

**WHICH ARTS THERAPY FOR WHICH CLIENT
AND WHY?**

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ABSTRACT

The Centre, a Charity founded by the Author in 1993, offers arts therapies interventions – Art, Dance Movement, Drama and Music – to clients of all ages and needs.

This research represents an attempt to determine which modality of arts therapy should be recommended to any client on referral.

A programme of each of the 4 arts therapies in sequence was offered to 109 clients of varying age and needs, in 10 Locations within the local conurbation. Four aims were identified for each client and the effectiveness of the arts therapies intervention was measured both quantitatively and qualitatively.

Analysis revealed that although there was no one overall result, an average of 89.6% clients reported overall improvement at the end of the programme. Indications suggested the most successful aim addressed was enjoyment, although the most common aim identified was to be able to work in a group. Interventions of music therapy with male clients were the most effective for enhancement of self-esteem. Other, sometimes unexpected, results provide the basis for recommendations to referrers and guidance for providers of arts therapies services.

DEDICATION

**To all the Centre therapists, administrative staff and clients,
without whose support and consideration throughout the years this work
would not have been possible**

**and to my husband Peter,
whose patient presence has been my life-line.**

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1. PERSONAL PERSPECTIVE AND RATIONALE

Introduction and Personal Perspective

In 1993, the present researcher founded a charitable Centre for arts therapies, a form of intervention officially classified as belonging to the ‘psychological therapies’ and defined as ‘any form of psychological treatment that aims to produce a desired change of emotions, cognition and behaviour in the context of a relationship between a patient or group of patients and a trained professional’ (Caparrotta and Ghaffari, 2004, p.4). Within a few years, the Centre had become well enough known to receive referrals of clients of all ages, presenting with varying diagnoses and areas of special needs.

The Centre is unique in the UK, in that access to all four arts therapies (art, drama, music and dance movement), as modalities for interventions, is available for potential clients of all ages, whether within statutory provision or on a private basis. When a client is referred to the Centre for an arts therapies programme, members of staff are frequently asked by a referrer which therapy would be advised for the special needs of their clients – or for themselves, if self-referred. Questions are asked such as whether the modality of therapy should be dependent on the personal preference of the client, the suggestions of the referrer, or on an assessment by a potential therapist.

In 2002, the researcher was one of two arts therapists on the Allied Health Professions Clinical Effectiveness Forum (AHCPCEF) – a sub-group of the National Institute for Health and Care (NICE). The work of this forum was linked to the setting up of clinical guidelines for all allied health professions, which included the modalities of art, drama and music therapy¹. Within the Health & Care Professions Council (HCPC), standards of education and training (SETS) are given, by which the council assesses education and training programmes within the arts therapies professions, but these do not, to the researcher’s knowledge, include advice regarding recommendations for referrals to a specific arts modality. Standards of Proficiency (SOPS) for Arts Therapists issued by the HCPC do differentiate between the three

¹ *To the current date, dance movement therapy has not yet obtained registration.*

recognised modalities in sections concerning the key concepts of knowledge base and the drawing on appropriate knowledge and skills to inform practice (HCPC 2013), but these do not appear to include guidelines or reasons for the actual recommendation of one modality of arts therapy in preference to another. The researcher therefore felt that it would be timely to initiate an investigation to address the issue: ‘Which arts therapy for which client and why?’

It appeared that the professional experience of the researcher as a music therapist of many years standing, supported by the inclusivity of the Centre and access to practices in each of the four modalities, offered the potential to provide contact with a wide variety of clients and arts therapists who might be invited to become participants in the research, supported by accompanying resources necessary for a study of this question, the results of which would not only provide answers to referrers’ questions, but would also provide a basis from which further work could be evaluated and guidelines for future practice be established.

Historical perspective

Communication and relationships with others provide meaning, support and opportunities. In social interactions, people have an impact on one another; we influence and affect each other (Thompson, 2009). Consequently, deficient or defective social interactions are seen to be a major source of physical and mental disorders and of daily stress. Because of the apparently spontaneous and deep-seated role that art forms historically have within the field of human self-expression, they may also be regarded as channels through which to restore physical and mental health. The shaman, witch doctor and voodoo priest all use art forms in their healing rituals to facilitate, enhance and support the impact that their medication and personality has on their patients (Ingeman, 2004). The healer links with the person to be healed, using art forms to facilitate empathy between the two and to open channels through which healing may take place.

In Western civilisations, the use of arts modalities within the healing professions has emerged as the profession of arts therapies - art therapy, dramatherapy², music therapy and dance

² *It is traditional amongst dramatherapists to refer to the profession in one complete word, rather than two (drama therapy). This nomenclature will be adopted throughout the present study.*

movement therapy. These have become recognised as one of the forms of treatment in psychological therapy and counselling (DoH³, 2001). A brief summary of the three State Registered Professions in a DOH (2002) briefing document states that:

- ‘Art therapists provide a psychotherapeutic intervention which enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.
- Dramatherapists encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.
- Music therapists facilitate interaction and development of insight into clients’ behaviour and emotional difficulties through music.’

cited in Shaverein and Odell-Miller (2002, p.87)

The focus on non-verbal interaction is a key aspect in the arts therapies; working through an arts modality can facilitate and encourage communication for those who find spoken language inaccessible, difficult, or inadequate to express deep-seated and obscure feelings. The unique way in which it is possible to build up a relationship with a person and through this to use arts modalities to work towards change, is well documented in many texts, for example Wigram et al., (1996); Malchiodi (2006a); Grainger (1990) and Meekums (2002), to name practitioners, each representative of their particular modality.

This current study, however, is not concerned with the validity of the use of arts therapies as a treatment *per se*, but rather, with the question that has existed from pre-historic times to the present, namely that if an individual *homo sapiens* chooses to decorate his ‘cave’ with paintings, while another dances, sings, makes sounds on a musical instrument or delights in expression through words, does it follow that this individually chosen modality of self-expression would be the best through which to facilitate healing for that person? Perhaps the

³ DoH = Department of Health

opposite might be true, namely that if that person felt inhibited in self-expression through body-language or movement, perhaps because of having a low degree of bodily self-esteem, he should engage in a modality of therapy (dance movement therapy) that liberated this inhibited side, rather than to excel in his most fluent form of artistic self-expression.⁴

Hinz (2009) echoes this question when he states that within the modality of art therapy, answering the question of how to decide the appropriate media for clients and under what circumstances their use will be therapeutic has been a crucial aspect involved in defining the field of art therapy; but he continues to ask how a conclusion should be reached as to which of the arts therapies modalities themselves is most appropriate for the varying clients who are referred for this form of intervention.

Rationale and Practical Process of Research

Aims of Research

The research question was not so much concerned with actually measuring to what *extent* a particular arts therapies modality might have facilitated change in a client. This has been addressed by many arts therapists using established psychological personality measurement tools, both within quantitative and qualitative research, for example Bradt, et al., (2010); Meekums, et al., (2012); Chasen (2011). In contrast, there were three principal aims for this research.

The first aim was to determine whether, for optimum clinical results, there was any evidence that the presenting symptomatology of a client indicated referral to any one specific modality of arts therapies treatment programme.

⁴ *When referring in general to a client, the male pronoun 'he' or 'him' will be used throughout, unless referring to a specific person*

The second aim was to determine whether a client would benefit even more, by being able to access all four therapies in sequence – in which case, whether this should be in any specific developmental order.

The third aim was to ensure that the proposed arts therapies research programme would result in practical outcomes, namely that the clients concerned would find participation in the research programme a positive experience in itself, leading to amelioration of their personal concerns and that the results of this research would provide guidelines for assessments and programmes, both for the original clients involved and for clients referred in the future. Such data would lead to information relating to evidence based practice and the cost effectiveness of this type of intervention, providing factual evidence for establishment of further posts within the National Health Service and other work contexts, especially at this time of continuing national financial austerity.

In addition to these three aims, other subsidiary questions arise, which will be addressed in the course of later discussion, including:

- Who makes decisions as to whether or not a client is referred, the aims of the therapy and when the therapy should end – the client, the parent / carer / professional, or the therapist?
- Is the modality of therapy more or less important than the personality of the therapist?
- What are the optimum practical conditions under which therapy sessions are conducted?

Review of Literature

In preparation for the practical work – and continuing alongside it – a review of literature and informal consultation with other practising arts therapists was conducted. In addition to studying some of the wealth of related literature associated with the profession and practice of arts therapies, the questions and theories under consideration were discussed with many leading arts therapists, at ‘cross-cultural’ seminars and conferences such as those organised by the European Consortium for Arts Therapies Education (ECArTE) and other arts therapies

conferences. This was both stimulating and informative, providing varying view-points held by professional colleagues, on which the present researcher could reflect in consideration of her own study.

As part of the review of literature and to aid the understanding of the actual process of the arts therapies intervention by the reader, it was necessary to describe the inter-relationship between the personality of the therapist, the modality itself and the *persona* of the client. This is a three-fold relationship, each element of which has a unique contribution to make. Each was considered in relation to the present research. In addition, individual schools of psychological methodology used in the field of arts therapies intervention were described and contrasted ⁵.

Methodology

In order to achieve the purpose of the research, an appropriate methodology was devised. Consequently, programmes of practical arts therapies interventions in varying locations within the local conurbation were designed and implemented. Consecutive interventions in all four arts therapies modalities were carried out in rotation, with each group of clients participating in all four arts therapies. The outcomes of these programmes were then evaluated both quantitatively and qualitatively, in order to determine which of the four arts therapies modalities had apparently achieved best results for specified aims appropriate for each client, as evaluated according to the views of teacher / manager, therapist and client.

The client base, drawn from the Centre's own clientele, included both children and adults, having as wide a variety of diagnoses and special needs as was practically possible. Clients from a variety of ethnic backgrounds included infant / primary and secondary age children with behavioural or other difficulties, both attending, or excluded from, mainstream schools; children from two different special schools, adults with brain injury and resulting trauma and elderly people living in residential care, suffering from visual disabilities, dementia and/or other symptoms. In all, research programmes of arts therapies interventions were

⁵ See discussion in Chapter 2 p29 et seq.

implemented within 10 different locations, involving a total of 109 different clients, although for a variety of practical reasons, not all clients eventually were able to participate in all four modalities of therapy sessions.

Psychological orientation of the therapists

Therapists offering to work within the programme were drawn from those having self-employed contracts with the Centre. It was recognised that the personality and psychological orientation of each participating arts therapist would be different, within the triangular relationship of therapist / client / arts modality and that each practitioner would bring to the sessions a particular clinical orientation that could be linked to personal values and larger philosophical views, such as physiological, developmental, supportive, psychodynamic, humanistic and transpersonal approaches (Bunt and Hoskyns, 2002).

Therapists agreeing to participate in the current research study might subscribe to any of the above approaches, or integrate them into their practices depending on the needs of the client with whom they were working. No specific methodological approach was required of the participating therapists. As a similar relationship between therapist, arts modality and client exists in each modality of therapy, it would be deemed sufficient that each therapist had undergone one of the Health and Care Professions Council's recognised training courses, or equivalent, and would therefore possess professional skills to a level capable of undertaking the requirements of the programme, rather than that they should adhere to a particular psychological or methodological approach.

The Time-scale

The time-scale of the study was dependent on the fact that the researcher remained in full-time employment as Director of the Centre throughout the whole of the research programme. This post included both administrative work and also her practical case-load of music therapy clients for 7½ hrs., per week. Research time necessary for completion of the work included time for preparation of practical work, reading and organisation of the actual practical

interventions, followed by further time needed for carrying out the follow-up structured interviews and writing up of the results. These factors resulted in the research not being achieved as quickly as was at first envisaged. A Gant chart of the time-scale of the whole research project is given in the appendix.⁶

On a practical level, however, there were some advantages as well as disadvantages, in relation to undertaking the research at the same time as continuing in her present post. Positive aspects included the fact that all practical work for the research was undertaken either by therapists working within the Centre organisation, or by therapists known personally to the researcher, in partnership with herself as coordinator and director of the research programme.

In addition, the Centre possessed a small specialist library of books on arts therapies and related topics, with funding made available for purchase of new books. Access to all four professional arts therapies associations within the UK was available, together with their publications. Personal membership of the National Arts Therapies Research Committee was available; at the time of commencing the research, the committee was compiling a research register of all arts therapies research carried out in the UK. Moreover, the researcher's international lecturing and correspondence provided contact with many other arts therapists on a world-wide basis and access to their experience in the field.

Disadvantages to undertaking this work included the very real conflict of allocation of time between Directorship of the Centre and other professional / personal work. In the latter years of the research, however, the Centre appointed a Project Development Manager, partly sponsored by some European Regional Development Fund (ERDF) monies. This access to extra funding enabled the researcher to delegate some of the administrative duties to the newly-appointed member of staff, allowing more time to study and complete the research. At the termination of the ERDF Funding, this project development manager continued in her post, offering valuable assistance in the administration of the Centre, which freed the researcher to complete the final stages of the study.

⁶ See Table 1 Appendix 1 p. ii

Some initial funding (grants) had already been obtained and it appeared that this would be adequate for the payment of therapists undertaking work on a professional basis. In addition to receiving guidance from her university tutor, regular professional supervision as a professional music therapist was a requirement of continuing state registration. This was provided during the majority of the course of the research programme by a colleague who also held the Chair of Professor of Music Therapy at Aalborg University, in Denmark. In supervision sessions, issues relevant to the research were sometimes discussed, which was very supportive⁷.

Independence of Researcher

It might be argued that the best evaluations of such a study should be undertaken by an independent body, rather than by the researcher herself, being very much an ‘insider’, with the potential for bias in favour of success of the research. In response, it must be stated that throughout all stages of the programme – preparation, implementation of the programme and subsequent analysis of results obtained – the researcher was constantly aware of this possibility. At all times she tried adopt an objective position towards the work, which was constantly monitored by those involved, her university tutor, discussions with other professionals and the advice given in related literature. The study was necessarily a personal concept and approach. It is hoped that the following pages will prove that as independent a view as possible has been adopted throughout and that as such, the study remains a valid piece of work.

Outcomes of the Research

In addition to the stated aims, the Centre aspired to provide guidance for the choice of modalities in the arts therapies to arts therapists professionals and referrers in a wider context. It was hoped that ultimately these guidelines might become incorporated in the content of training courses in arts therapies recognised by the Health and Care Professions Council, as at

⁷ *It is of immense sadness to the researcher that this supervisor, Professor Tony Wigram, who was also a personal friend, died from a brain tumour, before completion of this research. The loss to the international world of music therapy as a result of his premature death is immense. His contribution to the present work is detailed in the ‘Acknowledgements’.*

present, it is believed that none of the courses provides such comparison between the modalities, each training course concentrating in the main on one specific arts modality.

There may also be other indirect results from the research, such as the provision of support for the carers⁸ of clients and developing the facility for contributing to comprehensive clinical guide-lines as collated by the National Institute for Health and Care Excellence (NICE).

In all, the researcher very much looked forward to completing this study, as the topic had been of great concern to her for so many years.

⁸ *The word 'carer' is taken to represent parents, teachers, residential home managers, or any person charged with the care of the client concerned.*

CHAPTER 2 – REVIEW OF LITERATURE

Areas of investigation

This review of literature investigated the following areas:

- The development and nature of the relationship between arts forms and the healing process, as a context for the setting of the research question

- The arts therapies intervention as a process, including discussion concerning participants in the arts therapies relationship:
 - the client
 - the therapist
 - the arts modalities

- Other parameters related to the context of the study:
 - the term ‘arts therapies’
 - one modality or four
 - ‘creative’ or ‘expressive’ arts therapies

- Evaluation of systematic reviews within the present field of enquiry

- A summary of the findings in relation to the current study

In order to undertake this review of literature, a search strategy was developed and undertaken through electronic databases such as Findit@B’ham, EMBASE, PsychINFO, ERIC, COPAC, Science Direct and the Web of Science; through theses on related subjects, using UBIRA - the University of Birmingham Research Archive and through peer-reviewed journal articles connected with the current topic, such as ‘The Arts in Psychotherapy’, ‘The British Journal of Psychotherapy’, journals of modality specific professional associations such as ‘The British Journal of Music Therapy’, ‘The Journal of Art Therapy’, ‘Dramatherapy’,

‘E-Motion’, ‘The Nordic Journal of Music Therapy’, www.musictherapyworld.net, ‘Occupational Therapy International’, and journals focussing on specific areas of special need, such as ‘The Journal of Dementia Care’. In addition, references cited in material obtained frequently offered an important source of further information.

‘Grey material’ included records of discussions with colleagues and research being carried out which had not yet been published. More general web based searches were also made, using such engines as Yahoo and Google. Because the research had been started in 2002, some references made at the initial stages of the investigation dated from the 1980’s – or earlier if the work was regarded as seminal to the context. More recent references include works published to the present day (2015). Searches were restricted to those published in English, namely those from UK, United States, Canada, Australia or other English-speaking publications such as the Nordic Journal of Music Therapy. The search was not limited to studies covering any specific age group and included references covering all gender groups, any type of disability and psychological approach, as the current study would cover these variants. Studies were not excluded based on their level of evidence.

In order to evaluate the field of systematic reviews of practice in arts therapies, both in general and within specific modalities and differing client groups, additional data was gathered from the Cochrane Central Register of Controlled Trials and Specialised Registers, supported by other databases and over-views in subject-specific books, journals and articles, Generalised reports such as those issued by the Health Management Information Consortium (HMIC) were searched and references were also obtained from books on research in the specific modalities, such as those by Aldridge (1996); Payne (2006); Gilroy (2006) and Jones (2007). The review was limited to samples of works published since the year 2000, carried out by practitioners who have received formal training in their arts therapy modality, as it was felt that as such research was a constantly changing and developing field, with new material being added on a daily basis, and that earlier meta-analyses and reviews had now been superseded by, and subsumed into, more recent studies.

The search was carried out by the use of keywords such as: art, drama, dance, music, therapy, creative arts therapies, expressive arts therapies. These were linked to such words as: comparison, therapist, client, history and the use of synonyms. The search was limited to

literature referring to arts therapies *per se*, rather than extending it to the use of arts in health and well-being, as this would have made the search too extensive and unmanageable⁹.

The development and nature of the relationship between arts forms and the healing process, as a context for the setting of the research question

Karkou and Sanderson (2006) describe the use of the arts for healing and well-being from earliest recorded times to the present day, providing reassurance that the current approach of the use of arts modalities in programmes of therapy has a credibility based on historical experience, customs and proof of effectiveness. This view is supported by (Malchiodi, 2006a), who maintains that the relationship between the arts and healing is a pairing as old as human society itself, having occurred repeatedly throughout our history across place and time. Indeed, evidence in archaeological records suggests that early humans began to create art forms – paintings, sculpture, music, dance, and drama - during the Upper Palaeolithic period, about 35,000- 45,000 years ago (Clottes and Lewis-Williams, 1998), (Higham et al., 2012). Bailey (2006) emphasises how dance and drama, in particular, were extremely useful in rites to create sympathetic and contagious magic, as well as to embody myths and rituals. Grainger (1990, p.127) underpins this hypothesis by stating: ‘We use it (*ritual*) because it is the native tongue of mysteries too profound to be described in words.’

These writers confirm that the arts are never superficial or without purpose when used in the context of healing. Sorell (1967, p.10) states: ‘It is not done because it ‘is the thing to do,’ but because it ‘is’ the thing’. The !Kung tribesmen of the Kalahari desert include everyone in the healing dance, because in healing, this culture makes no distinction between their physical, emotional and spiritual needs. The healing energy comes from the gods and the dances and songs heat up the energy to facilitate the healing process (Katz, 1976). Raviv (2014) describes how the traditional healer, the witchdoctor, the dramatherapist and the medical clown each conduct a dramatic, healing performance for the ill in their community. Their healing ability lies in their capacity of being intermediaries between two worlds;

⁹ Discussion on the relationship between arts therapies and arts in health is discussed in App 13.1 p. xli

between chaos and order, and between the factors which caused and accelerated the illness, and healing and mental powers.

Collier (1972, p.40), a former commissioner of American Indian affairs, describes how a Navajo 'sing' becomes communal healing, in which the sick patient responds directly with those around him, in a profound process of therapeutic suggestion and self-suggestion, which 'reaches to the obscure, central deeps of the body and soul'. Central elements of the singing cure are ceremonial dances and the dry paintings, or sand-paintings, which are almost exclusively symbolic and bring to mind Jung's archetypal images. This client / healer relationship appears have many parallels with the present-day practice of arts therapies and is an important element of the current research.

Alvin (1975), a pioneer music therapist, describes how in some parts of Africa, the medicine man still uses a magic drum and an ouombi harp to play over the stomach of a patient and in the Indian tribes of Ontario, magicians and shamans are also music teachers. Fleshman and Fryrear (1981) suggest that the actual using of the arts as a specific adjunct to medical treatment in European practice, emerged in the period from the late 1800s to the 1900s alongside the advent of psychiatry. Benenzon (1981) concurs with these views, stating that inferences about the use of music as a healing practice during prehistoric times are strengthened by the knowledge that they are still used today for that purpose.

Karkou and Sanderson (2006) point out that not all schools of philosophy have supported a positive role of the arts in healing; indeed in the middle ages, dance was regarded as sinful and the Victorian era sought to suppress, rather than to encourage, emotions. However, Heidegger (1935) holds that art had already established itself as a medium that might be used for self-expression and interpretation and as the coming of truth - the setting to work of the truth of beings. He purports that it is this same disclosure by the artist in his work of art, which forms the fundamental concept of the use of arts modalities in the process of healing and therapy. As Stulberg (1973, p.257) explains, when commenting on Heidegger's essay 'The Origin of the Work of Art', art is seen as 'a way in which the creator discloses the truth-of-all-being within a design and illumines a new, unfamiliar world beyond the existing

realm.’ Levine (1997, p.4) supports this view when he states that ‘there is in the use of art a capacity for self-expression that is desperately needed by those who suffer intensely’.

Malchiodi (2006b) traces the development of arts therapies in the healing profession, referring to existing documentation describing the use of music as a therapy following World War 1, when so-called ‘miracle cures’ resulting from reaching patients through music when they responded to nothing else, were reported. Marineau (2013) describes how, in 1923, J. L. Moreno, the founder of psychodrama, proposed the use of enactment as a way to restore mental health. Creative arts therapies became more widely known during the 1930’s and 1940’s when psychotherapists and artists began to realize that self-expression through nonverbal methods such as painting, music making, or movement might be helpful for people with severe mental illness (Malchiodi, 2011). Because there were many patients for whom the ‘talking cure’ was impractical, the arts therapies gradually began to find a place in treatment. Major psychiatric hospitals such as the Menninger Clinic in Kansas and St. Elizabeth’s in Washington, DC, incorporated the arts within treatment, both as activity therapies and as modalities with psychotherapeutic benefits.

Within the UK, accounts of art as a healing process survive from as early as 1901. Hogan (2010) relates how some patients in Scotland appeared to be compelled to make art works and would use found materials, if art materials were not to hand. This type of art work was dubbed ‘art brut’ or ‘raw art’. Reschke-Hernandez (2014) describe how during World War I, Paula Lind Ayers developed a systematic approach using familiar, live singing, that was effective in alleviating symptoms of shell shock. The years of World War II witnessed an amazing growth in the interdependence of music and medicine (Schullian, 1947), especially heightened by the role music played in military hospitals. Ainlay (1948) relates how music was rejected in the beginning of World War II, but later was accepted, due to the realization of the increased morale it gave to both healthy and ill soldiers. Ainlay points out that the pride of physicians might have been hurt to see results obtained by the use of anything but surgery, medicine, or orthodox procedures.

In addition, Hanson (1948) describes how it is recommended that the use of music when intended for therapeutic benefit, should be derived from a well-planned programme, taking

into account the emotional appeal in all its aspects for each recipient, together with analysis of the elements of the modality of music itself and the technical reasons why it should result in emotional responses to itself.¹⁰ This description relates directly to the current research, in that the present question under discussion is concerned with the individual approach to each client, trying to determine which modality of arts therapy should be recommended to any specific client and what elements of the art form might bring about specific aims for each client. Such aims as described by (Ainlay, 1948) were social adjustment, occupational therapy and educational activities, including recreation and entertainment.

It has been noted in the preceding descriptions of the use of the arts in healing, that these processes have evolved from the pre-history use of arts forms to the recognised adjunct to health-care which they are today. Alongside this development, challenges were made to practitioners to verify and systematise their work, to assess the influence of the art form on behaviour and to examine the outcome of any intervention in specific treatment plans (Bunt, 1994). However, although there does seem to be a foreshadowing of the modification of the varying art forms to empathise with client preferences within some of the examples of practices detailed above, there do not appear to be, to the current date, any references to the choice of a specific arts modality which would be selected for a distinct type of client, which is the subject of the present research.

The arts therapies intervention

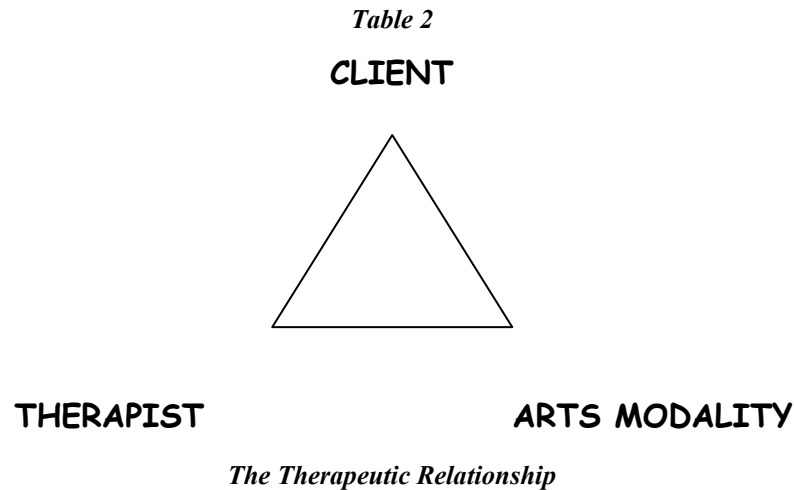
Consideration is now given to literature concerning discussion of the arts therapies intervention itself, both in general terms and with specific reference to the present study. This will enable the reader, if not already familiar with the practice, to understand more fully the underlying principles and features of arts therapies as a discipline and their application within features of the creative arts therapy process (Puetz, et al., 2013).¹¹

¹⁰ *It is worth noting that this description of the use of music refers to what would now be termed 'receptive music therapy'; however active participation, in which clients use instruments with which to improvise or create music themselves is actually stated by Ainlay (1948) to be the most beneficial activity of all.*

¹¹ *It is understood that each of the following paragraphs could form a chapter in themselves, however, a short introduction is offered here, to 'set the scene' for the context of the current study.*

Participants in the arts therapies relationship

Fenwick (2009) and Edwards (2013) argue that in considering any therapeutic process, it is observable that the dynamics of processes within a session depend on the inter-relationship between three factors, namely the client, the therapist and the art modality.¹²



The triangle may be regarded metaphorically as a ‘safe space’ offered by the therapist to the client(s) during the therapy sessions. The therapist guarantees that – as far as is possible – there will be certain conditions surrounding the session, such as environmental and physical safety, lack of interruption, adequate and appropriate equipment, a code of confidentiality and previous risk assessment, the support of the therapist’s training and experience and freedom from a judgemental, discriminatory or censorious atmosphere (IATE, 2014). Smeijsters and van den Hurk (1993) concur with this definition of a therapeutic space, the purpose of which

¹² In searching for a corporate term by which to refer to art, dance movement, drama and music, used within the healing process, it appeared that either the term ‘medium’, or the term ‘modality’, might be used. A ‘medium’ (www.Dictionary.com 2013) may be defined as ‘an intervening agency, means or instrument’. Within therapy, the varying art forms are certainly ‘intervening agencies’, linking clients – through the art form – with their conscious and subconscious emotions and feelings. The term ‘modality’, however, when used within a clinical setting, refers to the factors or agents that affect the patient. These modalities are used by various therapies to direct the perspectives of the patient’s, or the client’s, thought and may be used to provide counselling and solutions to the client’s problem (Researchomatic 2013). Within the present context, the latter definition appeared to be more appropriate, when referring to the arts forms used as the means by which clients may express their thoughts and feelings. The term ‘modality’ has therefore been adopted to refer to the varying art forms used within this current research and within other literature concerned with the practice of arts therapies (Doktor, 1998; Smeijsters and Cleven, 2006).

is to enable the client to make appropriate and intimate contact, so that there is an interaction of action and reaction and an emotional experience.

Levine (1997) describes how, by using non-verbal methods, the therapist can reach clients who have lost the capacity to speak in connected discourse, or, alternatively, who are trapped in a web of words. The aim of the therapist within the therapy session is to establish a relationship with the client, by means of the arts modality being used. Feder and Feder (1998) maintain that the ability to find the unique core of the individual constitutes the art of the therapist. Trainee therapists are encouraged to 'meet the client where they are at' – a term which implies empathising with the client and acting accordingly (Tingle, 2000 p.10).

Bruscia (2000, p.84) maintains that '...the main goal of therapy is to help clients to find greater meaning in life, or to find a new meaning which is more meaningful, or more useful, or more helpful.' In this sense, Bruscia maintains that 'meaning' is '...that overall sense of purpose and fulfilment in life that clients hope to find as the result of therapy.'

Bunt and Hoskyns (2002) further describe that the essential ingredient of any therapeutic relationship is seemingly in the meeting of two souls. At a most fundamental level is the need for the therapist just to 'be with' the person who is coming for therapy. Implied in this deceptively simple phrase is one of the therapist's hardest tasks. Sutton (1993, p. 267) gives us greater insight when she describes this 'being with', as she recalls the point in a music therapy session where the client 'brought the stick back to the drum head until it touched it softly, now looking directly at my hands as I quietly played a single chord. These few seconds encompassed his discovery of a link between his sounds and mine, a stretching out of the interaction that was usually so rushed and the longest period of silence we had experienced together'.

Winnicott (1971, p. xiv) further describes this meeting point when he states that 'experiences in the area of potential space (*between therapist and client – AF*) allow us to have periods of rest from the struggle to draw lines between ourselves and others'. Once this essential rapport has been established within the safe space represented by the \triangle , the therapeutic journey begins and the client may explore the deepest pain and seek wholeness (Tingle, 2000). In a

further definition of the process of therapy, Hinz (2006, p.6) has described how the process of using art as therapy ‘may be likened to midwifery, in that the therapist helps to deliver ideas and feelings that exist in clients in the form of imagery, waiting to be born. As clients experience the birth of these very personal images, they experience hope and faith in themselves and their abilities to heal.’ (Bella and Serlin, 2013) maintain that the arts modalities enable clients to facilitate a direct communication concerning their immediate experiences, which may not have been revealed through a verbal approach. For clients, more information becomes available as they tap into different modes of expression, enabling them to communicate a visual representation of their internal state, which may lead to a shift in both their experience and its expression. The current research aims to define this space and meeting point with the clients, by investigating which modality of arts form is best suited to which type of client and why this is so.

The client

As a descriptive term for a person referred for arts therapies, the word ‘client’ is the preferred term used by the Centre, after consideration of a range of alternative names found to be in current use, when considering those who benefit from services offered by such an organisation, such as: ‘patient’, ‘service-user’, ‘customer’, ‘just people’ or ‘client. In conducting evaluations and designing interventions, the Centre adopts a client-centred approach, in that the desires, interests, priorities and motivation of a client and/or the client’s family/significant others are honoured. Langley (2006, p.2) supports this approach, when he states that the expectation for therapy is ‘healing in the sense of relief or cure, a change of perspective or behaviour, adaptation to disability, coming to terms with reality, or simply personal growth’. The use of the term ‘client’ is thus used to refer to someone who engages in an arts therapies programme in order to obtain these ideal states.

Current mental health statistics show that within the U.K., 1 in 4 people will experience some kind of mental health problem in the course of a year, with mixed anxiety and depression being the most common mental disorder (MIND, 2015). About 10% of children have a mental health problem at any one time, while self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population.

The existence of the above statistics might suggest that fundamental concepts of ‘health’ and well-ness’ are universal – that all those who are ‘un-healthy’ or ‘un-well’ need, for their own sakes and for the sake of the communities in which they live, to be ‘healed’. However, it appears that there is no single universally agreed definition of mental health or ‘un-health’ and that lay conceptions of health may differ from those of professional healers. Seale et al., (2001) question what should count as fact and what should be regarded more as social prejudice and custom, in the defining of the word ‘health’. The opinions of members of the professional, orthodox health care sector, consisting of doctors and nurses who have been trained to base their practices on principles derived from Western bio-medicine, may differ radically from those of alternative practitioners, who are specialist healers working outside the mainstream of these principles, not only on the nature of disease, but on the question of when and how therapies should be evaluated. Moreover, these opinions may well contrast with those of the lay health care sector, whose reliance on self-medication, often in consultation with family and friends, is the norm (Seale et al., 2001).

The Mental Health Foundation (1999, p.60) states that definitions of mental health include factors such as ‘the ability to develop psychologically, emotionally, creatively, intellectually and spiritually; to initiate and sustain mutually satisfying personal relationships; to use and enjoy solitude; become aware of others and empathise with them; play and learn; develop a sense of right and wrong and resolve problems and set-backs and learn from them’. However, McConway and Davey (2001) maintain that there is more than one justifiable set of beliefs about the nature of health and disease. These writers suggest that beliefs about what illness is and what makes us ill, have changed radically over time and even now differ between different societies and between different groups within a single society.

Morgan and Ziglio (2006) differentiate between pathogenic theories and salutogenic perspectives, based on the assumption that health is the absence of illness. They suggest that pathogenic theory focuses on what makes people ill, the aim being to identify and eliminate the cause of the illness, to ‘fix’ the person and make them healthy again, while salutogenic perspectives are assets based approaches which focus on empowerment, accentuating positive capability to identify problems and activate solutions, thus promoting self-esteem of individuals and leading ultimately to less reliance on professional services. Within the world

of the arts therapies, it appears that sessions may operate within both pathogenic and salutogenic paradigms, acting on the one hand to encourage discovery – and overcoming – of hidden traumas and fears which may lie at the root of aberrant behaviour, while on the other, encouraging enhancement of clients’ self-esteem and belief in self.

In contrast, the Local Government and Information Unit and Children’s Services Network (2007, p.5) state that ‘mental health is not just the absence of mental illness, but the ability to make and keep relationships with others, being adaptable to change and other people’s expectations, being able to have fun and to be open to learning and being able to manage ordinary setbacks.’ This is what mental health and psychological well-being are really about. Merriman (2009), in her extensive discussion on definitions of mental health, again draws the distinction between the pathogenic and salutogenic perspectives of mental health, which result in fundamentally different approaches to the provision of mental health services and which refer to an individual’s capacities, emotions and observable behaviours. Some definitions also include reference to the individual’s response to their environment.

According to a generic definition of mental health given by the Mental Health Foundation (MHF), there is not necessarily one basic reality of ‘health’ which covers all modalities of living: ‘Mental health and well-being is the embodiment of social, emotional and spiritual well-being. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.’ (MHF, 2007, p.43). In the definition of mental health given by the Church of England Archbishop’s Council (2009, p.30), the Council suggests that everyone has mental health needs, whether or not they have a mental health diagnosis. The Council suggests that:

‘Mental health is not simply a characteristic of individuals. Whole neighbourhoods, organisations such as schools or workplaces, or specific groups of people, for example asylum seekers, may have low levels of mental health. There are links between poor mental health and poverty, deprivation, exclusion, isolation or low status. Poverty and social exclusion are both a cause as well as a result of mental health problems’.

The supposition might be, therefore, that clients selected for the current research programme in arts therapies would originate from these populations. However, Summers (2004) suggests that people of any age or background can grow and profit from the experience of therapy, there being no 'right' or 'wrong' time to begin.

Referring to his field of psychodrama, Moreno (2005) concurs that his work is not only for those wishing to deal with problematic situations. He sees the process as a path towards a more creative approach to life in general, from which all people can benefit.

AllPsychONLINE (2013) also supports this view, suggesting that therapy is not just for people with a serious mental illness, being also very helpful for people with mild to moderate depression, anxiety, relationship difficulties, sexual concerns and other conditions. A similar view was proposed by Feder and Feder (1998), who maintained that the beneficial effects of involvement in an arts therapies programme might apply to anyone, the basic goals of therapies for referred clients being regarded as self-understanding, interpersonal communication and personal growth.

Kelm (1998), an anthropologist, argues that the question of who may need healing has no single answer if taken out of a cultural context. Kelm suggests that in situations where an indigenous people have been over-run and colonised by another culture, the perception of 'health' and 'healing' may well be seen from different angles by those involved. The health of the aboriginal people of British Columbia, for example, was very much physically affected by the colonisation of their lands. First Nations themselves did not see disease as separate from the larger context of aboriginal interactions with the non-human and the non-native world. The result was either direct contest between the two views of aboriginal or colonial peoples, or the formation of hybrid approaches to sickness (Kelm, 1998). Evans and Rodger (1991) describe how Kenneth 'Bear Hawk' Cohen maintained that Native-American medicine could be contrasted with allopathic medicine, not just in terms with what each does, but more importantly, in terms of world view: focussing for example on restoring health versus defeating pathology; advisory versus authoritarian.

Similarly, Callaghan (2005) suggests that clients may experience ill health and be in need of support if, as asylum seekers, they live within the multi-ethnic societies of today, especially in

big cities. Such people may have neither status nor fluency in speaking or writing in English and find their lives suspended in limbo between the dangers they have fled and the safety they seek. Such people may be included as part of the clientele of the present study.

More recent knowledge of practices within other countries reveals that the attitudes towards those with mental health problems and physical disabilities may still vary considerably. Bignold and Gayton (2009) describe how in Romania, prior to the 1989 Revolution, overt discrimination was made towards Roma children, children with HIV / AIDS and children with disabilities. Such children were routinely put into institutions and orphanages, even if their natural parents were still living.

In further clarification of who might be a 'client', Dalley (1984) maintains that clients referred for arts therapies, from whatever background, are not there to become skilled artists, but to attempt to become more integrated members of society. Diaz (1992) also adds that clients are not required to have artistic talent in order for the therapy to be effective, the importance of the session residing in the insight that a client may gain about him or herself from engaging in a creative process, from interacting with the therapist. Talent is seen by Diaz as having no association with the depth of human experience involved in the creative act.

Sinason (1987) suggests that for some clients, hatred at the difference between handicapped self and normal could help to create opportunist handicap. She describes (Sinason, 1992) how the defensive use or abuse of the primary damage could sometimes be more powerful than the original handicap itself and that clients might not even understand or be able to cope with these behaviours, without assistance from another source. In what she terms 'secondary handicap' Sinason describes how this experience could cause even greater human distress and destruction than the original handicap (Sinason, 2010). 'Ill-health' may even arise from the fact that handicapped adults and children are too rarely seen to have words and thoughts of value inside them (Sinason, 2010) and only seldom are provided with a means of interpreting them or having them interpreted. Such clients may therefore give up the struggle to communicate and keep damaging thoughts locked up inside them, making a storehouse of personal pain. It is at this point that access to arts therapies intervention provides a means of

communication and subsequent release of such wounding processes, as may be observed in this present study.

Additionally, the parents or members of the social environment of the client, may project their own feelings concerning the condition or experience on to the client, thus exacerbating, or even initiating, the disturbed response. A wished-for baby who is born with a noticeable handicap – or even who is not the hoped-for sex – may make it hard for even the most loving, resourceful parent to feel deeply attached, thus leading to attempts to cover the cracks with a brilliant simulation of joy and love as a defensive manoeuvre (Sinason, 2010, p.124). The basic pain felt by the parents or extended family is projected onto the child, who may even adopt a smile, rather than expressing his true feelings, in order to keep his parents and others happy. The client may even behave in a certain way because he feels that those around him expect him to behave like this and he wishes to please them.

Sinason (2010, p.149) quotes Dostoevsky's character Myskin in 'The Idiot' (1869, p.71) as saying:

'But can I be an idiot now, when I am able to see for myself that people look upon me as an idiot?' As I come in I think: 'I see they look upon me as an idiot and yet I am sensible and they don't guess it.'

Often, as clients express themselves through the therapeutic modality, therapists know that they have shown them a true part of themselves which they have had to hide from public view. The presence of such a situation – a 'secondary handicap' – would be the dominant feature of a client referred within this research project and such factors would need to be taken into consideration when drawing conclusions from the results. Following on from these discussions, assessment is no longer conceived as a process of accurate definition of 'what is wrong with the patient' in a global diagnostic sense; rather it is seen as being about exploring and understanding the developmental and therapeutic tasks facing an individual in need (Caparrotta and Ghaffari, 2004).

Range of present-day client groups

In order to acquaint the reader with the extent to which the practice of arts therapies has extended in the twenty-first century and how these descriptions relate to client groups in the present study, a brief over-view is given of the rapidly expanding range of literature describing present-day arts therapies client groups, both in the UK and abroad. In a review of the international scope of arts therapies (Cruz, 2005), the number of named different countries represented by articles in that journal was 45 and it was believed that this did not cover all countries in which the practice was still in its infancy.

The present overview will refer to and compare work with client groups having specific conditions or disorders; work involving a specific age range of clients and those which focus on clients' gender. This wide diversity of client groups also demonstrates how the practice of arts therapies has extended to meet the needs of those unfortunate enough to have become involved in the most recent political and international disputes, such as those with migrant or refugee status, or those suffering from post-traumatic stress disorder. Brief reference is also made to work specifically with the human voice and arts therapies used in conjunction with other therapy disciplines, although this latter approach was not included in the present research.

Within the many writers describing varying arts therapies practices within the context of a specific condition or disorder such as dementia, palliative care, autism or learning difficulties, Aldridge (2008) edits accounts of work focussing on the role of music therapy in work with the elderly and those having dementia, Hartley and Payne (2008) present a collection of articles on the creative arts in palliative care. Martin (2009) and Chasen (2011) describe work undertaken in art therapy and dramatherapy respectively with children on the autistic spectrum, while Booker (2011) details dramatherapy work with clients with profound and multiple learning disabilities. Bull and O'Farrell (2012) describe how art therapy may be used with clients having learning difficulties, covering such aspects as loss and bereavement, how to cope with their disability, issues of attachment and separation, self and identity, while Malchiodi (2013) demonstrates the benefit of creative expression for those living with acute or chronic illness within health care, covering a wide range of conditions, from cancer care,

asthma, epilepsy and renal disease, neurological disorders and traumatic brain injuries and Alzheimer's disease, to clients suffering with physical disabilities.

Through these arts therapies programmes with adults, children or even work within the whole family, the contributors show how such clients may be enabled to regain a sense of empowerment and efficacy, improving their functioning and enhancing general health and well-being.

In addition to works describing specific client groups, collective over-views are also given by practitioners in specific arts modalities, such as Malchiodi (2011) and Edwards (2013) in the art modality; Bunt and Hoskyns (2002) in music; Meekums (2002) and Corrigan et al., (2006) in dance movement therapy; Langley (2006) and Grainger (2006) in dramatherapy. These descriptions usefully detail varieties of method and practice, which may inform the present study.

Within descriptions of practice based on the age range of clients involved, Martin (2009) states that it is often held that the early years, from infancy to 5 years of age, are the most dynamic and critical period in a child's life and therefore intervention at this age is crucial. Between the ages of 2-3 years old, when a child can manipulate materials to begin working on drawing, seems to be the best age at which to start to make art-making into a therapy process for children with, for example, autistic tendencies. In support of this view, Bunt and Stige (2014) maintain that in infancy, children's development of relationships to music is embedded in their attempts to build relationships to the world. This pattern of sound creation and turn-taking may be developed into the music therapy process and may provide the foundations of socialisation. Case and Dalley (2007) agree that art therapy may be used as an intervention from infancy to adolescence; McFerran (2010) emphasises the essential field of music therapy with adolescents. Karkou (2009) and Tomlinson et al., (2011) describe the work of arts therapies with school-aged children, specifically within both mainstream and special schools, as education becomes more inclusive of varying types of special needs.

In describing work with older clients, David Aldridge (2000) collates chapters by varying authors, describing a wide range of work undertaken by music therapists with clients suffering

from dementia. Gudrun Aldridge (2000) takes an approach more based on neurophysiology, detailing descriptions of the parts of the human brain which are involved in musical perception which remain available after the process of dementia may have begun, allowing for targeted interventions in areas of assessment and evaluation, cognitive skills, social / emotional skills and behaviour management. Brotons (2000) not only summarises existing music therapy literature relating to elderly people, but also purports that because the arts therapies in general rely less on verbal processing, they may offer a unique approach to accessing stored knowledge and memories that control certain behaviours. Within the current research, the use of all active, rather than passive, arts therapies, within all modalities, forms the basis of participation by older people.

Studies concerning the gender of the client within the varying arts modalities have been collated in a special edition of *The Arts in Psychotherapy* (Curtis, 2013), in which the rich complexity of gender and meaning and its multiple interactions with race, socio-economic status, sexuality, ability and age are examined. Discussion also includes consideration of the gender of the therapist him / herself and how this may affect the therapist / client relationship within programmes of therapy. It is outside the scope of this review to discuss this topic in detail, but the element of gender and response to the varying arts therapies modalities, including the gender of the therapist concerned in each session, is incorporated within the methodology and results of the current research, as outlined later in this study.

Work with specialised groups of clients in each of the four modalities of therapy reflect how current practice has developed to meet the growing need for responses to the challenges of the present diverse political and social climate, which development may be seminal to work with clients in the present study. Doktor (1998) brings together descriptions of arts therapies practice within the field of migrants and refugees. Bannister (2003) describes how all creative therapies may be used with traumatised children, while Rastogi and Wieling (2005) present a fascinating and unique compilation of experiences of arts therapists from Asian, African, Japanese and Ethnic Minority populations, emphasising that arts therapies are a vital tool in the combat against 'modern' global concerns, such as racism, class structures, victims and perpetrators of domestic violence, the relevance of family systems in clients of African descent and overviews of acculturation versus cultural identity.

Broadening the description of the range of present-day client groups, Ng (2005) describes how music therapy is increasingly used with survivors of war trauma in Singapore, however, Fawcett (2000) emphasises however that it is also necessary to help people to deal with their problems in their own way, rather than bringing in outsiders as 'rescuers'. Gray (2011) outlines how expressive arts therapies are used when working in rehabilitation of survivors of torture, demonstrating how such specialised areas of need are now addressed through the use of arts therapies. Sajnani and Kaplan (2012) discuss the role of creative arts therapies and their influence within social justice, in a group of articles published in special issue of the journal 'The Arts in Psychotherapy', in which the work and effects of arts therapies with varying client groups is examined from the point of view of the transformative powers of the arts therapies to empower social change. In their pilot study, Huss and Sarid (2014) describe how by transformation of the images by shape, colour, texture or size, health workers were able to reduce levels of distress purely through the art forms themselves, without verbalizing the meaning of the transformations.

Newham (1999) describes other approaches used in arts therapies techniques, concerning the role of the human voice in therapy, describing the technique of incorporating singing and vocal expression into therapy as a means to initiate social interaction and self-empowerment. This approach is supported by Baker and Uhlig (2011), who consider a wide range of practices covering the use of the voice in music therapy contexts. Developmental speech-language training through music for children with autistic spectrum disorders is described by Lim (2011), while Carnabucci and Anderson (2011) describe work in which the relationship between Systemic Constellation Work - an experiential healing process being embraced by a variety of 'helping professionals' - is compared with psychodrama, the original mind-body therapy.

Foreshadowing the supposition that arts therapists within the current research will interact with teachers, managers and other members of staff involved with each client, Wigram et al., (2002) describe how the use of arts therapies in conjunction with other therapy disciplines is now wide-spread, as arts therapists, as a rule, form part of the clinical team and their aims for sessions would form part of a multidisciplinary approach, together with other professionals involved, who might include speech therapists, physiotherapists, psychologists and teaching

consultant. Bunt and Hoskyns (2002) describe how arts therapies may also be used within specifically developed approaches, such as the use of 'Guided Imagery' within the field of music therapy. Similarly, Kosslyn et al., (2001) suggest that within the modality of art therapy, the guided imagery exercise of a 'safe space' may enable the art psychotherapist to verbally assist the client in creating an image that has an intentional direction.

Czamanski-Cohen et al., (2014) in practice use a combination of Cognitive Behaviour Therapy with Art Therapy, in a method they call CB-ART, to treat pain and symptoms accompanying coping with pain and chronic illness. As described by these writers in this protocol, the creation of an image becomes a process of symbolization that enables externalizing and distancing traumatic material, rather than using the art form as a basis of a relationship with the therapist.

Within all this range of practices, however, it is important to note that the underlying principles of arts therapies, as detailed in preceding paragraphs, still apply and will be relevant to the current programme. Aldridge (1996) had already reiterated this universality of approach by stating that the arts might be seen as a phenomenological creative process which enabled therapeutic interactions to take place, focussing on the hope and meaning in traumatic situations. Hartley and Payne (2008) concur with this, when they state that for all clients in therapeutic programmes, the arts bring with them possibilities; possibilities for motivation and growth, for coping and change, for self-actualisation and self-realisation. They also offer possibilities to make sense of situations and to create something of value, which is the basic the reason for referral of clients to the Centre.

The therapist

The literature reviewed references to the role of the therapist, covering the personality of the therapist and their basic relationship with the client, as this was seen to be an integral component of the therapeutic triangle.

Kramer (2000) states that when former clients are asked what they felt to be the most helpful factor in the course of their therapy, they almost never named a technique, interpretation or

theory, but mention immediately the personality of the therapist and the importance of the therapeutic relationship. In Kramer's opinion, new therapists are surprised to find that the actual theoretical bases for sessions are seldom mentioned by the clients. For the clients, effective therapy is a matter of the personality of the therapist, which is a concatenation of factors, many of which are intangible and a mystery. Kramer holds that for therapeutic chemistry, humanity is essential, that by being fully present, one conveys the powerful message of listening without having a strong opinion to express. For the therapist, the therapy process becomes two inter-penetrating worlds, namely that of the everyday professional domain, contrasting with the inner world of the therapist's subjective realm. Ultimately, personal maturation, seasoning and self-mastery become not a technique or therapy that therapists offer to clients, but rather the offering of who they themselves are. Rogers (1980) agrees with this, believing that sessions should only be led by therapists who are secure enough in themselves to know they will not get lost in what might turn out to be the strange or bizarre world of the other and that they can comfortably return to their own world when they wished.

The concept that it is the personality of the therapist which is more important than the actual modality being used and that this over-rides any approach based on a particular school of psychological thought, is supported by Cross and Papadopolous (2001), who are of the opinion that therapists select techniques and theories because of who they are as persons. The therapy strategies become manifestations of the therapist's personality. Within the session, the therapist as a person is the instrument of primary influence. A corollary of this principle is seen to be that the more the therapist accepts and values him/herself, the more effect he or she will be in helping clients come to know and appreciate themselves.

Again, Rowan and Jacobs (2002) suggest that it is not so much that there are alternative ways of being a therapist, but that there are, rather, different ways in which most therapists might be able to use the self, which are not mutually exclusive. Jones (2005) confirms that in his opinion, it is not only the artistic skills of the therapist that become involved in the therapeutic process. He maintains that the actual *persona* of the therapist plays a crucial role in the development of healing, through the relationship between therapist and client. Jones believes that the arts therapist and client together can inhabit a range of roles and paradigms within the

arts therapy space and that the relationship involves specific qualities of the artist within both the client and therapist.

Dives (2008) emphasises that, as most therapists work within varying contexts and with different client groups, one of the most important qualities to have for this work is flexibility and an ability to have a sense of the dynamics of each particular work place. Wylie and Turner (2011) add to this argument by stating that regardless of what approaches and techniques are used, good therapy requires the development of good listening skills and trust. Baldwin (2013) points out that this in turn can expose the vulnerability of the therapist, for his willingness to use his own self in therapy sessions means that he has to be willing to face his or her own pain, finite-ness and vulnerability. The importance of the basic relationship between therapist and client is further emphasised by Courouchi-Robertson (2013), who reiterates that to her, the modality used in therapy is of secondary importance to the relationship the therapist has with her clients; how it is formed, the appropriate distance maintained and the way in which the relationship is allowed to progress.

It will be seen in subsequent chapters of this study, how the differing personalities of the therapists undertaking work within the present study play a vital role affecting the outcome of the sessions and therefore on results obtained.

The arts modalities

Writers who are trying to define the nature of the various modalities through which the current research is implemented – art, drama, music and dance movement therapies – immediately reach an impasse, because not only does a word such as ‘music’ mean different things to different people, but the nature of ‘music’ cannot be represented through another concept, namely that of words.¹³ Cook (1994, p.1) suggested that music is a code, in which the deepest secrets of humanity are written. He states that ‘one cannot represent the essence

¹³ *One is reminded of the anecdote that describes how the composer Schumann, when asked by some one who had just listened to a piece of his music, ‘But what does it mean?’ replied, ‘Madam, it means this...’ and played the piece again.*

of 'music' through the modality of words, any more than one can verbalise a piece of sculpture or drama. This is merely turning the inner concept of the art form into a verbal metaphor; one is saying 'music is *like*...', rather than 'music *is*...'. Cook adds later (1998, p.77): 'No longer are there absolute artistic standards rooted in external reality, in the way things are. Instead, artistic value lies in the experience of the spectator, who is no longer detached from the artistic process but becomes an essential participant in it.'

Rita Simon (1989), a pioneer art therapist, expresses a similar opinion when she states that in her opinion the creative process has the last word and cannot be translated; the picture speaking for itself through the way it is made. For her, the image and meaning are identical. Supporting this view, the famous dancer, Isadora Duncan (1998, p.9) is said to have replied to a question about what her dancing meant: 'If I could *tell* you what it meant, there would be no point in dancing it.'

Similarly, within the modality of drama, Jennings and Cattanach (1994) state that one enters the portrayal of life within the play and drama that occupy extended time as children, who learn how to act through involvement in dramatic play where they are able to develop a range of appropriate roles and behaviour. It is not necessary (or even possible) to put these 'playings' into words, although words may be used as part of the enactments. Playing out past fears, rehearsing current strategies and anticipating new events can lead to therapeutic mechanisms which help deal with day-to-day life and the unexpected. Therapists find that even many adults need the opportunity to engage once again with dramatic play to enable self-healing to take place.

The various authors who contribute to Jennings and Cattanach's book demonstrate the rich canvas of dramatherapy practice, but what is common to all of them is the implicit or explicit assumption that the use of drama in therapy enables the creation of dramatic reality and therefore dramatic distancing (*ibid*). Client and therapist will work with a greater or lesser personal distance through the modality of dramatic enactment or role play, which calls upon the dramatic imagination. This engages all participants both in the outer space of the theatre or dramatherapy room and the inner space of the imagined world, together with the corporal space of the inner and outer body.

From these brief extracts, it appears therefore that exact definition of the four arts modalities cannot be expressed in actual words. As used within the therapeutic process, they become, in the words of Winnicott (1971, p.72), ‘transitional objects’ or ‘not – me’ possessions. This is a very practical and useful concept, which relates directly to the present study. Winnicott suggests that every individual who has reached the state of being a unit with a living membrane and an outside and an inside, also needs a third dimension – an intermediate area of experiencing, to which inner reality and external life both contribute. This transitional phenomena becomes a resting place for the individual engaged in the perpetual human task of keeping inner and outer reality separate and yet inter-related. The use of the arts in therapy allows clients to make use of this transitional space, in which the different modalities serve as objects through the use of which the therapeutic journey may be accomplished.

The term ‘Arts Therapies’

The writers quoted above appear to agree, that a definition of the terms ‘client’ and ‘arts modality’ seems impossible in mere words without presenting ambiguity. A similar paradox now seems to exist when seeking a definition of the word ‘therapy’ in conjunction with the word ‘arts’. Jones (2005, p.9) quotes the definition of therapy as given by psychotherapist Cox (1978, p.45): ‘A process in which the patient is enabled to do for himself what he cannot do on his own. The therapist does not do it for him, but he cannot do it without the therapist’. The term ‘therapy’ itself may also be a generic term, applied to the application of any technique used to improve a person’s physical or mental health functioning (AllPsychONLINE, 2013). Summers (2004) suggest that the desired outcome of therapy is an improvement in health and well being, translating into increased self-confidence, productivity and a greater sense of vitality and peace of mind. By developing insight and increased self awareness in the sessions, clients may be able to gain a better understanding of their own behaviour and the issues, feelings and events that motivate them. Jones (2005) also discusses how, as arts therapies have developed as disciplines, therapy and psychological thought have been mutually influenced by each other, having reciprocal influences on each other’s developments.

However, the nature of 'therapy' may be regarded differently in different cultural contexts. Tamasese (1994) suggested that the problem with most psychological and other research work in Africa was that there was a tendency to subordinate African cultural facts (empirically derived information) to assumptions, theories, concepts and world-views emanating from the West. Empirical data is insufficient and amounts to an injustice to the indigenous people. This quandary is further described in an article by Solomon (2005), who had returned to post-apartheid South Africa after completing a qualifying art therapy training course in the U.K. She believes that in order to be an effective therapist, an approach is needed which provides an understanding of the specific cultural contexts which individuals inhabit, giving a different lens through which to view art and healing. Solomon argues that it is necessary to recognise the importance of a culturally specific understanding of diagnosis, healing, mental distress, and trauma. The western bio-medical approach, for example, to healing war trauma should be regarded as only one of several possible ways of dealing with such healing imperatives in Africa, since there are other ways of understanding health and healing in post-conflict situations on this continent, which are culturally specific and in many cases more effective.

Supporting this view, Lai (2011) describes how arts therapies may be used within the Taiwanese culture in a programme designed to assist the mother-child relationship in situations of domestic violence. She emphasises, however, that in order to understand the methods involved, one first has to be knowledgeable about the general difficulties that may be encountered in the mother-child relationship in Chinese culture, such as the accepted role of male authority within a family and the discouraging of women and children to voice their opinions. Indirect communication is believed to 'preserve face' and avoid shame and interpersonal conflicts. Thus the advantage of arts therapies being a non-verbal form of intervention in a group setting, allows the therapists to organise, explore and find alternatives for a self-empowered future for their clients.

It is on this world stage that the current definition of mental health and consequently therapeutic approaches, have to be worked out (Fernando, 2010), especially with regard to clients of differing ethnic backgrounds participating in the present study. It may be that compromises are possible in the case of people who maintain their own cultures in predominantly western societies, through which traditional methods of healing can still be

adopted. However, these rituals may have to be adapted to become acceptable to the wider society (*ibid*). Inevitably, the practical methodology used by both therapist and esoteric healer will reflect the societies in which they live.

Casson (2004) agrees with this, stating that it is important to point out that although there may be different frameworks of practice, yet what is common to the practice of all modalities is creativity as a tool for healing. Jones (2005), in further support, goes as far as to say that a single definition for the arts therapies would not be useful to anyone, as there must be different definitions in response to different demands. Although both therapist and healer initiate and facilitate the healing process, they can only be effective if, through the elements of the arts modalities involved, they enter into an inner dialogue with the client, empathising with him and helping to construct a path-way along which to journey back to the community from which he has become alienated, by nature of his ill-health.

This concept might lead to the possibility that conclusions reached as a result of this research would not be valid in other contexts, as the majority of therapists involved may only be regarding their work in the light of their own, western approaches. However, although definitions may be elusive, this does not negate the underlying reality as acknowledged by healing professionals, or by the individual therapist's own personal belief in their practice of the arts therapies. Levin (2008) supports this view in a parallel context, when he suggests that although exoteric religions may differ dramatically in terms of outward manifestations of the belief, yet features of their respective esoteric or inner paths may converge along a common core pathway. Levin maintains that if there is a belief in illness being caused by, for example, the possession of a person by one or more forces, be they extrinsic or intrinsic, counteracting the malign (pathological) factor by the use of exorcism, may be as logical as treatment with psychotherapy or medication to counteract psychopathology. Thus an esoteric traditional healer may be perceived as performing a similar function to that of a psychologist or psychiatrist.

A summary of all points of view described by the above writers might be seen to be encapsulated by Winnicott (2005, p.72) when he states that 'If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to

enable to patient to become able to play... Playing is essential in that it is in playing that the patient is being creative ... by being creative, the individual discovers self.'

The use of one modality or four?

It may be questioned whether all four modalities of arts therapy could be used within one session, both in general practice and within this study. Jones (2005) discusses the traditions of offering a client access either to a range of modalities simultaneously, or to one modality only. He points out that the offering of modalities in plurality may be linked to the cultural traditions of the country in question, quoting, for example that in early Hindu plays in India, music, poetry, dance and costume were all involved in expressing the same creative urge. However, from the present search of literature, it appears that within the UK and European traditions, the arts modalities (art, drama, dance movement or music therapies) are more commonly used on an individual modality basis, rather than jointly (Edwards, 2013; Mackenzie, 2013).

In contrast to this approach, there are courses through which students can graduate to qualify to work within all four modalities, for example those that run at the Institute for Arts in Therapy and Education (IATE), London, whose published philosophy is to offer students the opportunity to explore the fundamental interconnection between the artistic process and psychotherapy, in terms of their mutual concern with in-depth communication of emotional experience, and with transformation and change. Students through this multi-modality approach are schooled in facilitating the richest possible relational and imaginal discourse between therapist and client (IATE, 2014). This rationale was not, however, the underpinning approach utilised within the present programme.

Mackenzie (2013) describes other options of therapy practice, involving work in which two or more therapists from different disciplines work together in the same session with the same client(s), for example in the sessions involving art, drama and music therapists, or where arts therapists are co-working with therapists from a difference discipline such as speech therapy or occupational therapy (Tywford and Watson, 2008). Such work is stated by Mackenzie to

offer a broader, complementary view point on a client's diagnoses than when one modality is used on its own.

This is not to say, however, that when an art therapist is working within a specific modality, other modalities will be totally excluded. The sessions may draw in part of the language of another form of art; a music therapist may involve and be conscious of the body language of the client when playing, or a dramatherapist may invite the client to make images. Lahad (1992) even goes as far as to suggest that dramatherapy is the only multi-modality therapy, as it enables both the therapist and client to move through different media and explore different areas. Yet more commonly within European traditions, each discipline remains separate and 'arts therapists of one discipline would not be seen to be qualified to work with other arts processes as a primary method in their work' (Jones, 2005, p.53). This is the approach adopted in the current research which is based on the question of which arts modality, when used on its own, is most effective for which type of client. The present literature search is therefore focussed on work with clients in one modality only.

'Creative' or 'expressive' arts therapies

Within the literature, the terms *creative* and *expressive* arts therapies are sometimes used synonymously. Serlin (2007), although stating that the primary focus for both approaches is using the arts as a vehicle for healing, yet differentiates between the two. For Bella and Serlin (2013) creative arts therapists are limited to one modality – as described by Jones above – the therapist having been trained in both the art form and its therapeutic application. In comparison, an expressive arts therapist would have been trained in a variety of arts-based modalities, tailored in each case to the client's needs.

Estrella (2005) holds that many practitioners believe that expressive arts therapists should be strictly delineated as the 'intermodal', 'multimodal' or 'integrated' approach, involving the use of various modalities. That is, any of the arts modalities may be used, as the therapist deems appropriate to meet the needs of the client. Malchiodi (2012) concurs with this belief when she states that in a given expressive arts session, more than one art form may be used to enhance therapy. Practitioners are trained to be sensitive to the unique properties in each art

form, sometimes working with the arts in sequence, simultaneously, or carefully transitioning from one art form to another, within a therapy session. Levine (1992) holds that expressive arts therapists do not consider themselves to be ‘jacks-of-all-trades and masters of none’, but rather believe their work to be a mastery of principles of integration and wholeness that underlie the individual specialisations of each distinct arts modality. However, within the European tradition, as discussed previously by Mackenzie (2013), it is more common to regard each modality as an individualised specialisation¹⁴. The current enquiry is directed towards those working within a creative, rather than an expressive practice, as defined above.

Evaluations of Practice

As Karkou and Sanderson (2006) point out, all arts therapists are continuously engaged in routine assessment and evaluation practices in the course of their work, keeping personalised notes of each session undertaken. However, the writing of progress notes on a client is not technically research (Wheeler, 2005). Wheeler describes the object of research as being to enable the researcher to be in a position to modify the way that things are done or thought about, as distinct from performing or writing about clinical practice. Generalised reports such as issued by the Health Management Information Consortium (HMIC) were consulted and references were also obtained from books on research in the specific modalities, such as those by Aldridge (1996); Gilroy (2006); Payne (2006) and Jones (2007).

In order to evaluate the field of systematic reviews of practice in arts therapies, both in general and within specific modalities and differing client groups, as distinct from narrative texts describing work undertaken as described in preceding paragraphs, data was gathered from the Cochrane Central Register of Controlled Trials and Specialised Registers, a number of major healthcare databases such as MEDLINE, PsycINFO ASSIA and COPAC, supported by other databases and over-views in subject-specific books, journals and articles, such as www.musictherapyworld.net, ‘The Arts in Psychotherapy’, ‘The British Journal of Psychotherapy’, journals of modality specific professional associations such as ‘The British Journal of Music Therapy’, ‘The Journal of Art Therapy’, ‘Dramatherapy’, ‘E-Motion’, ‘The

¹⁴ However, it is worth bearing in mind that in Holland, arts therapies are represented by the Dutch Association for Creative Therapy (*Nederlandse Vereniging voor Creatieve Therapie*) as described by Smeijsters (1993) and that an integrated approach was described by Speiser (1996) in Sweden and Scandinavia.

Nordic Journal of Music Therapy’, ‘Occupational Therapy International’, and journals focussing on specific areas of special need, such as ‘The Journal of Dementia Care’.

The research reviews were limited to samples of works published since the year 2000, carried out by practitioners who have received formal training in their arts therapy modality, as it was felt that as such research was a constantly changing and developing field, with new material being added on a daily basis, and that earlier meta-analyses and reviews had now been superseded by, and subsumed into, more recent studies.

Conclusions of these searches

36 examples of systematic reviews were studied, set within a wide range of practices, from collective meta-analyses to individual randomised controlled trials and case-study research. *(See following pages for tables of comparison of arts therapies research reviews).*

COMPARISON OF ARTS THERAPIES RESEARCH REVIEWS

Table 3a) The use of a specific modality of arts therapy with all types of disability

Author(s)	Year	Title	Publisher	Type of Trial	Modality of Art Form	Conclusions
Reynolds, M.W., Nabors, L., Quinlan, A.	2000	<i>The effectiveness of art therapy: does it work?</i>	Art Therapy. Journal of the American Art Therapy Association. Vol. 17(3) 207-213	Varied study designs	Art	<ol style="list-style-type: none"> 1. According to the authors, 5 of the 8 studies showed significant improvements in the primary outcome, whilst the remaining 3 trials showed mixed effects. 2. However, the reviewers state that the data suggest that there is little evidence to support the notion that art therapy is more effective than other interventions, or even that it is more effective than no intervention or usual care. 3. The authors state that there is a need for studies with larger sample sizes, and for cost benefit studies.
Maujean, A., Pepping, C.A., and Kendall E	2014	<i>A Systematic Review of Randomized Controlled Studies of Art Therapy</i>	Art Therapy: Journal of the American Art Therapy Association. Vol.31, Issue 1.	Randomised Controlled Studies	Art	<ol style="list-style-type: none"> 1. All but one study reported beneficial effects of art therapy. Art therapy may benefit a range of individuals, including older adults, war veterans, and prison inmates. 2. There is a need for further research using RCT's to examine more conclusively art therapy outcomes and the specific populations in which art therapy interventions offer greatest benefit.

<p>Koch, S., Kunz, T., Lykou, S., Cruz, R.</p>	<p>2014</p>	<p><i>Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis</i></p>	<p>The Arts in Psychotherapy Volume 41, Issue 1: 46–64</p>	<p>Meta analysis of varying approaches</p>	<p>Dance Movement</p>	<ol style="list-style-type: none"> 1. This study examines the current state of knowledge regarding the effectiveness of DMT and dance from 23 primary trials ($N = 1078$) on the variables of quality of life, body image, well-being, and clinical outcomes, with sub-analysis of depression, anxiety, and interpersonal competence. 2. Results suggest that DMT and dance are effective for increasing quality of life and decreasing clinical symptoms such as depression and anxiety. 3. Positive effects were also found on the increase of subjective well-being, positive mood, affect, and body image. 4. Effects for interpersonal competence were encouraging, but due to the heterogeneity of the data remained inconclusive. 5. Methodological shortcomings of many primary studies limit these encouraging results and, therefore, further investigations to strengthen and expand upon evidence-based research in DMT are necessary. 6. Implications of the findings for health care, research, and practice are discussed.
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Bräuninger, I.	2014	<i>Specific dance movement therapy interventions – Which are successful? An intervention and correlation study</i>	Arts in Psychotherapy, Vol.41. Issue 5.	Analysis of 70 intervention checklists on individual and 120 on group DMT interventions.	Dance Movement	<ol style="list-style-type: none"> 1. Specific DMT interventions could be identified that relate to the improvement of well-being. 2. Dance improvisation, spatial and effort synchrony, and working with a focus were effective individual DMT interventions. 3. Improvement of QOL, coping, stress with psychodynamic, Chace DMT, directive-non-directive leading and interpersonal closure. 4. A small number of specific DMT interventions should be used cautiously until further research proves their effectiveness.
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COMPARISON OF ARTS THERAPIES RESEARCH REVIEWS

Table 3b Specific modality of arts therapy with a specific disability

Author(s)	Year	Title	Publisher	Type of Review	Modality of Art Form	Conclusions
Ruddy, R. and Milnes, D.	2009	<i>Art Therapy for Schizophrenia or schizophrenia-like illnesses</i>	Cochrane Database of Systematic Reviews, Issue 4. No. CD003728, DOI	Randomised Controlled Trials	Art	<ol style="list-style-type: none"> 1. Not enough participants 2. Unclear conclusions 3. More research needed
Deshmukh, S.R., Holmes, J., Cardno A.	2014	<i>Art therapy for people with dementia</i>	Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No: CD011073.	Randomised Controlled Trials	Art	<ol style="list-style-type: none"> 1. This is the protocol only for a review. There are no conclusions yet.
Bradt, J, Goodill, S.W., Dileo, C.	2011	<i>Dance/movement therapy for improving psychological and physical outcomes in cancer patients</i>	Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD007103.	Randomised Controlled Trials	Dance Movement	<ol style="list-style-type: none"> 1. No support for an effect of dance/movement therapy on body image. 2. The findings of one study suggest that dance/movement therapy may have a beneficial effect on quality of life. 3. However, the limited number of studies prevented drawing conclusions concerning the effects of dance/movement therapy on psychological and physical outcomes in cancer patients.
Meekums. B., Karkou, V., Nelson, E.A.	2012	<i>Dance movement therapy for depression.</i>	Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No:CD009895		Dance Movement	<i>This Cochrane Review is at the protocol stage and there is no abstract or plain language summary.</i>
Ren. J., Xia, J.	2013	<i>Dance therapy for schizophrenia</i>	Cochrane Database of Systematic Reviews, Issue 10. Art. No.: CD006868	Randomised Controlled Trial	Dance Movement	<ol style="list-style-type: none"> 1. Based on predominantly moderate quality data, there is no evidence to support - or refute - the use of dance therapy in this group of people. 2. This therapy remains unproven and those with schizophrenia, their carers, trialists and funders of research may wish to encourage future work to increase high quality evidence in this area.
Ruddy, R., Dent-Brown, K.	2007	<i>Drama Therapy for Schizophrenia or schizophrenia-like illnesses</i>	Cochrane Database of Systematic Reviews, Issue 1. o.: CD005378	Randomised Controlled Trials	Drama	<ol style="list-style-type: none"> 1. No conclusive findings about the harms or benefits of drama therapy 2. Further research is necessary

Rousseau, C., Benoit, M., Gauthier, M.F., Lacroix, L., Alain, N., Rojas, M.V., Moran, A., Bourassa D	2007	<i>Classroom drama therapy program for immigrant and refugee adolescents: a pilot study.</i>	The Cochrane Central Register of Controlled Trials (CENTRAL) 2012 Issue 3	Randomised Controlled Trial	Drama	<ol style="list-style-type: none"> 1. No reported improvement in self-esteem or emotional and behavioural symptoms 2. However, the adolescents in the experimental group reported lower mean levels of impairment by symptoms than those in the control group, when baseline data were controlled for. 3. Their performance in mathematics also increased significantly compared to that of their control peers. 4. The workshops may have an impact on social adjustment. This drama therapy program appears to be a promising way of working preventively and in a non-stigmatizing manner with adolescents who have been exposed to diverse forms of adversity, among which are war and violence.
Goyal, A. and Keightley, M. L.	2008	<i>Expressive art for the social and community integration of adolescents with acquired brain injuries: a systematic review</i>	Research in Drama Education: The Journal of Applied Theatre and Performance Volume 13, Issue 3, 2008	Varied approaches; case studies: RCT's; qualitative approaches; descriptive and pilot studies	Drama	<ol style="list-style-type: none"> 1. The effects of the drama therapy interventions are improvements in four main areas that include psychological health, emotional intelligence, cognitive functioning, and social integration. 2. Adolescents with ABI's are similar to the populations addressed in the review, but it remains inconclusive if drama therapy could improve the social and community integration of adolescents with ABI's because drama therapy has not been tested on this population in the past and because improved community integration as an effect of drama therapy has not been formally or scientifically indicated in any of the reviewed studies. 3. This review calls for the advanced study of drama-based interventions administered to adolescents with ABIs, specifically for the purpose of formally measuring its effect on their community integration skills in addition to social integration skills.
Jaaniste,J., Linnell, S., Ollerton, R.L., Slewa-Younan, S d	2015	<i>Drama therapy with older people with dementia—does it improve Quality of Life?</i>	Pilot study aimed to evaluate the effect of drama therapy on the quality of life (QoL) of elderly people with mild to moderate dementia, using a mixed method (quantitative and qualitative) approach.	The Arts in Psychotherapy Available on-line December 2014	Drama	<ol style="list-style-type: none"> 1. Although not statistically significantly different, the average QoL-AD score increased for the drama therapy group while it decreased for the movie group. 2. Qualitative findings established an unambiguous participant ability to express ideas and feelings through drama therapy as well as an unveiling of conscious awareness of participants' own wellbeing and QoL. 3. The findings also indicate the potential worth of a future larger study along the lines exemplified here.

Vink, A.C., Bruinsma, M.S., Scholten, R.J.P.M.	2004	<i>Music therapy for people with dementia</i>	Cochrane Database of Systematic Reviews 2004, Issue 3. Art. No:CD003477	Randomised Controlled Trials	Music	<ol style="list-style-type: none"> 1. Ten studies were included. 2. The methodological quality and the reporting of the included studies were too poor to draw any useful conclusions.
Maratos, A., Gold, C., Wang, X., Crawford, M.	2008	<i>Music therapy for depression.</i>	Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD004517	Randomised Controlled Trials	Music	<ol style="list-style-type: none"> 1. Marked variations in methodology meant meta-analysis not possible. 2. Music therapy is accepted by people with depression and is associated with improvements in mood. 3. High quality trials evaluating the effects of music therapy on depression are required.
Guetin, S., Portet, F., Picot M.C, Defez, C., Pose, C., Blayac, J.P., Touchon, J.	2009	<i>Impact of music therapy on anxiety and depression for patients with Alzheimer's disease and on the burden felt by the main caregiver (feasibility study). [Article in French]</i>	<u>Encephale</u> . 2009 Feb;35(1):57-65.	Feasibility Study – Receptive Music Therapy Programme	Music	<ol style="list-style-type: none"> 1. This preliminary study demonstrated the feasibility as well as the initial efficacy of music therapy in terms of its impact on the overall care for patients suffering from Alzheimer's disease. 2. This easily applicable technique can be useful in treating anxiety and depression in a patient with Alzheimer's disease and also in relieving the emotional and physical burden experienced by the main caregiver.
Bradt, J., Magee, W., Dileo, C., Wheeler, B.L., McGilloway, E.	2010	<i>Music Therapy for Acquired Brain Injury</i>	Cochrane Database of Systematic Reviews 2010 Issue 7. Art.No: CD006787	Randomised Controlled Trials and Quasi-randomised controlled trials	Music	<ol style="list-style-type: none"> 1. The results suggest that rhythmic auditory stimulation may be beneficial for improving measures of walking 2. However, there was insufficient information to examine the effect of music therapy on other outcomes. Further clinical trials are needed.
Bradt, J., Dileo C.	2010	<i>Music Therapy for End of Life Care</i>	Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No: CD007169.	Randomised Controlled Trial	Music	<ol style="list-style-type: none"> 1. There is insufficient evidence of high quality to support the effect of music therapy on quality of life of people in end-of-life care. 2. More research is needed in all areas of this work.
Mössler, K., Chen, X., Heldal, T.O., Gold, C.	2011	<i>Music therapy for people with schizophrenia and schizophrenia-like disorders.</i>	Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD004025	Randomised Controlled Trials	Music	<ol style="list-style-type: none"> 1. Music therapy as an addition to standard care helps people with schizophrenia to improve their global state, mental state (including negative symptoms) and social functioning if a sufficient number of music therapy sessions are provided by qualified music therapists. 2. Further research should especially address the long-term effects of music therapy, dose-response relationships, as well as the relevance of outcomes measures in relation to music therapy.

Bradt, J., Dileo, C., Shim, M.	2013	<i>Music interventions for preoperative anxiety.</i>	Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD006908.	Randomised Controlled Trial and Quasi-Randomised Trials	Music	<ol style="list-style-type: none"> 1. This systematic review indicates that music listening may have a beneficial effect on preoperative anxiety. 2. These findings are consistent with the findings of three other Cochrane systematic reviews on the use of music interventions for anxiety reduction in medical patients. 3. Therefore, it is concluded that music interventions may provide a viable alternative to sedatives and anti-anxiety drugs for reducing preoperative anxiety.
Bradt, J., Dileo, C..	2014	<i>Music interventions for mechanically ventilated patients</i>	Cochrane Database of Systematic Reviews 2014, Issue 12. Art. No.: CD006902.	Meta analysis of trials on music intervention by music therapists or medical personal.	Music	<ol style="list-style-type: none"> 1. This updated systematic review indicates that music listening may have a beneficial effect on anxiety in mechanically ventilated patients. 2. These findings are consistent with the findings of three other Cochrane systematic reviews on the use of music interventions for anxiety reduction in medical patients. 3. The review furthermore suggests that music listening consistently reduces respiratory rate and systolic blood pressure. 4. Finally, results indicate a possible beneficial impact on the consumption of sedatives and analgesics. 5. Therefore, we conclude that music interventions may provide a viable anxiety management option to mechanically ventilated patients.
Geretsegger, M., Elefant, C., Mössler, K.A., Gold, C.	2014	<i>Music therapy for people with autism spectrum disorder</i>	Cochrane Database of Systematic Reviews 2014, Issue 6. Art. No.: CD004381	Randomised Controlled Trials	Music	<ol style="list-style-type: none"> 1. Music therapy may help children with ADD to improve their skills in important areas such as social interaction and communication. 2. Music therapy may also contribute to increasing social adaptation skills in children with ADS and to promoting the quality of parent-child relationships. 3. More research with adequate design and using larger numbers of patients is needed. 4. It is important to specifically examine how long the effects of music therapy last. 5. The application of music therapy requires specialised academic and clinical training. This is important when applying the results review to practice.
LaGasse, Blythe, A.	2014	<i>Effects of a Music Therapy Group Intervention on Enhancing Social Skills in Children with Autism</i>	Journal of Music Therapy 5.13 : 250-75.	Randomised Controlled Trial	Music	<ol style="list-style-type: none"> 1. The results of this study support further research on the use of music therapy group interventions for social skills in children with ASD. 2. Statistical results demonstrate initial support for the

						use of music therapy social groups to develop joint attention.
Ayelet, A., Dorit, A.	2014	<i>The Role of Singing Familiar Songs in Encouraging Conversation Among People with Middle to Late Stage Alzheimer's Disease</i>	Journal of Music Therapy 51.2 : 131-53.	Qualitative Study	Music	<ol style="list-style-type: none"> 1. Analyses indicated that conversation related to the singing was extensive and the act of group singing encouraged spontaneous responses. 2. After singing, group members expressed positive feelings, a sense of accomplishment, and belonging. 3. Carefully selecting music from the participants' past can encourage conversation. 4. Considering the failure in spontaneous speech in people with middle to late stage AD, it is important to emphasize that group members' responses to each other occurred spontaneously without the researcher's encouragement.

COMPARISON OF ARTS THERAPIES RESEARCH REVIEWS

Table 3c Use of multiple modalities of arts therapies within all disabilities

Author(s)	Year	Title	Publisher	Type of Review	Modality of Art Form	Conclusions
Snow, A., D'Amico, M., Tanguay, D.	2003	<i>Therapeutic Theatre and Well-being</i>	The Arts in Psychotherapy 30. Issue:2. 73-82	Review of concept of 'Therapeutic theatre'	All creative arts included within therapeutic theatre work, although drama is main activity	1. Results indicate that this approach has considerable therapeutic value for participants with developmental disabilities, autism, and psychiatric disorder, who show deficits in communication, cognition and social skills.
Upmale,A., Martinsone,K., Vaverniece, I., and Vende, K.	2012	<i>Patient Groups in art therapies: A Case study of the health care field in Latvia</i>	SHS Web of Conferences 2, 00036	Conference paper describing use of therapy services in a childrens' hospital over a year	Art, Dance, Music	1. The art and dance movement therapists were working most frequently with clients who had behaviour or emotional disorders. 2. Music therapists were working with clients who had mental retardation.

COMPARISON OF ARTS THERAPIES RESEARCH REVIEWS

Table 3d Use of multiple modalities of arts therapies within a specific disability

Author(s)	Year	Title	Publisher	Type of Review	Modality of Art Form	Conclusions
West, C., Hesketh, A., Vail, A., Bowen, A.	2004	<i>Interventions for apraxia of speech following stroke.</i>	Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD004298.	Randomised Controlled Trials	Multiple	1. There is no evidence from randomised trials to support or refute the effectiveness of therapeutic interventions for apraxia of speech. 2. There is a need for high quality randomised trials to be undertaken in this area. (<i>Although arts therapists work with stroke clients – AF</i>)
Odell-Miller, H., Hughes, P., Westacott, M.	2006	<i>An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems.</i>	Psychotherapy research 16:1. 122-39 Elsevier	Randomised Controlled Trials	Multiple	1. The numerical results were not conclusive owing to high variability and small sample size, but the qualitative data reveal interesting facets of the process (e.g., that the therapists' and patients' perceptions of the treatment coincided in all treatment cases).
Puig, A., Lee, S.M., Goodwin, L., Sherrard, P.A.D.	2006	<i>The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: A preliminary study.</i>	Arts in Psychotherapy Vol. 33. Issue 3. 218:228 Elsevier Inc.	Randomised Controlled Trials	Multiple	1. Intervention was not effective in enhancing the emotional approach coping style of emotional expression or level of spirituality of subjects in this sample. 2. However, participation in the creative arts therapy intervention enhanced psychological well-being by decreasing negative emotional states and enhancing positive ones of experimental group subjects. 3. Recommendations are made for future research.
Madden, J.R., Mowry, P., Gao, D., Cullen, P.M., Foreman, N.K.	2010	<i>Creative arts therapy improves quality of life for paediatric brain tumour patients receiving outpatient chemotherapy</i>	Journal of paediatric oncology nursing. Vo. 27. Issue 3. 133:145	Randomised Controlled Trials	Multiple	1. Future research with a larger sample size is needed to document the impact of incorporating creative arts into the healing process.
Kelly, C. G., Cudney, S., Weinert, C.	2012	<i>Use of creative arts as a complementary therapy by rural women coping with chronic illness</i>	Journal of holistic nursing, USA Vol.30. Issue 1. 48-54	11-week research-based computer intervention	Multiple	1. The use of creative arts and developing art-making interventions could significantly benefit rural individuals coping with chronic illness. 2. Discovering methods of implementing creative arts interventions in rural populations warrants further study.

Boehm, K., Cramer, H., Staroszynski, T., Ostermann, T.	2014	<i>Arts Therapies for Anxiety, Depression, and Quality of Life in Breast Cancer Patients: A Systematic Review and Meta-Analysis</i>	Evidence-Based Complementary and Alternative Medicine Volume 2014 , Article ID 103297,	Randomised Controlled Trials	Multiple	<p>1. This meta-analysis showed that arts therapies seem to positively affect the extent to which breast cancer patients score in anxiety and depression but not quality of life.</p> <p>2. Recommendation that in breast cancer patients the option of participation in arts therapies is suggested and shown to be significantly effective for reduction of anxiety and depression over control.</p> <p>3. Apart from case reports, there are currently only a small number of empirical studies investigating the effect of art therapy on psychological parameters such as coping and quality of life accompanying the breast cancer diagnosis and treatment.</p>
Puetz, T.W., Morley, C.A., Herring, M.P.	2013	<i>Effects of creative arts therapies on psychological symptoms and quality of life in patients with cancer</i>	JAMA Internal Medicine 173(11):960:969.	Randomised Controlled Trials	Multiple	<p>1. Creative arts therapies could reduce the symptoms of anxiety, depression and pain, and improve quality of life, for cancer patients after treatment, but the effects were reduced at follow up.</p> <p>2. Reviewers suggest that the conclusions should be treated with caution given concerns over methodology.</p> <p>This article was criticised by Bradt and Goodill (2013) as not offering a definition of creative arts therapies, using it to cover interventions either by qualified or non-qualified arts therapists or arts volunteers. An absence of definition compromised the analysis at its foundation.</p>
Sterz C, Heimes S, Blessing T, Flachenecker P	2013	<i>Creative arts therapy improves quality of life in MS - Results of a randomized controlled trial during inpatient rehabilitation.</i>	Neurologie und Rehabilitation Vol.19.Issue 3. 176:182 Germany. Hippocampus Verlag	Randomised Controlled Trials	Multiple	<p>1. Creative arts therapy improves Quality of Life in Multiple Sclerosis, with particular effects on mood, self-efficacy, social behaviour and fatigue. 2. It may also have influence on the creation of coping strategies. This needs to be determined in further studies.</p>
Zubala, A., MacIntyre, D.J., Gleeson, N., Karkou, V.	2014	<i>Description of arts therapies practice with adults suffering from depression in the UK: Qualitative findings from the nationwide survey</i>	The Arts in Psychotherapy Elsevier. In Press Oct. 2014	On-line Structured Interview to Arts Therapies Survey was conducted in	Multiple	<p>1. Arts therapists struggled with the tension of providing care according to guidelines, which they found inflexible and at times misguided. Therapists tended to vary the theoretical model of their therapeutic approach depending on individual client factors and often collaborated</p>

				the UK in 2011; 395 arts therapists participated.		with other professionals using a variety of standardised tools to measure outcomes. 2. The findings further offer a detailed understanding of the therapeutic process and describe the meaning of clinical practice within arts therapies.
Van Westrhenen, N., Fritz, E.	2014	<i>Creative Expressive Arts Therapy as treatment for child trauma: an overview</i>	The Arts in Psychotherapy Elsevier. In Press Oct. 2014	Meta-analysis of 38 research studies	Multiple	1. The majority of articles reported their findings narratively, with a lot of emphasis placed on the process followed. 2. It was recommended that therapist should work closely with researchers to make creative arts therapies less of an outlier in the therapeutic approaches for traumatized children.

Study of these tables revealed that reviews fell into four categories:

Table 4

Subject of Review	No. of Reviews studied
<i>The use of a specific modality of arts therapy with all types of disability</i>	4
<i>The use of a specific modality of arts therapy within a specific disability</i>	20
<i>The use of multiple modalities of arts therapies with all types of disability</i>	2
<i>The use of multiple modalities of arts therapies within a specific disability</i>	10

Analysis of 36 research reviews studied

This appears to show that researchers prefer to work within the field of specific disability, using one modality, or multiple modalities, in preference to working within all types of disability. This might indicate that the subject of the present research is attempting to cover too wide a subject area. However, as this is the question posed on an almost daily basis within the Centre, it was seen to be a valid question, the answer of which would provide valuable guide-lines for future practice.

When analysing the tables further, it appears that the art and dance movement modalities are more represented within the field of the use of a specific modality with all types of client, but that over all, the use of the music modality is more widely represented than the other modalities, especially in the type of review using a specific modality within a specific disability.

Table 5

Type of review	Modality	Number of Reviews
Specific modality with all types of clients	Art	2
	Dance Movement	2
	Drama	0
	Music	0
Specific modality within a specific disability	Art	2
	Dance Movement	3
	Drama	4
	Music	11

Which modality favoured which type of research

However, on closer investigation of the tabled results, it appears that while many studies noted some positive outcomes of arts therapies interventions, almost no research had been conducted without a number of reservations being expressed by the authors in their conclusions, indicating that there was a need for further investigations into the chosen fields of study, for a variety of reasons:

- Some studies are only a pilot, protocol or feasibility study, preparing the way for further research: Guetin et al., (2009); Meekums et al.,(2012); Deshmukh et al., (2014).
- The studies had been conducted with an insufficient number of sample sizes: Reynolds et al., (2000); Odell-Miller et al.,(2006); Ruddy and Milnes (2009); Madden et al., (2010); Bradt et al., (2011); Geretsegger et al., (2014).
- Methodological quality of reporting of included studies were ‘too poor to draw useful conclusions’: Vink et al., (2004) or ‘conclusions are unclear’: Ruddy and Milnes (2009) or ‘results should be treated with caution, given concerns over methodology’: Peutz et al.,(2013)¹⁵.
- Marked variations in methodology meant that meta-analysis was not possible: Odell-Miller et al., (2006); Maratos et al., (2008).
- There is a need for outcomes and specific populations in which art therapy interventions (*and other modalities – AF*) offer greatest benefit : Maujean et al., (2014).
- Methodological shortcomings of many primary studies limit results, even if these results are encouraging: Koch et al., (2014); Geretsegger et al.,(2014), the majority of articles reported their findings narratively, with a lot of emphasis placed on the process followed. It was stated that therapists should work closely with researchers to make creative arts therapies less of an outlier in therapy approaches: Van Westrhenen and Fritz (2014).

¹⁵ This article was criticised by Bradt and Goodill (2013) as not offering a definition of creative arts therapists and using this term to cover interventions either by qualified or non-qualified arts therapists or arts volunteers. They reported that an absence of definition compromised the analysis at its foundation.

- A small number of specific dance movement interventions should be used cautiously until further research proves their effectiveness: Bräunigger (2014).
- Further high quality evidence is needed: Maratos et al., (2008); Bradt and Dileo (2010); Ren and Xia (2013); this should include long-term effects of the intervention, dose-response relationships and relevance of outcomes measures: West et al., (2004); Mössler et al., (2011); Geretsegger et al., (2014).
- No conclusive findings about the harms or benefits of the modality have been found; further research is necessary: Ruddy and Dent-Brown (2007).
- More advanced study is necessary of specific effects: Goyal and Keightley (2008).
- The findings, although positive in certain areas, indicate potential worth of further, larger clinical trials: Puig et al., (2006); Bradt et al., (2010); Kelly et al., (2012); Sterz et al., (2013); Jaaniste et al., (2014); LaGasse and Blythe (2014); Boehm et al., (2014).
- Arts therapists struggled with the tension of providing care according to guide-lines, which they found inflexible and at some times, misguided: Zubala et al., (2014).
- Some therapists tended to vary the theoretical model of their therapeutic approach depending on individual client factors and often collaborated with other professionals using a variety of standardised tools to measure outcomes: Zubala et al., (2014).

Positive reviews include:

- The programme (dramatherapy) appeared to be a promising way of working preventively in a non-stigmatizing manner with this specific client group: Rousseau et al., (2007)
- This systemic review indicated that music listening may have a beneficial effect on pre-operative anxiety, as a viable alternative to the use of sedatives and anti-anxiety drugs: Bradt et al., (2013); this also applies to mechanically ventilated patients: Bradt and Dileo (2014).
- The review of the use of music (singing) with patients with middle to late stage Alzheimer's Disease reported a number of positive aspects of the therapy, such as

spontaneous responses, a sense of accomplishment and belonging, and encouraging of conversation without the researcher's encouragement: Ayelet and Dorit (2014).

- Therapeutic theatre has considerable value for participants with developmental disabilities, autism and psychiatric disorders, who show deficits in communication, cognition and social skills: Snow et al., (2003).
- The findings offered a detailed understanding of the therapeutic process and described the meaning of clinical practice within arts therapies: Zubala et al., (2014).

Further comments:

- Specialised academic and clinical training is important when applying the results of the review to practice: Geretsegger et al., (2014).
- Within therapy services in a Children's hospital in Latvia, it was shown that art and dance movement therapists were working most frequently with clients who had behavioural or emotional disorders, while music therapists were working with clients who had mental retardation: Upmale et al., (2012).
- The therapists' and patients' perceptions of the treatment coincided in all treatment cases in this review: Odell-Miller et al., (2006)
- It is interesting to note that Boehm et al (2014) also suggest that arts therapies are made use of especially by motivated patients who want to participate actively in their healing process, while a study found in a large New Zealand health survey which sampled 12,529 people, aged 15 years and older, being established users of complementary or alternative therapies, were more likely to be middle aged, rich, well educated, of European descent and female (Pledger et al., 2012).

From the search of Cochrane reviews of randomised control trials and other studies, it appears therefore, that although there are reports concerning the effectiveness of one particular therapy in a given context, the comparison of effectiveness of individual modalities with specific illnesses or special needs has not been undertaken. This may well be because the subject matter would be considered too diverse and would not be seen immediately to fall into any specific methodological research paradigm. If such a report(s) were to exist, it would have formed the basis of operation for the Centre as a protocol for referral, rather than the

allocation of clients to services described by Thompson and Blair (1998), who suggest that the use of the creative therapy services seem to be on a somewhat *ad hoc* basis, with unclear rationales for why one particular therapy is chosen over another and that greater attention should be concentrated on finding out which specific creative arts are best used in a particular set of circumstances. This view is supported by Mackenzie (2013), who found in her review of available literature, that the benefits of the arts therapies were more often described individually than assessed collectively and that few comparative studies had been conducted in this field.

In the wider field of psychotherapy services generally, the Review of Strategic Policy in England, made on behalf of the NHS by Parry and Richardson (1996), some emphasis is made of the notion of matching diagnosis with treatment modality. However, it is also stated that this is an area which needs further research and debate. In addition, even although arts therapies are later classified as one of the psychological therapies (DoH, 2007 and DoH, 2012), there still appears to be recognition that further research needs to be made into the improvement of the effectiveness of the different psychological therapies (Burstow, 2011).

This supports an earlier opinion offered by Beutler et al., (2002), who suggest that the sheer number of disorders and variation of client idiosyncracies makes it improbable that disorder-specific, manualised treatments will become a viable way of deciding which treatment should be allocated for which client, except in a small number of the most common disorders. Gaffari and Caparrotta (2004), however, also state their belief that experience in general psychiatric (therapeutic) setting and within a multidisciplinary context is fundamental to a sensitive diagnostic assessment, which they consider to be necessary for an appropriate choice of treatment.

Summary of findings in relation to the current study

The review of literature has considered the nature and history of arts modalities and their use in what has now become termed ‘arts therapies’ interventions, providing much evidence on which to base the current enquiry. However, as (Jones, 2005, p. 221) points out: ‘It is not as if there is one approach that dominates the arts therapies as a whole, nor even a single

approach within one modality such as art therapy or music therapy.... The range of the conditions and situations that clients bring to arts therapy need to be met as closely as possible by the most appropriate ways of understanding efficacy.’ This comment resonates with those of Fernando (2010), when he suggests that mental health is a very personal matter and can never be defined in exactly the same terms for any two people. In addition, in his comprehensive commentary on articles comparing the varying paradigms used within the creative arts therapies of trauma, Johnson (2009) examines the conflicting trends which seem to be at work in therapy practice. However, although describing each approach in detail, there is no mention in any of these writings of which arts therapy is recommended for any one particular client.

Even within a single modality such as art therapy, Gilroy and Tipple (2012) state that generally speaking, British authors are not explicit about which clients with what diagnosis, problems or conditions are suitable for art therapy, nor have they specified who might benefit from a particular treatment approach within this modality.

Smitskamp (1995) states that it might also be argued that when presented with any arts therapeutic situation – in a room filled with musical instruments, or an art studio filled with available materials – most clients will understand that an artistic response is expected, only being hampered by possibly perceived fear of making a mistake, or of appearing to be clumsy. However, this statement presupposes that an initial choice has already been made to ascertain which modality is most suited to the client, without discussing how this decision has been reached.

The closest approach to the question posed in the current thesis was found in Pulliam et al., (1988), in which a method of assessment was adopted which utilised three arts therapists – one in each of the art, music and dance modalities, in each group assessment of clients at West Oaks Hospital in Houston, Texas. Over the course of two sessions, each therapist conducted activities in their own discipline within the sessions, focussing on different areas of assessment. At the end of these sessions, the therapists processed the data collected in intrapsychic, object relations, family dynamics and group dynamics data, jointly reviewing each client’s use of, and response to, each of the three modalities. Finally, recommendations for

treatment were decided, based on all of the information presented. However, as in the study by Mackenzie (2013) the assessments are used to gain greater insight into the client's mental state, rather than indicating why one particular modality for further treatment should be chosen.

In addition, as Pulliam et al., discuss, there are weaknesses inherent in this 3-modality model, namely the fact that there is no time in the music activities to learn of the client's musical history and background, which may often be a helpful prediction the usefulness of music therapy. Likewise it is difficult for the art therapist to learn much about the client's graphic development. Pulliam et al., do, however, argue that it is seen as advantageous that three therapists are involved, who may balance each other's views. Sometimes the same factors or trends seen in one modality appear in another - the converse also being true. The authors are also interested to note a new factor in the assessment process, namely the clients' reactions to the differing personalities of the three therapists, including male/female issues, as often the therapists are all female, while the clients may be male. However, it is stated that a strength of their method is that, unlike the verbal quality of other assessments, the Expressive Arts Group Assessment accesses material non-verbally, which method is seen by physicians as a helpful diagnostic tool.

In this assessment method, it may be observed that the therapists may allow the client (or *direct* the client) to use varying modalities within the assessment session, which allows greater insight into the client's psyche and 'problems', leading to focus / aims for 'treatment'. However this appears to be the reverse of the present research question, which is: 'If one already knows the presenting symptoms of a client (especially as described in their referral notes), can one infer what therapy should be used to facilitate progress in combating these problems?' Even the final comment of the authors is that although they have a working model of assessment, it is still in a stage of development that should be further advanced.¹⁶

Overall, it was hard to find any literature that related to the specific content of the present study, namely the comparison of the effectiveness of one modality against another, in relation

¹⁶ *There is no mention of a dramatherapy intervention in this method of assessment*

to a specific client base. The closest reference to this concept was found in Boehm et al., (2014), in their meta-analysis of studies of the effectiveness of the use of arts therapies for anxiety, depression and quality of life in breast cancer patients; they state that the arts therapist often needs to intervene in very different ways with each patient as well as sometimes in each session.. They continue:

‘Since this review could not show a positive effect of art therapy on quality of life, what needs to follow is **a comparative discussion of different intervention strategies according to phase of treatment in particular**. In phases of great physical strain relaxation, oriented listening to music in receptive music therapy can result in fast effects, while those of a more confronting theme oriented intervention in visual art therapy possibly can be shown only in a longer interval’.

(No page numbers given in original on-line text)

The reviewers here, however, appear to be suggesting that it should be the same therapist who is able to ‘intervene in very different ways’ (an expressive therapist), rather than there being different therapists involved, each being able to offer interventions in their own modality (creative therapists), which is the situation in the present study.

Nevertheless, the concept of flexibility of approach and the offering to the client of different modalities according to nature of the referral in this study by Boehm et al., (2014) is conceptually closer to the present research question than any other approaches mentioned previously. Here it can be seen that the authors recognise that different strategies of arts therapies interventions should be offered to clients, according to their current stage of treatment and mental state of mind, although the text quoted refers to both active and passive participation in arts therapies sessions, whereas the present study focussed on active involvement of the client(s) in the sessions. However, the above authors do not go as far as to question which of the four arts therapies modalities is the most appropriate for any particular client and what the reasons are for this decision.

It is this apparent lack of such studies that has prompted the present research, although paradoxically, it is this very flexibility of approach which gives rise to difficulties in evaluating the effects of arts therapies, as in seen in the following chapter of this study.

CHAPTER 3 – METHODOLOGY AND PRACTICAL DESIGN

Introduction

The current chapter will begin with consideration of the varying paradigms which informed the choice of the methodology and current research design, because, ‘If you can’t define it clearly, you cannot... measure it validly’ (Ebel, 1975, p.84). This is followed by discussion of ethical protocols related to such a study; commonalities and differences between the four arts modalities employed; a description of the practical design of the programme, including the practical design of the project methods adopted for evaluation; the proposed structured interviews and considerations concerning the methodology of the research, such as the possible conflicting interests of researcher and clients, validity, reliability, bias and limitations of the research.

Methodology

Requirements of appropriate research design

Research into arts therapies has been undertaken for many years, being essential, alongside underpinning rationale, to provide a base for and strengthen the clinical practice of arts therapies. It was suggested by Gaston (1968) that theory, clinical practice and research form a tripod, each necessary for the other to stand. As the researcher investigates the relationships between the three elements of theory, practice and research, it becomes apparent that research is dependent on theory, whether initially or as a result of the research carried out. The result of good research based on theory leads to the achievement of improvement of arts therapies practice.

Feder and Feder (1998) suggest that changes will occur for a client whether or not they are in therapy. The issue for the arts therapist is to be able to recognize and identify the nature of the changes and to know with some assurance, the degree to which such changes are the direct result of the intervention and not coincidental with it. The present research design should

establish not only whether change has occurred as a direct result of the arts therapies intervention and to what degree, but also which modality of art form appeared to have been the most efficacious in facilitating any observed change.

Determining the research design and underpinning rationale

Wheeler (1995) postulates that methods of arts therapies research are generally part of a larger conception of research, with particular adaptations to the needs of the arts modalities and arts therapies. Original paradigms developed by researchers in other fields such as social sciences, psychology, education and sociology have then been applied to the field of arts therapies, in which the use of the creative arts processes and artistic relationships contained within an interpersonal, clinical context are studied. A number of these paradigms are now discussed, a comparison of which led to the methodology adopted for the current research question.

The Quantitative perspective

In the process of identifying an appropriate methodology to be adopted, it was questioned whether a quantitative or qualitative approach would be more appropriate - whether the investigation should be viewed from a Positivist or Non Positivist stand-point. Bruscia (1995), in discussion concerning the definition of positivism and its relevance to music therapy research, states that to the positivist, absolute truth and reality exist in the form of immutable laws and mechanisms of nature. Research can reveal the truth and the way things really are by discovering time- and context- free generalisations, the primary purpose of such a stand-point being to explain phenomena in terms of cause-effect relationships. Bruscia also suggests that the positivist holds that discoveries of science may be additive; thus, each research finding adds a fact to a general repository of human knowledge about the real world and that findings can be generalised from one setting to another in a value-free manner. Feder and Feder (1998) add that because of this generalisation, given appropriate methods, it is possible to control and predict human behaviour in a manner similar to the expectations of animal and plant behaviour. Through the use of quantitative methodology involving measurement and

evaluation, biologists, physicists and other scientists can control and predict actions of inanimate objects.

For the therapist, the necessity of approaching research questions in this way could be both an advantage and disadvantage. Acceptance of such an approach might lead to cross-professional work between therapists and colleagues from other disciplines. However, this form of research might also result in the disregarding of characteristics of the client-therapist relationship, regarded by qualitative researchers as basic to the process of therapy. Aigen (1993) suggested that reliance on research paradigms such as those established in psychology and the biological sciences, may have limited usefulness when used for evaluating actual clinical music therapy techniques involving improvisation and other creative process.

Indeed, Feder and Feder (1998) hold that the very concept of the objectivity associated with a quantitative approach is suspect to those who use qualitative methods. It does not necessarily follow that findings from one situation may be generalised into other similar contexts, although if studied in broader contexts, it may be possible to observe trends of behaviour patterns which may make future behaviour predictable. There will always be, however, exceptions to the norm. Quantitative research methodologies, therefore, became less favoured amongst some arts therapists, because of the emphasis on the inter-relationship between the individual personalities of therapist and client in the arts therapies process.

The majority of medical research is based on the positive approach and in the early years of arts therapies research (the late 1980's and 1990's), arts therapists tended to adopt this framework, employing methods already established within the practices of psychology, the behavioural sciences, medicine and other clinical practices, on which to base their research (Bunt and Hoskyns, 2002). By validating their work in such a manner, it may have been felt by the arts therapists that colleagues in a medical work-place context could understand and also accept the powerful value of the modality (arts forms) being used (Bergström-Isacson, 2008), thereby increasing support for their work as part of accepted medical practice. However, as already suggested by Aigen (1993), Wheeler (2005) concluded that quantitative research methods when used in music therapy, are ineffective in answering the questions most relevant to clinicians.

The present researcher therefore concluded that the present research should make use of quantitative methodology in part, but that qualitative approaches should also be utilised. This would provide greater insight into the inter-personal relationships engendered by the arts therapies sessions, together with a clearer understanding of the characteristics of the arts modalities through which the sessions are facilitated and their role in assisting achievement of the aims for the clients' referral.

The Qualitative perspective

In contrast to the quantitative, the qualitative, non-positivist approach states that all discoveries are bound to the time and context of the enquiry. It is not possible to separate cause and effect, as all entities are in a constant state of reciprocal influence.¹⁷ Non-positivists believe that it is essential to take into account the interaction between the researcher and the participant(s) being studied; not all that is important can be reduced to measurements (Wheeler, 2005). This implies that findings cannot be generalised beyond the context in which they are discovered, values being inherent in, and central to, any investigation. Qualitative enquiry is necessarily personal; the researcher becomes the instrument of enquiry. 'The personal and interpersonal nature of qualitative enquiry is its great strength, a source of direct, experiential insight. It is also what sparks controversy among those whose very definition of research involves excluding the personal and interpersonal as potential sources of bias.' (Patton, 2015, p.xiv).

As the process of arts therapies intervention and the nature of the current research involved the personalities and interaction of clients, therapists and referrers, together with analysis of the therapy process – the identification, classification and explanation of patterns, recurrences, themes and regularities that could be observed in the clients' responses to the four arts modalities' processes – the qualitative paradigm appeared to be specifically relevant to the present study.

¹⁷ *As in an arts therapies session*

Action Research, Practitioner Research and Evaluation Research

Consideration of the qualitative research paradigm, led to investigation of varying methods of research, such as Action Research, Practitioner Research and Evaluation Research, and their possible utilisation as a basis for the design for the present study.

According to Bulmer (1978), Action Research seeks to engage the researcher in active involvement in bringing about change, usually in specific projects, in which achievement of improvement and involvement are described as being central. There is, firstly, the improvement of a *practice* of some kind; secondly, the improvement of the *understanding* of a practice by its practitioners; and thirdly, the improvement of the *situation* in which the practice takes place (Robson, 2002). Collaboration between researchers and those who are the focus of the research, and their participation in the process, are typically seen as central to action research. This approach involves self-reflective enquiry undertaken by participants in social situations (Robinson and Reed, 1998).

Currently, action research is being used in such areas as racial issues, health, education and women's rights. The researcher becomes an activist – perhaps in helping local people gain community facilities. The people involved are turned into researchers themselves, in the belief that people learn best, and apply more willingly what they have learned, when they do it themselves (O'Brien, 1998). Those being researched become part of the research process, learning new skills and having their awareness raised as part of a conscious empowerment or quality enhancement strategy. For example, a nursing team may use action research to evaluate an aspect of care delivery, making appropriate changes, as the need for these is identified. The personal characteristics and perspectives of the researcher are also regarded as part of the research and debate is centred on other issues such as empowerment of the researched, involvement in changing society and commitment to using a variety of methods in any investigation.

The terms Participatory Research (Park, 1993) or Participatory Action Research (Selener, 1997) are also used to describe similar approaches to research, such as in a report by Bennett and Roberts (2004) into poverty in the UK, in which the researchers focus on the participation

of people with direct experience of poverty and their experiences. Such an approach respects the expertise of such people, resulting in them having more control over the research process and more influence over how findings are used. Such people are regarded as having both this expertise in the matter of poverty and also the right to be involved. By including such people, the effectiveness of the research becomes more effective and the understanding of poverty and national policy impact is deepened.

These three approaches, however, were not seen as mirroring the focal point of the present study. In the examples quoted above, the participants become part of the research process and of its subsequent development, unlike the current project being studied, in which the comments of the participants concerning their responses to the various therapeutic interventions were indeed sought, but did not – at the time of the intervention – influence the actual method of delivery by the therapists. If delivery of future programmes of therapy were to be based on clients' experiences and opinions of current therapy programmes, leading to changes being made to these programmes, which were then, in turn, analysed and used to modify future programmes, then Action Research might indeed have been seen to be appropriate. The present study, however, was not aiming to modify actual delivery of therapy programmes, but rather to define, if possible, which appeared to be most beneficial for which type of client and therefore, which should be recommended for initial assessment processes.

Practitioner Research, in which research into a professional situation is carried out by the practitioners themselves¹⁸, appeared initially to describe more closely the methods being undertaken in the current programme. The aim of this method is to follow a research process, the outcome of which will inform practice within a specific clinical setting (that is, the setting in which the research actually takes place). However, as results may not be generalisable, because they are specific to only one setting, it appeared that practitioner research was not an appropriate method for the present study, which hopes to be able to discover guidelines for application on a wider basis than just the context of the original locations.

¹⁸ *In the present study, by the researcher and by the therapists*

Evaluation Research in greater detail

In the first of his books on qualitative methods in evaluation, (Patton, 1982) describes evaluation research as involving the systematic collection of information about the activities, characteristics and outcomes of programmes, personnel and products to be used by nominated groups of people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programmes, personnel, or products are doing and affecting. Aims for the evaluation can be to discuss whether or not a programme meets the needs of those taking part, evaluating the effectiveness and appropriateness of an innovation or programme in a specific setting, making use of both flexible and fixed research strategies. This practice covers the need for systematic information collection within the present research and the fact that, to achieve the aim of providing future guidance for arts therapist practitioners, the evaluation will be used to inform future therapy programmes. Within this method, unplanned or unanticipated outcomes or processes might also emerge during the course of evaluation.

In addition, Patton states that evaluation research can, and does, make use of both flexible and fixed research strategies. It can target such questions as whether or not a programme meets the needs of those taking part. The flexibility in design and execution of the case study, together with the fact that most evaluations are concerned with the effectiveness and appropriateness of an innovation or programme in a specific setting (i.e. that it is a 'case', rather than a sample), makes the case study strategy appropriate for many evaluations. The current study did attempt to draw conclusions from consideration of a variety of individual/group cases in varying contexts.

This description of evaluation research is echoed by (Robson, 2002 p.459) who states that evaluation research is '... a study which has a distinctive purpose; it is not a new or different research strategy. The purpose is to assess the effects and effectiveness of something, typically some innovation, intervention, policy, practice or service. Fixed or flexible designs can be used, with either quantitative or qualitative methods, or some combination of both types'. Bruscia (2005) confirms this definition when he states that evaluation research focuses on the resulting change in the client. The main concern of evaluation research is to demonstrate the outcomes or effects of the therapy intervention.

Evaluation always starts with some base-line value, explicit or implicit – for example, it is good to live a long time; then a goal is formulated derived from this value... for example, that fewer people should develop coronary disease (Suchman, 1967). It was planned that in the current research, stages of the evaluation process would consist firstly in defining the base-line, namely a description of current processes of arts therapies intervention.¹⁹ This would be followed by defining a goal-attaining activity – in the current study, namely the programme of arts therapy sessions, designed to address the question posed by this research. The sessions would then be put into operation. At the end of the programme would come the assessment of the programme, which would include evaluation of the degree to which it had achieved the pre-determined aims.

Within the current research, the discussion of outcomes concerned whether a method could be formulated by which potential clients could be advised as to which arts therapy programme might be the most appropriate for them in order that they might achieve their personal aims / reasons for referral. From conclusions reached, new values may be set, or old values re-affirmed, re-assessed or re-defined, which would equate to setting new guidelines for future operation in the Centre. It might also provide a basis for advising a wider, more generalised method of practice within the arts therapies. Of all the methods discussed above, evaluation research seemed to come closest to the nature of the present study. This method therefore formed the basis of the qualitative approach to the current research.

Possible drawbacks of use of Evaluation Research

Drawbacks of this method include the fact that there will be no possibility of believable controls or randomisation. In the research, as already stated, it will not be possible to compare clients who have undergone the programme of intervention with a control group who have not – or who have undergone alternative forms of therapy. This might be possible if greater time and resources were available, but even then, it would be difficult, if not impossible, to find exact control groups.

¹⁹ See Chapter 2

It was estimated that the numbers of clients expected to participate in the programme (about 100) would not be very large, but according to the statistician who was offering support for the analysis of the results, this number was adequate to provide reliable results. It might be possible that future studies could explore continuation of the current research, by re-defining contexts such as limiting certain parameters of the study, focusing on a specified type of client disability, age group or specific clients' aims.

Utilisation of both Quantitative and Qualitative approaches

The opposing characteristics of quantitative or qualitative paradigms posed a dilemma in the search for methodology for the current research, as one of the aims of the study was to establish whether these results could be replicated by using the same methodology, using a different client sample.²⁰

Such an aim for the current methodology might suggest that a quantitative, positive approach would be the more appropriate paradigm to follow. It was particularly felt by the researcher that quantitative data in the form of numerical evaluation of sessions would highlight not only success or otherwise of the stated aims of the sessions, but also would allow for comparison of individual factors such as the varying modalities employed. In contrast, however, it has appeared from historical professional experience in the field of arts therapies, that individual factors inherent in each situation would make it unlikely that consistent results could be expected from one therapy experience to another and that the experiences of each situation would be unique.

However, (Patton, 2015, p.316) states that: 'Studies that use only one method are more vulnerable to errors linked to that particular method (e.g. loaded interview questions, biased or untrue responses), unlike studies that use multiple methods, in which different types of data provide cross-data validity checks.'

²⁰ For example would current results establish that an autistic male child aged 7yrs., with a given set of aims for the therapy, would always benefit most from, say, an art therapy programme. This result could then be applied to a future, more restricted, study.

As both quantitative and qualitative paradigms appeared to contribute procedures which would support the present investigation, the researcher decided that an approach involving both quantitative and qualitative approaches, which would complement each other, should be adopted. A study by Nicholas and Gilbert (1980, p.207) concluded that: '75% of the respondents agreed that quantitative research studies...were not relevant to their daily functioning as music therapists'. Built into the qualitative approach are mechanisms that ensure the relevance of the research product for the intended audience. As one of the three evaluations sought, concerning the efficacy of the therapy programmes, was that of the client: 'The strongest contesters of both these research paradigms are those who argue for research to be emancipatory; that there needs to be a sea change in the power relationship between researcher and researched and to privilege the voice of the disabled.' (Porter and Lacey, 2005, p.x).

This view was supported by Aigen (1995) who stated that because many studies within a music therapy (*or other modality - AF*) context could be studied either quantitatively or qualitatively, it would ultimately be the researcher's interests, preferences and prior research training which would determine the method and research focus. Both types of researchers share standards for formulating research questions, namely the gathering of data, analysing data and initial reporting. However, the use of quantitative methodology exclusively, brings limitations to a domain such as the arts therapies, where factors such as creativity, nonverbal expression and human relationships play an important role.

Many arts therapists see no need to choose between the two paradigms, saying that all research combines elements of each: 'Typically, discussion of the values underpinning research, tend to polarize viewpoints, seeking to make firm distinctions and emphasise differences. The result can be a stereotyping, a caricature of people working within different paradigms. Traditionally a distinction is made between quantitative and qualitative approaches to research but ... there is a need to go beyond simply categorising research with respect to the type of data produced and to look at the underlying philosophy.' (Porter and Lacey, 2005, p.x).

It was the intention of the present study that, as in qualitative research, a broad focus for the inquiry had been identified, which would be refined as the study progressed. It was not possible to identify or define all of the variables which would control outcomes. The intent was to examine the phenomenon openly and as it was, but within an interpersonal context of observed / observer. As discussed below, it was proposed that four arts therapies programmes (one in each modality) would be set up in rotation, in each of ten locations, which would represent a variety of symptomatology and age-groups of client. These would provide, as far as was practically possible, a holistic picture of the phenomenon in all its variations, obtained through observation, interview and the study of artefacts. The studies were being undertaken in an ecological setting, that is, in the therapy room or residential setting of the client, rather than in a laboratory. The phenomenon and its context were inseparable and reciprocal in influence. In all these situations, as far as was possible, the voice of the client played a major part in production and interpretations of results.

In addition, while not being personally involved in practical delivery of the therapy programmes, the researcher was actively involved, after conclusion of each of the practical programmes, in interviewing client / carers / therapists involved, adding personal involvement to interpretation of data. Thus in a qualitative manner, data collected was interpreted using inductive rather than deductive reasoning, that is, the study attempted to explicate whatever realities presented themselves, as viewed by the researcher, rather than directing the search towards specific facts or truths. At such a point, the researcher's personal thinking, feelings and beliefs also became relevant to, and influenced, interpretation of data.

The preceding arguments might be summarised therefore, by suggesting that to use only one of these approaches (quantitative or qualitative) or any of their sub-divisions, rather than a combination of both, would be a violation of the rights of the client to the complete benefits of the therapeutic modality. As Bruscia (1995, p.73) states: 'The positivist and non-positivist paradigms are not two ends or directions on the same road, they are two different roads altogether.... However, there may be places where the roads have converging directions, share the same scenery, road signs, rest stops, or have the same rules. One road is not necessarily better than the other; it all depends on where one is going and how one wants to get there.'

Aigen (1995) confirms this opinion by maintaining that because the qualitative researcher does not invoke the following of a predetermined method as guarantor of truth, a flexible approach to method would not be considered to corrupt research findings. Because it was not possible to specify in advance what would be discovered, it was impossible (as well as inadvisable) to establish a rigid, predetermined research procedure. This might also have implied that not only might the method evolve as the study progressed, but the actual research focus or question might developed in a similar fashion. In fact, the current research question did not vary, but other factors might arise which will influenced the final conclusions reached.

Mixed Method Approach

On the basis of comparison of the above paradigms, the researcher decided to adopt a mixed method approach, utilising both quantitative and qualitative approaches. By giving numerical values to the opinions of managers/teachers (M/T), clients (C) and therapists (Th) as to the success or otherwise of achieving 4 pre-determined aims for each client – which aims would remain constant through the programme – statistical evaluation of the effects of the interventions would be enabled. This data could then analysed with a comparison of different aspects of the sessions, such as the gender of the client, age, special needs, frequency of choice of aims, which aim was deemed to have been achieved the most successfully and by which modality of therapy.

In contrast to the quantitative approach, a structured interview, conducted at the end of the interventions, allowed for qualitative data to be gathered, providing greater insight into the experiences of the three parties involved and facilitating opportunities for personal opinions and reflections of all participants in the programmes to be expressed. Evaluation of responses from structured interviews provided qualitative evidence to support and/or compare with the quantitative results already obtained. Comparison of the two sets of data – quantitative and qualitative – then formed the basis for discussion at the termination of the current project and contributed to the collation of guidance for future practice.

Ethical Protocols

At the time of commencement of the present research, the University of Birmingham did not require specific adherence to a Code of Ethics. As it was necessary, however, to establish that ethical standards were being maintained throughout, the code of ethics of the Health Professions Council (HCPC)²¹ and that of the Association of Professional Music Therapists²² (as being representative of the respective professional arts therapies associations) were adopted as being the codes to which the therapist practitioners and researcher adhered.²³ These codes covered such issues as acting at all times in the best interests of clients, managers/teachers, the therapists themselves and the researcher; respecting issues of confidentiality; the rights, safety, dignity and well-being of all involved in the programme; together with the maintaining of high standards of personal conduct. As re-registration with the HCPC on a bi-annual basis is a requirement of professional qualification to practise, all therapists involved in the research – including the researcher, who was also a professional music therapist – were bound by both codes of ethics throughout the duration of the research programme.

It is now (2015) understood, however, that Ethical Approval granted by the respective Research Ethics Committees (REC) is necessary before commencement of a research programme, in order to ensure that:

- Informed consent from research participants is obtained
- Any potential detrimental effects on participants and researchers are considered
- Indemnity, safeguarding and complaint procedures are in place
- Confidentiality, anonymity and privacy are maintained
- Safe data storage and protection are ensured

Farrant et al., (2011, p.9)

²¹ Now known as the Health and Care Professions Council (HCPC)

²² Now known as the British Association for Music Therapy

²³ See Appendix 2 p. iii and Appendix 3 p. iv for respective Codes of Conduct, Performance and Ethics

Approval by such a committee would cover provision as described by the Mental Capacity Act (2005) for situations in which, for example, clients to be involved in the proposed therapy programme were not able to give informed consent to participate in the research, or to answer for themselves, even if alternative methods of communication such as Makaton or gesturing were available. In addition, REC approval would take into account the position of participants deemed to be ‘vulnerable’, such as those who were in community care or who had conditions such as dementia, autism, brain damage or learning difficulties. Any children under the age of 16 would now need the consent of parents or guardian. In the current research, teachers’ verbal permission was given for all children participating, but not all parents of children involved were contacted.

All therapists involved in the research programme already had Enhanced CRB²⁴ checks and were covered by their own professional insurance, which would act on their behalf if any claim concerning mal-practice of therapists or researcher were to be registered.

Present-day REC’s would also have considered scientific justification for the research, namely that the intended research would benefit clients and practitioners by extending existing practice in this field. The methodology followed would require REC approval, together with confirmation that all data collection instruments and tools were appropriate for the methods, research questions and nature of the participants. In actuality, at the time of commencement of the research programme, the proposed methodology and research tools such as the structured interview were discussed with the university tutor and members of staff at the varying institutions involved, who advised on these issues and gave their (verbal) approval before procedures were implemented. However, these instruments were not laid before a REC, as would currently be necessary.

Practical Design of the Arts Therapies Programme

A programme consisting of all four arts therapies modalities (art, dance movement, drama and music carried out in sequence) was planned, within a sample of locations serving a range of

²⁴ *Now called Enhanced DBS checks*

types of client, over given periods of time. Through this method, each client participating in the programme would experience sessions in all four arts therapy modalities. The duration of each session would last for either half an hour or an hour, depending on the nature of the client and after discussion with the manager / teacher and therapist, taking into consideration such factors as attention span and ability to remain involved. If a client should indicate that they wished to leave the session before the allocated time, then this would be accommodated. Clients would not, however, be able to extend the duration of any session beyond the time allocated. The four modalities would not be delivered in any set order, as the possible developmental nature of one modality over another was thought to be a discussion beyond the scope of the present research ²⁵ - indeed to deliver all four modalities in the same order to all clients would be logistically very difficult to implement.

Each session was based on the inherent capacity of each client to respond to the arts modalities in their own individual way. Artefacts associated with each arts modality were made available to the clients in the therapy room, who were then free to use them as they wished to express their current feelings in improvised object-making, musical expressions, vocal responses and participation in dramatic and movement activities. The therapist leading the sessions supported these responses – usually by ‘mirroring’ the clients’ actions, moving with the client (‘authentic movement’), joining in musical improvisation or dramatic activity, or just ‘being with’ the client in the therapeutic space.

Careful preparation before sessions started, consisting of discussions by the researcher with the manager/teacher involved in each location and with the therapists delivering the service ensured, as far as possible, consistency of approach and response to the programme from all involved. These preliminary discussions included consideration of the therapeutic process, practical delivery of the programme and proposed methods for evaluation of outcomes. Consideration was also given to the issue of whether or not sessions would be held on a 1:1 or group basis, which depended on the individual needs of the clients themselves and the reasons for their referral. Although each therapist had their own approach to the leading of a therapy

²⁵ *By this discussion is meant the possibility that, for example, dance movement therapy might relate to the earliest development of the foetus in the womb and therefore should be the first mode of therapy presented to a client, whereas music or art therapies, which depend on auditory and visual perception which develop later in the foetus, might be presented later.*

session, such preliminary discussions ensured uniformity of approach to the project, as far as was possible within the given parameters of the project, its implementation and the experience of each client.

Selection of Participants

The clients and the locations

Clients to be involved in the current research were chosen to represent a purposive sample of those commonly attending arts therapies sessions at the Centre, being as truly representative of the larger population of clients as possible and who would also assist in generalizing the findings at a later stage (Bruscia, 1995). It was not possible, for practical reasons, to include clients from the whole range of the Centre's referrals, but those chosen would form as representative a sample as possible, showing maximum variations of special needs, so that a holistic understanding of the research question could be achieved. Thus the range included those from the youngest (5yrs.) to the oldest (80 yrs.) age groups, both male and female. Within those clients still attending school, clients were chosen from a variety of educational contexts, such as referral units, special schools and mainstream schools, of both primary and secondary ages. Adult clients were from residential homes or specialist centres. Special needs or symptomatology included children and young people with emotional / behavioural / social difficulties, learning disabilities of varying levels and autism. Adult clients included those with brain damage and dementia. A number of these clients, although not in mental health contexts, had mental health symptoms.

Within varying locations already known to the Centre, managers and teachers were invited to refer clients whom they thought would benefit from the interventions. All therapy sessions would be delivered within the clients' own locations, whether this was a school, a centre, a home or a unit, as it was not practical to arrange that all participants would be brought to the Centre.

Criteria for inclusion

Criteria for inclusion included the requirement that ideally every client in each location should be available for the duration of the programme, that is, long enough to experience all of the four arts therapies modalities in sequence. It was also stipulated that clients participating in the research programme should not have previously taken part in any arts therapies programmes, as this might influence the level of engagement in the programme and hence the results. It was understood, however, that familiarity with, and expectations from, everyone involved in the arts therapies programme would vary.

Clients were not invited to self-refer in this study, although all had the right to refuse to participate when invited and would be free to leave the programme after its commencement, if they so wished. Self-referral would have involved much wider explanation of the purposes of the study to many who might not eventually participate and it was envisaged that this would not be logistically possible. Up to 6 clients should be referred from any one location, this being the maximum number advisable for work within an arts therapies group. The range of clients participating would also depend on the willingness of the managers / head teachers of the varying locations to participate in a programme which would cover a considerable number of weeks, probably resulting in some disruption to incumbent routines.

Reasons for referral and aims of arts therapies programmes

The fundamental goals of therapies for referred clients might be regarded as self-understanding, interpersonal communication and personal growth (Feder and Feder 1998). Snow et al.,(2003, p.81), in their analysis of aims of a therapeutic theatre and well-being study, describe the aims accomplished in this activity as being:

- ‘-reduced sense of stigmatization and improvement of self-image
- increased socialization
- enhanced communication and inter-personal skills
- improved self-confidence

- more spontaneity and freedom of self-expression
- increased sense of responsibility and maturity
- a sense of accomplishment
- an expanded, more positive sense of self'

It was interesting to see whether the aims defined in the current study proved to be similar to these, or whether others, such as enjoyment of the experience, were also included. Aims were specific to the nature of the clients being referred and varied according to age, stage of personal development and circumstances of each client, according to the sample chosen.

It was recognised that in the present study, there was not an opportunity to evaluate the long-term effects of the interventions – that is, those changes in the client which perpetuated after an interval of at least 6 months. As MacKay (1996, p.166) writes: ‘It is impossible always to know what long-term experiences like these have on participants. I have long felt that we cannot speak of cures, but rather of experiences of healthy functioning and healthy relationship which may become bench-marks in future development.’ Possible long-term effects of the therapies are discussed in Chapter 6.

In the present study, a referral form²⁶ detailed the reasons for referral of clients by the M/T's, which required definition of four aims for each client during the programme²⁷. This referral procedure provided the basis for initial assessment by the therapist in the first session of the programme, after which the observations of the therapist, the client's opinions – as far as they were able to offer these – and the referrers' views were synthesised to confirm the aims originally stated in the referral form, with modification where necessary.

The arts therapists practitioners

Therapists delivering the programme were chosen from those currently holding contracts with the Centre, who had expressed an interest to participate in the research, but who would,

²⁶ See Appendix 4 p. vi

²⁷ See Appendix 12.1 Table 6 a/b p. xxii

nevertheless, present an unbiased opinion towards the study. All therapists were registered with the Health and Care Professions Council (HCPC) or relevant professional association and held the necessary skills / experience to work with any of the client groups participating in the programme. Therapists were personally briefed by the researcher prior to commencement of the programme, with regard to the nature of the research and practical details of implementation, in order to ensure, as far as possible, standardisation of procedures²⁸.

Practical arrangements for therapy sessions

Length of programme

Each programme of 4 interventions (one in each arts modality) was planned to last for 6 weeks, making a total of 24 weeks in all, for each client. This length of duration was chosen to enable the programme to be completed within a school year (although, of course, not all clients were children). It was recognised that the majority of arts therapies interventions are actually of longer duration than 6 weeks, but it was hoped that this would allow sufficient time for each of the therapy interventions to show at least initial changes in the clients' behaviours.

As the programme developed, however, the length of duration of each intervention was lengthened to 12 weeks for each modality after the first 4 placements had been completed, as the therapists felt that 6 weeks was not a long enough time for progress towards attainments of the clients' aims to be achieved. Thus for each client, the projected total involvement in the programme became 48 weeks of contact therapy time.

A 'safe space'

It was emphasised to location managers and teachers in preliminary discussions that the room or space allocated for sessions should be appropriate, offering adequate space for those

²⁸ See p. 74 above.

sessions which encouraged movement on the part of the clients, access to water for the art sessions, minimised disturbance from nearby classroom or other rooms and guaranteed privacy to the participants. Unnecessary interruptions were discouraged and it was agreed that the therapist taking the session would end the session at the appropriate time personally, rather than an assistant or carer interrupting the end of each session.

Issues of confidentiality were discussed prior to the start of the sessions with all concerned, in conformity with the therapists' code of ethics, so that all concerned were aware that ethical procedures were being followed concerning the work to be undertaken, including the security of data received and gathered.

Line management

It was important to establish a line manager for each location, in order to provide continuity throughout the implementation of the four modality programmes. One teacher / manager, or person nominated by them, was invited to act as the person through whom negotiations within the placement would be managed and with whom the researcher would have direct contact. This ensured that the researcher was not involved in practical arrangements once the programme was started, which might have influenced results.

Quantitative evaluation of practical therapy sessions

Collection of quantitative data

At the completion of each 6-week modality programme, the researcher made personal visits to each location, to obtain quantitative results (named as 'ratings') from the referring manager/teacher concerned. Referrers evaluated the outcome of sessions according to their perception of the progress of the client from an 'outside' point of view, as they themselves were not personally involved in the sessions. Results were given according to the referrers' assessment of the clients' apparent progress towards achieving their stated aims since

commencement of each modality programme, including assessment of the clients' ability to generalise progress made during sessions, to behaviour within a wider context.

Clients' evaluations, when available, represented their own personal opinions of how they themselves felt they had progressed during sessions, within the aims set. If it was not possible to obtain some clients' results in person, then managers or teachers were invited to provide such scores, according to their perception of the clients' responses. This was felt to be an acceptable – although not optimum – alternative²⁹. The therapists who had been leading the therapy sessions provided the 3rd. set of ratings. As therapists did not have opportunities to observe any changes of clients' behaviour in contexts outside of the therapy room, their evaluation represented changes perceived during the actual therapy sessions³⁰. This 3-fold evaluation of consulting multiple perspectives offered an opportunity for triangular assessment, the rationale being that when a convergence of results generated in different ways and by different individuals is obtained, those results become more credible and thereby increase the validity of results obtained (Aigen, 2005). Thus in the analysis of results, data collected from the three differing sources were compared, as the study progressed.

'Scoring'

The use of psychological personality tests for the measurement of results of therapeutic intervention appeared not to be generally welcomed on a practical level by managers and teachers involved. It had been the experience of the researcher that a previous psychology graduate on placement had attempted to use such a test in evaluating therapy services, but that staff members, while agreeing to participate in the survey, had not eventually been able to provide the time required for the filling in of detailed evaluation forms at varying stages of the process, either by themselves or by the clients concerned. It was therefore decided that the use of such tests for the current research would prove to be impractical. In measurement of

²⁹ *It is realised that there are alternative options which can be provided to assist non-verbal clients in making their own comments. Where possible managers and teachers engaged clients as much as they could, in their assessment of the progress they felt they had made during the sessions. Sometimes, however, the offering of an opinion was beyond the capabilities of the client.*

³⁰ *See Appendix 5 p. vii for example of Score Sheet*

the success, or otherwise, of the aims of the practical therapy sessions, numerical scoring would be on a scale from 1-6, as in the table below:

Table 7

Rating	Description of Rating
1	Deteriorated
2	No Improvement
3	Slight Improvement
4	Noticeable Improvement
5	Considerable Improvement
6	Achieved Aim

Description of Rating Values

Coding³¹

Two types of coding were used in analysis of data obtained through the processes described above. The first was a numerical / alphabetical code used to anonymise names of locations, identity of persons involved, categorization of aims, references to the different modalities, ages of clients and similar data. The second was the adoption of a system of coding in analysis of the qualitative data obtained from the structured interviews. This latter coding involved the identification of the initial questions in numerical order (open coding), which would then be further defined by following recurring themes and vocabulary within each group of responses (axial coding). Emerging core strategies and sub-categories of each participant's responses were then reviewed, in order to determine relative themes and experiences (selective coding) (Amir, 2005).

These systems of coding, agreed with the analyst, enabled statistical data to be entered in a format consistent with the ANOVA system, thus enabling comparisons to be made between varying components of the quantitative analysis, firstly in a 2-way analysis, e.g. teacher v. placement, teacher v. therapy, etc., and, as analysis progressed, as a multiple approach, e.g. category of aims v. mode of therapy v. age categories. The coding adopted for analysis of qualitative data made it possible to determine the most frequently recurring terms used by the respondents in their descriptions of experiences of the sessions and their evaluation of varying

³¹ See Appendix 12.5 – Table 16 p. xxix for further details

aspects of the programme as a whole. In turn, this allowed the researcher to reflect on the varying opinions offered by participants and formulate conclusions concerning the success, or otherwise, of the programme.

In order to preserve anonymity of locations, in initial documentation, a letter-name was allocated to each. In analysis, the numbers 1-10 replaced letters. The letters 'M / T' referred to managers and teachers (abbreviated to 'T' in the analysis) who had been responsible for referral of clients. 'C' referred to clients and 'Th' to therapists leading the practical sessions. 'View' referred to the scores allocated by managers/teachers, therapists and clients, thus 'TV' would be the score noted by a manager or teacher.

On the original referral forms and scoring sheets, clients were allocated a location 'letter' referring to each particular location and a number within that location; however, in the statistical analysis this became individual reference numbers, from 1 – 109.

When describing any one particular age group of client, 0 = 5-10yrs; 1 = 11-19yrs; 2 = 20-30yrs; 3 = 31-45yrs; 4 = 46 – 61 yrs., (61 being the age of the oldest client involved in the programme); *m* = male and *f* = female.

In analysis of the aims stated in the referral process (see Chap.4), groups of aims were allocated the numbers 1-8; therapy modalities were numbered from 1-4 (1 = Art; 2 = Dance movement; 3 = Dramatherapy; 4 = Music therapy). Therapists were identified by initial only.

When indicating whether there was consensus within separate analyses, C = Consensus; P = Partial consensus and N = No consensus.

Statistical analysis of quantitative data

Because advanced statistical analysis of the quantitative data was outside the academic experience of the researcher, advice and support in this respect was given by a statistician who enabled the researcher to analyse the results (or 'Views') obtained from Manager /

Teacher (M/T), Therapist (Th) and Client (C). This statistician was employed by Birmingham University as a Senior Lecturer in Medical Statistics within the Department of Primary Care and General Practice. Permission to use such assistance was discussed with, and agreed by, the researcher's current supervisor. Results thus obtained were presented and initial comments made in the following chapter.

Questions to be asked from analysis of quantitative data

In initial preparatory discussion with the statistician concerning the questions to be asked of the analysis, it became apparent that some of the researcher's suggested wording needed to be adjusted, as the questions were not such as could be answered through statistical processes. For example, in Question 2, the researcher's original wording was '*On average, were the therapies thought to be effective?*' The statistician had pointed out that 'effective' is not a word that might be applied statistically. The wording was therefore adjusted to, '*Statistically, overall, were there signs of improvement?*' Likewise, the original wording for Question 8: '*Was one Aim thought to be more successfully addressed than all others?*', became '*How do the scores obtained so far match up with the prevalence of the Aims?*'. Other proposed questions, such as, '*Which were the most prevalent Aims?*' would not need statistical analysis for evaluation.

Some questions originally proposed by the researcher were omitted, after discussion with the statistician. These included the original question concerning correlation between individual characteristics of client and their scores. It was felt that despite the fact that every client was regarded as an individual in his own right, it would not be possible to include detailed statistical coding for each individual characteristic of every client (based on their clinical diagnosis) and although general reasons for referral of clients were included in original documentation, these were not specific enough to be identified separately. What could be identified separately, however, were the actual aims for each client and the effectiveness of individual therapies in addressing these. This topic, therefore, was included in the questions included in the structured interview.

The researcher was originally concerned whether the ‘popularity’ of any one therapist might correlate with the highest scores? The statistician had commented that this appeared to be a meaningless question, as there was no existing quantitative measure for ‘popularity’. In fact, the answer to this would already be included in Question 5. It could be argued, however, that the highest scoring by manager/teacher (TV) score might be deemed to be ‘the most *successful* therapist’, whereas the clients’ (CV) score might indicate ‘the most *popular* therapist’. The question in the original wording was therefore omitted.

The final question proposed by the researcher, namely how the statistical results might compare with the answers given in the structured interviews, was not seen to be a question which would be answered by statistical analysis. Discussion of this question is included in chapter 6.

The final list of questions to be addressed through analysis of the quantitative data, after discussion with the analyst, is listed below:

Table 9

No:	Question
1	Is there any difference in scores between the 6-week / 12-week locations?
2	Statistically, overall, were there signs of improvement?
3	Did one location have better results over all than another?
4	Did one modality produce better results than another?
5	Did one therapist have better results than another?
6	Which were the most prevalent aims?
7	Was one aim more prevalent with any particular age group?
8	How do the scores obtained so far match up with the prevalence of the aims?
9	Was there correlation between ages of client and their overall scores?
10	Was there correlation between ages of client and the most successful therapy?
11	Was one aim more successfully addressed with one particular modality of therapy?
12	Using the above data and analyses, is it possible to answer the question: ‘Which Arts Therapy for Which Client and Why?’

Final list of questions to be asked of statistical data analysis

The Structured Interview

Following the initial practical arts therapies programme and quantitative results obtained from this, a structured interview was implemented as a second stage of evaluation, again involving responses from representatives of all three points of view, namely ‘manager/teacher’, ‘therapist’ and ‘client’ views, providing the triangulation necessary to validate the accuracy of data and ensuring that resulting constructions are grounded in the sense of being as well-informed and holistic as possible (Bruscia, 1995b).³²

The purpose of adding such a structured interview to the quantitative data already obtained was to offer participants opportunities to express their views verbally, allowing for more flexibility in ‘feed-back’ on the situations encountered, which were not possible within the limitations of numerical evaluation. The structured interview also offered the possibility of comparing whether, on analysis, quantitative and qualitative data had resulted in similar conclusions.

In designing this structured interview, it was necessary to decide on a format which would meet the purpose of such an exercise, bearing in mind that the respondents ranged from managers/teachers (who would be accustomed to such procedures), to the clients themselves (who might find such a task quite daunting, or even incomprehensible). The utilisation of a ‘tick box’ questionnaire was discarded, as it was felt that this format – although possibly easier to analyse on completion – would not allow for the freedom of expression which it was hoped the structured interview would encourage: the structured interview would be the basis of a face-to-face discussion, as written responses required by a questionnaire might pose difficulties to some and might be seen as requiring too much time to complete, by others.

Munn and Drever (2004) claim that the most suitable approach to questionnaires for use in small-scale research is that which can be completed without the presence of the teacher / researcher. This is to avoid any obvious influence on the results of the questionnaire, to ensure that the answers are as candid as possible. This apprehension about the possibility of bias affecting the validity of responses is indeed of the utmost importance. However, it was

³² See Appendix 6 p. viii for examples of the Structured Interviews

felt in the current circumstances that owing to the variety of respondents and potential levels of engagement, the most effective method of conducting the qualitative evaluation of the programme would be in the form already described, led by the researcher in conversation with each of the participants in their own locations, as this would ensure a more flexible approach, which could be modified, if necessary, according to context and nature of the interviewee. In addition, when conducting the interviews against the set questions, clients would not be interrupted in their responses, even if they were not totally relevant to the question, as this would give greater freedom and confidence to those being interviewed.

Questions were formulated which could be represented in similar form, although differently worded, for each of the three groups of participants, namely M / T, Th and C, to allow for their differing roles in the programme. The questions covered the views of participants concerning issues arising from the practical sessions, ranging from personal experiences of the actual sessions, to opinions concerning strengths and weaknesses of the programme itself. The interviews were held in a private room in each location, where every client had the opportunity of expressing their thoughts and feelings concerning the programme of arts therapies freely. Interviews were recorded by the researcher using a small, unobtrusive hand-held voice recorder (with the permission of the respondent). Recordings were later transcribed into document form for comparison and analysis.

The researcher was fully aware of the possibility of answers being given ‘in order to please the researcher’ – or of answers which were given by client because they thought that they were obliged to respond in a certain way. Before the commencement of each interview, each respondent was reassured that they were free to say what they liked in response to the questions posed and that all answers were regarded as confidential. The purpose of the structured interview and how material gathered would subsequently be used and presented, were also explained. If the respondent was not fluent in the English language, because of nationality, possible brain damage, or other impediment to understanding, the questions were re-phrased, in order to ensure understanding and avoid any possible embarrassment. Occasionally this required the presence of an interpreter or person who was more familiar with a client’s methods of communication than the researcher. These people were bound by the same code of confidentiality as those involved in the actual research. In conducting the

interviews, the researcher only led the conversations back to the item under discussion, if considerable deviation from the original point was being made, or if the question appeared to have been misunderstood. Through this method, greater detail became available concerning the experiences of clients and others involved in the programme. At the same time, at the end of the set questions, personal opinions concerning the management of the programmes and the suitability of follow-up sessions were encouraged. These last opinions were not issues connected to the main question of the research, but were included in order to provide useful information for future arts therapies work.

Analysis of Qualitative Data

The common emphasis in all methods of quantitative analysis is on categorising data and making connections between categories. These tasks also constitute the core of qualitative analysis. As part of the process, apparent 'irregularities' of response are noted as much as those responses which are in accord with each other, for it might be that the one dissonant opinion will inform the current research as much as all of those in agreement (Dey, 1993, p.6). Whereas quantitative data deals with numbers, qualitative data deals with meanings. Quality is stated by Dey (1993, p.22) to be a measure of relative value, based on an evaluation of the general character or intrinsic nature of what is assessed. As the format of the structured interview was not asking respondents to evaluate on a numerical scale, all replies were in verbal, descriptive form allowing respondents to add their own opinions and information.

In the analysis of the qualitative data, the researcher tried to be careful to analyse the data with an open mind, being aware of any pre-conceived ideas and examining evidence in a new and critical way (Edson, 1988). As outlined on p.81, in collating the present qualitative evidence, responses to each question of the structured interview were taken in turn from each interview and analysis made of the frequency of 'key words', ideas and opinions formulated by the interviewees, using facilities available for word searching, patterns and correlation of responses. This led to compilations of a majority response to each question asked, so that a number of responses to each question could be collated, coded and subsequent comparisons made, which would be used to give insight into the drawing up of final conclusions and conceptualise the success or otherwise of the programme. This method of analysis of

qualitative data followed that of Colaizzi's 1978 study, as presented by Forinash and Grocke (2000), in which phrases that directly pertain to the study are extracted from original scripts and grouped into individual themes by the researcher. These themes are then clustered to produce a further reduction of general themes and production of culminated results. Participants are then asked how these results compare with their own experiences and modifications are made to include any new data which has emerged.

In quoting from responses, references and confidential codings were used for each respondent, so that it was clear to the researcher who was making the comments, at the same time as anonymity was observed. To avoid confusion, questions asked in the quantitative analysis were designated by the letter 'Q', whereas those within the structured interviews were referred to as 'QQ'.

Some of the questions in the structured interview, such as those concerned with practical arrangements, availability of equipment, etc., were included for practical and administrative reasons only. These questions did not affect the results and were therefore not analysed within the formal results. Comments made under these headings were included in the Discussion (Chapter 7) and Conclusion (Chapter 8) where they were relevant to the research topic. Points were chosen as most closely relating to the original research question '*Which arts therapy for which client and why?*' Other results obtained have the potential to form the basis of future guidelines, outside the actual remit of the present study. A full description of results of the qualitative data obtained and initial discussion is given in Chapter 5.

Considerations concerning the methodology of the research

The researcher as therapist and / or observer

The researcher aimed to draw a distinction between the work of the therapists actually engaged in delivering the therapy programmes and her own stance as the person drawing together and analysing the resulting data. The clients could only develop relatedness and communicativeness if they were offered someone – the therapists – with whom to relate and

communicate. In the course of the therapy process, therapist and clients become equals (Aigen, 1993). As a professional music therapist herself, the researcher was inevitably concerned in the 'life' of the research, rather than merely its documentation. This position contrasts starkly with the premises of total positivistic research, in which the researcher is required to be a detached observer who does not interact with the subject or site of research for risk of contaminating the research findings.

Rather than trying to rid herself of personal reactions which might be considered experimenter bias, the researcher tried to develop a robust awareness of any implications or bias, so that the results of the research were not destroyed by any form of subjective approach. Previous professional experience in this field was used to direct and inform the process of research, rather being bound by prior conceptions of any outcome. 'When the focus of research is therapy process and practices, it is essential to be able to discern the presence of phenomena which may lie outside of our own particular clinical frame of reference' (Aigen, 1998, p.158). Inevitably, when making initial visits to head teachers and managers to discuss the research programme, personal involvement of the researcher was present in the conversations. However, the fact that at no point was the researcher involved in delivering the actual therapy sessions ensured that, as far as possible, an objective stance was maintained throughout the study and that any prior conceptions did not influence analysis of results.

Validity

A structured interview can be said to be valid if it examines the full scope of the research question in a balanced way, i.e. it measures what it aims to measure (Black *et al.* 1998). In this research a number of aspects of validity were examined. Criterion validity may be assessed by comparing a new measure with an existing gold standard scale. As far as the researcher has discovered, there is no such scale of measurement for the specific question under discussion, indeed, if such a scale had already been developed, then there would be no need for the current research. The researcher did, however, compare certain sections of the research, for example, the consideration of a code of ethics, to the approved gold standard – in

this case, the criteria as set down by the HCPC. In addition, assumptions were made based on the result of others' research experience, as outlined in the review of literature in Chapter 2.

Factual validity can be assessed by comparing quantitative results of the locations and responses to the results of the structured interviews, with information recorded from therapists' clinical notes and the researcher's own observations made as she visited each location for collection of quantitative results and at the interview stage. Prolonged engagement – in that the study operated for a minimum of 24 weeks and latterly 48 weeks – helped to establish trust amongst participants, so that results could be interpreted within the context of the culture in which the events and experiences were originated (Aigen, 2005). The face validity of the results can be examined by allowing those involved to comment on the final conclusions, to see whether these were in agreement with their real opinions. This was achieved at the conclusion of the analysis of both quantitative and qualitative results by referring results to a sample of those concerned. These people included the statistical analyst, a representative manager/head teacher and one of the therapists themselves. Each was invited to give their overall opinions and their responses noted in the final chapter of the research.

To establish validity further, as it would not be possible to re-interview the actual participating clients, the researcher informally interviewed current Centre clients, to see whether their opinions of the therapies service was in agreement with the results of the research, even although they had not taken part in the programme. These clients have, however, experienced their own chosen therapies, so it would be useful to compare how they had functioned in their therapy programmes and why they had chosen a particular modality in the first place – especially if they personally had chosen the mode of therapy, rather than having the modality chosen for them by a manager/teacher. For example the client might be asked, 'Why did you choose dance therapy, rather than music therapy?' or similar question.

Reliability

Reliability is defined as an assessment of the reproducibility and consistency of an instrument (Black *et al.*, 1998). There are a number of aspects of reliability which may be examined. Amongst these are re-test reliability, in which participants are invited to complete the same

structured interview on two separate occasions, approximately 2 to 3 weeks apart, assuming that their circumstances have not changed in the interim; the internal consistency of the responses, which may be determined by asking a question or questions in more than one way during the interviews and comparing results; or consistency of results can be tested over time – temporal reliability and inter-observer reliability (how well do different judges or observers agree on their observations and/or their conclusions)?

In the current research, it was impractical to retest participants, or to re-visit all those interviewed in the original structured interviews, as situations had changed and time was not available either on the part of the researcher, or on the side of the participants. It would be interesting at a future stage, however, to assess possible implementation of recommendations and consequent adaptations to current practice made as a result of this research. This could, in fact, form part of the future studies at the Centre.

It might have been possible, when considering the reliability of the data, that a client had made progress towards the achieving of his stated aims during the first therapy modality intervention, resulting in commencing the second modality intervention with some of his aims ‘further along his journey’ than he was at the outset. He would also have become more familiar with the concept of therapy itself. This might have affected the actual ‘scores’ given or comments made in the structured interviews. However, the evaluation made of each separate intervention reflected the actual progress made during that specific intervention.

If a client actually achieved one or more of his aims during the earlier interventions and if this achievement was maintained in subsequent sessions, then this was evaluated by the highest score from the first time of achieving this result onwards. It might be surmised that this would impact unfairly on the final results, but it is to be remembered that relapses in achievement by the client were always a possibility and that maintaining the ability to achieve the highest score in changing contexts was evidence of continuing ability to confront this particular aim successfully.

Bias

The central requirement in analysis is clear thinking on the part of the analyst, the analysis being as much a test of the enquirer as it is a test of the data and that first and foremost, analysis is a test of the ability to think – to process information in a meaningful and useful manner (Robson, 2002). Qualitative analysis remains much closer to codified common sense than the complexities of statistical analysis of quantitative data. However, humans as ‘natural analysts’ have deficiencies and biases corresponding to the problems that they have, both as observers and as participants.

Within the content of both the quantitative and qualitative results resulting from the present study, bias might have been present in the information and judgments supplied by the managers/teachers, therapists and clients. This may have been due in part to the Hawthorne effect (also referred to as the Observer Effect) – a term referring to the tendency of some people to work harder and perform better when they are participants in an experiment (Cherry 2015). As observed within this effect, individuals may change their behaviour due to the attention they are receiving from researchers, rather than because of any manipulation of independent variables such as the therapy sessions themselves. Within a randomised controlled trial, the Hawthorne effect should not affect assessment of the difference between intervention and control, but it may result in an inflated estimate of effect size in routine clinical settings by over-estimating response in both groups (McCarney et al., 2007).

Within the present study, this effect might have been manifest in the fact that participating clients did so willingly, possibly implying that they were already favourably disposed towards the research and might have been biased towards attaining success in achievement of their personal goals. Clients might have been unconsciously stimulated not only by the therapeutic process itself, but also by the added attention which they received. In addition, for managers, teachers and therapists, the fact that they had agreed to support research connected to a possible higher degree, might have influenced their efforts to ensure that the study was successful, by increased attention to practical details and heightened awareness of outcomes. This might have resulted in over-estimation of quantitative response and evaluation of results.

Personal bias might also have been present in the context of the structured interviews, in which data was based on the inter-personal relationship of the researcher and the interviewee. When conducting interviews, the researcher's own interests, experience and expectations might have affected the manner in which questions were presented – by tone of voice, body language and facial expressions, even although the questions were in a structured form. In order to off-set any potential partiality, the researcher tried to guard against leading comments and remained non-judgmental to responses given, allowing participants to respond freely and expecting negative as well as positive comments.

In addition, as the answers given to the questions were tape-recorded, bias resulting from the researcher's possible selective memory of responses given, was less likely. Equally, the researcher tried to avoid any bias which might have arisen from previous relationships with the interviewee, such as the fact that she might have worked professionally as a therapist herself, in a particular location, or she might have known the manager / teacher / therapist as a friend or professional colleague. The researcher tried to start each interview with an open mind, keeping it unbiased throughout and attempted to remain objective in drawing of any final conclusions, however much it she may be hoped to have a positive, definitive answer to the research questions.

In the analysing of information received, the researcher accepted all data given by participants at its face value, analysing the information in an impersonal manner, guided by the statistician, as any modification of responses, or values placed on them by the researcher, could well have indicated further bias on the part of the researcher. However, as consequences of the effects of bias were spread across all modalities, although results might have been enhanced, this should not have affected the inter-modality ratio of results and final conclusions.

Limitations of Research

Within the whole research process, some limitations were inherent in the researcher's personal circumstances. The carrying out of the research needed to be encompassed within her other work commitments, as it was not be possible to be seconded from her current

employment during the research period. This meant that not only was the whole study spread over a longer period of time than would have been ideal, but specifically, her availability to conduct the structured interviews was limited, which led to unavoidable lapses of time between the conclusion of therapy programmes and the actual interviews.

In addition, some clients involved were not able to answer the questions given in the interview, on account of their mental capacity or availability after completion of the programme. Clients from the residential home for blind and elderly residents, for example, did take part in the structured interview, but their capacity to respond was limited, even when the questions were simplified or expanded. In interviewing, the researcher occasionally used a 'reminder'- if the client had forgotten the sessions - but tried to avoid 'prompting', as this might have affected the answers given.³³ With such reminders, these clients provided insight into their perception of the sessions.

It is acknowledged that methods are available which might have been utilised in order to try to facilitate responses from non-verbal clients, but again, time did not permit extensive use of these. The researcher attempted to interview as many clients as were able to respond, but in some situations, it was necessary to rely on the managers/teachers to assist in interpreting clients' verbal responses, if difficult to understand. It was emphasised to such people that such interpretations should not be a duplication of their own personal opinions, but should try to represent the opinions of the clients, as far as possible. Moreover, as some clients had moved to new locations before completing all four therapy sessions, it became necessary to consider a 'type' of client in each location, rather than as an individual and to allow a 'similar' client to complete the sessions. This also applied to the answering of the structured interviews, if the original client was not available. In addition, one teacher said that she did not wish her interview to be recorded, as she was not the original teacher who had been in post at the time of setting up the programme. In her case, she agreed that notes should be taken during the interview, which would be used later by the researcher in place of a transcription of a tape.

³³ *As an example of a 'reminder', if a client could not remember the sessions, the researcher might say, 'Do you remember when you played musical instruments with ...?' Or, 'I believe you made some art work with ...?' However, no specific 'prompt' was made by the researcher to the client concerning their actual reaction to a session, such as 'Did you enjoy it when you did the music sessions...?' or 'How did you feel when....?', as this might have influenced the client's response.*

The time factor also applied to a few of the therapists involved, in that they were not available to answer the structured interviews at the end of the programme, having moved to new posts in the meantime. In such instances, the researcher visited these therapists in their new places of work, to conduct their part of the structured interview. One therapist was not able to complete the final interview as she had gone on maternity leave and had left the locality. It was encouraging to note, however, that although there had been some time delays, the willingness to complete the research interviews was genuine and therapists responded with enthusiasm and insight.

It is recognised that all these limitations meant that the practical arrangements for the conducting of the research was not ideal, but it was hoped that enough valid data would be collected to make analysis meaningful and that possible conclusions could be drawn at the end of the research. Indeed, much additional information given during the course of the interviews – not necessarily that relating specifically to the research questions – also proved to be of value in the general carrying out of the therapy programmes, including recommendations for the future.

CHAPTER 4 – THE QUANTITATIVE RESULTS

Quantitative Results

Results obtained from assessment of the practical therapies programme fell into two categories, quantitative and qualitative. In this chapter, an analysis of the quantitative results will be presented and brief comments made on the results of this analysis.

Quantitative data, annotated as ‘Views’ (V), were collected from every location at the termination of each modality session in art, dance movement, drama and music therapies. In some instances however, the managers / teachers (M/T) felt that their clients would not be able to understand the concept of giving their experiences a numerical value. In such cases, the M/T’s acted as intermediaries between the researcher and the client, encouraging the client to respond in a manner understood by both, indicating values that they felt clients would have submitted, if they had had the capacity to do so.³⁴ The validity of giving responses in this manner may be questioned, but those who gave these estimates did know their clients well and their figures were as close as possible to the values that they felt would have been stated by the clients. It is interesting to note that the figures proposed on behalf of clients are not the same as those proposed by the M/T’s themselves, indicating that M/T’s were trying to give as objective a View as possible, on behalf of the clients.

The scores allocated represented the individual assessments of each person interviewed. There was no ‘inter-observer’ reliability, that is, there were no different judges or observers available to offer agreement or otherwise on conclusions reached. It is hoped that enough results were obtained from different people to reduce any bias on the part of the respondents, although it could be argued that this might have been present in some scorings.³⁵

³⁴ *It is recognised that if time and resources had been available, greater use could have been made of creative adaptations of communication which would have offered the clients a wider facility through which to indicate their personal views. Such options will certainly be used in any subsequent investigations into specific client groups’ responses to the research question.*

³⁵ *See discussion on this point, Chapter 3 p. 92*

In discussing the quantitative results, the contextual data, that is, the physical details of the locations will first be described. This will be followed by a discussion of the age range and gender of clients, the types of disability encountered, the length of the programmes in each location and the range of aims determined for each client. An analysis of the scores ('Views') will then be given, together with initial comments on the results.

Results of Contextual Data

This section summarises details of the programmes and the aims chosen for the interventions. When describing the type of disability, descriptive information collected from the final structured interview is included, in order to provide greater detail concerning individual locations.

Summary of locations and clients referred

While each client referred was considered as an individual in their own right, the very nature of their allocation to a specific *genre* of location implied that there were certain disabilities held in common by all clients in that venue (*see Table 10 on following page*)³⁶.

³⁶ *More detailed descriptions of locations and clients referred, based on information given by M/T's in their additional responses to the questionnaire, are listed in Appendix 7 p. xi*

Table 10

Location Ref:	Length of Programme	Description of location	No. of different clients participating	Age range	Average Age	Sex	
						M	F
1	6 weeks	Primary Age Exclusion Centre	13	8 – 11 yrs.	9.4yrs.	13	0
2	6 weeks	Secondary Age Exclusion Centre	12	12 – 15 yrs.	13.1 yrs.	10	2
3	6 weeks	Primary Mainstream School	15	8 – 11yrs.	8.7 yrs.	13	2
4	6 weeks	Elderly Peoples' Residential Home (also with visual disabilities)	8	29 – 61 yrs.	50 yrs.	6	2
5	12 weeks	Primary Special School for Children with Learning Disabilities	8	7 yrs.	7 yrs.	3	5
6	12 weeks	Infant Mainstream School	11	5 – 7 yrs.	5.9 yrs.	7	4
7	12 weeks	Secondary Special School for Children with Autism	11	11-16 yrs.	12.8 yrs.	9	2
8	12 weeks	Secondary Mainstream School (High % of Ethnic Minority Pupils)	6	12 yrs.	12 yrs.	0	6
9	12 weeks	Secondary Mainstream School	8	13–15 yrs.	13.6 yrs.	6	2
10	12 weeks	Brain Injury Rehabilitation Unit	17	25–60 yrs.	32.9yrs.	9	8
Total No:			109	5 – 61 yrs.	16.31 yrs	76	33

Types of Locations and Clients referred

Age range and gender of clients

Clients' ages ranged from 5yrs. – 61yrs. Ages were grouped as shown below (allowing for the fact secondary special education may include young people of 19 yrs. of age). The number of clients in each age group is shown as a percentage of the total number of participants in that age group. The variation between these groups is not significant.

Table 11

	5-10yrs.	11-19yrs.	20-30yrs.	31-45yrs.	46-61yrs.	Overall
Statistical Ref:	0	1	2	3	4	
Male	75%	69%	57%	60%	63%	64.8%
Female	25%	31%	43%	40%	37%	35.2%

Age Range and Gender of Clients

Out of a total of 109 clients referred, the percentage of male to female clients was 64.8% to 35.2% (a ratio of 76:33). This is seen to be more than twice the number of male clients to female. It is interesting to note that these figures coincide with those issued by the DCFS,³⁷ in their Attainment by Pupil Characteristics in England 2007/8, in which it is stated that girls out-performed boys for both Foundation Stage Profile and Key Stage 1, suggesting that boys need greater support and special interventions within the educational context than girls (DCSF 2008).

However, with regard to occurrence of mental ill health in adults, Department of Health figures for 2011 state that one in four adults experience mental illness at some point during their lifetime and one in six experience symptoms at any one time (DoH 2011), making mental illness the largest single cause of disability in our society. Nationally, women are more likely to have been treated for a mental health problem than men (29% compared to 17%), but this could be because, when asked, women are more likely to report symptoms of common mental health problems (National Statistics 2003).

These figures concerning mental health issues or disability do not, of course, imply that all clients referred for the arts therapies programmes were included in these categories. Clients who were children in mainstream schools, or those adults who were in a brain injury unit would not all be assumed to have mental health problems. However, all the clients referred, of whatever age, did have emotional, behavioural or social problems which hindered them from reaching their full potential, which it was hoped the arts therapies interventions would address.

³⁷ *The Department for Children, Schools and Families*

Length of Programmes

Originally, it was envisaged that each of the 10 locations would consist of interventions by each of the 4 modalities of therapy for a period of 6 weeks, making a total of 24 weeks of intervention. However, after the first period of the programme in 4 concurrent locations, the therapists stated that they felt that a 6-week period of intervention did not afford enough time for adequate relationships with the clients to become established, or to make effective progress within the stated aims. It was therefore agreed with the head teachers / managers of the remaining 6 locations, that each modality would be a 12-week intervention, making a total of 48 weeks of therapies intervention in all.

The extending of the length of the programmes from 6 to 12 weeks, however, proved in itself to result in practical difficulties. In some locations, for example in schools and exclusion centres, children changed classes or groupings during such a long period, which lasted beyond the duration of a school year. This was especially so in exclusion centres, where the aim of the centre was to minimise the necessity for a long stay at the centre itself and to enable the clients to return to their original schools as soon as possible. As a result, not all clients were able to attend sessions in all four arts modalities. Likewise within adult settings, such as the brain injury rehabilitation unit, clients were often discharged before completion of the full 48 weeks. It was therefore agreed that although each client was viewed as an individual, in some locations, they would be representative of all clients in that venue.

Individual aims of referrals

Referrals were initially made by the managers or teachers (M/T) in each location. Aims for each client were identified after discussion between the M/T, therapist (Th) and client (C) – in cases where the client was able to offer a personal opinion. In all, 55 different aims were identified by referrers, across the 10 locations, which involved participation by 109 different clients.

Categories of Aims

109 clients, with 4 aims allocated for each client, resulted in 436 aims. Many of these aims were duplicated from one client to another, resulting in 51 different aims. It therefore became apparent that, although each client was regarded as an individual in his/her respective therapies, for purposes of analysis, the 51 different aims would have to be grouped into 8 categories, according to common areas of concern, namely those being directed towards greater personal development on various levels, greater ability to function within a group and being more socially aware.^{38, 39}

This grouping of aims was supported by one head teacher of an exclusion centre, who said, ‘After all, they have all been sent here for the same reason – namely that they cannot cope with a mainstream school context, so they will all have similar aims, but with individual differences’. In fact, on collation of aims, it appeared that 5 out of the 10 locations had submitted similar aims for all clients involved at that location.

The 8 categories identified were:

1. To enhance self-esteem
2. To allow individual expression of emotions in an acceptable⁴⁰ form and for participants to be able to acknowledge these personal emotions
3. To be able to participate as a member of a group in an appropriate⁴¹ way and to benefit from so doing
4. Enjoyment / freedom
5. To respond individually in an appropriate manner
6. To benefit physically
7. For relaxation and reduction of stress
8. Motivation and mental stimulation

³⁸ See Appendix 12:2 Table 12 p. xxiv

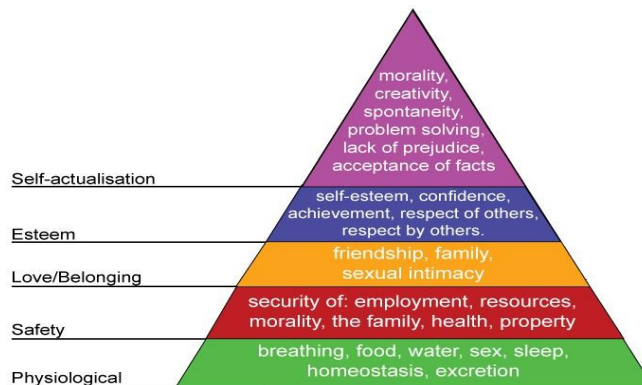
³⁹ See Appendix 12:3 Table 13a p. xxv, Table 13b p. xxvii

⁴⁰ The meaning of the word ‘acceptable’ implies the possibility of self-expression in a manner that is ‘safe’ both to the client and to the observer

⁴¹ The meaning of the word ‘appropriate’ is taken to mean: ‘in a manner suitable to the context’, the client taking into account and being aware of the effects of his/her behaviour.

It is relevant to compare these 8 categories of aims as defined by the researcher, with Maslow's Hierarchy of Needs:

Table 14



Maslow's Hierarchy of Needs – McLeod (2007)

The majority of aims fell within Maslow's two higher categories of 'Esteem' and 'Self-Actualisation', rather than those of 'Love /Belonging' (although being a member of a group could fall within this category rather than within 'Esteem'), 'Safety' and 'Physiological'.

In none of the aims was it stated that the purpose of the sessions was to find out what was the *cause* of any aberrant behaviour. The aims merely stated what the intended *outcome* of the sessions should be. Consequently, it was up to the therapists themselves – within the sessions – to deal with the underlying causes for the problems identified. This fell within the code of practice of confidentiality as practised by the HCPC and the Centre's arts therapists.⁴² Referral forms were submitted to the managers / head teachers at the start of the programmes, but these did not necessarily explore underlying causes for behavioural traits.

Emphasis on 'success' of aims, rather than on type of disability

In consideration of the quantitative results, it is important to remember that clients are referred for arts therapies because of their inability to reach their full potential, rather than because of their physical or mental disabilities, or other medical conditions. Therapy is not expected, for

⁴² See Appendix 8 p. xiv

example, to cure autism itself, but rather to enable clients to reach the fullest personal potential of which they are capable, which may be hindered by negative, emotional / behavioural / social responses to their condition and environment⁴³. Therefore, results were analysed according to the rated 'success' or otherwise in achieving agreed aims for the sessions, rather than by specific identification of disabilities.

Analysis of Quantitative Data

Collection of Statistical Data

Although ultimately, as discussed earlier, it became impossible to obtain quantitative data from each individual participant, the statistician assisting assured the researcher that the number of clients participating over all (109 in total) meant that results would still be valid, although not all had 'Views' entered for each arts modality.

Coding for Analysis of Statistics

Statistical results were firstly collated by the researcher, after each of the interventions in each of the four modalities in each of the 10 locations. These results were then entered into a scoring 'table' format.⁴⁴ For the purposes of analysis, however, coding appropriate to statistical analysis was necessary. This included coding for client references, aim numbers, category of aims, modality of therapy, numerical coding of results, coding for therapists and locations, and coding for ages of clients.⁴⁵ This coding was then used in the statistical analysis, as previously described in Chapter 3 (p.15).

⁴³ See reference to 'secondary handicap' Chapter 2 p23

⁴⁴ See Appendix 12:4 Table 15 p. xviii

⁴⁵ See Appendix 12:5 Table 16 p. xix

Statistical results of questions and initial comments

Each of the questions identified earlier⁴⁶ was analysed individually and initial comments noted.

Q1. Is there any difference in scores between the 6-week / 12 week locations?⁴⁷

Table 18

View	Locations 1-4 (6 weeks)	Locations 5 -10 (12 weeks)
TV	3.7	3.83
ThV	3.88*	4.04*
CV	4.2	4.25

Scoring for 6-week v. 12-week Locations

**ThV – Significant $p=0.025$, others not significant, using ANOVA statistical test*

Therapists' scores show that they valued the extension of the period of sessions from 6 to 12 weeks the most.⁴⁸ For the Teachers / Managers and the clients, there was little improvement in scores for the longer interventions.

Q2. Statistically, overall, were there signs of improvement?

Rating and coding for signs of improvement were according to the following table:

Table 19

Rating	Description of Rating
1	Deteriorated
2	No Improvement
3	Slight Improvement
4	Noticeable Improvement
5	Considerable Improvement
6	Achieved Aim

Coding for rating of scores

⁴⁶ See Table 9 p. 84

⁴⁷ See Table 10 p. 98

⁴⁸ See Appendix 12.7 Table 17 p. xxxii for Table of Therapists' Views; Appendix 10 p. xvii for Therapists' Verbal Responses to QQ1b

The analyst advised the researcher to analyse these results in 2 categories, the first being for Codes 1-2 (*Deteriorated / No improvement*) v. 3-6 (*Slight improvement / Achieved aim*), while the second analysis compared 1-3 (*Deteriorated / Slight improvement*) against 4-6 (*Noticeable improvement / Achieved aim*). This would give some idea of whether the differences in improvement between TV, ThV and CV varied with the level of improvement.

Table 20

View	Results	Results
	Coding: 1-2 / 3-6	Coding: 1-3 / 4-6
TV	85%	60%
ThV	89.7%	65%
CV	94%	74%

Scoring for signs of improvement

The clients themselves felt there were the greatest signs of improvement, scoring 94% in the category '*Slight Improvement / Achieved Aim*' and 74% in that of '*Noticeable Improvement / Achieved Aim*'. The teacher / managers' scores are 85% in the first category, compared with 60% in the second. These are lower than the clients' ratings.

The therapists' scores fall between these two, reflecting that progress towards achieving the aims is more apparent within the therapy sessions themselves, rather than progress observed by teachers / managers, which might be judged by generalisation of client behaviour outside the therapy room.⁴⁹

Gender of the client v. Signs of improvement

No specific questions were asked in the original quantitative questions, as to which gender of clients had been assessed to have found the programmes most successful (or, indeed, whether therapists preferred working with either *m* or *f* clients). Varying aspects which involved an *m* v *f* comparison had occurred later in the quantitative analysis, but the researcher felt that it would be advisable to re-address the initial issue as to whether, in general, *m* or *f* clients showed any pattern of overall success, one over the other.

⁴⁹ Further discussion on 'Generalisation' appears in Chapter 6 pp. 188/189

Out of a total of 109 clients, 76 (64.8%) were male, while 33 (35.2%) were female. Although clients were chosen strictly to cover a range of needs, no attempt was made to select any specific proportion of *m* to *f* clients. This proportion reflects the needs of clients requiring special interventions within the educational context, or those experiencing mental illness in adulthood.

When overall signs of improvement were further analysed, to fill the gap in the original analysis, the following table emerged:

Table 21

View	Results	Results	Results
	Male	Female	overall
Teacher	55%	70%	60%
Therapist	62%	70%	65%
Client	72%	76%	74%

Scoring for m/f v. Signs of improvement

This rating covers the scoring of 4-6, that is, clients who had ‘noticeable improvement’, ‘considerable improvement’ or ‘achieved aim’ as a result of their therapy sessions. Even although the analysis allows for the fact that there were more *m* than *f* clients, more *f* clients than *m* clients were judged by M/T’s, Th’s and C’s, to have made improvement at varying levels, as a result of the therapy sessions, the proportion over all being 1*m* : 1.21*f*.

In all Views, female clients were considered to have been more successful than males. This concurs with the national statistics which state that more males than females experience difficulties in educational and mental health problems.

Q3. Did one location have better results over all than another?

Table 22

View	BEST	WORST
TV	8	2
ThV	6	2
CV	9	10

Scoring for Location v. Results

The location with the highest score, in the Teachers' View, is location 8.⁵⁰ This was the secondary school in which there was a high proportion of immigrant children and where the conditions for the art therapy (modality 1) were so poor that the art therapist eventually had to abandon the work and no scores were therefore submitted.

Table 23

PLACEMENT 8 - Art							PLACEMENT 8 - Dance Movement										
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL		
G1	F	12						G1	F	12	5	5	5	5	20		
G2	F	12						G2	F	12	5	5	5	5	20		
G3	F	12						G3	F	12	5	5	5	5	20		
G4	F	12						G4	F	12	5	5	5	5	20		
G5	F	12						G5	F	12	4	4	4	4	16		
G6	F	12						G6	F	12	5	5	5	5	20		
							29								29	29	116
Average:							0.00	Average:							4.83		

PLACEMENT 8 - Drama							PLACEMENT 8 - Music												
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL				
G1	F	12	5	5	5	5	20	G1	F	12	6	6	6	6	24				
G2	F	12	5	5	5	5	20	G2	F	12	6	6	6	6	24				
G3	F	12	5	5	5	5	20	G3	F	12	3	3	3	3	12				
G4	F	12	5	5	5	5	20	G4	F	12	5	5	5	5	20				
G5	F	12	4	4	4	4	16	G5	F	12	3	3	3	3	12				
G6	F	12	5	5	5	5	20	G6	F	12	4	4	4	4	16				
							29								27	27	27	27	108
Average:							4.83	Average:							4.50				

Teacher's scores for all modalities, in Location 8

(N.B. Average T's score = 4.72, where: 4 = Noticeable improvement, 5 = Considerable improvement and 6 = Achieved aim)

Upon examination of the teacher's ratings, however, the average scores were: dance movement - 4.83, drama - 4.83 and music - 4.5, indicating considerable improvement for all clients in all of the three modalities which were completed.

The poor conditions in this location have not apparently affected the Th's View as, on average, they felt that Location 6 (the infant mainstream school) was the most successful, while the clients in the secondary mainstream school (location 9) gave scores which resulted in their location being that with the highest rating of all the locations.

There is agreement between teachers and therapists on the least successful location, which is Location 2. This was the secondary age exclusion centre, where interventions of any kind are

⁵⁰ See Table 10 p. 98 for details of locations and clients referred

generally reported to be difficult. However, the clients in location 10 (the brain injury rehabilitation unit) have the lowest score. At this location, the researcher was only able to acquire CV numerical results for the music modality, as it was stated by the unit's staff that the clients were not able to provide reliable data because of the nature of their disabilities, which they said could have caused their conclusions to become biased or inconsistent. If this location is 'disallowed' because of this fact, then the lowest score by client / location is 7 – the school for secondary special school for children with autism.

Q4. Did one modality have better results than another?

Table 24

View	BEST	WORST
TV	2 (3 is close)	1
ThV	2 (4 is close)	1
CV	3	1

Scoring for modality type v. Results

Modality: 1 = Art; Modality 2 = Dance movement; Modality 3 = Drama; Modality 4 = Music

In the view of teachers and therapists, dance movement is the most successful therapy in achieving the aims set, with drama and music close. In the view of the clients, dramatherapy scores the highest. All agree that art therapy is the least successful.

Q5. Did one therapist have better results than another?

Table 25

TV	Best = 3/4,7,2,5,6,1,8 Worst
ThV	Best = 2,6,4,5,8,1,7,3 Worst
CV	Best = 2/5,4,6,1,7,8 Worst*

Best to worst ordering for therapists by results

**(There is no score for therapist 3 in CV as there was insufficient client data relating to this therapist.)*

Nine different therapists participated in the practical delivery of the research project, however the ninth was obliged to withdraw in mid-programme, because of maternity leave, so her scores are not included in the quantitative results. Individual names of therapists have been

initialised for reasons of confidentiality. There is less difference in the scores offered by the teachers. The analyst commented that a high score on the part of the teachers might be interpreted as ‘the most successful’, while a high score by the clients might be interpreted as ‘the most popular’. However, there is a high correlation between CV and TV, indicating that there is agreement that ‘success’ and ‘popularity’ go hand in hand. Therapist 8 is ranked lowest by teacher and clients, but not by therapists’ scores.

Q6. Which were the most prevalent aims?

A summary of the 51 original aims and their allocation to categories,⁵¹ produced the following table of prevalence:

Table 26

Category Letter of	Code	Aim	No. of Times this Aim was Chosen	% of Total No. of Aims (436)
C	3	To be able to participate as a member of a group in an appropriate way and to benefit from so doing	134	30.7%
E	5	To respond individually in an appropriate manner	85	19.5%
B	2	To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions	83	19.0%
A	1	To enhance self-esteem	68	15.6%
D	4	Enjoyment / freedom	41	9.4%
G	7	For relaxation and reduction of stress	10	2.3%
F	6	To benefit physically	9	2.1%
H	8	Motivation and mental stimulation	6	1.4%

The most prevalent aims

⁵¹ See Appendix 12.2 Table12 p. xxiv

Table 27

Aim No:	Mean Age (years)	Youngest*
1	12.1	*
2	18.7	*
3	15.7	*
4	14.9	*
5	15.4	*
6	36.7	*
7	25.1	*
8	47.3	Oldest

Mean age per aim

**This indicates where the oldest and the youngest fall on the scale – at the extremes*

The most common aim chosen was that covering the need for the client to be able to participate in an appropriate manner within a group – that is, in a social context. The next most frequently chosen aims were those to do with appropriate individual responses and for expressing and acknowledging personal emotions. Older clients chose aims concerned with benefitting physically and mental and motivational stimulation more than younger clients. As already mentioned, the majority of these aims appeared to fall within the top two ‘tiers’ of Maslow’s ‘Hierarchy of Need’ of ‘Self actualisation’ and ‘Esteem’, confirming that the purpose of therapeutic intervention is seen to cover these areas of need, in preference to actual physical or mental stimulation. The concept of ‘motivation’, became very important in the subsequent analysis of Question 8.

Q7 *Was one aim more prevalent with any particular age group?*

Table 28

Age	5-10yrs.	11-19yrs.	20-30yrs.	31-45yrs.	46-61yrs.
Code	0	1	2	3	4

Coding given to different age groups

Table 29

Age of Client	Most Prevalent Aim	
	<i>m</i>	<i>f</i>
0	3	2
1	3/5	5
2	3	3
3	2	2
4	2/3	3

Age of client v Most prevalent aim v m / f

There is a fair degree of correlation between male and female, whichever the age range of the clients, and the most prevalent aim chosen. As expected from the results of Q6, the most commonly chosen aim is 3 – ‘*To be able to participate as a member of a group in an appropriate way and to benefit from so doing.*’ The only age in which this does not appear to be the most prevalent, is the 31-45yr.old age group. Younger female children, together with the age range 31-45yrs. seem to prefer aim 2 – ‘*Freedom of expression of emotions,*’ while the age range 11-19yrs., (secondary school age) prefer aim 5 – ‘*Responding individually in an appropriate manner.*’

Q8 *How do the scores obtained so far match up with the prevalence of aims?*

Table 30

View	BEST	WORST
TV	4	3
ThV	4	5
CV	4	3/5

Scores obtained v. Prevalence of aims

(Aims 6,7,8 were omitted from analysis, as only a few clients had these aims, therefore there was not sufficient data to compare).

All agree that Aim 4 was addressed the most successfully. This was defined as: ‘*Enjoyment / Freedom*’ and covered such aims as ‘*To have fun*’, ‘*To enjoy sessions*’, ‘*To have the opportunity to work in a less formal setting*’. This does not support the frequency in which the aims that were chosen, which were – in order of frequency – aims C, E, B and A. Informal discussion with both referrers and clients (not forming part of the official investigation), after these results were beginning to become apparent, indicated that both parties supported the importance of the fact that the clients should have ‘*enjoyment and freedom*’ within the

sessions. It was stressed that without these elements being present in the sessions, other issues could not be addressed with confidence. Moreover, ‘enjoyment’ was also linked with ‘motivation’. If ‘motivation’ was not present, then no progress would be made towards the achieving of any of the aims. In these circumstances, it would be unlikely that any mode of therapy chosen would be successful.⁵²

Q9. Was there correlation between ages of clients and their overall scores?

Table 31

View	BEST	WORST
TV	46 - 61	30 - 45
ThV	5 - 10	30 - 45
CV	46 - 61	30 - 45

Ages of clients v. Overall scores

The results of the middle age group of 30-45 were viewed to be the least successful, by all three categories of those giving ‘results’. Referrers judged that the most successful work was undertaken with the oldest group, while the therapists reported that such work was undertaken with the youngest age group. Amongst the ‘Views’ of the clients, there did not seem to be a specific age at which they felt that their aims might be particularly successfully addressed.⁵³

⁵² See further discussion of Motivation in Chapter 7 p. 236

⁵³ See Chapter 6 p.193 for further discussion concerning the age of the client

Q.10. Was there correlation between ages of clients and the most successful therapy?

Table 32

Age of Client	TV		ThV		CV		Consensus	
	Best	Worst	Best	Worst	Best	Worst	Best	Worst
0 (5- 10 yrs.)	3	1	2	1	2	1	2P	1C
1 (11 – 19 yrs.)	1	2	4	1	3	1	N	1P
2 (20 – 30 yrs.)	3	4	3	2 (no.1)	2	4 (only 2 modalities)	3P	4P
3 (31 – 45 yrs.)	1	4	1/3	2	(Incomplete)		1P	N
4 (46 – 61yrs.)	2	1	3	1	4	1	N	1C

Ages of clients v. Most successful therapy

*(1 = Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)
(C = Consensus; P – Partial Consensus; N = No Consensus)⁵⁴*

Code 0 (5- 10 yrs.): Teachers, therapists and clients are agreed that modality 1 (art therapy) is the least successful. There is less agreement, however, as to which is the best. Therapists and clients think dance movement, teachers decide on drama.

Code 1 (11 – 19 yrs.): Therapists and clients agree that modality 1 (art therapy) is the least successful, but this is not the opinion of the teachers, who think that modality 1 is the best for the 11-19 age group. Teachers think that dance movement is the least successful, while therapists believe that music is the best and the clients choose drama.

Code 2 (20 – 30 yrs.): The pattern changes for this age group. Therapists and clients agree that dance movement is the most successful, while teachers choose drama. Music seems to be the least popular in the opinions of both teachers and clients.

Code 3 (31 – 45 yrs.): Art therapy is judged again to be the most successful by the teachers and the therapists - (therapists also finding drama to be successful). Music and dance movement are judged by teachers and therapists respectively to be the least successful. There are not enough ‘Views’ collated from clients in the category to make analysis meaningful.

⁵⁴ Consensus was calculated by comparing the results in each age category, according to ‘best’ and ‘worst’ columns. Thus in category 0 (5-10yrs.), ‘best’ scores were 3/2/2/, i.e. two (ThV and CV) agreed in their evaluation (consensus = C), while one (TV) did not (no consensus = N). This led to 2 x partial consensus (2P). In the ‘worst’ column, all 3 Views agreed that No.1 modality was the worst, leading to the consensus of 1C.

Code 4 (46 – 61yrs.): Art therapy is seen unanimously to be the least successful with this age group. Opinion is equally divided between dance movement, drama and music as to which is the best.

Table 33

	View	BEST	WORST
Q4 Did one modality (type of therapy) have better results than another? Modality 1 = Art; Modality 2 = Dance Movement; Modality 3 = Drama; Modality 4 = Music	TV	2 (3 is close)	1
	ThV	2 (4 is close)	1
	CV	3	1

Modality of therapy v. Success of results

Q11. Was one aim more successfully addressed with one particular Modality of therapy?

On analysis, it appeared that this question would have to be sub-divided, as follows:

Q.11.i Success of aims v. modality of therapy

Q.11.ii Consensus of frequencies of success of aims v. modality of therapy

Q.11.iii Are these the same results for both m and f?

Q.11.iv Were the results consistent over all age-groups?

Results would also have to be presented in the 3 forms of TV, ThV and CV:

Q11.i. Success of aims v. modality of therapy

Table 34

No. of Aim	Most successful modality of therapy		
	TV	ThV	CV
1	4	4	4
2	2	3	3
3	3	2	2
4	4	3	2/3
5	3	4	3
6	2	4	2
7	2	3	2
8	2	2	3

Success of aims v. modality of therapy

(1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

Q11.ii – Consensus of frequencies of success of aims v. Modality of therapy

Table 35

Aim	Modality of Therapy				Consensus
	1	2	3	4	
1	-	-	-	3	C
2	-	1	2	-	P
3	-	2	1	-	P
4	-	1	1	1	N
5	-	-	2	1	P
6	-	2	-	1	P
7	-	2	1	-	P
8	-	2	1	-	P

Consensus of frequencies of success of aims v. Modality of therapy

*C=Total Consensus; P= Partial; N = No Consensus
(1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)*

Results as shown in these tables appear to lead to the following conclusions:

Aim 1: To enhance self esteem

The unanimous choice here is music therapy.

Aim 2: To allow expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions

Here, dramatherapy is the choice of therapist and clients, while teachers (carers and parents) feel that dance movement is more successful.

Aim 3: To be able to participate as a member of a group in an appropriate way and to benefit from so doing

Dance movement is the 1st. choice of therapists and clients. TV indicates dramatherapy.

Aim 4: Enjoyment / freedom

This aim was felt to be the most successfully addressed of all the aims (*see above Q5*), but there was no consensus as to which modality of therapy was the best for so doing. According to the TV, music therapy provided the most enjoyment and freedom, while for the ThV, drama did so. For the client, there was a divided opinion between dance movement and drama.

Aim 5: To respond individually in an appropriate manner

Here, TV and CV appear to support dramatherapy, while the ThV feels that music allows the most successful approach.

Aim 6: To benefit physically

Dance movement is chosen by TV and CV, while the ThV favours music therapy. It may be that the therapist is judging more on the side of muscle relaxation, rather than on the level of gross motor skills.

Aim 7: For relaxation and reduction of stress TV and CV agree that dance movement is the best modality of therapy for relaxation and reduction of stress, which the ThV supports drama.

Aim 8: Motivation and mental stimulation

TV and ThV agree here that dance movement best addresses this aim. CV supports drama.

Art therapy does not appear as the 1st. choice for any of the aims, although as is shown in Q11b below, art therapy is 1st. choice within certain age groups. This is because the numbers in the age groups vary and art therapy comes 1st. in age groups which contain smaller number of clients.

Q11.iii Was one aim more successfully addressed with one particular modality of therapy, AND, iii, was this the same for both sexes?

Table 36

AIM	TV		ThV		CV		Consensus	
	<i>m</i>	<i>f</i>	<i>m</i>	<i>f</i>	<i>m</i>	<i>f</i>	<i>m</i>	<i>f</i>
1	4	2	4	4	4	3	4C	N
2	3	2	3	2	3	3	3C	2P
3	3	4	2	3	2	2	2P	N
4	4	4	3	4	3	2	3P	4P
5	3	2	4	2	4	3	4P	2P
6	2	2	4	3/4	2	-	2P	N
7	2	2	3/4	2/3	2	1/2	2P	N
8	2	1	2	2	3	1	2P	1P

Aims v Modality v m/f and consensus

(C = Consensus; P – Partial consensus; N = No consensus)
 (1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

The only consensus is that *m* clients are most successful in aim 1: *To enhance self esteem*, using music therapy (there is no consensus at all amongst *f* clients for Aim 1), while *m* clients find that dramatherapy is most successful in addressing aim 2: *To allow expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions*. There is only partial consensus amongst *f* clients for aim 2, who are divided between dramatherapy and dance movement therapy. Other aims show no over all consensus of result.

Aim 3: *To be able to participate as a member of a group in an appropriate way and to benefit from so doing* - shows that *m* clients find more success in dance movement than drama; *f* clients show no consensus at all.

Aim 4: *Enjoyment / freedom* – *M* clients show partial consensus for dramatherapy, while *f* clients show a partial consensus for music therapy.

Aim 5: *To respond individually in an appropriate manner* - *M* clients show partial consensus for music therapy, while *f* clients show partial consensus for dance movement therapy.

Aim 6: *To benefit physically* - *M* clients show partial consensus for dance movement therapy, while *f* clients no consensus at all.

Aim 7: *For relaxation and reduction of stress* - *M* clients show partial consensus for dance movement therapy, whereas *f* clients show no consensus.

Aim 8: *Motivation and mental stimulation* - *M* clients show partial consensus for dance movement, whereas *f* clients show partial consensus for art.

It would appear that – in the Views of M/T, Th and CV – *m* clients are in greater agreement that dance movement therapy addresses more of their aims. *F* clients – in the Views of M/T, Th and CV – are less likely to agree on any one modality of therapy for any particular aim.

Q11.iv Was one aim more successfully addressed with one particular modality of therapy, AND, was this the same over all age groups?

Teacher / Manager View (TV):

Table 37

Age	5-10yrs.	11-19yrs.	20-30yrs.	31-45yrs.	46-61yrs.	Consensus
Aim 1	2	4	2	1	-	2P
Aim 2	2	3	3	1	2	3/2P
Aim 3	3	4	3	2	2	3/2P
Aim 4	3	3	3	1	4	3P
Aim 5	3	1	3	1	4	3/1P
Aim 6	-	-	2	2	2	C
Aim 7	-	2	2	2	1/2	2P
Aim 8	-	-	2	1	1	1P

Success of aims v Modality v Age groups – ALL TV's

(A '-' entry indicates that there was insufficient data to analyse for these aims)

(C = Consensus; P – Partial consensus; N = No consensus)

(1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

Here the only consensus amongst M/T's Views are that dance movement addresses aim 6 (*To benefit physically*) the most successfully with all age groups. They are nearly in agreement that aim 7 (*For relaxation and reduction of stress*) is best addressed with dance movement.

Otherwise there is only partial consensus for:

Aim 1: *To enhance self esteem* – Dance movement, with the 5-10yrs. and 20-30yrs. age groups.

Aim 2: *To allow expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions* – divided between dance movement for 5-10yrs. and 46-61yrs. age groups , and drama for 11-19yrs. and 20-30yrs. age groups.

Aim 3: *To be able to participate as a member of a group in an appropriate way and to benefit from so doing* – also divided between dance movement 5-10yrs. and 20-30yrs., age groups and drama for both 31-45yrs. and 46-61yrs. age groups

Aim 4: *Enjoyment / freedom* shows partial consensus for drama for 3 age-groups, namely 5-10yrs., 11-19yrs., and 20-30yrs.

Aim 5: *To respond individually in an appropriate manner* - Consensus is divided between drama 5 – 10yrs. and 20-30yrs. age groups and art – 11-19yrs. and 31-45yrs. age groups.

Aim 8: *Motivation and mental stimulation*- here there is partial consensus, especially for the 31-45yrs. and 46-61yrs. age groups of clients, that art therapy is the most successful.

Therapist View (ThV):

Table 38

Age	5-10yrs.	11-19yrs.	20-30yrs.	31-45yrs.	46-61yrs.	Consensus
Aim 1	2	4	2/3	1	-	N
Aim 2	2	4	3	4	3	3/4P
Aim 3	2	4	3	1/3	3	3P
Aim 4	2	2	3	3	3/4	2/3P
Aim 5	4	4	3	1	2	4P
Aim 6	-	-	4	4	3	4P
Aim 7	-	2	3	3	2	2/3P
Aim 8	-	-	2	3	2	2P

Success of aims v Modality v Age groups – ALL ThV's

(C = Consensus; P – Partial consensus; N = No consensus)

(1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

Aim 1: To enhance self esteem - There is almost no consensus of opinion here on the part of the therapists as to the most successful therapy to achieve this aim. There is a slight weighting in favour of dance movement for the 5-10yrs. and divided opinion for the 20-30yrs. age groups.

Aim 2: To allow expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions - Music is seen to be best for the 11-19yrs. and 31-45yrs. age groups; drama for the 11-19yrs. and 20-30yrs. age groups. There is no overall consensus.

Aim 3: To be able to participate as a member of a group in an appropriate way and to benefit from so doing - Drama is seen by the majority to be best the, but only for the older age groups.

Aim 4: Enjoyment / freedom - Again, there is only partial consensus. It appears that dance movement is seen to be the best for the younger ages of 5-10yrs. and 11-19yrs., whereas drama is favoured for the older ages 20-30yrs.; 31-45yrs. and 46-61yrs. *Aim 5: To respond individually in an appropriate manner* - There is partial agreement amongst therapists that

music therapy is the most successful modality for individual self- expression amongst the children - 5-10yrs. and 11-19yrs. For older age groups, there is no such consensus.

Aim 6: To benefit physically - For the middle age groups, namely the 20-30yrs. and 31-45yrs. year olds, it seems that music therapy is deemed to have partial consensus for therapists. It might have been thought that dance movement would be the most appropriate modality for this aim, but the figures do not concur with this.

Aim 7: For relaxation and reduction of stress - Dance movement for the 11-19yrs. and 46-61yrs. age groups, and drama for the 20-30yrs. and 31-45yrs. age groups are seen to have partial consensus.

Aim 8: Motivation and mental stimulation - Dance movement has partial consensus for the 20-30yrs. and 46-61yrs. age groups.

Client View (CV)

Table 39

Age	5-10yrs.	11-19yrs.	20-30yrs.	31-45yrs.	46-61yrs.	Consensus
Aim 1	4	3	-	4	-	4P
Aim 2	3	3	4	4	2	3/4P
Aim 3	2	2	2	4	4	2P
Aim 4	3	4	-	-	2	N
Aim 5	4	3	4	4	1	4P
Aim 6	-	-	4	4	2	4P
Aim 7	-	2	2	4	1/2	2P
Aim 8	-	-	2	-	3	2/3P

Success of aims v Modality v Age groups – ALL CV's

(C = Consensus; P – Partial consensus; N = No consensus)

(1 – Art therapy; 2= Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

Aim 1: To enhance self esteem - Music therapy within the 5-10yrs. and 31-45yrs. age groups has partial consensus here.

Aim 2: To allow expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions - Drama for age groups 5-10yrs. and 11-19yrs. shares the partial consensus with music for the 20-30yrs. and 31-45yrs.

Aim 3: To be able to participate as a member of a group in an appropriate way and to benefit from so doing - Dance movement is seen as having the greatest consensus for the younger age groups, namely 5-10yrs., 11-19yrs., and 20-30yrs.

Aim 4: Enjoyment / freedom - There is no consensus at all within any age group. All sessions are regarded by all ages as enjoyable and offering freedom.

Aim 5: To respond individually in an appropriate manner - Music is seen to have the greatest consensus, in the 5-10yrs., 20-30yrs. and 31-45yrs. age groups.

Aim 6: To benefit physically - Again, music is chosen to have the consensus in this age groups 20-30yrs. and 31-45yrs.

Aim 7: For relaxation and reduction of stress - dance movement has the consensus of opinion here, for the 11-19yrs., 20-30yrs. and 46-61yrs. age groups.

Aim 8: Motivation and mental stimulation - Dance movement and drama have partial consensus for the 20-30yrs. and 46-61yrs. age groups respectively.

Q11.iv - Was one aim more successfully addressed with one particular modality of therapy, AND, was this the same over all age groups? + Consensus of previous tables

Table 40a

Age	T/V					ThV					CV				
	5 - 10	11-19	20-30	31-45	46-61	5 - 10	11-19	20-30	31-45	46-61	5 - 10	11-19	20-30	31-45	46-61
Aim 1	2	4	2	1	-	2	4	2/3	1	-	4	3	-	4	-
Aim 2	2	3	3	1	2	2	4	3	4	3	3	3	4	4	2
Aim 3	3	4	3	2	2	2	4	3	1/3	3	2	2	2	4	4
Aim 4	3	3	3	1	4	2	2	3	3	3/4	3	4	-	-	2
Aim 5	3	1	3	1	4	4	4	3	1	2	4	3	4	4	1
Aim 6	-	-	2	2	2	-	-	4	4	3	-	-	4	4	2
Aim 7	-	2	2	2	1/2	-	2	3	3	2	-	2	2	4	1/2
Aim 8	-	-	2	1	1	-	-	2	3	2	-	-	2	-	3

Was one aim more successfully addressed with one particular modality of therapy, TV/ThV/CV

Table 40b

CONSENSUS					
Age	5 - 10	11-19	20-30	31-45	46-61
Aim 1	2P	4P	2P	1P	-
Aim 2	2P	3P	3P	4P	2P
Aim 3	2P	4P	3P	N	N
Aim 4	3P	N	3P	1/3	4P
Aim 5	4P	N	3P	1P	N
Aim 6	-	-	4P	4P	2P
Aim 7	-	2C	2P	N	2P
Aim 8	-	-	2C	N	N

CONSENSUS v Was this the same over each age group?

(C = Consensus; P – Partial consensus; N = No consensus)

(1 – Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

From the above table showing consensus between TV/ThV and CV as to which aim was most successfully addressed by which therapy, it can be seen that there is very little overall consensus, but considerable partial consensus⁵⁵. Within this analysis many of the variables have been compared, so that – for example – one might infer that if a secondary aged client (11-19yrs.) wished to address aim 7: *‘For relaxation and reduction of stress’*, the above table would indicate that it was most likely that dance movement would be the most appropriate therapy, or if the need was for Aim 1 *‘To enhance self-esteem’*, then music therapy would be suggested. If, however it was agreed that Aim 5 *‘To respond individually in an appropriate manner’* should be addressed, there would not be any guidelines available, as to which

⁵⁵ *This Table does not differentiate between m/f clients for each age group*

modality should be suggested. It is also to be remembered that the above table does not take into account the gender of the client. This is addressed in *Table 29*. However, in this case, there is no allowance made for the age of the client. This problem is discussed in Q12 below.

Q 12. Using the above data and analyses, is it possible to answer the question: ‘Which arts therapy for which client and why?’

At this point, it became apparent that there were too many variables to make a straightforward deduction from the above analyses.

Limitations of Quantitative Results

The design for this research did not allow for quantitative results to be as stringently measured as might be required in a randomised control trial approach, owing to the **many** inherent variable factors within the research, such as assessment of individual personalities of the clients and therapists concerned, the sequence in which therapies were experienced and the practical impossibility for every participating client to experience all four therapies. In order to achieve quantitative results which might be regarded as statistically reliable, more stringent controls would have to be exercised and the number of contributing variables considerably reduced.

The value of the present quantitative data, therefore, was principally as a means of reflection, rather than as substantive evidence to support specific conclusions.

CHAPTER 5 – THE QUALITATIVE RESULTS

Introduction

In this chapter, verbal responses made by teachers/managers (M/T), therapists (Th) and clients (C) in the face-to-face structured interviews are analysed. The interviews were conducted by the researcher at the conclusion of all four stages of the therapies programmes. Pre-planned questions covered specific topics such as whether a particular therapy had been felt to be the most effective for clients and if so, for what reason; the role and personality of the therapist; practical aspects of the programme and thoughts for future programmes.

Analysis of responses ⁵⁶

QQ1 (M/T): In general, do you think that your programmes helped your clients?

QQ1 (Th): In general, do you think that your programmes have helped your clients?

QQ1 (C): In general, do you think that the arts therapies have helped you?

After colour-coding,⁵⁷ responses to this question were placed into groups representing:

- ‘positive responses’ – responses ranging from the benefits of the sessions in general, to improvements in relationships of the clients to group participation, individual progress and levels of enjoyment
- ‘negative responses’ – detailing apparent inhibited, reserved or suspicious behaviour on the part of clients or practical and management difficulties
- ‘unexpected responses’ – comments made which the researcher had not foreseen when planning the structured interview
- ‘other responses’ - any comments not included in the above categories

⁵⁶ Numbering of questions in the questionnaire will be designated by ‘QQ’, to differentiate between these questions and those of the quantitative analysis.

⁵⁷ For example of qualitative analysis see Appendix 9 p. xv

QQ1 – M/T Responses

Table 42

Positive Responses:

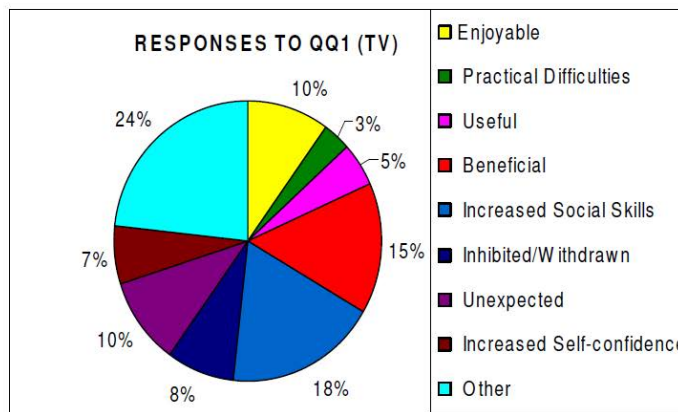
- Enjoy(able); fun
- Useful
- Beneficial
- Increased Social Skills
- Increased Self-Confidence/ Self-esteem,

Negative Responses:

- Practical / Management Difficulties
- Inhibited / Reserved / Suspicious

Others:

- Unexpected results / Different approach
- Other comments



Showing Managers / Teachers' Responses to QQ1

All managers/teachers of the 10 locations involved in the project responded to the structured interviews, making a total of 10 sets of M/T responses in all. Of these, in QQ1, a total 55% responses were 'positive', 11% 'negative', 10% 'unexpected' and 24% 'other'.⁵⁸

Within the 'positive' responses, it would appear that from the manager/teacher point of view, the programmes were most successful in areas of social relationships - in clients' interactivity and ability to function within a group (18%), followed by that of general benefit, supporting clients' progress, with giving overall very helpful results (15%). Words associated with increased self-confidence, self-esteem and increased belief in themselves, appeared less frequently (7%) in manager/teachers' responses.

⁵⁸ See Appendix 12.6 Table 40 p. xxxi for details of analysis of Tables 42 – 44. These figures are given as a percentage of total 'key word' usage and are to the nearest decimal point.

Negative comments referred to the feeling that some clients had felt inhibited during sessions or that clients were reserved or suspicious – which managers/teachers regarded as a deterrent to participation (8%). Management problems (3%) were mostly connected to disruption of school routine or disturbance to other activities caused by the therapy programme. If one compares these managers/teachers' comments with the clients' responses,⁵⁹ these reservations do not necessarily seem to be consistent with the manner in which the clients viewed the sessions.

Unexpected results / different approach (10%) included facts such as – as one head teacher put it: 'I think that it's given us a completely different approach, which was eye-opening to both children and staff. Different children react in different ways to different circumstances and this was very beneficial to them'. Another teacher commented that they had seen unexpected results in the sort of behaviour and in the way that the children interacted during therapy sessions, while having difficulties within the school setting. This teacher even wondered whether the approach adopted in the class-room was not so suitable for these particular children.

Other comments (24%) were the largest group of responses. They included the fact that one teacher felt that he could not give an overall opinion, as children's responses to the therapy programmes varied from one child to another; another teacher commented that he knew that his children had enjoyed the sessions because they came out of the sessions with an eagerness to discuss with him what had happened in the sessions. A third teacher commented that one child had made superb progress – which had been maintained well after the sessions had taken place, but she did not know whether she could attribute this to the arts therapies, or to other concurrent factors. However, in her following remarks, the teacher stated that the therapy sessions did play an important part in the child's improvements, as the child '..became much calmer in class, much more able to express her feelings when she gets frustrated, and so we don't have the temper tantrums that we had prior to the arts therapies'.

⁵⁹ See Table 44 p. 131 below

This last comment was reflected by further teacher who felt that some children had improved, but she could not say whether it was the therapy that had made the difference. She referred in particular to one girl, who had now been able to go on work experience, but said that she felt that the children probably would have developed anyway. She also stated that they had a learning support centre in the school, which helped the children to improve, so she felt that it was hard to differentiate what had caused improvement.

The factor of not being sure whether it was the therapy sessions themselves which had caused changes in behaviour and attitude in the children was reflected by another teacher, who said she had difficulty ‘... assessing the degree of help and the sustainability of it. Because it was a project, and it was for a fixed term, and the youngsters are autistic, I think any answers, to some extent, have got to remain speculative. But I did notice that there were a number of youngsters that were quite specific. There was J., who responded very well to the art therapy and there was L., who responded very well to the dance movement therapy, as an example.’ This comment reflected the discussion of whether it was not only the programme in its totality which had provided benefit, or whether it was one specific modality.

Another comment made was that the therapy sessions must be ‘... part of the big programme. It’s not just the therapy activities and it’s not a quick fix solution... it’s got to be that whole ethos that runs through the school and the children have got to be getting that support from the school.’ A teacher who worked in a unit for children referred because of behavioural issues commented that although he had noticed changes within the children during the therapy sessions themselves, ‘Perhaps hasn’t helped the improvement of their behaviour outside of the session.’ These ‘other comments’ are all very important points, which will be discussed in the next chapter.

QQ1 – Th. Responses

In total, 9 arts therapists participated in the delivering of the programme. Of these, 8 responded to the structured interviews, the 9th. having moved away from the district, was unavailable for interview. The 8 therapists gave a high percentage of positive responses in

their answers to this question (54%),⁶⁰ indicating that their therapy programmes enabled clients to express things that were going on for them, which they could not express otherwise; the ‘supra-verbal’ activity allowed clients to address issues that had perhaps remained dormant for some time, but which now had the opportunity to be expressed and considered. The therapists also reported positive feedback from both staff and clients at the end of sessions.

Table 43

Positive Responses:

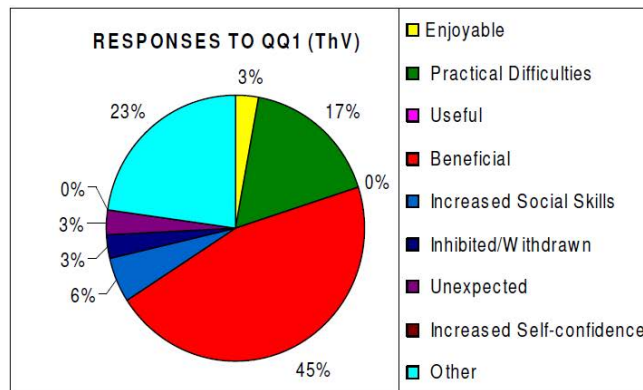
- Enjoy(able); fun
- Useful
- Beneficial
- Increased Social Skills
- Increased Self-Confidence/ Self-esteem,

Negative Responses:

- Practical / Management Difficulties
- Inhibited / Reserved / Suspicious

Others:

- Unexpected results / Different approach
- Other comments



Showing Therapists' Responses to QQ1
(‘Useful’ and ‘Increased Self-Confidence’ = 0%)

On the negative side, more than one therapist mentioned the underlying ‘reserved-ness’ or even ‘suspicion’ exhibited by some clients, when confronted with the opportunity of free self-expression and apparent lack of directed activities by the therapists. Other negative comments made by the therapists were based on a number of points, such as that the environment in which the therapy was to be conducted was physically totally unsuitable, owing to shortage of rooms in the location. Secondly, the same therapist felt that sometimes sufficient attention had not been given to the referral of clients, or that support generally from other staff members was lacking. This therapist mentioned that perhaps she was not the right person to be working with

⁶⁰ Therapists could only comment on their own modality of therapy, as they had not been present in sessions operating in modalities other than their own.

that type of child⁶¹ and raised the possibility that perhaps her modality just ‘... may not have been the appropriate therapy for them.’

Another point raised by therapists, that did not apply to the actual therapy programme but was still pertinent to the process as a whole, was the question of ‘follow-up’. It was pointed out that in order to support any progress made by clients, there should have been more provision made for continuation of the programme, if it was felt that the client concerned had not reached a ‘natural end’ of his/her need for intervention. It was the very nature of the programme that sessions were limited to 12-weeks (only 6 weeks for the first four locations) and it was felt that some clients would have benefitting from a prolonging of an individual programme.

There were few ‘Unexpected’ responses. One therapist in particular reported that as his style of work used elements of other modalities besides his own main subject - ‘I work in a cross-cultural modality’ - clients were able to ‘get a lift’ from the freedom of restriction to one modality only.

‘Other’ responses included the need for clients’ personal ‘space’ to be respected, as well as the physical space in which sessions are conducted. It was also suggested that the therapy space (physical) was an opportunity for clients to experience a ‘safe space’ - one of the fundamental factors in the therapy process. The importance of the non-verbal relationship, which is one of the underlying concepts of arts therapies, was also stressed in the ‘other’ category. One question which arose from therapists’ comments was that it might, after a few weeks of participation in sessions, have been advisable for a client to move from one group to another, or from a group context to a 1:1 situation. This flexibility would be available within normal working practice, but was not available within the context of the research programme.

⁶¹ This point is further discussed in *QQ4* p. 157, concerning the personality of the therapist.

QQ1 – C Responses

Table 44

Positive Responses:

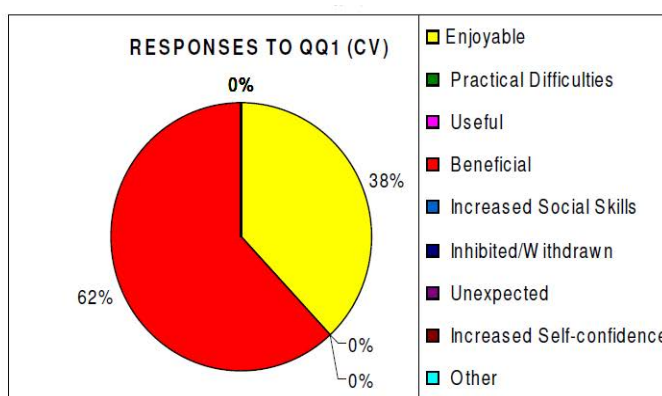
- Enjoy(able); fun
- Useful
- Beneficial
- Increased Social Skills
- Increased Self-Confidence/ Self-esteem,

Negative Responses:

- Practical / Management Difficulties
- Inhibited / Reserved / Suspicious

Others:

- Unexpected results / Different approach
- Other comments



Showing Clients' Responses to QQ1

(‘Negative’, ‘Unexpected’ or ‘Other’ comments = 0%)

It proved very difficult to obtain responses from the clients themselves to the structured interviews, for a number of reasons. As the total number of sessions continued for more than a school year, many of the school age clients had moved from one school to another and teachers stated that they were either no longer available to respond, or that too much time had elapsed between the commencement of the first sessions and the end of the programme, for the children to be able to remember details. Some clients, such as those from the brain injury unit or from schools for learning disabled were deemed by their managers/teachers to be unable to respond. In such instances, ‘scores’ were entered on behalf of the clients by the managers/teachers concerned, on behalf of the client. Although this was far from satisfactory, those who responded in a ‘proxy’ role did attempt to ‘think themselves’ into the clients’ positions and suggest what they thought the client would have answered, had they been able to. Of the 8 clients who did participate fully in the structured interviews, all responded positively, saying that they thought that the therapy sessions had been either enjoyable or beneficial. One elderly client said specifically how much he had enjoyed the dramatherapy, as this had encouraged him to remember winter and summer and his trips to the seaside when he was young. He said that he had looked forward to a Friday morning, because that was when the dramatherapy was held. Many comments were made by clients about how they ‘felt better’

after the sessions. There were no ‘negative’, ‘unexpected’ or ‘other’ comments to this question from the clients.

QQ1 – Summary of All Responses

Table 45

Positive Responses:

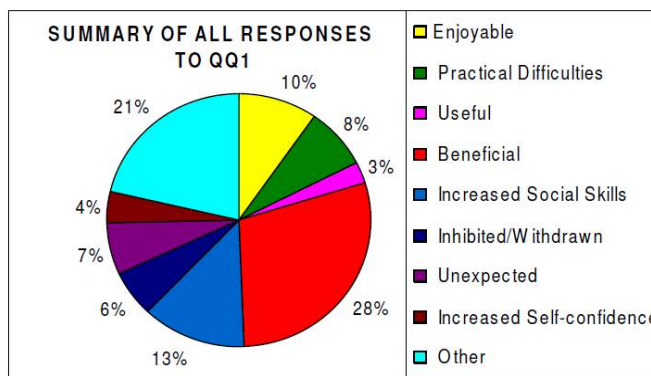
- Enjoy(able); fun
- Useful
- Beneficial
- Increased Social Skills
- Increased Self-Confidence/ Self-esteem,

Negative Responses:

- Practical / Management Difficulties
- Inhibited / Reserved / Suspicious

Others:

- Unexpected results / Different approach
- Other comments



Summary of All Responses to QQ1

The total of all ‘positive’ responses (58%) to the interventions considerably outnumber the ‘negative’ ones (14%), with ‘unexpected’ (7%) and ‘other’ comments (21%) adding up to (28%). The ‘other’ entries (21%), tended to group themselves into comments from the therapists about the ‘technical’ side of the therapy, or their personal relationships with the clients; the validity of accrediting observed improvements in the clients to the therapy programme; and whether results obtained in the sessions were also apparent outside the therapy room (generalisation); these points are further discussed in chapter 6. As the majority of the ‘unexpected’ and ‘other’ comments are positive, it appeared that a very high percentage of comments and the observed results were supportive of the programme as a whole.

QQ1b (Therapists only) – Did you feel the switch to a 12-week programme was advantageous?

This question was only put to the 9 therapists, as managers/teachers and clients were not offered the choice of a 6-week or 12-week intervention and therefore could not offer an opinion. Not all therapists had participated in both 6-week and 12-week programmes, therefore not all could answer this question from experience gained within the research programme, but could offer opinions based on general professional experience. In considering the responses given, it becomes immediately apparent that the majority of therapists were preferred the 12-week programme to that of only 6-weeks.⁶²

The 6-week Programme

The length of individual sessions remained constant throughout the 6 – or 12 – week programmes. Overall, the shorter period of intervention was not felt to be satisfactory by the therapists. Two therapists just stated that the shorter period was basically ‘not enough time’. Others gave reasons, such as that the clients did not feel enough support during the shorter time (x 1) or that there was an inadequacy of time in which to make relationships with the clients and for the clients’ needs to be fully assessed and addressed (x 3). One therapist felt that a 6-week programme was not sufficient in which to gain the clients’ trust, while another felt that it was necessary to allow for a period of closure, which was not possible within the 6-week programme.

However, some therapists did suggest that the shorter length of time might be helpful for the more able clients, as they could more quickly assess the new situation and make use of it. It was also commented that perhaps younger children, being more able to trust quickly and ‘not being so cynical’ were able to ‘get there’ more quickly; however, this was in contradiction to another therapist’s comments, namely that a younger client group would benefit from a longer period of intervention.

⁶² See Appendix 12: 7 Table 17 p xxxii and Appendix 10 p xvii for details of QQ1b: Th. Views on 6 – or 12 – week programmes

The 12-week Programme

The 12-week programme was felt by most therapists to be ‘absolutely critical’, ‘an obvious gain and advantage’ and was ‘essential for all the groups’ (x 3). Therapists stated that this allowed for the 3 stages of therapy to take place, namely the assessment, the ‘middle process’ in which clients needs and aims were intensively addressed and the final closure period (x 2). The longer period also gave much more opportunity to engage (x 2) and the process ‘became more meaningful’ (x 2), providing ‘a good sense of what we (the therapists) could achieve’ (x 2), as well as the progress achieved by the clients (x 1). In addition, the 12-week period allowed clients to become more immersed in the process of therapy (x 2) which led to a greater feeling of purpose for the sessions (x 2).

QQ2 / 3 - Which Therapy do you consider was the most effective and why? ⁶³

The next two questions (QQ2 / QQ3) will be considered together, as they link two related considerations, namely, which modality was felt to be the most effective and why was this so? The questions were worded slightly differently in order to be appropriate for each group of respondents.

For managers and teachers (M/T)’s:

QQ2 – Which therapy do you think was the most effective?

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients?

For clients (C)’s:

QQ2 – Which therapy do you think was the most effective?

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your needs?

⁶³ See Appendix 13.2 p. xliii for discussion of commonalities and differences between the arts modalities

For therapists (Th)'s:

QQ2 – Which client group do you think benefitted most (from your own therapy)?

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to this particular client group?

Initially, analysis was made of the data given in response to these questions by considering the M/T, Th, and C's responses separately, taking into comparison all locations together.⁶⁴

However, as each type of location had a different characteristic / age group, the researcher felt that a second analysis, comparing each type of location individually with the M/T, Th and C's views as to which type of therapy they thought best for that location, might prove to be of greater significance in relation to the original research question.

Responses to **QQ1 - 3** below, are therefore listed in order of location. As stated above, responses are listed by location, together with their chosen aims, so that the reader may be reminded which type of aim was felt to be of greatest significance within each location, how this might link with the therapy which was felt to be the most effective in dealing with these aims (**QQ2**) and why this might be (**QQ3**). The numbers in brackets after each aim indicate how many times this aim was chosen within each location, in order of priority.

Location 1 – Primary special school for excluded children

The aims for this client group

To be able to participate as a member of a group in an appropriate way and to benefit from so doing(26); To enhance self-esteem(13); To use the opportunity to work in a less formal setting(13).

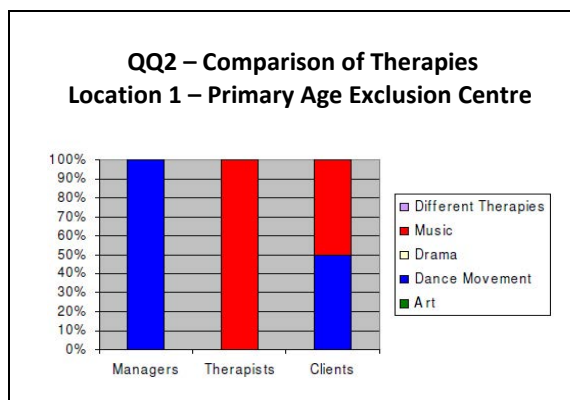
The predominance of aims for this client group concern being able to participate as a member of a group in an appropriate way and to benefit from so doing (chosen both from the point of

⁶⁴ See Appendix 12.8 Table 46 a /b p. xxxiii / xxxiv for original analyses of M/T Responses; Table 46 c/d p. xxxvi for C Responses and Table 46 e/f p. xxxviii/xxxix for Th responses to QQ2/3

view of sharing with others and turn taking / respect for others). Enhancing self-esteem and using the opportunity to work in a less formal setting, take equal second place in importance.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 47



QQ2 Comparison of therapies – Location 1

There was no doubt here that dance movement and music were the first choices for the head teacher and therapist respectively. The clients were divided in their most favoured modality, but agreed with the choice of these 2 modalities by the head teacher and therapists.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The head teacher felt that his behaviourally disturbed children found enjoyment in the new approach of dance movement, revelling from the freedom of space, in which they had less chance of behaving inappropriately, compared with the necessary discipline of the class-room context. He said that this enjoyment in the therapy session supported the motivation of the therapeutic process – his type of child could not progress in a subject if they did not feel motivated towards it.

The music therapist felt that as well as helping with behavioural difficulties, the music sessions had provided an immediate means of communication and transmission of feelings, which had led to a build-up of self confidence. This was supported by the dance movement therapist who felt that the children had ‘gained a lift’ from the freedom of movement and self-expression.

The children themselves had enjoyed the freedom of the dance movement and the new ways of using instruments; they felt that the art and drama therapies had not been so successful and the therapists commented that the sessions had been ‘difficult’. For the dramatherapist, this had also been an issue of balance between ‘control’ and ‘freedom’ of the children’s behaviour.

Location 2 – Secondary Age Exclusion Centre

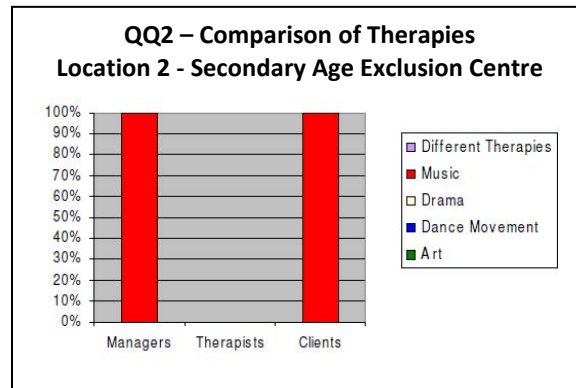
The aims for this client group

To develop listening skills and concentration / decrease derogatory comments / follow instructions (23); To enhance self-esteem (12): To show respect for others(12); To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions(1).

Predominant aims here are those which concern responding individually in an appropriate manner. Enhancing self-esteem and showing respect for others follow. Only one client has the aim of allowing individual expression of emotions in an acceptable form and being able to acknowledge these emotions.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 48



QQ2 – Comparison of therapies – Location 2

In this location, there was unanimous opinion from the head teacher and clients that the music therapy programme had been the most effective – although none of the therapists specifically mentioned having felt that this location had been successful – hence the entry in the ‘no response’ column.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The head teacher of the exclusion unit felt that the music had been the most successful because it had provided the children with a ‘hands-on’ experience which was close to their own personal experiences. They were free to experiment with the sounds – which they enjoyed. The head teacher also said that he felt that the attitude of the therapist ‘... encouraged them to experiment and gave the children individual attention.’

The therapists, when commenting about the responses of older children in general, felt that this age-group was more quickly responsive than adults to this modality, especially relating to the rhythm of the music, which is also a strong feature of pop music, with which they already feel at ease. A dramatherapist felt that, especially with older children, she had become a figure of authority against which the children could rebel; they could come up with ideas which she had to contain on their behalf, until they were able to control them for themselves.

The children felt that they needed the authority or containment of the therapist within a session, as well as the freedom which the therapy sessions allowed. Although they challenged the therapists (see above), the head teacher stated that the children still wished that the therapist would remain in control. Apart from the familiarity of the musical idiom, the children had also felt that the music therapist was more experienced in setting boundaries and that they therefore felt 'more comfortable' in the music sessions. The therapist concerned had been a head teacher himself in the past, which may have been an advantage with this client group.

Location 3 – Primary Mainstream School (with a high ethnic majority of children)

The aims for this client group

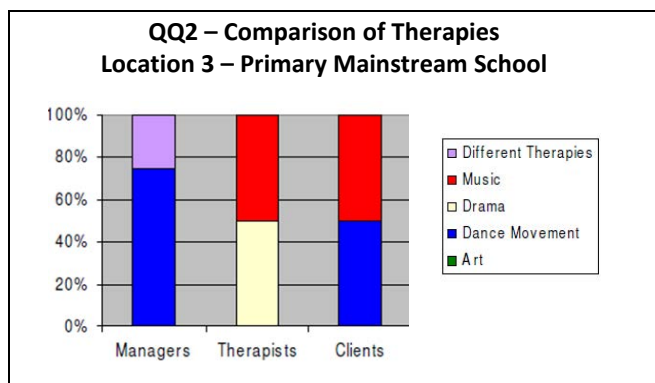
To communicate with / respond to / respect / empathise with others in a positive way, both at home and at school / to share / to increase participation in activities (26);

To stop swearing/ control aggression / avoid being drawn into situations which don't affect him/ improve listening skills / help with anger management / work in a controlled environment (17); to enjoy the sessions (7); to raise self-esteem / feel valued (3).

In this school, greatest emphasis is given to varying ways of being able to participate in a group. Of second importance is the ability to respond individually in an appropriate manner. Enjoyment in sessions is given third priority, while raising self esteem and feeling valued is chosen only 3 times as an aim.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 49



QQ2 – Comparison of therapies – Location 3

In this school the head teacher felt that dance movement therapy had been the most successful, although he also said that each therapy was effective in a different way. The children agreed with him concerning the dance movement, but felt that they had also enjoyed and benefitted from the music. The dramatherapist had felt that all the children in this location had done well – although neither the head teacher nor children had mentioned this.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

For the head teacher in this school, it was important that the referred children – who had many personal difficulties – should have the experience of moving freely, in contrast to restrictions experienced within their home context. For example, outside schools hours, they would not be allowed to go into the parks to play, but would be kept at home for most of the day.⁶⁵ It was valuable, the head teacher said, for them to have an opportunity to use space – with all that this represented – and to be free to move and interact within this space. He also said that he felt that

⁶⁵ *This might be because of fear of racial harassment – AF*

the personality of the therapist had a large part to play in the successful outcome of the dance movement therapy.

Both the therapists concerned (in music and dance movement) felt that the children at this school had done very well and had benefitted. In contrast, the art therapist felt that this had not been an easy location, in that the space for therapy had not been suitable – they had had many interruptions and the children were not allowed to ‘make a mess’. The dramatherapist felt that she could ‘go with’ the younger children, and that games and role-play can help to ‘sort things out’. She felt that the use of projective techniques had really helped with this group.

The support teacher who had attended sessions with the children in this location said that he felt that these two therapies had been the most successful in addressing the very disturbing issues which a number of the children had. He stated that one child in particular – who behaved with considerable aggression – had been able to moderate his behaviour noticeably, although it was harder for him to sustain this outside the therapy session. Continuing difficulties at his home also exacerbated the situation, which made generalisation of improved behaviour patterns difficult for him to maintain.

Location 4 – Elderly Peoples’ Residential Home

The aims for this client group

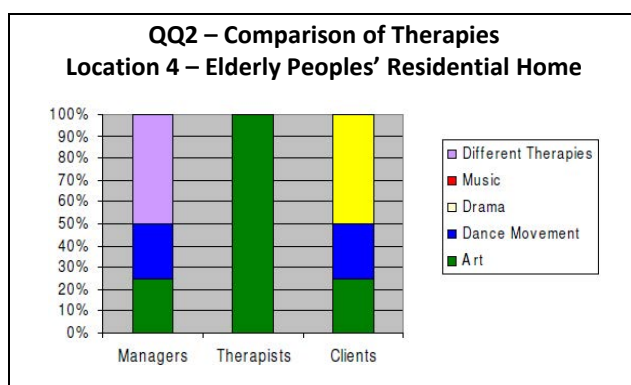
To increase participation in group activities / increase communication / become more aware of surroundings and other people/ not to interrupt others (11); To have an opportunity for self- expression as a release from emotions / assist in assertiveness and making choices (7); To increase motivation (5); To enjoy the sessions – which may be judged by facial expressions and body image (3); To improve listening and concentration / to increase self-awareness (3); For relaxation and reduction of stress (2); To help the client to become more supple (1)

Emphasis for these older clients is still focused on group participation. Second in importance is individual self-expression, making choices and self-assertiveness. Enjoyment, improvement

of listening and concentration skills, relaxation and reduction of stress follow, with opportunities for a client to become more supple coming last.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 50



QQ2 Comparison of therapies – Location 4

No mention at all of music is made at this location, although it is generally recognised that music therapy is very effective with elderly clients (Bright 1973, Odell- Miller 2002). The drama and art modalities are chosen as being the most effective, although the manager in particular stressed that in different ways, each therapy met the individual needs of the clients.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

Within the drama and dance movement, the manager felt that some members of the group had ‘over-powered’ the others and for this reason she had felt that the art therapy had been the most successful as it was relaxing and enjoyable for all. The clients had a wide choice of activities and they could express themselves and enjoy the practical, tactile aspect of the therapy. She felt that the dance movement had been limited by lack of space in the location.

The art therapist felt that the clients, despite having dementia and visual difficulties had done very well at this location. In particular, they had enjoyed the tactile feel of materials and the sense of having created something which could actually be observed. This had given a sense of achievement.

Client E used her hands to describe the dance movement activity – she had liked the art because ‘it’s quite interesting’. Client G indicated that he preferred the art because he felt very relaxed and he was able to recall the time – from a painting which he had done – when they had been on a trip to the seaside and enjoyed the lovely time, whereas in the drama, although he loved it, it was, ‘Stand up, sit down, stand up...’. Client F said that as time (*life in general*) goes by, she didn’t have the interest in doing anything, but ‘enjoyed the winter and summer in the drama’.

Location 5 – Primary Special School for Children with Learning Disabilities

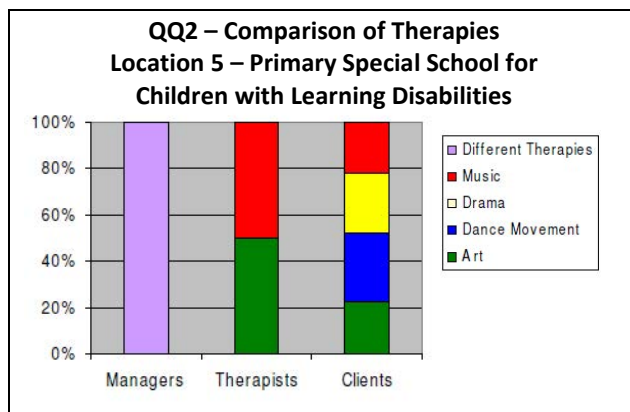
The aims for this client group

To encourage self-expression / to encourage two-way communication (12); to stimulate interaction, especially between client and therapist / to interact and play with others / to stimulate equal play / to share with others (11); to enhance self-esteem(6); to encourage acceptance of change of environment / to increase his auditory response to his name (3).

Almost equal in importance in this location are encouragement of self-expression and ability to participate in a group. Enhancing self-esteem comes 3rd., with responding appropriately individually, last.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 51



QQ2 Comparison of therapies – Location 5

In this school, the head teacher felt that different therapies were suitable for different children – even although they all had learning difficulties. The music and art therapists felt that they had been very successful in this location, whereas the children were almost equally divided in their opinions, showing a slight preference for art and drama.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The head teacher in her running of the school was guided by Gardner’s (2006) Multiple Intelligences. She emphasised that children had different learning styles, therefore one could match each therapy to whichever learning modality they preferred., e.g. H. was more responsive to music, while finding communication (for example in drama) difficult, therefore he should be offered music therapy and would be expected to find this the best modality in which to relate to his difficulties.

The art therapist felt that, as with other young children, these children related intuitively to the art material, which led to increase of self-confidence and development of their individual styles. The dance movement therapist was satisfied with the way the sessions had gone in this

location, feeling that the children had progressed well towards their stated aims. The dramatherapist was also satisfied, although she did say that some children had difficulties with imagination and role-playing, although this improved as sessions continued. She would have liked even longer than the 12-week programme. The music therapist was particularly appreciative of the support received from staff during sessions, which she felt had led to a more advantageous experience.

Each of the children had found that they could relate to at least one of the four modalities offered. Unfortunately, information is not available as to which type of 'Intelligence' each child was considered to have and how this might relate to their chosen modality.

Location 6 – Infant mainstream school

The aims for this client group

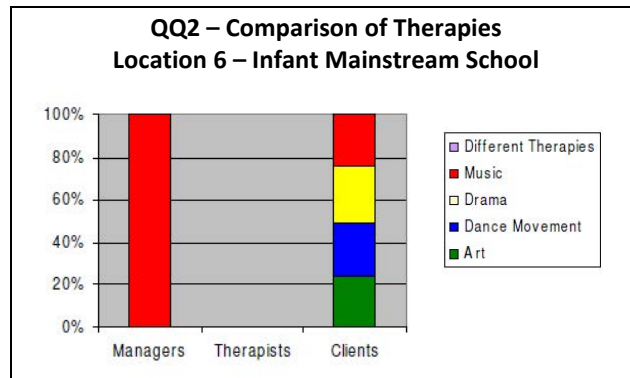
To allow alternative form of self-expression (11); to be able to participate as a member of a group(11); to have fun(11); to enhance self-esteem(11).

In this school, all aims are judged to be of equal importance, in respect of all clients.

The aims of this mainstream infant school, when compared with those of the school for excluded primary children are similar, namely: *'To enhance self-esteem'*; *'To be able to participate as a member of a group in an appropriate way and to benefit from so doing'* and *'To have fun and enjoy sessions'*. The variation between the two schools – in that the mainstream school chooses *'To allow alternative form of self expression'* as distinct from *'to use the opportunity to work in a less formal setting'* – may reflect that it is a matter of degree of conformity or achievement of social behaviour, which differentiates between the two types of child.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 52



QQ2 Comparison of therapies – Location 6

The head teacher in this school was quite sure that the music therapy had produced the best results, while the therapists did not express any specific opinions about this school and the clients were totally divided in their opinions.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The head teacher said that the reason why she felt that music had been the most successful modality was that she felt the children had a special relationship with the therapist presenting the therapy. She said that the children enjoyed the sessions, being allowed to ‘do what they liked with the instruments’ and express themselves as they wished. They did not have an opportunity to do this on a regular basis, as the school did not have a strong musical tradition.

However, although the head teacher felt that the music sessions had been the most successful, the therapist concerned said that she had actually found this location quite difficult. The reason for this was that she was more used to working in a venue where the therapist was regarded as one of the clinical team, which she did not feel was the case here. She must, however, still

have been able to establish a good relationship with the children for this to be especially remarked on by the head teacher.

The children, who were almost equally divided as to which therapy they felt was the most successful, were not able to comment on the reasons for this, as, disappointingly, they had moved to another school by the time of the interviews.

Location 7 - Secondary special school for children with autism

The aims for this client group

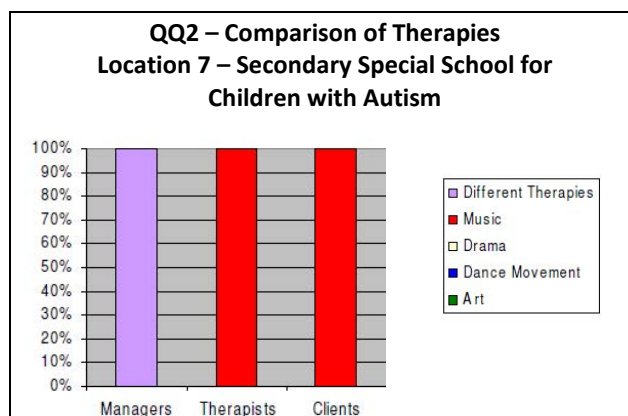
To stimulate interaction and play with others (11); freedom of expression(11); increase of self-esteem(11); increase non-verbal communication and encourage equal relationship with therapist (11)

This is another school where the aims were the same for each client.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

The head teacher in this school said that she felt that different children would do best in different modalities. However, in contrast to this, the music therapist felt that work with this client group had been the most effective, while the children agreed that the music had been the most effective therapy for them.

Table 53



QQ2 Comparison of therapies – Location 7

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

As mentioned, the head teacher felt that it was difficult to generalise between one therapy and the next, as this was ‘highly personal’ to each child. The child’s own personal interests would lead to different learning styles and therefore different therapies would apply.⁶⁶ She did not expand this comment to say what personal characteristics might indicate which therapy would be best, but repeated that each child was different, so one could not generalise.

The music therapist appointed to work in this school felt that perhaps he felt most at ease in this school as he used to be the head teacher there himself some time ago and therefore understood the children very well, although he did not know the current children in the school. He and the children quickly established a rapport and connection through the music being improvised and this led them to express themselves freely in this context, which was conducive to a good outcome of addressing the stated aims. The children already felt at ease in this modality as the school had a high level of musical input even apart from the therapy sessions and therefore were able to relate to the activities with confidence.⁶⁷

Location 8 – Secondary mainstream school (with a high % of ethnic minority children)

The aims for this client group

To increase confidence/ recognition of personal individuality (12); to increase sense of identity in relation to culture (6); to be seen and heard (6).

The aims in respect of this group of clients were very much directed towards the increase of self- confidence. All 4 aims were similarly directed, although placed in different categories.

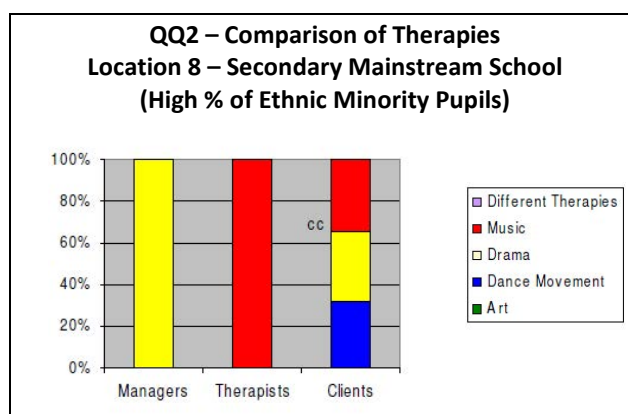
⁶⁶ See reference to Gardner in Location 5 above – p. 144

⁶⁷ The prior influence of the ‘ethos’ of the school on the outcome of the therapy sessions is discussed in Chapter 6.

Although location 3 also had a high proportion of ethnic minority children, this location is the only one in which the issue of culture is specifically mentioned.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 54



QQ2 Comparison of therapies – Location 8

The representative teacher from this school said that she thought that the drama had been much the best therapy for the children, who had divided into two groups; the first was very withdrawn while the second was much more overt. She was not the teacher who had made the referrals (this original teacher involved had since left the school). The respondent said that if she had been choosing the children to be referred, she would have chosen different children. However, for the group of clients, she felt that this was most effective. The only therapist to mention specifically that his therapy was successful here was the music therapist.

As stated by the teacher, the children formed two very different groups, whose opinions concerning the therapies which they felt had been the most effective were divided between music, drama and dance movement.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

Because she had not actually chosen the children who had attended the sessions, the respondent teacher at this school did not give reasons why she had felt that the drama had been the most effective therapy. She had, however, stated that she had felt that the personality of the dramatherapist had been the most effective in working with what could be quite a disruptive group of children (especially the second group).

The music therapist felt that for an older age group of children, music was appealing because the under-lying elements of music (rhythm, volume, etc.), could be related to any culture. This was felt to provide an immediate means of communication, which led to build up of self-confidence and ability to work within the modalities, whether withdrawn or more extrovert. The dramatherapist said that she felt that the modality of drama was very flexible and that she was able to adapt varying techniques according to the varied needs of the children – ‘you can go with them’. She felt that they could ‘explore and let off steam’ within role-playing and that they also were given choice and were agents of their own therapy.

The art therapist, however, found that the conditions provided for her work were not conducive to therapy and therefore discontinued the sessions before the end of the 12-week period. This was due to continual interruptions by staff during sessions (she had been given the domestic science room in which to work, because there was running water there, but support staff continually came in to do the washing. She had tried to discuss this with senior staff, but had found it was almost impossible to obtain a time for discussion. Any discussion which had been held, had not led to an improvement in conditions, so she felt that the children had not been given a ‘fair chance’ to experience the art therapy.

The clients themselves certainly responded in their varying ways to the other 3 therapy modalities, as could be seen from the high scores they obtained as a result of the interventions. However, it was not possible to discover which type of child (introverted or extroverted) was more drawn to which of the 3 therapies chosen, as the children were unexpectedly on work placement at the time that the researcher visited the school to do the interviews and the teacher concerned did not think that she should come back on a second occasion to interview them.

Location 9 – Secondary mainstream school

The aims for this client group

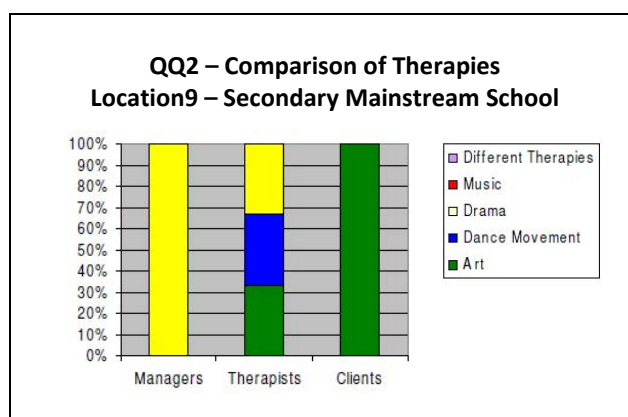
To take account of other peoples’ feelings / be more friendly towards / feel more comfortable with peers (10); To express positive thoughts / be more honest about his own feelings / separate the real from fantasy (9); To increase self-confidence express his thoughts clearly(both positive and negative) / be able to accept support (6); To reduce anxiety and contribute towards group work / give a chance to relax (5); to enjoy the sessions (2)

Although not a priority, this is the only school to include reduction of stress and relaxation as one of the aims. The teacher stated this was because of the type of clients referred, rather than being typical of the whole school. Group participation and freedom of self-expression are judged to be the most important aims. Increase of self-confidence comes mid-way.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

There were very clear indications here from the responding teacher and the children as to which therapy they felt had been most effective. The teacher thought that the drama had been by far the best – while the children judged the art more highly. Therapists were divided in their opinions. The drama, art and dance movement therapists had all felt that their sessions had had good results, but the music therapist did not rank this location as highly as some others.

Table 55



QQ2 Comparison of therapies – Location 9

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The teacher stated clearly why she felt the drama had been the most successful. Firstly, she said that she thought that over all the children had enjoyed it – although there had been individual preferences for other modalities. This led to the children giving it a ‘better go’ than another therapy. In particular the teacher had valued the feed-back from the dramatherapist, which had enabled relevant staff to be more aware of individual children’s personal circumstances, without codes of confidentiality having been compromised by sharing this information. The teacher said: ‘Children actually want to role play with what most of us would just consider as quite normal kind of family experiences. This was valuable. It has probably not had a huge effect on how they have been in their lessons, but long-term, that is probably helping them to resolve and deal with some issues that they have got, in a kind of non-threatening way. Without long-term counselling, a lot of these kids just could not do it, it just would not happen. A lot of their issues are being dealt with in a slightly more subtle way, you know, rather than full on asking them full on to tell me about their problems.’ She suggested that if the approach was more confrontational, the children would just ‘shut up’, particularly the boys.

She said that one client, who particularly opened up in a drama session, got very angry, which had been ‘brilliant’, because it had given him an outlet and a way for him to deal with his anger. She felt that the therapy worked best for the clients with low self-esteem, because it gave them confidence, particularly in the drama sessions. Some months later – outside of this project – children had been chosen for music therapy because they were musical / interested in music, therefore they enjoyed the sessions. She said that if children had been chosen who had hated music, then they would not have been able to have the same experience.

The art, drama and dance movement therapists all felt that their therapies had been successful at this location. The dance movement therapist said this was particularly so because the clients could explore other modalities than they would have access to within the normal school curriculum, which gave a fresh approach to addressing individual difficulties. The

dramatherapist emphasised how withdrawn clients could build confidence through role-playing and story-making, within which they could take risks and be creative about personal difficulties. The art therapist felt that the clients had been able to find their own style, within which they could explore issues non-verbally.

The clients themselves gave detailed replies as to why they had chosen the art. The first felt that in art, you were 'free to draw what you wanted – you couldn't do your own thing in music'. She felt that relationships with others were easier in a small group and that 'it doesn't matter if you go wrong in a small group'. This child had said that actually she felt she could take part in any of the therapies, even if she did not usually like that subject, because 'it doesn't matter if you are good at it'. She felt that the whole group was happy in the subject that they liked most.

The second client added that the art had 'helped me with my stress, because I can't do this anywhere else'. Although he played drums in a pop group, he said he didn't like the music therapy so much.

The third client said that he enjoyed the art because it had helped to boost his self-confidence – he used to draw 'loads of cartoons, as a kid'. He would much rather do something he enjoyed. This client showed insight into the purpose of the therapies, in that he liked drama the least, 'because it showed my immature behaviour'.

The fourth client interviewed said that he got nervous and therefore did not like doing the dance movement and the drama, which he felt made him conspicuous. He liked the freedom of the art, although he felt that the actual room in which they had had the art sessions had been too cramped.

Location 10 – Brain injury rehabilitation unit

The aims for this client group

To improve flexible thinking and self-awareness / improve focus and attention into something meaningful (19); To improve social interaction(16); To improve motor control, especially through playing the instruments in music(10); To increase concentration(10); To improve

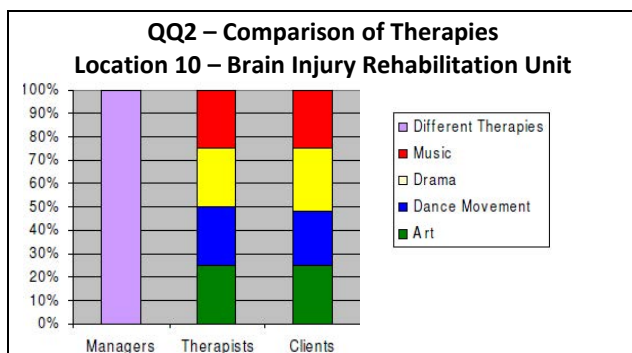
self-confidence / self-esteem(6); To allow a space for non-verbal as well as verbal emotional expression (including anger) and relaxation / reduce anxiety levels (3).

The table shows a concentration of aims into the area of meaningful self-expression.

Group inter-action is also important, together with consideration of increase of concentration and improvement of motor control. Improvement of self-confidence and self-esteem come next, with relaxation and reduction of anxiety levels last.

QQ2 – Which therapy do you think was the most effective / which clients benefitted most?

Table 56



QQ2 Comparison of therapies – Location 10

The manager in this unit felt that different therapies were appropriate for different clients. This is reflected by the therapists, each of whom felt that their therapies had been successful, even if this client group was not seen as having benefitted the most. The clients’ opinions were also almost equally divided.

QQ3 – Why do you think this was so? Were there any features of the modalities themselves which you felt were more appropriate to your clients / your needs / this particular client group?

The manager said that in the art sessions the clients enjoyed the quiet and calm, however, in art there was a disadvantage because the expectation was that they would have to produce something at the end – a piece of work. One client had had an interest in art anyway and this probably assisted his progress in this modality. The manager felt that the dance movement had

been good because the clients, some of whom were speech impaired because of their brain injury, did not have to say anything. She said that the clients were happy to do dance movement, because they could communicate in a group, which they cannot normally do. Drama was helpful because they could act out their frustrations – they didn't have to rely on poor memories or use of speech if they did not want to. Drama was also good because it used 'props' which were good prompts. 'Props' were helpful because this meant the clients did not have to concentrate on language. She felt that the dramatherapist had an excellent rapport with the clients.

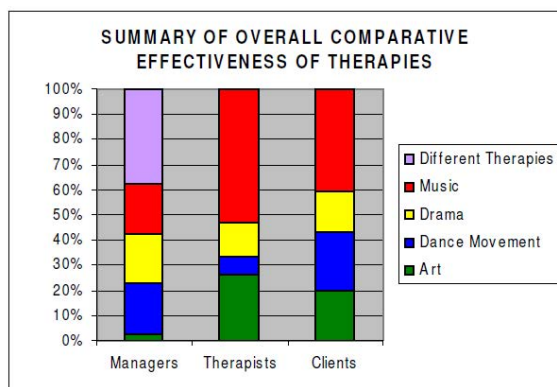
She commented that within the music, perhaps certain clients never had a chance to have a childhood and that the music had given them the opportunity to have fun and laugh ('I'd never seen this client laugh before'). In general, the therapy sessions had 'allowed them to imagine they were free of their impairments.' In addition, the clients' reactions had not always been what staff would anticipate, therefore the staff learnt more about the clients, when they took part in the sessions with them.

The therapists had not commented in great detail about this group, apart from the art therapist, who said that she felt that these clients had done well, although it had been difficult working with them, for varying practical reasons, such as facilities and regularity of attendance. She did, however, feel that the non-verbal modality of self-expression suited these clients well. The music therapist said that she had felt that the rhythmic work had helped in improving clients' co-ordination. She also felt that working through the elements of music was more successful with this type of client than the psycho-dynamic approach, which would involve talking.

As discussed in chapter 3, the clients were not felt by the manager to have the capacity to answer these questions, suggesting their answers might have been personally inconsistent and that they might not have been able to remember the details of the sessions after an elapse of time. However, the manager felt that she felt that they had benefitted from the sessions in varying ways and had also enjoyed them.

QQ2 / QQ3 – Summary of all responses

Table 57



Summary of effectiveness of therapies

A summary of all responses to the comparative effectiveness of the four arts modalities shows that there is discrepancy in the opinions of manager/teachers, therapists and clients.

The managers/teachers expressed the opinion that different therapies are needed for each individual client or personality of client and that the choice of modalities cannot be applied to every client in the diverse range of clients that may be found in any one location, even if that location is assigned a certain type of client. They felt that just because a school or centre is designated as being, for example, for excluded or brain damaged clients, that still did not mean that a similar approach would be suitable for all in this category.

Apart from the art, managers/teachers' opinions are almost equally divided between music, dance movement and drama. It appears that few of them have put art therapy as being the most effective. The summary for therapists appears to indicate that the music therapists think that their work applied to the widest range of clients.

A wider range of clients are in favour of music and appear to achieve better results overall through music than through the other modalities. However, as all clients are different, even when in the same location, an apparent 'one fits all' model is not appropriate in every situation.

The personality of the therapist

QQ4 (M/T): What influence did you feel the personality of the therapist had to the success, or otherwise, of the therapy?

The responses to the question not only included discussion about the personality of the therapist, but also detailed what qualities might be advisable, in order to be a successful therapist. These are included in the summary below, as being relevant to the concept of a ‘suitable’ personality for a therapist.

Personality

All managers/teachers felt that the personality of the therapist was of prime importance. This was said to be a key factor in the success of any therapy. One teacher said that, having tried a number of therapies with the same pupils, it was, as a rule, not so much the subject matter or activity, but the personality and ability of the therapist and the way that they presented the activity that was important. If the personality of the therapist did not lead to the creation of an appropriate relationship, the success of the therapy would be greatly limited (3).⁶⁸

It was sometimes felt that the individual personality of the therapist should suit the differing modalities in which they were working. For example, the atmosphere created by the dance movement therapist was described as: ‘... very fun and lively sessions - everybody gave their whole heart into that and they (*the clients*) really enjoyed them’. The same manager felt that, in contrast, in the art therapy session, it was not possible to have a constant lively manner, because it was: ‘... a thoughtful session, where people are thinking about things and putting their thoughts down into what they’re drawing or making’. The personality of the therapist apparently suited this quieter approach (4).

Another manager reflected the same thoughts when she described the drama as being very calm and quiet, while the dance movement was ‘brilliant’. She stated that the art therapist ‘had some clashes with the pupils – she was a bit more rigid’ – but despite this, art was a

⁶⁸ Numbers in the following paragraphs refer to the location reference number

favourite therapy with some of the children from this location (9). In contrast, one manager felt that the modality of the therapy was more powerful than the actual personality of the therapist (5) and that the clients would be more attracted to the art form than to the personality of the therapist.

The following qualities were felt to be desirable, for a therapist to be successful:

Relationship Building

The therapist's ability to be able to make a connection with clients, to establish rapport and build relationships founded on trust and confidence was seen to be a crucial factor that could only be partly learned or developed with experience (1). This ability was related to the personality of the individual therapist, whether working with individuals or groups (3). Some children responded better to different therapists. If they responded better and the relationship was better, then this was seen to result in the therapy being more effective (5).

A good relationship was seen to be essential, because in the therapy sessions, many clients were taking personal risks. In the opinion of one teacher: 'If they (*the clients*) feel that you are somebody who is going to encourage them and not criticise them when they are taking those risks, you are more likely to succeed, because the people that the therapists are working with are our most vulnerable students, who feel comfortable with us (*teachers*), because they know and trust us, but put in a situation with a new person, that person does have to build up trust. This building up of trust is not an instant process – in fact it may take some time to build up' (9). Although the teacher felt that the content of the session should be enough in itself, she felt that it was more about the delivery and ways of building up the relationship. If therapists were not able to build up a relationship, or there was a clash of personalities (6), then the therapy would not happen, although this was not seen to be the only factor (1).

Experience, training, being willing to take advice

Good planning ability and experience were seen to be fundamental. It was felt that the therapist needed to be directive, without using authority to gain uniformity (2). The ability of

the therapist to structure sessions was necessary, but this needed to fit comfortably with each individual child, which might be different for different children (7). There were seen to be aspects of the therapists' role which could clearly be learned, but even so, there would be good and bad practice involved in the role. Therapists were advised to be willing to take advice from other staff members, who knew the clients. Therapists should then adapt their method of delivery of the therapy accordingly, otherwise it would be difficult to work with the staff, as well as with the clients (10). Teaching experience, in addition to training as therapist, could be seen to be useful (2). One therapist, apparently, was not used to working with young children, so the children had not taken to that person as well as they did to the other therapists.

Meeting the clients where they are

Emphasis was laid on the therapists' ability to talk to clients at their own level (1) and to be respectful of their clients, not patronising them, whatever their disability (10). It was suggested that therapists should not do activities with which the clients were uncomfortable (1). It was also pointed out that therapists should be tolerant and should explain activities clearly, as they might well have to explain things more than once (10).

Gender / Ethnicity

In the opinion of the managers/teachers, ethnicity and gender did not matter (2), although heritage and cultural traditions may be influential in respect of some clients forming therapeutic relationships with the therapist (7).

Adaptability

It was felt that if therapists were not adaptable to the immediate mood of the group, the clients would pick up on that and feel very deflated. This would lead to the session failing (4). For example, it was felt that the drama therapist concerned with sessional delivery at this manager's location was by nature bright and bubbly, but if someone in her session was upset, she would be calmer, which showed how adaptable she could be. Motivation was also seen to be important. The music therapist in this location 'was lovely'; the dance movement therapist

(female) had a lovely rapport with the clients (10). ‘If the therapist has very set ideas, which do not sit comfortably with our students’ routines, then the students don’t engage in the same way’. (7)

QQ4 (Th): What influence did you feel your own personality had to the success, or otherwise, of the therapy?⁶⁹

(In these responses, 1 = Art therapist; 2,7 = Dance movement therapists; 3,5,9 = Dramatherapists; 4,6,8 = Music therapists)

Personality

Therapists were very aware of the impact that their own personality had on the therapy process(1)(2)(3). Some therapists stated the importance of personal self-knowledge with such comments as: ‘This is obviously a major factor.’ (4) Others joked – while still agreeing with the key issue covered by this topic: ‘Well, it’s my dynamic personality!’(4), or: ‘That’s always the million dollar question, isn’t it!’(8). Some found the question hard to answer, or put into words (8), while others were able to share their thoughts about their own personalities and the influence that this would have on the therapy process. One therapist even went so far as to say: ‘I think the personality of the therapist is more important than the modality they are working in, regardless of the modality.’ (1)

Having fun

Different personality types were described. Some therapists felt that they were extrovert in nature: ‘I have a very outgoing, extrovert personality that clients relate to, and because I come from a different culture, I can put a broader perspective on things.’ (2); ‘I feel that my personality is able to put people at ease.’(9) Another therapist felt that their personal strength lay in being able to create a playful atmosphere in the therapy: ‘I think that one of my particular strengths is to evoke a very playful atmosphere, so that people can come out and be

⁶⁹ *The researcher acknowledges that she is deeply indebted to her colleague therapists for their willingness to offer insight into their own personalities, in order to assist her with this research.*

more spontaneous and playful.’(5) This playfulness becomes part of this therapist’s ‘tool-kit’ in the building of a therapeutic relationship with the clients.

Other therapists felt that being ‘laid back’ was important for their approach and in building a therapeutic relationship: ‘I’m fairly laid back in my personality and just try to get on with it. Like with the autistic and ASD kids, they responded well. I just did tend to get on with those things and present the music, and try to get a bit in their skins, and to sort of see how they are. Maybe I have got a bit of autism myself!’(4)

Another said: ‘When I am working with a client group, I feel that I am able to have fun with them and try not to take things too seriously with them at first, which might put them off. They might be feeling, ‘Gosh, this is therapy, what’s it all going to be like?’ I feel it’s very much a case of ‘breaking people in gently’, having a bit of fun, having a bit of a laugh and joke with them, as well as at the same time, being able to be creative, and deliver the actual therapy. I would hope that would be something that would help.’(9)

Does a certain type of person become a certain type of therapist?

The question of whether a certain type of personality tends to become a therapist in a specific modality is a question which could be debated at length, although not at this point of the discussion. However, it is noteworthy that a dance movement therapist felt that their personality matched their arts modality: ‘My personality and the influence of the dance movement, marry each other.... The dance movement comes from me, from my personality and the dance movement more or less is two sides of the same coin. The people relate to the dance movement and they relate to my personality. I gesticulate a lot, I speak in very positive tones, and people relate to that, and so the dance movement comes naturally, and the personality is just there as part of the process. So, I think that they are there and that they are complementary.’ (2)

Another therapist felt that not all therapists using a similar modality necessarily had the same personality. According to this point of view, some therapists: ‘... don’t want to show that much of their personalities in therapy... I have met people who are like that, and that’s how

they believe that the therapy works.’ She herself does not adopt this style of working: ‘I do try to join in quite a lot, you know, to put people at ease, whereas some people say that’s not a very good thing to do, because then you might not be able to stand back as much. So I think that there are very different ways of working. Not all dramatherapists are the same. It’s a matter of how much of your own personality you should reveal and how much you should actually join in, rather than just stand back from the situation and not get involved.’(9)

Relationship to client group

The building of a therapeutic relationship with the client is dependent on personality. One therapist felt that she was able to create a bond of understanding between herself and the clients. In her opinion, this may also be related to the process of transference, in which the client is projecting thought and feelings onto the therapist (1). The importance of being non-judgmental – as highlighted as a desirable personality trait by managers/teachers (*see above*) – is recognised by therapists as well: ‘I don’t judge or pigeon-hole clients, so they feel the freedom to explore and identify with things that maybe in a normal context they would not be able to identify with, so they can express themselves in a way that no one might expect them to. So that aspect of my personality integrated with my work, and clients related to that very easily, and it brought sunshine into them.’(2) This was reflected by another therapist who said: ‘I think that because I’m not judgmental, I’m very accepting, so I think that certainly influenced how the children related to me, and trusted, and were then more able, I think, to enjoy some drama.’(3)

Affinity of a therapist to particular client groups

One therapist admitted that she actually felt more comfortable in some environments than others, rather than feeling that she could work with any type of client. ‘I tend to be wary of the nature of my contacts with people, because I am not always as confident as I could be and sometimes this impacts on the nature of my relationships.... At one school, I felt that it was a very difficult situation, with breakdowns on many fronts, not just on my abilities, but this did contribute to the breakdown of sessions there.’ This therapist felt she worked much better with older clients: ‘With the older people I think that I had quite a rapport. I felt quite at ease

there, I didn't feel threatened, because I felt that the energy that the children brought was threatening in some way, and the dynamics of working with elderly people, you know, I felt more at ease, so I had no problems there.'(1)

The feeling of being able to work with one client group better than another was echoed by another therapist: 'I found the older teenagers more difficult, I had to deal with a lot of resistances there. However, I did get past a big wall of resistance and was able to get to do a bit of expressive work with them. .. but by the time that it had got to that stage, there wasn't really much time left, and there wasn't really time to go into anything really, in any depth. By the time I had got there it was almost time to finish!' (3)

Another therapist felt she worked better with younger clients: 'With the younger children in particular I felt that I was able to understand, make a connection with them through understanding some of the ways they were relating, you know, when they were behaving in a seemingly aggressive way, but I understood the reasons why they were doing it... I felt that I was able to make a connection with that group, and create quite a safe space for them to actually start trusting and exploring some issues through drama for themselves, because of this.'(3)

For some therapists, working with a particularly familiar type of client group was helpful: 'I got on a bit better with the sorts of groups that I'm more familiar with, like the autistic children... and actually in a way, the exclusion centres and the kids who are disenchanted or disaffected, because I can be fairly laid back myself and can sympathise perhaps, with the problems they have.'(4)

One therapist felt that he worked better with clients he 'liked': 'I always tend to find that people or kids, that I feel I like or respond to well, I probably work better with. I suppose that's a fault if you like, because I ought to be able to work with anybody.'(4)

Gender

Some therapists agreed with the managers/teachers that they felt that their gender did affect the therapeutic relationship, especially with certain types of client: 'If I look at some of the less successful things, such as the secondary school, I, personally, always have felt a bit inept with girls of that age, sort of around puberty or just beyond. There's a sort of silliness which is probably exaggerated or exacerbated by having a male therapist, whereas you can be direct and frank with boys... you don't have to think so much about the protocols.'(4)

Another therapist stated: 'I found it perhaps harder to empathise and be involved in the same way with the teenage guys at that school. I don't think that it was altogether a negative experience, you know, but some of them I found to be a bit difficult, and I didn't feel that I was the best person to work with those... a woman might have been more successful.' (4)

Authoritarian / Directive

One therapist, who had been a head teacher, suggested that he found it easier to be a therapist than a person who had to exercise authority: 'I don't know, it's very hard, because I am also in a different situation from the situation as an authoritarian at school, with teachers or whatever, in my role here, so, that allows me to perhaps get a bit closer to the clients.'(4)

Do clients work in different ways with different therapists?

Some therapists felt that clients might respond in different ways to different therapists, even within the same modality. 'I've no doubt that some clients work in different ways, with different therapists, and I suppose it is hard for me to say how they related to me personally. I guess that some clients probably feel that they related better to me than some other clients did, but it's hard for me to judge, not having seen the different situations.'(8)

Willingness to learn from others

Therapists were willing to share the fact that they felt that their own personalities were still developing and that they could learn through their experiences, as well as lead the sessions: ‘I feel I have grown a lot through the work, so I would imagine that the last group that I did was not like the first group that I did, and of course that gains on my own experience. I have matured as a therapist.’ (5)

Work situation / Working as a member of the clinical team

The question of being valued as a member of the clinical / therapeutic team was mentioned by some therapists: ‘In terms of my personality, I do thrive with working in a team environment where we are thinking together, and there is a higher clinical focus on it at my other place of work (*at a prison for people with mental health issues*). I think when you are working in a school, that’s more difficult to achieve, and obviously, you have got differences between the educational and therapeutic approach.’(6)

QQ4 (C): What influence did you feel the personality of the therapist had to the success, or otherwise, of the therapy?

Clients of all ages were almost unanimous in their opinion that the personality of the therapist was all important: ‘... The personality of the therapist is the most important thing. In fact, probably the person who is taking it (*the therapy session*) is more important than the subject’. ‘I think it was the personality I got on with her.’ However, some clients could not answer this question. For example, when the researcher asked one client whether it was the character of the therapist that they liked, or was it the art form they were using, the client responded, ‘Both of them really ... I don’t know really... I’ve never thought...’.

Qualities of a good personality (for the clients)

The ability to ‘get people involved and joined in’ was seen to be very important, although clients’ opinion was not always consistent. Some clients would ‘go with that sort of

therapist’. Conversely, if the client did not like the therapist, they probably would not like the therapy sessions either: ‘...I didn’t like the music much ... because of the person taking it.’ However, later in the interview, this same client actually contradicts himself, because he decides that he would continue to go to the sessions if he liked the subject, even if he was not too keen on the therapist. In his opinion, the subject is more important than the personality of the therapist. This is supported by another client: ‘... no, it’s not the personality of the therapist.’ The majority of clients, however, did think that it was very important to feel at ease with the therapist, in order to participate purposefully in the sessions.

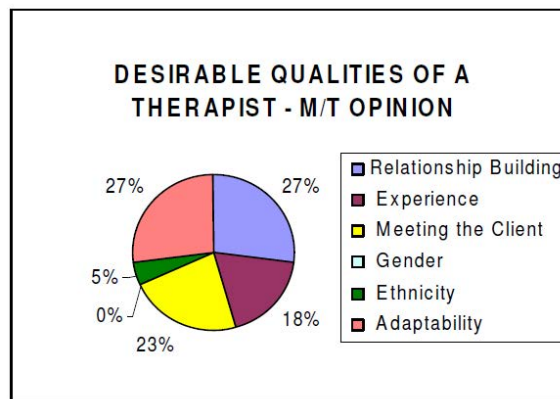
Summary of questions relating to personality

Managers/teachers

In summary it might be said that all except one manager/teacher said that they felt the personality of the therapist was the key factor in establishing a good therapeutic process. The only manager/teacher who did not agree with this said that the modality of the therapy was more powerful than the personality of the therapist.

Qualities of personality

Table 58

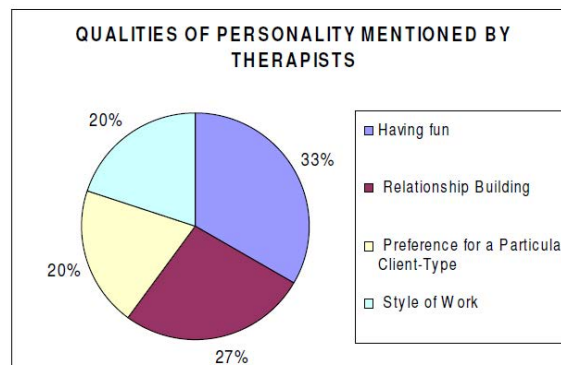


Desirable qualities of a therapist – M/T opinion

Of the qualities mentioned, it seemed to be that the most desirable quality was that of being able to build a relationship with the clients and adaptability (27%). Next in importance was the ability to meet the client where they were (23%). Experience and willingness to learn came next (18%). The ethnicity (5%) and gender (0%) were seen to be of much lower significance.

Therapists

Table 59



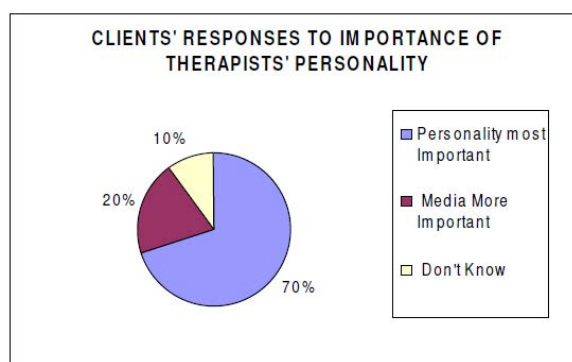
Desirable qualities of a therapist – Therapist’s opinion

Therapists acknowledged that the impact of their personality was of paramount importance to the therapeutic relationship. Style of delivery might vary from person to person, but it was fundamental to the process – and therefore to the training of therapists – that a comprehensive knowledge of self was a pre-requisite and fundamental to any professional undertaking.

The table above shows the number of times certain aspects of personality were mentioned in the interviews with them. It is interesting that being able to ‘have fun’ was mentioned by the greatest number of therapists (33%), because it has already been shown (*see chapter 4*) that the aim in sessions of ‘*Having fun*’ was felt by M/T, Th and C to have been the most successfully addressed. The next priority was the personal ability to build relationships (27%), followed by consideration of different styles of work (20%) and preference for a particular client group – both of which were mentioned in 20% of responses.

Clients

Table 60



Desirable qualities of a therapist – C opinion

Clients regarded the personality of the therapist as fundamental to the success of the therapy sessions (70%). Only 20% thought that the modality itself might be more important, while 10% were not sure whether they could answer the question.

QQ5 (M/T): Would you wish to continue the sessions? If so, would you choose one particular therapy, or would you like to see all four therapies in sequence again?

QQ6 (M/T): If all four in sequence, do you think it makes any difference in which order the art, drama, music and dance movement occur?⁷⁰

Managers/teachers in all 10 of the locations said that they would like to continue with sessions. Some, however, added additional information or concerns. These comments have been grouped either into issues concerning the actual implementation of the programme, or those concerning the practicality of incorporating an arts therapies sessions into the location routine.

⁷⁰ Questions 5 and 6 are considered together, as they relate to future provision of the therapy programme and opinions as to the sequence of therapies.

Table 61

Pl. No. No.	Type of Client	Continue?		Comments		
		Yes	No	Wish to continue?	Any particular therapy or all 4?	Any particular order?
1	Primary age exclusion centre	✓	-	2	12 - All 4 13	26,27,28 – Dance Movement 1st.
2	Secondary age exclusion centre	✓	-	3	14 – All 4	29 – Music, Dance Movement, Art
3	Primary mainstream school	✓	-	1	15 – 1 only 16	30,31,32 - Art / Drama, Dance Movement, Music
4	Elderly peoples’ residential home	✓	-	4, 5	17 – Art and Dance Movement	33 – No particular order
5	Primary special school for children with learning disabilities	✓	-	6	18 – Music 19	N/A
6	Infant mainstream school	✓	-	7	20 – Music and Art 21	34 - Art
7	Secondary special school for children with autism	✓	-	8	22 – All 4	35,36 Music, Dance Movement, Art Drama
8	Secondary mainstream school (high % of ethnic minority children)	✓	-	9	23 – Dance Movement	N/A
9	Secondary mainstream school	✓	-	10	24 – All 4	37, 38 – Drama, Music, Art, Dance Movement
10	Brain injury rehabilitation unit	✓	-	11	25 - Drama	39 - Irrelevant

Which M/T’s would like to continue the sessions – and in any particular order?

(For details of specific numbered comments see Appendix 11 p. xix)

Regarding the conducting of the therapy programmes, the head teacher of the centre for excluded primary children said that he felt that group work was not as effective with his children as 1:1 work, especially if the therapist could not manage the children’s behaviour in a group context. The head teacher of the centre for excluded secondary children said that as their

children were only in the centre for a 6-week period, they would not offer therapy to them unless the therapy was starting at the beginning of their stay for the six weeks and that it was on a regular basis, until the end of their residence there.

Another comment was made by a manager/teacher that their location would like to have a programme of arts therapies again, but not necessarily to have all four. It would depend on who the clients were and what their needs were. A further teacher responded that she would very much like to see a continuation of the therapy input, but that she felt that the wrong children had been selected by the previous teacher⁷¹.

Practical concerns covered the possible cost to the location and general disruption to school routine. Three of the location managers / teachers said that they would be very willing to continue with all the therapy sessions, but could not afford to fund the programmes themselves. This statement was echoed by a number of other managers/teachers, by implication⁷². Another manager / teacher commented that he would be pleased if the sessions could continue, but would have to take into account the disruption to other school activities and lessons. Other teachers in the school would have to be better prepared for extra noise and disturbance to school routine, as some children had had to miss scheduled curriculum lessons in order to attend the therapy programme. He felt that a meeting for all the staff should be held, before commencement of the programme, so that they knew what to expect and could take ownership of the scheme as a whole school, rather than a few classes only being involved.

Any one particular therapy or all four?

Many managers/teachers felt that all the clients in their location should have the opportunity to be assessed in all four therapies. Each modality had its own specific benefits and values and the intrinsic characteristics of each modality might be more suitable for one client than another: 'I can think of a group of children that would certainly respond much better to music, and then another group who would respond better to the art'.

⁷¹ This brings up the whole question of why children are selected and by whom – by the M/T, by the therapist, or even at the request of the client themselves.

⁷² See comment in 1st. paragraph p. 171, also in Appendix 13.7 – Funding. p. lvi

Finance was the issue for another manager / teacher, who said, 'I would like to see all four to be honest. I think that the dramatherapy was brilliant - the kids really enjoyed that. The dance movement therapy was just phenomenal, the therapist was fantastic and inspired the kids into doing things that they would never have done, which I think is brilliant for their confidence. And the music therapy, I would like that too... but you know my budgets, they are just shrinking.'

When faced with the question of whether to have one particular therapy or all four, one manager/teacher commented that the clients themselves might not be consistent in their choice of therapy – that they might choose one modality one day and another the next, which raised the issue for them of who actually makes the decision as to which therapy is chosen for which clients – should it be the manager/teacher, the therapist or the client? Some managers/teachers suggested that rather than have all four modalities available, the manager/teacher should decide on one therapy only to be available to all the clients. Again, this raised the question for them as to who should decide which of the modalities this should be.

One response suggested that the group aspects of the modalities would be beneficial for their clients, in that many of them did not have the opportunity to function in a group. It was felt by this manager/teacher that the dance movement in particular was good for group interaction. She felt that their quieter clients had benefitted from the drama or art, because they could concentrate and think about themselves, whereas the more extrovert clients had been better suited to the dance movement and music, as these had seen to be more ebullient activities.

Another manager/teacher, on being asked to choose 'Which modality or all four?', was quite definite that she would choose the music therapy, because she felt that so many of her students: '... get so much from the modality of music. Even students whose cognitive levels are quite limited, seem to be able to use music as a way of expression, far more than maybe drama or dance movement.' (This was a special school for learning disabled primary aged children). Music was felt to have a more general appeal than any of the other modalities.

The same teacher also felt that that music was the modality that the school could accommodate far more easily than drama or art. She felt that if a school could not provide the appropriate accommodation for a particular modality, then this limits the effectiveness of the therapy experience. This was echoed by another teacher who felt that: 'I would actually like to make sure that we could provide the right sort of facilities as well, because I think that the environment makes a big, big difference. For example, the dance movement was done in the PE gym. The gym is tall, it is echo-y, and that in itself wasn't ideal for youngsters, just as it was not really suitable that the music therapy had to be done in the hall.' Another teacher said she would choose the drama and would have liked to choose the music as well, but felt that this would be difficult because of the logistics of storing the instruments.

Another teacher chose music because the children had enjoyed that the most, but also chose art, because within that modality they had discovered information about a certain child A, whose imagination had been sparked through the art and had revealed details about himself that had not been apparent within the context of the teaching routine. Another child, N., had disclosed information about what was going on at home, because she had talked to the therapist while doing her art work. This, the teacher felt, was the strength of the therapies and the purpose of providing a form of non-verbal communication, which could lead to verbal descriptions in support, on the part of the client. Talking about the art work would not be an essential part of the therapy for all children, but for some might prove to be the means through which certain issues are approached.

This same teacher also felt that a non-verbal form of expression, such as music, would be chosen for assisting in 'drawing out' more withdrawn children, because they could: '... make a lot of noise, without it actually being them making the noise. They didn't have to communicate (*in words*), but they could express their feelings.' The teacher described the use of the arts modalities as a transitional object through which feelings can be expressed supra-verbally.

The teacher in the secondary school who felt that the dance movement had been the most successful modality said that she would be willing to try the dance movement again. She suggested that information should be gathered from the feeder primary school to choose children who might need therapy in advance. There should be more facilities for co-operation

between schools, so that ‘problem children’ whose difficulties were already acknowledged could have the opportunity of immediately being able to access therapy – or continue doing so, if they had already been involved in sessions at primary stage.

If all four – in any particular order?

A number of respondents said that they did not know enough about the varying characteristics of the four modalities to be able to judge in which order they should be presented, if all four were to be made available to each client. They felt that this would be dependent on the individual nature of the children who have been referred and that different clients would need different therapies, probably in different orders for each individual client, if clients were to have access to all four.

An interesting adjunct to this opinion was that the first therapy had to be successful. For the manager/teacher making this comment, the dance movement had been seen to be very successful and this had ‘started everything off in a sound way’. It was felt that if the children had not enjoyed the first therapy, then there might have been resistance to the following ones. Again, in another location the personality of the therapist was mentioned. This manager/teacher would choose music first, because that therapist had been very successful. Then they would probably choose the dance movement, followed by the art (no mention was made of the drama, or why this choice had been made).

Another reason for choosing dance movement to be first was stated to be because, ‘It’s a straightforward way to start with. All our children are physically able. The purpose is not about their skill level anyway, but it’s their motivation, through the fact that they believe they can do it. If you say ‘We can all do dance movement’, that is a great starting point.’

It was emphasised that the success, or otherwise, of the preceding therapy could be influential on the attitude brought by clients to the subsequent therapy. To quote one head teacher: ‘I think that the drama sessions had difficulties, following soon after the movement, because the children expected it to carry on in a similar way. But the space was different (smaller) and drama sessions were held in a classroom where there were desks. It wasn’t the same venue.’

As well as the practical issues involved in the previous response, the issue was raised concerning the situation when a relationship established with the therapist in one modality might then influence the following sessions in a different modality. It was seen to be difficult for the clients to relate to four different people, especially as the inter-personal aspect of the therapeutic process is so fundamental to the success or otherwise of the therapy. Although every client who participated in the programme was informed in advance that each of the sessions was only to be for a certain number of weeks and that then a different person would come, in practice it was not easy for clients to accept that one had to 'start all over again' in building a new relationship with another therapist. On the other hand, if the client had not felt that their relationship with a particular therapist had been very satisfactory, they might welcome the chance to change to another modality.

The perceived qualities of the art form itself were the dominant factor for the choice of order of therapies for the head teacher in the infant mainstream school. She felt that she would choose the art or the drama to start with, because, in her opinion, art and drama did not require the same loudness of voice or inherent dominance of actual movement, as much as the other two. She said that she would certainly put music last, because that was the biggest shock to her children, being even more different to anything else that they had ever done. (Music did not feature largely in the curriculum of this particular school).

Concerning skills which clients might already have, as distinct from being required to develop new ones, the same teacher felt that all of her children had already reached a certain standard, with regards to artistic or dramatic skills. She felt that within the therapy process, one is taking skills which the children already have and allowing them to express themselves in a slightly different way. The children already had a foundation on which one could build, in a variety of different ways. She did not, therefore, from a developmental point of view, feel that there was any difference in the order in which therapies should be presented.

The teacher who had commented on the art modality having been so successful in providing access to information about a particular child felt that she would probably choose this modality first for all her children because then having learnt more about the child(ren), this would

provide a basis for planning the programmes for the subsequent modalities. In fact, other managers/teachers commented that they too had learned information about their respective clients from other modalities than the art, but this teacher was obviously very impressed by the results that had occurred in her school.

The question of the age of the clients involved – in this case children – was said by another teacher to be a factor influencing the choice of order of presentation of the four modalities, She observed: ‘I think that it depends upon the age of the child. I think in an ideal world, (and again, this is intuitive, observing the youngsters, I am not sure, you would need more research I think, to support it), but I think that music and dance movement is more fundamental to the early years way of operating. Drama and art, I would bring in at a slightly older age, probably art first and then drama, but I am not sure about that, I wouldn’t be hard and fast about that, but I think that that they may well be the order that we would try next time. I would like more research to find out.’

The same teacher continued: ‘If you look at the early developmental stages of a youngster, movement comes first – the vision comes in a little bit later, doesn’t it? So, it’s the movement, it’s the smell, it’s those sort of very, very earthy fundamental experiences that actually are significant to the youngster. Because autism is a developmental delay, or a developmental difficulty, one could think that if you took youngsters through that sequence, (*music and dance movement, then drama and art*), that might be a way forward for them. If only the children could actually understand what you are trying to do and engage in that. That is really up to the skill of the therapist isn’t it?’

The teacher at the secondary mainstream school also supported the concept that the first therapy experienced should be the one in which they could gain confidence. However, she felt that the dance movement should go last – rather than be first choice as other M/T suggested – because she felt that for her children, dance movement was the most challenging and the clients should already have built up confidence in themselves and in their therapy group, before doing this modality. She felt that dance movement was the modality with which they were at first uncomfortable and that it had taken a while for them to become more confident in self-expression. She said that not all of her clients had got as much out of

the dance movement as they did some of the other therapies. She did, however, still think that it was good to challenge her clients, but did think that this modality should probably go last, or towards the end, because of the confidence issue.

This teacher felt that some of them had not as much confidence in the music. For this reason, for her clients, she would choose the drama and art first. The order would therefore be drama, music, art and then the dance movement. She also suggested that the sessions had happened too quickly after each other and that a longer break between modalities would have been better. She remarked that these comments may reflect the age of the clients, in that they were teenagers, who might have been feeling more self-conscious. However, this contrasts with the teacher from another location working with secondary age children, who had felt that dance movement had been the best. The manager at the location for the elderly said that because a lot of their clients had memory problems, the order of therapies would be irrelevant to them.

QQ5 (C): *Would you wish to continue the sessions? If so, would you choose one particular therapy, or would you like to see all four therapies in sequence again?*

QQ6 (C): *If all four in sequence, do you think it makes any difference in which order the art, drama, music and dance movement occur?*

Table 62

Client No.	Type of Client	Continue?		Comments		
		Yes	No	Wish to continue?	Any particular therapy or all 4?	Any particular order?
A	Mainstream secondary	✓		1	7 – Music	14 – It doesn't matter
B	Mainstream secondary	✓		2	8 – Art	16 – Not really
C	Mainstream secondary	✓		3	9 – Art	17 – It doesn't make any difference
D	Mainstream secondary	✓		4	10 – Art	18 – Not sure really
E	Blind, elderly	-		5	-	-
F	Blind, elderly	✓		6	12 – Drama	-
G	Blind, elderly	✓			13 – All 4	-

Which clients would like to continue the sessions – and in any particular order?

Comments – would you wish to continue?

All of the clients who answered the structured interviews indicated that they would wish to continue sessions, apart from one client in the residential home for the elderly, who did not respond to this question. One secondary aged client felt that although he would like to, he would not be able to, because he was going to leave school and go to college and did not feel he would necessarily like to continue with therapy there. Another secondary aged client said that he would like to continue with the art, but it would have to be in a group, not a 1:1 situation, as he got shy on his own. Another at the same school said he would probably like to continue, but he didn't think he would need any more therapy, because '..I'm all right now.'

Of the elderly clients, one said that she personally would like to continue, but she couldn't speak for the others in the home. Another at this location said that he would like to do all four again.

As already explained, these interviews were limited. In the opinion of managers/teachers speaking on behalf of the clients, there were few clients who would not wish to continue with one, or all, of the therapy modalities.

Any one particular therapy or all four?

If asked to choose whether one therapy or all four, the first client who responded from the secondary school said that she would probably choose the music, because although she liked the art the best, in music, '... even though I tried to do it, but I just couldn't, but I thought 'Oh...,' but I would probably do music, because you can actually play with an instrument and get to know people, so, I would say music.' This client chose to do a subject in which she felt less able, because of the attraction of playing an instrument and working in a group. The other clients in this location chose art, rather than doing all four.

In the home for the elderly, one client chose drama because she found it very interesting and another said that he had liked them all and therefore could not choose one in particular.

If all four – in any particular order?

None of the clients expressed any strong opinion to this question, except that one client said that if they did not feel comfortable in any particular modality, then they would not want to do that any more. One older client said that she was not sure of the answer to this question.

QQ5 (Th): Would you wish to continue the sessions? If so, would you choose one particular client group, or would you like to see all clients experience all four therapies in sequence again?

QQ6 (Th): If all four in sequence, do you think it makes any difference in which order the art, drama, music and dance movement occur?

Table 63

Th. No.	Therapist's Modality	Continue?		Comment Numbers (see below)			
		Yes	No	QQ6. Wish to continue ?	QQ6. Any particular Client Group?	QQ6. All four therapies in Sequence?	QQ7. Any Particular Order?
1	Art	?	?	1,	8	14	21,22,23,24
2	Dance Movement	✓	-	2,	9	15	25,26,27
3	Drama	✓	-	-	10	16	28
4	Music	✓	-	4	11	17	-
5	Drama	✓	-		12	18	29
6	Music	✓	-	6	-	19	30,31
7	<i>Not available</i>						
8	Music	✓	-	7	-	-	-
9	Drama	✓	-	-	13	20	-

Which therapists would wish to continue sessions, which client group they might choose, or whether all four in sequence and in any particular order?

*Would you wish to continue the sessions?*⁷³

All the therapists answered positively to this question, apart from the art therapist, who was viewing this from the view-point of the clients. She commented that from their point of view, it would depend on what had happened in the lives of the clients since the time of the therapy sessions. There were some clients who she had felt would have benefitted from continuation of sessions, when they had come to the end of the set period of sessions. However, these clients had gone on to do other therapies and so she was not certain whether – after further interventions, even if in a different modality – they would still need therapy sessions. There might, however, be some clients who were still wanting to do further art therapy, even after having experienced all of the therapies.

Other therapists gave a whole-hearted ‘Yes!’, saying that they always enjoyed working with clients – implying that the clients enjoyed it also – and so would wish to continue. Some therapists said that they felt that some of the clients would have benefitted by continuing sessions, but others would not.

Another therapist replied that she felt that it would have been good for some of the clients to have continued, but that certain clients would have benefitted more from being transferred to a 1:1 situation, rather than continuing in the group. Although a music therapist herself, this therapist felt that some clients in the brain injury unit might have benefitted from a more visual stimulus such as art, if they had continued.

⁷³ *In answering this question, there was some misunderstanding among the therapists as to whether the question meant, ‘Do you (personally) wish to continue the sessions’, or ‘Do you think the clients should continue the sessions?’ The researcher did not intervene in this by offering a prompt, so the answers remain as they were given.*

Would you choose one particular client group?

One therapist felt that if she were to start a new series of therapy with any of the clients, then all would have to be re-assessed to determine whether or not it was suitable that they should start again. This was not quite how the researcher had meant the question to apply, but was a valid answer, if seen from the view-point of clients starting again, rather than stating which client group she would choose. This therapist stated that she would prefer to continue with the younger group of clients, because she felt that they had not had enough time to explore all their issues. She also felt that the groups with which she had been asked to work in some locations were too large.⁷⁴ She had felt that the children themselves had considered one group in particular to be too large, especially (she thought) with the difficulties that some of the children were experiencing. If therapy was to continue, she would recommend that some children had 1:1 interventions. She also commented that the space provided for the sessions was not satisfactory.

A different music therapist said that he would prefer to work in the exclusion units and that it would be very good to have an on-going service with them. This opinion was similar to those of the teachers of these units. Another opinion offered by a therapist was that she would like to work with clients having greater cognitive ability, because she had done a lot of work with clients having less ability and would like a change of type of client. However, she did emphasise that this was her personal choice and did not necessarily take into account the needs of the clients themselves.

One of the dramatherapists particularly enjoyed working with the teenagers, as she saw this client group as her 'specialty': 'When I went in with the teenagers, I just saw how well they enjoyed the drama. I have a lot of experience working with teenagers and it's a kind of a bit of a baby of mine, if you like. I feel quite strongly that drama is a very good modality for them

⁷⁴ *It had been stated on the researcher's first visit to each location, that 6 was the maximum number suitable in a group. However, it might have been that when the therapist actually started the work, the M/T's had tried to increase the recommended number and the therapist had agreed.*

and it's something that can break down barriers, especially when there is all this business of 'street cred' and everything. I think that drama can cut through all of that and I think that it is particularly useful there. I think it has done a similar thing with prisoners. It's because of role play – you can put yourself into another modality and you can project things into other modalities, but to actually have a cathartic experience and to be able to put yourself completely into someone else's shoes, put them into a different character, is a very useful thing in dramatherapy.' Other therapists said that they enjoyed working with all types of client and would not have any particular choice.

Would you like to see all clients experience all four therapies in sequence again?

Again, the therapists' responses varied. Some felt that to experience all four was actually excessive, because it involved making new relationships with each of the four therapists involved in each modality. Those who held this opinion felt that one therapy only should be chosen for any one client, because of this. This was supported by a therapist who said that she felt that as some clients would have responded more to one modality than another, so they should have the opportunity to continue in the modality in which they had had most success.

However, in contrast, other therapists felt that clients should have the opportunity to explore all four, as this gave them the opportunity to explore different approaches to their problems and that only having the one, would limit the possibilities for personal progress. If clients were able to do this, they would still relate to one stimulus rather than another, so it might not matter in which order the modalities were presented.

One therapist commented that, although they did receive 'hand over' notes from the preceding therapist in any one client group, they would have loved to be able to watch how each group of clients had responded within other modalities.

If all four - in what order?

Some therapists said that they had not been totally aware of the order in which her varying groups had experienced the different modalities and what influence this might have had on the

outcome of their own work. They found this an interesting topic, but could not immediately give an answer, as they had not been able to observe their clients' responses in another context from their own. Sometimes clients had expressed opinions about the best modality which they knew they were going to experience, but as the therapists were not able to witness the outcomes of the new interventions, they could not judge what sequence of modalities was best. Another therapist went so far as to say that he would very much have liked to see how the clients with whom he had worked, actually functioned within another context. He would then have been able to note similarities and differences in their responses, which might have influenced the order in which the modalities were experienced. This therapist also said that from a scientific point of view, he did not have the evidence base to express an opinion.

Another opinion stated was that it might depend on the needs of the individual and also the personality of a particular therapist. For example: '... because somebody who is finding themselves very resistant to therapy, might benefit more from having a therapist with a very big personality, very dynamic, someone who could draw them in, as opposed to someone who worked more quietly, or a bit more subtly.' She felt that one therapist might not have the personality to 'bring in' the person who was resistant whilst a more dynamic person might work in a different way, which would be more effective.

One therapist suggested that if some clients had experienced, for example, physical injuries while still very young, some level of movement development initially could have facilitated greater use of other arts modalities later. Another point of view expressed was that if a client was experiencing a low level of self-esteem, drama or movement therapy might be the best therapies to experience first.

One therapist stated that she felt that the clients who came to the art group after having just completed the dance movement group found her modality very restrictive. The dance movement had been conducted in a large space, but the art had to use a much smaller space. Moreover, as art does not involve a lot of movement, the contrast worked adversely for them. The therapist commented that perhaps this was so in other consecutive therapies – that one had to compare the impact of the previous therapy when starting with a group which had just finished working within a different approach.

One therapist felt that perhaps her own modality of drama was the best for clients to experience first, because ‘... often in drama therapy, you use different elements of art and music (*She laughed at this point*). When I say elements, I mean different materials, like when in the assessment I did with the children, I used a drawing structure for a story telling of assessment,... and that helped to ground them and calm them. On another occasion, I might use some music - when I say music, I mean a drum and some percussion instruments. Perhaps having drama therapy first might be a way of introducing a little bit of other arts therapies as well as drama and then they could see which parts, which elements they liked best.’

Again, the question of the difficulty for the clients in relinquishing one relationship with the therapist to move to sessions run by another is echoed by this therapist’s response: ‘I think it makes a difference whether they have developed a good relationship with the previous therapist. I remember in one of my locations, that one group had had a really good relationship to the previous therapist and I felt that they hadn’t really said ‘good-bye’ to that. They wanted to carry on the previous therapy with me and it was really difficult (*for them*) to ‘let in’ someone new. The order in which therapies are experienced is down to each client’s personal experience.’

One therapist suggested that each client could have 12 weeks in each of the 4 therapies as assessments, in order to be able to judge which the most suitable modality would be for future sessions. This therapist saw some clients that she felt would be appropriate for just the music therapy, but there were other clients who might have had more success through art therapy, or through dance movement. She felt that it would have been very helpful, as therapists, to be able to exchange ideas about how each of them worked and what the most appropriate way to work with each client would be.

Remaining responses to Structured Interview

Questions 7 – 10 covered the administrative side of the programme, such as the practical arrangements for sessions, whether or not initial information given was adequate, benefits for staff / parents as well as to the clients, etc. These questions were included in the structured interview for practical reasons of administration, possible referral of future clients and general

interest, so their consideration did not feature in the present analysis. Sometimes, in fact, such details have already been included in responses given to other questions. However, the responses obtained in these latter questions did contain a wealth of information which remains available for future planning of therapy programmes.

CHAPTER 6 – DISCUSSION

Introduction

Results obtained from both quantitative and qualitative approaches, offered a number of answers to the original research question: ‘Which arts therapy for which client and why?’, some supporting definitive recommendations in varying areas of concern, others being less conclusive. The current study can be regarded as having made a contribution to this previously under-explored area of arts therapies practice.

Discussion of results will focus on specific factors within the therapeutic process, including the gender of the client; age; presenting special needs and initial reasons for referral. Reference will also be made to relevant literature, both that identified earlier⁷⁵ and new sources of information, in order to offer explanations and provide support for the varying outcomes and conclusions reached in this study.

In some instances, respondents to the structured interview gave information relating to wider details of practice and managerial issues of the programme. These included:

- whether the client has any preference between a male or female therapist
- whether group or 1:1 therapy sessions would be more appropriate
- details concerning other members of the family / group
- how long the sessions are expected to be and for how many weeks
- what might happen after the initial period of the current programme
- the actual location of sessions – whether at the client’s location or at the Centre
- how the sessions will be funded; either through statutory funding, or, as the Centre is a charity, whether financial assistance is to be sought from the Centre or from another charitable source.

⁷⁵ See Chapter 2 p. 11

Such issues are considered to be in addition to the focus of the present work, but are included in the appendix, where they may form the basis for possible guidelines for future practice.⁷⁶

General responses from Managers / Teachers, Therapists and Clients

The quantitative and qualitative data both reveal that everyone participating was very supportive of the programmes of arts therapies as a valid form of intervention through which to address a client's stated aims.⁷⁷ In the quantitative data, 94% of clients stated that they felt that the interventions had resulted in them achieving 'Slight improvement' to 'Achieved aim', at the end of the programmes. Therapists had agreed that 89.7% of clients had benefitted to this extent, while managers/teachers felt that 85% had done so. Figures for the more rigorous classification of 'Noticeable improvement / Achieved aim' were similarly encouraging, being 74%, 65% and 60% respectively. Qualitative results supported these findings and gave details or reasons for the positive responses. Use of words such as 'beneficial', 'increased social skills' and 'increased self-confidence / self-esteem' were frequent. The clients themselves further reinforced these results by dividing their responses into two positive categories only, namely 'beneficial' or 'enjoyable'. The findings concur with those found in work described by Dubowski and Evans (2001); Darnley-Smith and Patey (2003); Martin (2009); Karkou (2009); Chasen (2011); Booker (2011); Edwards (2013) and Malchiodi (2013), to name but a few of the many accounts of work undertaken in the field of arts therapies.

Clients' responses

The fact that the clients rated the arts therapies programmes the highest, with managers/teachers lowest and therapists in between, may indicate that clients favoured the programme, being eager to perceive improvement in themselves. In addition, they had shown a willingness to be included in the programmes and may have had the highest personal

⁷⁶ See Appendix 13 p. xli

⁷⁷ See Tables of Responses in Chapter 4, Table 20 p. 105 and Chapter 5, Tables 42,43,44,45 pp. 126 -132

investment in such an undertaking. However, if they had not experienced feelings of improvement, it is likely that they would have been the first to say this and might well have abandoned the programme in their disappointment that the approach had failed. Clients were very open and honest in their responses, especially during the structured interviews. The researcher is of the opinion that clients were not just answering in a manner which they thought would 'please' her, as the interviewer; moreover, the equally supportive quantitative statistical results did not depend on interviews. The clients' exclusive use of words which were classed either within the 'beneficial' or 'enjoyable' categories - with no responses at all under 'negative', 'unexpected' or 'other' - further supported their confidence in the programmes experienced and the subsequent outcomes.

Managers / Teachers' responses

The more modest scores of the managers/teachers in general may reflect that they were naturally a little more reticent, needing to be more circumspect in their views, in that their responses might have been influenced by the feeling that if strong support for the therapy service had been made, this would also have had implications for funding of further sessions in the future; however, this was not a universal influence as some managers/teachers fully supported the programmes, even although they knew they would not be able to afford to continue with sessions. Another reason for offering a more circumspect view might have been based on the fact that managers/teachers had not had the personal experience of being involved as a client or observer in the actual sessions. Furthermore, although QQ1 referred specifically to the effects of the programme on their clients, some managers/teachers tended to include the other implications of the intervention in their responses, such as disruption to the school routine. This affected their scoring for this question. On the positive side, managers/teachers in general were very supportive of the effects of the programme on their clients, noting improvement in clients' attitude, increase in confidence, better relationships with others and belief in themselves, especially in clients who were initially more reserved.

Therapists' responses

Therapists' scores appeared to fall between those of the managers/teachers and the clients. As with the managers/teachers, this may reflect that responses tended to cover wider issues than those specifically concerning the client's progress during the sessions, resulting in less frequent use of the 'positive' words. A higher success rate given by therapists, as distinct from managers/teachers, may be attributed to the fact that progress towards achieving the aims was more apparent within the therapy sessions themselves, rather than progress observed by teachers /managers to be generalised into change of client behaviour outside the therapy room. This issue is discussed below.

Generalisation of the effects of an arts therapies intervention

It might be assumed that progress made by the client during the sessions would also extend to behaviour outside the therapy room – an effect given the name of 'generalisation'. However, there appeared to be some concern expressed by managers/teachers and therapists, who were in a position to evaluate the client's hope-for modified behaviour outside of the therapy space, that changes observed by therapists within the context of the therapy session were not necessarily generalised or transferred to another context. This view was supported by one teacher who worked in a unit for children referred because of behavioural issues. The teacher had commented that although he had noticed changes within the children during the therapy sessions themselves, perhaps the sessions had not helped the improvement of their behaviour outside of the session.

In order to monitor the generalisation of behavioural changes observed within the therapy sessions to behaviour in more general contexts, however, a more stringent research design - involving a control group - would have to be adopted. Trends in modified behaviour, or possible 'carry-over' from the sessions appear to have been noted by some teachers, but it was not possible to interpret these as being specific results of the therapy sessions, owing to lack of detailed relevant information.

Within the present study, as part of the therapy process, clients were supported to make their own choices to behave in new ways, as they learned and understood more about themselves. In order to provide an optimum environment which would support the client's modified behaviour outside the context of the therapy room, therapists understood that it was their responsibility to inform the manager/teacher and/or members of the clinical team of any apparent change in behavioural patterns demonstrated by the client during the therapy session. Appropriate action could then be taken to support and encourage the client in the future, which might include modifications to the class-room, institution or home background, if practical or possible. This 'new information' about the client shared between the therapist and the clinical team could also allow the manager/teacher/parent to see the client in a different manner from before and to modify their own relationship with him accordingly.

Broader issues concerning the success of an arts therapies intervention

A teacher mentioned not being sure whether it was the therapy sessions *per se* which had caused changes in behaviour and attitudes and said she had had difficulty assessing the degree of help given by the sessions and the sustainability of the effects. She reasoned that because it was a 'project' and it was for a fixed term with clients who (*in this location*) were autistic, to some extent all results had to remain speculative. However, the teacher did notice that there were a number of clients who had shown quite specific results, which could not be accounted for by considering any other activity already offered by the school. She quoted one particular client who had responded very well to the art therapy and another who had responded very well to the dance movement sessions.

Another teacher in a different location commented that she felt that some children had improved, but she could not say whether it was the therapy that had made the difference. She referred in particular to one girl, who had been able to go on work experience, perhaps owing to increased confidence gained through the therapy sessions. However, the teacher also commented that she felt that the client probably would have developed this confidence anyway, as a result of specialised support available within the school, such as through their learning support centre, which helped children to improve. She therefore felt that it was hard to distinguish what had caused improvement.

Specific responses to the programme

The age of the client

It was interesting to see whether there was any particular age at which these arts therapies interventions appeared to be more or less successful. If this were proved to be the case, then it would be a relevant factor in advising potential referrers as to the best age at which to refer clients. Evidence exists concerning the general success of arts therapies interventions with clients from all age ranges, but in addition, many examples of work undertaken by therapists specializing in a particular age group of client have been noted, such as those recorded by Martin (2009) and Bunt and Stige (2014), who hold that intervention at an early stage of a child's life is especially critical.

Results obtained from the current study will be discussed in order to determine not only whether the interventions proved successful, but whether there was indication of a higher success rate in any one particular age group, within the overall age range of 5 – 61 yrs., of clients within the present programme. A number of correlations were examined between ages of clients and their overall scores. These included: whether one location (providing for a specific age-group) had better results than another; whether there was correlation between ages of clients and the most successful therapy; whether there was correlation between the age of clients and the most prevalent aim and the final analysis, which combined these varying factors.

Within the qualitative analyses, as in the question of *m. v. f.* success rate, there was no specific question asked of any of the respondents concerning which specific age group they thought had been most successful within the programmes, as managers/teachers and clients would not have had knowledge of age groups other than those in their own location. Therapists' comments concerning age-related topics will be discussed when they occur within their responses to other questions. Such comments could, for example, be included in an answer concerning which client group each therapist considered the most successful, as this would be age-related as well as being related to the type of client.

Was there correlation between ages of clients and their overall scores?(Q9)

As reported previously, there was agreement between managers/teachers and clients as to which client group was deemed to have had the best over all scores, namely the 46-61yr. old groups. It was unexpected that this age-group should have been the most ‘successful’. Perhaps managers/teachers and clients within the lower age ranges had a more ‘intense’ expectancy from the therapy sessions and therefore were more critical of the outcomes when giving scores. Conversely, managers/teachers, clients and therapists were all in agreement that therapy sessions with clients belonging to the middle age group of 30 – 45 yrs. were judged to be the least successful. This is considered below, when discussing the question of the widely-held response that those in their ‘middle age’ felt ‘left out’ from service provision generally.

Did one location have better results over all than another? v. Age of client

As varying locations consisted of different aged client groups, a new table was formulated, to see whether this might give an indication of whether arts therapies were best when experienced at a particular age.

Table 64

	Most Successful Results			Least Successful Results		
	Location	Age Range	Average	Location	Age	Average
M/T V	8	12	12	2	12 - 15	13.1
Th V	6	5 - 7	5.9	2	12 - 15	13.1
C V	9	13 - 15	13.6	10	25 - 60	32.9

Ages of clients with ‘Most Successful’ and Least Successful’ results

Location 2 = Secondary age exclusion centre; Location 6 = Infant mainstream school; Location 8 = Secondary mainstream school (high % of ethnic minority pupils); Location 9 =Secondary mainstream school; Location 10 = Brain injury rehabilitation unit

It would appear that there is a weighting here by managers/teachers and clients in favour of the younger secondary aged children, whereas therapists considered the primary age group to be more successful. However, when considering which location was felt to have the poorest

results, both managers/teachers and therapists felt that this was the secondary age exclusion unit, which had an average age range of 13.1 yrs., i.e. almost exactly the same age-range as those which had the best results. These results appear to be in direct conflict with each other. This might be accounted for by the fact that the clients had differing ‘problems’. The secondary schools were mainstream, whereas those in Location 2 were in an exclusion unit and therefore might be assumed to have experienced greater ‘failure’ in the past to address their problems – hence the need for a segregated placement.

It might be argued that the 3 highest scores noted from the respective locations indicate that these are the types of children who benefit most from arts therapies. Similarly, does the fact that both managers/teachers and therapists allocated the lowest success rates to the secondary referral unit and the fact that clients from Location 10 (the unit for those with brain injuries) deemed themselves to have the worst results indicate that these clients are the least likely to benefit from the programmes? The situation is obviously more complex than this. Additional questions such as, ‘What were the aims in each of these locations?’ or ‘Was there a higher proportion of *m/f* clients in any one of these locations – and if there was, did this make any difference?’, should also be taken into consideration.

Therapists’ opinions on the most successful age groups

In contrast with managers/teachers and clients, therapists appeared to think, both in their Views stated in the quantitative results and in responses to the structured interview, that the best results were obtained with the youngest age group (5- 10yrs.) clients. This is in contrast to the comments made in the previous paragraph by managers/teachers and clients that the younger secondary aged clients were deemed by them to have the most successful results. Some therapists felt that the younger age groups responded more intuitively to the materials provided and were more quickly responsive than adults. The younger age group was also felt to be less self-conscious or inhibited. For the oldest age group, the comment was made that it was good that the clients had been able to explore new things and that this was something which could be offered to add a new incentive to life for this age-range. However, some therapists felt that all age-groups of clients had benefitted in their individual ways and that the

success or otherwise of the therapy interventions was also dependent on positive support from staff and general helpfulness of the institutions.

Age of client v. Most successful modality and consensus

Table 65

Age of client	TV		ThV		CV		Consensus	
	Most Successful	Least Successful	Most Successful	Least Successful	Most Successful	Least Successful	Most Successful	Least Successful
0 (5- 10 yrs.)	3	1	2	1	2	1	2P	1C
1 (11 – 19 yrs.)	1	2	4	1	3	1	N	1P
2 (20 – 30 yrs.)	3	4	3	2 (no.1)	2	4 (only 2 modalities)	3P	4P
3 (31 – 45 yrs.)	1	4	1/3	2	(Incomplete)		1P	N
4 (46 – 61 yrs.)	2	1	3	1	4	1	N	1C

Ages of clients v. Most successful modality and consensus

(1 = Art therapy; 2 = Dance movement therapy; 3 = Dramatherapy; 4 = Music therapy)

Considering which modality might be the most appropriate to recommend for which age group, this additional table would seem to suggest that apart from art therapy apparently being deemed to be the least successful with the 5-10yrs. old and the 46 – 51yrs. old age groups, there is no general consensus of opinion. This opinion concerning art therapy was a surprising result, as at the Centre many elderly clients – including some who are 90 yrs. of age and who have Alzheimer’s disease – very much enjoy art therapy. There may be other factors involved in this particular result, such as personalities involved, or the inappropriate physical location of the art therapy programme.

There is a preference for dance movement with the 5-10yr. olds, dramatherapy with the 20-30yrs. age group and art with the 31-45yrs. group, but there is only a partial consensus in this. The results noted in the previous chapter state that there is complete unanimity between managers/teachers, therapists and clients, in that the least successful age group to take part in the programme was that of age group 3, namely the 30 - 45yrs. clients. This correlates with the fact that the clients themselves in Location 10 (the brain injury rehabilitation unit) felt that they had had the least successful experience. In fact, they were the only representatives of the 30-45yrs. old age group.

Unexpected 'new' facts about middle-aged clients

There was complete unanimity between managers/teachers, therapists and clients that the least successful age group to take part in the programme was that of age group 3: the 30 - 45yrs. clients; the Centre has fewer referrals for arts therapies programmes from this 'middle age' age-group than any others. Comparing this fact with official government figures, a DHSSPS (2004:601) report states that although younger middle aged (16-44yrs.) and middle aged people (45-64yrs.) are significant more likely to experience a great deal of worry or stress, (12% and 14%) respectively, compared to those aged 65+ yrs. (9%), both men and women in the middle aged group apparently do not identify themselves with services for 'older people' and therefore tend to feel ignored by generic adult services.

According to Bowers *et al* (2003), for those in their 50's who are experiencing multiple changes and transitions, such as decisions about work and employment, illness and death of older parents, children becoming independent and grandparenthood, this age can be a very stressful period. Information from Mind (2011) emphasises the fact that many people of this age group experience powerful and emotional upheavals which may be connected with unresolved difficulties in the past, dissatisfaction with the present, a sense of lost opportunities, a fear of diminished opportunities for the future and growing older in an ageist society.

Milne and Williams (2003) report that women in mid-life face a range of specific challenges including multiple family and caring commitments, which places them at an enhanced risk of psychological and emotional distress. They state that many women find themselves in the 'poverty trap' in mid-life, primarily as a consequence of lower-pay, part-time working, family care-giving and inadequate pension provision. Widowhood, divorcees, black and minority ethnic women are particularly vulnerable to poverty in midlife. Those with caring responsibilities and women who primarily work inside the home are at an increased risk of becoming depressed and having low self esteem. Although specialist strategies are being implemented to combat this apparent area of neglect, such as are mentioned by Bowers *et al* (2003), it might well be that this research has indicated a particular need within this apparently under-represented group of clients.

Gardner (2004), in his theory of Multiple Intelligences (MI), was asked whether there was any difference in the way that these function in later life, as distinct from childhood. He replied that although MI seem to be a particular gift of childhood, as individuals become older, intelligences simply become more internalised – indeed, modalities of mental representation were likely to increase throughout active life. The differences simply became less manifest to outside observers. But the recesses of the mind remain concealed; the mind makes maximum use of the resources at its disposal at any age and those resources consist in our several intelligences. This would imply that any influence which consideration of this theory might have on the choice of modality of therapies would not be affected by the chronological or mental age of the client. The use of MI theory in adulthood has also been investigated by Viens and Kallenbach (2004), who confirm that the theory can apply equally well to adult education classes and later-life work.

Did one location (type of client) have better results over all than another?

In the teachers' view, the location with the highest success rate was the secondary school which consisted of a high proportion of immigrant children. The teacher in this location actually gave scores which were in the range of 'considerable improvement' or 'achieved aim', although this was the locality in which the art therapy sessions had been discontinued, because of the totally impractical room provided and apparent lack of staff support. The quantitative results from this teacher were all the more surprising, as her actual comments in the structured interview were not overall supportive, being critical of her colleague's handling of the administration of the programme.

The teacher indicated that she gave high scores for the clients' achievements because she thought that they had definitely improved as a result of the arts therapies intervention. Many of the children were from minority ethnic backgrounds and had two opposing forms of behaviour. One group was overly extrovert and assertive, while the other was introvert and withdrawn. She felt that each of the 3 successful modalities had been flexible in their approaches and had appealed to the two different personality groups of clients in different ways. The therapists had been very sympathetic to the varying needs of the clients. This was

an interesting example of the same therapists modifying their approaches to work with opposing personality types.

The same teacher, however, said she could not be absolutely certain whether the observed change in behaviours was the sole result of the therapy programmes, surmising that the children would probably have developed any way, because of the learning support centre which the school provided. Despite this, her scores were the highest of all the teachers/managers' scores recorded. This supports the researcher's argument that it is not possible to state that results obtained are exclusively attributable to the therapy interventions, but will hopefully enable clients to be more open to all interventions offered to them. Ideally, therapy work and the learning support centre in this school would work together to provide a seamless service for referred clients.

The therapists' quantitative Views appeared to show that when considering which client group they felt had benefitted the most, the mainstream infant school was the most successful over all. However, when discussing results of one location compared with another during the (qualitative) interview, therapists felt that the art therapy had been most successful with the elderly client group, the learning disability primary school and the secondary mainstream school; the dance movement had been the most successful in the secondary mainstream school and the secondary mainstream school with a high proportion of ethnic minority children; the dramatherapy with primary mainstream and secondary mainstream; the music therapy with primary children with moderate learning difficulties and children generally. There appeared to be consensus here that the secondary mainstream school, with the age range 11-19yrs., appeared to be the most successful location over all. This is supported by the opinion of the clients themselves, as has already been described.

Attendance of carers and others in therapy sessions

Participants stated that the success or otherwise of the therapy interventions was also dependent on additional factors such as positive support from staff and the facilities provided. The secondary mainstream school had been regarded as being particularly supportive in this way, although therapists thought that overall, the mainstream infant school had actually had

the most successful results. From responses to the structured interview, it was apparent that a number of occasions had occurred in which a third party had been present in sessions besides the therapist and the clients. Generally, comments made by the therapists concerning this had been favourable, in that – as has already been mentioned – providing the support given to the therapist is informed and sympathetic, the person attending can add to the session and can also learn from it. One teacher commented that, as a result of his new experiences gained by participating in sessions, he intended to continue the sessions in a more general manner after the therapy programme had concluded.

Effect on clients of ‘inclusion’ or ‘exclusion’ from mainstream provision

As already recorded, views from the clients attending the secondary mainstream school were the highest of all location scores. This may be related to the therapist’s comment that the staff at this school had been particularly supportive.

The results of the interventions are compared from the point of view of whether or not the clients were in a ‘mainstream’ or ‘special’ environment, with the following results.

Table 66

Ref:	Name of Location	Main-stream	Special	Quantitative		Qualitative	
				Positive	Negative	Positive	Negative
1	Primary age exclusion centre		√			√	√
2	Secondary age exclusion centre		√		√√		
5	Primary special school for children with learning difficulties		√			√√	
4	Elderly peoples’ residential home		√			√	
7	Secondary special school for children with autism		√		√	√	
10	Brain injury rehabilitation unit		√		√	√	√
3	Primary mainstream school	√				√√√	
6	Infant mainstream school	√		√			√
8	Secondary mainstream school (high % ethnic minority pupils)	√		√		√√	
9	Secondary mainstream school	√		√		√√√	

Proportion of mainstream to special locations and specific results / comments

Of the 10 locations in which the programme was conducted, 6 were ‘special’ and 4 were ‘mainstream’. Comparing this with the quantitative Q3: *‘Did one location have better results over all than another?’* and the therapists’ qualitative QQ3: *‘Which client group do you think benefitted most?’* and allowing for the fact that the proportion of special : mainstream locations was 3:2, mainstream locations had a total of 11 positive and 1 negative comments/results, while special locations had only 5 positive and 4 negative comments/results. There were also many general comments made, such as, ‘All groups of clients benefitted in different ways’, ‘It depended on the group make-up as much as their particular difficulties’ – or even, ‘I can’t say – the issues are different from group to group’; but it is interesting that the mainstream locations had such good results, when traditionally the majority of therapy work has been carried out in special needs locations.

There are many arguments both for and against ‘inclusion’ in its varying forms, which may be relevant to the provision of arts therapies. As outlined in the on-line publication by Southwest Educational Development Laboratory (SEDL) – a private, non-profit education research, development and dissemination (RDandD) corporation based in Austin, Texas – some who are in favour of total inclusion argue that there is now substantial evidence that most, if not all, children with disabilities, including children with very severe difficulties, can be educated appropriately without isolation from peers who do not have disabilities (Ringer and Kerr, 1988).

Further supportive arguments include the fact that coordinated work between special education and mainstream teachers tends to raise their own expectations for their students with disabilities, as well as student self-esteem and sense of belonging. Staub and Peck (1994/1995) and McGregor (1993) maintain that by interacting with their disabled peers, mainstream students learn to understand those who are different from themselves, becoming more tolerant and understanding of them and developing true friendships. The so-called ‘labelling effects’ of children allocated to special school provision may lead to stigma, the impact of which lowers expectations and leads to poor self-esteem (Lipsky and Gartner, 1992).

Conversely, Tornillo (1994) is concerned that inclusion, as it is all too frequently implemented, leaves classroom teachers without the resources, training and other supports necessary to teach students with disabilities in their classrooms. Consequently, the disabled children do not receive appropriate, specialized care and attention and care and the regular students' education is seen to be constantly disrupted. In addition, there are frequent concerns that mainstream education teachers have neither the time nor the expertise to meet their children's needs. In addition, some parents of students with more severe disabilities are concerned about the opportunities their children will have to develop basic life-skills in a regular classroom setting. They are cautious about inclusion because of fears that their children will be ridiculed by other students.

In 1997, the Department for Education and Employment (DfEE) published a green paper which stated that:

'We (the government) want to develop an educational system in which special provision is seen as an integral part of overall provision aiming wherever possible to return children to the mainstream and to increase the skills and resources available to mainstream school and to ensure that the LEA support services are used to support mainstream placement' (DfEE 1997:44).

However, the development of inclusive education was still hampered by lack of definition of the word 'inclusion' and by future governments' acceptance of this form of education. In 2014 the Children and Families Act 2014 placed a legal duty on local authorities to ensure that all children and adult services should involve in multi-agency working, to promote the integration of care, support and health services. This was seen to be vital to enable a child with Special Educational Needs (SEN) to succeed physically, socially, emotionally and educationally; however multi-agency partnerships can also present challenges in areas of funding and resources, roles and responsibilities, competing priorities and communication (Hodgkinson, 2015).

Effective, multi-agency partnerships involve the sharing of ideas and resources and work ever more cooperatively across professional boundaries. This enables the individual needs of each

child to be considered, resulting in improved educational attainment and better engagement in schooling by children with SEN. It would also enable improved support for parents, with children's needs being addressed more appropriately and within a holistic, rather than a single disciplinary, context (Atkinson, et al 2002).

All children are seen to be complex individuals, who have the right to participate and achieve fully within the education system. Etkins and Grimes (2009) suggest that the arguments both for and against inclusion might be summarised by asking whether the pupils are enjoying school more than they were when segregated, whether they are participating more than previously and whether they are achieving and learning to their full potential.

Which therapy (modality) was considered to be the most effective and why?

QQ2/3 of the structured interview invited respondents to consider specifically not only which therapy they had felt to be the most effective with their particular client group, but also why they had felt this to be so. For the therapists, the first half of the question had been modified to ask which client group they felt had benefitted most from their therapy, as they were operating within one modality only. Initial detailed analysis of responses was made by the researcher, taking into comparison all locations together⁷⁸. This analysis provided remarkable insight into perceptions of the characteristics of the four modalities by varying types of participants in the programme. However, as detailed in chapter 5, it was then considered that a second analysis, comparing each location individually in comparison with the aims of the location and their preferred modalities, might prove to be of greater significance in relation to the original research question.⁷⁹

A summary of all responses to the comparative effectiveness of the four arts modalities showed that there was a lack of consensus in the opinions of manager/teachers, therapists and clients in identifying characteristics of individual modalities which might indicate specific qualities considered to be more applicable for different types of clients or their individual

⁷⁸ See Chapter 5 Table 57 p. 156 and Tables 46a-46f in Appendix 12.8 p. xxxiii-xxxix

⁷⁹ See Chapter 5 p. 136 for individual analysis of each location

aims. As described by Karkou and Sanderson (2006, p,50), the overall role of the arts in therapy is ‘To provide a medium for engagement on the part of the client which is on a preverbal level, involving the person as a whole; this may include sensori-motor, perceptual, cognitive, emotional, social and spiritual aspects, allowing each client to be creative within their expression of emotional health and maturity. Once creativity is mobilized, clients can become creative in the way they perceive themselves, run their own lives and/or relate to others.’ These authors conclude that after mapping the current range of arts therapies practices, certain modalities appeared to relate more to certain areas of work and client special need, depending amongst other factors on the history of the professional development of each modality of therapy, in addition to the characteristics of the art forms themselves: ‘The arts are the very first things that attract many practitioners to the field and at times they are the very first thing that is responsible for therapeutic change in the client.’ (*ibid*, p.276)

The results of the current study show that each modality possesses unique characteristics which may provide the medium for engagement and subsequent change. Individual characteristics of each modality were not seen by the participants to be neatly separated, but consisted of varying factors which could be held in common, or individually, by each modality. It was seen to be dependent on the personality of the therapist and their relationship with the client, within the therapeutic triangle, to utilise these similarities and differences to the greatest benefit for achievement of the aims of the sessions.

The aims of the sessions

The most prevalent aims

Detailed quantified analysis of the most prevalent aims⁸⁰ indicated that the most common reasons for referral were those associated with the client’s inability to function adequately in a social context – chosen 134 times out of a total of 436 aims (30.7%). This was followed by ‘*Being able to respond individually in an appropriate manner*’ – chosen 85 times (19.5%) and, chosen almost an equal number of times (19.0%), ‘*To be able to express their emotions freely in an acceptable manner and to acknowledge these emotions*’.

⁸⁰ See Chapter 4 Table 26 p. 109

This appears to show that a referrer is usually most concerned with how the client is relating to his social surroundings and the effect that his behaviour is having on his peers and family, rather than the other way round. Referrers rarely imply that it might be their own behaviour – or the client’s environment – which is causing the problem.

Age v. Aims - Was one aim more prevalent with any particular age group?

When comparing the age of the client with the most prevalent aim, it might have been expected that the aims selected for each client would relate to the normal pattern of development for that person, as he progresses through from 5-10yrs.; 11-19yrs.; 20-30yrs.; ‘middle age’ 31-45yrs.; and ‘older middle age’ 46-61yrs., but this did not appear to be the case; neither did it appear that any one aim was more prevalent with any particular age group.

Which aim is best addressed by which therapy? v. Gender of client

In Chapter 4,⁸¹ the findings indicate that only on 2 occasions was there consensus of opinion concerning ‘*Which aim obtained best results from which therapy?*’ v. *Gender of the client.*’ Male clients appeared to find that music therapy best addressed the aim of ‘*Enhancing self-esteem*’ and that male clients agreed that dramatherapy best addressed the aim of ‘*Allowing freedom of expression in an acceptable form and for participants to be able to acknowledge these personal emotions*’. This analysis did not, however, take into account the age of the client.

Was one aim more successfully addressed with one particular modality of therapy v. Age of the client?

When considering whether there was consensus of opinion regarding *Aims v. Modality of therapy v. Age of client*, the only consensus was that for managers/teachers,⁸² who felt that dance movement was the most successful in addressing aim 6 ‘*To benefit physically*’. Nearly

⁸¹ See Chapter 4 Table 36 p. 117

⁸² See Chapter 4 Table 37 p. 118

all managers/teachers agreed that dance movement was best for aim 7: *'For relaxation and reduction of stress'*.

Quantitatively, therapists⁸³ were not in total agreement as to which aim was most successfully addressed by which therapy. Again, for the clients⁸⁴, there was no complete consensus, but in partial consensus, dance movement was seen to have higher consensus for the younger age groups (5-10yrs., 11- 19yrs., and 20-30yrs.) in addressing aim 3: *'To be able to participate as a member of a group in an appropriate way and to benefit from so doing'*; while music therapy was seen to have greater consensus in addressing aim 5: *'To respond individually in an appropriate manner'* within the age groups 5-10yrs., 20-30yrs., and 31-45yrs.

When the M/T View, Th View and Client V were compared to see whether there was any consensus between these 3 points of view,⁸⁵ it appeared that there was only one total consensus, namely that all 3 parties agreed that aim 8: *'Motivation and mental stimulation'* was best addressed through dance movement therapy in the age group 20-30yrs. However, there was partial consensus on the best modality of therapy for a high proportion of the aims, comparing with the ages of the clients. As it has been argued above⁸⁶ that there is a fair degree of correlation between *m* and *f* clients, whichever the age range of the clients, for the most prevalent aim chosen (Aim 3), it might follow that Tables 36 -39 (pp.117-123), given in Chapter 4, could form a fair basis for possible advice to be given to a referrer concerning the relationship between 3 variants, firstly between *Aims chosen v. Modality of therapy v. Gender*, secondly between *Aims chosen v. Modality of therapy v. Age of the client*, finally *Aim v Modality, Consensus v Age*. It was not possible to combine more variants into these analyses.

Which aim was most successfully addressed over all?

It has already been established in Chapter 4 that teachers, managers, therapists and clients of all ages, genders and types, are in full agreement that aim 4: *'To have fun, to enjoy sessions'*

⁸³ See Chapter 4 Table 38 p. 120

⁸⁴ See Chapter 4 Table 39 p. 121

⁸⁵ See Chapter 4 Tables 40 a/b p. 123

⁸⁶ See Chapter 4 Table 29 p. 111

was the most successfully addressed by the arts therapies programme.⁸⁷ This was not the most frequently chosen aim (which was Aim 3: *'To be able to participate as a member of a group in an appropriate way and to benefit from so doing'*), but was felt by all to have been the most successful over all.

On first consideration of this unanimous agreement, it was felt that *'To have fun, to enjoy sessions'* was a less 'serious' aim than some of the other aims, which were more concerned with the client's personal development or the welfare of the group and his/her social context; however, on closer reflection it was realized that the factor of enjoyment lies at the root of all therapy work undertaken. In his analysis of statements made by participants in a music therapy group experiment, Bunt (1994, p.146) states that 'the ability to get used to doing something for fun and enjoyment initially' was one of the contributions which was unique to his intervention, as distinct from other interventions available to clients within the hospital setting. He also states that clients felt that music therapy contained 'less unsettling analysis compared with art therapy.'

Clients must like what they are going to do, or they will not feel motivated to undertake what may be a strenuous journey. 'A basic premise in the arts therapies, is that the therapist must meet the client at the client's level of comfort' (Feder and Feder 1998, p.246). They continue to suggest that ongoing research supports the commonsense view that clients are more responsive to the arts forms they like, rather than those they don't like. This knowledge may be acquired by the therapist simply by asking a potential client or their referrer about leisure activities, preferences, or previous training or experience. It will also be easier for the potential client to manifest his specific problems and deficiencies and the state of a disorder or dysfunction, through a modality with which he feels familiar. Therapists are also in agreement with this attitude, as has already been discussed. The ability to 'have fun' was stated by the therapists as being the most important quality of personality needed when facilitating therapy sessions.⁸⁸

⁸⁷ See Chapter 4 Table 30 p. 111

⁸⁸ See Chapter 5 Table 59 p. 167

It might be argued that the majority of clients who come for therapy, do not have as much ‘fun and enjoyment’ in their lives as those without disabilities or ‘problems’. ‘To have fun’ implies that a relationship exists between the client and either another person (or group) or an object. One can also ‘have fun’ with an inanimate object such as a piece of clay or a musical instrument, by making humorous body-movements or by being involved in a playful drama group. It could be argued that clients, at the point of referral, may not be able to establish a relationship with a person or object, with whom – or through whom – they might experience ‘fun’ and ‘enjoyment’. This may be particularly so with clients who have a disability which lies within the autistic spectrum, who may be described as isolated and not playing with other children (Perez and Gonzalez, 2007), or be unable to realise the significance of a joke or irony (Rivière, 1997).

From a physical point of view, ‘fun’ releases endorphins, which have the ability to produce analgesia and a feeling of well-being. Endorphins give the ability to keep going, despite pain. A ‘high’ may well be produced from completing a challenge, rather than as a result of exertion (Hinton and Taylor, 1986). Thus a successful, enjoyable arts therapy session will help clients to disregard physical discomfort or depressing thoughts, replacing these with the pleasure of achievement and companionship with a fellow human.

Other details of arts therapies interventions

Relationship to other professionals in the client’s care programme; working as a team

It has already been mentioned that the therapists involved in the research programme valued integration and exchange of information with staff team members. Therapists described how they had felt that their acceptance within the clinical/special needs teams greatly influenced the significance and success of the therapy programme, reflecting for good on the clients themselves and on other members of the team.

Being a member of a team is a two-way process, in that not only did the therapists benefit from being able to discuss matters concerning their work with teachers or clinicians involved,

but also they felt that other team members benefitted from discussing case details with the therapists. Especially if unfamiliar with the role of an arts therapist, the confidence of other members of the team had to be 'built up', so that they could understand in greater detail the therapist's role and what would be expected of staff members, in order to support the therapy intervention.

As therapists were not full-time staff members within the varying locations – and as they also had professional commitments elsewhere – it was not always possible for them to be as involved in team meetings as they might have wished, had their time been unlimited, or had they been full-time, rather than sessional, workers. In addition, as it was obvious that each of the arts therapies modalities programmes was only going to be in place for a maximum of 12 weeks, there might have been a feeling of not being as much part of the team as if they had been full-time members of staff. As one therapist commented, 'We didn't contribute to case conferences as much as we would have done, because it was known that the sessions were limited to 6(12) weeks.' Full written reports were submitted, however, at the end of each period of intervention, which would be available at future case conferences for reference.

In order to try to combat the limited opportunities for communication between therapists and staff/clinicians, it was essential for therapists to have at least one person with whom they could liaise regarding information gained during a session and *vice versa*. Regular feed-back times were always helpful. Without these, therapists felt that, if they did not know who to talk with in a placement, the liaison with staff was less than desired and things might become a little 'hit and miss'.

In order to try to combat the feeling of not being part of the full-time team, staff members at each location had been briefed in advance by the researcher and the manager or head teacher as far as possible. In a number of cases, according to the therapists, this had resulted in staff members being excited about the project and feeling that they could learn from it themselves. It was helpful for the resident staff team to think they that could give the therapists information about the clients before the programme actually started. So in all cases, as one therapist expressed it: 'A relationship with the staff came first...' and '...by the time that we actually came to run the project, you felt that you really knew the staff already, because you'd

gone through the stuff, so it was really nice, it was good.’ Such team-work was essential, for without it the therapists might feel that they were on their own. Indeed, one therapist even felt that belonging to the team was so important that if this were not so in certain locations, she wondered whether the programme at the location justified the cost of its implementation.

With full knowledge on the part of the staff as to the purpose of the therapy came commitment from them to support the programme. If this commitment was not there, sometimes therapists found that, for example, clients might not have been enabled to attend the sessions, or clients who were expected did not arrive. Lack of understanding on the part of the resident staff sometimes also led to lack of provision of a suitable place in which the therapists could work and a lack of respect for the session itself (people might walk through a hall, or interrupt a session). There might also be the feeling that the therapy sessions were seen as ‘co-laterals’; there might be the feeling that what the therapists were doing did not come under the umbrella of what the staff were doing. Staff sometimes viewed the therapies as extra curricula activities, not part of the mainstream activities. Sometimes there was inconsistency in staff support, as it was not always the same staff who attended sessions (if staff did attend the sessions).

Sometimes therapists even felt threatened by resident staff. A therapist said that in one specific location, he observed a different receptivity. He felt that the staff wanted to make sure that the therapists were ‘behaving properly’. It also followed that if therapists felt that there was a negative attitude towards them, then conditions for work and the ethos surrounding the investigation would suffer accordingly. Sometimes lack of time at a location made one therapist feel as if she was a ‘ship coming in at night and then leaving again’ .

In another location, staff members were quite wary, because they had been in the habit of placing art materials all over the school, for children to use whenever they wanted. The art therapist here wondered whether staff understood the difference between therapy and education. ‘We didn’t have a chance to meet with parents, but the staff learnt a lot about therapy’. In other places, staff members were supportive and understood the aims of the programme. An interesting idea, suggested by one therapist, was that staff at a special school

might be more sympathetic towards a therapy approach than staff within mainstream, because of their closer contact and experience with disability and special needs.

Discussion between therapists and staff members also revealed how directive or non-directive therapists might be in their work: ‘Some staff clearly struggled with the therapists’ less directive approach, but did ask me about this and acknowledged that as teachers they were used to behaving differently with the children. Over time, agreement emerged between directive and non-directive approaches and we worked more sensitively together and used both as appropriate. This was a very positive development as staff began to understand music therapy and the approach that I used.’

To summarise the experiences of the current research therapy team, as one therapist, who also worked in a clinical environment elsewhere, said: ‘I thrive when working in a team environment. My current place of work now is very much a team environment. We are thinking together and there is a higher clinical focus on my work. When you are working out in a school, it is more difficult to achieve, and obviously you have got more differences between education and therapy, whereas where I work now, it’s not seen in the same way. It’s a very different way of working.’

This same therapist stated that there were times when the medical side of the team could be a little overpowering, but she had understood that there was now a very big push to move to more psychological therapies, which would be helpful. This move would allow each professional involved to think outside their own disciplines. It would also be useful to look at the difference between the varying arts modalities, if more than one was employed within the same location. In addition, linking up with CBT and DBT and CAT⁸⁹ practitioners and informing each other’s practice would give all members of the team a much better overview of where the arts therapies work fits in and how to develop within a collaborative approach.

The structured interview findings relating to the importance of the working together of all professionals involved in a client’s programme reflect issues already stressed by Bunt (1994),

⁸⁹ CBT = Cognitive Behavioural Therapy; DBT = Dialectical Behavioural Therapy; CAT = Cognitive Analytic Therapy

when he described the involvement of the whole clinical team in the assessment and consequent interventions for the client, John. Team-working gives the advantage of utilizing the expertise of varying approaches to a common problem, which together will support the client more surely than when each individual member of the team works in isolation. The input of the different disciplines is discussed and a programme is then drafted, in which specific roles and responsibilities are clarified. Every discipline involved may assist and support each other, for example, some members of the team may not be used to working closely with emotions. Moreover, team-working provides an opportunity to share ways of processing difficult or challenging experiences and feelings.

Inter-professional collaboration and team-working are now widely considered to be central to the effective provision of mental health care, the central tenet being that workers involved in a patient's care should be part of a multi-professional, person-centred process (Twyford and Watson, 2008). This approach has been emphasised by Government legislation concerning both adults and children. Many policies and guidelines emphasise the importance of seamless Health and Social Care (DoH, 1997; DoH, 2000) and offer guidance for practitioners (Sainsbury Centre for Mental Health (SCMH), 2001). In 2004 the Department of Health published the green paper 'Change for Children – Every Child Matters', responding to the case of Victoria Climbié who 'at the hands of those entrusted with her care, suffered appallingly and eventually died' (DfES 2004a p.1). Common failures in all such cases were seen to have arisen primarily from poor coordination between services and a failure to share information, resulting in children falling through the cracks between different services. Children experiencing difficulties at home were receiving too little help too late (ibid. p5). Stated outcomes of the green paper for children and young people were:

- ‘ - **Being healthy:** enjoying good physical and mental health and living a healthy lifestyle
- **Staying safe:** being protected from harm and neglect
- **Enjoying and achieving:** getting the most out of life and developing the skills for adulthood
- **Making a positive contribution:** being involved with the community and society and not engaging in anti-social or offending behaviour

- **Economic well-being:** not being prevented by economic disadvantage from achieving their full potential in life.’ (ibid p7)

Later in the year, the important white paper ‘The National Service Framework for Children, Young People and Maternity Services. Change for Children – Every Child Matters’ (DoH, 2004) was published, which sets out the strategies needed to achieve the outcomes listed above, in a 10-year plan. In this paper, co-ordination of services and team-work are emphasised, in conjunction with appropriate support for parents.

More recently, as already quoted when considering the concept of inclusion⁹⁰, the Children and Families Act 2014 emphasises the importance of integration, including a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities e.g. health and housing. It also requires seamless transitions for young people moving to adult social care services (DoH 2014).

When collaborative work comes from client need, has a clear focus and purpose, provides a sense of achievement and is undertaken with an awareness of the roles of all collaborators, then the process has significant potential (Twyford and Watson, 2008). Within team working, one accesses a collaborative problem-solving, akin to what social psychologist Middleton (1998) had described as ‘talking work’, in which by discussion with each other, team members continually handle uncertainties concerning their work, for example, what should they be doing next in relation to problematic cases, or whether there are any misunderstandings of purpose between the various professionals involved and between team members and their families. Team members’ talk about their work therefore may provide the opportunity to give voice to contradictory and dilemmatic aspects of team practice.

Sometimes, therapists may feel threatened, in that they may believe that the medical or educational team is regarding the arts therapist merely as a ‘light-weight partner’. It has been said that one of the greatest challenges in team working is that of establishing trust (Kurtzberg and Amabile, 2001). In a trusting environment, radical ideas are respectfully considered, opportunities for full participation are guaranteed, and peers and co-workers, as

⁹⁰ See pp. 197 et seq.

well as leaders, are influential in creative outcomes. Moreover, as Twyford and Watson (2008) suggest, medical and psychological alliance does not rob the therapist of identity, it strengthens it.

Personality of the Therapist

The nature of the therapist's actual personality was seen in the previous chapter to be a key factor in the success of the therapy. One client went so far as to say that if he did not like the therapist, he would not work with him, regardless of the content of the sessions. It might almost be deduced from this comment, that if a programme of therapy was particularly successful, it could not be assumed that it was the modality of therapy being used with the client which was achieving the desired effects; it might simply imply that this particular therapist had established a very good relationship with the client, which was efficacious in itself.

In the structured interview findings, there were many aspects of the therapist's personality which were noted as being helpful both to the therapeutic relationship and to the other members of the staff team. Such qualities included being able to establish a relationship (rapport) with ease, talking to clients at their own level, being able to control without being too directive, being adaptable and motivated, being respectful of the clients, being willing to accept advice from other staff members, having the ability to engender trust and confidence in the clients to take risks in the sessions and – most importantly – being able to listen. All these were seen as being crucial components in the personality of the therapist, contributing to the success of the therapeutic process. In related literature, there appears to be two opposing schools of thought: one suggesting that therapist-client *similarity* of personality results in optimised outcomes and the other suggesting that *dissimilarity* leads to better results (Herman, 1998).

Similarities may occur between therapist and client in such areas as gender, race, personality and mental health, all of which are stated to have a profound impact on the psychotherapeutic process and outcome (Norcross, 1981). Research in this area has even gone as far as to state that the outcome of sessions is dependent on therapist/client variables, rather than the specific

techniques used (Lambert, 1996); Smith et al., 1980). A number of similar studies have investigated the relationship between therapists' methods of communication and the outcomes of sessions (Dormaar et al., 1989). It has been found that client-therapist similarity generally resulted in more effective sessions, as judged by both clients and therapists.

Support favouring dissimilarity comes from a body of literature which regards psychotherapy more as an educational experience. For therapy to be effective, the client must be presented by their therapists with information that is new or different, which they would not 'learn' on their own (Herman, 1998). Therapists who are too similar to their clients will be unable to present a different perspective, or any new learning (Mahoney and Norcross, 1993).

In an experiment carried out by Herman in 1992, both therapist and client took psychological tests prior to the psychotherapy processes being carried out. It was interesting that findings from that research showed that therapists were likely to employ specific techniques that were consistent with their own personality structures, as being more pertinent to their own issues (Herman, 1992). Likewise, clients were apt to see techniques consistent with their own personality structures as more pertinent to their issues. Lazarus (1993), as had Rogers (1959) before him, emphasised the need to meet the client on his or her own terms. Similarity of personality between therapists and clients does appear to have a positive impact on the effectiveness of psychotherapy outcome. It is interesting to note that in the study described by Herman (1992), this phenomenon occurred regardless of the therapist's status as a student or even the number of his or her years of experience.

Group or 1:1 sessions

One client in his response to a question in the interview said that he had really liked the art sessions, 'Because the therapist was really listening to me and giving me time. The other teachers don't do that.' The art therapist working with this client commented: 'In art therapy, a client just feels he has his own piece of paper. He might find music in a group quite threatening, for example, having to play an instrument in front of others.'

The same therapist remarked, on being asked whether she wished to continue working with a certain group of clients, ‘Yes, but there were two clients in the group whom I would have suggested had therapy on their own. They had too much to carry in their personal lives and this was causing them to be ill. But they couldn’t discuss this within a group, however supportive the other members of the group were.’ She maintained that it was inadvisable to form a group from clients who are in the same class or day centre, just because it is easier, practically, to do so. Group members should be chosen with care, according to their individual needs, not because this is the group within which they function for the rest of the day as well.

Some therapists stated that they prefer to conduct an initial assessment on a 1:1 basis and then, when they feel they understand the client and his needs better, make further suggestions as to whether it would be better to continue within a 1:1 situation, or become part of a group. It may be the situation that in some instances a whole group of clients is referred together, in which case it may become apparent – as mentioned by the previous therapist – that one or more clients would progress further in a 1:1 situation. A client said that she would like to continue the therapy, ‘... but not on my own, because I get shy.’

Who else benefits?

The staff and other members of the clinical team

One of the questions asked in the structured interview and not yet addressed in analysis of the results, was whether or not anyone else besides the clients had benefitted from the therapy sessions.

It has already been mentioned that one head teacher had said that he felt the whole school had benefitted, as the staff had become aware of different approaches to teaching. At first, staff members had found this quite threatening, but after consideration, some had modified their own teaching methods accordingly. Some individual members of staff had attended the group therapy sessions on a regular basis, both to support the therapist and to learn from them. In one setting, a staff member was then able to use a similar – but modified – approach in her

own art work with the clients after the programme had ended, which was especially useful to her as she was working with 'difficult' children. She was able to see the work 'from another angle.' It also allowed her to see the clients in a different light from how they reacted in the class-room and helped her to gain insight into their characters, which might not have been apparent within the class-room context.

One head teacher, with reference to how the staff had benefitted (or otherwise) from the therapies, said to me in his interview, 'I'll never forget. One of the teachers came in to my office and said 'Mr. C., I've just looked into the drama therapy and there was a child sort of jumping off a chair pretending to be Batman. I think you need to go to rescue the therapist' – to which I replied 'No, I don't, that's fine. That is what I would expect' ...and the look I got from the teacher was incredible, sort of incredible!'

This head teacher said that he felt that the staff had not been adequately prepared for the fact that the sessions might be noisy, or client participation apparently unrestrained. They were not aware of why it was being done in this way. Because of this initial reaction by the staff, the researcher had made a visit to them. The therapy process had been discussed openly; consequently staff members were able to appreciate the differences between traditional art or drama sessions and therapy sessions. It became a learning experience for the staff and also assisted in building up mutual trust and respect between therapists and staff members. What was also interesting was that the clients themselves were able to understand that they should not take 'therapy' behaviour back into the classroom. It was good that the children did not 'run riot' in the therapy sessions, even although they had more freedom to express themselves. The head teacher remarked that the therapist still controlled the sessions, but in a different way.

Another manager said that staff who had participated in sessions as supporters found them very up-lifting for themselves as well and that after the dance movement therapist in particular had left, everyone felt 'merry and bubbly'. After the art and the drama, people were quieter, because they were thinking about things which the sessions had brought up and supporters had gained insight into their clients' characters. The manager herself said that she had found it valuable to be able to discuss 'the psychological side of it' with the therapist afterwards – especially in the context of the art therapy. These discussions would also affect work by clients' key-workers after the sessions had ended. Some staff had been provided with an incentive by the sessions to attend further experiential courses designed for those interested in

learning more about the therapies, which would guide them when considering interventions for their clients in the future.

Another member of staff stated that being involved in a different approach gave her an alternative view of the client: ‘One girl had to be restrained at the end of the session because she didn’t want to leave. But I found another way as a result of the work that I had done, to be able to figure out how to support her so that she could leave the sessions better.’

A further teacher had found the art sessions with a particular child very emotional, because the child had built himself a ‘safe space’ and had hidden in it. Through this, the child had disclosed that his father had snatched him, when he was quite young, from his mother’s house after the parents had separated and he had been forced to live with his father in a car for over two weeks. This had had a profound effect on the boy, but he had never told anyone about it. The art therapy had provided an opportunity for the boy to share this terrifying experience with someone else. This art session had changed the teacher’s attitude towards the boy, as she came to understand his behaviour and had journeyed through his traumatic experience with him.

In another location, the resident occupational therapist and psychologist were particularly involved with the therapist’s work. They said that although they had differing views in some matters, they regarded this as a challenge which they were happy to accept and that they had all learned from this interdisciplinary discussion. It had become a learning experience for the other staff and for themselves.

In all, there is no doubt that others involved in the therapies programme felt that they had gained in insight and understanding. These included staff and other members of the clinical team – especially as the sessions allowed them to see their clients in a ‘new light’, which may have led them to modify their approaches accordingly. One occupational therapist in particular had said that it was ‘eye-opening’ for her to see different clients’ responses to different therapists. Being professionals themselves, the staff were at first rather sceptical, but they found that, to their surprise, the clients really took to the therapies and staff had learnt a lot from watching the therapists work and discussing issues with them afterwards.

Sometimes an assistant invited to attend sessions to support the therapist can have a negative effect on the session, as happened in one school. The assistant was very critical of the therapist and was looking at the session from a teacher's point of view and expecting the same behaviour from the clients that they would exhibit in the classroom. In this case, the assistant 'didn't quite get the hang of it' and this caused friction between the therapist and the assistant, which was detrimental to the therapy process.

The therapists

One therapist in particular mentioned in his response to the structured interview that he had had good feedback from the heads of the centres when they were talking afterwards. The opportunity of being able to meet with at least one member of staff – even if not with the whole team – had allowed the therapist to feel valued, especially if the staff member was pleased with the results being obtained. Other therapists reported that they had found it professionally beneficial to be working with a new variety of client groups. It had greatly broadened their professional expertise and practical skills.

Therapists stated that it had also been good to work more closely with therapists operating in different arts modalities from their own. Previously, this contact had not been so frequent. They did, however, feel that they could have had even more discussions on a regular basis, in order to have more detailed knowledge about the progress of each client as they passed from one arts modality to another. This would have been preferable, but had been logistically impossible to arrange.

The parents

General comments concerning parents was that teachers and managers had written to them informing them that the sessions were taking part, but that they did not necessarily have specific contact with them afterwards to discuss any outcomes. This was disappointing, in that it would have been good for parents to have been able to discuss their children's progress and even to have met the therapists concerned. This did not happen, largely because of the time factor. However, in one location, some parents were interested and it spurred a number

of them to seek additional resources, or take a similar approach with related experiences outside school hours.

Assessment in all four arts modalities

Respondents' discussion concerning this point⁹¹ seems to indicate that many referrers would like the opportunity for their clients to experience assessments in all four of the arts modalities, each modality having its own specific benefits and values. One therapist said that she might even go so far as to say that she might recommend a modality of therapy different from her own, if she felt that this would be more suitable for the client group. Her view was that in an ideal world, the particular client should experience an holistic arts therapies assessment, which assesses which therapy is going to be the best modality for them. However, this was seen as idealistic, rather than a practical option.

Speculation on the use of multi-modality (cross-cultural) approaches

As was discussed in chapter 2, the concept of using more than one modality of art form within a single programme of sessions, is one with which many arts therapists – including the researcher – find it difficult to concur. It is interesting that Bruscia (1998, p.6) also expressed concern about the crossing over of modalities by therapists who may not have the knowledge or skills that are required by the individual arts therapies associations for their own members. Bruscia queries:

‘Are arts therapists qualified to do assessments only in their own modality? ... Can a movement therapist assess musical responses? Can a music therapist analyse client paintings? Can an art therapist interpret movement?’

This is not to say, however, that one might not occasionally involve practical activities or techniques of a different modality from one's own, from time to time. As a music therapist,

⁹¹ See Chapter 5 p. 168 et seq.

the researcher might suggest to the client ideas connected to colour or movement, but this would not imply that she would consider herself to be an art or dance movement therapist. It appears from responses to the structured interview that most therapists would not hinder their clients if they were to show an interest in incorporating elements from modalities other than the one in which they are currently engaged, but would still focus on operating within their own art form.

One of the Centre's dance movement therapists involved in the current programme intentionally works in a 'cross cultural modality'. Thus within his session, clients would have an opportunity – if they wished – to use musical instruments, costumes or role play and to go across the other modalities and integrate them at will, with no barriers. The client would be given a 'level playing field', in which there were no barriers or space issues to deal with, except that each would client know – and guard – his/her own space. This therapist believes that his clients gain confidence by being allowed to explore other modalities if they feel so inclined; he has a wide and varied experience of the world of dance and as such, has the ability to 'allow' his clients to integrate a variety of modalities into their therapy. The only concern would be that a therapist who is less skilled in his own art form and less experienced in his understanding of the use of it in a clinical context, might attempt to offer many modalities, but be unable to be fully expert in any of them, in order to offer informed and grounded practice.

If all four therapies were available in sequence, do you think it makes any difference in which order the art, drama, music or dance movement are experienced?(QQ6.)

Respondents were invited to comment on whether they felt that advisability or otherwise of experiencing the four therapies in a pre-determined order might reflect the process of human development, such as might be experienced by the foetus in the womb and the neonate. This possibility was supported by one teacher, who conjectured that as movement is the first ability to develop in the foetus at 8 weeks, so dance movement might be the most basic or instinctive modality for a client to experience. Further development of the brain and consequent activity of the neonate as described by Joseph (2001) might support the supposition that the developmental order of arts therapies modalities should be dance movement first, followed by

music, then art and finally drama. However, his theories do not indicate which modality might require the greatest cognitive ability and this supposition is conjectural.

The Final Question

Which modality of therapy (art, drama, dance movement or music) gave the best results, bearing in mind all the factors involved?

In chapters 4 and 5, Q4 of the quantitative results and QQ2 of the qualitative results were analysed, concerning whether one modality produced better results overall than another.⁹² In chapter 5, which considered analysis of qualitative data, QQ3 concerning *'Why do you think this was so?'* was considered in conjunction with QQ2, so that reasons why any one modality was chosen in preference to the others, could be taken into consideration. There was obviously no equivalent quantitative question concerning the reasons *why* respondents thought a particular therapy was best, as this could not be expressed in numerical form, but as the quantitative question (Q11): *'Was one aim more successfully addressed with one particular modality of therapy?'* covered a similar aspect, this is being included in the present discussion.

The quantitative results from Q4 showed that overall, there was no consensus as to which modality was most successful, when not differentiating between aims, gender or age of the clients.⁹³ Managers / teachers and therapists chose dance movement (with drama and music a close second choice); clients chose drama. There was consensus of opinion that art was considered overall to be the least successful modality of the four.

Q11⁹⁴ went into greater detail, in order to take into account the varying factors of aims, gender and age. The analyses differentiated between the 3 viewpoints, namely M/T, Th and C. Here it was shown that when considering *Aims v. Modality* of therapy, there was total

⁹² Reminding readers that 'Q' refers to a quantitative and 'QQ' refers to a qualitative, question

⁹³ See Chapter 4 Table 33 p. 114

⁹⁴ See Chapter 4 Table 35 p. 115

consensus of opinion in that music was seen to be the best modality to address the aim 'To enhance self-esteem'. This result is further discussed below. In comparison of other *Aims v. Modality*, there is only partial consensus between the 3 Views and in aim 4 'Enjoyment / Freedom' it is interesting that although this was felt to be the most successfully addressed aim overall, there was no consensus at all as to which therapy was best suited to meet this aim. There is only partial consensus of views when considering 'Aims v. m/f and consensus' ⁹⁵. When considering 'Success of aims v. age groups – All TV's', Managers/teachers were in agreement that aim 6 – 'To benefit physically' - was best addressed by dance movement; they also are in almost total agreement that dance movement best addresses Aim 7 'For relaxation and reduction of stress'.⁹⁶ Within the therapists' and clients' view of 'Success of aims v. Age groups' there is only partial consensus of opinion.⁹⁷ In the overall comparison of 'Was one aim more successfully addressed with one particular modality of therapy, TV/ThV/CV and Consensus v. Was this the same over each age group?', it is noted that although there is partial consensus in certain comparison of some variables, there is no overall consensus to answer the original research question. ⁹⁸

In relation to this, it should be noted that within her responses to the structured interview, one dramatherapist, when asked which client group she thought had benefitted most from her own modality and why this might have been so, had felt that even within one specific modality, adaptations of techniques could be made to suit a particular client group, if she felt that the original approach she was using was not proving suitable for that group.

Total consensus for music, in consideration of aim 'To enhance self-esteem'

When considering a restricted number of variables, however, some consensus of opinion became more apparent. In particular, the analysis of results for Q4ii indicated the unexpected result that, when considered over all genders and ages, there was total consensus in the Views

⁹⁵ See Chapter 4 Table 36 p. 117

⁹⁶ See Chapter 4 Table 37 p. 118

⁹⁷ See Chapter 4 Table 38 p. 120, Table 39 p. 121

⁹⁸ See Chapter 4 Tables 40a / 40b p. 123

of M/T, Th and C, in that for Aim 1: *'To enhance self-esteem'*, music therapy was considered to be the best modality, while for other aims, there was only partial consensus.⁹⁹

In QQ2/QQ3,¹⁰⁰ the question was asked 'Which therapy do you consider was the most effective (*in your location*) and why?' The structured interview did not specifically ask 'Which *aim* do you consider was best addressed by which modality?' However, by considering which location had chosen which aims, the answer to '*and why*' would be seen to be inherent in their responses, that is, that the modality seen to be the best for each location would automatically be the best modality to address the aims of that location. In general, the view in the qualitative data of music being the best modality in consideration of the aim '*To enhance self-esteem*' was supported throughout all locations, although with some qualifying details being added by a few locations.

For example, in Location 6, the head teacher said that there was not a strong musical tradition, which might have increased the positive response by the clients, as they explored a less-known modality. However, the draw-back of not feeling she was regarded as 'part of the team' in this location was stressed by the music therapist; this she had found difficult, despite the head teacher's preference for her modality. The aims of Location 8 – the mainstream secondary school with a high ethnic majority – focused largely on '*Increase of self-confidence and self-esteem*', particularly in regard to trying to remedy the negative effects for clients of belonging to minority ethnic groups. In some locations, dance movement was also seen as being very supportive of clients in achieving this aim. It should be recalled here that the therapist leading the dance movement encouraged the children to bring their own music CDs to the dance-movement session, thus supporting the inter-relationship between dance and music in this modality and respecting the clients' personal integrity.

Qualifying their views on this result, Location 2 stressed that the personality of the therapist was a major contributory factor to the success of the music sessions, while in Location 7 – the special school for autistic secondary children – in which the aims were focused on the ability of clients '*To interact with each other*', '*To increase non-verbal communication*' and '*To*

⁹⁹ See Chapter 4 Table 35 p. 115

¹⁰⁰ See Chapter 5 p. 134

express themselves freely’, in addition to *‘To increase self-esteem’*, the teacher’s opinion was that each child should be viewed individually and that one could not suggest that one modality would be better than another in order to address specific aims. She was strongly in support of the ‘Multiple Intelligence’ approach, although probably not to the extent of the manager/teacher of Location 5. However, both the therapists and the clients in Location 7 were totally in agreement that music was the preferred choice of modality for these aims. It has already been mentioned that this might have been due to the familiarity of the music therapist with the location, as he had previously been the head teacher there himself – although not with the current set of clients. Once again, this points to the importance to the process, of the therapist having a sympathetic personality.

The conclusion to the preceding discussion, therefore, appears to be that if the main aim of a referral includes *‘Enhancing self-esteem’*, the modality of music therapy should be recommended. This is supported by both quantitative and qualitative results. However, some respondents stated that the results from their location could not be regarded as applying to all the clients in that location – even although all clients had similar overall needs. Even within a certain ‘category’ of client disability, there were still individual differences of needs which would have to be taken into account. Indeed, some locations did not include *‘Enhancing self-esteem’* as an aim at all, but in many cases, it appears that a client who was aware of his personal disabilities may well in addition have had a low self-esteem.¹⁰¹

Varying modalities for any aim

In contrast to the importance of music being the most successful modality for *‘Enhancing self-esteem’*, it was felt in some locations, especially in the views of the managers/teachers, that different therapies were suited to different clients, regardless of the aims. For example, within Location 5 – the primary special school for children with learning disabilities – where there was a strong ethos towards Gardner’s (2004) ‘Multiple Intelligence’ theory of learning, the managers / teachers did not differentiate between one modality or another, but were in total agreement that each child should have a different approach, based on his or her own

¹⁰¹ It is interesting to compare these findings with the reference by Ainlay (1948) that music was used to increase the morale of both healthy and ill soldiers in World War II (see Chapter 2, p17)

preferred learning styles. The managers/teachers did not actually go as far as to say which modality they thought was more appropriate for which Intelligence – this would be an interesting, although necessarily separate, study. Therapists in this location were in favour of music or art; clients were equally divided between the four modalities. Of importance in this location is the support from staff, which the music therapist in particular felt she had experienced. This, for her, had increased the efficacy of the sessions.

Location 10 – the brain injury rehabilitation unit – also had aims which focused largely on personal self-awareness, self-esteem and communication, coupled with being more able to communicate within a group situation, but again, the managers / teachers agreed that each client should be regarded as an individual and that it was not possible to say that one particular modality was more successful in achieving these aims than another. This was reflected by therapists and clients, who were equally divided in their views that all four were successful. Practically, the art therapist had found it difficult here, in that clients' attendance at sessions was not necessarily consistent, because the nature of their brain damage led to inconsistent behaviour. Moreover, these clients were less likely to have attended sessions in all four modalities, owing to the greater rate of discharge of clients from the unit.

A similar modality to clients' existing artistic strengths recommended

Within the qualitative responses given by managers / teachers, therapists and clients, when discussing reasons why a certain modality had been successful with their clients, the following responses supported the view that similar modalities to the clients' preferences and existing artistic strengths were best.

Managers / teachers felt that clients could relax within a modality in which they already felt comfortable – it was not too challenging, but echoed their own experiences. Music was felt to be 'comfortable' for younger children because it gives repeating rhythmic patterns, which younger children like. They also commented that if the modality chosen was similar to the way in which the client experienced the world (*see* Gardner's Multiple Intelligences (MI)) then it would be more successful. For example, art would be good for those who liked a tactile experience, or if a client was good at drama, then he would progress more in the

dramatherapy. Gardner (2004) also stated – in support of children working within their ‘comfort zone’ – that 81% schools had reported improvement in student discipline after adopting MI theory, therefore, if clients are given a modality which is in accord with their Intelligence, they should feel more affinity to that modality and therefore better results should follow.

Therapists commented that younger children relate to art material intuitively and that therefore this is particularly comfortable for the younger ages. Drama was similar to natural play, therefore an older age group felt more comfortable doing this, as it appeared to be a less challenging approach. Teenage clients responded especially to music, because this was their familiar background. This view is supported by the famous dramatherapist Lehad (1992), whose approach is to reinforce the autonomy of the client by discovering the strengths, rather than focusing on the weaknesses or problems, through his application of the ‘Fairy story’ method. This view is also supported by the fact that the most successful aim addressed was Aim 4 – ‘*Enjoyment / Freedom*’ – which included such components as ‘*To have fun*’, ‘*To enjoy sessions*’, ‘*To have the opportunity to work in a less formal setting*’.¹⁰² It is conjectured that enjoyment of sessions leads to increased motivation to achieve the aims of the original referral.

The clients themselves felt that a modality in which they felt ‘comfortable’ meant that there was less chance of them expressing themselves inappropriately or ‘making a mistake’. This would lead to a feeling of self-confidence in themselves and the situation, which would encourage progression. A group of secondary aged clients stated that they felt safer in the art modality, because it was a smaller group. In a group modality like dance and drama, one client felt less at ease because she felt more exposed and it was not so comfortable an experience. The clients in this group said that they did not feel comfortable in a large group, when discussing personal matters. One client said that she felt that the whole group was happier in the subject which the group liked most. Another client welcomed the chance of doing something she liked, because she could not do it anywhere else. A third client said he did not do well in music because he did not like that sort of music. A client in the same

¹⁰² See Chapter 4 Table 30 p. 111

location said he enjoyed the art because he used to draw loads of cartoons 'as a kid', therefore he felt at ease in the art. He said, 'I liked the art because it was interesting'; another client said, 'I liked the drama because it was easy'. However, one older client really felt out of her 'comfort zone' in the drama, because it was 'stand up, sit down, stand up, sit down, all the time'. Another elderly client liked remembering things, therefore enjoyed doing art therapy, because he enjoyed drawing things which brought back memories which could be discussed with the therapist.

Dissimilar modality supported

The opposing view, namely that a modality should be adopted in which a client learns a new approach to his problems, is actually one with which an experienced artist might feel more at ease, being drawn to a therapist who practised in the modality in which he himself felt least ability, the argument being that if the client were to bring himself to feel more at ease within an unfamiliar modality, then other issues would perhaps appear easier. One manager/teacher said that the experience of freedom of movement was 'quite new' to his children and that that had appealed to them, as being different from their usual experiences: 'They wouldn't be allowed to do this at home or in the class-room'. Another manager / teacher said that she felt that her clients had responded well to a new experience because it was not available within the school (music) - they had therefore been able to experiment in something new to them.

One teenage client showed what appeared to be good understanding of the therapy process when she said, 'I was able to take part in anything (*modality*), even if I don't usually like it, because it doesn't matter if you're good at it, in therapy'. She said that the group enjoyed doing 'different' things and being able to explore other modalities. However, there was a limit to this, as they did not feel that it was 'cool' to do some things.

Support for experience in all four modalities

A further point of view supported the premise that the most appropriate modality for a client would change according to his developing age and experience and that experience in all four modalities would be recommended at varying stages of the client's development. It might be

that a client would do well in music when young and drama when it became more necessary to develop social skills and interpersonal relationships. However, the opinion was expressed that different clients used different modalities in different ways, so it was not possible to generalise.

CHAPTER 7 – CONCLUSIONS

Introduction

In the introduction to this work, it was stated that the aims of the research were three-fold. The first aim was to determine whether there was any evidence on which to base a referral for a specific symptomatology to a specific modality of arts therapies. The second was to examine whether it would be advantageous for a client to be able to experience all four modalities in sequence; if so, should this be in any particular order of intervention? Finally, it was hoped that the programme would provide a good experience for all participants and lead to enhancement of guidelines for assessments and programmes for the future.

Confirming that the research question is relevant to present practice, at the Centre, two referrers rang asking for advice. One was a mother enquiring about her 4yr. old son, who has language and understanding difficulties: ‘Would music therapy help him?’ The other was a self-referral: ‘I am a 53 yr. old woman and I have suffered trauma in the past... I was sexually abused as a child. I feel I must get rid of this trauma. I love dancing ... what should I do?’ It is hoped that the research has produced some answers – although not necessarily the answers which were expected.

The Experience of the Programme itself

Positive aspects

One of the major strengths of the programme – which fulfilled the third aim of the project – was that it was well received and supported by those to whom it was offered, all participants benefitting according to their personal role in it. Both quantitative and qualitative results obtained from the research indicated that the intervention of an arts therapies approach was recognised by clients, therapists and referrers (managers/teachers/ parents/carers), as having had a positive result. These positive results were as much as 94% in the opinions of the clients concerned, with 89.7% for therapists and 85% for managers and teachers. Moreover,

it appeared that these results were not prejudiced in favour of success, as some individual 'scores' were in the negative region.

There was not one location which declined to participate and that fact in itself expressed and underpinned the confidence which managers/teachers, therapists and clients had in the overall programme. The clients themselves took part with enthusiasm, benefitting from the sessions and enjoying them, even if the sessions were not always continued for as long as might have been the case had this not been a time-limited programme. In addition, managers / teachers and other staff members involved learned from the processes of the programmes, either by participating in actual sessions, or through discussions afterwards. The therapists gained experience by working in some locations with client groups with which they were unfamiliar and by being able to discuss among themselves, with staff members and with the researcher, the varying outcomes of their work. As a result of the research, it is hoped that the Centre will now be in a position to offer a more definitive and informed response to referrers' initial queries. Guidance notes for future practice which are additional to the core text are included in the appendix,¹⁰³ thereby achieving the second half of the third aim.

Less positive aspects

Many practical difficulties were encountered, such as inconsistency of clients, time delays, changing of managers/teachers concerned, difficulties at individual locations and other problems which have already been described and which might be regarded as weaknesses in the programme methodology and could justifiably be considered to have led to unreliable quantitative results. It might also be argued that the research question covered too wide an area of study – that there were too many variables. This would mean that it would be impossible to reach definitive conclusions. As one therapist stated, 'The context was too diverse; the research should have been carried out over a five year period, not less.' Support for the study, however, came from another therapist, who said, 'You are well ahead of your time. Let's do it again, but take longer!' It might even be possible in a future study to

¹⁰³ See Appendix 13 p. xli

introduce new elements of discussion, such as whether there should be a difference in the programme between those who have acquired a disability since birth – for example, those with acquired brain injury – and those whose disability is congenital, for example autism or learning difficulties. One might certainly introduce a follow-up study of the effects of the programmes on clients after given periods of time, for example after 6 months, 1 year and 5 years.

Practical circumstances resulted in the programme being undertaken over a considerable length of time, with even further time elapsing before the final conclusions were written down. However, the time lapse between commencement of the programme and its conclusion allowed the researcher to reflect on outcomes as they became apparent and to compare these with the ongoing work situation. These reflections were both beneficial and pertinent, resulting in greater insight into discussions concerning the two sets of results.

As the overall length of the 4 x 12-week programmes was 48 weeks, some participating clients were not able to experience all four arts therapy modalities, owing to their discharge from intermediary units or change of schools, before the end of the programme. In discussion between the researcher and managers/teachers concerning this problem, their opinion seemed to be that as clients had been assigned to each specific location because of their individual needs, all clients at that location would have similar problems with which to contend and might therefore be regarded as being representative of that particular location. It would therefore be valid that they should be chosen to replace those who had discontinued the programme, while still regarded as individual people in their own right.

All scoring of results in the quantitative section of the research depended on the individual opinions of the person making the scores. It is possible that if different people had been making these judgments, they might have given different scores. However, each set of scores was judged from 3 sets of view-points, namely those of managers / teachers, therapists and clients, which assisted in assuring validity of the results. Where there was a marked difference between two different view-points (which did not happen very often), this became a point for discussion, rather than a weakness in the methodology.

It was also not possible to take into account the effects that everyone concerned in the programme experienced, as each modality followed in succession. The results – both quantitative and qualitative – of subsequent sessions may well have been affected by experiences of the previous modality, both from the accrued understanding of the therapy process itself and also by experiences which may have built on each other, for better or worse cumulative effect. One can only say that the final results proved that the total experience had proved beneficial for all who participated.

However, if regarded as a starting point for further research and the provision of operative guidelines for the Centre's future arts therapies service, the researcher does not consider that the study could have been limited to a more restricted number of client 'types' or actual arts therapies modalities, certainly not at this stage of the enquiry. If asked whether things could have been done differently, the researcher would reply that at this initial stage of attempting to answer the original question, she does not see that they could have been. Again, in a follow-up study, the number of variables might be reduced by limiting the research to one specific client group, or targeting one specific client aim, providing an alternative context for further study.

An Overview of Conclusions reached

The current research has shown that overall, a high percentage of participating managers/teachers, therapists and the clients themselves, felt that the various arts therapies programmes had produced beneficial results. This statement is supported not only by the quantitative and qualitative results of the present study, but is supported by the findings of many other studies in arts therapies which have been undertaken and which were reviewed in Chapter 2.

It was also emphasised that in order for results of the programme to become as effective as possible, the therapist should be regarded as a member of the client's clinical team, to facilitate discussion concerning changes in the client's behaviour and to ensure that disclosures made by the client concerning abuse or dysfunctional home situations are referred to the relevant agencies. If the client is living in a residential home, the therapist may be able

to act as an advocate, if necessary, on the part of a disempowered client, if expressed needs appear to have been overlooked or ignored.

In addition, in order to extend the effects of the sessional work into the clients' changed behaviour patterns outside the therapy room, it was established by respondents in the structured interviews that any positive outcomes would be enhanced by involvement of other members of the client's family at some stage in the therapy, either as a separate therapy for the parent / referrer, or within a family group setting of parents / siblings and the client.¹⁰⁴ This might be supported by modifications concerning relationships to peer groups or other external factors.

Specific Details

Gender

It appeared that statistically, male clients were more likely to ask for therapy, but might be less likely to benefit from it. The difference in success rate between *m* and *f* clients was not very great, being of the proportion 1.21 : 1 in favour of *f* clients.

Age

A number of questions related age to a second factor. There was consensus of opinion between managers / teachers and clients, that clients in the 46-61 yr. old age range appeared to experience greatest success, whereas therapists felt that this was true for the 5-10yr. age range. There was, however, total consensus from all three groups of respondents that the 30-45yr. old range did least well.

¹⁰⁴ *Or initial therapy could be offered initially for both the client and the parent individually. Family work might then take place at a later stage, when both parties had been able to gain greater insight into the current relationships within the home.*

Location v Age

When considering which location (in relation to age of client) had the best results, it appeared that the average age for best results was the early secondary age (12.8yrs.), but this also proved to be – in managers / teachers’ and therapists’ opinion – the least successful age. This led to a discussion as to whether these results were influenced by the type of client, one being in a mainstream context and the other in an exclusion unit. Results appeared to depend on the personal history of the client, in addition to their chronological age. The fact that the clients concerned also had a variety of differing aims would also need to be taken into account when considering optimum age for referral.

Modality of therapy v. age of client

When considering the age of the client against the most successful modality of therapy, there was partial consensus that dance movement for the 5-10yr. old, dramatherapy for the 20-30yr. age group and art for the 31-45yr. group were the best. There was general consensus of opinion that art therapy appeared to be the least successful with the 5-10yr. and the 46-61yr. age groups.

This concurred with the emerging theory that dance movement might be the best therapy to use as a first intervention, as movement is the earliest developmental ability of a foetus before birth. This initial development is followed by awareness of sound – music therapy was recommended especially for younger children – followed by drama and then art, which might both be more dependent on cognitive ability, which is a later function to develop. However, the firm opinion was given by all therapists that it was best to start therapy at the earliest age of intervention that was practical, regardless of the modality.

‘Middle-aged’ clients

An interesting and unexpected fact arose at this point, namely that it was middle-aged clients who usually felt excluded from provision of any programme of intervention (not only arts therapies programmes), feeling too young for interventions targeting an older age group, but

too old for the younger age group. This concurred with national statistics. It was thought that this fact might be followed up at a later date, by reviewing target groups for the Centre's services.

Which location had benefitted most

In the research, when results were analysed regarding which location / client group had benefitted most overall, there was consensus that the secondary mainstream school appeared to be the most successful, although both managers/teachers and therapists commented that this success also depended on positive support from staff and facilities provided. Out of the 10 locations in which the programme operated, 6 were classed as 'special', while the remaining 4 were 'mainstream'. Considering that therapy interventions have been traditionally associated with 'special provision', the fact that a mainstream school, rather than a special school, was seen to have benefitted most overall was unexpected. Indeed, results indicated that mainstream locations generally had higher levels of positive comments compared to the special locations. As a consequence of current educational policy that all children with special needs should be incorporated as far as possible into mainstream provision, it is possible that managers / teachers in such schools may have less experience (or motivation) in working with such clients. This may in turn have led to the therapy interventions being especially welcome, as arts therapists are trained in working with special needs clients, whereas the teachers themselves may not have been.

Medication

The effects of possible medication were discussed with the respondents, with the challenging thought of whether a client participates in therapy sessions as he is (while medicated), or as he would be when not medicated. There are so many varying factors surrounding this topic that it is hard to generalise. It is certainly the case that changes in clients' medication during the course of the therapy programme might have led to responses which were wrongly attributed to the effects of the intervention, rather than to the medication. Unfortunately, this could not be verified at the time.

Aims

When considering the client and his ‘personality’ or individual needs and subsequent identified aims, it became apparent that the actual breadth of clients’ needs – from the point of view of increase of range of ethnicity, integration of children with special educational needs into mainstream education, re-categorising of mental health states of mind and other changing factors in today’s society – meant that the highest score in the ‘aims’ category provided most guidance for recommendations to a potential referrer.

Here it was observed that although the aim of *‘Being able to participate as a member of a group in an appropriate way and to benefit from so doing’*, was by far the most frequently chosen aim, yet on analysis of results, the most successfully addressed aim was that involving *‘Enjoyment and freedom’*. This covered such targets as *‘To have fun’*, *‘To enjoy sessions’*, *‘To have the opportunity to work in a less formal setting’*. This result was supported in the interviews at the conclusion of the research, in which managers / teachers, therapists and clients all stressed that without these elements being present in the sessions, other issues could not be addressed with confidence, as enjoyment led to motivation, which was the key to all progress. The argument was presented that if clients were not motivated and did not wish to participate in the therapy offered, then how could a successful outcome be achieved?

When considering which aim had been best met by which modality, a surprising consensus arose between all three groups of respondents concerning the fact that when considered over all genders and ages, the aim *‘To enhance self-esteem’*, was best addressed by music therapy. This was supported by partial consensus in a number of individual locations. When discussing this with another professional, the comment was made that perhaps looking at it the other way – namely to be told that one is ‘bad at music’ or ‘you sing out of tune’ may be a crushing blow to fragile self-esteem.

When considering *‘Which aim v. Which gender of client?’ (all ages)* it was interesting to note that *m* clients appeared to find that music therapy best addressed the aim *‘To enhance self-esteem’* and dramatherapy *‘To allow freedom of expression’*. There was no consensus for *f* clients. When considering *‘Aim v. Modality of therapy v. Age of client’*, it was felt by

managers / teachers that dance movement best addressed both *'To benefit physically'* and *'For relaxation and reduction of stress'*. It might not have been surprising that dance movement was best for physical benefit, but less expected that this should also be thought of as best for relaxation and reduction of stress within the oldest age group.

Amongst the clients, there was only partial consensus, in that dance movement was seen by the younger age groups (5–10 yrs., 11–19 yrs., and 20–30yrs.) to be best for *'Participation as a member of a group'*, while music therapy was seen to have greater consensus in addressing *'To respond individually in an appropriate manner (individual self-expression)*, amongst the age groups 5–10 yrs., and 20–30yrs. Overall, it was found that one could not necessarily expect that specified aims would follow any developmental or age related pattern.

Gardner (2004) suggests that what we need to give clients are 'overall strategies' for coping with life, rather than concentrating on specific problems. He maintains, for example, that it is more important that students learn how to think like a historian and how historians handle data and draw conclusions than to try to cover every topic in history. Perhaps our contribution to the client in the therapy sessions is not only how to succeed with a specific aim, but also that clients should be able to learn strategies which could be applied to other problematic situations in their life, perhaps as yet not even experienced.

How directive should the therapist be?

Within the area of achievement of aims, managers / teachers, therapists and sometimes clients debated how directive a therapist should be in encouraging a client to participate, or progress in a certain direction. It appeared in discussion that each therapist would address this issue in different ways, according to their individual approaches and the personality of the client involved. While some clients might feel more comfortable if surrounded by a 'safe boundary', others might feel limited or threatened by it. This could be one area of the therapeutic process which would differ in every context, depending on the relationship between the therapist and participating client involved.

Motivation

The result that *'To have fun and enjoyment'* was the most successfully addressed aim, supported the importance of clients' positive motivation towards the therapy process. It was stated that clients who are referred having some sort of disability – either physical or mental – may well feel isolated from the experience of pleasure. Consequently, to experience 'fun' and 'joy' would not only be important factors in their therapy experiences, but might even be the first time the client had been able to experience these emotions on a regular basis. This in itself could lead to healing through the physical release of endorphins and the psychological reinforcement that such experiences would give towards clients' motivation to self-heal. Therapists even suggested that some clients may have lost the will to 'get better', preferring to remain dependent on others. If a client was in a state of depression, this could be a most de-motivating and debilitating experience, leading to total inability to start to 'climb out of the hole' without assistance.

It therefore follows that if a modality is recommended in which the client feels comfortable and experiences enjoyment, motivation will be initiated, leading to addressing areas of life which are not so positive and support self-healing. Feder and Feder (1998) maintain that a basic premise in the arts therapies is that the therapist must meet the client at the client's level of comfort and that ongoing research supports the commonsense view that clients and patients are more responsive to the art form they like, than to those they do not like. In planning treatment programmes therefore, Feder and Feder advise that it is important to identify these abilities, interests and preferences. This view is supported by Gardner (2004) who suggests that if students' confidence and sense of efficacy is built up, they will be more willing to take on difficult materials.

The Therapist

Considerable discussion took place in the preceding chapter concerning the personality of the therapist and the influence which this has on the outcome of the sessions. It appeared that the therapist would need to be a remarkable person indeed, in order to meet all the criteria

recommended. For some respondents, it was of crucial importance to the therapeutic process that the client should feel at ease with the therapist, which might include similarities between therapist and client in such areas as gender, race, personality and mental health; this point of view is also supported by Norcross (1981). In ideal circumstances, it might be possible for the referrer or client to request such personal characteristics of the therapist, but many providers of a therapy service might not have such extensive resources. In contrast to this suggestion, however, it might be recalled that Herman (1998) and Mahoney and Norcross (1993) are of the opinion that for optimum outcome, too much similarity between personality of client and therapist might not be advisable.

It was found on analysis of both quantitative and qualitative results that the therapist would need not only to be able to establish an empathetic relationship with the client – including greater or lesser directive-ness of approach depending on the client's needs – but should also be able to function as a member of the multi-disciplinary team concerned with the client. This would have advantages for both the therapist and for other members of the team. Support and exchange of ideas could be given and received by both sides to their mutual advantage.

Discussion took place as to whether one particular psychological approach or practice on the part of the therapist would ensure success of outcomes. It was shown to be the case, however, both in a number of studies reviewed in Chapter 2 and in the present work, that the actual techniques used by therapists were less important than the therapists' overall personalities. In addition, support of the therapists by staff members and their acceptance as members of the clinical team, were seen to be crucial factors in the integration of the arts therapies intervention into the overall programme devised for each client. Some therapists preferred working in a more clinical context and this was contrasted with the atmosphere of working in a school (educational context). Therapists might have to modify their approaches to fit in with the ethos of the location.

Other topics arose from the open-ended questions in the interviews concerning practical implementation of the therapeutic intervention itself. These included discussions concerning whether the client preferred working in a 1:1 situation or a group; the actual location of the sessions; the length of the therapeutic intervention and possible number of sessions; waiting

times, methods of closure of sessions and sources of funding. As these topics were not strictly part of the original research question, but are considered by the researcher to be very relevant to the success of the therapy, paragraphs outlining these discussions have been included as recommendations in the appendix.¹⁰⁵

The Therapies

Which modality was most successful overall?

The quantitative results (Q4) indicate that dance movement is considered by managers / teachers and therapists to have the best results, with drama and music close; according to clients, drama is best. All participants in the study considered art to be the least successful, although this might have indicated that the personality of the therapist was more influential than the actual modality used.

One therapist said that she thought that all therapists should be able to judge, during the assessment, that if her own therapy did not seem totally appropriate for the client – or the client seemed to be more drawn to another modality – then her training should allow her to be able to deduce this from the client’s actions and recommend a switch to another therapy. Of course, if she is the only therapist available in the location in which she is working, then she will have to adapt her own modality to become as suitable for the client as is possible, rather than the client actually changing modality.

Which modality should be advised on initial referral?

From the previous discussions, it appears that the majority of opinion is in favour of clients being allowed to start their therapeutic journey within the modality in which they feel most comfortable. The therapist facilitating the sessions may then have a greater chance of ‘meeting the client in their comfort zone’ – as one therapist put it. However, after an initial

¹⁰⁵ See Appendix 13 p. xli

rapport has been established and confidence in the modality gained, it might then be good to challenge the client – even within this ‘safe’ modality – so that they might extend themselves and experience new ideas, thus progressing into new and previously unknown territory, in furtherance of achieving their aims. In addition, the question of whether or not a client feels more at ease with a therapist who is similar in personality to himself has already been discussed, as has the premise that perhaps in some cases it is better to have a more challenging relationship within the therapy sessions, rather than to feel in total accord with the therapist throughout.

Multi-modality therapy

Answering the second of the stated aims of the research, namely whether it would be advantageous for a client to be able to experience all four modalities in sequence – and if so, should this be in any particular order of intervention – it was suggested that if funding and time were not limited, every client should have the opportunity to receive an assessment in all four modalities of the arts therapies. Some respondents thought that this should be in accordance with the possible foetal developmental order – dance movement, music, drama, art – while others felt that it did not matter in which order therapies were experienced. Methods of assessment which take into account varying types of client personality are available, but there is not yet one standard assessment tool used across all the arts therapies.

Validity of the Research

It has been frequently stated throughout the evaluation of quantitative data that to obtain reliable and valid results which would verify the effects of the different modalities, larger numbers of clients would be necessary and more stringent procedures would need to be put in place, including the use of randomised controlled groups. However, this does not negate the overall results of the study, especially those concerned with its qualitative approach.

Managers / teachers and some therapists questioned whether results obtained could be attributed to the therapy programme only. Again, a number of comments made during the

evaluation process dwelt on the fact that it was not possible to deduce that results observed emanated solely as a result of the therapy programme, with no contribution from other sources. As observed by Feder and Feder (1998, p.78): 'All procedures involve a complex interaction between the client and the observer. Whatever behaviour the observer notes, even in a 'naturalistic' setting, is only a sample of the total behaviour of the client, and it is influenced by factors that may never again co-exist in precisely the same way'. Thus any observed behavioural changes are only valid for that moment of time in which they occur, which may be dependent on many other factors than the effects of the therapy sessions themselves. Moreover, results and future recommendations should be trustworthy, that is, they must truthfully mirror the experiences of all research participants (Lincoln and Guba, 1985). What can be hoped for, however, is that if the therapy sessions have been successful in assisting the client to achieve his aims, then he will be more open to other supportive interventions and influences available to him, so that jointly, these may assist him to lead as whole a life as possible.

Implications for future practice

Aigen (1995) suggested that one of the reasons why many clinician-researchers pursue qualitative research is that these researchers reverse the traditional hierarchy of allowing method to dictate content and instead work towards developing and adapting methods appropriate to the questions they would like to explore. These researchers understand that each branch of science generates procedures and standards appropriate to its particular domain, and that good research results from developing thorough and in-depth methods of inquiry appropriate to answering interesting questions. Consequently, it is hoped that the unique approach of this research may provide both a basis for further study and provision of guidelines for changes to referral processes currently in practice.¹⁰⁶

¹⁰⁶ *For discussion of the differentiation between Arts Therapies and Arts in Health, see Appendix 13.1 p. xli*

Training of arts therapists

One therapist observed that perhaps all therapists should be trained to observe, during the assessment phase of therapy, in which areas of their own modality the client experiences the greatest freedom and enjoyment. If, while creating an object or playing a musical instrument, the client is very mobile, using much uninhibited movement, then perhaps the therapist should be given training which would enable him to recommend that, for example, dance movement therapy would be a more appropriate modality for that client. This is not suggesting that every therapist should be trained in each of the modalities, but that they should be trained to observe whether clients' responses appear to fall into categories associated with the dominant characteristics of a particular modality.¹⁰⁷ Training courses might consider in greater depth the differences and commonalities between the four modalities and provide a basis for future practitioners to be able to recommend an appropriate modality, based on this knowledge.

Priorities

A question about which the researcher is much concerned is the complex discussion concerning priorities in therapy and selection of clients. This was reflected in answers to questions related to the continuation of therapy after the research programme was ended. Most managers / teachers would have chosen to continue, with as many clients participating as possible, if funding had been available. Especially at the present time, when financial restraints are very severe, the question of which clients should receive priority for arts therapies sessions, is a very difficult one. Should it be the clients who are younger and have their whole lives in front of them, or should it be those who may have completed the larger part of their lives, having served the community all their working lives, but are now in a state of dementia or physical weakness? In current circumstances, this seems to be an ethical question without a solution, despite the attitude of the present commissioning teams, who seem to put 'getting back into a job' and provision of facilities for younger clients, as their prime target. Teachers / managers were divided in their responses to the question of priority, especially when they considered – in a home or a school – whether one client should receive

¹⁰⁷ For discussion of commonalities and differences between modalities, see Appendix 13.2 p. xliii

an expensive, long-term intervention, as opposed to a greater number of clients receiving shorter, possibly less effective, interventions. The question of ‘cost effectiveness’ was considered (of necessity) in some cases to be more important than the well-being of every client.

General availability of arts therapies services

Work such as this study and all the excellent work carried out and described in the many books and articles produced by arts therapies colleagues world-wide leads to the consideration of whether access to such interventions should be available as a matter of course for every person, whether ‘dis-ease’ has manifest itself in symptoms or not. This raises the question of who would be responsible for funding such interventions and establishing further arts therapists posts – especially in the current financial climate. It is hoped that this study may make a contribution to the growing knowledge base concerning the arts therapies, by providing a presentation of facts to general practitioners and local commissioning bodies of the efficacy of arts therapies in addressing specific personality disorders and special needs. As such, these facts could be made available to the NHS and to all who request arts therapies or arts in health programmes, via the Centre’s web-site and availability of summaries of the study.

Such initiatives as the original New Savoy Partnership (2007)¹⁰⁸ and its successor (Burstow, 2010/2011), which promised new funding resources to improve the research base into the effectiveness of different psychological therapies, amongst which arts therapies are included, do not yet appear to have shown practical results from a financial point of view. More recently, the Arts, Health and Wellbeing All Party Parliamentary Group (2014) has been considering how the arts can contribute to humanising health care,¹⁰⁹ but this researcher fears that arts therapies are now becoming subsumed under the umbrella of arts in health generally, rather than being recognised as the originating professional service in this field and consulted accordingly on future developments in the field. In a document published in 2014 by the

¹⁰⁸ See discussion on Funding in Appendix 13.7 p. lvi

¹⁰⁹ See Appendix 13.1 p. xli

Royal Society for Public Health and the Philipp Family Foundation entitled ‘Arts, Health and Wellbeing: Beyond the Millennium: How far have we come and where do we want to go?’, there is only one brief mention to the practice of arts therapies specifically¹¹⁰, in which the discipline is stated as being: ‘... part of clinical treatment given by professionally trained therapists to help people find alternative means of expressing thoughts and feelings’ (RSPH 2014, p.3.2). The remainder of the document is devoted to discussion concerning the use of arts in health practices, rather than to arts therapies.

The development of professional arts therapies associations and of legislation covering the practice of arts therapies *per se* over the last 30 years, has led to increased official recognition of the use of the arts in healing. This continually-developing legislation assisted in the concept of the present study being accepted by managers / teachers as being an acknowledged form of intervention in the programmes offered to those with special needs. Although all participants in the study were not initially familiar with the concept of arts therapies, officially recognised status added weight to the validity of the present research. However, it is at yet unclear as to who should provide these services which the clients and their managers / teachers are requesting, if results of present legislation appear to be failing in this respect and the researcher understands from enquiries made to the Centre, that despite all official initiatives, professionally qualified arts therapists are still finding it generally difficult to obtain employment. It is of extreme relevance to the present research question that the NHS is increasingly seeking to commission services from voluntary organisations and non-governmental organisations (NGO’s) such as the Centre, in order to try to address the question of increasingly limited financial resources.

Development of current study

On the basis of the findings of this current study, the researcher would recommend that the Centre’s therapists and possibly other centres offering comparative programmes – even if in a limited number of modalities – should consider evaluating their own future practices in a similar manner to those adopted here, using the findings of this research to inform their work

¹¹⁰ See Appendix 13.1 p. xli

and extend the range of clients observed in varying contexts. Moreover, as in more recent years, increasing importance is being given generally to service user involvement in planning and setting up of programmes, it is recommended that this should be reflected in any such future studies.

Results of this study will be offered to students in any of the Centre's training courses or future degree programmes; they should be used to inform publicity about the work of the Centre and formalised in publications for schools, homes and other centres, in order to provide a 'base-line' for future programmes and they should form the basis of the Centre's Service Level Agreements. It might even be – as stated in the previous chapter – that codes of practice within a referring location itself become modified as a result of the present therapy intervention. This has already been suggested by some managers / teachers and members of staff who have been able to see their clients in a new light, after witnessing a 'different side' to them, as a result of the therapy intervention.

Regular systematic responses from managers / teachers, therapists and clients to therapy interventions should also be requested as a regular part of the Centre's service procedure, to be used as indicators of good practice or otherwise, leading to outcome measurement, evidence based practice and practical implementation for future services. If possible, this would in itself form an 'informal' additional continuation of the present programme. It is already planned that any specific projects for which the Centre receives funding will be conducted and evaluated under similar methodology to the present programme.¹¹¹ Future research programmes will also be considered – in fact if future work within the Centre is based on the results of the current work, continuation of the current research might already be considered to be taking place.

¹¹¹ *New projects to work with clients from ethnic minorities and children/young people who are in care, have recently been commissioned within the Centre. This work will be implemented following the guidelines issuing from this research.*

Closing Personal Reflection

In all this research, there is one aspect which has not been included, but which is crucial to the whole process of healing, namely the 'spiritual' belief held by both the therapist and the client that healing will take place. If there is no commitment and confidence in the process, then it is unlikely that any intervention will prove effective. This belief may be based on a religious conviction, or other personal belief systems, which underpin credibility that one can progress from one state of mind, body and health to another. The researcher personally believes that any ability she may have to empathise with, and to relate to, a client through music, is a God-given gift which cannot but be used to further the end for which it was given. Not all therapists will have the same belief, but without personal conviction on the part of the therapist or healer that the therapy will work, it appears very unlikely that change will occur. The therapist must have confidence that the process will work; this should prove to be self-fulfilling, but is dependent on the personality and convictions of all involved.

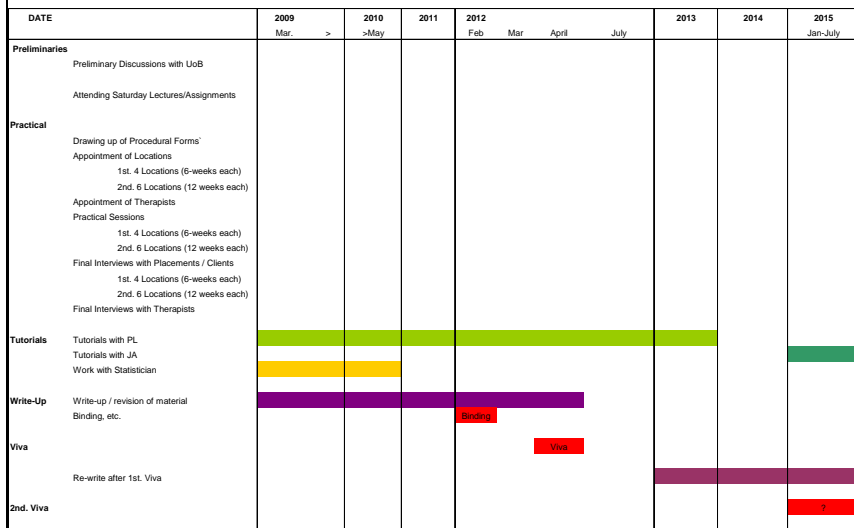
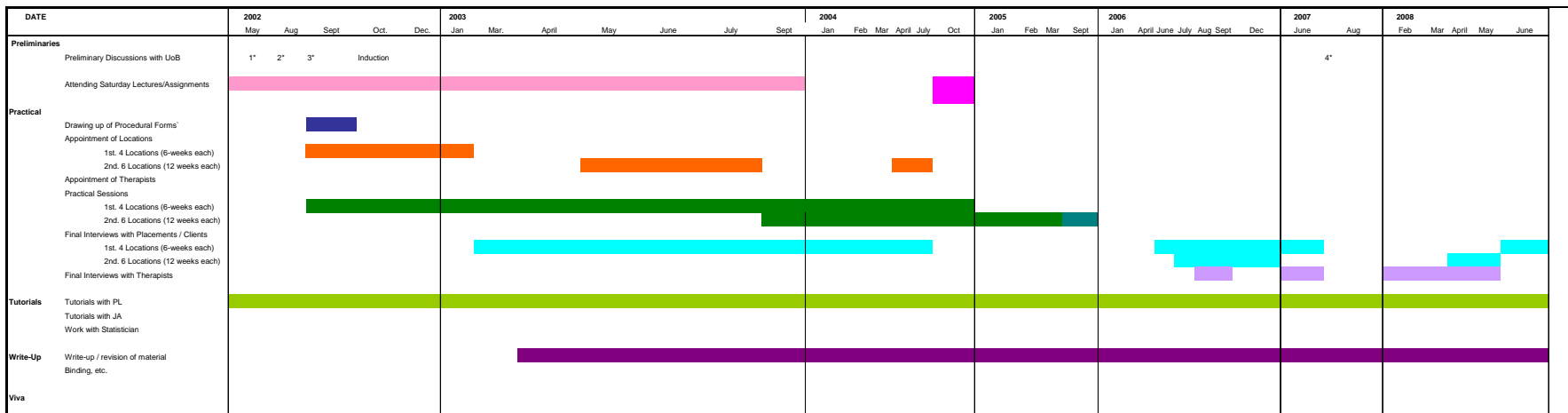
The researcher's vision for the Centre and for the practice in general is that a service which provides a continuous process from therapy, through arts in health, to performance and exhibition – represented by an overlapping and intertwining series of lines and circles – will one day become possible, but this can only be based on a thorough grounding and training in the process and belief in the spiritual aspect of therapeutic work. As Wigram is quoted as saying: 'The basis of good research is good clinical work; the basis of being a good music therapist is good musicianship.' (Gold 2011, p.205). This researcher would add that in addition, to be a good therapist and a good musician requires spiritual conviction.

After the period of 13 years since this study was initiated, hindsight has added more critical insights and reflections into the original research and its design. This process in itself has given opportunity for extensive debate between all originally involved and also with others who have been more recently involved in the Centre as a whole, including the very valuable comments made by clients themselves. These discussions and insights have informed and modified the researcher's own professional practice and will provide opportunities for future debate and the continual improvement to the service offered. It may well eventually prove that the present study is only a beginning.

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Appendix 1 – Table 1 Gant Chart for time-scale of research



NOTES
 1* S B invited by P L to be co-tutor
 2* August 2002 - B W-B and T W invited to be a Referees for application to submit PhD
 3* Proposal submitted
 4* Proposal submitted for transfer to PhD from MPhil

*Appendix 2 – HCPC Code of Conduct, Performance and Ethics
(Summary - 2015)*



Your duties as a registrant

The standards of conduct, performance and ethics you must keep to

- 1 You must act in the best interests of service users.
- 2 You must respect the confidentiality of service users.
- 3 You must keep high standards of personal conduct.
- 4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.
- 5 You must keep your professional knowledge and skills up to date.
- 6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.
- 7 You must communicate properly and effectively with service users and other practitioners.
- 8 You must effectively supervise tasks that you have asked other people to carry out.
- 9 You must get informed consent to provide care or services (so far as possible).
- 10 You must keep accurate records.
- 11 You must deal fairly and safely with the risks of infection.
- 12 You must limit your work or stop practising if your performance or judgment is affected by your health.
- 13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.
- 14 You must make sure that any advertising you do is accurate.

This document sets out the standards of conduct, performance and ethics we expect from our registrants. The standards also apply to people who are applying to become registered.

<http://www.hcpc-uk.org/publications/standards/index.asp?id=38>

**Appendix 3 – Code of Conduct, Performance and Ethics
of the Centre – 2015**

Centre
Logo

This Code applies to all who work on behalf of (*the Centre*), whether as employees, volunteers, sessional workers or students on placement.

At all times, (*the Centre*) expects you to conduct yourself as a representative of (*the Centre*) and behave accordingly.

Any person who is found to have bullied or victimised any other worker will be guilty of misconduct and this could lead to disciplinary action being taken and could lead to your dismissal as a (*Centre*) worker.

Failure to carry out your work as and when directed in an efficient and conscientious manner may be considered misconduct and could lead to disciplinary action being taken and possibly dismissal from your work within (*the Centre*).

The following are examples of conduct which (*the Centre*) Trustees regard as misconduct or gross misconduct. It is a rule of your work within (*the Centre*) that you will not commit acts of misconduct or gross misconduct as set out below or of a similar or any other nature.

Misconduct:

- Bad time-keeping
- Unauthorised absence
- Minor damage to (*the Centre*) or (*the Centre*)'s premises
- Minor breach of (*the Centre*) rules
- Failure to observe (*the Centre*)'s procedures
- Rudeness to clients, colleagues and other (*the Centre*) workers
- Abusive behaviour
- Unsatisfactory attendance
- Unsatisfactory sickness record
- Careless loss or damage of (*the Centre*)'s tools or equipment
- Unauthorised use of (*the Centre*)'s telephone
- Unfitting behaviour or failure to carry out lawful instructions
- Unauthorised use of or access to the internet or database

Gross Misconduct:

- Theft or unauthorised possession of any property belonging to (*the Centre*) or any fellow worker or of clients or visitors
- Serious damage to (*the Centre*)'s property
- Falsification of reports, accounts, expense claims or self-certification forms
- Refusal to carry out duties or reasonable instructions
- Illegal drugs in your possession on BCAT premises
- Fighting or other violent, dangerous or intimidatory conduct
- Sexual, racial or other harassment of a fellow worker, client or visitor
- Bullying of a fellow worker
- Gross negligence or incompetence
- Conviction on a criminal charge

- Receiving any sentence of imprisonment
 - Bringing *(the Centre)* into disrepute
 - Sending abusive, scandalous, obscene or defamatory communications of any kind including e-mail within the office or on the internet or any other media.
 - Accessing or downloading any rude or obscene images or other material from the internet or by e-mail or otherwise being in possession of rude or obscene material or publications or images in any media at *(the Centre)* or during working hours.
-
- **In addition, all those working for *(the Centre)* in a professional capacity, e.g. as a therapist, business adviser, financial adviser, solicitor, etc., whether part-time or full-time, will be expected to abide by the HCPC's own professions' Code of Conduct and Code of Ethics.**

Always remember that you represent (the Centre) at all times. Your conduct towards colleagues, clients and members of the public should reflect that.

App.4 – Example of Referral Form

“WHICH CLIENT FOR WHICH THERAPY and WHY”



CLIENTS' PERSONAL RECORD SHEET

Name of Client: A. [unclear] Ref. No¹: H.4
D. of B.: 22/12/88 M/F: F
Address²: T. [unclear] H. [unclear] B. [unclear] S. [unclear]
Tel: 0 [unclear] Teacher / Carer: M. [unclear]

Brief background of Client, with mention of any 'defined' disability / special need :

Myotonic Dystrophy (muscle wasting disease)
Teased a lot about smelling - not being
clean. Low self-esteem
"Person's incoherent experience (mild learning difficulties)" - JB

Medication (if any):

AIMS FOR THERAPY SESSIONS³:

1. Develop self-confidence
2. To enjoy sessions / Personal growth
3. To express feelings through therapy activities
4. Participate in group work

¹ This will assigned by Office
² This will be the School or Residential Home address
³ A person will evaluate client changes 'outside' the actual therapy sessions
⁴ These remain constant throughout all four therapy interventions

App.5 – Example of d Score Form

SCORES FOR THERAPY SESSIONS⁵:

Name of Client: ... *A* *M* Ref: No: ... *E5*

Therapy	Date		Aim No:	Teacher / Carer View ⁶	Therapist View ⁷	Client View ⁸	Total
	Start	Finish					
Type: <i>Art</i> Therapist ⁹ : <i>J.B.</i> No: of Sessions ¹⁰ : <i>14</i>			1	1	6	3	
			2	2	4	3	
			3	6	6	3	
			4	6	4	3	
			Total		20		
Type: <i>Music</i> Therapist ⁹ : <i>V.S.</i> No: of Sessions ¹⁰ : <i>120</i>			1	5	3	5	
			2	3	3	5	
			3	5	5	5	
			4	5	5	5	
			Total				
Type: <i>Drama</i> Therapist ⁹ : <i>MR</i> No: of Sessions ¹⁰ : <i>10</i>			1	5	6	6	
			2	3	6	3	
			3	5	6	5	
			4	4	5	4	
			Total				
Type: <i>Dance</i> Therapist ⁹ : <i>T.B.</i> No: of Sessions ¹⁰ : Total:			1	5	6	5	
			2	4	5	4	
			3	5	6	6	
			4	4	5	5	
			Total				

Scoring:

- | | |
|------------------------|------------------------------|
| 1 = Deteriorated | 4 = Noticeable Improvement |
| 2 = No Improvement | 5 = Considerable Improvement |
| 3 = Slight Improvement | 6 = Achieved Aim |

⁵ These should be entered in chronological order

⁶ Representing View of Progress outside the therapy context

⁷ Representing View of Progress within the therapy context

⁸ This can be entered only if the client is able to impart this information

⁹ Initials only

¹⁰ This should be \emptyset – please state if not so

App. 6 – Examples of Questions for Structured Interviews

RESEARCH PROJECT: “WHICH ARTS THERAPY FOR WHICH CLIENT AND WHY?”

1. A Structured Interview Schedule with Headteacher / Manager of Therapies Placement

Name of Venue:.....
..... Tel:.....
Contact Person:..... Position:.....
Type of Clients:.....
Characteristics of Clients:.....
.....
Length of Placement (6 weeks or 12 weeks):.....

1. In general, do you think that the Arts Therapies have helped your clients?
2. Which therapy do you think was the most effective?
3. Why do you think this was so? Were there any features of the media itself which you felt were more appropriate to your clients?
4. What influence did you feel the personality of the therapist had to the success, or otherwise, of the therapy?
5. Would you wish to continue the sessions? If so, would you choose one particular therapy, or would you like to see all four therapies in sequence again?
6. If all four in sequence, do you think it makes any difference in which order the Art, Drama, Music, Dance Movement occur?
7. Did the parents / staff benefit from the sessions as well?
8. Were the arrangements for the programme satisfactory:
 - a. Initial explanations of content of programme /methods of working
 - b. Arrangements for liaison with staff
 - c. Adequate space for sessions
 - d. Adequate equipment
 - e. Visits from director of programme / collation of results
 - f. Comments on methodology
9. Would you like to see a specific follow-up of the programme for identified clients who have already taken part? If so, which therapy would you prefer?
10. Any further comments

Signed:..... Project Director:.....

Date:.....

RESEARCH PROJECT: “WHICH ARTS THERAPY FOR WHICH CLIENT AND WHY?”

2. A Structured Interview Schedule with Participating Therapists

Name of Therapist:.....

Discipline:

1. In which Placements did you work:

Group 1: 6 – weeks:

A..... Centre B..... Centre
C..... School T..... G.....

Group 2: 12 – weeks

B..... School B..... C..... School
B..... I..... Unit D...E.....Special School
C..... School G..... H.....School

2. In general, do you think that your programmes have helped your clients?

3. Did you feel the switch to a 12-week programme was advantageous?

4. Which client group do you think benefited most?

5. Why do you think this was so? Were there any features of the modality itself which you felt were more appropriate to this particular client group?

6. What influence did you feel your own personality had to the success, or otherwise, of the therapy?

7. Would you wish to continue the sessions? If so, would you choose one particular client group, or would you like to see all clients experience all four therapies in sequence again?

8. If all four in sequence, do you think it makes any difference in which order the Art, Drama, Music, Dance Movement occur?

9. Did the parents / staff benefit from the sessions as well?

10. Were the arrangements for the programme satisfactory:

- a. Initial explanations of content of programme /methods of working
- b. Arrangements for liaison with staff
- c. Adequate space for sessions
- d. Adequate equipment
- e. Visits from director of programme / collation of results
- f. Comments on methodology

11. Any further comments

Signed:..... Project Director:.....

Date:.....

RESEARCH PROJECT: “WHICH ARTS THERAPY FOR WHICH CLIENT AND WHY?”

3. A Structured Interview Schedule with Participating Clients

Name of Venue:.....
..... Tel:.....
Name of Client:..... Ref. No:.....
Type of Client:.....
Characteristics of Client:.....
.....
Length of Placement (6 weeks or 12 weeks):.....

1. In general, do you think that the arts therapies have helped you?
2. Which therapy do you think was the most effective?
3. Why do you think this was so? Were there any features of the media itself which you felt were more appropriate to your needs?
4. What influence did you feel the personality of the therapist had to the success, or otherwise, of the therapy?
5. Would you wish to continue the sessions? If so, would you choose one particular therapy, or would you like to see all four therapies in sequence again?
6. If all four in sequence, do you think it makes any difference in which order the Art, Drama, Music, Dance Movement occur?
7. Do you think your parents / staff benefitted from the sessions as well?
8. Were the arrangements for the programme satisfactory:
 - a. Initial explanations of content of programme /methods of working
 - b. Arrangements for liaison with staff
 - c. Adequate space for sessions
 - d. Adequate equipment
 - e. Visits from director of programme / collation of results
 - f. Comments on methodology
9. Any further comments

Signed:..... Project Director:.....

Date:.....

App. 7 – Details of Clients referred and Locations of sessions

The following descriptions of clients are based on information given by M/T's in their responses to the Questionnaire, being additional to basic responses to the questionnaire.

Each of the following 4 locations had a 6-week intervention in each arts modality.

Location 1

Children in this Exclusion Centre were of primary age, classified as having 'SEBD – Social, Emotional and Behavioural Difficulties'. The children had either been permanently excluded from school, or were on the verge of it, on account of various behavioural difficulties, including confrontational behaviour. Often these children exhibited violent behaviour towards peers and staff and a lacking in self-control. In the words of the head teacher: "These children have an ability to be in the wrong place at the wrong time, resulting in a style of learning where they become disaffected, so they often use tactics to make sure that they don't actually learn and would prefer to be in trouble, because they find that more interesting and more easy to manage than actually being put on the spot and trying to manage their own learning".

The children came from a variety of different backgrounds. The head teacher said that often their parents were very supportive by the time children reached this Centre, because they have "gone through the mill" on account of their children's behavioural difficulties, culminating in exclusion from school. The Centre is often the last opportunity for the children to try and get themselves back into school and education. The Centre's support processes then either put children into the statementing procedures to ensure that they are able to be managed in a mainstream school, or they go on to special education.

Location 2

This location consisted of children of secondary age in an Exclusion Unit, who had been unable to sustain their place within mainstream educational provision (or, it might be argued, the mainstream school had been unable to provide the right environment for the children to succeed) and had therefore been placed in this Exclusion Unit, on either a temporary or permanent basis.

To quote the head teacher: 'The children at this Centre were either permanently excluded from a mainstream school, or they came to us on a shared provision programme, either for three weeks or for six weeks, referred to us by their school. We work with them and teach them anger management skills, social skills, help them to go back to school and to be successful'.

Location 3

This was a Primary School within one of the poorest areas of the country, according to the Poverty Indicator. The vast majority of the children had English as an additional language and needed to be involved in a wide range of approaches. Some children had specific needs that were different to other children, because of their home backgrounds.

According to the head teacher, problematic behaviour was not a "massive issue" as such, but they did have children who had personal difficulties for a variety of reasons. For example, one of the children had lost his father "in suspicious circumstances". Another had got severe problems at home because of parental dysfunction. The breadth of approaches used by the school included "from learning mentors to arts therapies", so that all children could be really helped. The head teacher said that "arts therapies offered us a different way forward".

Location 4

This location was a residential home for older adults, whose main reason for being in the Home was

because of their sensory losses - either visual impairment / blindness or hearing losses, often coupled with dementia. Some residents were quite frail, with additional mobility problems, mental health problems and/or learning disabilities. Some clients were reserved, while others tended to be more ebullient and make their wishes well known to all around. The age range within the home was 30yrs. – 84 yrs. old.

Each of the following 6 locations had a 12-week intervention in each arts modality.

Location 5

This was a primary aged special school for children with moderate learning difficulties. Children at this school were not so much behaviourally difficult, but were said to be “quite confused”. The head teacher said that she did not want to use the word “disturbed”, but they were quite damaged by life events, making them sensitive and vulnerable. In this school, it was not seen to be the role of the teaching staff members to involve a therapy approach – “because we haven’t got the skills and staff members are aware that they do not want to use this approach in a circle time session”.

Location 6

This was an infant mainstream school, which followed the National Curriculum. It was the policy of the school that if any child had a special need – “and most children will have some sort of special needs at some time during their stay” – these needs were said to be met easily through the school’s normal teaching. The school had a Special Educational Needs Co-ordinator (SENCO), who was responsible for working with parents or teachers, and others as necessary, to make sure each child was receiving the right sort of help. Parents were invited to the school to discuss any concerns and to help the staff proceed in the best way for the child.

Location 7

This was a special school for children of secondary age with Autistic Spectrum Disorders. Some children could be quite aggressive, while others were very concerned with obsessive behaviour or had great levels of self-consciousness, which hindered their social interactions. The level of ability and functioning ranged from severe autism to children having Asperger’s Syndrome.

Location 8

This location was a secondary mainstream school with a very high proportion of immigrant children, for whom English was not their first language. According to personal observations made by the researcher when visiting the school, this factor appeared to result in the children becoming either aggressive in order to establish their status in the school, or else becoming shy and withdrawn, both in response to their social status at home and in response to the challenging situation within the school. On asking for a fuller discussion on this ambivalent behaviour however, one therapist was informed that all pupils were regarded as “normal”, without special needs or disabilities. There was a SENCO in the school, who appeared to be very over-worked and was seldom available for consultation, although the head teacher had welcomed the programme, when the researcher visited initially. This difficult environment, especially from the point of view of the practical administration of the programme, meant that the art therapy intervention had to be terminated after two sessions, as the therapist concerned felt that she could not work in such conditions.

Location 9

This location was a secondary mainstream school, which, according to its brochure: “... is a highly successful school founded upon Christian principles. As a Catholic School we are committed to Gospel values and this is reflected in our strong sense of community and out-reach. The dedication of the staff over the last few years has resulted in our school being recognised nationally in academic, as well as sporting, achievement. Students not only achieve fantastic examination results but also have the opportunity to experience life to the full through our highly extensive programme of extra curricular activities and trips around the world”.

However, the children referred for the arts therapies programme had experienced some very distressing personal life events, including one child whose mother had recently committed suicide. Some children had a history of behaviour disorders and had been excluded from primary school for a period of time before coming to this school; another child was diagnosed with Asperger's syndrome and found it very hard to relate to others. In contrast, another child had a statement for speech and language problems, had been bullied, had a high level of anxiety and was confused by special instructions. Children referred from this school were referred, in the main, either for antisocial behaviour, or for unexplained failure to thrive.

Location 10

This location was a rehabilitation unit for adults who had suffered acquired brain damage. Clients in this unit had undergone a variety of events which had resulted in acquired brain injury, rather than having had brain damage since birth. Such events included results of car or other accidents, diabetic comas, drug or alcohol induced brain damage, epilepsy and other traumatic occurrences. Clients were, by the nature of the unit, only expected to remain in this location for 6-12 months, which meant that very few, if any of them, could participate in all four arts therapies modalities. However, as the clients exhibited a number of character traits in common, such as poor concentration span and memory, volatility and some speech and understanding difficulties, it was agreed that the unit would be included.

App. 8 – The Centre / HCPC Codes of Confidentiality

As the Centre works with a wide range of clients, issues of confidentiality and access to records held by others becomes complicated. There are two issues to consider:

1. The Code of Practice for Therapists with regard to their own issues of confidentiality in relation to clients

The following pages represent the “**Confidentiality – Guide for Registrants**” document as laid down by the Health Care Professions Council (HCPC) at:

<http://www.hpc-uk.org/assets/documents/1000237FConfidentialityGuidanceFinalVersion.pdf>

2. Access to records kept by others

As members of the team surrounding any client, the Centre’s therapists would expect to be allowed access to records concerning the client held by individual placements, such as NHS contexts, schools and other educational establishments, Social Health & Care establishments such as elderly people’s homes, and private establishments, as would be relevant to the therapists’ needs.

Such access would be at the discretion of, and with the consent of, the manager or head teacher of the placement concerned, but would be based on guidance laid down within:

- Health Records Act
- Education Records
- Social Health & Care

These are listed in the Centre’s “Policies and Procedures”, sections: 2.5.1; 2.5.2; 2.5.3

App.9 – Example of qualitative analysis by colour coding

6.1. QO1. In general, do you think that your programmes helped your clients?

Managers/Head teachers:

Placement 1: CP: Yes, definitely. A view that..., there were some **management issues** that we needed to look at, but for the individual children, they certainly **benefitted** from the use of the four **different** modalities that we used, and they in fact **enjoyed** it. So not only did they find it **useful**, **enjoyment** means that they want to come back again and try something else, and that is always going to be a good sign and so on the overall, there were **practical difficulties**, but we'll come to those later.

Placement 2: JF: Yes, I do..., Some of the clients..., some of the pupils we saw, we saw an **improvement** in their attitude. They **enjoyed** some of the work that they did in art, in drama, and in the dance movement... yes, and they thoroughly **enjoyed** the dance, and **they took** part in it, and the drama, some of the pupils were very **inhibited**, and **didn't want to show themselves up**, so it didn't work that well, but they left before they completed some of the sessions, and whether the arts therapists would have managed to draw them out of themselves, I wouldn't know about that.

So I was only the art that you weren't actually there for?... Yeah.

Placement 3: PC: I think that it's given us a completely **different** approach, and **different** children react in different ways to **different** circumstances, and this approach was certainly eye-opening to staff, and gave the children something different to what they previously had and we felt it made a difference, **not maybe in every case, but certainly in some cases**. The children gained a tremendous amount out of it, in terms of **confidence**, **relationships** with others and **belief in themselves**.

Placement 4: SK: Yes, I do, especially with the more **reserved** residents. The one lady in particular with the drama session, really, she was more vocal, and **liaised more** so with the tutors, and that was **beneficial**. It was hard because of them being six week sessions, to get a full idea, and not being with them during the sessions, but they **enjoyed** them as they were happening, because **they were telling me about them afterwards**.

Placement 5: CE: Yes, I think that they have been..., for some of the students, they have been extremely **beneficial**, and for some of them, we got some quite **unexpected** results, in sort of the behaviour, and in the way that they **interacted**, which maybe they have difficulties with, within the school setting, and maybe the classrooms.

Placement 6: ST: Well, obviously it's difficult to say, because most of the children are no longer with us, there's only one little girl who is still with us, and she has made superb **progress** since then but **whether that is a result of the arts therapy, no-one is going to know the answer to that, are they?** But she certainly is much more..., she is much **calmer in class**, she is much more **able to express her feelings** when she gets frustrated, and so we **don't have the temper tantrums that we had prior to the arts therapy**.

Placement 7: RA: so I think in general, that you could say that there was evidence that it's **helped** individual youngsters. For example, one young man in particular took to the dance.

Now **the difficulty I have is actually assessing the degree of help and the sustainability of it**. Because it was a project, and it was for a fixed term, and the youngsters are autistic, I did think any **answers, to some extent, have got to remain speculative**. Bit I have,, I did notice.. we did note that **there were a number of youngsters that were quite specific**. There was J..., who responded very well to the art therapy, there was L... that responded very well to the dance therapy, as an example. Yes, I think

that's the best examples that we could give.

Placement 8. VY: *(VR did not want to have her answers taped, so this is from the researcher's notes of the interview)*: I don't really think I can answer these questions as I was not the main teacher involved – she has left the school now – also I did not know the girls involved in the programme. I think that some of them have improved, but I cannot say whether it is the therapy that has made the difference. One girl – N – said that she thought it had helped her (they are in work experience now, so it is not possible for you to interview them individually). The others did not know. Probably they would have developed anyway.. we also have a learning support centre, which helps them to improve.

Placement 9. MW: I think so, but it's got to be part of the big programme, it's not just doing __ stuff here, it's not a quick fix solution. So I think that, yes, it's got to be that whole ethos that runs through it, and the children have got to be getting that support from the school.

Researcher: Yes, yes, so if the ethos is in the school, and they know what the therapist is about, they are more prepared to go along with it, and it becomes part of their curriculum.

Placement 10. JW: I, well, our unit specialises in people with behavioural difficulties, and I think that.. perhaps it hasn't helped the improvement of their behaviour outside of the session, but what I think that it did, was to provide a source of social activity that they found very enjoyable, but for the most part, whilst they were engaged within that activity, their behaviour was appropriate, and for a lot of our clients, to have them concentrate over a 30 to 45 minute period, doing something that was unfamiliar to the, and still to maintain an appropriate behaviour, is really useful. So I think that in that way, yes, it did help, and it helped in all the social skills that we work on all the time listening, turn taking, being polite, those kind of skills that can often affect people with brain injury. So those were all reinforced during the course of doing whatever therapy it was, so I think that from that point of view it was very useful.

App. 10 - Therapists' verbal responses to QQ1b (See also Table 43)

QQ1b – Did you feel the switch to a 12-week programme was advantageous?

This Question was only asked within those questions put to Therapists, as M/T and C were not offered the choice of a 6-week or 12-week intervention. Not all Therapists had participated in both 6-week and 12-week programmes, therefore not all could answer this question from experience within the research programme, but could offer opinions based on general professional experience.

Th.1: Yes, I think that I benefitted mainly because that was one of the things mainly that I particularly wanted to happen, because I felt that the 6-week programme didn't really offer any support, you know, people would enter into the process, and they would only just be immersed in the process and then it would be time to stop and then go on to someone else and make another attachment and another separation, so I felt that twelve weeks was absolutely critical. It did have benefits in the sense that people were able to be immersed in it for four or five weeks, in the middle process of the art therapy.

Th.2: Yes, particularly, I would think that with the young adults, for example, G... H... School and C... School. I remember that those two schools was where they wanted additional..., from the ten weeks to the twelve weeks, because they wanted to explore a bit more, because some of the students, they were enjoying the programme, but yet we had some who had joined late, yes, but there was those who were there from the beginning, who were enjoying the programme so much, that they wanted some extra hours put in, and the school decided that "Well look, even though you are in the, you are supposed to have a ten week period, the twelve week programme would be that much more of an opportunity to engage. So I think that the twelve week programme is much more advantageous than the ten week one, the one from six weeks, yeah. Sorry, sorry I'm missing on the....

(Researcher): We started on the six week programme, and then it was felt that it was better to switch to the twelve week programme.

Th.2: Oh right, right, I am mistakenly thinking that the general ten week one..., oh, alright. But, the answer is still the same, in the context of extending it. For example, right now I am doing some work at Woodside, and it has been said that if they enjoy it, they would like to extend it, so I was thinking in that context, so you will just have to address that to suit, yeah.

Th.3: (Researcher): Now the second question. In a way, isn't relevant to you, in that you didn't take part after it had switched to a twelve week programme, so could I slightly alter the question? And say that do you feel that six weeks was enough for what you would like to do?

Th.3: (Only took part in 6-week programmes) I don't think that six weeks was enough at all, and I think that it definitely needed to be longer.

Th.4: I certainly felt that moving from the 6-week programme to the 12-week programme made a lot of sense. I found that working for just 6 weeks with a particular group – it was quite difficult to get to know them well enough and one was just starting to get somewhere with them and then one had to stop and move on to somebody else, so the change to 12 weeks seemed an obvious gain and advantage and made the project a lot more meaningful both for myself and also for the various groups that participated.

Th.5: Yeah, definitely, I think that the six weeks was just basically not enough.

(Researcher): OK, because?..

Th.5: Because it takes time to build a relationship, on both sides, and before you begin with anything, it was ending again. But I think that twelve weeks was a minimum really.

Th.6: I think that twelve weeks showed a good sense of what we could achieve, but again, I feel that it was quite a short time for a group of children, especially who probably weren't in the same class, to work together in that kind of time.

Th.7: *(Not yet available)*

Th.8: (Researcher:) ... I mean, in general, would you think a 6-week programme might be helpful or not, with this type of client (Brain injury clients)?

Th.8: Uhhm.. for some of the clients, yes, some of the more able clients. For some of the clients, I think that six weeks is a little bit limiting, because you are still making assessments at that stage, and just getting to know what the difficulties are. So I would feel that the twelve week programme is better than the six.

Th.9. I think that probably, my initial reaction to that would be..., well I don't think that six weeks is a very long time to get something established, you know, because it can take so many weeks to actually **gain the trust of your clients**, and then of course you have got the actual work, and then you need a certain **period of closure**, you know, when you're winding down. But I have to say, that with the younger people that I worked with, I could imagine that six weeks, you could have probably managed, because I think, for one I think they probably teamed to **trust quite a bit easier**, because they **are not perhaps quite as cynical** as some of the other client groups that we worked with. So I think that you can kind of get in there sooner, a bit quicker, although I do think that given the choice, **I would go for the twelve weeks for all the client groups really.**

App. 11 - M/T's Detailed Responses to QQ5/6
(Numbers in brackets refer to location references)

Comments – Would you wish to continue?

1. (3) We would definitely want to continue the sessions.
2. (1) Group work is not as effective as individual work, especially if the therapist cannot manage the children.
3. (2) We have pupils who are here on a six-week placement. I wouldn't offer it to them unless the therapy was starting at the beginning of their stay for the six weeks and that it was on a regular basis, until the end of their six weeks.
4. (4) Yes, but cost is a major thing.
5. (4) I don't think I would have all 4 again – it would depend on who the clients were.
6. (5) Yes.
7. (6) I, personally, would like to see the sessions again, providing you could give me ear phones!
8. (7) In an ideal world, yes, I would like to carry on.
9. (8) I would be willing to carry on if I could be the coordinator (*the previous coordinator had retired owing to ill health*). However, I would not choose the same children – I don't think they were the right ones to choose.
10. (9) Yes, but my problem is obviously with funding.
11. (10) Yes, we do want to carry on, really, with the link with your organisation, because I think that's invaluable, and as I say, we are very grateful that we had the opportunity to work with you.

Any one particular therapy or all four?

12. (1) All four would have a place with our children: I think that it's very important that we should test all of the scenarios of which ones are the most effective.
13. (1) Children are not always consistent. They may choose one thing one day and another the next
14. (2) Maybe all four had their benefits and their value.
15. (3) I think that rather than go for a round-bat of activities, which is what we sort of went for originally, so I think that it would perhaps do better to be focusing on one of them, and it could be any one of the 4.
16. (3) Which would be the best? I think that would depend on the group of children, because I can think of a group of children that would certainly respond much better to music, and then another group who would respond better to the art.
17. (4) As a weekly group thing, something like the art and dance would be good, whereas the drama, I can see it being beneficial to two, but not the rest of the group, because they found it hard to concentrate and think about themselves, the parts and everything, but you know the other two, the quieter ones, did benefit from the drama.
18. (5) It would be the music therapy, because I think that for our pupils, music is... a lot of them get so much from the medium of music, and even students whose cognitive levels are quite limited, they seemed to be able to use music as a way of expression far more than maybe drama or dance.
19. (5) I wouldn't go for all 4. I think that music is perhaps one that we could probably accommodate far easier than maybe drama and also art. Because I think that if you can't manage that appropriately, then I don't think that the therapy is as affective as it could be.
20. (6) I would like the music and the art one, because I think that the children enjoyed that as well and the one young boy A., we discovered a lot about A. through that one, you know, he became lost in his own world, and some of the things that he produced, he was just living in a fantasy world really... another little one, N., we found out... not so much from what she did, but from the way that she talked whilst she was doing it, we found out about what was going on at home through the sessions.
21. (6) On the other hand I think that the music one, for those very withdrawn children was a good

one in drawing those children out. Because they could make a lot of noise, without it actually being them making the noise, and they didn't have to communicate, but they could express their feelings. ... So it's a hard one to say really.

22. (7) My constraints are financial priorities, if there were no financial constraints, in an ideal world, not only would I like to continue all of them, but I would actually like to make sure that there was the right sort of facilities as well, because I think that the environment makes a big, big difference. For example, the dance was done in the PE..., in the gym, the gym is tall, it is echo-y, and that in itself, wasn't ideal for youngsters, just as the music therapy was having to be done in the hall.
23. (8) Perhaps I would be willing to try the dance movement again. The present coordinator in the primary school could "choose children in advance".
24. (9) I would like to see all four to be honest. I think that the drama therapy was brilliant - the kids really enjoyed that. The dance therapy was just phenomenal, the therapist was fantastic, and inspired the kids into doing things that they would never have done, which I think is brilliant for their confidence. And the music therapy, I would like that too... but you know my budgets, they are just shrinking.
25. (10) We do want to continue the drama. I do think that the music was beneficial as well, but that's just more tricky because of logistics of storing the instruments.

If all four – in any particular order?

26. (1) I don't know enough to say in which order. It is completely down to the individual nature of the children that you are then working with.
27. (1) It was good that T. made the first connections with the children, and that started everything off in a sound way. I think that if the first one, they didn't enjoy, then you might get a resistance to the others.
28. (1) Movement - it's a straightforward way to start with. All our children are physically able. The purpose is not about their skill level anyway, but it's their motivation, through the fact that they believe they can do it. If you say "We can all dance", that is a great starting point.
29. (2) I would choose the music first, if it was (*named therapist*). That would get them an idea of the therapy and then probably the dance and then the art.
30. (3) I think that the drama sessions had difficulties following soon after the movement, because they expected it to carry on in a similar way and the space was different (smaller), in a classroom where there were desks. It wasn't the same venue.
31. (3) I think that I would perhaps go for the art or the drama to start with. Art doesn't require quite the same loudness of voice or movement, neither does drama, as much as the other two. I'd certainly put music last, because that was the biggest shock to them, and it was even more different to anything else that they had ever done.
32. (3) With regard to developmental abilities for each of the arts, they have all reached a certain standard, with regards to movement, with regards to artistic skills or with regards to drama, and you're taking skills which they have got and allowing them to express themselves in a slightly different way. They've already got a foundation on which you can build in a variety of different ways.
33. (4) No, because I think it's the appeal factor to the different..., the needs as well, you know, to different ones. It depends on who the clients are.
34. (6) The art one..., certainly for our children, having the art one first, because we would have found out a lot about A., we did find out a lot about A.
35. (7) I think that it depends upon the age of the child. I think in an ideal world (and again, this is intuitive, observing the youngsters, I am not sure, you would need more research I think, to support it), but I think that music and dance movement is more fundamental to the early years way of operating. Drama and art, I would bring in at a slightly older age, probably art first and then drama, but I am not sure about that, I wouldn't be hard and fast about that, but I think that

that they may well be the order that we would try next time. I would like more research to find out.

36. (7) ..If you look at the early developmental stages of a youngster, it's the movement, the vision comes in a little bit later doesn't it? So, it's the movement, it's the smell, it's those sort of very, very earthy fundamental experiences that actually are significant to the youngster. Because autism is a developmental delay, or a developmental difficulty, one could think that if you took youngsters through that sequence, (*music and dance, then drama and art*) that might be a way forward for them. If only they could actually understand what you are trying to do, and engage in that. That is really up to the skill of the therapist isn't it?
37. (9) I think that the dance needs to go last, because they need to have confidence, in themselves and in the group, because that is the most challenging one for them. That was the one that they were at first uncomfortable with, and it did take a while. And not all of them got that much out of the dance as they did some of the other therapies, but I still think that is good, because it challenges them, so I think that should probably go last, or towards the end, because of the confidence issue. Music then, is probably the one where some of them had not as much confidence in, and so possibly the drama and art first really. So the drama, music and art, then the dance, or something like that, and kind of break it up a little bit, and it's probably best to get them on site quickly with something that they are going to respond to.
38. (9) They should do something they find easy first, something like the drama or the art, possibly those, to get them to be more confident, rather than approaching them with something that they might find the hardest.
39. (10) I think that because a lot of our clients have memory problems, it's irrelevant to them, it doesn't matter.

Appendix 12 – Tables not included in main text of thesis

App. 12:1 – Table 6a: Location 4 – Elderly People’s Residential Home

Aims for Arts Therapies (Original Referencing)

Client No:	AIM							
	1	Aim Cat.	2	Aim Cat.	3	Aim Cat.	4	Aim Cat.
T1	Enjoyment of sessions, Judged by facial expressions, movement, etc.	D	Increased participation in activities	C	Evidence of listening / concentration	E	Increase in communication through chosen medium	B
T2	Enjoyment of sessions	D	Increased participation in activities	C	Increase in communication through chosen medium	B	Positive interaction with other members of the group	C
T3	To communicate / interact with the group	C	Self awareness	E	Increased motivation	H	Self-expression as a release from emotions	B
T4	Through movement to help him to become more supple	F	Develop communication with group	C	Motivation	H	Expression of emotions	B
T5	Develop communications skills in group activities	C	Aid in assertiveness - making choices	E	Develop motivation skills	H	Inter-reaction with others	C
T6	To create more awareness of surroundings and people in the group	C	To motivate and stimulate his mind	H	Aid with tension relief	G	Develop communication skills	B
T7	To develop awareness of others' needs in the group	C	Appropriate awareness of communication - not interrupting others	C	To motivate and stimulate	H	Aid in relief of stress "	G
T8	Enjoy taking part	D	Increase self expression	B	Be able to relate to others in the group	C	Develop self-awareness	B

*App. 12:1 – Table 6b: Location 4 – Elderly People’s Residential Home
Summary of Aims for Arts Therapies (Original Referencing)*

Category	No. of Aims in this Category
A	-
B	7
C	11
D	3
E	3
F	1
G	2
H	5

App. 12:2 – Table 12

List of aims and allocation to categories

Category	AIM
1	<u>To enhance self-esteem</u> ...through feelings being valued / special; to be seen and heard
2	<u>To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions</u> Allow/offer an alternative form / freedom of self-expression; expression of emotions; To provide a means for emotional expression; To express positive thoughts; To increase non-verbal communication; To be more honest about his feelings; To express both positive and negative thoughts; Self-expression as a relief from emotions; recognition of individuality; increase self-awareness; improve focus and attention into something meaningful
3	<u>To be able to participate as a member of a group in an appropriate way and to benefit from so doing</u> To be able participate as a member of a group; To stimulate (positive) interaction; To stimulate an equal relationship with other group members; To share with others and be involved with them; To become more socially interactive; To increase social inter-action; To interact more with peers; To take account of other peoples' feelings I show respect for others; To be more friendly towards his peers; To communicate with others in a positive way at home and at school; To wait for his turn to speak or act; To help her respond in a positive way to others; To learn to talk at the right time; To develop awareness of surroundings and of people in the group; To learn respect for others and others' property; To empower group members to develop a sense of control through providing choice; Turn- taking and respect for others; to respect and empathise with others; Ability to work alongside one another as a team; to develop positive personal relationships
4	<u>Enjoyment / Freedom</u> To have fun / enjoy sessions; Opportunity to work in a less formal setting;
5	<u>To respond individually in an appropriate manner</u> To aid in assertiveness and making of choices; To increase his auditory response with particular attention to his name ; Responding appropriately to instruction; To develop listening skills and concentration; To follow instructions; To decrease derogatory comments; To stop swearing (.which leads to fighting); To help him avoid getting drawn into situations which don't concern him; To work in a controlled environment; Not to be influenced by others; To help him cope with conflict; To develop self-awareness; To express thoughts in a more socially acceptable way; To express negative feelings in a more acceptable, less aggressive manner; anger management; to control behaviour and aggression, and need for revenge; To help him control his behaviour and aggression towards others; to encourage an acceptance of change of environment; To stimulate self-confidence; To increase self-confidence
6	<u>To benefit physically</u> To improve co-ordination; To become more physically supple through movement
7	<u>For relaxation and reduction of stress</u> For relaxation / reduce stress; To learn to relax; relief of stress; To reduce anxiety; To aid with tension relief
8	<u>Motivation and mental stimulation</u> To increase motivation /mental stimulation

App.12.3 – Table 13a

Aims for arts therapies – Complete analysis

No.	Aim	Types of Client	Age (Yrs.)	No. of times this Aim was Chosen	Location Ref:
1	<u>To enhance self-esteem</u> ...through feelings being valued / special; to be seen and heard	Excluded Primary	9 - 11yrs.	13	1
		Excluded Secondary	12 - 15 yrs	12	2
		Mainstream Infant	5 -7 yrs.	11	6
		Secondary Autistic Special	11 -15 yrs	11	7
		Primary MLD Special	7yrs.	6	5
		Mainstream Secondary (High % Ethnic Minority)	12 yrs.	6	8
		Brain Injured Adults	25 -60 yrs	6	10
		Mainstream Primary	8 - 11 yrs.	3	3
				Total: 68	
2	<u>To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions</u> Allow/offer an alternative form / freedom of self-expression; expression of emotions To provide a means for emotional expression; To express positive thoughts; To increase non-verbal communication; To be more honest about his feelings; To express both positive and negative thoughts; Self-expression as a relief from emotions; recognition of individuality; increase self-awareness; improve focus and attention into something meaningful	Brain Injured Adults	25- 60 yrs	19	10
		Primary MLD Special	7yrs.	12	5
		Mainstream Infant	5 -7 yrs.	11	6
		Secondary Autistic Special	11 -15 yrs	11	7
		Mainstream Secondary	12 yrs.	9	9
		Mainstream Primary	8 -11 yrs.	7	3
		Elderly Visually Impaired	29 - 61 yrs	7	4
		Mainstream Secondary (High % Ethnic Minority)	12 yrs.	6	8
		Excluded Secondary	9 - 11 yrs.	1	2
				Total: 83	
3	<u>To be able to participate as a member of a group in an appropriate way and to benefit from so doing</u> To be able participate as a member of a group; To stimulate (positive) interaction ; stimulate an equal relationship with other group members; To share with others and be involved with them; To become more socially interactive; To increase social action; To interact more with peers; To take account of other peoples' feelings / respect for others; To be more friendly towards his peers; To communicate with others in a positive way at home and at school; To wait for his turn to speak or act; To help her respond in a positive way to others; To learn to talk at the right time; develop awareness of surroundings and of people in the group; To learn respect for	Excluded Primary	9 - 11yrs.	26	1
		Mainstream Primary	8 -11 yrs.	26	3
		Brain Injured Adults	25- 60 yrs	16	10
		Excluded Secondary	12 -15 yrs	12	2
		Elderly Visually Impaired	29 -61 yrs	11	4
		Primary MLD Special	7yrs.	11	5
		Mainstream Infant	5 -7 yrs.	11	6
		Secondary Autistic Special	11 -15 yrs	11	7
		Mainstream Secondary	12 yrs.	10	9

	others and others' property; To empower group members to develop a sense of control through providing choice; Turn-taking and respect for others; to respect and empathise with others; Ability to work alongside one another as a team; to develop positive personal relationships			Total: 134	
4	<u>Enjoyment / Freedom</u> To have fun / enjoy sessions; Opportunity to work in a less formal setting;	Excluded Primary Mainstream Infant Mainstream Primary Brain Injured Adults Elderly Visually Impaired Mainstream Secondary	9 - llyrs. 5 -7 yrs. 8 - 11 yrs. 25- 60 yrs 29 - 61 yrs 12 yrs.	13 11 7 5 3 2	1 6 3 10 4 9
				Total: 41	
5	<u>To respond individually in an appropriate manner</u> To aid in assertiveness and making of choices; To increase his auditory response particular attention to his name ; Responding appropriately to instruction; To develop listening skills and concentration; To follow instructions; To decrease derogatory comments; To stop swearing (.which leads to fighting); To help him avoid getting drawn into situations which don't concern him; To work in a environment; Not to be influenced by others; To help him cope with conflict; To develop self-awareness; To express thoughts in a more socially acceptable way; To express negative feelings in a more acceptable, less aggressive manner; anger management; to control behaviour and aggression, and need for revenge; To help control his behaviour and aggression towards others; to encourage an acceptance of change of environment; To stimulate self-confidence; To increase self-confidence	Excluded Secondary Mainstream Primary Mainstream Secondary (High % Ethnic Minority) Secondary Autistic Special Brain Injured Adults Mainstream Secondary Elderly Visually Impaired Primary MLD Special	12 -15 yrs 8 -11 yrs. 12 yrs. 11 -15 yrs 25- 60 yrs 12 yrs. 29 -61 yrs 7yrs.	23 17 12 11 10 6 3 3	2 4 8 7 10 9 4 5
				Total: 85	
6	<u>To benefit physically</u> To improve co-ordination; To become more physically supple through movement	Brain Injured Adults Elderly Visually Impaired	25- 60 yrs 29 - 61 yrs	8 1	10 4
				Total: 9	
7	<u>For relaxation and reduction of Stress</u> For relaxation / reduce stress; To learn to relax; relief of stress; To reduce anxiety; To aid with tension relief	Mainstream Secondary Brain Injured Adults Elderly Visually Impaired	12 yrs. 25- 60 yrs 29 - 61 yrs	5 3 2	9 10 4
				Total: 10	
8	<u>Motivation and mental stimulation</u> To increase motivation I mental stimulation	Elderly Visually Impaired Brain Injured Adults	29 - 61 yrs 25- 60 yrs	5 1	4 10
				Total: 6	

App. 12.3 – Table 13b – Most prevalent aims

Total No. of Aims = 109 Clients x 4 Aims for each Client = 436

Ref. No. of Aim	Aim	No. of Times this Aim was Chosen	% of Total No. of Aims (436)
3	To be able to participate as a member of a group in an appropriate way and to benefit from so doing	134	30.7%
5	To respond individually in an appropriate manner	85	19.5%
2	To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions	83	19.0%
1	To enhance self-esteem	68	15.6%
4	Enjoyment/freedom	41	9.4%
7	For relaxation and reduction of stress	10	2.3%
6	To benefit physically	9	2.1%
8	Motivation and mental stimulation	6	1.4%

App.12:4 – Table 15 – Example of original scoring

Location 7 - Art													TOTALS								
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Th-V 1	Th-V 2	Th-V 3	Th-V 4	TOTAL	C-V 1	C-V 2	C-V 3	C-V 4	TOTAL	Aim 1	Aim 2	Aim 3	
H1	M	13						2	2	2	2	8						2	2	2	
H2	F	13	4	4	0	0	18	3	3	3	3	12	4	0	0	4	16	11	12	10	
H3	M	13	5	5	5	3	18	3	2	2	3	10	4	4	4	5	17	12	11	11	
H4	F	15	3	3	3	3	12	4	3	4	4	15	4	3	3	4	14	11	9	10	
H5	M	13						2.5	2	3	2	9.5						2.5	2	3	
H6	M	10	4	4	0	0	18	3	3	3	3	12	0	0	0	0	0	10	11	14	
H7	M	14						2	2	2	2	8						2	2	2	
H8	M	13	4	3	4	5	16	3	3	2	3	11	3	4	5	5	18	13	10	11	
			20	19	24	21	84	22.5	19	21	21	63.5	20	21	23	25	89	62.5	59	60	
Average:			4.2				Average:				3.61				Average:				4.45		

Location 7 - Dance Movement													TOTALS								
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Th-V 1	Th-V 2	Th-V 3	Th-V 4	TOTAL	C-V 1	C-V 2	C-V 3	C-V 4	TOTAL	Aim 1	Aim 2	Aim 3	
H1	M	13						5	5	5	5	20	4	5	5	5	19	15	15	16	
H2	F	13	6	5	6	4	21	5	4	5	4	17	6	5	5	4	20	16	13	15	
H3	M	13	4	4	5	3	16	5	4	5	4	17	6	5	6	5	24	15	18	16	
H4	F	15	5	6	5	4	20	5	6	5	4	20									
H5	M	13										0									
H6	M	15	4	5	6	6	21	4	4	4	4	16	5	5	5	5	21	13	14	15	
H7	M	14	3	4	4	5	16	4	4	4	4	16	6	6	6	5	24	13	14	14	
H8	M	13	3	3	4	5	15	5	5	4	4	18	5	5	5	5	25	12	12	13	
			26	17	38	27	109	27	28	27	27	109	32	32	32	32	128	84	87	89	
Average:			4.54				Average:				4.33				Average:				4.33		

Location 7 - Drama													TOTALS								
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Th-V 1	Th-V 2	Th-V 3	Th-V 4	TOTAL	C-V 1	C-V 2	C-V 3	C-V 4	TOTAL	Aim 1	Aim 2	Aim 3	
H1	M	13	3	3	3	4	13	2	3	3	3	11	4	5	3	3	17	3	11	3	
H2	F	13	4	5	6	4	19	5	5	5	4	19	5	5	6	5	21	14	15	17	
H3	M	13	3	5	5	3	16	4	3	4	5	16	4	4	5	4	17	11	12	14	
H4	F	15	4	6	4	4	18	4	4	4	5	17	5	6	5	5	21	13	16	13	
H5	M	13	3	4	4	4	15	3	3	3	3	12	5	5	5	5	20	11	16	12	
H6	M	15	5	4	5	3	17	4	4	3	4	15	5	5	6	5	21	14	13	14	
H7	M	14	3	4	5	4	16	4	3	4	4	15	5	5	5	5	20	12	12	14	
H8	M	13	4	4	4	5	17	4	5	3	4	16	4	4	5	4	17	12	12	12	
			29	32	38	31	130	38	35	42	37	152	37	39	40	39	155	96	104	103	
Average:			4.09				Average:				3.75				Average:				4.01		

Location 7 - Music													TOTALS								
Ref:	Sex	Age	T-V 1	T-V 2	T-V 3	T-V 4	TOTAL	Th-V 1	Th-V 2	Th-V 3	Th-V 4	TOTAL	C-V 1	C-V 2	C-V 3	C-V 4	TOTAL	Aim 1	Aim 2	Aim 3	
H1	M	13	5	3	4	3	15	2	3	2	3	10	4	5	4	4	17	3	11	10	
H2	F	13	3	3	6	3	15	4	4	5	4	17	2	3.5	6	5	16.5	3	10.5	17	
H3	M	13	4	4	4	4	16	4	3	4	5	16	3	4	4	4	15	11	11	12	
H4	F	15	4	5	3	5	17	5	6	5	6	23	4	5	3	4	16	14	16	15	
H5	M	13	3	4	4	4	15	3	3	4	4	14	5	5	4	5	19	11	12	12	
H6	M	15	3	2	4	2	11	5	5	5	5	20	3	3	4	4	14	11	10	13	
H7	M	14	3	3	3	2	11	3	2	4	3	12	3	3	3	3	12	3	8	10	
H8	M	13	3	3	4	5	15	3	4	4	4	15	4	3	4	4	15	13	10	12	
			26	17	31	28	103	36	35	33	34	127	28	31.5	32	31	124.5	86	88.5	97	
Average:			3.93				Average:				3.07				Average:				3.05		
Average T's View of All Therapies:			4.99				Average Th's View:				3.44				Average C's View:				4.03		

App. 12.5 – Table 16 – Coding for analysis of statistics

Placement Ref:

Name of Placement	<u>My Ref:</u>	<u>Statistics Ref:</u>
A..... Centre	Gp.1.A	1
B..... Centre	Gp.1.B	2
C..... School	Gp.1.C	3
TG..... Centre (Elderly Peoples' Home)	Gp.1.T	4
DEP Special school	Gp.2.D	5
C Infant School	Gp.2.E	6
B Special School	Gp.2.F	7
GH Secondary Mainstream School	Gp.2.G	8
BC Secondary Mainstream School	Gp.2.H	9
Brain Injury Unit	Gp.2.K	10

Client Ref:

Name of Placement	My Client Ref:	Statistics Ref:	Age of Client	Gender
A... Centre	A1	1	9	M
	A2	2	8	M
	A3	3	9	M
	A4	4	10	M
	AS	5	11	M
	A6	6	10	M
	A7	7	9	M
	AS	8	11	M
	A9	9	9	M
	A10	10	9	M
	A11	11	9	M
	A12	12	9	M
	A13	13	9	M
B... Centre	B1	14	13	M
	B2	15	13	M
	B3	16	12	M
	B4	17	13	M
	BS	18	12	F
	B6	19	15	M
	B7	20	13	M
	BS	21	13	M
	B9	22	14	M
	B10	23	13	F
	B11	24	12	M
	B12	25	14	M
C... School	C1	26	9	M
	C2	27	9	F
	C3	28	8	M
	C4	29	10	M
	(Clients 31-85 omitted)	C5	30	9

Secondary Mainstream Sch.	H2	86	13	F
	H3	87	13	M
	H4	88	15	F
	H5	89	13	M
	H6	90	15	M
	H7	91	14	M
	H8	92	13	M
Brain Injury Centre	K1	93	26	M
	K2	94	33	M
	K3	95	32	M
	K4	96	34	F
	K5	97	31	F
	K6	98	36	F
	K7	99	29	M
	K8	100	31	F
	K9	101	36	M
	K10	102	35	M
	K11	103	33	M
	K12	104	25	M
	K13	105	27	F
	K14	106	25	F
	K15	107	60	F
C	K16	108	26	F
a	K17	109	40	M

Aim No:

My Ref:	Statistics Ref:
1	1
2	2
3	3
4	4

Category of Aim: (See Table 13a for Details of Aims)

My Ref:	Statistics Ref:
A	1
B	2
C	3
D	4
E	5
F	6
G	7
H	8

App. 12.6 – Table 41 Analysis of key words in response to QQ1 of the Structured Interview

Positive Responses:

- Enjoy(able); fun
- Useful
- Benefit, Improvement, Beneficial, Progress, Positive feedback, Absolutely!, Helped some, Overall helpful, Good results, Yes!, Responded very well, Gave them a life, Definitely!
- Relationships, Interacted, Social skills, Took part, Social activity, Being polite, Turn-taking, Listening,
- Confidence (increased), Self-belief, Self-esteem, Able to express her feelings

Negative Responses:

- Practical difficulties / Management difficulties
- Inhibited (deterrent to participation), Reserved, Suspicious

Others:

- Different approach, children, ways, Unexpected results
- Other comments

Table 41

Placement Ref. and TV		Positive Responses					Negative Responses		Different / Unexpected	Other	Total use of key words
		■	■	■	■	■	■	■	■	■	
1	TV	2	1	1			2	2			8
2	TV	2		1	1			2			6
3	TV				1	2			5	1	9
4	TV	1		1	1			1		1	5
5	TV			1	1				1		3
6	TV			1	1					3	5
7	TV			2						3	5
8	TV									2	2
9	TV			1						3	4
10	TV	1	2	1	7	1				1	13
Total	TV	6	3	9	11	4	2	5	6	14	60
%	TV	10%	5%	15%	18%	7%	3%	8%	10%	23%	
Therapist Ref. and ThV											
1	ThV	1		1			4			1	7
2	ThV			4					1	1	6
3	ThV			2			1			1	4
4	ThV			1			1				2
5	ThV			1							1
6	ThV			2	2					1	6
7	ThV										-
8	ThV			4						1	5
9	ThV			1				1		3	4
Total	ThV	1	-	16	2	-	6	1	1	8	35
%	ThV	3%	-	46%	6%	-	17%	3%	3%	23%	
Client ref. and CV											
A	CV			1							1
B	CV			1							1
C	CV	1		1							2
D	CV			1							1
E	CV			1							1
F	CV	1									1
G	CV	1									1
Total		3	-	5	-	-	-	-	-	-	8
%		38%	-	62%	-	-	-	-	-	-	
TOTALS		10	3	30	13	4	8	6	7	22	103
		10%	3%	29%	13%	4%	8%	6%	7%	21%	

*App. 12.7 – Table 17 – Views on 6-week or 12-week programmes
(Therapists' Views only)*

6-Week Programme			No. of times mentioned
1	General:	- six weeks was just basically not enough. - definitely needed to be longer.	2
2	Specific:	Support:	- it didn't really offer any support 1
		Relationships:	- inadequacy of time to make relationships...then had to stop 3
			- not long enough to gain the trust of your clients 1
			- you need time for a period of closure 1
Helpful to some clients	- helpful to the more able - better for the younger people because they trust more easily and are not so cynical, so you can 'get there' quicker 1 1		
Assessments:	- not enough time to make full assessments 1		
12-Week Programme			No. of times mentioned
1	General:	- I felt that twelve weeks was absolutely critical. - I would feel that the twelve week programme is better than the six. - so the change to 12 weeks seemed an obvious gain and advantage - I would go for 12 weeks for all the groups, really	3 1
2	Specific:	Involvement:	- people were able to be immersed in it for four or five weeks, in the middle process - much more of an opportunity to engage 2
		Purpose:	- a lot more meaningful - gave a good sense of what we could achieve 2 1

App.12.8 – Table 44a – Original Analysis of QQ2 (M/T):
Which therapy do you think was the most effective?

Place- ment	Type of Client	Art	Dance Mvt.	Drama	Music	Different Therapies for different Clients	Other Comment
1	Exclude Primary		✓				
2	Excluded Secondary				✓		
3	Mainstream Primary (NEM)*		✓				Each effective in a different way
4	Elderly Impaired	✓	✓			✓	DIM for clients, Art for Manager. All 4 met individual needs in different ways
5	Learning Disability Primary					✓	Different therapies for different Clients
6	Mainstream Primary				✓		
7	Autistic Secondary					✓	Different therapies for different Clients
8	Mainstream Secondary (NEM)*						N/A Chose not to answer this question.
9	Mainstream Secondary			✓			Drama was chosen by the Teacher (Art by the Clients)
10	Brain Injured					✓	Different therapies for different Clients
TOTAL		1	3	1	2	4	

"NEM" = Non-European majority of Clients

App. 12:8 – Table 46b - QQ3 - (M/T): Why do you think this was so? Were there any features of the modality itself which you felt were more appropriate to your clients?

Place-ment	Type of Client	Choice of Most Effective Therapy	Other Comment
1	Excluded Primary	Dance Movement	<ul style="list-style-type: none"> - Enjoyment in Movement - Quite new - Freedom of space - Children can express themselves in a safe environment - Less chance of behaving inappropriately ⇒ helps with basic principle of therapy
2	Excluded Secondary	Music	<ul style="list-style-type: none"> - Practical – hands on - Experimenting - Familiar music close to personal experiences - Enjoyed <p>Attitude of therapist ("Th. encouraged them to do that - gave individual attention")</p>
3	Mainstream Primary (EM)*	Dance Movement "Each therapy effective in a different way"	<ul style="list-style-type: none"> - Personality of therapist important - Active movement made it more effective with the children referred - Doing things they wouldn't normally be doing (not allowed to go into local parks – at home most of day) - Amount of space valuable for them
4	Elderly Impaired	D / M for Clients, Art for Manager. "All 4 met individual needs in different ways"	<ul style="list-style-type: none"> - In different ways they all met their needs individually - Enjoyed involvement - In Dance Movement or drama - ?others in group overpowering the more quieter ones. - (not able to comment on music as was not there for that) - Clients enjoyed the practical side – tactile - Relaxing and enjoying - Lots of choice in what they did - Non-directive therapist - Clients could express themselves –bring their own feeling into it (Drama) <p>Dance Movement was limited because of space in our location</p>
5	Learning disability Primary	Different therapies for different Clients	<ul style="list-style-type: none"> - Children had different learning styles, therefore you could (should?) match each therapy to which learning medium they preferred. e.g. H. was more responsive to music – he found communication (e.g. drama) difficult.
6	Mainstream Primary	Music	<ul style="list-style-type: none"> - Special relationship with person presenting it - They could do what they wanted with the instruments - Enjoyment - Freedom to express themselves as they wanted to - Enjoyment of playing the instruments, which they don't do on a regular basis
7	Autistic Secondary	Different therapies for different clients	<ul style="list-style-type: none"> - Difficult to generalise; Highly personal to individual clients - Clients' own personal interests Clients' ⇒ Different learning styles - They need access to more than one type of therapy, to see what they are most comfortable with. This might change with age and experience - ?music when young, drama when older and more aware of need to develop social skills; interpersonal relationships become more important - Rhythm developmentally may appeal to youngsters –repeating patterns, as in nursery rhymes. As they get older, they are interested in other things. - Some were more self-conscious than others - Therapies provided opportunities to relate to prior experiences <p>Personality of the therapist important – or was it that that particular client group did not respond to the Art?</p>
8	Mainstream Secondary	NIA.	<i>Chose not to answer this question</i>

9	Mainstream Secondary	Art was chosen by the Clients, Drama by the Teacher	<ul style="list-style-type: none"> - Clients enjoyed it, but there were individual client preferences - If they are more interested in it, then they enjoy it more & give it a 'better go' than another therapy, e.g. X was good at drama, so he liked it. - Feedback from therapist very important for staff - Children just actually want to role play with what most of us would just consider as quite normal kind of family experiences. that was valuable, and it has probably not had a huge effect on how they have been in their lessons, but long-term, that is probably helping them to resolve, and deal with some issues that they have got in a non kind of threatening way, you know, without long-term counseling, a lot of these kids just could not do it, it just would not happen. - A lot of their issues are being dealt with in a slightly more subtle way, you know, rather than full on, "Tell me about your problems." And you know, they would just shut up, particularly the boys. - Another lad, who particularly opened up in a drama session, got very angry, and it was brilliant, because it gave him an outlet, it gave him a way for him to deal with that, and it was really good. - So I think that it might be the low self-esteem kids, give them a bit of confidence, particularly with the drama.
10	Brain Damaged	Different therapies for different Clients	<ul style="list-style-type: none"> - <u>Art</u> – they enjoyed the quiet and calm, however, in art there is a disadvantage because the expectation is that they have to produce something at the end – a piece of work - One client had an interest in art anyway - Possibly the therapist (Art) coloured my judgment because there was an issue with that. - <u>Dance</u> good because they didn't have to say anything – they were happy to do Dance, because they could communicate in a group, which they cannot normally do - In <u>Drama</u> they could act out their frustrations; they didn't have to rely on poor memories - Drama was good because it used props which were good prompts and therefore helped. Props were helpful and meant they did not have to concentrate on language - The Therapist had an excellent rapport with the clients (Drama). - In Dance and Drama they didn't have to use their voices (they may have had problems with speech) - <u>Music</u> - Perhaps certain clients never had a chance to have a childhood – music gave them the opportunity to have fun and laugh ("I'd never seen this client laugh before") <u>General</u> - They could imagine they were free of their impairments - Clients' reactions were not always what staff would anticipate, therefore the staff learnt more about the clients

App.12:8 – Table 46c – Original Analysis of QQ2(C): Which therapy do you think was the most effective (which therapy did you enjoy most)?

Client	Type of	Art	Dance Mvt.	Drama	Music
A	Mainstream Secondary	✓			
B	Mainstream Secondary	✓			
C	Mainstream Secondary	✓			
D	Mainstream Secondary	✓			
E	Blind, Elderly		✓		
F	Blind, Elderly			✓	
G	Blind, Elderly	✓		✓	
TOTAL		5	1	2	

**App.12:8 – Table 46d - QQ3(C): Why do you think this was so?
Were there features of the modality itself which you felt were more appropriate to your needs?**

Client Ref:	Type of client	Therapy Chosen	Reasons why
Client A	Mainstream secondary	Art	<i>(Chose art, although she “hates drawing”!</i> <u>Personal:</u> - Freedom of choice to draw what she wanted (“you couldn’t ‘do your own thing’ in music) - Relationships with others are easier if you’re in a small group - The therapist talked to us and asked what we were doing - We enjoyed it - She was willing to ‘have a go’ at anything - “I felt able to take part in anything, even if I don’t usually like it, because it doesn’t matter if you are good at it or not. <u>General</u> – I felt the whole group was happy in the subject they liked the most - Some others liked drama more <i>(these clients were not available to interview)</i>
Client B	Mainstream Secondary	Art	- “You can do more” - It helped me with my stress - You can do stuff - “I can’t do this anywhere else” - He didn’t like music – “Don’t like it much”
Client C	Mainstream Secondary	Art	- The art helped to boost my self-confidence – I used to draw loads of cartoons as a kid - I would rather do something I enjoy - Art was better than drama - I liked it (drama) least because it showed my immature behaviour
Client D	Mainstream Secondary	Art	- I get nervous. I don’t like doing the dance and the drama - I like more freedom, but we needed more space for the art
Client E	Blind, Elderly	Dance Movement / Art (2 nd .)	- I found it quite enjoyable really - <i>E is unable to say why she liked the dance movement, although she gestured with her hands to describe the activity</i> - <i>She also says she liked the art – “Because it’s quite interesting”</i>
Client F	Blind, Elderly	Drama	- As time goes by, I haven’t got the interest in doing anything at the moment.. but I enjoyed the winter and summer <i>(Drama)</i> on a Friday morning.
Client G	Blind, Elderly	Drama / Art (“a bit as well”)	<i>(G is quite confused, but the following comments are relevant)</i> - It was quite easy, it was easy, right. - The drama thing, I loved it.. and I would like to do it again... - When I was painting I felt very relaxed, but in the drama it was “Stand up, sit down, stand up..” - They helped me in a particular way, yeah. - <i>He remembered from the painting that they went on a trip to the seaside and enjoyed the lovely time – implying that remembering this brought him happiness</i> - <i>He doesn’t describe much about the dance movement or the music.</i>

**App.12:8 Table 46e Original Analysis of QQ2(Th):
Which Client Group do you think benefitted most?**

Therapist	Therapists' Modality	Which Client Group?										
		PI.1	PI.2	PI.3	PI.4	PI.5	PI.6	PI.7	PI.8	PI.9	PI.10	Other comment
		Primary Exclusion	Secondary Exclusion Unit	Primary Mainstream	Elderly, Visual Disabilities	Primary MLD Special	Infant Mainstream	Secondary Autistic Special	Secondary Mainstream Ethnic %	Secondary Mainstream	Brain Rehabilitation Unit	
Th. 1	Art	3		3	4	4			3	4	3/4	1,2,7
Th. 2	Dance Movement								4	4		
Th. 3	Drama			4								
Th. 4	Music	5		5				5				
Th. 5	Drama											6,7
Th. 6	Music					4	3					6
Th. 7	Dance Movement	<i>No response available from therapist</i>										
Th. 8	Music											8
Th. 9	Drama									4		1

1. All groups of clients benefitted in different ways
2. Every client benefitted
3. This placement had a difficult time
4. All did very well at this placement
5. Work with children generally
6. It also depends on the institution being helpful / being better supported by staff
7. I can't say - the issues are different from group to group
8. It depended on the group make-up as much as their particular difficulties

App.12:8 – Table 46f- QQ3 (Th): Why do you think this was so? Were there any features of the modality itself which you felt were more appropriate to this particular client group?

(The headings in the Table below have been formulated to reflect the therapists' responses)

Type of Therapy	Type of Client	Reasons for referral <i>(when mentioned by the therapist)</i>	Positive reasons and features of the modality	Negative reasons
Art	Young children General	Communication difficulties Behavioural problems Attention deficit	Related to material intuitively Gathered confidence Found own style Freedom of expression Doing things that were not always allowed Different Explore non-verbally Feel better at having created something Gives a sense of growth	Space for therapy not suitable - interruptions, not able to make a mess
Dance Movement	Secondary aged children Younger children Elderly	Behavioural difficulties	Able to explore other mediums Gave a lift emotionally Try new things, explore Not limited by therapist	Would just do things in one little pocket Are more limited in mobility
Drama	Younger children Secondary Aged Children	Behavioural Difficulties Autistic - some learning difficulties	Benefits of being in supportive group ⇨ not so self-conscious Enjoyment Can immediately get into character Similar to play Drama is flexible – more different ways of working than in other media (?) – you can ‘go with them’ Games and role-playing Can sort things out through play Projections really worked for them Getting into characters and playing, in a child-appropriate way Relationship to objects ⇨ More immediate response to which I related	Some had difficulties with imagination, although this improved as sessions continued Could have been explored further with more time (even than 12 weeks) Had difficulty getting into roles

		Behavioural issues	I became a figure of authority against which they could rebel; they could come up with ideas and I could contain them. They had choice and agency	Took a long time to get involved. Not 'so cool' to get involved in drama
		Withdrawn	Could explore and let off steam Projection / role-playing	Self-conscious Over-rebellious
		Autistic lower-functioning	Working through the body and physical relationship Relational – making sounds with steps Non-verbal communication	
		Higher level functioning	Role playing is good	
Music	Young and Secondary aged children		Immediate means of communication and transmission of feelings. Able to express feelings Build self-confidence More quickly responsive than adults Responded because this is my own background Response especially to rhythm, which is also in pop music, and tonality	
		Moderate learning difficulties	Greater support from staff led to more advantageous experience	Possibly circumstances rather than specific media Didn't feel I communicated so well with adults – maybe that's just me
	Adults	Brain damaged	Rhythm work helped improve coordination. Work with elements of music better than psychodynamic approach	Some would have done better with 1:1

App. 13 – Additional material from the current research to be used to inform future practice.

13.1 – Understanding of Arts Therapies v. Arts in Health

Responses from the therapists in particular to the questionnaire indicated that in a number of instances, referrers at the various locations were not necessarily sure of the difference between arts therapies and therapeutic arts, or the use of the arts in health contexts where the leader of the activity does not hold qualified arts therapies status. This was apparent in referrers' relationships with the therapists and their attitudes towards the therapy programmes. Therapists were not always regarded as being full members of the intervention team – whether educational or medical – but rather, the arts therapies sessions were seen as a recreational diversion from the more serious education / medical routine.

Implications for future practice based on these observations would indicate that therapists should be advised to be clear in their own minds as to the specific nature of the service they are providing and should be able to differentiate between the two practices when involved in initial discussions with referrers of potential clients for an arts therapy intervention.

As stated by Bradt & Goodill (2013 p.969):

“Creative arts therapists (CAT) involve the implementation of an arts intervention by a trained credentialed creative arts therapist; the presence of a systematic psychotherapeutic process and the use of individualized treatment interventions. Thus, CAT's use a wide range of arts experiences to address specific therapeutic issues identified individually for patients and always include patient assessment, treatment, and evaluation. Specialties include art therapy, music therapy, dance/movement therapy, drama therapy, psychodrama, poetry therapy, and expressive therapy. In contrast, arts intervention administered by volunteers or professionals in other health care disciplines typically follow a universally applied programme of arts activities and, in the case of music interventions, are often limited to passive listening to music.”

Areas of practice within the arts therapies and arts for health and well-being may overlap, but remain distinct. Arts therapists are specifically trained in the understanding of human development and in ways of working creatively with emotional and psychological distress, as has been observed and evaluated in the current study. Therapists are using people's ability to respond to one form or other of the arts, as described by the Committee for Arts Therapies in Education (CATE, 1993) as the foundation from which all arts therapies practices should develop. Arts in health practitioners are primarily practising artists coming from a wide variety of training and background, who work with

participants to offer an opportunity to experience and explore their own creativity (MHF 2006). This latter approach may well lead to participants commenting on the added value that participation in such creative projects bring to their lives, but would not necessarily be the core objective of such sessions. Further mention of arts in therapy and healthcare settings is given by the Royal Society for Public Health & the Philipp Family Foundation (2013 p.31), where it is stated:

“In hospitals and other healthcare settings, art is used in several ways. The traditional therapies such as art, music and drama therapy, are part of clinical treatment given by professionally trained therapists to help people find alternative means of expressing thoughts and feelings. Over the last few decades, other applications of arts have included:

- Enhancement of the clinical environment with visual art or design;
- Participative and non-participative activities for patients which aim to improve wellbeing and sometimes clinical outcomes;
- Arts activities to improve staff morale and skills; and
- Educational events using art to convey health messages.”

The subject is currently under consideration by the Arts, Health and Wellbeing All Party Parliamentary Group (2014), which in July of that year, considered how the arts and culture can contribute to improving the quality of care, following the Francis Inquiry. Within discussion at this group, the importance of the use of poetry was particularly stressed, as it can communicate the reality of disease and create empathy, allowing people to talk about things they are fearful about such as cancer, or understand the world of dementia. Training of medical staff in voice production and body image in relation to communication with clients is also being implemented. These are, however, examples of work undertaken by artists, rather than by arts therapists.

Future therapy practitioners should be able to advise referrers that there is a difference between the two approaches, although clients may move from one level of service provision to another, as successful outcomes in achieving aims are reached. Ultimate professionalism demands that bridges are built between the contrasting approaches of all four arts modalities, the overall practice of arts therapies and that of the work of arts in health, while recognizing that each discipline is a developing profession in its own right.

The current research has demonstrated that arts therapies are able to serve the wide range of clients' needs, but that clarification between the approaches of arts therapies or arts in health should be made before sessions are commenced.

13.2 – Commonalities and differences between the arts modalities

As the purpose of the present research was to identify “Which arts therapy for which client and why?”, it appeared advisable that as part of the research process, there should be a brief concurrent informal enquiry, separate from the actual therapy sessions, into the individual characteristics of each of the four modalities – art, dance movement, drama and music. It could then be determined whether some characteristics of the four different modalities were held in common, while others might be unique to a particular art form. This might indicate whether the unique features of a particular modality could be linked more precisely to a certain type of client or to a particular type of aim.

Two approaches were therefore adopted in order to address this enquiry, namely referral to literature covering the subject, supported by discussion with other arts therapists representing the four modalities involved.

Individual characteristics of each arts modality

Shiraev & Levy (2001:5) agree that arts therapies share between them a number of features that can be studied and presented through the search for common beliefs and practices (*absolutism*). They also see each of the arts therapies disciplines as having their own idiosyncrasies and unique character that make sense within a specific context (*relativism*), maintaining that within the arts therapies, there are not two cultures that are either entirely similar or entirely different, but that the arts therapies consist of separate disciplines which may be perceived as subcultures of a greater whole. This view is further described by Karkou & Sanderson (2006).

In informal discussions, arts therapists representing all four modalities were invited to list which characteristics they themselves felt was peculiar to their own discipline, which were not present in the others. Their responses are summarised as follows:

Features unique to art therapy

- the artwork becomes visible, it is a tangible reference / journal / evidence tool. This leads to the fact that it is re-visitible in its essence at a later stage.
- the surface of the artwork is a direct link to the matter – e.g. scratches in paint surface can remind the observer of the emotion / energy / body movement / expression present at the time of making the

art work; thus, prior knowledge of art materials will sometimes be an assistance, something both therapist and client can bring to the therapy without even knowing.

- mark-making is an innate drive in humans – to locate ourselves. Mark-making is also about our relationship to the world; it is both powerful and immediate (therefore potentially dangerous but also with great potential for healing and resolution); it provides a path into the unconscious.

Features unique to dance movement (cross-cultural)

- facilities are available for notating movement and movement analysis
- the use of the dance process can be the creative impetus to induce self-medication
- the use of music as a complement to the dance process, not a substitute support system, that influences the sensory experience
- within the cross-cultural paradigm, the dance movement therapy process is constructed in such way that the psychology of race, class, creed and other creative disciplines are sensitively acknowledged in context

Features unique to dramatherapy

- role-playing - both fictional roles and doubling
- the use of story, improvisation and enactment
- sculpting; chair work; the use of puppets and masks
- the use of metaphor; exploring internal and external dramas; guided visualisation; theatre;
- breathing and voice (*although this was considered to be present in other modalities as well*)

Features unique to music therapy

- a specific kind of listening as provided by the therapist to the music created
- the client's response to sound – even if he/she is brain-damaged or has limited auditory perception
- musical improvisation
- the musical skills of the therapist (as a performer and as a listener)
- the kinaesthetic properties of music which increase co-ordination and motor skills, providing stimulation and motivation to respond
- the promoting of non-verbal communication through vocalisations and use of instruments
- use of the elements of music like vibration e.g. on the resonance board or a speaker

- cause and effect - having the client to be in control of a session (*this may also be possible in other therapies*).

Summary of unique features of each arts modality

Knill et al. (1995) observe that while all of the expressive therapies involve action, each also has inherent differences. For example, visual expression is conducive to more private, isolated work and may lend itself to enhancing the process of individuation; music often taps feeling and may lend itself to socialization when people collaborate in song or in simultaneously playing instruments; and dance/movement offer opportunities to interact and form relationships. In other words, each form of expressive therapy has its unique properties and role in therapeutic work depending on its application, practitioner, client, setting, and objectives.

Features unique to each modality include the use by the client of the characteristics of equipment specific to each modality – for example, the symbolic and physical approaches to musical instruments in music therapy; the use of materials, colour and texture in art therapy; the use of chairs, puppets and masks in dramatherapy, and so on.

Whole body movement is probably more prominent in dance movement therapy, but in every modality, observation of body image and body language is important. However, in dance movement it might be said that this is the focal point of the modality. One participant in the discussion, who was a dancer involved in both classical and modern Indian dance, said that she felt ‘most naked’ in the art form of dance, because she used her whole body to portray her feelings, whereas in the other art forms, she could hide behind tools, instruments, words, or acting. In dancing, she could only use her whole self to communicate the inner feelings of the dance and of herself.

Commonalities

As Karkou & Sanderson (2006:115) suggest, commonalities across all four of the arts therapies include: the emphasis on creativity, the role of imagery and imagination, symbolism and metaphors, non-verbal communication, the significance of the client-therapist relationship and the type of therapeutic aims relevant to arts therapies. Any client referred for a programme of one of the arts therapies, will be able to utilise any or all of the above commonalities, supported by the therapist. These features will appear in any programme carried out within the present research and in themselves, will provide a wealth of opportunities within which clients may utilise in search for

amelioration of their personal situations.

It appears from the therapists' suggestions above that a number of the characteristics listed as being peculiar to one modality, actually seem to appear in more than one discipline. These include:

- The physical aspects of the sessions, including the physical nature of the equipment used and physical effects of vibration and resonance
- The interpersonal relationship between client(s) and therapist
- The emotional content of the activity
- The ability to 're-visit' or go back to visual or non-visual evidence of a previous part of the 'life journey'
- The use of improvisation, or 'un-planned', spontaneous activity, in varying forms, according to the modes being used
- Previous relationships of the client towards the particular art form – or lack of previous experience
- An innate drive inherent in most humans to 'make their mark', to be observed and to relate to others (this may link with subconscious, as well as conscious, processes, with their resultant behaviours).

Because of this instinctive wish to relate through art forms, a link may be made and become apparent to unconscious and sub-conscious thoughts and feelings; video-recordings and other recording techniques for record-keeping and re-visitation of an experience or 'journey'; the use of the voice, as part of the improvising, or as exchange of words – if the client has this ability - including use of the breath for varying purposes; the need to listen as well as to make sounds; the skills of the therapist; an opportunity for controlling others, as well as following someone else's lead and an opportunity for regression or reversion to earlier stages of personal development.

Awareness of these commonalities and differences may add to the breadth of practice available within each modality, enriching the sessions for all participants.

13.3 – Location of sessions

Comments made during the structured interview (questionnaires) showed that the actual physical location of sessions is a very important factor in the therapy process. This is emphasised by the number of times all three groups of respondents – Managers / Teachers, Therapists and Clients – referred to practical details of the locations in their responses to the questionnaire.

During the research programme, each group of therapy sessions was delivered in the clients' locations, whether this was a school, centre, a home or a unit. Thus the emotional connection to the environment of the sessions was already established in the minds of the clients and their referrers. It has already been noted that some spaces allocated for the sessions were not adequate, either in size, privacy, furnishings or equipment. This may lead to an inherent disadvantage through clients' associations already connected with these spaces and might damage the concept of the therapy space being a 'safe space', thus influencing the course of the therapy.

Because of these considerations, unless there are physical or practical restrictions, it is advisable that sessions be held in 'neutral' territory, such as a specifically designated centre, as this should not have any form of previous association for the client and should also contain all the necessary equipment. However, if sessions are to take place during school hours, or if a group of clients is involved, it may be impractical to hold the therapy sessions away from the 'home base. In that scenario, however, the study has demonstrated that all adequate facilities should be available before sessions commence and that the space allocated for sessions should provide a location which will not be disturbed during the session by casual visitors or on-site staff. Such details should be discussed with a potential referrer before assessment or regular sessions are started.

13.4 – Length of therapeutic intervention

This topic brings into discussion the question of whether, as a result of the present study, there appeared to be an ideal length of time recommended for a programme of therapy. Within this study, the number of sessions was already decided, namely 6 or 12 weeks. However, when asked in general practice by a referrer how many weeks it would be expected that a therapy intervention might take to achieve the aims of the referral, it is often difficult to give a definitive answer. Much depends on the causes of the initial referral and whether the condition of the client is expected to be of long or short-term duration.

This does not even take into account the personality of the client himself, or his ability to 'make use' of the opportunities for 'improvement' made available during the therapy sessions, which will in turn have an effect on the number of sessions required.

If practical circumstances allow, it is common practice to suggest an initial length of the intervention, which will be followed by a review and possible continuation for a further period of time, depending on progress achieved. A generally accepted length of time for the first period of intervention has been found to be 12 weeks. It has been shown already by responses to the questionnaire that therapists definitely felt that in most cases, a 6-week intervention was not sufficient and that many of them would have liked to continue beyond the set period of the programme. Indeed, therapists felt that although some clients were able to accept closure at the end of the 12-week intervention, others would have benefitted from extension of sessions.

Within the current programme, this had not been possible and therapists were concerned that some clients might have been distressed by this fact and the lack of flexibility of time for termination. Both quantitative and qualitative statistical analysis confirmed that the therapists particularly appeared to value the extension of the therapy programmes from 6 weeks to 12 weeks. Neither managers / teachers nor the clients were specifically asked whether they preferred the 6-week or 12-week interventions, as they had not been given the choice. The extension to the 12-week programme came after the first 4 interventions of 6 weeks each, at the specific request of the therapists.

It might be assumed that the longer the duration of sessions, the more successful the outcome. However, perhaps it was suggested that if the clients know in advance that the sessions are only going to last for 6 weeks, they may try to 'get as much out of them' as they can in the weeks available. The therapists as a whole, however, felt that 6 weeks was barely a sufficient length of time in which to

carry out an initial assessment of any type of client and to produce a notable change within the therapy sessions.

Eventually it may depend on practical details such as available funding, length of school term or discharge from the location, which may decide the length of intervention. This may seem to be a compromise, but cannot be avoided. It seems unlikely that a satisfactory answer to the optimum duration of sessions will ever be found - unless there is adequate funding and sufficient therapists, both to support those who only need a short-term intervention, to providing continuing care for those who will never fully recover, but whose lives will be greatly enhanced by the benefits gained from the sessions.

13.5 – Wider issues concerning number of sessions required

From consideration of the range of types of client participating in the study, there appeared to be two overall types of client, each having differing needs, which could be called 'acute' or 'chronic'.

Within the first category would be included clients who have suffered a reaction to a stress-causing event with which they have been unable to cope, such as a bereavement (including loss of job, home, or other situation, as well as actual bereavement by death); an anxiety state; various phobias or similar disorders caused by immediate circumstances such as bullying, physical or sexual abuse or similar traumatic issues. Until these events took place, such clients might have been living well-adjusted lives, being able to cope on a personal basis with any problems which occurred.

However, an event such as one of those mentioned, might prove to be too much for the client to bear on his own, despite support from friends and relatives, or others who might also be struggling to cope with the same situation. Indeed the perpetrator of the traumatic event might still be present in the client's life. The assistance of an 'outside' person - a therapist - with an alternative approach to the problem, might be the intervention that would assist such a client to regain their pre-traumatic state and ability to lead a satisfying life. Therapy sessions in such cases might not last more than 12 weeks, or occasionally less, depending on how traumatised the client appeared to be, their overall personality and their ability to 'come to terms' with the cause of the trauma.

In contrast, other clients participated in the study who presented with chronic illnesses, such as autism, dementia, schizophrenia, chronic depression, bi-polar disorders and brain damage. In such situations, it might be that ideally, the length of sessions was much more 'open-ended'. For such clients, the weekly arts therapy session - whether in 1:1 situation or group - became an event to which to look forward, a weekly 'up-lift'. It was also a situation - especially in cases of dementia - where the session assisted the clients to maintain contact with reality for as long as possible and assisted in slowing down cognitive decline. These therapy sessions - especially those in the long-stay residential home for the elderly - became a focus for the week and assisted in memory recall, renewed creativity and improvement in general physical health. They provided occasions for socialisation which extended beyond the duration of the session itself.

It is of value in this respect to compare the stated aims for the clients referred within the present programme who might be considered as having 'acute' needs, against those who might be considered having 'chronic' needs.

'Acute':

1. Primary age exclusion centre
2. Secondary age exclusion centre
3. Primary mainstream school
6. Infant mainstream School
8. Secondary mainstream school - High % ethnic minority pupils
9. Secondary mainstream school

'Chronic':

4. Elderly visually impaired
5. Primary moderate learning difficulty school
7. Secondary autistic special school
10. Brain injury rehabilitation unit (adult)

Table 67

Aim No:	Description	No. of times chosen by a location	
		Acute	Chronic
1	To enhance self-esteem	5	3
2	To allow individual expression of emotions in an acceptable form and for participants to be able to acknowledge these personal emotions	5	4
3	To be able to participate as a member of a group in an appropriate way and to benefit from so doing	5	4
4	Freedom / enjoyment	4	2
5	To respond individually in an appropriate manner	4	4
6	To benefit physically	0	2
7	For relaxation and reduction of stress	1	2
8	Motivation and mental stimulation	0	2

*Aims chosen by 'Acute' or 'Chronic' clients**

** N.B. These figures have not been modified to allow for the fact that there are 6 'Acute' to 4 'Chronic' Locations*

From this table, it may be seen that aim 6 "To benefit physically" and aim 8 "Motivation and aental stimulation" were not chosen by any of the 'Acute' Locations, while Aim 7 "For Relaxation and Reduction of Stress", was only chosen once. Otherwise, taking into account that there are numerically more 'Acute' locations than 'Chronic', the choice of aims appear to be fairly evenly distributed. It might even be argued that aim 6 is not necessarily an aim specifically addressed by therapy, although if the clients concerned had mental health problems in addition to their physical

condition, it might need a more specialised approach to be able to achieve motivation to *"benefit physically"*.

It is also interesting to note that Location 8, which had a high % of ethnic minority children, might have chosen aims within the 'chronic' range, as ethnicity will not change with age and therefore it might be thought that aims associated with this factor might reflect long-term issues. However, this location did not even choose aim 3 *"Group Participation"*, or aim 4 *"Enjoyment / Freedom"* for any of its clients, which is surprising. The table shows that ethnicity is not - and indeed in an ideal society should not - be regarded as a long-term disadvantage. This school therefore remains in the 'Acute' category.

13.6 – Closure of sessions

Following on from consideration of the length of the therapeutic intervention and the wider issues concerning the number of sessions which may be required, closure of sessions is a very important part of the complete programme of therapy. From the point of view of the present study, all three parties – managers/teachers, therapists and clients had all said that they would wish the therapy sessions to continue longer, the conditions for which varied from one location to another¹.

In general, closure, or termination of sessions may depend on a number of factors. The dominant factor is whether it is felt by the client and members of the clinical team, that the original aims have been achieved, or that as much progress as is likely to occur towards these goals, has been reached. There may also be practical reasons, including situations such as the client's move to another location (school, home, moving out of the district); coming to the end of funding sources; the physical death of the client; the decision by the manager/teacher that it is now 'someone else's turn' to benefit from therapy sessions; the decision of the therapist that they should use their available time to work with other clients or even that the client himself chooses to terminate the sessions.

It is advisable to define the boundaries of each therapy session itself in terms of duration of time and number of sessions to be held, before the commencement of the intervention. This adds to the feeling of safety and security of the client. It is also advisable that the sessions occur at the same time and place, on a regular basis (Bunt & Hoskyns 2002). Moreover, clients (or their carers) should not be allowed to manipulate the timing of the sessions, to extend the amount of time spent during each session – for example, by prolonging discussion at the end of the session or by arriving late and expecting the session to be extended accordingly. The only exception to this rule might be if a 'break-through' has occurred during the session, which demands immediate follow-up, but the allowance of time beyond the stated sessional time should not jeopardise the sessional times of any subsequent clients with whom the therapist has an appointment. It should also be understood in advance of commencement of sessions, that a carer or parent should not enter the therapy room until the therapist has indicated that the session has finished.

The length of the actual session may vary according to the needs of the client. A standard time is one hour duration once a week, but this may be modified in the case of children, or those whose physical or cognitive abilities limit toleration of this length of time. Once decided, the timing should remain consistent for each session, unless the client indicates that they wish for the session to

¹ See Chapter 5 QQ5/6

close sooner than the agreed time. Preferably, the therapist should agree with this decision. As a pattern usually emerges for the content of a session with each client, it is interesting that both client and therapist get a 'feel' for the timing and naturally close each session almost without looking at the clock.

Therapists must also work out their personal timings for note-keeping and reflection. This may become part of the allocated time, i.e. the client might leave after 50 mins. of sessional time, allowing 10 mins., for the therapist to move mentally from one situation to the next. It is always good for the therapist to be able to write down initial notes concerning the session immediately at the end of the session, even if fuller 'writing up' should be delayed until a later stage. If the therapist is working in a situation where a number of clients are coming in quick succession, it may not be possible to recollect details of sessions, even if they seem very important at the time of occurrence. The ending of sessions could be discussed at greater length than is possible here. Bunt and Hoskyns (2002) give a summary of factors to be taken into account and a suitable series of actions to be taken.

13.7 – Funding

It was helpful that funding was available to support both the researcher and the therapists working within the present study.² This is not always the situation and in order to continue this work, commissions for therapy sessions are being sought from the local authority, in addition to applications for grants from charitable trusts.

These monies are not easy to obtain and when enquiring about provision of services for the disabled, the researcher was recently discussing the possibility of a contract for therapy sessions, with an officer of the City Council Officer in the Learning Disabilities Directorate. It was disappointing to understand that his prime aim was - as he saw it - to 'get clients back into employment'. When it was mentioned to him that many of the clients with whom therapists work will never be able to become employed, he appeared to lose interest in the conversation. This officer followed local council policies which at the time stated that funding would only be available for those clients who were likely to become employed in the future. No funding would be available - from this particular source - for those who would never achieve this position.³

It appears that funding arrangements for individual clients are in a constant state of change. Currently (2012) Individual Personal Allowances are being developed to allow clients greater control in spending of personal budgets. However, if these allowances are dependent on assessment by social workers or others, it becomes apparent that the local authority 'holds the purse strings'. With regard to other governmental strategies, it was promising when, in 2007, the Government announced new resources to Increase Access to Psychological Therapies (IAPT) - of which the Arts Therapies are considered a part - within the Savoy Agreement (DoH 2007):

“Depression and anxiety affect millions of people in the UK, yet few receive the psychological therapies that could help with recovery. Many with the courage to seek help have to wait for many months for treatment or have to pay for it privately.

The Government has committed itself to turning this around and to implementing NICE Guidelines for depression and anxiety so that everyone can have timely access to state-of-the-art evidence-based therapies.

² See Chapter 1 p. 9

³ This introduces many more questions, such as 'cost effectiveness within the therapies', priority of needs and allocation of therapists' limited time, which are far-reaching topics which would need to be included in future guidelines.

We congratulate the Government on this welcome initiative and call on the NHS to offer appropriate psychological therapies free at the point of delivery to all people who need them, within six years. We call for people to be given a choice of appropriate, evidence-based therapies available close to home when they need them. And we urge Government to invest in the further development and evaluation of psychological therapies to make the UK a world leader in this field.

We commit to working together to support the NHS to build up its psychological therapy provision and to ensure that the new services are safe, effective and successful.”

However, it appears that since then in fact the majority of funding has been concentrated on development of Cognitive Behaviour Therapy (CBT).

The original Savoy Agreement was followed in 2010 and 2011 speeches by Paul Burstow MP, the then Care Services Minister, to the New Savoy Conferences, stating:

“By 2015 every patient in the country should be able to get timely access and real choice of proven psychological therapies. CBT has helped to get us on the road. Now we’ll invest the money and work with the local NHS to up-skill staff in counselling, interpersonal therapy, brief dynamic therapy and couples therapy.

What’s been doubly welcome are the positive steps that organisations in the New Savoy Partnership have taken to solve some of the problems we face. Like the e-mental health applications it’s developing that help expand the number of people who can be treated. And improving the research base into the effectiveness of different psychological therapies.” <http://www.newsavoypartnership.org/declaration.htm#signatory>

This has led to a little more funding being allocated towards counselling and Interpersonal Psychotherapy (IPT), but not the hoped-for increase in funding for arts therapies posts. This is very disappointing, especially when mental health clients, when asked what services they would like and they suggest arts therapies, are told that no increased funding is available for this. It still seems the case that in order to fund arts therapies services, each case still has to be fought on its own merits - and often results in sessions having to be privately funded, or supported through charitable trusts, despite all the positive proof available as to the efficacy of this work.

13.8 – Waiting times

If it is felt that an arts therapies intervention is appropriate, inevitably a referrer will ask how long it will be before sessions can start. This was not a question which was included in the main body of the research, but it is relevant to include a brief discussion here, as the subject was mentioned in responses and is of prime importance to a potential referrer.

Within the NHS, clients have the right to start consultant led treatment within a maximum of 18 weeks from referral, however, in January 2012, the total number of patients waiting more than 18 weeks for treatment had risen by 43% since the then government came into power ("Guardian", 19th. Jan.2012). Much discussion is currently taking place over the role of privatisation within the NHS and also the increased role of charities in supplying interventions, when the public body is stretched beyond its means. Clients are given the choice of waiting for NHS treatment or 'going private'. This is a political debate outside the focus of the current discussion.

There are, of course, different lengths of waiting times for different procedures, but regardless of which treatment is being sought, the anxiety levels which delay causes can, in many cases - especially those based on emotional and behavioural issues - exacerbate the situation. There are many schools of thought which regard the majority of illness as being psychosomatic in origin. The feeling especially of being unable to control events in one's life, may serve to enhance the basic anxiety, which in turn fuels the roots of the cause of the original illness (Barlow 2001).

Within the field of mental health, the figures quoted above correspond with MIND's research (MIND, 2012) which found that 1 in 5 people are waiting for over a year between asking for help (*within the mental health services*) and receiving treatment, but that those who got help quickly were more likely to be happy with their treatment and be able to return to work more quickly. MIND urges the government to continue to work with local health services to explore why some Primary Care Trusts (PCT's) are still failing to provide IAPT⁴ services at all and ensure that the NHS provides a full range of evidence-based psychological therapies to all who need them, within 28 days of requesting referral.

One head teacher interviewed in the current research stated that he was so grateful that the programme had been introduced, as he had tried to access assistance for a particular child, but there had been increasing delays in provision of a service of assessment and intervention by Social Services. He felt

⁴ IAPT – Increasing Access to Psychological Therapies (especially Cognitive Behaviour Therapy – CBT)

that the arts therapies programme had come just at the right time for this child, who had greatly benefitted from the programme, at a time of great need.

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