequent sessions, the fashion experts gave demonstrations and instructions concerning correct facial make-up, hair styling, dress designing, proper foundation garments, and simple exercises to improve posture and develop poise.' (Miller et al. 1960: 42)	• takes as a starting point that the subject is made up of the mind and the body – corporeality – and that body is dressed • takes as a starting point a definition of health by the WTO not only as the absence of illness, but a balance between the body, the psyche and the social (Rufo 2007: 90) etc.	• body as starting point for self • definitions of body schema and body image
gender	• normative standards of femininity and feminine beauty • aim = to 'recreate healthy feminine characteristics in a selected group of women patients' (Miller et al. 1960: 42). etc.	• *Espace Arthur* female/male signs marking wardrobes • re-iteration of gender binary • CHI Fréjus – costume for both girls and boys – but princesses and pistols play on standardised gender roles without acknowledgement etc.	• biological differences between men and women • different neurological starting points, different hormonal processes • gender determines behaviour to some extent, e.g. women more prone to AN (Grunwald, AI, 24.8.2007) etc.
dress	• dress = fashion • fashion = positive • fashionable dressing is duty • normative standards of feminine dress etc.	• dress = fashion • notions of dress vary considerably between practitioners • second skin, communicator, armour, anti-depressant, diagnostic indicator, game, diversion, cultural agent • metaphor for adolescence etc.	• 'dress as body related practice / action' (Grunwald, AI, 24.8.2007) • dress as mean to an end • dress as substitute for touch • not reflected on much – could be different material and different method
therapy (theory / practice)	• the notion of "help" etc.	• cultural & physical notion of therapy etc.	• the notion of "help" • competing therapeutic discourses – CBT as lobby with strong interest to dominate field
health / illness		• takes as a starting point a definition of health by the WTO not only as the absence of illness, but a balance between the body, the psyche and the social (Rufo 2007: 90) etc.	• disorder – not choice • adequacy as defining health / survivability
discursive construction of the relationship between dress and self	• self immanent in appearance & changeable through it • 'Doctors and personnel of mental hospitals are recognizing that personal appearance is one of the clues to mental health. Consequently, some are	• self immanent in appearance & changeable through it • 'La mode est une construction de soi.' (Rufo 2010 • 'Effectively dress is an anti-depressant.' (Rufo, AI, 3.4.2008)	• not dress but touch – dress only as substitute – so more about relationship between touch and self than dress • the discursive construction between touch and self is used to

	incorporating Fashion Therapy in the treatment of the mentally ill.' (Thompson 1962b: 835) etc.	• 'Les habits font le moine.' / *'The habit makes the monk.'* (Rufo, AI, 3.4.2008) etc.	legitimise the use of dress in SST – to legitimise creating the haptic suit and asking patients to wear a garment that is potentially tight, hot, uncomfortable
discursive construction of the relationship between dress and mental health/ illness	• appearance representative of mental state • fashionable dress can have positive impact on mental state • look good, feel better etc.	• appearance representative of mental state • fashionable dress can have positive impact on mental state • look good, feel better etc.	• touch through dress can influence subconscious perception of self (body schema) – result in more adequate perception thus determine survivability of organism – touch/dress direct impact on mental & physical health etc.
how are these discursive construction formative of therapeutic practices? (e.g.• how is the discursive construction of self, body, dress, therapy, illness formative of practice • the gendering / non-gendering of practice • how is discursive construction the relationship between dress and self mobilised?)	• normalising dress = normalising mind • dress as a normalising mechanism • standardised notions of feminine beauty and behaviour legitimise the main aim (recreation of healthy feminine characteristics) and the means to do so etc.	• naturalisation that to be beautiful contributes to well-being of adolescents – legitimisation of practice of *vêtothérapie* • 'En septembre 1999, l'Espace Mode proposait l'idée qu'être beau, participe au bien-être des adolescents.' (Battista 2000) • socialising effect of dress as positive • conceived as group activity etc	• mobilisation of dress as substitute for touch • Grunwald constructs counter-discourse to CBT, how vision- and language based theories of self are formative of CBT of AN • Grunwald proposes a competing discourse / discursively constructs the relationships between body and self differently in order to bring forth and legitimise another treatment approach: haptic suit etc.
visual and/or tactile understanding of dress	• predominantly visual • tactile in relation to fabrics	• 'The habit makes the monk.' (Rufo, AI, 3.4.2008) = visual approach etc.	• mainly tactile approach • sensing self through haptic suit – remapping body schema • but patient also chose colours of suit at Charité
types of touch activated / enabled through dress	• passive & active • passive touch – being touched by fashion expert for make-up / hair & styling sessions • active touch – fabric • interhuman etc.	• active touch • knowledge in process of selecting garments • passive touch • comfort • sensual touch	• stimulative • controlling / supporting • passive • non-interactive (body therapy interactive!)
terminology / naming • what are patients being referred to? • what are their "illnesses" being referred to?	<u>patients</u> • 'women patients' (Miller et al. 1960: 42) etc.	<u>patients</u> • 'les adolescents hospitalisés' (APHP: 2005) • 'les jeunes hospitalisés' (Rufo in APHP: 2005) etc.	<u>patients</u> • 'the girls' (Riess in Hilgemeier 2016) • 'our adolescents' (Riess in Hilgemeier 2016) • 'patients' (Riess in mdr 2010) • male and female patients / *'der/die PatientIn'* (ÖGKJP 2015)

• what is the practice being referred to? • dress or fashion or?			etc.
reflections on role of therapist / on own role	• the notion of "help": being able to help as 'experts' and in need of help as patients • construction of fashion professionals as experts & their truths • authoritative role of volunteers • etc.	• necessity of adolescent medicine as self-justificatory discourse • reflection on own role / role of therapist as essential in *soins culturels* – to make it a legitimate therapy not just an activity to kill time (Rufo 2007) etc.	• legitimisation of own role of therapist – suit not to be worn without psycho-medical support etc.
national & cultural specificities underpinning approach	• notion of gender specific to America in the 1960s • humanisation of hospitals 1950s US • open-door policy employed in treatment of mentally ill from mid-50s in US • rise of psycho-tropic drugs • change in role of fashion specific to US etc.	• fashion as part of French culture • 'La mode c'est culture.' (Rufo, AI, 3.4.2008) • discourse of humanisation of hospitals in France since 1920s, increased in 1950s and culturally underwritten • the role of culture within hospitals – *soins culturels* etc.	• German haptic tradition – also at University of Leipzig • ocularcentric turn – Germany and occident etc.
conditions of possibility (i.e. how did and how could it become what it is? how could this type of knowledge be created? why is this type of therapeutic practice possible?)	• gender expectations in US at turn of 60s – women to beautify themselves – standardised notions of female physical beauty and dress • authoritative setup of mental hospitals – telling women what to wear • etc.	• general perception of role of fashion as intrinsic part of French culture • fashion is good for you / makes you feel good • internalised notions of dress behaviour • etc.	• German haptic tradition • Grunwald's good working collaborations with head of psychiatric clinic • Grunwald portrays himself as being ahead of his time – but he is still of his time – his work enabled through the support of clinic, through self-funding on the basis of his work for industry • Riess being given carte blanche at Charité
technologies of self	• dress employed as a technology of the normalised, social, embodied & gendered self • dress employed as normalising and disciplining technology of the self • technology of self which can normalise ones relationship with oneself and others	• *vêtothérapie* = specific historico-cultural physical and mental practice directed at developing the self = technology of self • *vêtothérapie* employed as a technology of the dressed, embodied, social, gendered, cultural "therapeutable" self • *vêtothérapie* is understood as a technology of self which can normalise one's relationship with oneself and others etc.	• haptic suit as normalising technology of self – aimed at normalising the body schema of patients
technologies of power	• aim = designed to 'recreate healthy feminine characteristics in a selected	• *vêtothérapie* in particular is a technique for the direction of others – therapist not unlike a teacher manages patients to	• "suggesting" suit to patients

(power/ knowledge relations & gender/ power relations, also considering doctor/ patient relationship – age, class, race relations) i.e. what networks of power relations do the practitioners find themselves positioned in?	group of women patients' (Miller et al. 1960: 42). • construction of expert knowledge & truth & authority experts telling about "proper" / "correct" / "how to …" - unknowing women • by starting with a professional fashion show – the project set an aesthetic standard: how to look, how to move, what to wear & how to wear it • normative gender performances expected of female patients etc.	manage their appearance, manage themselves • the actual authority practiced by both therapist and stylist at *Maison de Solenn* – in telling patients what suited them and what did not – although their imagined authority was already dictating the session • space / architecture • the nature of institutional space and the enactment of power through it • the mirror / mirror work / transparency / showing – linked very closely to technologies of truth & power etc.	• in how far are suggestions in a hospital environment governed by power structures of (i.e. the ascribed authority of doctors and medical staff) • power relations concerning patients – underaged and with potentially life threatening disease
technologies of truth (i.e. practitioners do certain things because they hold certain truths • what are the truths embraced? • what are the truths to be legitimised? • what are practitioners' strategies for truth creation or orchestration? • what truth games are practitioners caught up in and in which do they participate? e.g. institutions of consecrations and legitimisations such as academic journals)	• 'Doctors and personnel of mental hospitals are recognizing that personal appearance is one of the clues to mental health. Consequently, some are incorporating Fashion Therapy in the treatment of the mentally ill.' (Thompson 1962b: 835) • orderly appearance = orderly mind • 'fashion as a therapy = additional tool in the reactivation of women patients' (Miller et al. 1960: 43)	• fashion is good for you – makes you feel good & helps you to discover true sense of self • fashion = therapy • positive social interaction is enabled through dress / fashion – through dressing up together and commenting on one another • you need to make an effort to look good and dress well etc.	• truth Grunwald embraces = CBT is dominant to treating AN, but ineffective • AN needs to be treated haptically • touch can be substituted with dress • Grunwald constructing alternative truth – haptocentric truth / counter-discourse • rejection of publication of SST research as something the academic world is not ready for • scientific knowledge depends on validation by academic journals – part of struggle of scientists and academics • Grunwald coming up against cultures of academic validation
naturalisations (the production of objectivity // • assumptions that go unquestioned & unspoken in the acts and utterances of medical staff • "common sense"	• orderly appearance = orderly mind • 'beauty is your duty' – especially for women • look good – feel better • experts telling about "proper" / "correct" – unknowing women • subjectivity of the medical / therapeutic and voluntary staff etc.	• *vêtothérapie* is based on a multitude of underlying assumptions concerning the self, body, gender, dress and therapy – largely unreflected • fashion is something positive • adolescents are interested in fashion • look good – feel better etc.	• diving suit treated as tool to substitute touch – a neutral garment – gender not addressed – aesthetic dimension not addressed by Grunwald (colour choices only as to get talking to patients and get them engaged) • AN as female disease etc.
silences	• unspoken normative notions of female physical beauty & beauty behaviour • normative notions of gendered behaviour • unspoken, yet very clear role expectations, e.g. what 'healthy feminine characteristics' are	• the human body is dressed – instinctual response to working with youth on body image to use dress as a communicator • garments treated as neutral material – in spite of the fact that cloth/ing is embued with highly subjective / personal – culturally and socially specific standards of gender, body,	• mechanisms of scientific knowledge creation and validation • possible side-effects of suit etc.

	• what if women do not want to beautify themselves or play different roles? • improved appearance will lead to improved interior, i.e. mental health etc.	beauty & social and cultural contexts – is loaded • normative values (beauty, gender, body, social, taste) attached to garments and fashion are not recognised etc.	
how do truth games / naturalisations / silences and the resulting truths shape therapeutic practice?	• positive percepetion of fashionable and gendering effect of dress determine treatment approach etc.	• the assumption that dress is good for you, aids self-discover and well-being legitimises whole approach • assumption that adolescents cannot decide for themselves legitimises the role of therapist and stylist in session, advising youths (Battista 2000) etc.	• diving suit re-inscribed therapeutically on the basis of scientific knowledge etc.
discursive strategies (i.e. what discursive strategies do the practitioners draw on to legitimate their versions of self etc and of the truth of dress therapy? e.g. interviews as spaces of self-construction and representation and so part of discursive strategies)	• article written by doctors including images (Miller et al. 1960) • journalists invited to sessions, taking pictures • public fashion shows – fundraisers	• Rufo speaking to journalists and at conferences about *vêtothérapie* • staff publications (Battista 2000 & 2004; Descloux et al. 2001; Kagan et al. 2012) • inviting journalists to *vêtothérapie* sessions (e.g. Gaume 2001; Groskop 2001a&b; Sage 2001; Sultan 2001a) • recounting certain "success" case stories such as Caroline to journalists and in interviews (Gaume 2001; Sultan 2001a)	• construction of scientific knowledge • legitimisation through academic publications • self-construction in interviews etc.
textual sources referred to by interviewees / practitioners	n/a	Michèle Battista: • de Clérambault, Gaëtan Gatian (1908/2002) *Passion érotique des étoffes chez la femme*. Paris: Empêcheurs de penser en rond. • Winnicott Marcel Rufo: • Winnicott *Espace intermédiaire / espace potentiel* = intermediate area (Rufo, AI, 3.4.2008) etc.	• Harlow, Harry F. (1974) *Learning to Love.* New York & London: Jason Aronson. • Harlow, Harry F. & Mears, Clara (1979) *The Human Model: Primate Perspectives.* Washington: V. H. Winston. etc.
analytical keywords & tools / theoretical texts for analysis	• performativity of gender in relation to dress (Butler 1993) • womanliness as masquerade (Riviere 1929) etc.	• Humanisation of hospitals in France (Nardin ed. 2009) • notion of culture in France (Lüsenbrink 2004) etc.	• visual and haptic concepts of self/dress (Lacan 1949/1977; Anzieu 1989; Cooley 1902; Mead 1925; Merleau-Ponty 1962) etc.

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interviews & visits

• author interview (preliminary), Odette Galeski, *Institut Mode Méditerranée*, Marseille, France, 10.9.2004

• author interview Dr Grunwald, head of haptic laboratory, University of Leipzig, Germany, 24.8.2007

• author interview Dr Michèle Battista, child psychiatrist, Psychatrie Infanto-juvénile, Centre Hospitalier Intercommunal Fréjus Saint-Raphaël, Fréjus, France, 2.4.2008

• author interview Catherine Muolo, nurse, Psychatrie Infanto-juvénile, Centre Hospitalier Intercommunal Fréjus Saint-Raphaël, Fréjus, France, 2.4.2008

• visit to the children's *vêtothèque*, Psychatrie Infanto-juvénile, Centre Hospitalier Intercommunal Fréjus Saint-Raphaël, France, 2.4.2008

• author interview Professor Rufo, child psychiatrist and head of pedo-psychiatric service, Hôpital Sainte-Marguerite, Marseille, France, 3.4.2008

• visit to the *vêtothèque* at *Espace Arthur*, Hôpital Sainte-Marguerite, Marseille, France, 3.4.2008

• informal interview with one patient and two members of staff: Jean Goedertier (nurse) and Michèle Burki (psychologist), 3.4.2008

• author interview Martine Kagan, *educatrice spécialisée*, *Maison de Solenn*, Hôpital Cochin, Paris, France, 10.4.2008

• visit to the *vêtothèque* at *Maison de Solenn*, Hôpital Cochin, Paris, France, 10.4.2008

• participant observation, *vêtothérapie* session, Maison de Solenn, Paris, France, 23.1.2009

• author interview Martine Kagan, *Maison de Solenn*, Hôpital Cochin, Paris, France, 23.1.2009

• author interview Maï Pietri, freelance stylist and volunteer at *Maison de Solenn*, Hôpital Cochin, Paris, France, 23.1.2009

• author interview Gabriele Riess, body therapist, Charité Berlin, Germany, 11.9.2013

• author interview Maryline Bellieud-Vigouroux, director of *Institut Mode Méditerranée*, Marseille, France, 18.9.2013

• visit to the *vêtothèque* at *Espace Méditerranéen de l'Adolescent* (E.M.A), Marseille, France, 19.9.2013

• Author interview Sidonie Fouquet, *educatrice spécialisée,* E.M.A, Marseille, France, 19.9.2013

• author interview Eugénie de Mortemart, freelance stylist and volunteer at *Maison de Solenn*, Paris, France, 27.6.2014

• author interview Jean Meek-Barker, volunteer of "Therapy of Fashion", member of The Fashion Group, telephone, 17.11.2015

• author interview Dr Grunwald, University of Leipzig, Germany, email, 8.7.2016

• author interview Prof Dr Leonhard Thun-Hohenstein, head of department of child and adolescent psychiatry, University Clinic Salzburg, Austria, email, 6.9.2016

• author interview Gabriele Riess, Charité Berlin, Germany, email, 11.9.2016

• author interview Maryline Bellieud-Vigouroux, public relations and *mécénat*, *Maison Méditerranéenne des Métiers de la Mode*, email, 3.10.2016