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ERASMUS INTENSIVE PROGRAMME

ARTS THERAPIES FOR DIFFERENT CLIENT/PATIENT GROUPS

Collection of articles

Education and Culture DG
Lifelong Learning Programme

RĪGAS STRADIŅA UNIVERSITĀTE

ARTS THERAPIES SUMMER SCHOOL 2012

ERASMUS INTENSIVE PROGRAMME

ARTS THERAPIES FOR DIFFERENT CLIENT/PATIENT GROUPS

Collection of articles

Authors of compilation:
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2013

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ArtsTherapies for Different Client/Patient Groups
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Collection of articles "Arts Therapies for Different Client/Patient Groups"

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Faculty of Rehabilitation
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Special gratitude to Kristine Grintale

In collaboration with:

Foundation Vidzeme Regional Support Centre "Valdardze" (Latvia)
Hogeschool Arnhem Nijmegen (HAN) (The Netherlands)
Leeds Metropolitan University (Great Britain)
Liepaja Music Therapy Centre (Latvia)
Liepaja University (Latvia)
Lithuanian University of Educational Sciences (Lithuania)
Queen Margaret University (Great Britain)
Centre of Rehabilitation "Akrona" (Latvia)
Children's Clinical University Hospital "Gaiļezers" (Latvia)
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ABSTRACT

This collection of articles is created and published by the Erasmus Lifelong Learning Intensive programme project "Arts Therapies for different client/patient groups" (2011/2012) in Rīga Stradiņš University, Faculty of Rehabilitation, Professional Master's study programme "Arts Therapies" in collaboration with project partners. The articles are based on the content of theoretical presentations and workshops from the authors during Intensive programme activities.

The collection of articles describes theoretical and practical work with health care discipline – arts therapies specialisations – art therapy, dance movement therapy, music therapy possibilities with different client/patient groups in health care, social care and educational settings.

The collection of articles includes different arts therapists from Estonia, Latvia, Lithuania, Germany and Great Britain, and their practical experience summary. The case studies are results of recent research in the field of arts therapies. The articles emphasise and characterise the specifics of arts therapies specialisations, and offer the possibilities in work with different client/patient groups.

Multidimensional views to practical part of arts therapies work are offered in the collection. It also demonstrates various therapeutic frameworks, integration of medical, psychological theories used as basis of the applicability of arts therapies, offers some aspects of art-based assessment, and shares useful experience. The authors offer contemporary approaches in arts therapies work.

The main goals of the project were to provide exchange of experiences through activities among project partners; to acquire and develop new knowledge and skills; to create guidance materials for arts therapies work for different client/patient groups; and to encourage further arts therapies development in the project participating countries.

ACKNOWLEDGEMENTS

The collection of articles is created and published by the Erasmus Lifelong Learning Intensive programme project "Arts Therapies for different client/patient groups" (2011/2012), based on the content of theoretical presentations and workshops by the authors of the articles. The Project "Arts Therapies for different client/patient groups" was a new challenge for the authors and organisers of it – Rīga Stradiņš University (further – RSU), Faculty of Rehabilitation, Professional Master's study programme "Arts Therapies" (head of the programme Kristine Martinsone, PhD, MSc (Health Science), Associate Professor) and Department of Academic and Foreign Affairs (head of the Department Juta Kroica, Professor). The project was completed in collaboration with the teaching staff from several foreign higher educational institutions in Europe. Successful management of the project led to the contributions of many people within the two years from the project idea till the moment of its realisation.

First, our gratitude goes to Professor Janis Gardovskis**,** Rector of RSU, Professor Aivars Vetra, Dean of Faculty of Rehabilitation, Professor Juta Kroica, Head of the Department of Academic and Foreign Affairs International Office for the given support during the completion process of project activities.

Second, we are grateful to Erasmus Institutional coordinators of Department of Academic and Foreign Affairs Erasmus Office for intensive cooperation work to establish partnership with project partners in higher educational institutions abroad – Erasmus coordinators, teachers and students. Additionally, all project partners in governmental institutions and non-governmental organisations in Latvia who have helped to organise the exchange of practical experience and meetings with the multidisciplinary team deserve our appreciation as well.

We are very thankful to all project scientific and organising committee members, student volunteer team for personal investments for taking care of the project providing technical and organisational support. Gratitude to all teaching staff for well prepared and well organised theoretical presentations and workshops.

Thanks to every person who has provided any support and assistance in the project organisational activities.

Assoc. Prof., PhD Kristine Martinsone
RSU Arts Therapies Master Study programme director

Mg. scal. sc. Edite Krevica
Qualitative project coordinator

ACKNOWLEDGEMENTS

Dear participants, stakeholders and readers!

There are so many ways and means of expressing our identity and conveying our feelings and emotions. We can interact with each other by talking, touching, writing or just by the wink of an eye or a short glimpse. Likewise, we can turn our deepest senses and message to the world into music, art and dance.

Summer School 2012 "Arts Therapies with Different Client/Patient Groups" within Erasmus Lifelong Learning Intensive programme, hosted by Rīga Stradiņš University was all about conveying the deepest strings of human soul through various disciplines of arts therapies: music therapy, dance movement therapy, art therapy and drama therapy. Ten days of intensive work in the middle of a warm and joyful summer in Latvia showed that there are many people to help others by treating them with a touch of art and by helping to get rid of the shell of uncertainty and mental disorders.

I express my sincerest gratitude to all participants from Rīga Stradiņš University (RSU), Liepaja University, Lithuanian University of Educational Sciences, Tallinn University, HAN University of Applied Sciences, Leeds Metropolitan University, Queen Margaret University and University of Leeds, and especially to teachers, who devoted their time and shared best practices and lifelong work experience with students, colleagues and stakeholders, in other words, to those who decided to link their work and life with Arts Therapies. This event would not be organised without the help of volunteers and staff of administration. In particular, I would like to express my gratitude to the administrative staff of the Children's Clinical University Hospital "Gaiļezers", Centre of Rehabilitation "Akrona", Foundation "Vidzeme Regional support centre "Valdardze"" and Liepaja Music Therapy centre. Despite the fact that RSU was hosting the event for the first time and the existent space for improvement, I am sure that we all enjoyed the project and brought a bunch of ideas and useful experiences back home.

Sincerely,
Lana Amosova,
Administrative Project Coordinator

OVERVIEW OF ERASMUS INTENSIVE PROGRAMME ACTIVITIES

30th June – 9th July, 2012 RĪGA, LATVIA

I PAPER PRESENTATIONS/WORKSHOPS

ART THERAPY

***Chris Wood** (Leeds Metropolitan University and Sheffield Health and Social Care NHS Foundation Trust, Great Britain)*

- Using research evidence to consider art therapy approaches to clients with different mental health diagnosis
- Art therapy approaches to work with people with a diagnosis of schizophrenia
- The therapeutic frame: a metaphor for practice
- Workshops on using images to think about client work
- Workshops on assessments for therapy

***Eha Rüütel** (Tallin University, Estonia)*

- Solution oriented approach combining art therapy and vibroacoustic therapy in prevention and treatment of eating disorders

***Kristine Martinsone** (Rīga Stradiņš University, Latvia)*

- Quo vadis Arts Therapies: some nowaday issues

***Edite Krevica, Iveta Jermolajeva** (Rīga Stradiņš University, Latvia)*

- Art therapy with youths with behavioural disorder

***Ilze Dzilna-Silova, Kristine Martinsone, Anda Upmale** (Rīga Stradiņš University, Latvia)*

- Art-based assesment in art therapy with abused children

***Jolanta Leinarte, Ilze Embrika** (Latvia)*

- Art therapy applied to a patient of anxiety depression

DANCE MOVEMENT THERAPY

***Bonnie Meekums** (University of Leeds, Great Britain)*

- Creative approaches to working with adult survivors of child sexual abuse

***Vicky Karkou (**Queen Margaret University, Great Britain)*

- Approaches to somatic change in dance movement psychotherapy

***Julie Joseph** (Queen Margaret University, Great Britain)*

- Dance movement psychotherapy for adolescents

Indra Majore-Dusele *(Rīga Stradiņš University, Latvia)*

- Dance movement therapy with emotional eating disorders

Kristine Vende *(Rīga Stradiņš University, Latvia)*

- Dance movement therapy for children with behavioural and emotional disorders
- Dance movement therapy for elderly with dementia

Zanda Lauva *(Rīga Stradiņš University, Latvia)*

- Dance movement therapy as part of multidisciplinary team's work with abused and neglected children and their accompanying non-violent persons

MUSIC THERAPY

Emma Pethybridge, Vicky Karkou, Julie Joseph *(Queen Margaret University, Great Britain)*

- Music therapy and dance movement psychotherapy for children

Emma Pethybridge *(Queen Margaret University, Great Britain)*

- Music therapy group work with children

Reiner Haus *(Universität Witten/Herdecke, Germany)*

- Piano and vocal improvisation in individual settings
- Music therapy for patients with chronic pain
- Music therapy in respiratory care
- Music therapy with autistic children
- Music therapy for patient's language development disorders
- Music therapy in neonatology and intense care
- Music therapy in oncology

Vilmante Aleksiene *(Lithuanian University of Educational Sciences, Lithuania)*

- Containment of Fears

Heidi Fausch-Pfister *(Switzerland)*

- Music therapy and psychodrama in neuro-rehabilitation
- Development through work with role cluster

Mirdza Paipare, Anda Upmale *(Rīga Stradiņš University, Liepaja University, Latvia)*

- Music therapy in neurological rehabilitation

Anzela Belska *(Latvia)*

- Development of communicative basic skills in music therapy for children with multiple and severe psychophysiological development disorders

Aralda Buzere *(Latvia)*

- Improvisation effectiveness for reducing of the depression symptoms in music therapy

Ineta Heinsberga *(Rīga Stradiņš University, Latvia)*

- Improvisation in music therapy; its opportunities for life quality change for persons with CCP; a case study

Liga Engele *(Liepaja University, Latvia)*

- Usage possibilities of music therapy methods for a pre-school aged child with psychical development retardation

Olga Blauzde *(Liepaja University, Latvia)*

- Music therapy opportunities for children with genetic diseases

DRAMA THERAPY

Aelita Vagale *(Rīga Stradiņš University, Latvia)*

- Use of drama therapy in work with addicted persons

Oliver Schneider, Emilia de Gruijter *(Hogeschool Arnhem Nijmegen (HAN), The Netherlands)*

- How to work with hand puppets in therapy: different possibilities in working with children, adults, relationships and families
- Drama therapy with children and adolescents (working with subsystems in drama therapy
- How to work with fairytales in drama therapy with children, adults, relationships and families
- Drama therapy and body: from movement to developmental transformations
- Drama therapy and cognitive behaviour therapy

Anna Steina, Evija Vilka, Kristine Martinsone *(Rīga Stradiņš University, Latvia)*

- Drama therapy for reducing level of depression symptoms and increasing self-esteem to patients with symptomatic eating disorders
- Case study: use of drama therapy while working with adult patients attending psychiatric day treatment center

Eva Tabore *(Latvia)*

- Drama therapy with alcohol addicted patients with low alcohol abstinence's self-efficacy in Minnesota programme

Ieva Muktupavela *(Latvia)*

- Drama therapy for children and youth with light, medium and medium severe mental development disorders

Rita Garnaka, Kristine Martinsone *(Latvia)*

- Drama therapy for Parkinson's disease patients with anxiety

ART, DANCE MOVEMENT, MUSIC THERAPIES

Ania Zubala, Vicky Karkou *(Queen Margaret University, Great Britain)*

- Addressing depression through art and movement psychotherapy: the evidence so far

Anda Upmale, Kristine Vende, Simona Orinska, Sandra Barsinevica, Zane Kriumane, Dace Visnola *(Rīga Stradiņš University, Latvia)*

- Patient groups in art therapies: practice report

Simona Orinska, Kristine Vende, Anda Upmale, Dace Visnola *(Rīga Stradiņš University, Latvia)*

- Use of dance movement therapy and art therapy with eating disorders

Simona Orinska, Sandra Barsinevica *(Rīga Stradiņš University, Latvia)*

- Music therapy and dance movement therapy for children having autistic spectrum disorders at Children's Clinical University Hospital "Gaiļezers"

CIRCUS THERAPY

Helena Ehrenbusch *(Estonia)*

- Circus therapy with various client groups, especially psychiatric clients

II WORK IN GROUPS/DISCUSSIONS

1. ***Determination of Intensive programme tasks***
   (student and teacher questionnaires, participant personal goals, students individual work – essay).
2. ***Arts Therapies profession topicality in your country***
   (topicality regarding the development of art therapist profession in participant countries in work with different client/patient groups – setting up guidelines, methods, researches, main difficulties, solutions).
3. ***Role of art therapist in multidisciplinary team***
   (experiences of art therapist's role in multidisciplinary team, cooperation with different specialists, exchange of good, collaboration experiences).
4. ***Creative work in group*** *"Most empowered topic today", reflection.*
5. ***Work in group's result summarisation for all participants.***

III PRACTICAL EXPERIENCES EXCHANGE

1. ***Visiting Children's Clinical University Hospital "Gaiļezers" (Rīga)***
   Meeting with the medical personnel, expounding of arts therapies work and needs, art therapist's role in multidisciplinary team, art therapist's work places in hospital.
2. ***Visiting Centre of Rehabilitation "Akrona" (Rīga)***
   Introduction with European Social Foundation Project "10 step" – art therapist's work and role in practice social rehabilitation programme for addicted patients after treatment.

3. Visiting Vidzeme Regional Support Centre "Valdardze" (Valmiera)
Meeting with the specialist team; expounding of art therapist's work and needs, specific characters, role in multidisciplinary team.

4. Visiting Liepaja Music Therapy Centre (Liepāja)
Meeting with the specialist team; expounding of art therapist's work and needs, specific characters, role in multidisciplinary team.

5. Practical experience result summarization
Sharing experience, arts therapist's work specifics and methods; exchange of ideas and good practice.

IV STUDENTS INDIVIDUAL WORK

Students' individual work – essay: description of experience, reflections, professional development issues.

ERASMUS INTENSIVE PROGRAMME PROJECT IN PHOTOS

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Figure 2. *Opening plenary at Rīga Stradiņš University, from left – Indra Majore-Dusele, mentor of the plenary, Edite Krevica, Iveta Jermolajeva*

Figure 3. *Chris Wood, Leeds Metropolitan University, Great Britain*

Figure 4. *Paper presentation by Chris Wood*

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FOREWORD

This collection of articles is created and published by the Erasmus Lifelong Learning Intensive programme project "Arts Therapies for different client/patient groups" in Rīga Stradiņš University, Faculty of Rehabilitation, Professional Master's Study programme in health care "Arts Therapies" (further – RSU MA) in collaboration with project partners from different higher educational institutions (further – HEI) in Europe. The content of the articles is based on theoretical presentations and workshops during project activities from 30th June till 9th July, 2012 in Rīga, Latvia. The collection of articles is one of the project's expected outcomes.

This international project has been an important meeting point and time of professional growth for Latvian arts therapists, arts therapies' students and academic staff, as well as for project partners – teaching personnel and students alike. It was a great possibility to develop cooperation links among new project partners during project activities and continue cooperation with a number of well-known persons in the field of arts therapies in Europe, who have an important role in Latvia's arts therapies' profession development – Vicky Karkou, PhD (Queen Margaret University, Great Britain), Bonnie Meekums, PhD (Leeds University, Great Britain), Vilmante Aleksiene, PhD (Lithuanian University of Educational Sciences, Lithuania), Dr. rer. medic. Reiner Haus (Universität Witten/Herdecke, Germany).

From historical viewpoint, arts therapies is one of the newest health care professions in Latvia – the result of the integration of different discipline sciences, which has experienced approbation and recognition in several countries in the world for more than half a century and has acquired a stable position in health care.

The development of arts therapies' profession in Latvia has taken place since the independence of the Republic of Latvia in 1999, due to the intense work that results with arts therapist's (4 specialisations) profession recognition in health care system. Arts therapist's profession is included in various Latvian regulatory acts: "Law on Medicine", classification of professions; arts therapies four specialities have been approved as medical technologies, where the competence in treatment is determined.

Two HEI provide MA study programmes in Latvia. RSU provides full time studies for all four arts therapies specialities – art therapy, dance movement therapy, music therapy, drama therapy. Studies give the possibility to acquire the master's degree in health care and professional education in arts therapies according to the chosen field – art therapy, dance and movement therapy, music therapy and drama therapy. Liepaja University has part time studies in music therapy. The teaching personnel collaborates with arts therapies' students, and graduate arts therapists work together to develop and improve arts therapies as a profession, and continue establishing the position of the profession in Latvia.

In order to make the study process more effective and to carry out scientific work, the international cooperation is being developed. RSU MA has already successfully established continuous cooperation with colleagues who have appreciated the attempts made in Latvia – at first starting in the study process with Caryl Sibbet, PhD, (agreement with Queen's University Belfast, Northern Ireland), through Erasmus Mobility agreement with Vicky Karkou, PhD (Queen Margaret University, Great Britain), Genevieve Smyth, (Queen Margaret University, Great Britain), Bonnie Meekums, PhD (Leeds University, Great Britain). Dr. rer. medic. Reiner Haus (Universität Witten/Herdecke, Germany) has promoted the development of music therapy in Liepaja University, he is Honorary Doctorate at Liepaja University. Likewise, long-term cooperation has been established with a music therapist, Vilmante Aleksiene, PhD (Lithuanian University of Educational Sciences, Lithuania) in RSU MA and Liepaja University.

Arts therapies is continuing to develop its professional language, integrates knowledge and results of practice-based evidence and research. Great Britain's experience in arts therapies working model is of special importance in Latvia. The teaching staff and new professionals have published a number of books, arts therapists take active part in interdisciplinary scientific conferences with their scientific research papers. Graduate arts therapists participate in professional associations. Members of arts therapies' professional associations have organised a number of annual international conferences in Latvia. The important achievement is the development of colaboration with a number of health care institutions, educational and social institutions for students' clinical practice at regional and national levels. This collaboration has discovered rich possibilities of interaction among different disciplines and has given possibilities to include arts therapists as multidisciplinary team members.

Nowadays, cooperation with HEI in Latvia and abroad is the basis of sustainable and successful development. The main aims are oriented towards developing practice-based evidence (realised more during this project), exchange of experience collaboration with colleagues from abroad HEI, support life-long ideas among academic staff, students and graduates according to contemporary health care field needs at national and international levels.

One of current developmental needs of the arts therapies' profession in Latvia is to increase its cooperation with HEI in Europe, to strengthen students' scientific work and research activities, to publish results of scientific work in international journals, activate international dimension of studies and research, work out guidance materials for arts therapies with different client/patient groups.

Contemporary developmental task of arts therapies' profession is realised through RSU MA Erasmus Lifelong Learning programme in collaboration with Liepaja University (Latvia), in cooperation with foreign academic staff members from study programmes of foreign universities – *Lithuanian University of Educational Sciences*

(Lithuania), Tallinn University (Estonia), Hogeschool Arnhem Nijmegen (The Netherlands), Queen Margaret University (United Kingdom), University of Leeds (United Kingdom), Leeds Metropolitan University (United Kingdom), Universität Witten Herdecke (Germany) with following academic staff in art therapy: *Chris Wood, PhD (United Kingdom), Eha Rüütel, PhD (Estonia);* in drama therapy: *Oliver Schneider, Emilia de Gruijter (The Netherlands);* in dance movement therapy: *Bonnie Meekums, PhD (United Kingdom), Vassiliky Karkou, PhD (United Kingdom);* in music therapy: *Vilmante Aleksiene, PhD (Lithuania), Emma Pethybridge (United Kingdom), Julie Joseph (United Kingdom), Heidi Fausch-Pfister (Switzerland)*, *Dr. rer. medic. Reiner Haus* (*German*). The following guest educators participated in the project: *Helena Ehrenbusch (Estonia)* and *Heidi Fausch-Pfister (Switzerland).*

RSU and Liepaja University arts therapies' academic staff and graduate arts therapists performed with paper presentations and/or workshops – *Kristine Martinsone, PhD, Indra Majore-Dusele, Anda Upmale, Mirdza Paipare, Aelita Vagale, Ilze Dzilna-Silova, Iveta Jermolajeva, Edite Krevica, Kristine Vende, Simona Orinska, Zanda Lauva, Evija Vilka, Anna Steina, Sandra Barsinevica, Ineta Heinsberga, Olga Blauzde, Anzela Belska, Liga Engele, Aralda Buzere, Eva Tabore, Rita Garnaka, Jolanta Leinarte, Ieva Muktupavela.*

300 participants were involved in the completion of the project, including 8 teaching staff and 20 students from foreign HEI, teaching staff and students from RSU and Liepaja University, graduate arts therapists and other specialists who are interested in arts therapies.

The main activities of the project were the learning activities, including theoretical lectures and workshops, practical work in groups, practical exchange of experience, including visiting health care and social care institutions, meetings with multidisciplinary teams at different working environments, creation of educational materials, student's individual work. All these activities were to promote students and arts therapies' practitioners to theoretical and practical experience exchange, learning new knowledge, improving skills, making partnerships in scientific work among students and academic staff, deepening understanding about recent European tendencies in arts therapies working with international team.

One of the most important parts of activities was to work in groups and create discussions among students and practitioners about arts therapies' topical issues in all participant countries – Estonia, Germany, Latvia, Lithuania, Great Britain, The Netherlands. Such themes as arts therapists' role in multidisciplinary team, exchange of good multidisciplinary teams work practice in health, social care, educational environments, and discussion about ethical dilemmas in arts therapist's practice with client/patient and support of supervision were part of the focus of the project. The discussions revealed important questions and reflected on similar issues in project partnership countries such as arts therapists employment, increase of governmental funding, new work place development, recognition of arts therapies' profession among different

working environments and wider society. Discussions among arts therapies' students, teaching staff, arts therapists about personal and professional development confirmed a high level of motivation and professional interest in the field, analysis of best practice examples in participating countries. Discussions among project participants found the necessity to improve some aspects for further arts therapies' development such as evidence-based researches, evidence-based practice, methods to describe more specific arts therapists practice with different client/patient population, to affect questions about professional identity development, to cooperate in multidisciplinary team, the need to increase the level of knowledge about achievements in the field.

Work in groups outlined further developmental tasks of profession: to increase a practice-based evidence and evidence-based practice, to increase a number of scientific researches in the field of arts therapies, to create guidelines for work with different client/patient groups, to develop short term arts therapies interventions, to promote publicity of scientific research at international level and dissemination of results, to establish and maintain communication with different professionals from health care, social care and educational fields.

Erasmus Lifelong Learning Intensive programme project achieved the planned learning outcomes and gave the opportunities to increase student's knowledge and practical skills of working with resources and techniques in compliance with arts therapies specialisation by trainings of competent specialists, collaboration with other students in interdisciplinary and international team; to deepen the understanding about the tendencies and experiences in arts therapies work with different client/patient groups; to foster students' motivation of further education and lifelong learning. From projects organisers' viewpoint, the important benefits are the recognitions that exchange of experience is necessary to develop a common understanding about professional practice. This project helped to observe similarities and differences in arts therapies' practice among project partner countries that are useful informational resources to strengthen and prepare the unit, qualitative standards for arts therapies education programmes and work in practice.

As a result of this project is the collection of articles *"Arts Therapies for different client/patient groups"* which explains health care discipline – arts therapies specialities – art therapy, dance movement therapy, music therapy – work possibilities with different client/patient groups in health care, social care and educational settings. However, due to the limited time frame of the project, not all of the presented topics are included in this collection of articles. No drama therapy work in practice has been included as part of this book because of the obstacles of limited time.

This collection of articles includes practical art therapists experience, results of researches, examples of case studies by Estonian, German, British, Latvian, Lithuanian arts therapists, higher educational institution academic staff, it also describes arts therapist's work in multidisciplinary team, characterizing arts therapies' speci-

ficity of each specialisation and the possibilities in work with different client/patient groups. The articles offer a multidimensional view to practical part of arts therapies' work, demonstrate various therapeutic frameworks, integration of psychological theories used as basis of arts therapies practical work, offer some aspects of art-based assessment, share useful experience. The authors have discovered contemporary approaches in arts therapies working in various environments – health care clinics, crisis centers, schools.

The project organisers hope that International Erasmus Lifelong Learning Intensive programme project in Latvia was an important meeting place for all participants with a sense of community, time for personal and professional development, creative place for exchange of experience and space for creativity that has built stronger cooperation links between the participating countries. We appreciate every opportunity of the project to broaden cooperation and collaboration possibilities in European context, to raise the level of skills, knowledge and competences among arts therapies' academic staff, students and others, to improve study, programme quality, to increase an international cooperation and teachers and students mobility in Europe.

We hope that the time spent together provided an opportunity for every participant to discuss the important professional issues, to gain new practical experience, promote cooperation, begin a new tradition in arts therapies field not only in Latvia, but also in partnership countries.

We hope that art therapists, arts therapies' students, health and social care professionals will get many new ideas and the collection of the articles will be a useful resource for art therapists of every specialisation, arts therapies students, specialists from different disciplines, who use arts methods and techniques in practice, for every reader who has an interest in contemporary development trends in health care, social care, educational and arts fields.

Let you be inspired for new ideas, experience emotional fulfillment in such a sense that would encourage for further arts therapies' development in all the project partner countries!

Asoc. prof., PhD Kristine Martinsone
Rīga Stradiņš University, Faculty of Rehabilitation
Arts Therapies Master Study programme director

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Organizing committee member

I. ARTS THERAPIES: PROFFESION DEVELOPMENT ISSUES

Kristine Martinsone, Ieva Vaverniece, Janis Ivans Mihailovs

Rīga Stradiņš University, Faculty of Rehabilitation, Latvia

QUO VADIS ARTS THERAPIES: RELEVANT ISSUES OF THE PROFESSIONAL PRACTICE AND FURTHER DEVELOPMENT

Abstract

The development of arts therapies (art therapy, music therapy, dance movement therapy and drama therapy) has a very different history in various countries. This is the reason why there is no common approach to these professions nowadays; there are diverse traditions and understandings of many arts therapies' aspects such as theoretical frameworks, lengths of the study and training programmes, education and practice, understanding about the assessment and process of arts therapies, co-operation with different client/patient groups, the legal status of the profession as well as the nature of the professional environment. This article analyses the issues of professional identity, research and professional practice (especially regarding the setting of the aims). Unequivocal solutions are not provided in the article; it, however, discusses the main questions in relation to them. The importance lies in being aware of these questions for respect of the variety, for attraction of the recourses, the development of the dialogue and co-operation of art therapists from different countries, and possibly also for reaching the goal to create and co-ordinate the space of common identity of arts therapies profession in the future.

Keywords: arts therapies, education of arts therapies, professional practice, professional status, professional identity, evidence based practice, aims of arts therapies.

Introduction

Arts (art, music, dance and theatre) have existed since the very beginning of the humanity with their various functions: investigation of reality, mirroring, transformation, communication, passing the experience, uniting, heeling etc. "Doing analyses of art as a human phenomena, we can talk about two ways of expression. One is represented mostly by artists or people who create planned artworks which also exist just as artworks. Another – represented by people who are social beings in other activities

and have no direct connection to the arts. These two ways of expression of art have their beginnings in very ancient ages and have existed all the time" (Kacalova, 1993).

Undoubtedly, these ways of expression of arts and their meanings of contents undergo transformation with the development of society – with the change of society's values, social practice, understanding about beauty etc.; also the boundaries of arts' functions and application in different social areas are getting broader and have their place in such fields as education, culture, health, social care etc. Specialists of different specialisations do broaden the classical understanding and the contexts of arts in their professional practice (Martinsone, Mihailovs et al., 2008). Among such professionals are arts therapists in all four specialisations which include art, music, dance and drama.

The new integrative field of health promotion and health care – arts therapies – started its development in Europe and the USA in the 40/50-ies of the 20th century. Already in the 1960/1970-ies professional organisations started to develop, and educational programmes of arts therapies as well as journal and books started to emerge (Vaverniece, 2011). Thus, over a 40-year-period it has been possible to obtain education in arts therapies and professional qualification of art therapist[1] in different higher educational establishments and professional schools in the world which is the basis for further working platforms in the fields of health and social care, as well as educational area and private practice. Any professional practice also provides motivation for the development of professional capacity for further development such as supervisions and continuing education.

Although four specialisations of arts therapies (art, dance-movement, music and drama therapy) have existed since the beginning of the 20th century, their development was not simultaneous throughout the world. Nowadays there is no common understanding about the arts therapies profession – the traditions of education and practice are different. Theoretical frameworks, structure and lengths of training programmes, the aims and understanding about the assessment and the process of arts therapies as well as the idea about the co-operation possibilities with different patient/client groups differ a lot. The differences can be pointed out also at the legal status of arts therapists and their professional fields – areas where arts therapists belong with their professional status and placement. In countries where arts therapies are health care professions, activities of art therapists are regulated and inspected/controlled by the state. However, the professional activities and regulations of arts therapies are rather open and have little regulations in countries where arts therapies are not part of health care system (Karkou, Martinsone, Nazarova, Vaverniece, 2011).

Latvia is an example where the professional development of arts therapies evolved according to the system in the UK (Martinsone, 2011), which includes a quite

[1] Here and further the term "art therapist" will be used for all arts therapies specialisations, professionals of four professions according to his specialisation. Also masculine gender is used for the descriptions of persons (art therapist, patient/client, researcher etc.) here and further with the meaning that here we talk about male and female professionals.

detailed regulation system (including the Law on Medicine) in the Regulations issued by the Cabinet of Ministers – strict competences of arts therapist have been defined in health care. In Latvia, four arts therapies specialisations have been approved, which influences the order of arts therapists professional activities and finances. It also impacts the character of the relationships with clients/patients. To be able to start the professional activity as an art therapist, professional education (Master's degree in health care) and professional qualification in one of four specialisations are needed, and by starting the practice of an art therapist, one has to take part in supervisions regularly, according to the hours of weekly practice. Those who work in health care system must be certified under the Union of the Latvian Health Care Person' Professional Organizations; moreover, this certification has to be regularly renewed (which serves as the approval of successful examination of the professional qualification).

Nevertheless, it must be admitted that arts therapies are not recognized as a profession in many states. This explains why there are no common requirements of competences for the education in arts therapies. Many different professional organisations are active, frequently parallel to one another, in one country, and each of them gathers a particular amount of professionals and people who are interested in the respective field.

By summarising the aspect of arts therapies theoretical framework, regulations, professional organisations and diversity of experience, several fields of issues can be defined (which are not the only ones): arts therapist has an opportunity to choose the aspect of focus in his work:

- theory or professional and personal experience;
- illness (symptom) or patient (his needs);
- evidence-based practice or point of view that each case is absolutely unique;
- work in (multiprofessional) team (in different environments) or private practice.

By ignoring theses aspects, it is not possible to understand why specialists from different countries and fields present their experiences differently. The context of professional practice of the country a specialist is from, is important and can effectively be understood by reading the collection of articles which provides an overview about the working themes of the Arts Therapies Summer School 2012 in Latvia.

Professional identity

Interdisciplinary roots of arts therapies have to be stressed and the question has to be asked about the identity of an art (music, drama, dance and movement) therapist which is one's belonging to the particular profession and group of professionals with the list of values, interactions, knowledge etc. It is characterized by consistent individual features, professional conditions and consistence of the content. It implies also one's ability to be aware and sense the specification and uniqueness of

the particular profession, to be able to go for consistent professional development. In the context of caring professions, also one's ability to work with different patient groups, to find individual and grounded approach to each patient, keeping alive competent professional view, despite the influences from the environmental events, social changes etc. (Beta, 2012).

The professionals of arts therapies who work/practice in different scientific and professional fields in different countries have gained rich experience with application of the methods and techniques as well as an experience in the use of the creative process with different client/patient groups. And this should be seen as a big resource.

A question can be asked about the professional identity of an art therapist and how its development takes place. The professional identity not only promotes professional self-positioning, but also sets the boundaries of professional competences of an art therapist and boundaries towards other professions and the society in general, working also as a field of information for the recognition of the clients/patients. Despite the definition of the profession and clear professional identity (for example, belonging to a particular group of professions), additional effort, interest, scientific explanations are needed to make such a process fruitful for the co-ordination of the co-operation between professionals from different countries in the field of arts therapies' development.

To promote such process two different types of professionals and their working areas should be pointed out. First, specialists with professional education and qualification (possibly who are/will be part of the regulated health care system); second, specialists from different areas and people who are interested in using methods and techniques of arts in their main work, for example, assisting personnel and those from the field of education – pedagogues, psychologists, psychotherapists, social workers and even artists (who possibly might develop the idea about the therapeutic art – a belief that arts and their creation have a healing effect from the emotional and physical point of view, because the process of creation promotes the improvement of psychical state). Support of such professional activities is very important and welcomed. Psychologists and pedagogues, and social workers who use methods and techniques of arts in their professional practice gain good results (Kopytin, Svistovskaja, 2007; Martinsone, Mihailovs, Vaverniece, 2010).

In order to promote the development of the profession and professional identity, the separation of arts therapists from specialists who use arts in their professional practice took place in the USA and the UK during the 80/90-ies of the 20th century (Karkou, Sanders, 2006). Such terms as "arts therapies" and "therapeutic arts" as well as "methods and techniques of arts in professional practice" have been separated in Latvia (Martinsone, Mihailovs, Vaverniece, 2010; Vaverniece, 2011). Research of literature indicates that related issues have been discussed in Russia (Kopytin, Svistovskaja, 2007) and in a slightly different context in the Netherlands (Smeijsters, 2009a). This leads to the deduction that these questions are topical in the countries

where arts therapies have a separated status as professions, have their research approaches, practice fields etc.

Although arts have been used in different contexts of professional practice, the methods and techniques of arts, their aims, tasks, the environment and status are different. The process and results of work with clients/patients and also the responsibility about the co-operation process and results differ, because every professional field applies arts upon different context. Methods and techniques of arts can be applied in diverse ways by different specialists, according to their acquired education, specialisation, qualification and professional field. The development of arts therapies in different countries shows that the recognition of the profession of arts therapies can be reached with the differentiation of professional fields and by defining the boundaries of professional practice and responsibilities. Doing so, also legal regulation takes place which has direct influences on the content and character of professional relationships as well as on the promotion of professional (self) regulation, self-government and representation of interest.

A different answer to the question – what is the identity of an art therapist according to examples from other professions – would be to develop strong international organisations. Already in the 20th century *ECArTE* was established, and one of its tasks is to promote the development of education in arts therapies. Its members regularly organise conferences in different European cities as education is the first step on the way to professional identity. Here the basics of the understanding are created about one's personality, its features, as well as the intention about the professional carrier. This points to the need of guidelines for the content and length of arts therapies' education in Europe, for instance, thus serving as a crucial investment for the development of the profession and herewith also the professional identity (Martinsone, Mihailova, Mihailovs, 2008, 2011; Martinsone, Vaverniece, Paipare, Mihailovs, 2009).

Despite the fact that the establishment of a common space of arts therapies education in Europe is taking place, for example, the Process of Bologna and gradual harmonisation of national educational programmes in Europe, over a 15-year-period of the *ECArTE* ECArte (http://www.ecarte.info/) there has been no success to establish common guidelines for arts therapies education which would also serve as basis for study goals and results. The lack can be explained by quite radical difference in the sense of professional identity, set by the leaders of professional education training programmes, the difference of the policy and system of education in various states in Europe.

The development of professional identity, a constant part of professional activity, can be strengthened by further education (also regular supervisions) and influenced by social (working) environment, membership of professional organisations, ethics and also standards of professional practice. Another important aspect is the ability of sharing the experience, to show the diversity of beliefs, attitudes, approaches and

methods which provide the possibility of exchange and enrichment, for example, also at international level which is one of the aims of the summer school in Latvia.

At the international level, specialists who work with music therapy are united in the European Music Therapy Confederation (EMTC). This organisation was established as a forum for the experience exchange for professional music therapists. EMTC unites members from 28 countries with the aim to promote further development of music therapy practice and exchange (http://emtc-eu.com/).

In 2010 the European Association of Dance Movement Therapy (EADMT) was established. National professional dance-movement therapy associations are represented there, working actively to promote further development of professional practice and legal recognition of the profession. The EADMT assures and promotes the quality of dance movement therapy practice and trainings for the protection of clients, professionals and institutions (http://eadmt.com/).

In October of 2011 serious work was started at the development and establishment of the European Drama Therapy Federation. The status of the federation has not been recognized yet (at the moment when the article is written). The draft of the aims of the Drama Therapy Federation state: (1) to strengthen a clear position of drama therapy in Europe; (2) to investigate and respect the standards of drama therapy practice and the Code of Ethics in the countries where drama therapy specialists work; (3) to be as the informative source and the impulse for the exchange in the field of professional drama therapy; (4) to gather the information about the empiric researches of drama therapy in different countries (5); to promote professional development of drama therapists by co-operating between the countries which are members of the federation; and (6) to promote the exchange of the information regarding different criteria in each country thus being able to practice as drama therapists. These are very clearly defined aims for the common development of drama therapy professional space in Europe.

Unfortunately, arts therapists until now do not have any uniting international organisation with the aim of promoting co-operation and establishing a platform for discussions in broader professional field.

It should be stressed that the co-operation in the framework of different international organisations allows arts therapies' professionals to learn form each other and the language of the specialists from other arts therapies specialisations. Both languages involved in the process of arts therapies should be clear – the language of arts and the language of therapy. Another important aspect of effective communication is the exchange between the colleagues, specialists from other professions and with clients/patients.

The above mentioned lets us conclude that the culturally-historical and socially-economical background has been different for any of the four arts therapies speciali-

sations. It might lead to an idea that no common understanding and professional framework in general is needed. Possibly, strong local professional organisations are enough to take care, to protect professional, economic and other interests and to promote professional activities (supervisions, conferences, further education, seminars, training programmes and workshops) which strengthen professional identity. But such approach would promote segregation and isolation which nowadays, in the situation of high mobility, are not acceptable. With ignorance of experiences of international colleagues, it is not possible to gain excellence in one's own country.

Herewith, strengthening of professional identity and further development of professional competences are and will stay as one of the most important arts therapies' tasks, including making partnership bridges between colleagues from different professions, other arts therapies' specialisations and also clients/patients in various environments. As long as there is weak understanding about arts therapies' possibilities and services in society, there is a risk to remain without the acknowledgement from a broader part of society. These issues are also connected to finances, especially from the state and local governments.

Research in arts therapies

To promote the sustainability of arts therapies, the recognition of arts therapies services and their requirement in the society, to promote self-identification and do successful co-operation with specialists from other professions and fields, an art therapist can not avoid research. An important part of professional practice nowadays is evidence-based practice; thus such approaches have been developed which are oriented towards practice-based evidence.

Evidence-based practice is a political and social phenomenon, and the development of it is closely connected to the guidelines in social, health, legal and educational fields of particular countries. It is a cycle of activities for striving to guarantee that all intervention is based on the application of best evidences (available research data) by integrating the context as well as knowledge of a particular specialist, individual clinical experience, needs of clients/patients and the results of previous clinical research. According to these aspects the intervention can be clinically and economically effective (Bowling, 2002; Gilroy, 2006). Practice-based evidence has led to the belief that the experience and intuition does not provide the so-called *good practice*. The practice has to be based on research, which is repeatable and objective.

The "traditional paradigm" in health care depended on knowledge about the reasons of the illness, actions for prevention and treatment, but the new paradigm (based on evidence-based practice) requires also the investigation of the treatment results. It means that nowadays specialists, who are oriented towards good practice, can not ignore research as part of the practice. The "traditional paradigm" with highly evaluated stan-

dardised approach, and where it was enough with the clinical experience and authority for setting the diagnoses and treatment, is not valid anymore (Richardson, 2001).

The development of evidence-based practice in professional practice demands knowledge of the types of evidence and their hierarchy levels (for example, in Latvia the hierarchy levels and research types according to them have been defined by the requirements of the Cabinet of Ministers as of 25th May, 2010 No 469 "Order how the clinical guidelines are worked out, evaluated, registered and introduced". These terms refer to particular clinical actions which include diagnostic, prevention, treatment methods, the time of the observation, rehabilitation). In other words, the particular specialist should have competences in the research methodology, should be informed about research strategies and broad spectrum of research designs with the context of gains and limitations for each of them.

The attention should be paid to the evidence-based practice also as a subject of discussions. Although it provides obviously effective and sufficient evidence, not for all researches the frame of the evidence-based practice can be applied.

By identifying the levels of the research (for example, Ball et al,. 1998; Mace, Moorey, 2001; Ecclos, 1998; Parry, 2001, as cited in Gilroy, 2006) the *golden standard* is named as *systematic reviews* which are designed according to the precise and unbendable criteria and to the criteria of the expenses (expenses are important criteria for the choice of the *value-driven health care*), which includes *randomised controlled trial* (RCT) which is characterised by objective and experimental approach. It means that an ideal researcher is an observer: he creates a design of the experiment and does observation without any interpretation about what is happening. Then the treatment results are fixed by particular measurement which does not provide any place for the interpretation or suggestions and the treatment (medication) is precisely defined (standardised). Herewith, in the paradigm of evidence-based practice the *randomised controlled trial* becomes a research design with more privilege in comparison to others, especially to qualitative research and to the process orientated researches, but actually switches off enormous amount of knowledge (Martinsone, 2011b).

This approach is very effective for pharmacological researches and has encouraged debates if evidence-based practice is appropriate for professions where there are no classical biomedical models and research methods. The concern is whether such standards and criteria can be applied for research and practice also in other fields, because in the linear way and in the way of causal relationship understanding the interventions can not be evaluated, as they are related to social relationships, experience, trust, human interactions etc. Here the patterns and features are not always possible to divide in measurable components (Mace, Moorey, Roberts, 2001; Gray, 2004; Gilroy, 2006; McGloin, 2008). It means that evidence-based practice is focused on the treatment and results and not on the promotion of the understanding about, for example, complicated situations in the field of mental health, and the

context, and social or cultural factors (Schmiedebacka, 2002). Eventually evidence-based practice creates winners and losers: winning are particular patients or groups of illnesses or diagnoses better matching the centralised diagnostic criteria, but there are problems in the situations which are complicated to investigate according to the principles of evidence-based practice.

In arts therapies therapeutic relationships and the creative process have a very important role, so we see that the orthodox paradigm of evidence-based practice is hard to apply here or more precisely – it narrows the approach of researches, motivating a researcher to investigate the disturbances (Smeijsters, 2009b), and so to disregard arts and the therapeutic relationships.

Even though evidence-based practice is a discussable paradigm, the debates about its essence and influence have been described in literature of social and health care as well as in educational and legal branches. It has influenced research and practice by demanding safe, effective and economic approaches in the particular professions and regular reviews of the practitioners about their practice to be able to adjust it according to the latest research results. It has to be admitted that evidence-based practice has a potential to develop and provide an objective base for a good and effective professional practice in different sectors, including also new and creative practices such as arts therapies (Gilroy, 2006). But before arts therapists engage themselves in the discussions about the adequacy of evidence-based practice, they have to be clear which professional group they belong to – their identity and competence should be clear (because the understanding of evidence, types of evidences, their gains and interpretation is defined also by the profession (its connection to the scientific field).

It is possible that difficulties of arts therapies standardisation based on evidence-based practice is the weakest point, but the therapeutic process has its importance, because arts in their nature are playful at a particular level and also unpredictably have a quality to awake new and also old situations, actions and feelings promoting work for the patient's welfare and better quality of life.

Second aspect which is important in this context is another tendency in the research field – towards the development of practically oriented knowledge without pointing out the levels of evidences, but establishing the dialogue between different levels – it is the motivation to get *practice-based evidence,* which improves, renews and develops professional competences in practice. In this case the practice and research both are based on the problem which has to be researched. It means that also from the practically thinking practitioners the expectations exist that they will systematically do a review of their practice.

All this leads to the point that from a trained specialist, also an art therapist, it is expected that he not only will count on his sensations that the therapy process is developing *well enough*, but he will also become a practitioner which builds up

his own approach by checking what is appropriate and what is not. In other words, he will work on the development to transit from reflecting practitioner to the scientific practitioner to connect the working models (theories with the small "t") from practice with scientific evidences (Theories with the capital "T"). It is the basis and the field for indirectly expressed knowledge to be converted into clearly formulated knowledge which can and would be analysed, combined, developed und improved by integrating with knowledge form other specialists, theoretical statements and aspects from other researches (Smeijsters, 2009a)[2].

Thus, it can be claimed that research promotes co-operation of specialists and their linking up in the context of practice, because professionals who are exposed to similar problems in their work do co-operate to exchange knowledge, develop it. It also helps to strengthen one's professional identity and further development of professional competence.

This, however, leads to the conclusion that researches are important for the gain of a specialist to be able to justify his professional practice, the applied methods and also for the development and verification of concepts and theories with the additional value of the investment in the development of science and herewith – to improve services of health care and promote the diverse professional co-operations (also in the research field) individually and in multidisciplinary team. Even more – it should be admitted that art therapists do not have another choice to be able to promote the development of the profession and its prestige as to be a part of evidence-based practice by confirming that their practice is based on researches and other forms of evidence (but it should be done with full understanding of principles and politics where evidence-based practice has its place) (Gilroy, 2006). Another task is to generate the research in practice to create a transparent, effective and highly qualified performance (Smeijsters, 2009b).

It means that art therapists have to do researches, because these are basic conditions for the sustainability and development of the profession as well as for the identity of a specialist and to have a valid reason for the choice of therapeutic methods. This again leads to the question which group of professions arts therapists belong to. Although art therapists always have stressed the interdisciplinary roots of arts therapies as a precious resource, such viewpoint can disturb the strengthening of professional identity and precise formulation of problems, indications, aims, interventions and logical evidence which can be the reasons for not a smooth development and identification of arts therapies.

[2] De Bie names action models as "t" theories. Each professional has his own action models, which are adapted to the problem fields the particular professional practices with. These action models have proved their suitability to the practice. In opposite to the theories with the small "t" exist also theories with the capital "T" – scientific ones which offer explanations in abstract level as well as empirically proved hypothesis. These theories are approbated (by summing) in different models [Smeijsters, 2009a].

Assessment, aims and arts therapies process

By setting the third question in the middle of the attention – about the process of arts therapies – contradictions are there, precisely – several questions can be interpreted differently. Arts therapists with their working methods practice in different environments with different clients/patients and with a broad spectrum of problems. It means that the services, according to their content, and also the payment are different. For example, the work of an arts therapist in a multiprofessional team (which might mean financial support from the state and also accomplishment of clear requirements and regulations of particular normative documentations etc.) vs. the work in private practice (with the main problem of positioning, attraction of clients and the big individual responsibility about one's work). Arts therapist has a choice to manipulate with different (arts therapies) languages how to describe the reality, the working process, how to communicate with other colleagues and other arts therapists. The choice of this kind of language and its character has been defined by professional identity and sense of belonging to the particular profession (it is clear that the way of the description of the reality in the context of health care profession differs form the way of communication in educational environment etc.).

One of the potential difficulties in professional practice of an arts therapist can be that he/she is better at one of the two main branches (according to his education) – arts or therapy language. It is clear that part of everyday reality for an arts therapist is within arts materials, observation of dynamics etc. But there is a point when he chooses the criteria for the evaluation of the forms and content of the arts which are created by clients/patients. If the description of therapeutic process stays at the level of language of arts, colleagues, especially in health and social spheres, can be unsure about understanding the arts therapist appropriately. Contrary – if just medical terminology is used, the artistic content and the contexts of the creative therapy process can suffer. Here the question arises how to keep the balance between the nonverbal language and such everyday expressions of clinical environment as instructions, regulations, templates, observation systems, indications etc. It is also important to be aware how to apply different thinking models which might help professionals to think and have the realisation of their practice.

Therefore, a relevant question in arts therapies – how to translate one's experience, knowledge, process and results of particular work (partly nonverbal) into the environment of professionals, for example, to the members of a multiprofessional team in the rehabilitation or to a broader society – clients/patients etc.– by keeping awareness about the entire process of arts therapies and its specific aspects – assessment of the problem (possibly in a team), formulation of possible results, setting aims and making agreement with a client on therapeutic aims, realisation of arts therapies' process by using particular interventions and conducting the evaluation.

Further explanation of the issue will follow without setting all stages of the process of arts therapies, but by taking just one part of the process as an example – the formulation of aims of arts therapies, because this is the stage which shows how the arts therapist sees the client/patient and what he/she plans to do – because there is a strong connection between the aims, indications and results (we see that the formulation of the aims is closely connected with the previously discussed questions about the identity and research of arts therapist). So how, and what aims do arts therapists set? And if/what differences in these formulations are there in comparison to other professionals?

Indisputably, the theoretical arguments are very multiform. That is the strong and weak point of arts therapies at the same time. The strong one due to arts therapists proving the possibility of integration of different views and thinking directions. But at the same time it shows that arts therapies have tried to build the connection to theoretical models throughout several decades; however, theoretical ground and volume for arts is missing.

It is known that theoretical basis for arts therapists and the framework of professional practice (besides the understanding of the application of arts and creative process) comes from psychology and psychotherapy (and we know that each of them uses different and specific language, by proposing different worldviews as well). For example, in one case, if a specialist radically comes from the humanistic approach, his motto will be: "Go, meet the human (being)!", and the question about the assessment procedures to set the aims will be not needed. It this case the formulation of the aims will include such words as self-expression, growth etc. If an arts therapist looks at the world trough the psychodynamic perspective, the focus will be turned to the functioning level and the structure of the character. Here the focus of assessment will be the transference and contra-transference and the analysis of the creative process and its results. But if one's experience is connected to the cognitive-behavioural approach, most possibly that as the aim of arts therapies will become the work for reduction of some specific symptom etc.

If an arts therapist works with a particular patient in clinical environment (and the patient has a diagnose according to the ICD-10/ DSM-IV or the International Classification of Functioning, Disability and Health (ICF), it means the requirement of usage of particular terminology according to the therapeutic framework of the medical context), then the arts therapist might be a part of the multidisciplinary team which means that psychological (or free) formulation of aims for the treatment will not promote good co-operation with colleagues. It might even prevent the entire process by giving space for doubts about competences and place in the team of such arts therapist.

In the treatment of medical problems and setting the aims, arts therapists might focus on physical problems which are in accordance with medical ones, or make the accent to reduce such medical problem (reducing the complaint of the patient) if he is not able to provide a base (also by using researches) about a broader view

to a person (that medical problems can be caused in a direct and also in an indirect way) which means that the attention to difficulties (created by particular disturbances) and solution of them, also the solving of the prior problem is promoted.

If an arts therapist works in clinical environment, the broad view will get under some pressure most possibly, because in such team work aims which are orientated to the symptoms are more welcome – with a direct way to the diagnose, set by doctors. (If we look at the previous topic of evidence-based practice, we see that evidences are of the highest level if research methods are used to investigate symptoms).

One of the leading arts therapies' researchers in the Netherlands, professor H. Smeijsters, suggests a rational approach to the aim setting (2009a) – to sort out the primary aims (how to influence symptom/problem which is directly connected to the disturbance), secondary aims and tercial aims (indirectly pointed to the problem). Taking over this experience, arts therapists in Latvia, similarly as other functional specialists (physiotherapists, occupational therapists, speech therapists etc.) are informed about the classification, used by doctors, and they have learned to apply the approach of the ICF. It means during training and also at work in clinical environment, an arts therapist uses this division of three levels for the formulation of aims. It means secondary and tercial aims are formulated according to the ICF, because this frame helps to understand each other. Also from the point of view of the content, this classification looks at health problems in the context with everyday life with the concentration on the quality of life and participation (Upmale, Majore-Dusele, 2011).

Possibly that as more arts therapies will root in health care system, more directly specialists will address diagnoses with the ability to adjust to the logical causation of the diagnoses and the view to the treatment, possibly even more – developing an understanding, focused on symptoms. In this case in the centre of the attention would come a particular problem more, not the person. We have to conclude that although a common classification helps to gain an equal relation to patients, the standardised formulations also include diversity of human needs. Very often it is needed that the professional could develop his understanding during the treatment process about the patients' needs and possibilities by also changing the formulations according to the dialogue between the professional and the client/patient. It means that the chosen therapeutic approach can include the possibility of some aims which are not directly connected to the problem and in the formulation – therapeutic framework – a connection should be found between the treatment aims (primary), secondary and tercial aims and the problem. Therefore, it is important that arts therapists can choose models of their work, achieve focus to the problems which get visible in arts, and apply integrative methods by choosing broader perspective with the acknowledgment that arts therapies touch also such aims which promote awareness, help to clarify, to express and to regulate the emotions, improve communication, develop cognitive skills and behavioural patterns etc. If needed, the attention can be paid

to arts therapies' methods which provide the development by trying to influence the problem in an indirect way (towards the development oriented working methods an arts therapist often concentrates on the client's abilities, creating conditions that the client is in the centre without his problems directly). It is possible to put client's life as the scope of focus using the method (Smeijsters, 2009a).

We can conclude that arts therapists have potential for a broader view to a persona, to skip one-dimensional theoretical and ideological assumptions and to concentrate on different aspects if it is relevant for solving the problem. It is important to demonstrate that aims for arts therapies' process will be promoted by getting well of other clients and it is also important to have professional clinical evidence of it.

It must be admitted though that nowadays' science has no ambitions to create the ideal theories; even more, there has never existed one ideal approach. It is rooted in the age of the Enlightenment and its ideas of the universalism. Its relevance today can be traced in the need "firstly to skip the myth about the equality of theoretical homogeneity of knowledge. It means declining from deep conclusions (and hopes), from thinking of the age of the Enlightenment, which is included in the statement as the one which is comprehended as real, is also an arranged and systematised world which is (potentially) equal for everyone" (Shotter, 1997; 69–70). Thus, the possibility to gain universal *overknowldge* must be denied.

Yet, it has to be mentioned that particular environment always makes pressure for the usage of particular language, principles of collegiate co-operation can be taken into account etc.

Conclusion

For the development of professional identity and competences for an arts therapist as well as self-positioning, there are important features to take into account to start a successful professional practice and continue with different client/patient groups. It means that arts therapists themselves (in several cases by overcoming the routine, tendency to the introversion etc.) would have to involve in the development processes of the profession, because their personal input is important for the general and also specific (for particular country and environment) arts therapies' development, and in the context of services.

Another important point of discussion refers to the familiarity of the profession; if the profession is not visible enough in the communication with the state, employers, social partners etc, and there is no common educational system, such profession will not be fully recognized and understood (it means also complications in co-operation with other colleagues, and it may not be requested by clients/patients).

This is the moment when arts therapies in Latvia have concluded their first crucial stage of development (from several activities in the groups of people who are

interested in arts therapies to health care professionals with regulations and education at the level of Master's degree). This is the stage when the attention should be paid to such issues as professional identity, professional practice and research as well as aspects of international co-operation. These are the tasks for arts therapies in the nearest future, and with a big importance is the aspect of involvement of new arts therapists who just start their professional career. New impulses are very important for the development of each profession at the same time with the balance with ideas which are based on the experience in practice.

The result of the Summer School, the collection of articles, is a step closer towards the co-operation and research which can be continued to ensure the recognition of arts therapies, establishing the role of art therapists among other specialists and identifying what role they will have in the treatment process. Additionally, if there is a view at these professions as effective tools for treatment, it must be defined what will the place of arts therapies among other therapies be, and a not less important aspect – what will the working possibilities and salaries of arts therapists in the international working context be. A broader viewpoint makes professionals be aware of further development stages of arts therapies in Latvia, in Europe and worldwide.

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II. ART THERAPY WITH DIFFERENT CLIENT/PATIENT GROUPS

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ART THERAPY APPROACHES TO WORK WITH PEOPLE WITH DIAGNOSIS OF SHIZOPHRENIA

Abstract

This paper briefly situates an understanding of the diagnosis of schizophrenia within the history of mental health care. Throughout history to the present time there has been a range of evidence showing the social economic poverty of the majority who receive the diagnosis. Explanations of psychosis are best provided by people who have been through the experience: some of their stories are briefly told together with what it is possible to learn about an art therapy approach to working with people with this diagnosis.

An indication is offered about what the literature and the evidence so far suggests about an adapted *specific* arts therapies approach for people with a history of psychosis.

Keywords: history of attitudes to madness; historical circumstances influencing treatment; recovery models; art therapy history; art therapy adaptations for people with a diagnosis of schizophrenia: Matisse RCT and NICE guidelines on Schizophrenia.

Introduction

One of the paintings made by a man in an art therapy group with me is called "Large pike and little fish". It depicts a large fish chasing or certainly considering chasing a much smaller fish. This artist's life has been difficult; consequently he has had contact with psychiatric services over many years. His painting comes out of his love of sitting on the bank of a river while fishing with a rod. I think it also shows his feelings about being "a small fish" that swims uncertain of the safety of doing so alongside the big fish or "large pike" of psychiatry. The painting suggests that there are worries about the power of psychiatric services. This is the tension that has existed in various forms throughout the history of schizophrenia.

History of attitudes to madness

Prior to the French Revolution, it was common throughout Europe and America to treat people who went mad as though they were animals. A visitor to the York Asylum in 1814 (not the York Retreat) discovered a series of small cells: "In a very horrid and filthy condition … the walls were daubed with excrement; the air-holes, of which there was one in each cell were partly filled with it" (Warner, 1985; 102). This unpleasant environment resulted from a belief that once someone had succumbed to madness they became insensible to ordinary human distress.

Charles Dickens recorded that the old asylums provided "coercion for the outward man, and rabid physicking for the inward man. Chains, straw, filthy solitude, darkness and starvation" (Dickens, 1850–1859, in Stone, ed., 1968; 381–391). "Filthy solitude" still describes the experience of many people diagnosed with schizophrenia living in the world's cities. Similarly the potential for "coercion" and the use of medication as a form of "rabid physicking" are topics much spoken about by Service Users today.

Hogarth's cartoon of Bedlam (in the series *The Rake's Progress,* 1735) is satirical. It shows two well to-do women making a tour of the hospital, implying that "mad" people were visited and viewed like animals in circus. Nevertheless, the engraving provides a sanitised impression of what must have been squalor. Similarly, the painting by Fleury (1876), one hundred years after the French Revolution, *Pinel loosening the chains* seems to offer a domesticated version of terrible conditions in the Parisian hospital for the insane, Salpêtrière. From the early stages of the French Revolution, the ideas of the famous psychiatrist Pinel led to lasting improvements in the care of mentally ill throughout the world.

In England the Quaker family (the Tukes) were influenced by Pinel who advocated treating the person diagnosed as insane with care and kindness. Tuke's book (1813) refers to Pinel's *Traité Medico-philosophique sur L'Aliénation Mentale* (1801). The phrase "traitement moral" has been adapted from this work but it is not well translated by the phrase "moral treatment". Pinel's phrase translates more closely as "treatment through emotions" (Jones, 1996; xi).

Belief in the possibilities for engaging with the patient's *own* agency was epitomised in the methods used by the York Retreat. William Tuke's daughter-in-law gave one of the descriptions of the Retreat that does most to convey the quality of its work. She suggested the name Retreat as opposed to a Hospital or Asylum. She wanted to describe "a quiet heaven in which the shattered bark might find the means of reparation" (cited by Kathleen Jones, 1972).

The principles advocated by Tuke are powerful and have provided the historical foundations for the work of many mental health professions including arts therapists.

"I By what means the power of the patient to control the disorder is strengthened and assisted?
II What modes of coercion are employed when restraint is absolutely necessary?
III By what means the general comfort of the insane is promoted?" (Tuke, 1813; 139)

In Tuke's lifetime, the methods developed at York Retreat were widely adopted in several countries and by many interpretations seen as successful. However, Warner (1985) indicates that despite their success in Britain and America, the methods of moral treatment gradually fell into disuse during the second part of the industrial revolution.

Strange ideas about insanity continued to occur occasionally, such as those in physiognomy which proposed that it is possible to see the shape and evidence of madness in a person's face (see Figure 1).

Figure 1 *Monomania with love and monomania with depression. Images cited in Vieda Skultan's (1975) 'Madness and Morals: Ideas on Insanity in the Nineteenth Century'. London and Boston: Routledge & Kegan Paul, pp. 71–78. Skulton refers to Alexander Morison's 'Outlines of Mental Diseases' (1824).*

Additionally, vestiges of prejudicial beliefs about people who have episodes of insanity have persisted throughout the world. In Britain the *Ordinance of Labourers* of 1349 distinguished "sturdy beggars" who were considered as fit for work form the "deserving poor" who were not considered fit because they were either ill, or too young or old. Anyone found helping a sturdy beggar the work to avoid as by providing food or charity they risked imprisonment. This distinction survived and was repeated in the Poor Law of 1834 in which the deterrent of the workhouse was introduced. It is possible to uncover the problematic distinction between notions of the "deserving" and the "undeserving" in all subsequent attitudes, policies and legislation concerning "provision" for the poor, the unemployed, and the insane (Wood, 2001).

The image of the dreaded workhouse (see Figure 2) makes it possible to understand why people wanted to avoid its strictures.

Figure 2 *London Workhouse circa 1900*

Yet increasingly the pressure of the Industrial Revolution meant that the inhabitants of the workhouse were needed for the production lines of the new factories and so gradually the old workhouse buildings (see Figure 3) were given a different purpose and used as mental hospitals. Interestingly in Foucault's historical analysis (1967) those people who occupy mental hospitals are said to be those who will not work.

Figure 3 *Headington Workhouse Oxford later becomes a hospital*

The picture by Gustave Doré *Over London by Rail*, c. 1870 and other images by him about the Industrial Revolution indicate the massive social changes that resulted from industrialisation, with large sections of the population moving from the country to crowded living conditions in cities. Images of children working in factories (see Figure 4) echo the image of people lined up in the workhouse and they indicate something of the ways in which the classifications of people are linked to their socio economic status. Sadly, when efforts are made to invoke a more scientific scrutiny for psychiatry, the economic realities of clients' lives are often overlooked.

Figure 4 *Child labour Industrial Revolution*

Towards the end of the nineteenth century a more scientific approach to psychiatric diagnosis began. Classifications for what we now know as schizophrenia were developed by Kraepelin.

"Few psychiatrists since Kraepelin… found the course of schizophrenia to be so malignant as originally portrayed. As Kraepelin's classification was adopted around the world, nevertheless, so was the impression that the illness was inevitably progressive and incurable. To varying degrees the same view holds sway today — that without treatment the outlook is hopeless — despite considerable evidence to the contrary" (Warner, 1985; 13–14).

Historical circumstances influence all mental health treatment philosophies

The author of the article has conducted a number of literature reviews which focus upon explanations of how circumstances of a historical period influence the shape and course of disorders and forms of treatment that emerge (Wood, 2011b). There are

different but powerful explanations of the ways in which historical forces influence treatment in works like that of Doerner (1969) and Warner (1985). There is also contemporary epidemiological research which shows similar phenomena in both physical and mental health (Wilkinson & Pickett, 2009; Marmot, 2010).

It is often surprising for people working in mental health to realise that treatment philosophies in the field concerned with emotional and psychological health are strongly responsive to external historical forces.

For many people throughout the world, the French Revolution generated enthusiasm that led to world wide improvements in the treatment and conditions of psychiatric patients as moral treatment was implemented. The Industrial Revolution saw some earlier reforms lost: the moral treatment movement succumbed to the pressures of large movements of population. Former workhouse buildings became large mental institutions for people who had little chance of finding work in the new factories. After the horrors of World War Two there was relief, hope and a reforming zeal which led to the development of Social Psychiatry. The Opec Crisis which started at the end of the 1970s saw the World Bank insisting on cuts to services, initially in Britain. This meant that mental health reforms such as community care were not properly implemented. Contemporary external forces are wide ranging and difficult: wars, diaspora on a huge scale, and the dwindling proportion of GNP (Gross National Product) available for services have all had impacts on mental health and its treatment.

One striking illustration of this within the field of schizophrenia shows the links between rates of recovery with average unemployment rates in the USA and the UK during the four periods of history of the twentieth century (Warner, 1985; 72), (see Figure 5). Warner's remarkable work shows how recovery rates drop dramatically during periods of economic recession and then improve with the fortunes of economy.

Admissions	Complete Recovery %	Social recovery %	US Unemployment %	UK Unemployment %
1901–1920	20	41	4.7	3.5
1921– 1940	12	29	11.9	14.0
1941–1955	23	44	4.1	1.5
1956–1985	22	45	5.4	2.7

Figure 5 *Correlation of recovery rates in schizophrenia with average unemployment rates in the USA and UK during four periods of twentieth century history (Warner, 1985; 72).*

Some of the Recovery Models during the history of the diagnosis

Despite pessimism that often follows in the wake of a diagnosis of schizophrenia, there has been a recurrence of recovery models for its treatment during the history of the condition. These have included: the emergence of moral treatment following the French Revolution, in the work of Pinel and the Tuke family.

Prior to the turn of the twentieth century, Eugen Bleuler renamed the disorder as schizophrenia. This removed the connotations of inevitable decline implied in the term coined earlier by Kraepelin of "dementia praecox". Eugen and Manfred Bleuler, father and son, were both advocates of the reform (Barham, 1995). They aimed at providing careful attention, kindness and normalcy for clients with a diagnosis, enabling many to live in the community. Throughout twenty years their practice and research provided positive results. Their approach to recovery seemed to develop out of the relative calm of a Swiss Mental Hospital in need of reform.

The social psychiatry perspective developed throughout the world after the Second World War and strengthened during the social and political upheavals of the late 1960s and 1970s. This model considers the relationships between individuals and society and the ways in which people's attitudes, values, and behaviours are acquired, organized, and changed through social interaction, social influence, and the social construction of knowledge. The model tries, where possible, to evade explanations relying on ideas about individual pathology alone.

As economic conditions became more complex during the OPEC crisis (1973), the World Bank told the Wilson government to cut public sector spending and as a result a social psychiatric perspective diminished in Britain, even though the ethos was retained in many European and all Scandinavian countries.

Although it is hard to ignore the socio-economic circumstances that shape a client's life, it is unusual now to hear these discussed routinely in psychiatric teams in Britain. There is research evidence to suggest that rehabilitative efforts during the periods of social psychiatry (the 1960s and early 1970s) were successful (e.g. Warner, 1985; Cook & Wright, 1995; Fryers, et.al 2000; Rutz, 2006). Art therapy in Britain (at that time in its second historical period of development) became established during the era of social psychiatry.

The psychiatrist R. D. Laing had a marked influence on psychiatric practice in the last years of the twentieth century. He

"... took the problem of human suffering seriously, though he approached it with humour. His work at the Tavistock meant that his criticisms of some of the more reified aspects of psychoanalytical relationships were well informed. He suggested that there could be more democracy in therapeutic relationships and this may have appealed to art therapists who were working at the time" (Wood, 1991; 177).

He wrote about the plight of people diagnosed as schizophrenic. International sales of his books were very high over a long period — particularly *The Divided Self* (1959) and *The Self and Others* (1961). Although he made no claim to offer "a comprehensive theory of schizophrenia" (Laing, 1959; 9), or to recommend forms of therapy for people with psychoses, he, nevertheless, advanced insightful ideas about psychotic experiences. His descriptions of the forms which can be assumed by psychotic despair "engulfment", "implosion", and "petrification" are helpful.

Some in the psychiatric establishment saw Laing as proposing the non-existence of madness. This is a persistent misconception, which may explain the force of the reaction against him. Yet Laing himself made only the modest claim that it is "far more possible than is generally supposed to understand people diagnosed as psychotic" (Laing, 1959; 11).

Richard Warner's (1985) seminal text *Recovery from Schizophrenia: Psychiatry and Political Economy* and his subsequent untiring work in favour of a recovery model being both evidence based and feasible has provided a strong impulse for optimism.

"The recovery model is a social movement that is influencing mental health service development round the world. It refers to the subjective experience of optimism about outcome from psychosis, to a belief in the value of the empowerment of people with mental illness, and to a focus on services in which decisions about treatment are taken collaboratively with the user and which aim to find productive roles for people with mental illness" (Warner, 2010; 3).

This impulse towards a recovery model has been grasped and developed by Service User movements in a number of countries. They include a range of Service User campaigns against stigma, prejudice, and discrimination. For example, there is often a media-led anxiety about people with serious mental disorders living in the community. User campaigns cite statistics that demonstrate the level of media over-reaction. "From 1957 to 1995, during the period of deinstitutionalisation, the proportion of homicides committed by people with a mental disorder actually fell steadily from 35% to 11.5% according to home office figures" (from MIND: Sayce, 2000; 33).

The *Voices Movement* began in the early 1990s in the Netherlands and it has been a positive force for change. It challenges explanations of the phenomena of "hearing voices" and it works in a number of countries to establish networks of users who can support voice-hearers through self-help groups. Its demands are clear. It is not "anti-psychiatry", but it does ask for a more judicious prescription of medication, more psychological intervention, and professional support in establishing self-help groups.

Service User Movements make it difficult to dismiss the concerns of the millions throughout the world who succumb to psychosis and other forms of mental distress. Increasingly, research and service representation cannot overlook the voice of the user and it is increasingly advocating for recovery models.

In countries that spend a greater proportion of their GNP on health, social psychiatry approaches have continued. Pilgrim and Rogers (2005) suggest that the prospects for social psychiatry approaches in Britain remain challenging. They wryly summarise the ideological tensions at play:

"A more optimistic scenario would require concessions on both sides. Psychiatry would need to admit its lack of reflexive capacity to understand its own theory and practice, as contentious socio-political phenomena. This would mean a re-engagement with debates about the role of psychiatry in society and the profession's reified diagnostic categories. In this respect the newer "critical psychiatrists" who have not been ready recruits to the traditional cause of social psychiatry, are likely to play a central role. Sociologists would need to rediscover epidemiology and shed the anti-realism of post-modernism. They may discover that it is possible to be empirical without necessarily being empiricist" (Pilgrim and Rogers, 2005; 319).

Four Periods of Art Therapy History

Not surprisingly, the impact of external historical forces is also seen in the development of art therapy. The author of the article has written about this in relation to the work of British art therapists with people with a diagnosis of schizophrenia (Wood, 1997a) and in relation to the development of the profession in general (Wood, 2011a).

In the 2011a research edition each of these periods has been characterised as a way of trying to identify the beliefs and the historical circumstances which had had an influence. The first period sees the belief in art and the healing power of expression in the relief following the World War Two (1930s–1950s). The second period is formed from ideas in social psychiatry and its anti-psychiatry influence that grew out of social questioning that came with the confidence of a stable economy (1960s–1970s). The third period developed knowledge of psychodynamic theories based on psychoanalysis with a notion of the unconscious and the centrality of the therapeutic relationship, an inward gaze seemed to be the response to the difficult economic period (1980s–1990s). The fourth contemporary period has been developing from the beginning of this century (from 2000). The contemporary period seems to be one in which what has been learned in earlier periods is being woven together and used in efforts to adapt practice in ways that are effective. Efforts are made to adapt to the circumstances of services and client lives (BAAT AGM, 2010). Arts therapists are increasingly aware of research evidence in their own (Gilroy, 2006) and in related fields through the development of strong research networks (ATPrN in Britain and the International Research Coalition). Additionally, there are signs of increasing international cooperation between arts therapies with professional journals becoming international and professional literature taking an international perspective.

Adaptations relevant to a diagnosis of schizophrenia

Theories of the unconscious can help in thinking about the overwhelming experience of psychosis, which one client described "like dreaming whilst awake". Psychoanalytic concepts may help in acknowledging the nature of the anxiety and terror generated by a psychotic episode (Wood, 1997b) and the concept of "containment" (Winnicott, 1954 and 1980) is particularly relevant to the efforts to respond to the confusion created in its midst. A period of disturbed thinking has been helpfully described with the phrase "attacks on linking" (Bion, 1967).

Nevertheless, my own experience and that of the colleagues nationally (Art Therapy Courses Northern Programme Conference, 2011) is that art therapists would consider it inappropriate to use a directly psychodynamic approach in face to face to work with people vulnerable to psychotic episodes. What is increasingly described is the use of adapted forms of art therapy which integrates approaches appropriate to the needs of particular clients with a particular diagnosis. The NICE guidelines on Schizophrenia (2009–2010) imply that what is effective for people with a diagnosis of schizophrenia is just such an adapted art therapy approach (NICE, 2009–2010), whereas the trial known as the Matisse study (Crawford et al, 2012) tested a psychodynamic notion of art therapy from an earlier historical period, in which one size fits all (one art therapy approach for all clients and all diagnosis); this did not prove effective.

Art therapy method for work with clients with a diagnosis of schizophrenia

An individual vignette illustrates the need for an adapted approach. It concerns Janet (pseudonym), a young woman who was in the midst of a frightening episode of psychosis. She had been admitted to hospital and I met her in a room on the ward. When I arrived she was crouching in the corner. After listening to what she had told me, I made a suggestion about how frightened she seemed to be feeling. With someone not in the midst of a psychotic episode I think my comment could have provided reassurance that I was listening and taking her seriously, but for Janet in the midst of an experience in which the boundaries of herself seemed to be melting and merging with the room and everything in it, my comment only served to make her believe that I too could penetrate her boundaries and read her mind. It was hard to convince her otherwise.

Over time, I found I could address Janet's fears less directly by avoiding comments that could be experienced as penetrating. I had to work with her in a straightforward, supportive way until she felt able to make some artwork. I realised that with her (and with other clients since) it can be helpful to be directive. Whereas, in my experience, when clients are having trouble thinking, taking an overly non-directive approach can raise anxieties beyond a reasonable level. Similarly, when a client

is actively disturbed making direct comments on the nature of the relationship (for example, in terms of their personal agency or the impression of their transference feelings) may heighten confusion and fear. In contrast, if I directly encourage and support clients who are particularly vulnerable (or even actively disturbed) to make art, I often see that they manage to compose themselves and their thinking whilst feeling contained and composing an artwork.

I try to use language appropriate to the client, and when feasible, I remind clients what has happened when they made art in the past. For example, if someone arrives to see me in the midst of an episode of difficulty in thinking, I gently remind them that sometimes making art has helped them feel less muddled in the past. This seems to me to be akin to the psychological process described in the therapeutic literature as "mentalising" (Bateman & Fonagy, 2006). However, I think that my therapeutic role is mainly concerned with containment and enabling the person to compose themself and recover their capacity to think through making art. The art made may not be obviously symbolic and it could take some considerable time before a client could make use of a more exploratory art therapy relationship (Killick & Greenwood, 1995). Nevertheless, the making of artwork in an art therapy group environment, or in an individual art therapy relationship, provides a vehicle in which inner anxieties and outer realities can meet and maybe find some sense of resolution (at least temporarily).

Therapeutic work with clients vulnerable to frightening disturbances of mind is not without a range of "real-world" considerations (Wood, 2011). For example, I was recently with a group of clients in which one group member spoke about their worries about money and about their benefits being reduced. Another spoke about wanting to move out of an institutionalised care-home setting, but implied, in a world-weary way, that they would not be able to convince the people in charge. Another spoke about wanting to reduce their medication and being refused. Money; lack of power; the nature of attachment and "home"; and the effects of medication are regularly mentioned. Recent government proposals in Britain to change disability living allowances (2012) have left some people with the diagnosis feeling frightened and even persecuted (see Rethink website for 2012 GP survey). These issues need acknowledgement, along with recognition of the difficulties about relating in a group or to an individual therapist when thought processes are disturbed. The need for acknowledgement tends to support a directive "side by side" art therapy approach for clients with this diagnosis as advocated by Greenwood and Layton (1987) and described as "participatory" in current practice (Mahony, 2011); as opposed to the dynamic approach proposed for use by therapists in the Matisse study who were asked to use Waller's group interactive group art therapy approach (Waller, 1993).

Not surprisingly, current financial pressures on services throughout the world are having an impact upon treatment philosophies. Sometimes it is hard to know whether the ideas like the one that vulnerable people may need modulated doses of psychologi-

cal intervention (Warner, 1985; the contemporary Recovery Movement; and ideas about working with people in ways that enable them to (thaw) at their own pace Papadopoulos, 2002) are a reflection of the historical period or based upon a correct perception of need. My impression from my therapeutic work is that a moderated approach seems to enable people who are feeling very troubled to engage with services.

Sadly, the form and details of a specific art therapy approach for people with a diagnosis of schizophrenia were not considered by the Matisse trial (see below). Nor have the details of the work been considered in other systematic research. However, two systematic *reviews* undertaken by the NASA psychiatrist Kanas with experience in both the US and the UK (Kanas, 1986 and 1996), indicated that group work for these clients is both safe and effective and the NICE guidelines (NICE, 2009–2010) still contain undisputed findings (Richardson et al., 2007) about the impact of art therapy on the negative symptoms of schizophrenia.

The NICE Guideline on Core interventions in the treatment and management of Schizophrenia (March 2009 substantial update, republished with minor updates in 2010)

The Guidelines open with this statement.

"There are still many inequalities that exist in mental health, some of which are particularly pertinent for people with schizophrenia, such as not getting access to effective and evidence based psychological and pharmacological treatments. These inequalities are even more difficult to overcome for people from ethnic minorities ... The guideline provides *all* the evidence underpinning which services are provided for people with schizophrenia ... such as family interventions, CBT, arts therapies and careful use of antipsychotics ..." (Forward NGS, 2010, Professor Dinesh Bhugra, President: Royal College of Psychiatrists).

The Guideline Development Group (GDG) consisted of multi-disciplinary professionals from different services and academic institutions. However, importantly the CDG included service user and carer representatives. The most striking part of the guideline is the excellent illustrative narrative from three service users and five carers. These stories powerfully show the impact a diagnosis can have upon a person's life and just how much the service needs to improve in order to provide meaningful care in a timelier manner.

I think reading the guidelines offer a way of understanding the range of thinking in the field of schizophrenia. Briefly my understanding of the conclusions by *NICE* about user and carer experience is that:

- a 30-year survey strongly suggests that there have been real improvements in the treatments for this client population.
- BUT it is clearly still a frightening and often a lonely experience for users and carers to receive a diagnosis of schizophrenia.
- Also it is clear that despite the existence of modern medicines, the effects of the medication still mean that many people do not want to take them.

I am impressed with the quality and the impartiality of these particular guidelines, because they do not shrink from reporting the difficulties involved in providing meaningful help for people with a diagnosis. Similarly the guideline reports honestly about the nature of the medication and the significant proportion of people who run away and live on the street rather than take it. Interestingly though, almost nothing in the user accounts mentions psychological interventions, although most people, users and carers express strong concerns about medication.

An earlier survey by the campaigning group Rethink about the most important elements of treatment for clients found that they are having concerns taken seriously; having a choice of medication; and being treated with respect (Borneo, 2008). These three are fundamental to the approach of many arts therapists, but maybe we do not articulate this often enough, for ourselves or for others. We need to articulate the issues. Another Rethink survey showed that fewer people who had had CBT found it helpful (69%) than arts therapies (83%) or "other talking therapy" (80%) (Borneo, 2008).

The Randomised Control Trial (RCT) known as Matisse

This RCT reported its conclusions in the British Medical Journal (BMJ) during February 2012. The conclusion stated "referring people with established schizophrenia to group art therapy as delivered in this trial did not improve global functioning, mental health, or other health related outcomes" (Crawford, 2012; 344). Of course, when a trial of such size and cost reaches a conclusion, it is necessary to consider the outcome and learn from the results. Also it is likely that if criticisms are made they may be seen as suspect and only made because those making the criticisms do not like the outcome. I still venture to indicate that there are criticisms to be made because a number of discussions are indicating that there were methodological problems with the way the trial was conducted. The criticisms are listed.

1. There was no clear definition or protocol for what kind of art therapy approach was being tested. A trial guideline of approximately 423 words was all that was provided for participating art therapists.
2. Given this vagueness of art therapy approach it is not surprising that there was not sufficient consistency across the trial sites.
3. Differences between trial sites and their results have not been clarified.

4. The art therapy approach was not appropriately adapted for work with people with a diagnosis of schizophrenia. Diane Waller's (1993) book was offered to therapists participating in the trial as guide to group practice, but the approach of the book Group Interactive Art Therapy is not aimed at people with a diagnosis of schizophrenia and the book makes no mention of the diagnosis.
5. The huge costs involved did not serve this historically and contemporarily disadvantaged client group well.
6. Despite collecting hundreds of client art works during the life of the trial, no art work was considered by the research despite the fact that the brief definition used by the trial suggested that art making is central to art therapy. This aspect of the trial also begs the question of what was being tested.
7. Client preference was not considered and client engagement in the groups was abnormally low.
8. There is a question whether or not all clients were followed up for the purposes of outcome.

I respect the professional credentials of those involved in the research, so I find it puzzling that some of these methodological issues do not seem to have been resolved during the life of the trial.

Systematic research

In contrast to the approach of the Matisse trial (Crawford et al., 2012), the earlier NICE (2009–2010) guidelines clarified a definition of an arts therapies' approach appropriate to work with people with a diagnosis of schizophrenia.

"***Definition:*** Arts Therapies are complex interventions that combine psychotherapeutic techniques with activities aimed at promoting creative expression. In all arts therapies:

- the creative process is used to facilitate self-expression within a specific therapeutic framework;
- the aesthetic form is used to "contain" and give meaning to the service user's experience;
- the artistic medium is used as a bridge to verbal dialogue and insight-based psychological development if appropriate;
- the aim is to enable the patient to experience him/herself differently and develop new ways of relating to others" (NICE, 2009–2010; 252).

In this definition the model used in the arts therapies is seen as pluralistic and adaptive.

"Although the rationales for medical, psychological and psychosocial interventions are derived from a variety of different biological, psychological and social theories, the development of the stress-vulnerability model (Zubin & Spring, 1977; Nuechterlein, 1987) has

undoubtedly facilitated the theoretical and practical integration of disparate treatment approaches ... individuals develop vulnerability to psychosis attributable to biological, psychological and social factors" (NICE, 2009–2010; 244).

All treatments aim to protect the vulnerable person, reduce relapse and severity of episodes and work with persisting symptoms. Consequently it is appropriate that the arts therapies integrate a range of different approaches in response to the client's life and the service context. International evidence cited by NICE (2009–2010) suggests that for this client group an integrative approach is helpful.

This also seems to confirm the idea that this contemporary historical period is one of the adaptations for the arts therapies. One of the examples of this is seen in the adaptations described in the art therapy literature for working with clients with a diagnosis of schizophrenia (Greenwood & Layton, 1987 and 1988; Greenwood, 1994; Mahony, 2011; Wood, 2011a and 2011b). Although the results from Matisse are disappointing, we can learn from them mainly through agreeing clear arts therapies protocols for particular client groups with particular forms of difficulties, and then subject these protocols to well constructed trials. Fundamentally, the arts therapies use a recovery model approach and as we have seen in the history this model has long been anti-discriminatory and it has long followed the troughs and highs of socio economic history. Consequently, it is worth persisting with making the case for using the arts therapies as a valuable way of working with people with a diagnosis of schizophrenia. One image that stays in my mind is by an art therapy client who had succumbed to repeated episodes of psychosis, partly as a result of a difficult and deprived history of attachment. Sometimes she is shy and very frightened, but she made a bold image of a warrior with a bow and arrow. If she can imagine herself a warrior, we can certainly overcome the disappointment of the Matisse trial and through continued work and research we can raise ourselves, along side her, to her defence.

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SOLUTION-FOCUSED ART THERAPY IN PREVENTION AND TREATMENT OF EATING DISORDERS

Abstract

This article describes solution-focused approach in art therapy and main principles of solution-focused work with people with body dissatisfaction and eating disorders (anorexia nervosa and bulimia nervosa). The multifaceted concept of body image, its stability and fluidity and positive and negative aspects are described. Positive body image can be considered as a psychological resource and a source of overall wellbeing, and thus needs special attention in therapy. Solution-focused therapy focuses on solutions and strengths rather than problems, supposing that people have resources needed for making changes. Solution-focused techniques as means for externalising the problem, reframing, scaling, and theoretical underpinning of picture-work are described and respective case illustrations presented. The idea of combining vibroacoustic therapy with art therapy is introduced.

Keywords: body image, eating disorders, solution-focused approach, art therapy, vibroacoustic therapy.

Introduction

The focus of this article is on the importance of embodiment in the prevention and treatment of eating disorders, primarily anorexia nervosa and bulimia nervosa. It addresses the meaning, components and changes of body image across life span pointing to the multifaceted nature of the psychological experience of embodiment. Body dissatisfaction is considered the most important component of disturbance of body image since it refers to negative subjective evaluations of one's physical body (the majority of people reporting dissatisfaction with weight or body shape). However, body dissatisfaction is not the opposite of body satisfaction, they exist in parallel. A decrease in body dissatisfaction does not automatically lead to an increase in body satisfaction. Therefore, especially the factors shaping positive body image can be important in the prevention and treatment of eating disorders. I bear in mind the controversial assumption inherent in eating disorders that eating is an activity that helps to relieve anxiety and bodily discomfort, whereas the consumed food becomes the source of bodily discomfort and anxiety, and thus should be removed from the body. Because of that "difficult knot" of logic I do not focus on eating and food in therapy process if there is no specific need for that, but pay attention to the factors of positive body

image, primarily to respect for the body by attending to its needs, and engaging in body supportive behaviours, thus strengthening mind-body connections and self-efficacy that lead to changes in eating behaviour. Based on the principles of solution focused therapy, clients have the necessary internal resources and competencies to solve their own problems. Working cooperatively, with the client being the "expert" in her treatment and defining the goal of therapy, the artwork can function as a map of solutions and a pictorial metaphor of client's success stories.

Embodiment and body image

Embodiment introduces a physical perspective into arts therapies – body awareness, bodily perception of space, material, creation and creative processes, nonverbal aspects of interaction. Embodiment offers possibility to explore bodily experience within the therapy space. Embodiment as a core process in arts therapies concerns the ways in which someone's body relates to their identity (Jones, 2005). Thus, body image is the key feature in working with and through the body in art therapy.

Body image is the term that has come to be widely accepted as the internal representation of one's outer appearance. However, there are different terms used to define the different components of body image (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; 10) and there are over fifty measures for the scientific investigation or clinical assessment of body image (Thompson, 2004). Body image contains both positive and negative features and refers to the multifaceted psychological experience of embodiment, especially but not exclusively one's physical appearance, which encompasses one's body-related self-perceptions and self-attitudes, including thoughts, beliefs, feelings, and behaviours (Cash, 2004; 1–2). That is, body image encompasses not only the affective evaluations people make towards their bodies in determining their body satisfaction, but also the value individuals place on different dimensions of their bodies (aesthetic and functional dimensions), and the behavioural investment made to maintain these dimensions (Abbott & Barber, 2010). Values are defined as the degree of importance an individual places on a particular body dimension. Behavioural investment refers to behaviours aimed at improving or maintaining a particular body dimension.

From the therapeutic perspective, it is necessary to take into account that body image contains certain stable elements while research also emphasises the importance of considering body image fluidity in everyday life (Cash, 2002). Self-image changes with biological/developmental or health/illness-related changes in the body, changes in appearance due to age, trauma or cosmetic surgery, trends in fashion. All these are emotionally experienced through individual self-perception, views, attitudes and socio-cultural background. Body image evolves slowly in the process of development and learning, functions in relation to socio-culturally accepted standard, and can influence a person's wellbeing and ability. At the same time, holistic description of body image is complicated, because the observation of one's experience of creating and maintaining body image is to a great extent unconscious.

Tiggemann (2004) points out three aspects of body image across life span: aging moves women (and men) further from the youthful thin ideal; body dissatisfaction remains relatively stable; the importance of body appearance seems to decrease with increasing age. Two processes (increasing deviation from the beauty ideal and decreasing importance) counterbalance one another to produce a stable level of body dissatisfaction. Thus, stable levels of dissatisfaction should not be taken as an indication that "body image" in all its facets remains stable across the life span. Findings in the Estonian sample also support this (Rüütel, 2004), indicating the decrease in dysfunctional behaviour related to body image in middle-aged women. Thereby, a relatively stable level of drive for thinness indicates a clearly expressed attitude, which Rodin, Silberstein and Striegel-Moore (1985) characterised as "a normative discontent". The orientation towards thinness seems to be even more stable in Estonian men, at least in young age. However, it is three times lower than in women (Rüütel, 2004). Here are some important aspects that can be taken into consideration and applied in body image therapy – satisfaction and dissatisfaction with one's body are the natural parts of body attitude, which across life span acquires different accents; in case of body image problems it is important to study both aesthetic and functional dimensions of body, as clients may evaluate their bodies based upon their satisfaction and dissatisfaction with different body dimensions, aesthetic appeal or functional qualities (Abbott & Barber, 2010; Fredrickson & Roberts, 1997). Halliwell and Dittmar (2003) in their qualitative investigation on women and men's attitudes towards ageing found that women tended to focus on display (the appearance of the body) and men on functionality (physical capabilities of their bodies). Thus, changes in the way their bodies look seemed less important for men and less threatening to their self-esteem. Women were concerned with maintaining a youthful appearance as an indicator of their value and attractiveness. Here a study by Tiggemann and Rüütel (2004) highlights the need to consider self-imposed general expectations and cultural differences. The investigation showed that Estonian women set for themselves high expectations for both traditional (home/family) and non-traditional (appearance, achievement) values, which may prove hard to fulfil. Compared to Australian women, Estonians rated all traditional sex-role concerns (being a mother, being a good homemaker, and the ability to tend to the needs of others) considerably higher. Estonian women also rated higher physical appearance (slimness and physical attractiveness), popularity and, from attributes of achievement – intelligence (but not professional success).

Often body image problems are expressed in dissatisfaction with body weight and related eating behaviour (as means for controlling the body weight). Waller (1994) in her article about the power of food points to the cultural background of eating disorders suggesting that in the societies in which food is powerful, either there is too much of it or too little of it, and where a family's identity and a woman's role is closely bound up with it, it is not surprising that it can acquire a negative as well as positive significance. Nowadays the pressure to (food) consumption expressed in the me-

dia is common for both genders. The extraordinary food availability combined with socially (and also medically) valued thinness simultaneously gives enticements and warnings focussing attention to the body and placing a person into "bulimic conflict" (Rüütel, 2004). The body/health sabotaging choices can easily come into the situation, where social values and health aspects are interwoven, the border between healthy and unhealthy is unclear, and the quest for personal success makes the person susceptible to advantage-promising stimuli.

Promoting positive body image

It is characteristic of people to seek pleasant experience and avoid the unpleasant. Nevertheless, life exposes us to one and the other. There are many enjoyable bodily feelings, e.g. for somebody the pleasure of physical activity, the sensation under the sole of the foot when walking on dew-covered grass or pebbles, the sun and the breeze caressing the body. There are unpleasant bodily experiences, e.g. the agonising pain of the frost-bitten toes, the stinging of the sunburnt skin, and stomach ache after a heavy meal. There is really bad experience one would rather forget, e.g. suffering due to disease or trauma, pain induced by a punishing twig or strap, distress and pain of an assault. How good or bad an experience seems to someone, depends on what meaning he/she gives to it. For example, one can think that a deserved punishment may leave a less painful trace than a wrongful recommendation. In therapy the therapist has the possibility to guide what kind of body experience to highlight and what to focus on.

Striegel-Moore and Cachelin (1999; 87) have stated that "understanding the combination of factors that lead to a positive body image and healthy eating is important for developing prevention efforts in the area of eating disorders". However, the common standpoint is that positive body image is solely the absence of negative features and interventions geared to reduce negative body image will result in increases in positive body image (Wood-Barcalow, Tylka, & Augustus-Horvath, 2010). According to the complicated nature of body image, the changes are not so simple. Negative and positive body images are not opposite qualities but parallel. Avalos, Tylka, and Wood-Barcalow (2005) have identified four qualities suggestive of positive body image: favourable opinions of the body, body acceptance, respect for the body by attending to its needs and engaging in healthy behaviours, and protecting the body by rejecting unrealistic ideal body images portrayed in the media. Positive body image can be considered as a psychological resource and a source of overall wellbeing and thus needs special attention in therapy. Awareness of embodiment, perception of pleasant aspects and dimensions of body image, exploring the exceptions – the times when this certain body dissatisfaction did not exist or was less, and describing what client did different in these life situations – help to discover the different facets and situational aspects of body image and bring to the focus inner resources for forming a change towards positive self-image.

Main principles of solution-focused approach in treatment and prevention of body dissatisfaction and eating disorders

Solution-oriented approach requires both the client and therapist to go beyond seeking to understand the problem and presses for the development of solutions that take advantages of competences and resiliencies inherent in the client (McFarland, 1995). The key factor is self-efficacy, the determinants of which are identified by the client rather than the therapist. Solution-oriented approach looks to the future and seeks to answer the question "What needs to be different?" and focuses on exceptions, that is, those times when the problem is not happening or is less acute.

Solution-focused therapy (de Shazer, 1985; 1988) was developed in the 1980s. Its philosophical background comes from social constructionism where the knowledge of the world and self is considered to have its origin in human relationships and relationship is seen as central to human wellbeing (Gergen, 2006). Solution focused therapy emphasises the collaborative relationship between therapist and client and unique way of cooperation of each family, individual and couple (de Shazer, 1982; 9–10), thus the concept of resistance does not fit with principles of solution-focused therapy.

Solution-focused therapy focuses on solutions and strengths rather than on problems, supposing that people have resources needed for making changes. Three simple rules of solution-focused therapy based on de Shazer (1990) are as follows:

- If it ain't broke, don't fix it = if it works, don't change it. Client is an expert of his/her life and knows what his/her problem is;
- Once you know what works, do more of it. This points to the discovering/remembering meaningful exceptions to the problem-situation;
- If it doesn't work, then don't do it again; do something different – "Just about anything that is different stands a chance of making a difference" (de Shazer, 1990).

Solution-focused therapy is a brief therapy model; however, here "brief" does not mean "quick". Lipchik (2002) emphasises that brevity will be the result of the best-fitting intervention for the particular client, not speedy application of technique; premature use of technique can prolong treatment because it may focus on complaints that are not related to what the client really wants from the therapy. The principle is that no more therapy than necessary. Thus, treatment usually is provided in shorter periods. Solution-focused therapy is used slowly for cases that require therapeutic support for years. Episodes of intense contact during crisis interspersed with mild ongoing support can yield surprising improvement in functioning over time if the focus remains on small goals identified by clients and worked on in a secure emotional climate (Lipchik, 2002).

Traditionally eating disorders in chronic and serious forms have been considered to require a long term and complicated treatment and extremely difficult to cure. Much hope has been invested in cognitive behavioural therapy, and in the case of eating disorders, it is the best researched therapy modality. However, many patients still fail to benefit from this or any of the other existing treatments that are on offer. Buckroyd and Rother (2008) emphasise that the needs of patients are most likely met when the eating behaviour is understood as a voice and communication. They point to the relative lack of attention to the psychological issues that underlie the genetic, physiological, nutritional, social, cultural, class and gender issues of eating disorders, especially when binge eating and obesity are concerned, e. g. emotional issues.

Riley (2004; 185), one of the few promoters of solution-focused approach in art therapy, has stated: "When we ask our clients to project an image (right-brain activity) and contemplate the meaning of the image (left-brain activity), we are offering an opportunity for an integrated experience that can lead to new creative choices." In solution-focused approach special importance is attached to novel and personally meaningful interpretation of experiences, actions, and events. Solutions are easier to find if creative work is discussed in the form of metaphor. Any kind of creative visual expression of certain situation or theme using any kind of art and craft materials can be seen as a picture. Solutions are formed and resources are discovered through creative process. Changing the perspective and distance and relying on subjective perception of the composition, the client can experiment with materials and images and change the picture until a satisfactory outcome. Visual changes in the picture bring along new ideas and changes in initial meanings of images. Rabin (2003) suggests that when working with clients with eating disorders, it is useful to provide set tasks within which the client is free in choosing art materials for the completion of the task. This provides a balance between control and freedom.

McFarland (1995) has written a praiseworthy book about solution-focused approach to clients with eating disorders. Based on the main principles of solution-focused therapy, she has listed basic clinical assumptions about eating disorders and the solution-focused therapeutic process:

- Eating disorder clients have the necessary internal resources and competencies to surmount their own difficulties or solve their own problems;
- After eliciting the client's personal competencies, strengths and resources, the therapist uses these characteristics to individualise the solution and lead the client to their desired goal;
- Client and therapist work together cooperatively, with the client functioning as the "expert" in her treatment and defining the goal of therapy;
- Change is viewed as inevitable and constant, and the therapeutic process is based on the belief that one small change in the system affects change in other parts of the system;
- Treatment focuses on what is possible and changeable. Knowing a great deal about the complaint or focusing on "causes" is usually unnecessary;

- The therapist strives to be as economical as possible in obtaining desired therapeutic ends;
- Rapid change and healing is possible and meaningful;
- The therapist is an active participant in the process and her primary role is to identify, reinforce, and amplify change.

McFarland (1995) describes the therapist's strategies that promote a cooperative, trusting therapeutic relationship within a short time emphasising curiosity regarding the client's reality and customs, sensitivity to the client's use of language referring to the eating behaviours in the same terms, and sensitivity to goals that are salient to the client and refrain from passing judgement, especially in regard to food choices or eating patterns. She underlines the establishment of a client-determined focus for therapy; thus therapist not only makes the best use of therapy time but also, and most importantly, fosters deeper client trust and cooperativeness within the relationship.

Some solution-focused techniques and case illustrations

Solution-focused therapy relies on the assumption that the change occurs through language when recognition of exceptions and existing and potential strengths create new actions (Lipchik, 2002). However, language is not intended to mean only the words people speak. "Art is a principal means of communicating ideas and emotional meanings from one person to another, from one group to another, from one generation to another. When people have new experiences, they symbolize the experiences in an art form; they observe their art and then obtain new insight about their experiences" (McFee & Degge, 1977; 272; cf Jones, 2005; 97). The figurative language of art is very rich and individual. When we look at another author's artwork, we become co-authors, we personally relate to that work through the images and meanings the artwork inspires. A client is the author of and an expert on his or her picture. The therapist as an inquisitive participant can facilitate the client's creative thinking and guide him or her towards looking for solutions hidden in the picture.

Externalising the problem. Solution-focused therapy views problems as inevitable ups and downs in living and the shift from "problem talk" to "solution talk" should be made as soon as possible (de Shazer, 1994). However, solution-focused therapy states also that it is important to appreciate the client's problem. Clients will always want to describe what is concerning them, and if the therapist tries to forestall/shorten them, they will simply come back to it later and will persist until they believe the therapist has heard and/or understood their concern sufficiently (Henden, 2008). When the therapist respectfully explores the art product and listens to how the client perceives it and its meaning, the client feels heard (Riley & Malchiodi, 2002). The use of metaphors and symbolic art expression makes it easier to talk about an emotionally loaded problem-situation and also gives the possibility not to talk about problems –

sometimes it is enough if it is expressed in an art work. Art expression allows for a healthy detachment from the problem in order to gain a more objective perspective and to expand opportunities for solutions to emerge (Matto, Corcran, & Fassler, 2003).

A middle-aged woman with anorexia nervosa (Client A) depicted her eating disorder as an expressionless face with an enormous mouth, positioned in the centre of a white page resting on a used sheet of wrapping paper (see Figure 1.1). I asked her where she was in that picture. She replied she was behind the teeth. I asked if she could come out. She replied she could not. She attempted to erase jaw line to create a passage for herself but that proved impossible. Without further attention to the picture depicting the eating disorder, I started asking questions about her daily activities, people with whom she communicated, her interests, things to which she attached value. I asked her to depict everything we spoke about in her picture. When we spoke about things going on in her life, she modified the face of the eating disorder, making it more cheerful.

Figure 1.1. *Eating disorder and life outside of eating disorder*

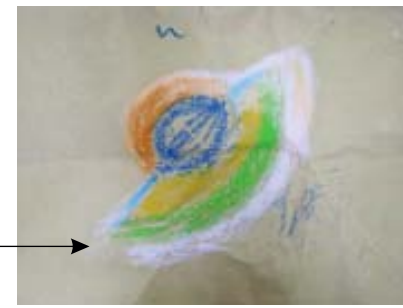

Figure 1.2. *"Sideproduct"*

In the process of work with her picture, she simultaneously elaborated on a small image on the brown wrapping paper (see Figure 1.2). After we had finished our conversation about her daily life, hobbies and relationships, I asked her again where she was in the completed picture. With surprise she discovered that now she was a small tortoise at the bottom of the picture. She was not able to explain how it had happened that she had come out from behind the teeth. Then I asked what the little image on the wrapping paper was she had not yet spoken about. That image also surprised her, she had not been aware of drawing it, but she was happy with the result – it reminded her of a beam of city lights one can see through the car window when travelling at a high speed. As the outcome of that session she concluded that if she pays more attention to things that she does and which she is interested in, as well as people around her, she can "get out of her disease" and some surprises will happen.

Reframing. To reframe means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning (Watzlawick, Weakland, & Fisch, 1974; 95), and

a behaviour change will follow (de Shazer, 1982; 96). When clients create an art piece, they gain access to the many layers of meaning contained in the metaphor at both conscious and unconscious levels. Looking at situations from new perspectives and making them concrete in visual images provides opportunities to reframe the experiences (Moon, 2007). The client becomes a maker and an audience to his/her art work which enables to discover a new relationship to themselves and life situations. Visualising change through art can foster commitment to the change process (Matto, Corcran, & Fassler, 2003). Art works, which are created during therapy process, allow distancing, monitoring and assessing changes in client's perceptions, the metaphoric interpretations of the same art work my change over time (Moon, 2007).

Below there is a picture drawn by the same Client A. In that session she was seeking to clarify the sadness accompanying eating. I suggested drawing a picture about this sadness. First she drew a green creature "Anxiety" (see Figure 2).

Figure 2. *"Anxiety" and "Chippollino"*

It took her about half an hour: she was drawing slowly, prudently, seriously. When she had completed the picture, a bulging part of the creature's body attracted her attention (the client viewed it as a symbol of a full stomach). I asked her to draw a separate picture of that bulge. She drew a mirror-image of two bulges on a small piece of cardboard paper. I asked her to look at that image from a distance and inquired of what it reminded her. She saw the onion-boy Chippollino in that image and she turned the image into the onion-boy. I asked her to put the two images next to each other and compare the green bulged Anxiety and Chippollino. She came to the conclusion that one and the same thing may occur in two different contexts. We began to look for the positive qualities of Anxiety (reframing): strong body, stamina, strong physical sensation, an ability to feel the physical sensation; anxiety may also be a signal – use the opportunity to change the context, you have a chance. As client's anxiety had disappeared she also changed the context of the green

creature in her picture – she gave it wings and a yellow background. After that she drew a big tear in its eye – crying is beneficial, since it relieves and purifies. The shape of the tear reminded of Chippollino. She started to laugh and drew roots to the tear. The message the client received from the image of the green creature was, "Change the context and enjoy sunshine". The message of the onion-boy image was, "Focus outside you – Chipollino has closed his eye and enjoys himself, and does not care what he and the others look like".

Scaling. An important technique in solution focused therapy is scaling. A scale may seem too rational and unsuitable in the context of creative self-expression, but scales are a good tool for assessing the objectives, situation and process, and improving clarity of communication with other professionals who may be involved with the client. They help the client to move from all-or-nothing goals towards less daunting, manageable, steps (MacDonald, 2007). A scale may consist of images and be a tool for mapping the current situation and goals as in Figure 3.

To define goals, I suggested Client A to draw the desired situation. She drew three images depicting her relationship with her disease. The image on the left shows how eating disorder (the red triangle) has engulfed her. That situation is characterised by the keywords "will", "power", "courage", "own path", "external assistance". In the second image the eating disorder has been left behind and the keyword is "sunbeam". The third image depicts the situation she wishes to have in her life. The keyword of this image is "freedom"; the shape of a triangle that in her picture symbolises the eating disorder has become the pattern of her dress: "as it (the eating disorder, E.R.) is in my life anyway, so let it be of some use". I asked her to imagine that the first image of her relationship with the eating disorder was 0 and the last image was 10 on a scale, where on that scale she would currently be. She replied at 3.5, which is characterised by the keywords "giving in to hunger", "experience", "nothing just happens (is not accidental, E.R)". We discussed what had helped her to move from 0 to 3.5 and I asked her, where on that scale a sufficiently good place for her would be. She replied at 5. I asked what she needed to do to achieve that. She answered that she needed to change her thinking – it is not necessary to give in to hunger, instead she needs to fight the feeling of discomfort accompanying a full stomach. I asked what the first step towards achieving that goal could be. She replied that it would be eating together with someone and added that she was going to meet some friends on that day. Looking at her self-development through such scale of images, she proudly gave her picture the title "Kift mutt (Awesome chick)!"

Figure 3. *Picture-scale*

Theoretical underpinning of solution-focused art work

Artist and analytic psychotherapist Joy Schaverien (1992) looks at art works made in therapy from two aspects – *life in the picture* and *life of the picture* – emphasising equally the process of image making and processes which revolve around the image once it exists. Schaverien points out that the *life in the picture* has a direct correspondence to the life of the author. Although this analysis of the process of making an artwork relies on analytical approach, the principles of Schaverien's approach are also applicable to solution-focused artwork. In the first case, *life in the picture*, Schaverien makes a distinction between two types of pictures. *Diagrammatic* pictures are merely descriptive, e.g. schematic pictures, which also contain textual explanations and often characterise a situation, relations, and intentions known to the person. Diagrammatic pictures constitute a valuable source of information supporting resource and solution-oriented artwork especially when exploring the situation (see Figures 1.1 and 3).

According to Schaverien, when a picture or an image in the picture is important for the person, which is reflected by the fact that he or she finishes it with great care, working intently and not commenting on his/her activity, then it becomes an *embodied* image. An embodied image can emerge as a surprise for the person and is as significant as the process of its creation (e.g. Figure 1.2 and Figure 2 "Anxiety"). The picture may have a complex affect and effect in the therapeutic process. The embodied image is not immediately amenable to discourse, but is more easily explored when depicting its images as characters of a metaphoric narrative. During the process of therapy the schematic drawings may gradually give place to more complicated pictures, client puts more effort into creative work and less time is spent on conversations. This may be considered as a sign about acquiring skills in using pictorial images for gaining awareness and constructing personal knowledge. Thus, the picture completed in silence with deep concentration and comprehension may be evidence of client's self-awareness and self-confidence pointing to recognition of his or her resources and possibilities in the current life situation (Rüütel, 2012).

Beside *life in the picture* Schaverien (1992) describes *life of the picture*, which relates to *empowered* images. Some embodied images become empowered in their process of their making or during the life of the picture depending on the type or the quality of the investment which the person has made in an artwork. Such picture or image is especially important for the client and they usually wish to continue thinking about it and take it with them, sometimes cutting out a certain part from the bigger picture or separating a small part from a composition or a clay work or making a small copy of the picture. Some pictures lose their power once the implications of the image have been consciously assimilated; others continue to be empowered for a long time after the therapy session when they were made. Solution-focused pictures may have manifold value. First, because of the significant solutions or the way how solutions were found; second, for the emotional self-enhancing experiences related to discoveries of personal strengths; third, for the experience of artistic self-expression and the meaningful value of the product of the creative process.

Application of body oriented methods and techniques – integrated approach

A young woman came to therapy because of the binge-purge behaviour that recurred every time her partner was away. Her partner's job involved frequent travelling. In the first therapy session, the client depicted herself within firmly closed boundaries: it was safer there than outside where one needs to consider other people's opinions and expectations. One half of the self-figure was shaded – this represented her bad qualities and binge-purge behaviour. I asked if she ever left the boundaries. Her answer was negative. I asked whether in principle she would be able to leave these boundaries if she wanted. She replied that it would be very difficult; however, she agreed to try it in the picture.

She cautiously began to draw a path out from the boundaries. When she had finished drawing, I asked what was different when she was outside the boundaries. She explained that the other people's opinion became unimportant. Another thing that emerged was her positive body image (the figure was not any more divided into the light and dark sides). The path she drew did not have an end. A similar motive of an endless path also emerged in subsequent sessions, whereas the destination of her journey remained unclear. In her sixth session she drew herself again within the boundaries, this time the border being thinner and with exits and leaving the safe boundaries was easier than in the first occasion, but it was still unclear where the path was leading and what her destination was. I asked her to continue her journey through several pictures, asking: Would it be possible to go forward? If you continue your way, what will the next picture look like? In the fourth picture she reached her destination and named the picture "Rest".

With this case example, I wish to emphasise the importance of "discovering" the needs of one's body as an important trigger of changes. Body image problems are often accompanied by an unnoticed/unaccepted need to allow oneself (one's body) to rest. Integrating different techniques for developing body perception and awareness could create complementary opportunities for progress in the therapy process. Use of movement exercises and breathing exercises as warm-ups can predispose studying and accentuating the positive quality of body image. There are also tactile methods of treatment suitable for integrated approach, for example vibroacoustic therapy.

Vibroacoustic (VA) treatment is a therapeutic and relaxation method based on audio-tactile effect (hearing and body sensation) of music and sound vibrations (Grocke & Wigram, 2007; Skille, 1989; Skille & Wigram, 1995). Music therapists use VA treatment as a method of receptive music therapy. The pulsed low frequency sound programmes mostly between 30–90 Hz are used. During a therapy session the client lies on a bed with inbuilt loudspeakers; low frequency sound stimulation is delivered through the loudspeakers. Relaxing music or sounds of nature may be added to masque the audible part of low frequency sounds and provide musical support to the objectives of the therapy. The duration and number of sessions vary depending on the needs of each client. Our practical experience of twenty years of implementation and research on VA therapy at the Tallinn University has proved that ten sessions are appropriate for promoting relaxation, reducing stress and relieving symptoms of anxiety and depression (Rüütel & Vinkel, 2011).

A qualitative study (Rüütel, Ratnik, Tamm, & Zilensk, 2004) carried out with 10 girls (aged 15–18) with elevated anxiety, combined with low self-esteem and/or body image problems (five girls with body weight dissatisfaction) gave essential information about the processes taking place during integrated treatment programme. The 10 sessions of individual treatment included VA treatment (applied in every session) and drawing, mood check-lists, music and conversations with therapist (added to the VA treatment according to the study plan). Instructions for the therapists

were: 1) to use active listening and open-ended questions; 2) to be supportive and oriented to coping resources.

Five girls who had body weight dissatisfaction pointed out the importance of VA treatment in the therapy programme. Three of them belonged to the group described as "tension release" where VA treatment was considered by the girls as the most important component of the programme. The changes noticed by the girls during the therapeutic intervention point at the importance of the physical component. All girls emphasised the positive bodily experience that can be expressed through two complementary qualities of VA treatment:

- Physical self-awareness – discovering the significance of bodily needs (rest, relaxation, care);
- Physical comfort – fulfilling the bodily needs.

VA treatment can also be considered as the medium for reflections giving peaceful time to absorb the new information and continue the thoughts around unfinished or unclear topics raised in the conversations. The study drew attention to the importance of directly body-oriented treatment that the client perceives as pleasant. It can be supposed that a new and positive bodily feeling (physical relaxation) can promote the acceptance of one's body and through this enhance satisfaction with the body and oneself in general in the case of body image disturbances.

Conclusion

By this brief overview of the issues of body image and eating disorders, I wish to highlight two aspects that I consider important in my therapy practice – awareness of embodiment and focusing on constructive solutions. As a solution-focused therapist I rely on the approach of brief therapy, which does not mean achieving results and finishing the therapy in hurry, but focusing on the client's strengths, on what the client already does that supports coping and finding solutions. Solution-focused approach requires an exploratory starting position and finding out about the client's as his or her own life's expert's experience, values, expectations and goals with a forward-looking perspective, as metaphorically formulated by Fletcher Peacock (2001; 39): "We have chosen to water the flowers, the seeds ... not the weeds".

Based on the above, I consider it essential to focus on verbal structure and body component in the tripartite relationship – therapist-client-art. It is important how the client speaks about his or her body, in which everyday areas and situations the problem does not occur or occurs less, what the client has already done to reduce the problem, which measures have been successful. Changes begin with a change in the viewpoint on minor life events. Therefore, I view cyclic therapy process as essential. Five to ten therapy sessions may give a significant impetus for further changes where the therapist's intervention is not necessary or the other specialist is needed. Thus, in every session also the needs assessment for the continuation of the therapy should take place.

In this article I also introduced the idea of combining vibroacoustic therapy with art therapy as research results and practical experience are promising in the treatment of body dissatisfaction and eating disorders. With this I want to emphasise the solution-focused principle – do more that what works – and arising from that, the integration of media if that facilitates the achievement of client's health related goals.

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ART-BASED ASSESSMENT WITHIN STRUCTURE OF THE EXPRESSIVE THERAPIES CONTINUUM IN ART THERAPY WITH ABUSED CHILDREN

Abstract

The Expressive Therapies Continuum (ETC) provides a theoretical model for art-based assessment and applications of media in art therapy. The tree levels of the ETC – Kinesthetic/Sensory, Perceptual/Affective and Cognitive/Symbolic – appear to reflect different functions and structures in the brain that process visual and affective information. The ETC as art-based assessment provides a structure how to assess clients'/patients' strengths and difficulties in processing visual and affective information based on their interaction with art materials, formal elements of created art work and clients'/patients' verbal feedback, during the first three sessions. Nondirective approach in assessment within structure of the ETC in art therapy with abused children helps to restore child's sense of control, allows him/her to feel comfortable and playful, thus enabling engagement in therapeutic process. The benefits and limitations of the ETC as a form of assessment in short-term art therapy with abused children are discussed in this article and illustrated with a case example.

Keywords: art therapy, art-based assessment, the Expressive Therapies Continuum, abused children**,** levels of visual expression.

Introduction

The use of art in trauma-related work goes back to the early 1990s when Nader, Pynoos et al. used drawings to interview children to "identify traumatic experience and to assess the embedded perceptual aspects of the trauma" *(*Nader, Pynoos et al., 1990; 379, as cited in Steel, Malchiodi, 2012; 13). More recently, arts therapies have been most often used to address child abuse (Coulter, 2000; Pifalo, 2002; Klorer, 2008; Malchiodi, 2010 as cited in Steel, Malchiodi, 2012; 13). According to the International Society of Traumatic Stress Studies (Foa, Keane, Friedman, & Cohen, 2008 as cited in Steel, Malchiodi, 2012; 13), art therapies are accepted ways to access nonverbal material and are suited to work with children who have experienced trauma. The main benefit of expressive approaches is their sensory quality and their relationship to neurological functioning and neurodevelopment (Steel, Malchiodi, 2012; 13).

Art therapists often work in multiprofessional teams. In this article art therapy is seen as part of social rehabilitation programme which is carried out by a multiprofessional team – social worker, psychologist, art therapist, psychiatrist, teacher.

In the first period of art therapy, art therapist carries out several basic tasks: assessment, formation of hypothesis about clients'/patients' difficulties/problems, sets the goals of art therapy and creates an art therapy plan (Upmale, Majore-Dusele, 2011; 110); in multiprofessional team tasks are carried out in collaboration with other professionals. The purpose of conducting an assessment is to formulate an appropriate individualized treatment plan. In art therapy with abused children individual approach is essential, because "two children exposed to the same traumatic event will respond differently, as they have experienced that exposure in different ways (Steel, Malchiodi, 2012; 23).

According to Medical Technology of Arts Therapies in Latvia (http://www.vmnvd.gov.lv), assessment includes technologies for assessment and analysis of clients'/patients' actual physical, psychological state and social situation: procuring primary information (making contact and interview with the patient); analysis of patient's difficulties and analysis of the situation, obtaining additional information from relatives and health care professionals; self-appraisal questionnaires; objective assessment tests; art-based assessment in art therapy; formation of overall overview (the summarization of information acquired from assessment, from results of examination carried out by multiprofessional team of professionals and analysis of patient's case-record), and advance and formulation of hypothesis for art therapist work, formulation of art therapy goals and tasks, planning evaluation of art therapy results; when art therapist works in a multiprofessional rehabilitation team – integration of goals of art therapy in team work plan.

In art therapy with abused children it is important to ground on the principles of trauma-informed care (Steel, Malchiodi, 2012). Consequently art-based assessment is one part of comprehensive trauma-informed assessment based on the principles of trauma-informed art therapy (Malchiodi, 2010 in Steel, Malchiodi, 2012; 50).

The article will offer an understanding of the Expressive Therapies Continuum (ETC) (Lusebrink, 1990, 2010, 2011; Lusebrink, Martinsone, & Dzilna-Silova, 2012) as art-based assessment tool in short-term art therapy with abused children. Theoretical description of the ETC and the use of the ETC in assessment is described in the first part of the article. In the second part of the article specific features of art-based assessment in art therapy with abused children are described. In the third part of the article case example with abused girl illustrates the use of the ETC as an assessment tool in short-term art therapy.

The goal of the article is to summarize the conclusions of benefits and limitations of the assessment within structure of the ETC in short-term art therapy with abused children.

Description of the Expressive Therapies Continuum (ETC) and the use of the ETC as an assessment tool in art therapy

The ETC provides a theoretical model for art-based assessment and application of media in art therapy (Lusebrink, 2010; 168). The ETC consists of tree stepwise levels: Kinesthetic/Sensory, Perceptual/Affective and Cognitive/Symbolic all of which are interconnected by the Creative level (Lusebrink, 1990, 2010). (see Figure 1)

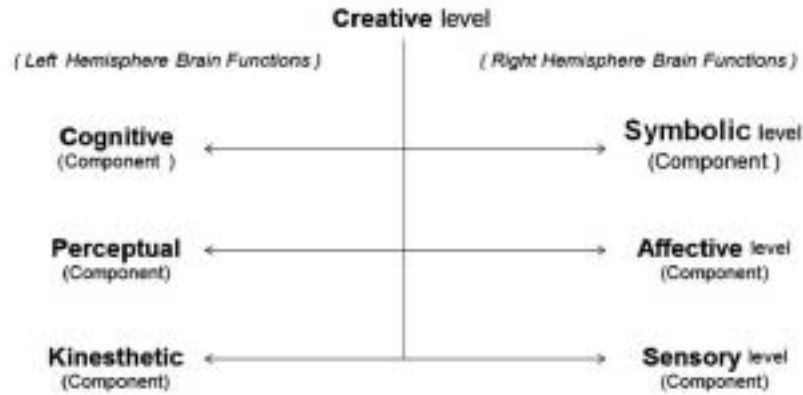

Figure 1. *Schematic representation of the ETC. (Lusebrink, Imagery and visual expression, 1990; 92; Hinz, Expressive Therapies Continuum, 2009; 5)*

The expression and the use of media and techniques in art therapy can be seen as taking place at different levels. These levels represent information processing from a spontaneous reaction to the expression of thought and feelings trough art media. Each level of the ETC is described as a continuum between two opposite poles. The extreme pole of each level represents variations found in visual expressions on that particular level. The sequence of the first three levels (Kinesthetic/Sensory, Perceptual/Affective and Cognitive/Symbolic) reflects the mental and graphical development in progression from simple to more complex levels of information processing (Lusebrink 2004, 2010). The fourth (Creative) level can occur at any single level of the ETC or can represent the integration of functioning from all levels (Lusebrink, Martinsone, & Dzilna-Silova, 2012; 3). These levels appear to reflect different functions and structures in the brain that process visual and affective information (Lusebrink, 2010; 168).

In art therapy the execution of art experiences and expressions involve kinesthetic and sensory activities that are modulated by affective input and combined with basic cognitive and mental operations. Assessment within the framework of the ETC addresses the predominance of one or more levels of sensory information processing depending on how certain formal elements present in artwork are configured. These formal

elements are similar to the ones laid out by the DDS (Cohen et. al., 1998), the PPAT (Gant & Tabone, 1998), and the Formal Elements of Visual Expression (Lusebrink, 1975 as cited in Lusebrink, 2010; 170), but instead of using rating scales, this assessment uses descriptions of the visual elements present at each level of the ETC. The assessment is distinguished by its focus on clients'/patients' strengths and difficulties with information processing at each of the ETC levels. Areas of strength indicate lack of difficulty in processing visual information at particular levels of the ETC. These areas provide secure base from which to explore other areas that may contain psychopathology or to address the "missing links" in the sequence of visual information processing. Visual expressions based on secure areas of the ETC carry potential for the creative process to activate internal movement in affective and cognitive processes and thus bridge over areas of difficulties. Indications of clients'/patients' strengths in information processing at any level and their difficulties at other levels become guidelines for starting points, pathways, and goals in art therapy (Lusebrink, 2010; 170–171). General overview of the predominant characteristics of visual expressions at each level of the ETC are characterised in detail in Lisa Hinz's book (Hinz, 2009; 205–207) and in Vija Bergs Lusebrink's article (Lusebrink, 2010; 172).

The ETC provides a structure for assessing the choice of preferred art materials, interaction with media, art-work formal elements and verbal feedback to determine resources and difficulties in processing visual and affective information. Unlike other art-based assessment tools, ETC based assessment is non-directive. This provides freedom to choose art materials and the content of art expression.

Assessment within the structure of the ETC:

- Free access to a continuum of art media form resistive to fluid, 2-d and 3-d materials, various sizes and qualities of paper, and appropriate tools for working with each medium.

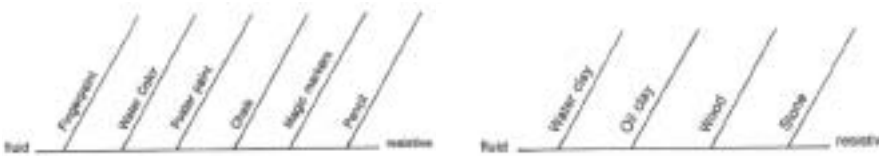

Figure 2. *Approximate media properties for some two- and three-dimensional media (Lusebrink, 1990; 85)*

- 3–5 tasks carried out in one session or in series of three sessions.
- Clients are free to choose materials and content.

The assessment within the framework of the ETC focuses on how people process information to form images. Such assessment in the structure of the ETC can provide suggestions about where to begin a course of therapy, the direction of therapeutic work and the choice of therapeutic art media. The ETC does provide an

organized and efficient manner in which to assess client's skills and abilities, devise individualised treatment goals and conduct treatment (Hinz, 2009; 193).

Assessment Element	Component Parts
Preferred medium	Media properties Strength of preference Risk taking
Manner of interaction with medium	Responses to boundaries and limits Commitment and frustration tolerance Level of energy Coping skills
Stylistic or expressive elements of final art product	Developmental level Line quality Form quality Use of space colour use Integration Organic indications Content and symbolism Organizing function
Verbal communication	Quality of verbal comments Rate and volume of speech Logic displayed

Figure 3. *Elements of art-based assessment using the Expressive Therapies Continuum framework (Hinz, 2009; 196)*

In determining clients'/patients' preferred level of the ETC, art therapists will review information gathered over the period of the first three to five art therapy tasks. Assessment elements and component parts presented in this table summarize types of information gathered in the assessment sessions.

Art-based assessment and its specific features in art therapy with abused children

Art therapist uses various assessment tools – interviews, observation, questionnaires, tests and art-based assessments. The latter in art therapy include projective drawing tests (often used by psychologists; important when art therapist works in a multiprofessional team), art therapy tests and analysis of art therapy process and created artworks. Art-based assessment in art therapy with abused children is one part of comprehensive trauma-informed assessment based on the principles of trauma-informed art therapy and is considered as sensory-based assessment (Malchiodi, 2010 in Steel, Malchiodi, 2012; 50). In providing sensory-based assessments, it is important to know that traumatized children have a critical need for safety. While most art- and play-based assessments may be perceived as nonthreatening, there is

a potential for re-traumatizing events to occur when tapping sensory-based memories via sensory means. It is suggested to approach the assessment as a witness to children's experiences and stories and to be curious about every aspect of what they do. Furthermore, art therapist should keep track on their own projections and impressions about children's creative expressions. In sensory-based, trauma-informed assessment, the goal is not to take a pathology oriented stance, but to try to determine children's responses, and personal worldviews (Steel, Malchiodi, 2012; 71–72).

Violence against children comprises all physical and/or emotional cruelty, sexual abuse, neglect or abandonment of negligent treatment or commercial, or a different way of exploitation forms, which can lead to real or potential harm to child's health, life, or development of self-esteem, while a child is in relationship of responsibility, trust and/or power (WHO, 1999).

While individuals react to trauma in idiosyncratic ways, trauma affects psychological, social, physical and cognitive aspects. Childhood trauma reactions are **psychological** – dysregulation in affective functioning (Van der Kolk, 2009), feeling sad or hopeless, guilty, angry, hostile, defiant, anxious, fearful, with repressed or denied feelings; **social** – re-enactment, opposition, mistrust, extra compliance (Van der Kolk, 2009), isolation, communication problems, behavioural problems; **physical** – low energy level, sleep disturbance, physical injuries, pains, fatigue; **cognitive** – confusion, dissociation, repetitive thoughts about trauma events, (Van der Kolk, 2009), negative thoughts about self, self-blaming, difficulties to concentrate, loss of interests.

Traumatized children are sometimes hesitant to talk about their experiences during standardized assessments for many reasons:

- They may find it difficult to explain events verbally because of cognitive and emotional challenges that interfere with conceptualization and perception;
- Experiences of terror affect language areas of the brain, leaving child with "speechless terror" that limits communication via words;
- Self-reports may even stir up feelings of extreme fear, worry, and confusion when flight, fight, or freeze responses surface if children are confronted with exhaustive, multiple interviews.

Traumatic events are experienced and stored in the right hemisphere of the brain and "this suggests that allowing children a period of time to access and stimulate the right hemisphere of the brain could eventually activate the necessary (explicit) functions of the left hemisphere of the brain, which appears to shut down during traumatic experiences" (Gil, 2006).

In processing the traumatic experience child's behaviour is being led by two basic drives – a tendency to manage the painful and confusing experience by trying to restore sense of control and another tendency is to avoid painful emotions that include avoidance to engage also in therapeutic work (Gil, 2006). Therefore, the basic goal in trauma treatment is the restoration of sense of security and internal balance (Malchiodi, 2010),

which takes a central role in short-term art therapy and reveals the need for careful assessment, which enables the identification of child's individual needs (Gil, 2006).

E. Gil (Gil, 2002 as cited in Malchiodi, 2003; 52) encourages assessment process that is nondirective, which allows children to develop sense of comfort and safety, expand their potential to communicate through symbol language and sets the context for subsequent therapeutic work. In assessment programme Extended Developmental Assessment (Gil, 2003; Gil & Green as cited in Malchiodi, 2003; 51) designed for 10–12 sessions, Gil suggests free, nondirective play and art expression for first three, four sessions to help children feel safe and comfortable. In many environments, practitioners do not have the luxury of providing lengthy assessment over the course of 10 or more meetings. The assessment within the structure of the ETC provides nondirective approach, which conforms with Gil's suggestion about free, nondirective approach in first three, four sessions. The ETC provides a structure how to assess resources and difficulties during these first sessions, as well as providing possibilities for a child to feel comfortable, re-establish sense of control and internal balance.

The following case example will illustrate the use of the ETC as an assessment tool in short-term art therapy with an abused child.

Case example of assessment within structure of the ETC

Girl Anna (pseudonym), 5 years, was physically abused from her step-father, her mother was alcoholic. During the first session an art therapist observed that she did not show any interest in talking or listening to the art therapist's talk. She looked at art materials and wanted to start working with them as soon as possible. The first two sessions were very similar. In the first two sessions she chose a large piece of paper (A1) and gouache. She used gouache in thick layers, used many colours, the choice of colours was spontaneous. The art therapist hypothesized that Anna's visual expression was predominantly related to Affective component of the Affective/Perceptual level of the ETC, because of large format, most of the space was used. Large coloured area, no lines or concrete forms, bright, intensive, spontaneously chosen colours, fluid art material was chosen and interaction with colour was expressive. In the process of painting she mixed and spread colours with a big brush at first and then started to use her fingers and hands in mixing and smearing colours on the surface. The art therapist observed sensory exploration of gouache and surface and hypothesized about presence of Sensory component of the Kinesthetic/Sensory level in Anna's visual expression. While smearing the colour, she said "how messy" and showed unpleasant feelings, thus reacting to sensations. The involvement level in visual expression was high; she worked quite quickly and expressively, which appeared to the art therapist as Kinesthetic component of visual expression on Kines-

thetic/Sensory level. Anna was not worried about boarders of paper or the amount of gouache she used. Anna did not make pauses and did not look at her painting, forms were unclear, and there were no lines or details. The art therapist hypothesized that she probably had difficulties with Perceptual component of the Affective/Perceptual level. In the first session during the expressive process Anna spontaneously told that her step-father often hits her and shortly after she continued about her fear of darkness and thunder. Her speech was spontaneous, fragmented, with pauses and her voice was silent. The more engaged in the process of creating artwork Anna got, the greater mess she had created around her. Her coping skills were limited, she seemed frustrated. So the art therapist decided to help strengthen control over medium. In the second session during the process of making artwork Anna started to talk again about her fears of darkness. She said that she believes that there are wolves in the darkness and that they are very dangerous and she has deep fear from them. The art therapist hypothesized that Anna has intense fears and it is difficult for her to gain control over these feelings. In visual expression she felt unpleasant sensations of dirtiness, which were probably linked to darkness and fears.

Figure 4. *Painting in the 1st session*

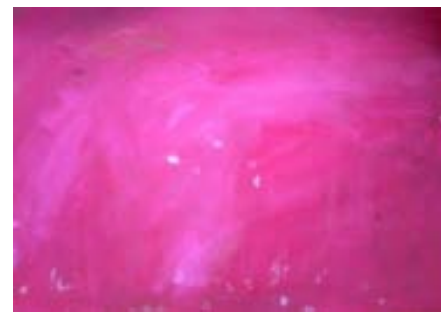

Figure 5. *Painting in the 2nd session*

In the third session Anna chose a large piece of paper (A1) and gouache again; that was habitual and safe for her. She mixed and spread colours with her hands again thus showing involvement in sensory explorations (Sensory component of the Kinesthetic/Sensory level). Movements slowed down gradually in this session, which indicated changes with Kinesthetic component of the Kinesthetic/Sensory level. She made pauses and looked at her artwork several times, which appeared to the art therapist as the growth in Perceptual component, which balanced Anna's visual expression on Perceptual/Affective level. She told the art therapist that she would paint the wolf (her fear), so she was able to make the decision and express her intentions verbally. The art therapist hypothesized that cognitive operations were present and Cognitive component of the Cognitive /Symbolic level was integrated in her visual expression, although the form of the wolf remained unrecognizable, which probably showed difficulties with Perceptual and Cognitive components.

In this session she felt safe enough to face her fears. Her voice was silent and calm. She could stop visual expression herself and could decide when the artwork was completed, which indicated the growth in her ability to control.

Figure 6. *Painting the wolf, handprints in the 3rd session*

This example with Anna illustrates that nondirective approach of the ETC provides freedom to choose art materials and the content of art expression offering a "transitional space" and making it easier to communicate through the language of images and symbols, thus promoting involvement in the therapeutic process (Gil, 2006). The ability to choose art materials and the content in the context of therapeutic relationships contributes to the restoration of sense of control, encourages empowerment, playfulness, promotes movement form passive state to activity, and encourages inner movement, direction.

The assessment of Anna's visual expression within structure of the ETC showed her strengths on Kinesthetic/Sensory level. In her visual expression the emphasis was on affective involvement as well, but difficulties there were traced at Perceptual/Affective level. Through the involvement in sensory and affective expression, Anna was able to get in contact with her feelings of fear and could express them verbally. As it was seen in the first session, Anna's feelings were overwhelming and it was difficult for her to control her visual expression, she became frustrated. Free choice of art work content, especially at the initial phase of art therapy, correlates with more personal meaning of the creative self-expression and reflects the most important issues (Ellenbecker, 2003 in Hinz, 2009; 195). This draws the attention to risks of nondirective approach and limitations of assessment within structure of the ETC. Traumatized children have a critical need for safety. While most art- and play-based assessments may be perceived as nonthreatening, there is a potential for re-traumatizing events to occur when tapping sensory-based memories via sensory means. Practitioners should watch children for signs of distress such as increased anxiety,

withdrawal, or dissociation during the implementation of any of these assessments (Steel, Malchiodi, 2012). Therefore, nondirective approach may work with some children, but with others directed activities may be necessary.

To strengthen Anna's sense of safety and control over feelings of fear, art therapist focused on the integration of sensory and kinesthetic experience of visual expression and balancing expression at Perceptual/Affective level. The questions were used to focus on sensory and kinesthetic experiences and encourage to talk about sensations and perceptions (Is it cold, warm? Is it smooth, soft, sharp, rough etc.? What it is like to do that? Can you repeat this rhythm, movement etc.?), and to focus on perception (What kind of forms do you see?, what is bigger, smaller?, What is in the middle?, focus on details of forms etc.).

Conclusion

The assessment within structure of the ETC ensures nondirective approach and possibility to assess strengths and difficulties in a short period of time, providing opportunities for emotionally supportive functions of art therapy simulaniously, which are considerable issues in short-term art therapy with abused children.

The assessment within framework of the ETC provides a structure how to assess strengths and difficulties at different levels of the ETC, based on assessment of free, nondirective visual expression and formal elements and helps to create individualized treatment plan. Treatment planning can identify stepwise transitions between the ETC levels as well as horizontal transformations within each level.

Children who enter treatment due to abuse have been through a series of verbal interviews by helping professionals. They usually enter the clinical setting hesitant and guarded, unable or unwilling to respond to additional queries about what happened and how they feel. Furthermore, there is no much time to build therapeutic relationship. The ETC as assessment tool provides nondirective approach, which enables engagement in therapeutic process and helps to restore child's sense of control, allows him/her to feel comfortable and playful, eases communication, through the language of images and symbols, promotes movement form passive state (victim) to activity, encourages inner movement, direction (survivor). On the other hand, nondirective approach may work with some children, but with others, directed activities may be necessary, because nondirective approach can increase anxiety, children may feel unsafe, resistant, free expression may cause overwhelming feelings, sometimes the chosen material can be cumbersome. While most art-based assessments may be perceived as nonthreatening, there is a potential for re-traumatizing events to occur when tapping sensory-based memories via sensory means.

In many environments, practitioners do not have the luxury of providing lengthy assessment over the course of 10 or more meetings. The assessment within the structure of

the ETC provides a possibility to assess strengths and difficulties in a short period of time, 3–5 free art expressions can be carried out in one session or in series of three sessions.

The ETC model provides an effective and appropriate way to assess resources and difficulties in information processing, as well as sets up individual goals of art therapy with abused children and manages the art therapy process, while providing opportunities for emotionally supportive functions of art therapy at the same time. Art-based assessment in the structure of the ETC model supports effective use of art therapy in social rehabilitation teamwork with abused children.

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III. DANCE MOVEMENT THERAPY WITH DIFFERENT CLIENT/PATIENT GROUPS

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ARTS THERAPIES PRACTICE WITH SURVIVORS OF CHILD SEXUAL ABUSE: THE IMPORTANCE OF SAFETY

This paper is based on the research completed for my doctorate (Meekums, 1998) and since developed and refined (Meekums 1999, 2000, 2002 and 2006). It is also rooted in clinical practice continually refined in response to client feedback over many years.

My research concerned a group therapy for women in a mental health setting who had a history of sexual victimisation as children and who attributed their mental health problems primarily to this history. The arts therapy modalities used in the groups that were studied for my research included dramatherapy, dance movement therapy and art (visual) therapy, in various combinations. This allowed me to build a theoretical model of the recovery process that integrated all three of these modalities (music therapy was omitted merely because of its unavailability in the geographical area in which the research took place). In so doing, and through my own practice in multi-modal settings, I have been able to develop an evidence-based approach to working with survivors. Much of this has been reported in my 2000 book, but continues to be refined.

The detail of my research is reported in Meekums (1998, 1999). In this paper, I intend to focus on one key aspect of the theoretical model, because it was mentioned by all 14 participants in my research and is so fundamental that it deserves special mention. This is the establishment of the client's sense of (psychological and physical) safety. What my research revealed, in a way that had not previously been articulated, is that when the individual feels safe, it is possible to let go into the therapy process and make use of it in order to develop and change. However, when this sense of safety is not present, far from this being experienced as a benign absence or merely leading to a lack of progress in therapy, the client's experience is one of a malign presence; a non-safety that leads to deterioration. Deterioration rates are consistent across therapies at about ten per cent (Hoffmann et al., 2008). Despite a recent focus in research on the importance of feedback to the therapist in reducing the risk of deterioration (Slade et al., 2008), this research has not included a focus on the client's sense of safety. My own finding awaits large scale validation outside of the arts therapies setting and outside of the context of survivors of child sexual abuse. However, I have tested it

in a small focus group of therapists (n = 6) from another modality (counselling), inviting narratives that might contradict the model, and have been unable to find anything to contradict my finding; in fact, the importance of safety has been substantiated.[12]

As a result of my research and practice over many years, I have developed an integrative approach[23]to therapy for survivors that can be used with both women and men. I will, in this paper, introduce some techniques that can be used to enhance a client's sense of safety, in order to promote safe and ethical practice. My firm assertion is that disclosure-oriented work or body-focussed work that does not pay attention to the importance of safety could constitute unsafe practice.

Beginning therapy: trying to cope

Clients who come for therapy having been sexually victimised as children have usually tried many ways to survive. They may have tried to change their patterns of thinking, feeling and behaviour but to no avail, as this quotation from my doctoral research illustrates:

I've talked it through and said what I think I want to feel, but it's not actually worked in practice. Words are fine. I can say yes, I feel great, yes, this will happen, oh yes, that doesn't bother me. It's very easy to say that, but putting it into practice is not always the same.

In this pre-therapy or early therapy phase, the body acts as a container for past and present hurts and so must be denied rather than lived in. This can lead to avoidance of feeling, memory gaps, out of body experiences, misuse of substances, punishing exercise routines, minimisation of injury, failure to seek medical or other help, risky behaviour, self-harming, difficulties with sex or sleep, overeating, self-poisoning, and a wide range of other problematic issues.

As the above list suggests, the very things the client tries to do to cope with distress may result in greater difficulties. The abuse and also the means by which clients cope may leave them feeling shamed, and so clients are usually desperate when they finally make the decision to enter therapy. Attempts to deny feelings result in them

[1] This was a small scale study involving four of my own students and two qualified colleagues, and therefore it can be assumed that there was a high risk of bias. However, all participants had been trained over some years to argue with me, and all gave very detailed narratives from their own experience that seemed to illustrate and support the model. Each participant was practising as an integrative counsellor (one was also a psychotherapist, more strongly influenced by the psychodynamic tradition) and had received their own therapy, offering a unique service user perspective. Four of the participants were also currently engaged in a personal development group as part of their training and offered useful insights into this context. Participants were presented with my model (Meekums, 1999) and asked to complete a narrative proforma, describing their own experiences from both client and therapist perspectives and explaining how they might suggest modifications to the model.

[2] By integrative, I mean both that I integrate a psychodynamic, cognitive behavioural and humanistic approach, and that I integrate arts therapies approaches according to the requirements of the therapeutic task and the preferences of the client. As a dance movement psychotherapist, I pay special attention to the client's needs for embodiment together with the challenges this poses, given that the body is the site of trauma in the case of survivors of sexual abuse.

being buried deeper into the body and ever present in the here and now. Sometimes the client finds it impossible to contain overwhelming feelings, resulting in intrusive imagery, nightmares, somatization and an inability to "switch off":

I used to be able to switch off to any person. I can't now. I can't switch my feelings off either. And I don't think it's very good, that. I'd rather be able to switch off.

As therapists, we may feel that the client needs to re-embody in order to effectively self care, yet the client often finds this too difficult. The burial of painful feelings means burying all feelings including those that most people might consider pleasurable:

It's not just the bad things that are closed up inside you; it's all the good qualities that could have developed. And they can't, they're choking. You know, it's like weeds choking flowers. You've got to get rid of them and pull enough up to let (the flowers) grow.

Safety as a vector catalyst within the therapeutic relationship

The most important factor that has been shown to be crucial for therapy outcome is the therapeutic relationship (Norcross & Wampold, 2011). From my research, I would argue that the most important aspect of the therapeutic relationship is the establishment of the client's sense of safety. This was the most frequently mentioned aspect of recovery in my doctoral research, identified by all 14 participants. My participants reported that a sense of safety within the therapeutic milieu enabled them to engage with therapeutic opportunities from which they could move forward. In that sense, the sense of safety acted as a catalyst[3][4]for therapy:

Nobody was judged by anybody … there was the opportunity to be heard; nothing was rushed.

However, when they reported more painful experiences in therapy and in previous encounters with mental health services, it became apparent that the *absence* of a sense of safety did not merely mean that movement forward did not occur:

I didn't feel safe … if I you had a problem within the group you either had to share it with the whole group or not share it … so I tended to take things home with me.

The absence of safety was experienced rather as a *presence* of something bad and harmful, and resulted in deterioration. I, therefore, decided to use the term *vector catalyst*[4][5]because the presence of safety catalyses positive change but its absence acts like

[3] The term catalyst is borrowed from chemistry, in which context it means a substance that accelerates a chemical reaction without being changed itself

[4] The term vector is borrowed from physics, in which context it means a force that has directionality. These two terms (vector and catalyst) together imply a quality that can under the right conditions assist therapy, but which has directionality i.e. can move the process forwards or backwards. In the case of safety, its presence moves the process forwards, but its absence can be seen as a kind of negative, with the opposite direction i.e. towards deterioration.

a *negative and malevolent presence*, signaling danger. This negative presence can lead to deterioration, reversing the direction of progress, as one of the therapists in my focus group identified:

There were other times when (I) reached the crisis point and I turned back, which may be because it was not safe. These included abandoning meditative practice because it opened up a terrifying emotional turmoil. After that I felt blank, defeated, empty – so it was a deterioration. My very analytic therapist interpreted these times as resistance, which may well be true but was not a particularly helpful label because although I could see the resistance was related to fear, that did not get us very far. It isn't enough to have an intellectual understanding of why something happens. Love casts out fear, but fear casts out love as well, and this has happened time and again. Getting to the love is the hard thing, and trusting it enough to take the next step. I don't mean just someone else's love for me, but a loving way of being with myself and getting to my love for them as well, which for me seems to mean getting through the projections.

Another focus group member reminded me that safety, once established, must be worked on and maintained lovingly:

... if safety is lost after being established then the barrier to re-establish it is higher than it was at the beginning. Or the forces required to create the vector are greater than before ... Furthermore (your theoretical model) implies safety as evenly distributed in the environment – its structural facets all having equally value. This may be so theoretically – but as a chain is only as strong as its weakest link, so the degree of safety felt by an individual in a group or other environment will be controlled by the factor contributing the lowest amount of safety – that which we have least trust in.

My participant is referring here to the group experience; in this case, the personal development group in counsellor training. However, such fractures in trust can be repaired, often resulting in a shift towards greater trust:

During several weeks in a group in which there was a sustained element of conflict, I stated I would leave if I felt upset and unsafe. The reaction of the therapist was empathic, accepting and indicated I had been heard. As a result of this I did not leave.

Movement anchors

Safety must be established early and maintained through the therapeutic alliance. In addition, I have found that safety can be enhanced through the use of body/movement "anchors". I borrow the term "anchor" from Rothschild (2000), for whom an anchor is a grounding thought that helps clients reduce anxiety. I have developed movement anchors as movement phrases, positions, deliberately recalled embodied memories or imagined (constructed) embodied "memories" that connect with a feeling of safety. Below is an example of how I might take a group of people through the exercise of finding a movement anchor.

I suggest that you either lie or stand or sit, whichever is most comfortable for you right now. Be sure to pay attention to what feels right. There is no need to push yourself into places that do not feel absolutely right. Remember you have a choice. Once you are in a comfortable stillness, you might want to close your eyes in order to focus on your internal world. If this does not feel comfortable, it might help to look down at the floor and de-focus your eyes. Spend a bit of time checking through your body, just noticing how you feel. You don't need to do anything. Be compassionate to yourself. Just notice, without judging.

Now, allow your mind to wander to a time you felt really safe. If you can't recall one, then make one up; the time you would like to have in your bank of memories as the time you felt safe. And allow that image to develop in your mind, as if you are there right now. What are you wearing? What are your surroundings? Is there anyone else in this place with you? What sounds can you hear, if any? What smells or tastes? Colours? Notice the sensations in your body as you allow yourself to enter more deeply into the experience. Now, allow your body to respond in movement to this memory. What movements or gestures or positions does your body want to explore, to deepen and embody your memory of feeling safe in this place and time?

After exploring this memory in movement for about 15 minutes or so, depending on how I feel the group is getting on, I continue:

Now allow your body to find a movement or posture that somehow sums up or crystallises this memory. Now allow this movement or posture to become expressed in just one part of your body, and to become very small, almost imperceptible, yet bringing with it the whole experience you have just been exploring. Now repeat this movement or hold the gesture for a while, so that you ground it in your body, as a way of recalling the whole experience of feeling safe whenever you want or need it. This is your movement anchor. Once you feel you have it in your body, you can slowly open your eyes, stretch and breathe, and come back to the circle. I suggest you repeat the movement anchor approximately every hour before you go to bed tonight, and once in the morning, then at intervals whenever you think of it so that it becomes second nature to you. You can then use it at times of stress, as a way to cope.

Other ways to work with safety

There are a number of structural things that therapists can also do to assist the development of a sense of safety:

- Contracting for confidentiality.
- Valuing difference and adopting a non-judgmental attitude, so that clients feel accepted.
- The right to say no to participation in any activity on offer.

- Structuring the therapeutic space with areas for action and reflection.
- Checking on outside support and encouraging clients to use informal and professional support networks.
- Containment or grounding activities to build up a sense of strength before exploratory exercises. For example, I might focus on standing with a firm rooting in the ground, and a feeling of strength.
- Balancing freedom (as in improvisation) and structure (which assists those who are less confident with arts activities).
- Timing: giving enough time for activities, yet with clear time boundaries.
- Humour: some of my doctoral research participants specifically mentioned the release of tension associated with humour. However, this needs to be tempered with sensitivity, and never such that it could be construed as laughing at someone.
- In group settings, or in the use of bibliotherapy and education, working to develop the sense of "I am not alone" (Universality, Yalom 1975).
- To promote a sense of hope through the opportunity to see or hear others' stories about struggle and then recovery.

More ideas on how to do some of these are given in Meekums (2000).

Discussion

In this article, I have described the importance of the client's sense of safety in arts therapies practice, within the context of work with survivors of child sexual abuse. I have identified this as a *vector catalyst*, which can either assist therapeutic progress or lead to deterioration.

Judith Herman (1992, 2001) discusses the response to trauma, which includes descriptions similar to the burial and failure to contain feelings identified in my discussion above. This indicates the need for caution before attempting any kind of therapy that could lead to re-traumatization. The importance of safety is well documented in other literature and arguably is enshrined in Rogers' (1957) core conditions including the need for the client's perception of the therapist's empathy, genuineness and positive regard. In this sense, the client's sense of safety can be seen as a central facet of the therapeutic relationship linked to empathy, alliance and (in group therapy) cohesion, all of which have been shown by Norcross & Wampold (2011) to be crucial for therapeutic progress. Therapists who lack empathy, use poor technique, underestimate problem severity, disagree with their clients about the therapy, make too many transference interpretations or invite negative transference are associated with negative outcome in therapy (Mohr, 1995). These factors could be seen as endangering the client's sense of safety. In the training context, Payne (2001) found that safety was a critical factor in personal development groups within Dance Movement Therapy training. This finding has also been substantiated through the narratives of my focus group.

The fact that six colleagues, four of whom were students, have broadly agreed with the model might simply be a function of their wish to please. However, the narratives

they presented had the power of immediacy that rings true, and all were in the habit of challenging me, the researcher. The fact that they were not arts therapists suggests that my findings may have relevance beyond the domain of arts therapies practice, and also beyond the domain of work with survivors of child sexual abuse. My focus group participants supported the model as a whole (Meekums, 1999) and not just the aspect of safety presented here. However, it should be remembered that like any theoretical model this is a story, or as Judith Herman (1992; 155) would have it a "convenient fiction".

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RESEARCH INTO DANCE MOVEMENT PSYCHOTHERAPY WITH ADOLESCENTS: A RATIONALE

Introduction

Working with adolescents is a fairly common area of work for a number of dance movement psychotherapists as argued by Karkou, Fullarton and Scarth (2010). However, theoretical and research literature that explains ways in which dance movement psychotherapists work with this difficult age in one's life and support young people to get through the turmoil of adolescent life remains particularly thin.

Experience suggests that dance movement psychotherapy may have a lot to offer to this client group. For example, the first author has worked for over 15 years with children and adolescents who have substantial attachment and trauma issues, offering therapeutic residential care and education. During her studies for the MSc in Dance Movement Psychotherapy at Queen Margaret University, she completed her studies in group dance movement psychotherapy with adolescents in a secondary school. Her MSc project titled "An Artistic Enquiry into Moments of Holding within a Group Dance Movement Psychotherapy with Adolescents in a Mainstream School" identified useful ways of working with this population that included the need to connect with the self, with one other and with the group (Joseph, 2011).

The second author, coming from a teaching background and having worked and researched in this area (Karkou and Sanderson, 2001; Karkou and Glasman, 2004; Karkou, 2010; Oliver and Karkou, 2012 in preparation) has supported this work believing that further systematic work is needed in the area in order to identify what is therapeutically valuable and whether dance movement psychotherapy is indeed effective.

This paper presents relevant theoretical frames and existing research evidence and indicates ways in which research studies are currently under development at Queen Margaret University, Edinburgh, Scotland.

Adolescence as a period of change

The adolescence phase of development is understood as a time of substantial change and transition. Adolescents are coping with complex and paradoxical physical, cognitive, emotional and social changes. Developmentally they have a number of significant tasks to negotiate during this phase: separation from the family, devel-

opment of a personal and sexual identity, decisions around future and educational goals (Stanton-Jones, 1992), development of a moral value system (Malekoff, 2004) and learning to reason logically (Piaget, 1950).

There are a number of theorists who discuss the issues and characteristics of adolescence and the complexity of this phase of development. The transient feelings of depression that can arise from the radical changes in body image are discussed by Anna Freud (1958). While both Anna Freud and Winnicott (1971) discuss how unresolved issues or traumas that are often unconscious and can reappear during this adolescent period. The transitioning from childhood to adulthood, the loss of the familiar, combined with the changes in family relationships and the sense of mourning are aspects discussed by Blos (1962) and Block (2001). Adolescence is a period of identity formation by Erikson (1968) and, in discussing identity, goes as far as to describe adolescence as a time of crisis; if not appropriately supported, it may lead to "identity defusion".

Thus, with so much change to manage adolescence is a complex phase even for those young people with healthy internal resources. For those with significant unresolved past issues or attachment issues it can become a time of real vulnerability which threatens or prevents any healthy transitioning into adulthood. Bowlby's (1969) work on attachment theory describes how the early relationships between infant and the significant caregiver can impact on the success of future relationships and the ability to master normal social and emotional development. His work on attachment informs much of the work of arts therapists working with young people and children today.

The contribution of group DMP with adolescents

Friends and peers become of crucial importance to adolescents as they separate from their familiar family ties, therefore groups can gain in significance for them during this period (Wilson, 1991). Groups are also an ideal place to guide adolescents through the transition phase and to safely practice for democratic adult life, offering a space for experimentation (Malekoff, 2004; Linesh, 1988). Within the framework of therapeutic work a benefit of groups, rather than individual sessions, is that the group helps to combat the adolescent fear of being excluded and guard against self-consciousness (Payne, 1992).

Looking specifically at the contribution of DMP, it is useful to consider the adolescents natural affinity with the arts. They often turn to dance, music, art or drama for an emotional release, in order to support their new identity or as a way of making sense of their changing world. As a result of their experience of the creative arts adolescents have a deep understanding of the creative arts ability to heal (Emunah, 1990). Blos (1962) states that the decline of the unusual artistic activity at the close of adolescence is an indication that it is actually a function of the adolescent process. One way in which adolescents use the creative arts is defined by Emunah

(1990; 104) who states that "creative art activity enables the adolescent to discover and utilize structuring mechanisms that arise from within the self, rather than being enforced from outside". The particular benefits of creative group techniques are that they stimulate affect within adolescents while simultaneously offering them cognitive insight and behavioural observation (Veach & Gladding, 2007).

Furthermore, from a movement perspective Schmais (1985) argues that there are 8 potential healing aspects of group DMP. She names these as synchrony, expression, rhythm, vitalization, integration, cohesion, education and symbolism.

Evidence seems to support group working with adolescents and a growing body of evidence supports the specific benefits of the creative therapies. A meta-analysis of the effects of Dance/Movement Therapy by Ritter and Low (1996) conclude that adolescents do benefit from Dance Movement Therapy and that they actually benefit more than children.

DMP within educational settings

Dance Movement Psychotherapists work with adolescents in a range of settings such as residential schools, special schools and psychiatric settings (Payne, 1992; Brown, 1999; Stanton-Jones, 1992) and around 40% work in some form of educational setting (Karkou & Sanderson, 2006). Still literature focused on DMP with adolescents in mainstream school settings remains thin.

Schools, however, are ideally placed to support adolescents and curriculums in both England and Scotland offer courses designed to support the adolescent transitional stage and to help address social and emotional issues (Qualifications and Curriculum Authority, 2000; Curriculum for Excellence, 2011). Yet, lack of training on mental health issues for teachers means that schools are poorly equipped to deal with the psychological needs of pupils (Ofsted, 2007).

Eke and Gent (2009) is one of the few studies on group DMP with adolescents in a secondary school setting and they concluded that "a therapeutic alliance between secondary schools and DMP group work has the potential of offering the troubled adolescents what he/she craves: a physical space reflecting an inner place where trust can develop between peer members of the group and facilitators" (Eke & Gent, 2009; 55).

This study is useful because it offers insight into the practical implications of DMP in a mainstream school as well as setting out the limitations and potential issues of working with vulnerable adolescents in the school setting; however, the sample was fairly small. Furthermore, methodologically it did not engage in generating evidence but rather reports on the method and rationale for their intervention.

Similarly, Joseph's (2011) artistic enquiry was essentially a small case study on one group facilitated and researched by the author, Joseph looked particularly at Win-

nicott's notion of holding. She defined holding as: "Support and protection for the client from any impingement. Within it the client has a safe space in which to work with external and internal realities. This in turn promotes the clients self-experience" (Joseph, 2011; 3).

Joseph (2011) found that in this particular group there were three key moments of holding. The first was holding by their own internal rhythm supported by an object, the second key moment was holding in relationship with another and the third moment was holding by the group.

As a study with an artistic methodology, it summarized findings in a final artistic piece. Artistic inquiry as a methodology accommodates data generation through creative processes without the necessity to translate. It also allows for any bias of the dual role of therapist researcher and for data generated in the therapy session. However, as a small scale study that did not collect any quantitative data this study remains short of convincing critical audience of the effectiveness of group DMP for this client group.

Another study with adolescents in secondary schools (Karkou et al., 2010) reported that the student's valued working with other students and that peer feedback was valuable to them. Methodologically the study was a pilot randomized controlled trial that collected both qualitative and quantitative data mainly through participant observations and standardized tests. It seems that confidence, sense of relationship, body image and vitality all improved and teachers reported a reduction in "internalizing" behaviours of those who took part. However, given the small scale of this study conclusions remain tentative.

Mainstream schools have a responsibility to support adolescent development, and in the UK they offer courses designed to support the adolescent transitional stage and to help address social and emotional issues (Qualifications and Curriculum Authority, 2000; Curriculum for Excellence, 2011). However, Ofsted (2007) reports lack of mental health training for teachers in the UK.

Conclusion

Both theoretical and research literature suggests that group DMP could be of particular value to adolescents in secondary schools. Theoretically group DMP can be beneficial meeting the needs of the adolescent for self-development, social skills, communication skills, increased confidence and self-awareness and empathy for others. Groups not only offer support during the process of psychological separation from the family but also a space to practise and learn new strategies. Group work may also combat the adolescent fear of being seen and guard against their self-consciousness. Furthermore, therapeutic play and movement gives the adolescent an opportunity to communicate through their bodies creatively.

From a research perspective there is evidence that supports these theoretical ideas. However, all the studies so far are small scale, primarily small case studies. Although the type of evidence is diverse, i.e. artistic, text and/or number based, they are limited in their capacity to generalize their findings. Larger studies with opportunities for quantitative methods to gather evidence are required to further our understanding of the value of group DMP with adolescents.

A new PhD study has begun at Queen Margaret University that is titled "An Investigation into the practice of Dance Movement Psychotherapy with adolescents within the UK" and is expected to offer further support in the development of our understanding into the field. It has two main questions:

1. How do Dance Movement Psychotherapists in the UK work with adolescents?
2. What is the value of this work as perceived by therapists, clients, parent/carers and teachers?

It is expected that this study will follow a mixed methodology and be in two phases. The first phase will involve analyzing existing national survey data and interviewing experienced practitioners. The second phase will involve using small mixed method random controlled trials to pilot some of the first measures and discover aspects of good practice.

As a result, methodologically it will attempt to combat limitations from previous studies. For example, it will look at national data rather than looking simply at the work of one practitioner. Similarly, it will collect data on the value of this intervention beyond the limits on one single group. The data will not rely simply on either qualitative or arts-based information. Standardized tests will also be used with a sample which will be large enough to be able to draw some conclusions.

It is hoped that this will not remain an isolated piece of work, but it will be a study that will generate funding opportunities for larger studies beyond the limits of a PhD study in one location and in one country. A call for therapists and researchers interested in this area is made to gather forces and expertise for further work in this area.

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DANCE MOVEMENT THERAPY FOR PATIENTS WITH OBESITY AND EMOTIONAL EATING DISORDER

Abstract

This article summarizes the outcomes of a controlled study and therapeutic work in dance movement therapy done with women patients suffering from obesity and emotional eating. Dance movement therapy (DMT) was offered as a possibly useful treatment strategy where patients may rebuild connection with their bodies and sensitively address emotional aspects underlying distorted eating behaviour. The study was carried out with n = 92 women participating in commercial weight loss program. Experimental group (n = 30) was involved in 10 DMT sessions during a 5-week period when one control group was involved in some physical activities (n = 32), but another control group did no physical activities (n = 30). The DMT group showed statistically decreased psychological distress, decreased body image distress, and increased self-esteem compared to controls. Emotional eating reduced in DMT and exercise groups. Working therapeutically allowed understanding needs of this patient group – increasing body awareness, self-acceptance, safety and encouragement for emotional expression in the group.

Keywords: obesity; dance movement therapy; emotional eating; controlled study; psychological distress; body image distress; guidelines.

Introduction

Obesity has become an epidemic in European health care system. More than one-third of citizens of the EU are overweight and one person in ten is obese (BMI ≥ 30). 400,000 children of school age become overweight each year. The Foresight report (discussed by Aylott et al., 2008, cited in Meekums, Vaverniece et al., 2012; 126) predicted that if no action was taken, more than half of the UK adult population would be obese (60% of men, 50% of women) by 2050. the concern of the issue is in the fact that there are serious health risks that increase with obesity – hypertension; increased blood cholesterol levels; type two diabetes; coronary heart disease (Craig and Hirani, 2009, cited in Meekums, Vaverniece et al., 2012; 126); stroke; and after the menopause – cancer of the breast and uterus, osteoporosis and joint problems (Twigg, 2006, cited in Meekums, Vaverniece et al., 2012; 126) leading to the reduced life expectancy.

Obesity has become a significant burden on health and social system as eight per cent of health care expenses are directed towards solutions for the obesity problem (European Parliament, 2008, cited in Meekums, Vaverniece et al., 2012; 126). Consequences of obesity are not just physical; the quality of life of obese persons is reduced, because obesity impacts physical, emotional and social functioning.

Overeating as a reaction to emotional states is named **emotional eating** (Van Strien, 2002). There is correlation between obesity and emotional eating. But emotional eating is recognized with a dangerous link between psychological discomfort, low self-esteem, negative body image and affective disturbances, also – obese people are subjected to stigmatization, discrimination and lower life quality (Annis et al., 2004, cited in Meekums, Vaverniece et al., 2012; 127). There are many commercial weight loss programmes in Western culture, but mostly results are evaluated in a short-term. The people regain the lost weight during several years, because no inner motives and reasons are identified for the desire and tendency for overeating or emotional eating (Shaw et al., 2005, cited in Meekums, Vaverniece et al., 2012; 127). Complex relationships between emotional eating, body image distress and psychological consequences suggest the need for a non-stigmatizing therapy that allows participants to safely access their emotions and which encourages self-reflection, includes diet and physical exercise and addresses the complex relationships identified in obesity with emotional eating. An optimal therapy for this client group focuses on psychological issues associated with weight loss, because overeating is seen as a symptom of deeper emotional problems and permanent changes in eating behaviour are unlikely without addressing these underlying issues (Van Strien, 2002, cited in Vaverniece & Majore-Dusele, 2010; 254). Dance movement therapy (DMT) was thus envisaged as a potential psychological treatment because it encompasses awareness of and reflection on body image and emotional states, whilst also offering the benefits of an exercise programme. The present study was developed based on the study design of the dance movement psychotherapist PhD Bonnie Meekums (2005, 2010). The study concludes that DMT could form part of the treatment for obese women with emotional eating as DMT group showed statistically decreased psychological distress, decreased body image distress, and increased self-esteem compared to controls (Meekums, Vaverniece, Majore-Dusele, Rasnacs 2012). There are different aspects of results coming from this study – results from quantitative, statistical analyses and results coming from practice of working with this client group. This article will point out the guidelines of working with this client/patient group taking into account evidences coming from the research and practice.

Psychological aspects of obesity and emotional eating

A number of studies has shown that there is a relationship between obesity and psychological disturbance or particular features of a personality. For example, adolescents who suffer from depression are more likely to become overweight adults

than adolescents who are not depressed (Stunkard, 2003, cited in Meekums, Vaverniece et al., 2012; 127). Obese people have significantly lower self-acceptance and self-esteem, they are at greater risk of psychological distress and suffer more day-to-day interpersonal discrimination, employment and institutional discrimination compared to normal weight individuals (Carr, Friedman, Jaffe, 2007, cited in Meekums, Vaverniece et al., 2012; 127). Another important relationship is between obesity and body image distress (BID), which is then linked with depression and low self-esteem. BID in overweight individuals decreases with weight loss, but increases as weight is regained (Sarwer & Thompson, 2002, cited in Vaverniece & Majore-Dusele, 2010; 253); depression decreases with weight loss overall but can increase if the degree of weight lost is lower than expected (Faulconbridge et al., 2009, cited in Meekums, Vaverniece et al., 2012; 127). Schwartz and Brownell report in their research that there is a relationship between obesity and poor body image, but they give a significant remark that not all obese people suffer from the body image distress. The risks are body mass, feminine gender and emotional eating (Schwartz & Brownell, 2004, cited in Vaverniece & Majore-Dusele, 2010; 252).

Emotional eating is closely linked to Binge Eating Disorder (BED) (American Psychiatric Association, 1994); both include the consumption of large amounts of food together with a subjective loss of control over both eating behaviour and psychological distress. Emotional eating as behaviour is closely linked with emotional states, even though these relationships are not purely clear. Psychosomatic approach considers emotional eating as week awareness of inner impulses, which manifest in difficulties to perceive sensations of hunger and satiety and also to distinguish them from emotional feelings (Van Strien, 2002, cited in Vaverniece & Majore-Dusele, 2010; 254). Overweight individuals are more likely to overeat in negative emotional situations than either normal or underweight individuals (underweight individuals being more likely to undereat in similar situations) (Geliebter & Aversa, 2003, cited in Meekums, Vaverniece et al., 2012; 127). Emotional eating as a reaction to emotions and feelings may be perceived as looking for emotional comfort. By loosing control over eating behaviour and emotions increases self-criticism, sense of guilt which results in low self-esteem. The link between self-esteem and eating disorders has been reported in several studies, and negative self evaluation has been recognized as a risk factor for the development of eating disorders (French et al., 2001, cited in Meekums, Vaverniece et al., 2012; 127).

An important aspect of appearance and body image is body weight, especially for women; if a woman evaluates her self-worth according to her appearance (self-esteem increasing with body image satisfaction) this poses a potential risk factor for both psychological distress and eating disturbance, including depression (Crocker & Garcia, 2005, cited in Meekums, Vaverniece et al., 2012; 127). Body image disturbances are recognized as a risk factor for the women who change their eating habits with the aim to change the appearance or to loose the weight, potentially eating disorders may develop. The preventive programmes are especially needed in such cases to pro-

mote the awareness of women's perceptions about their body image and its link to possible problems (Cash & Flemming, 2002, cited in Vaverniece & Majore-Dusele, 2010; 252). Researchers confirm that an optimal therapy for this client group is oriented to psychological problems more than to weight loss, because overeating is just a symptom of deeper emotional difficulties, and suggest non-stigmatizing therapy which allows to be in contact with emotions and encourages self-reflection, includes diet and also physical exercises and look at the complex relationships between eating behaviour and emotional states (Van Strien, 2002, Meekums, 2005, cited in Vaverniece & Majore-Dusele, 2010; 253). Therefore, dance movement therapy was seen as appropriate therapeutic intervention for this patient group and controlled study was realized to answer research questions:

1. Is DMT effective in increasing wellbeing and self-esteem and decreasing psychological symptoms for obese women with emotional eating?
2. Is DMT effective in decreasing body image distress for this patient group?

Research methods and results

This research design was based on a previously published review (Meekums, 2005). The sample was taken from women who participated in a commercial weight loss programme in Latvia, thus ensuring that all participants were following a similar diet. Inclusion criteria: engaged in the weight loss programme; body mass index (BMI) 30 or above (obese); emotional eating. This resulted in 158 participants being recruited for the participation in the study and 92 women were selected as fulfilling the criteria of emotional eating with a BMI 28 or more (insufficient amount of the respondents with BMI above 30), and gave their informed consent.

They were also asked whether or not they engaged in physical activity twice or more times a week in order to facilitate selection into one of the three groups:

1. Experimental treatment group (n = 24) – women with BMI 28 and above with emotional eating, involved in a weight loss programme who were not already participating in other physical activities and who attended 10 group DMT sessions twice a week during the period of five weeks;
2. control group exercising (n = 28) – women with BMI 28 and above with emotional eating, involved in a weight loss programme who participated in physical activities at least twice a week;
3. control group not exercising (n = 27) – women with BMI 28 and above with emotional eating, involved in a weight loss programme who were not participating in other physical activities.

As the aim of this article is to present understanding about the needs of this patient group and the working guidelines in DMT, the results of the controlled study will be

outlined only in general. The article that presents all the aspects of this study was published in April 2012, in The Arts in Psychotherapy "Dance movement therapy for obese women with emotional eating: A controlled pilot study" (Meekums, Vaverniece, Majore-Dusele, Rasnacs, 2012).

Results of this quazi-experimental controlled study demonstrated effectiveness of a DMT intervention group over both exercise and non exercise controls in increasing self-esteem and well-being for women defined as obese and emotional eaters. Women participating in the DMT group also had significantly decreased levels of psychological symptoms (depression, anxiety, trauma symptoms) and body image distress by the end of the programme. Weight loss was not the focus of this study; the data about weight were collected before and after the duration of the treatment group. The data concerning BMI demonstrate that there were statistically significant changes in BMI before and after the treatment period in all three groups; the treatment group and both controls lost weight. Also eating behaviour was not the focus of the study, but it was observed. The results showed a significant decrease in emotional eating after the intervention in the treatment group and in the control group with physical activities. Other control group did not show significant changes in comparison of before and after the intervention. Comparative results of control groups showed that losing the weight and physical activities per se did not have significant impact on the psychological well being and self-esteem of obese women. Despite methodological limitations, the present study suggests that DMT could offer an effective and acceptable treatment option for women who are obese, eat for emotional reasons and are motivated to lose weight by participating in a weight loss programme.

Statistical analysis of the data regarding body image distress provides interesting findings. Those women (control group exercising) who regularly participated in physical activities had higher scores at baseline on self-esteem and lower body image distress than those who did not do any physical exercise (Control group 2) or the treatment group (Exp) allocated to DMT. This group (control group exercising) also significantly decreased their emotional eating over time, despite no DMT intervention. These results allow no conclusions as to cause and effect between self-esteem, body image and physical activities, though they do suggest a correlation. It allows making an assumption that body image distress is the reason of avoiding physical activities for women with obesity, and affirm research findings that women with higher self-esteem exercise most often (Puhl et al., 2007, cited in Meekums, Vaverniece et al., 2012; 131). As the treatment group showed significant decrease in body image distress and increase in self-esteem, we may suggest a possible link between increased physical activity in the DMT group and decreased body image distress. DMT treatment group increased positive feelings regarding the self and the body, and we may expect that women who have not been physically active before DMT group may feel more confident in looking for regular physical activities for themselves afterwards.

DMT guidelines for patients with obesity and emotional eating

The aim of DMT working with this patient group is increasing mindfulness, emotional and body awareness, self-reflection skills and self-acceptance within supporting therapeutic environment and therapeutic relationships. Therapeutic process of 10 dance movement therapy sessions included directive and non-directive techniques, investigation of movement symbolism and movement metaphors, exploration of mind-body connection, work with props, self-expression and relaxation.

In this part the most meaningful aspects of DMT work will be described which were found to be the most appropriate and effective by working therapeutically with this patient group.

Increasing body awareness. The essential aspect of the beginning of every therapeutic group is to create a safe therapeutic environment where therapeutic alliance, safety, trust and openness may gradually develop. *Mindfulness* (an open awareness to present the moment with curiosity, openness, acceptance and kindness) is a skill and tool which can be used by dance movement therapist to create safe and accepting group environment and also to increase participant's *body awareness*. It happens by gently turning their attention towards the body, breathing, body boundaries, sensations coming from movement, breath and touch, feeling of grounding when paying attention to the feet, by being attentive to the space and other group members. Mindfulness helps to develop a listening to one's body, as well as to one's feelings, thoughts and images. Increased body awareness is a base needed for exploring a body-mind connection, for possibility to distinguish physical sensations from emotional feelings (for example, feeling the difference between sensation of hunger and sensation of anxiety) and to develop a positive body experience. When body awareness is developed in a framework of mindfulness then open, kind and *accepting attitude toward self* is gradually cultivated.

Exploring movement qualities – "weight". When there is more individual body awareness and more trust and openness in group, participants may feel encouraged to express themselves in movement and dance. Exploring the movement qualities (efforts – time, space, flow and weight) helps to recognize and develop individual movement dictionary and gradually become more spontaneous in self-expression. Investigating of movement effort "weight" (effort of weight is possible to observe as light, passive or strong) is emotionally challenging experience for this patient group. The quality of "strong weight" is perceived as "heavy weight" and it illustrates how sensitive this question for women with obesity is. Even though there are evasive attitude and confused feelings in the process of investigation of weight quality, it is helpful for the participants to get positive experience of feeling their own strength and using their weight in effective way (for example, by supporting other person's body or by bearing the physical pressure coming from another person). When the patients with obesity

can feel safe and accepted in the group, they can take on a challenge and explore emotionally sensitive aspect of a weight in physically supportive way using movement qualities and contact improvisation techniques.

Body-mind connection. When increases attention to the body, movement qualities, self and others in the space, naturally increases awareness of body-mind connection. Everyone in their own way may explore how different postures and gestures are felt physically, how they are perceived emotionally and how they reflect cognitively. Participants may discover, for example, that closed posture may feel uncomfortably, but seems emotionally comforting at that moment or staying grounded and physically balanced on both feet gives a feeling of confidence. And the other way – patients discover that fear and anxiety brings tension into their stomach or chest, but acceptance and kindness relax tension and may be felt as physical warmth in the body. When patients have this kind of personal experience, it increases their sense of confidence and self-control as they understand the signals coming from their mind and body better.

Investigating movement metaphors. Movement metaphor is a personally meaningful story which is expressed through the movement sequence or gesture. Only when we are aware of body-mind connection, we are able to pay attention and to make the meaning of stories our bodies tell us. Thus, images, symbols and metaphors growing out of the movement and dance. This is a moment where improvisation can arise. When working with obese patients, some improvisation themes are really appropriate as these allow exploring emotionally significant aspects of their difficulties. One of them is "*Giving-taking-holding-letting go*". When working with movement quality "weight", these patients showed difficulty to physically use their strength (give their weight), similarly in the improvisation patients showed resistance to let go, give away their gained props, in the same way as they where holding their feelings. When thinking about excessive weight as a broken balance between energy intake and consumption, the resistance of letting go (physical objects, feelings and emotions, thoughts, positions, energy) may help to understand better the psychological mechanisms of getting overweight. This kind of experience may bring insights into patients understanding of their own emotional functioning and may work as impulse for change.

Encouraging self-expression is the next step following insight about these patients' difficulties to give away, share and express emotions, thoughts and energy. As there is a deeper understanding in obesity mechanism in patients, there is need of support and encouragement for making the choice to experiment with new behaviour. This is a challenge not to hold her self back, but to express her self in movement, in sharing a feelings and thoughts, in being involved in relationships, in being active internally and in relation to others.

Positive body experience is an important need for this patient group. Increasing body awareness, experiencing a body-mind connection, self-expression in movement may give an experience of feeling a physical comfort, satisfaction and joy and this is

a meaningful alternative for these patients. As food represents comfort, it is important to have a different kind of tool how to control emotional discomfort and how to set themselves at ease. Also learning relaxation exercises may be a useful skill for patients with obesity and emotional eating.

Importance of the group. For these patients group intervention seems to be much more appropriate as individual. A group has its own therapeutic factors and for these patients it is important to know that there are others with a similar problem. The group provides support, acceptance, encouragement, insights and needed dose of challenge for change. The group setting naturally provokes self-expression and that is the needed impulse for patients who suffer from obesity and emotional eating.

Conclusions

Dance movement therapy may be seen as appropriate therapeutic intervention for women suffering from obesity and emotional eating. There are experimental controlled study results supporting this assertion, as DMT group showed significant increase in self-esteem and wellbeing and significantly decreased levels of psychological symptoms (depression, anxiety and trauma symptoms) and body image distress in comparison with control groups. Workings with this patient group allowed deeper understand their needs and to build the DMT treatment programme where attention is paid to important aspects of their difficulties – body awareness, self-acceptance and self-expression. Further research is needed with a longer treatment programme, larger samples, blind randomization and measurement, an intention to treat analysis and waiting list controls, with follow-up measurements to investigate long-term effects.

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USE OF EXPRESSIVE THERAPIES CONTINUUM IN DANCE MOVEMENT THERAPY WITH EATING DISORDER

Abstract

Dance movement therapy work with eating disorder patient at Children's Clinical University Hospital is presented in this article by using the Expressive Therapies Continuum. The cause of eating disorder development, specifics of illness and dance movement therapy, work specifics with this patient group in a multiprofessional team are also discussed in the article. The understanding of the Expressive Therapies Continuum levels in dance movement therapy is presented by using case of a patient, who has Anorexia Nervosa. The results show that the use of the Expressive Therapies Continuum gives valuable understanding of patient condition, helps adequately and productively assess patient and promotes dance movement therapy process with patient suffering from eating disorder. Dance movement therapy for patient with eating disorder can facilitate improvement, decrese depressive feelings and increase personal meaningfulness, communication, body awareness and acceptance.

Keywords: Anorexia Nervosa, dance movement therapy, eating disorders, Expressive Therapies Continuum.

According to International Classification of Function, Disability and Health – 10 (Further in text ICD-10), which has been worked out and for international use confirmed by the Wold Health Organization and is used in health practise in Latvia, eating disorders are included in psychiatric and behaviour disorder group: behavioural syndromes associated with physiological disturbances and physical factors, subgroup eating disorders: (F50), Anorexia Nervosa and Bulimia Nervosa.

It is observed in Children's Clinical University Hospital "Gaiļezers", psychiatric ward that mostly young females (15–17 years old) suffer from eating disorders. Patients with eating disorders make 3% of all patient groups (disorders of psychological development, behavioural and emotional disorders with onset usually occurring in childhood and adolescence, mental retardation, Schizophrenia, schizotypal and delusional disorders and Neurotic, stress-related and somatoform disorders) which dance movement therapist works with in inpatient unit and outpatient unit. Patients with eating disorders can have between 4–20 dance movement therapy (further in text DMT) sessions one or twice a week.

Description of Anorexia Nervosa

Anorexia Nervosa is classified as purposeful decrese of body mass, which is caused and maintained by patient. Teenage girls and young women are the most frequent victims of the illness. The disorder is characteristic with a specific psychopathology – overdone idea about potential thickness or diffuse body shape. The patient perceives small body mass as the main aim. The illness is also strengthened by malnutrition with secondary endocrine and metabolic changes and disorders of body functions. Restriction of diet, excessive physical activity, vomiting and use of diarrhea medicine are listed as symptoms of this disease. Anorexia can be defined as a complex illness in which physical, cognitive, emotional and social aspects are combined. Those patients have difficulties in cognitive aspect (obsessive thoughts and negative view about themselves, excessive weight control), emotional aspect (depressive mood or mood swings, sense of little self-worth and desperation, anxiety, etc.), behavioural aspect (not eating or overeating, excessive physical activity or decrease of energy and activity, physical discomfort, disturbances of physical functions) and social aspect (absence of communication, social isolation or secrecy, absence of initiation and interests) (ICD-10; Rehavia-Hanauer, 2003, Farrel, 2001).

Physical symptoms of the illness are: loss of body weight, disturbances in menstruations and cognitive perception of one's body weight and body image disturbances, for example, a very thin girl perceives herself as very fat (Slade, Russel, 1973; Jones, Leung, Harris, 2007; 156–171; Cooper, Shafran, Gilbert, 2008). Also psychomotor delay and absence of pleasant sensations are present (ICD-10). Eating disorders are related to depression or depressive feelings (Shah, Waller, 2000, 2001), anxiety (Welburn, Coristine, Dagg, Pontefract & Jordan, 2002) and distress (Schmidt, 1995). Depressive episodes are characterised by depressive mood, decrese of energy, activity, interests, concentration skills and ability to enjoy life. Almost always patients have low self-esteem and ideas of low self-worth and guilt.

Eating disorders are related also with denial of feminity and sexuality (Krantz, 1999; 81–103). There is an unrecognized wish to keep childishness which manifests itself in physical way (Crisp, 1980), disturbances in family system and mother-child dyad (Farrel, 2001). Patients with Anorexia Nervosa want to control everything in contrast to loss of control in reality (Rehavia-Hanauer, 2003; 137–149). On the one hand, those patients, usually unaware of it, are looking for lost relationship experience, which is needed for the development of Ego. On the another hand, the need of these relationships is denied (Rehavia-Hanauer, 2003; 137–149).

The causes of illness are multifactorial – sociocultural, family, psychological, biological as well as genetic predisposition. As the illness usually starts in puberty, it is important to keep in mind the characteristics of this developmental stage: inability to resolve individualisation-separation conflict (Eisler, 1995), inability to overcome Oedipus complex (for girls Electra complex) and step in puberty developmental stage (Rehavia-Hanauer, 2003; 137–149).

Dance movement therapy as part of multiprofessional team

Dance movement therapists work as part of a multiprofessional team in Children's Clinical University Hospital "Gaiļezers". The multiprofessional team consists of children's psychiatrist, psychotherapist, psychologist, speech therapist, medical nurse, medical nurse's assistant, social worker, physiotherapist, interest education teacher, arts therapist and music therapist. Multiprofessional team is lead by children's psychiatrist – doctor. The team meets once a week in collegial meetings, in which the important questions relating to patient's health and recovery dynamics are discussed. Each specialist sets goals in relation to a patient based on their professional competences in health care, which are mutually agreed among multiprofessional team professionals. Dance movement therapists in Children's Clinical University Hospital "Gaiļezers" work in multiprofessional team by realizing patient's psychical rehabilitation program. In their work, dance movement therapists assess patients, set aims of therapy (in relation to rehabilitation aims), evaluate DMT process and results and participate in multiprofessional team meetings by analysing the process and results of rehabilitation.

Dance movement therapists in Latvia, who work in health care and are involved in a multiprofessional team work, integrate assessment criteria by using ICD-10 and leading Netherlands arts therapist and researcher Henk Smeijster's approach in relation to primary and secondary aims. DMT primary aims in relations to eating disorders are the decrese of depressive feelings, secondary – the development of bodily awareness, body image acceptance, development of communication skills, strengthening of impulse control (in relation to bulimia attacks), increase of self-esteem and personal resources.

Dance movement therapists use the integrative-eclective approach when they work in health care. It consists of psychodynamic orientated, humanistic, patient-centered and art-based approach, which is appropriate to patient's needs, environment and DMT aims (Mihailova, Majore-Dusele, Vende, 2011; 325–331). Rudolf Laban developed Laban Movement Analysis (further in text LMA) Judith Kestenberg created Kestenberg Movement Profile (further in text KKP) which are used as art based assessment and DMT process and result evaluation and have been approved as assessment technology in Latvia and listed in DMT medical technologies (Approved Medical Technology of Art Therapy in Latvia, http://www.vmnvd.gov.lv).

LMA is a movement notation and an analysis system which consists of 4 main categories: Body, Space, Shape and Effort. Effort (sometimes also called Eukinetics) category has 4 subcategories: Weight, Space, Time and Flow, which describes movement qualitative aspect and reflects person's emotional state (Bloom, 2006). KKP integrates LMA and developmental theories, reflects individual's psychomotor and emotional development. It consists of 2 main systems. Tension-Flow-Effort-

System reflects individual's inner needs, feelings and affects and how he/she relates to changes in the environment. Tension-Flow-Shaping-System reflects individual's relationship to other individuals and things (Kestenberg, Loman, Lewis & Sossin, 1999).

LMA and KKP are used in DMT in order to describe person's movement, assess patient, in order to formulate hypothesis, aims, and DMT plan and to evaluate DMT process and results (Mihailova, Majore-Dusele & Vende, 2011).

For the first time also art-based assessment The Expressive Therapies Continuum (ETC) has been used in the treatment (Lusebrink, 1990, 2010, 2011; Lusebrink, Martinsone & Dzilna-Silova, 2012).

In order to understand and describe therapeutic process, Bonnie Meekums creative change cyclic model is used.

Dance movement for patients with eating disorders

The illness for patients with eating disorders manifests itself as the fight with one's body and denial of bodily needs. As DMT primary works with body and emotional aspects, it is considered that DMT is one of the suitable therapeutic forms for patients with eating disorders to reduce disorder symptoms (Krantz, 1999; 81–103; Levy, 2005; 253), to renew the bond between body and emotions, as well as to work with body image acceptance (Kleinman, Hall, 2005; Kleinman, 2009; 125–143).

Dance movement therapists must keep in mind patient's enervate body state, the risk of bradycardia (in case of Anorexia Nervosa), as well as an impact of medications on patient's physical and psychological state.

The resource of a patient usually is their interest in dance and movement technics used and the wish to participate in physical activities. However, dance movement therapists must keep in mind that patients sometimes might want to do physical activities excessively, because of the desire to lessen their weight. In those cases dance movement therapists must be conscious about it and limit the intensity of the activity.

In order to facilitate patient's functional level and plan DMT process Vija Bergs Lusebrink's conception about art expressive hierarchical levels is used. The Expressive Therapies Continuum consists of three stepwise levels – Kinesthetic/Sensory, Perceptual/Affective and Cognitive/Symbolic – interconnected by the Creative level (Lusebrink, 1990; Lusebrink, Martinsone & Dzilna-Silova, 2012). Each hierarchical level includes specific use off props and techniques, which reflect patient's mental and artistic developmental level, starting from spontaneous reactions to symbolic thinking. ECT helps to define the hierarchical level in which a patient mostly works, and which hierarchical level must be developed. So the ECT can be used for the assessment of patient and planning of DMT process (Upmale & Majore-Dusele, 2011; 138–142).

Use of the Expressive Therapies Continuum in DMT work with eating disorded patient

As mentioned above, the ETC hierarchical levels and their components help dance movement therapist to assess patient's level of functioning, dominant and not so well developed art expressive level and appropriate component in relation to DMT. It is suggested that for patients with eating disorders the dominant is Cognitive component. It means that it is necessary to facilitate Affective and Sensory component in development. However, if the Affective component was the dominant one, it would be helpful for a patient to develop their Cognitive, Perceptual and Sensory components. It would contribute to developing a balance between art expressive hierarchical levels, and consequently also to the decrease of disorder.

For the Kinesthetic component creative activities which facilitate liberation of rhythm, action and energy in Kinesthetic/Sensory hierarchical level are characteristic, i.e. when somebody expresses their tension and anger, or soothes rhythmical activity, when somebody expresses one's anxiety (Cottrell & Gallant, 2003; Lusebrink, 2004; Upmale & Majore-Dusele, 2011; 138–142). For patients with eating disorders this component is seen via different use of rhythm (after KMP – oral, anal, urethral, etc.), by exploring surfaces and different textures of materials and by expressing it in movement action (for example, shaking, twisting, running, etc.). Kinesthetic component also relates to Marian Chase's use of rhythmical activity, which can be described as the use of rhythmic movement in order to activate a patient and facilitate his/her expression of emotion (Mihailova, Majore-Dusele, Vende, 2011; 318–319).

Sensory component of Kinesthetic/Sensory hierarchical level defines that creative process is directed to senses (through visual, audial, taste, smell and touch media), which emerge when patient works with props and senses which are aroused by the environment. DMT activities at sensory level might be as a starting point for therapeutic process, because sensory experience can provoke emotion, memory at the Sensory level about the experienced situation in a patient. By fostering sensory senses, dance movement therapists can teach their patients to "listen" to their body and transfer the way patient perceives information form Cognitive to more Sensory level (Upmale & Majore-Dusele, 2011; 138–142). Sensory level in DMT relates to paying attention to textures of props, fabrics, temperature in the therapeutic space, smells, awareness of body sensations during movement (like, tension, relief, tingling, etc.), use of massage and touch. For patients with eating disorders this component manifests as an exploration of physical sense, awareness of physical boundaries, rhythmic synchronicity, mirroring and building up nonverbal communication.

Perceptive component of Perceptual/Affective hierarchical level: the main attention is drawn to movement of image structure and shape. In relation to this component, the objectivity of perception and the ability to realistically perceive and represent environment is developed. Perceptive component needs to be activated for those eat-

ing disorder patients whose overwhelming emotional expressions need to be lessened through encouraging them also to concentrate on shape and structure of image, not only on emotions which are aroused by it (Upmale & Majore-Dusele, 2011; 138–142). Perceptive component is facilitated in DMT by using such techniques like making sculptures, shaping in planes (after LMA), taking different kind of postures.

Affective component of Perceptual/Affective hierarchical level is connected to emotional expression in relation to different props by focusing attention to the creative process, not onto the result of it (Upmale & Majore-Dusele, 2011; 138–142). For DMT patients with eating disorders this level can manifest as the liberation of movement flow (after LMA), reducing of tension blocks in body, spontaneity, improvisation, bodily expression of emotions.

When a patient works with Cognitive component at Cognitive/Symbolic hierarchical level, the focus of attention for them is on logical thinking, successive thinking procedures and ability to plan one's actions. Cognitive component happens when there is work with mental images and verbal expression (Upmale & Majore-Dusele, 2011; 138–142). Cognitive component is usually the dominant one for patients with eating disorders. In DMT it can be noticed when a patient uses Light Weight, Vertical Dimension, Bound Flow (after LMA) and fragmentary movement. This component can be developed in DMT by using improvisation and images, paying attention to breath. The use of Cognitive component can facilitate awareness of body image and integration between physical actions and senses, as well as emotions and thinking.

Symbolic component of Perceptual/Affective hierarchical level focuses on creating intuitive concepts. Symbols can be multi-layered and multidimensional and they can be described from kinesthetic-dynamic, sensory, emotional and subjective or universal aspect of meaning (Upmale & Majore-Dusele, 2011; 138–142). This component for patients with eating disorders in DMT is facilitated by using images, metaphor and such a technique as making body sculptures.

To describe DMT process Bonnie Meekums' creative change cyclic model is used (Meekums, 2002). It consists of four stages: Preparation, Incubation, Illumination and Evaluation. Preparation stage is characterized by preparing and warming-up for creative process, by moving body and familiarizing oneself with props. Communication between patient and dance movement therapist is usually verbal and facilitates activity in the left (responsible for verbalization and logical thinking) hemisphere. When a patient works at Incubation stage, he/she gradually yields in creative process and lessens control of awareness. The brain activity usually takes place in the right hemisphere during this process. The meaning of images, metaphors and symbols become important at the Illumination stage. Brain activity is more concentrated in the left hemisphere. As a result of that, experienced emotions, images and senses are integrated (Meekums, 2002).

Blanche Evan's (Evan, 1981) model is used in DMT work with eating disorder patients. This model was created especially for this patient group, by underlying physical aspect (in order to illuminate individual's inner experience through physical movement), emphasizing mobility (provides the bond between feelings and movement) and improvisation (unaware psychophysical expression). DMT plan is based on dance movement therapist Ariele L. Riboh's (Riboh, 2009; 1–35) theroretical overview about DMT work with this patient group and oferred a three-step plan (Rice, Hardenbergh, Hornyak, 1989; 252–278). The main guidelines are: kinesthetic empathy, awareness and techniques such as mirroring and rhythmical synchrony.

Previously described model is integrated in DMT technologies (Approved Medical Technology of Art Therapy in Latvia, http://www.vmnvd.gov.lv), also including specific DMT methods or their elements such as Chase's interactive rhythmical movement or Mary Whitehouse's authentic movement. DMT session has three parts: warm-up, process and closure. The warm-up part of the session include: body warm-up techniques, techniques incresing body sensibility and movement coordination, breathing techniques. Dance movement therapist uses individualized active directive and nondirective techniques in process part of the session such as: movement development, mirroring, amplification or reducing of movement, techniques to develop positive body image, development of communicative skills, offering movement theme, development of movement metaphor, use of props. Finally in the closure part of the session verbalization, reflections and feedback tehcniques are used in order to facilitate integration of gained experience.

At the beginning of therapeutic process the main aim is to buld a therapeutic alliance between dance movement therapist and patient, and awareness of physical sensations. The main themes in DMT therapeutic process stage are exploring body image, self-esteem, relation between body and emotions. Finally, leading themes at the end of therapeutic process are: symbolic relationships between mother and child, increse of self regulatory skills and self-esteem and integration of the gained experience.

Overview of DMT work with eating disorder patients using the Expressive Therapies Continuum

The patient is 16 years old, diagnosed with Anorexia Nervosa with Bulimic attacks. The patient's weight was 47 kg when hospitalized in Children's Clinical University Hospital "Gaiļezers". She had lost her weight from 75 to 47 kg over a 5-months period. Also cachexy was found in this patient. Medical treatment therapy consisted of: Rispolepts, Anafranils, Cipramils 20 mg, Amoksicilin 500 mg, Mildronāts 250 mg, L-tiroksin 25 mkg, Ferrum lek 100 mg.

Accoring to the medical records, the patient's early development fits the norm. The patient lives together with her older brother and mother's brother. Father of the

patient is dead, but her mother has created a new family and lives separately. The patient started to become more and more emocionally withdrawn, lonely and insecure since she started to study in gymnasium. She started to smoke, excessively eat in the 6th grade. Also suicidial thoughts started to appear. It was hard for the patient to talk about her feeling. She told about her difficulties in school and family, and time when she was bullied at school without emotions. The girl also had had unsuccseful sexual relationships about which she felt ashamed and guilty. There was a lack of support from the patient's mother. the girl acknowledged that she had low self-esteem and expressed her dissatisfaction with her body. The patient complained about loneliness, anxiety, tearfullness, physical weakness and depressive feelings. Alltogether, the patient attended 16 DMT sessions.

The first two sessions of DMT were focussed on the assesment after LMA, KMP and ECT, setting aims and creating therapeutic alliance. The ECT's Cognitive component was often observed at the beginningg of the collaboration and starting every session. It relates to Meekums' creative change cyclic model's preparation stage in which the right hemisphere is dominant as verbalisation is evaluated as the expression of cognitive component. The way patient spoke, closed posture, insecure movements reminded of an infant, who supresses spontaneous need to say "yes" or "no" and can only quietly lament. As it is described in literature, patients with eating disorders become omnipotents, narcistic and helpless (Boris, 1984, 1988). It means that meaningful themes appear in verbalization which must be worked out at Sensory/Kinesthetic level. For example, metaphor of infant could point at the patient's need for keeping the environment, and emotionally close relationships with her mother. The patient unconsciously touches the left part of her head (it points at the rational part of the brain activity) and ear during verbalization. It could mean that Kinesthetic component like oral indulging rhythm – sucking (after KMP) is activated, but, in this case, the consolation is seeked out through the rational aspect. In general, the control over body and feelings remains. So it is significant for dance movement therapists to pay patient's attention to the sensory component, by exploring bodily senses and developing awareness of them.

The patient's movement vocabulary points at the habit to control body and feelings. Shaping in Planes happens in one plane, body shape is usually Spoke like (after LMA). Movements are insecure. It could indicate the patient's fear of the environment and contact. Sucking rhythm (after KMP) is observed, which means that the girl needs soothing activities. There are also bodily blocks in shoulder-spine area of body which points out at the prolonged tension. The use of Pre-Effort Hesitation (after KMP) could point at inner insecurity, difficulties in contact with other people. Other LMA quality light weight is related to difficulties accept one's body, as well the use of Sustained Time and Bound Flow might be related to not being in contact with one's emotions (also after LMA). This leads to the conclusion that Cognitive compo-

nent is dominant for this patient. So the dance movement therapist concluded that Kinesthetic component and Affective component had to be developed.

As a result of initial assesment, the dance movement therapist set such aims: primary, decrease of depressive feelings. Secondary – body awareness development, acceptance of body image, improvement of communications skills and impulse control skills (in relation to bulimia attacks), increase of self-esteem.

In order to develop Kinesthetic/Sensory hierarchical level, the dance movement therapist offered the patient a game with balls, which promoted expressions in action and through use of strength, as well sense of weight and body boundaries. It also promoted patient's nonverbal contact with the dance movement therapist and creating and developing of therapeutic alliance and sense of security, equivalence in mutual relationship. The patient started to use not only Oral Libidinal Rhythm – Sucking, but also Sadistic Rhythms like Leaping (urethral) and Stop-Go (outer genital – phallic) (after KMP). So the development of new movement qualities could be observed and also the development in relations to developmental stages (according to KMP). The development of urethral rhythm pointed out the patient's ability to say "no" and stop her impulses, which was significant in relations to her previous bulimia attacks. Also it is observed that the development of Kinesthetic/Sensory hierarchical level facilitates development of affective component in Perceptive/Affective hierarchical level, because strong rhythmic use of legs promotes emotional (in this case, joy) expression and self of worth awareness.

In order to pay attention to Cognitive/Symbolic hierarchical level, especially Symbolic component, because Cognitive component is too dominant, the dance movement therapist offered the patient improvisation as physical and symbolic ritual as a way of perceive herself, which leads to symbolic thinking (in the case of this patient, from metaphor of infant to metaphor of opening shell). The change in metaphor could mean that the patient had found the way how to tell about her feeling and being in the world in symbolic way, by using polarities of shell – loneliness and need for her own space, small child's need for mother and, on the other hand, the need for individualisation, feelings of shame and guilt about sexual relationships, on the one hand, and, on the other – the need for communication. As a turning point in DMT process was the 7th session in which the dance movement therapist offered the patient to embody herself as a sculpture, by that making it possible for the patient to see her body form (Perceptive component is activated). Such qualities like contact, balance and attention started to dominate in patient's improvisation duet with the dance movement therapist, which could mean that the patient started to trust and relax more and that the therapeutic alliance was strengthening. Working on the theme "mother-child relationships" (based on initial information about the patient) such interventions like: attunement, listening, mirroring and synchronisation were used. It could be suggested that Sensory component facilitate activation of Symbolic, Perceptive and Affective components.

The patient acknowledged that the metaphor "opening of the shell" as a movement made her think about her mother in a good way. So the shift form Kinesthetic/Sensory to Perceptive/Affective level happened. By using Sensory and Affective component, the patient started to create secure attachment with the dance movement therapist, because the symbolic mother was perceived now as secure and supportive, not destructive or denying. The patients expression of emotions was observed in the process stage of DMT, when rapid movement – jumping and leaping (Kinesthetic component) releases joy (Affective component). The wider use of space and movement was observed as well. Also the spectrum of emotions had broadened. The same can be said about the use of weight points on strengthening of self-esteem and power. The patient's contact in dialog was related to the ability to more in relationships. Based on all these observations, the dance movement therapist concluded that primary therapeutic aim had been achieved, because the patient's depressive feelings had reduced. At the end of DMT Cognitive component was activated in order to ensure integration of newly gained experience.

Conclusion

As a result of DMT, the patient's emotional relationships with her mother had improved. That increased patient's feelings of self-worth and reduced depressive feelings. The improvement in relationships was confirmed by the treating doctor – psychiatrist, patient and her mother. The patient' ability to use weight, physical resistance and balance in relation to the dance movement therapist, and sense of embodiment points out to the increase of self-esteem in the patient. The fact that the patient restarted freestyle wrestling could mean that she had started to accept her body image again. The patient also has found positive life scenario – she will continue to study at a high school, has become a participant of a student exchange program, by which it could be concluded that her self-esteem has increased.

The use of various rhythms (according to KMP), ability to express one's emotion more adequately combined with wider use of space points at the increase of body awareness and integration (between body and psyche). The patient's willingness to participate in movement improvisation in pairs, express her emotions bodily (Sensory and Affective components) means that she has become more spontaneous and creative, feels more secure in relationships. The fact that in dyadic relationships she feels herself more secure means that her feelings of self-worth and communicative skills have developed. However, Bound Flow can sometimes be observed (after LMA) which highlights that occasionally the patient still has not enough integrated emotional and bodily aspects.

After the discharge the patient's body weight was 74 kg, but after 4 months it decreased to 52 kg, which means that eating disorder has not been cured yet. Considering that it was a short-term DMT, it was complicated to reach all the aims set. In the last ses-

sion the patient expressed her worries about her future, which means that more therapeutic work is still required in order to strengthen the patient's self-regulation and autonomy.

Lusebrink's Expressive Therapies Continuum model gives a significant input on the developing understanding of patients by helping adequately do DMT assessment and facilitate DMT process for patients with eating disorders. It is concluded that DMT can give significant improvements for eating disorder patients – increase of bodily awareness and integration and development of adequate awareness of body image.

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IV. MUSIC THERAPY WITH DIFFERENT CLIENT/PATIENT GROUPS

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CONTAINMENT OF FEARS

Abstract

This paper introduces a theory of Fritz Riemann on basic existential impulses and fears; provides a group music therapy method based on Riemann's allegories and describes music therapy process of five procedural steps aiming to help clients to perceive, explore and accept fear, and achieve a greater balance of basic existential impulses.

Keywords: music therapy, basic existential impulses, fear.

Introduction

Fear is a universal and frequently experienced emotion. Positive role of fear is to help to adapt, to protect against risks, to fulfill one's needs. However, if fear starts dominating uncontrollably, it impacts health on bio-, psycho-, and social levels. If we perceive the role of fear in causing those impairments and analyze conditions which promote or block occurrence of fear, we can use preventive and therapeutic measures more effectively (Molicka, 2010).

A feeling of fear is a constituent of existence but each of us experiences our own variations of fear. Every person's fear is individual, characterised by the inner self. The attempt to face one's fear and acknowledge it marks the process of overcoming it, paves the way to a greater maturity, to the liberation of one's potentials (Riemann, 2010).

To confront one's own fear is not easy and pleasant, but the projections of fear embodied in aesthetic forms of artistic expression cause interest and attract us. This enables to observe fear from the artistic point of view – here one can play with fear, tame it, manage it. Thus, **the aim of this article** is to describe music therapy as a method used for exploration and containment of fears[16].

[1] This music therapy method was presented in a workshop of the Erasmus Lifelong Learning Programme "Arts Therapies for Different Client/Patient Groups", held in Rīga Stradiņš University on 8th July, 2012.

The ideas presented by Fritz Riemann (2010)[27]are beneficial for music therapy work as they give clearly perceived allegories on basic (existential) fears and corresponding personality types and/or life situations. According to F. Riemann, basic forms of fear correlate with our very existence, with two great antinomies in whose opposition and contradiction we must live. We live in the world that obeys four powerful forces: 1) our planet revolves in a certain rhythm around the Sun, the central star of our planetary system; that is the force called *revolution*; 2) simultaneously, the earth revolves around its own axis, executing the motion that is known as *rotation*. In addition, there exist two other opposing complementary forces that keep the solar system in motion and turn this motion into determined orbits: 3) the *centripetal* force (gravity) that directs towards the middle, holds together and exhibits something resembling, cohesive, constant; 4) the *centrifugal* force that flies away from the centre, exhibiting somewhat unstable, expulsive, letting-go. Balance and harmony among these forces assure the orderly, vital regularity. The dominance or disappearance of any one of these four would destroy this order (Riemann, 2010; 24).

F. Riemann postulates that we are running the same forces physically and mentally, and he draws the allegory between the cosmic forces and human behaviour (the most basic impulses/demands) (Riemann, 2010; 26–30):

- Rotation force as Individualisation Impulse manifested as "rotation around oneself", taking care of oneself. We should all become individuals, each of us preserving and delineating our own individuality from others, and, this way, becoming distinctive personalities and not exchangeable "mass men". The fear of "losing oneself" correlates with impulse of individualisation – a fear to depend, to belong, to devote. But the more we rotate about ourselves, the more we experience loneliness, isolation, exclusion;
- Revolution force as Socialisation Impulse. We have to open ourselves to the World, to communicate with what is outside ourselves. That is "rotation about the other", caring for the other, the immersion into life with others, i.e. socialisation. This need correlates with fear of seclusion, self-actualisation, loneliness and insecurity. However, the more we rotate about others, the more we lose ourselves, refuse our life and finally feel as victims.
- Centripetal force as Conservation Impulse. We should settle down, follow certain traditions, rules, procedures; plan towards a goal and look forward as if our life is stable and predictable. Conservation Impulse correlates with fear of change and challenge which is experienced as uncertainty, insecurity and transience. But the more we strive to maximise conservation, the more we find steadiness, routine, stagnation.
- Centrifugal force as Variation Impulse. We have to be continually prepared to face changes, consent to changes and processes, abandon things we are well familiar with, overstep traditions and habits, forever say farewell to things we have already achieved, march ahead incessantly and lively and do not stop, not to cling to anybody/anything, be open to diversity, novelty and the unknown. The impulse to take up something new,

[2] Fritz Riemann's theory was introduced for the first time in German in the book "Grundformen der Angst" published in 1961. In this article quotations from the Lithuanian translation are used: Riemann F., 2010. Pagrindinės baimės formos. Vilnius. Publishing House Alma litera.

risk and change is supported by the fear of necessity and duty which is experienced as stagnation, compulsion or restriction of freedom. Alas, the more you run to changes, variability, the more attain a feeling of uncontrolled, split up, crack.

Inevitably, a human in their life faces conflicting existential antinomies: individualisation versus socialisation and constancy versus variability (see Figure 1). The first antinomy has to do with the need to become an individual and to be sociable; to conquer the fear of declining oneself and becoming oneself. The second is to strive both for continuance and change, to overcome the fear of both uncontrollable transience and pending necessity. According to F. Riemann (2010), "…the lively order is possible only if we strive to balance these antinomous impulses. However, such a balance is not a static one – its fraught with inner dynamics because it never is what one has already achieved, on the contrary, it is what has to be constantly created" (Riemann, 2010; 31).

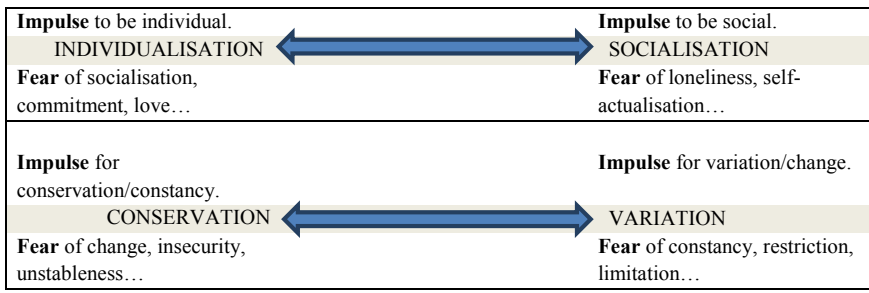

Figure 1. *Two antinomies of basic existential impulses and fears*

Every major task, every decision, every human encounter and every happening holds a potential of all four existential impulses and fears in it. Ideally, we should use all four impulses simultaneously. However, most frequently our conduct is one-sided, resembling irregular movement towards poles of the above mentioned antinomies. From the standpoint of heath disorder prevention, it is important for a person to perceive direction of an existential impulse and following fears when having in mind the entire construct. The following part of this article presents an **active group music therapy method** which is used as "containment of fears".

Objectives:

1) comprehending the whole of existential impulses and confronting fears;

2) understanding, accepting and exploring a primary impulse;

3) perceiving, accepting and exploring a confronting fear;

4) exploring the four impulses – fears in artistic way;

5) moving towards equilibrium of antinomous impulses, perceiving the whole.

Target groups: adult clients for personal growth, supervision or team building and also groups of clients with psychological or psychosocial problems.

Premises: a room where chairs for clients and a therapist are arranged in a circle with musical instruments in the center of it. In the corners of the room, plainly visible, the cards are placed. Each card has a name of an impulse, clearly and legibly (so that it could be read from a distance) written on it (as in self-assessment sheet, see Figure 2): Individualisation (I), Socialisation (S), Conservation (C), Variation (V).

Procedures: planned five steps (or five sessions) of music therapy work.

Equipment: various music instruments used by clients' choice.

Recommended time limit: 90 minutes per session.

Techniques included: visualisation, improvisation, reflection, focused group discussion, approving, evaluating, client self-evaluating.

First

- Tell your clients (group/team) about F. Riemann's cosmic allegories and antinomies of a human life.
- Ask them to think about a recently disturbing question, problem or concern. Pay close attention to what one's emotions, thoughts, behaviours in the terms of Riemann's model are. Give 3–5 minutes to think in silence.

Hand out each client a self-assessment sheet (see Figure 2) and ask them to mark the place on the first (Individualisation – Socialisation) or second (Conservation – Variation) axis indicating where they feel/find themselves in relation to that problem. (If the client marks the place in between the two axes, ask them to decide which one is the main problem axis to work on).

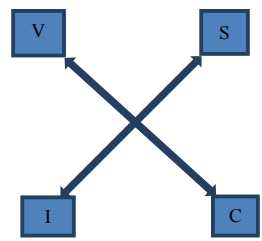

Figure 2. *Illustration of a self-assessment sheet*

Second

- Form sub-groups representing forces (Individualisation, Socialisation, Conservation, Variation). Locate sub-groups in the room imaging the same axes scheme (see Figure 2).
- Motivate sub-groups to share ideas how the force (the need) they represent would sound. Give a few minutes to talk in groups.
- Ask which group volunteers to start and invite this first group to choose music instruments they need and to play improvisation according to the force (for example, "Individualisation").

• When the improvisation is finished, give some time for the group to have a sensation of the music, then ask the sub-group members to spontaneously formulate their personal title (for example: "Finding my own way", "Taking care of myself", etc.). Accept every title in silence without comments.
• Continue the same way with other sub-groups so that all the forces were represented musically.

Third

• Invite sub-groups to explore forces starting from the comfort zone (as improvised in second step) and reaching the extreme of their force/need. Say the group that it is up to them to decide how much time they need for that improvisation. The purpose is to move in sound. (If the sub-group feels the need to repeat (comfort – extreme, comfort – extreme) – do that).
• Have in turn sub-groups' improvisations and reflections on experience of players and listeners (ask for reflections after each sub-group's improvisation).
• Ask the clients to take the sheets, read (in silence) their questions, think if there are some changes, and then write thoughts and insights on their problem.

Forth

• At this step start working with sub-groups on the antinomies: Individualisation ↔ Socialization and Conservation ↔ Variation. Invite clients to improvise starting from their space and little by little moving musically towards the opposite, integrating musical characteristics of the opposite and finally crossing the border of the opposite.
• Ask one of the sub-groups to volunteer, choose instruments and play. After a small pause invite the opposite force group to play.
• Follow similar tasks on the second antinomy with the other two sub-groups. After every improvisation keep a small pause which is required for musical perception.
• When the sub-groups experienced improvisations in different directions (individualisation → socialisation, socialisation → individualisation, conservation → variation, variation → conservation), motivate your clients to discuss experiences in sub-groups and later to share with others in a group.
• Return to their questions and ask to make notes on thoughts, feelings, etc.

Fifth

• Ask the clients to discuss with their sub-group a musical scenario starting from sub-group's force and exploring all the other forces moving as they wish. So, the groups are expected to play 4-part compositions as in sonatas or symphonies with breaks or without breaks.
• Suggest the sub-groups to find a title for a composition (improvisation) and the composition's parts using the same or different allegories/metaphors.
• Give each sub-group a sheet of paper and a felt-tip pen and ask them to write the titles down.

- Invite the sub-groups to play their compositions as a gift to the other groups. Act this musical part like a concert – with announcements and applause.
- After the performance of all four groups, ask clients to take their self-assessment sheets and to mark where they feel they are on the axis now. Notice whether there are any changes. Ask clients to note their findings. down
- Invite the sub-groups to join in a big circle and motivate to share their thoughts, insights with others.
- Give feedback for each client (for this it is necessary for a therapist to keep making notes on reflections during all the process).

Variations:

1. Other arts therapy (dance and movement, drama, poetry or art) techniques can be used instead of or with music improvisation.
2. The method with modification of some tasks can be used for individual music therapy/arts therapy sessions.

Conclusion

The above described allegory-based music therapy method helps to narrow down a stated problem to the imaginary point on the two existential antinomy axes (individualisation versus socialisation or conservation versus variation) indicating a state (sense or behaviour). If we drew a parallel between such a state and a physical object (e.g. a ball on a tennis table), we would describe this state as unstable and easily put in motion. This is what has a particular relevance in therapy when striving to positively change a model of thinking, situation understanding and behaviour.

We know that change can begin only after we have consciously perceived it, and we perceive once we produce a verbal or alternative representation of a thought or emotion. This kind of conscious representation of thoughts and feelings in music therapy is stimulated by the application of the following techniques: visualisation of existential antinomies (primary impulses and fears) and creation of audial moving image through musical improvisation. Improvisation allows an experimental game, i.e. playing with fear, approaching boundaries of tolerance. The intensity of movement and fear sensation as well as their interpretation differs in each individual case; thus, being in a group the client perceives his/her situation, feelings, behaviour and possibilities to move in a more versatile way. What is more, in the background of four latent impulses and fears, feelings and behaviors are perceived as being in correlated dynamics, and, because of this, the client experiences greater psychological balance and, during musical improvisation, experiments with the feeling of fear in a less restricted way. Audial representation allows the client to overstep certain limitations of their own and analyze the problem in hand wider and more impartially. The method is oriented towards client's mental and social health resources, motivation for growth and self-development.

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MUSIC THERAPY IN PAEDIATRY

Abstract

Music therapy as WHO acknowledged health care profession can optimize the quality of life for people of any age and can improve their physical, social, communicative, emotional, intellectual, and spiritual health. In particular, children have a natural interest in music; this can be utilized by the fact that they experience the stimulating motor and auditory activities in music more associated with play or fun than work or treatment. The efficacy of music therapy methods in paediatric fields as neuropaediatric care, social paediatrics, neonatology and intense care, paedaudiology and CI-rehabilitation, oncology, palliative care/pain management and paediatric psychiatry and psychotherapy has been evaluated in clinical studies in the last three decades with great success, so that this approach can be considered as an important part in health care in general. The article offers an overview on all different practice methods used in areas linked with recent research findings within the Music Therapy Master Program at Liepaja University, Latvia; for example, how to implement music therapy including academic training, practice service and research development in the health care system of a whole country. The practice experiences of this approach and the research work performed so far in combination with a model of implementation, offers a new perspective for the healthcare, which is beneficial and practicable.

Keywords: music therapy in paediatrics, efficacy of music therapy methods, Music therapy master program at Liepaja University, Latvia.

Introduction

The benefits of music in emotional and physical health have been well described across cultures over centuries. In more recent times, studies have shown the effects of music therapy in alleviating symptoms in a wide variety of physical and psychological conditions.

However, there are still misunderstandings of what music therapy is in terms of professionalism (theories of science, academic structure/training courses), what it deals with (concepts of methods), how it functions (research/efficacy) and whom it helps (field of application).

To offer a border non professional use of music therapy in healthcare, the community of music therapy lecturers, clinicians and researchers have set a definition given

by the World Federation of Music Therapy (WFMT), which has been acknowledged as standard in the European Higher Education an Research Area, as well.

"Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts" (WFMT, 2011).

Music therapy in Europe has to meet certain standards to ensure high quality of training, practice and research, which is the prerequisite to remain in the position as WHO acknowledged health care profession. To give a legal framework to this, the European Music Therapy Confederation (EMTC, official asbl status at EU) was founded in 1990 as a confederation of professional music therapy associations, working actively to promote the further development of professional practice in Europe, and to foster exchange and collaboration between member countries

Practice and research

Looking at the different approaches of music therapy, one can see a broad spectrum of different theoretical background following concepts of psychoanalytic, behavioural or humanistic psychology, which have been developed in Europe since the 1950s and implemented in the healthcare supply and so in paediatric care, too. Now, the purpose of this section of the book is not to give the whole picture on those approaches and schools in all details, but more to introduce clinicians of any healthcare profession working in the field of paediatrics to the basic meaning of the daily work, which many music therapists do in children hospitals and outpatient services for children. Therefore, this following overview is meant to give examples of practice and research in the field of music therapy. Not every single field of paediatric care is listed and not every author who might be important for the theory of science, clinical work or research development in the area of music therapy in paediatrics is quoted in the following passages. First the spectrum of interventions utilized by a music therapist is described to give the reader a conception of the practical application of it when music therapy is offered.

Additionally, the recent development in research in different paediatric fields will be focussed on to demonstrate that it would be a misconception to consider music therapy as a "sounding well-being framework" for children in hospitals, still far away to claim efficacy of its methods on the healing process or development disorders. Music therapy methods obviously can meet the standard of efficacy proved by clinical trials in many paediatric fields. The quoted literature may give some examples out of many, where to go into it more intense.

What does a music therapist do and why?

According to the definition of music therapy, a music therapist uses various active and receptive intervention techniques in individual and group work with children to improve their physical, social, communicative, emotional, intellectual, and spiritual health.The techniques of intervention are presented in Figure 1.

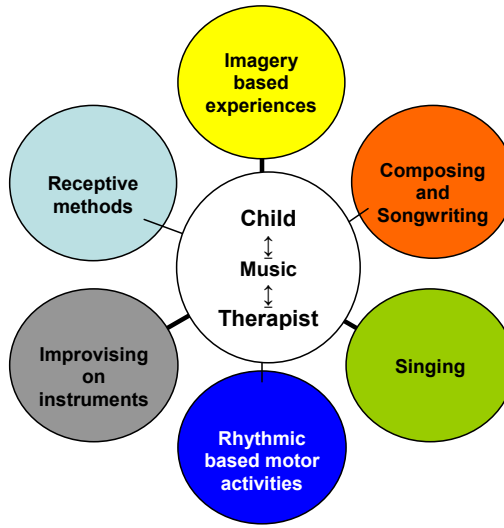

Figure 1. *Approaches by music therapy*

Improvising on instruments can improve motor coordination of children with motor impairments or neurological trauma related to head injury or a degenerative disease process. It can enhance attention and focus the activity on self-perception as well as interaction to others (i.e. providing opportunities for practicing various leadership-participant roles). Playing instruments in a creative improvisation opens the creative inner being of the child beyond any impairment or limitation caused by a disease or disorder. This part of the personality of every person one of the pioneers of music therapy in Europe has defined as the "music child" (1), an inner personal quality of participation in creative processes with a self-enabling dynamic, which strengthens hidden recourses of empowering one's emotional and physical state and supports the healing process. Improvising offers creative, nonverbal means of expressing thoughts and feelings. Improvisation is non-judgmental, easily approached, and requires no previous musical training. As such, it helps the therapist to establish a three-way relationship between the client, themselves and the music. Where words fail or emotions are too hard to express, music can fill the void. Where trust and interaction with others has been comprised due to abuse or neglect, improvisation provides a safe opportunity for restoration of meaningful interpersonal contact.

Where learning ability is limited, the opportunity to try different instruments, musical sounds, timbres and mediums may provide an opportunity for mastery of a new skill and increase life satisfaction. Although there is no music education requested to experience these benefits of music therapy, instrumental play may assist those children with prior musical experience to revisit previously learned skills, thereby allowing the individual to experience a renewed sense of pleasure and enjoyment. It can also develop increased well-being and self-esteem in those who are learning to play an instrument for the first time.

Rhythmic based motor activities can be used to facilitate and improve children range of motion, joint mobility/agility/strength, balance, coordination, gait consistency and relaxation. This, for example, is a tool for the first learning field in Cochlea-Implant rehabilitation, where the children start to relate between their motions and in synchronicity improvised sounds. Rhythm and beat are important in "priming" the motor areas of the brain, in regulating autonomic processes such as breathing and heart rate, and maintaining motivation or activity level following the removal of a musical stimulus. The use of rhythmic patterns can likewise assist those with receptive and expressive processing difficulties (i.e. posttraumatic aphasia) to improve their ability to tolerate and successfully process sensory information.

Singing is a therapeutic tool that assists in the development of articulation, rhythm, and breath control. Singing in a group setting can improve social skills and foster a greater awareness of others. For those children with psycho-emotional disorders related to a severe disease like cancer, singing can reduce anxiety and fear. For children with language development delays, music may stimulate the language centers in the brain promoting the motor coordination in the speech planning processes.

Composing/Songwriting is utilized to facilitate the sharing of feelings, ideas and experiences. For example, with hospitalized children writing songs is a channel of expressing and understanding fears. For children with a terminal illness, songwriting is a vehicle for examining feelings about the meaning of life and death. It may also provide an opportunity for creating a legacy or a shared experience with a caregiver, child or loved one, prior to death. Finally, lyric discussion and songwriting can help adolescents deal with painful memories, trauma, abuse, and express feelings and thoughts that are normally socially unacceptable, while fostering a sense of identification with a particular group or institution.

Imagery based experiences and music related to painting provide opportunities to reflect, process, and interact with unconscious or conscious material that may be reflected in an individual's life. Other expressive modalities, such as artwork and movement, can be used in combination with music. One important section of music therapy approaches Guided Imagery and Music (GIM) offers the theory of science and concepts of methods (2).

Receptive methods: Listening to music has many therapeutic applications. It helps to develop cognitive skills such as attention and memory. In situations where cognitive perceptions are comprised, such as in palliative care, listening can provide a sense of the familiar, and increase orientation to reality. In the area of child and youth psychiatry for those with mental illnesses such as early emotional traumatic disorders or juvenile schizophrenia, music listening can facilitate increased openness to discussion and provide motivation for engaging in social activity.

Music therapy methods and research in the field of paediatrics

Music therapy offers new perspectives for health care, especially in paediatrics. This statement would be only a bold claim, if this is given without providing a reliable evidence of it. Surgery, medication and other common therapy approaches like physiotherapy will sooner or later have to face their limitations, when it comes to the complexity of the interdependent psycho-emotional and physical factors in the child affecting the healing process. The development of special music therapy methods and the research on their efficacy can provide this evidence. The picture may give an overview, where this research work has been done successfully:

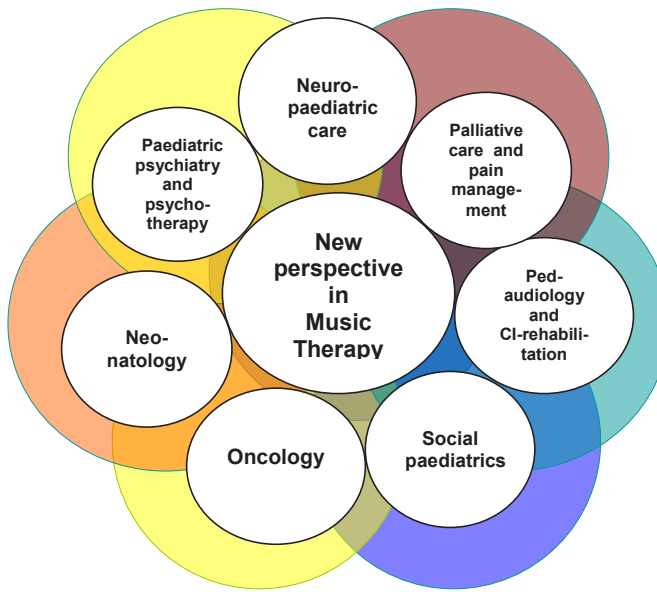

Figure 2. *The fields of potential application of music therapy*

Neuropaediatric care

If there is a therapy approach which combines all perception areas of a child in one activity and offers self-perception in time and space as well as relationship in interaction "music therapy is the most powerful therapy for impaired children that has ever existed": This statement was given by one of the pioneers of music therapy in Europe, Dr. Clive Robbins, who developed "Creative Music therapy" together with Dr. Paul Nordoff in the 50s and 60s of the last century (3). He lived in New York and worked as the founding Director of the Nordoff-Robbins Center for Music Therapy at New York University. He has left a huge heritage of practical experience, research work and, what is most important, a world wide network of higher education training centres offering an excellent professional training in music therapy. Based on this approach, many controlled trials have shown significant efficacy of music therapy methods for children with neuropaediatric diseases or disorders.

Developmental delay

Aldridge and Neugebauer's present findings of an RTC done in 1994 at the Institute of Music therapy, University Witten-Herdecke, Germany, which proved the efficacy of the creative Nordoff-Robbins-music therapy. Motor (eye-hand) coordination, language development and social awareness as subtest of the Griffith-scales are significantly improved in the treatment setting in cross-over design (4). In numerous case studies Orff describes the concept of methods of her music therapy approach (5), in which efficacy has been evaluated with high significance later in an RTC done by Plahl (6).

The methods used in this area include mostly all of those listed above applied in individual as well as group work.

Down's syndrom

The delay of language acquisition due to the hypotonia of mouth, hyperplasia of tongue and the retarded cognitive development are some of the most crucial factors of the therapeutic interventions offered for children with the Down's syndrome. Music therapy practice has improved this in an uncountable number of cases through special improvisation methods using singing and instrumental play. Carol presents "an effect on the children's total verbal output and rate of response..." which is caused by music therapy when offered in the combination of singing and drum playing. The intervention is an "effective method for stimulating verbal speech in the way it mirrored early language development by exploiting the prosodic characteristics of speech" (7). There is no question that music therapy is an effective method for facilitating the verbal output of young children with the Down's syndrome, who are in the very first stage of language development with explorative vowels as well as for those whose mean length of utterance have already one-two word sentence structures, which will improve the syntactic growth and cognitive development, too.

Rett-syndrome

Every clinician working with young girls suffering from this disease may have come to the conclusion that music activity is possible due to the lack of planned motor activity and intentional action in common. One the other hand, in literature females with Rett-syndrome are often reported to be responsive to music. Consequently, music therapy has been indicated as a relevant treatment where practitioners have demonstrated that intervention promotes and motivates their desire to interact and communicate, as well as to stimulate many aspects of development including "choice making, enhancing vocalization, improving eye contact, and opening channels for emotional and communicative expression" (8). The key is how to offer instruments, how to lead hands on drums meeting the structure of a song, how to include a child's vocal activity into the improvisation, even if sounds meaningless.

Neuro-rehabilitation

Children with acquired brain injury most often have to undergo a multidisciplinary rehabilitation process, in which the lack of experience like "play" or "creativity" might limit the motivation to go on with the daily process of re-establishing lost language and motor functions. Bower and Shoemark present a clinical case study in which a paediatric patient with an acquired brain injury and a sensory aphasia, who had the ability to talk but was unable to successfully interact with people. They showed that the prosodic elements of music were successfully used to initially engage the patient in musical interactions. Subsequently, combined music therapy methods and speech pathology interventions provided the patient with a non-verbal medium to rehearse interactive skills. This focus on increasing social capacity was fundamental in promoting engagement in functional speech rehabilitation for this patient (9).

Picture 1. *The author working on breath patterns and mouth motor co-ordination with a young boy affected by a rare genetic syndrome*

The research on this phenomenon called cerebral plasticity or neuroplasticity is often published in the neurological journals as a growing concept related to functional recovery showing how specific training models in music therapy utilizes this relatively recently identified phenomenon. Baker and Roth give an overview on the music therapy research dealing with the significant efficacy of special music therapy methods improving this re-establishing of neurological functions (10) (see Picture 1).

Social paediatrics

Autism spectrum disease (ASD) is one of the disorders related to this field, which music therapy might have the most obvious impact on, although this disorder expresses the extreme opposite of what music is mostly appreciated and evaluated for: empathy, understanding without words, meeting in time and space beyond the physical existence; these are the competences or experiences which a child, who is effected by ASD, will not present. However, music can offer the door to step into this intrapersonal and inter-relational qualities; this provides an implication that the immanent conversation taking place between keys, melodies, harmonies and rhythms can open a path for the child to leave the prison of limited understanding of human verbal communication. This does not consequently mean that any kind of music activity will bring this improvement; opposite to that, music activity can cause even more irritation and withdrawal if used with pressure and without high introspection for the sensitivity for the child and the level of its inner self-determination.

Prof. Dr. Tony Wigram, former chair of the PhD program in Music Therapy at the University of Aalborg, Denmark, an international lecturer with highest reputation and, probably, the world's most important researcher of ASD, was the first one to be doing recognizable researches in the field. He has published numerous of excellent studies proving the efficacy of music therapy in the work with autistic children. Methodically he has set standards with the terms of "dialoguing", a process where therapist and child communicate through their musical play and "musical framework", where the therapist provides a functional and consistent musical structure the child's musical play fits in (11). These methods have shown significant efficacy in disturbing and breaking through rigid patterns of musical behaviour and play (12). Looking at the different levels of his research, the major principle in his studies is the significant improvement of joint attention, which speaks about the frequency and duration of eye contact, joy and emotional synchronicity, musical synchronicity, imitation and turn-taking. Kim presents similar findings in her study on music therapy on joint attention. Under music therapy as described in practice and research section of this article, stereotype behaviour decreased measured by Pervasive Developmental Disorder Behaviour Inventory (PDDBI) and scores in the Early Social Communication scales (ESCS) increased with high significance in relation to just free play with the mother. "The results from both

standardized measurements (PDDBI and ESCS) and non-standardized measurements (session analysis) were generally in favour of music therapy over free play" (13).

Inter-synchronicity in the free improvisation due to the concept of Schumacher is presented in her publications as the key method in order to develop a dynamic personal relationship. Interactive patterns beyond verbal abilities, such as rhythmic, tempi and loudness synchronisation as well as nonverbal vocal dialogue patterns intensifies child's expressive production, which can be matched and reflected again in the therapist's music. This can be meeting the child in its crying or screaming, in its jumping, gickling, as well being in touch with the child synchronising its stereotype repeated behaviour patterns like sensor and/or visual self-stimulation. Improvisational music therapy in the approach of Nordoff/Robbins is typically a child-centred therapy, and for autistic children their response to this approach emerges when they realize that the therapist's music is reflecting something to do with them. Recent research studies as well as case examples and life demonstrations will present music therapy as one of the most important therapy approaches for children with ASD.

Neonatology and intense care

Music therapy is effective in the very first moments of life, even, when this life has begun much too early. In this field of paediatric care one has to quote first the pioneer of music therapy interventions for premature infants, Dr. Monika Nöcker-Ribaupierre, former general secretary of the European Music Therapy Confederation (EMTC) and clinician and teacher as well as researcher with highest international reputation. In her work on "short- and long-term effects of auditive stimulation on premature infants and their mothers" she has shown the efficacy of mother voice and singing on the physical and activity state of a premature child (14).

Her approach of auditory stimulation combines two different approaches:

1. psychodynamic area; "a therapeutic–functional approach of retaining or replacing something lost and a psychotherapeutic approach, addressing the developing subjective experience within the relationship between mother and child" (15).
2. improving of the physical state; there has been a significant physiological and developmental support for the infant, an essential approach of the study, which has to be acknowledged as the psychological and emotional impact of the voice.

The results of her studies showed high significance in both areas:

Short term:

"Without stimulation, there was no difference in increase and decrease of activity and in transcutaneous oxygen pressure ($tcPO^2$). During the stimulation period, infants showed significantly decreased activity ($p < 0.001$) and increased $tcPO^2$ of mean 5 Torr ($p < 0.02$)" (16).

Long term:

"Data analysis found that, at the corrected age of 5 months, the children in the experimental group showed significantly advanced motor and verbal development" (17). Haus showed similar findings with a different approach, using singing improvisation in synchronicity and/or dialogue with sensory stimulation. In his research on the premature reactions on specific synchronization of motor, sensory and acoustical stimulations are obvious and statistically significant, as well at the level of involuntary motional actions in the area of head, face and hand movements increased directly reactions of awareness on the coordination of sensomotor and acoustical stimulation have been observed (18).

"Significant increase of oxygen partial pressure and reduction of heart/pulse – rate during music therapy sessions – seem to cause positive physiological effects" (19). However, although providing a wide range of practice experiences in the music therapy service for premature infants, there are many varying methods used in this field, thus there is still the challenge in developing ways of linking different approaches for preterm infants in order to integrate them into neonatal care (20).

Music Therapy in respiratory care

Children under long term respiratory care are in the need of an intense daily programme of medical, nursing assistance. To overcome the lack of verbal interaction methods of facilitated communication (visual and compute-based strategies) have been focussed on in recent studies. Creative music therapy methods related to the approach of Nordoff-Robbins provide a communication tool directly applied with led hand motions (instrumental activity) and vocal activity as dialogue.

Picture 2. *The author working with a child suffering from a centronuclear myopathy under long term respiratory care*

Applying music therapy methods with this patient group the congruence of rhythmic patterns related to breath activity, and vocal improvisation intensifies head motions and breath sound use as communicative ability, which later is used in daily life as interaction pattern. The understanding of dialogical phrasing is presented by the children through increased mouth motions and increased mimic response (smile). Supported by two case studies music therapy service is demonstrated as significant benefit in long term respiratory care.

Pedaudiology and CI-rehabilitation

Hearing impaired children and children with disorders or delays in language acquisition are compared to other working areas of the earliest included population group, where music therapy practice documentation and research has taken place with the result of an enormous number of publications. One of the pioneers in this section, Claus Bang, could show already in the 1970s that music therapy could improve with high significance the voices, prosody and communication possibilities of the hearing impaired children through music therapy. Facing one of the main consequences of deafness and hearing impairment, a total or partial lack of control of the voice which leads to limited pitch variability (monotonous or tensed and forced voices), Bang used tone bars with low frequency played simultaneous to singing improvisation with words or sentences. The voice treatment and the speech therapy based on the use of tone bars became objects of substantial research by Claus Bang in cooperation with Copenhagen University and Aalborg University. The research resulted in detailed analyses of voice improvements gained from the work with the tone bars. The obtained data leads to the conclusion that some of the noise in the voices disappears at the same time as the voices gain a richer overtone content, which makes them easier to understand (21).

Music therapy for patients with language development disorders

Beside this huge number of controlled studies on the efficacy of music therapy methods, in the therapy for children with language development disorders and delays music therapy plays as important role in developmentment as speech therapy, since it affects directly the supra-segmental factors of speech like pitch flexibility (intonation), tense (accentuation) and rhythmic structure (22).

Nordoff-Robbins music therapy is related both to humanistic psychology and to musicology and is a therapeutic approach for children with language development disorders, which is considered as important complimentary addition to speech therapy. The various forms of retardation in psychomotor and language development as results of brain damages in early childhood due to cerebral palsy are focus of the therapeutic

work. Using the described therapeutic methods of synchronization in hand-motor and vocal activity, these disorders can be specifically influenced. The efficacy of music therapy in the treatment of developmentally delayed children has already been described in randomized controlled studies. In some single-case-reports of children with severe language development disorders due to spastic tetraparesis, Down's syndrome Prader-Willi syndrome over the course of several sessions, confirms the statement above. The possibilities of music therapy as an acknowledged practice methodology, together with the ongoing success in proving the efficacy in controlled studies, allows us to present the Nordoff-Robbins music therapy as a promising therapy in a complementary sense to the regular approaches of school medicine.

CI-Rehabilitation

After almost 20-year use in medical practice, the Cochlea implant (CI) for deaf children has become standard everywhere in Europe (see Picture 2). Even if it does require various time-consuming measures, the significance of music therapy methods in the overall rehabilitation concept is confirmed by a wealth of positive experiences in the rehabilitation process of CI children (23). In spite of some limitations at sublevels of hearing perception, CI children benefiting from music therapy show marked progress and reach a higher level of language perception and expression development than children provided with conventional hearing aids (24). Despite the recent software and technical concept of the CI-speech processor, this could be seen as paradigm shift in the language perception, there is no doubt that the CI-system still can not replace the tonal perception ability of the normal ear (25).

Picture 3. *The author working on hearing perception skills (pitch discrimination) on wooden tone bars with a 5-year old boy with Cochlea Implant*

Haus showed in his study that the overtone spectrum of some instruments and of the human voice as well is transferred in a completely different way as in normal physiological hearing perception due to the signal processing algorithm via the electric array. To reach an optimal hearing perception and understanding of pitch and melodies as prerequisite of the active prosodic elements of language acquisition requires certain methods with a special set of instruments. These are examples of music (descending or ascending intervals, little melodies) played in a structured improvisation setting on instruments with low overtone spectrum like xylophone, single wooden tone bars, wood bells and tuneable bongos or congas (26).

Oncology

Children suffering from cancer should be treated based on multilayered approach as the disease is too sensitive to design music therapy as a mono-causal improvement of the emotional and physical disorders related to this life-threatening disease or the secondary side effects of the chemo therapy easily. Cancer and its huge strain for emotions and communication affect the entire family, where anxiety and imbalance between rage and depression determines the parents, which is immediately transferred to the child. Therefore, anxiety reduction is identified as an important clinical objective for caregivers, and one that can be addressed by music therapy, since it supports reducing the intensity or duration of pain, alleviating anxiety, and decreasing the amount of analgesic medication needed (27).

In the recent scientific literature music therapy is mostly seen as part of a multiprofessional concept psycho-oncology under the aspect of psychodynamic processes. However, in addition to that, the efficacy of music therapy in the area of motor functions, somatic state and of common creative recourses is due to our experience in the paediatric oncology as important as the benefit of music therapy on the quality of intra-personal state and relationships. This statement is based on the obtained results from the department of paediatric oncology at the Children Hospital Datteln, University Witten-Herdecke, Germany; it describes two case-reports of music-therapeutic work in the segments. For a patient at the age of 2.9 years with anxiety-disorders, severe contact-defence and multiple motor disorders after resection of medulloblastoma level IV music-therapeutic methods could reduce the behaviour of anxiety and contact-defence. Moreover, music therapy re-established lost motor functions. For another patient at the age of 5.9 years with tendencies of overadaptability and strong self-control suffering from common lymphatic leucaemia music therapy could increase the level of motor creativity and led to a better self-perception, individual interest for regression and defence; concepts of free improvisation strengthened the ability and expression of self-determination. Even without the verbalisation symbolic contents of the interaction music therapy are able to build up a psychodynamic process, out of which factors relevant for the somatic state can be positively influenced.

There are many other practice reports and clinical trials on music therapy methods in oncology describing findings that music therapy with active improvisation including song-writing as well as receptive methods reduces anxiety, strengthens physical power and helps to overcome nausea and tiredness. Most direct is the effect of music therapy on the child play activity in general. A randomized controlled trial published by Barrera shows a significant improvement of motivation and creativity of the child under oncologic care, which is definitely necessary to prevent from hospitalisation (28).

Palliative care and pain management

Music therapy has an imminent factor accelerating the process of healing, but this in only one of the many effects. It also offers comfort, where no healing can take place anymore in a more intense way than words can. Literature study supports the use of music therapy as remedy to parents after the death of their child; this is known as "catharsis factor", although one can not talk about healing anymore. "It was something that we could all share together since music is a universal language and reaches all of us regardless of our age or cognitive level" (29). Music therapy offered with the different interventions mentioned above focuses on "the child's preserved healthy sides ... in the middle of sickness and process of death" (30). One good example is songwriting, which Aasgaard describes as "interplays of loveable acts between patients, parents and a music therapist", which indicates that the moments shared in music therapy can be highly emotional and remembered throughout time (31). The area of alternative therapeutic approaches in the field of paediatric pain management beside medication has obviously experienced an enormous interest in the scientific community in the last 10 years. Many European music therapists have published their practice experiences as well as research work related to the question whether music therapy methods can be effectively offered for children with chronic pain. Hoffmann demonstrated that free improvising can positively affect the perception and intensity of pain concerned and the secondary state of anxiety and depression (32). Haus offers an overview of several successful interventions in the daily work with children in palliative care and chronic pain (33).

In music therapy sessions, a therapist and a client are active in free improvisation of a wide range of instruments; the therapist focuses on the inter-relational activity levels, both in order to built up a diagnostic picture as well as to establish a field of experience and creativity, where the client can develop new ideas, interaction strategies out of his own resources.

These are:

- **the musical form and its quality** (rhythm, motives, musical themes, the use of harmony and melody in the clients music)

- **the quality of expression in the patients** music (the quality of sound; the expressive quality of musical parameters, the use of instruments)
- **the flexibility of the patients playing** (the quality of changes, differentiations, the developmental quality, the dynamics in the music of the client)
- **the quality of the inter-musical relationship in playing** (the quality of intermusical/interpersonal contact/ relationship, the quality of the communication in the music).

Paediatric psychiatry and psychotherapy

The inner world of children can become ill due to many psychosocial or clinical reasons. To meet the need of the multi-layered structure of psychiatric disease in childhood, a concept of methods with a broad spectrum of nonverbal interventions has to be included. Verbal psychotherapy as in common use in the psychiatric care for adults has many limitations if it is used as the approach non-reflected for children. Beside the systemic approach of family therapy additional interventions like play therapy, motion therapy, art therapy and music therapy can support the therapy process. Erkillä describes the combination of music and art therapy in his work with psychotic children. Including drawing as expression field for emotions and thoughts under the influence of one's own improvisation "represents a level of consciousness that is nearer secondary process thinking as compared with the improvisation that is more abstract. The picture, in this method, also condenses the abstract form of the music that flows through time, into one particular moment — a moment that can not be without significance" (34). For patients that may be unable to communicate about their inner conflicts verbally, music therapy is beneficial, because it uses musical interaction as a means of nonverbal communication. On the other hand, for those children who use verbal language it offers to rationalise what they cannot address emotionally, which allows them to express their feelings directly. Therefore, music therapy is applied to a much larger spectrum of mental disorders. The different approaches of music therapy are based on various theoretical backgrounds, including psychodynamic, behavioural, and humanistic theory concepts. The techniques used in music therapy in child psychiatry and psychotherapy can be categorized as described in the research and practice section of this article as active and/or receptive methods in free and/or structured improvisation. The most prominent models of music therapy with a psychodynamic orientation are Analytical Music Therapy (35) and Guided Imagery and Music (GIM) (36). An excellent overview on recent research on the efficacy of music therapy methods in work with children with psychiatric diseases can be found researching metaanalysis studies conducted by Gold, Voracek and Wigram, who listed and provided evidence to 11 of the most important clinical trials in this area. "Music therapy produces a clinically relevant effect of a considerable size and is, therefore, recommended for clinical use. Specifically, clients with behavioural or developmental disorders, or with multiple psychopathologies, may benefit from

music therapy. For both children and adolescents with psychopathologies, music therapy appears to be especially helpful when techniques from different music therapy approaches are combined (37).

Music therapy education and training in Europe and Latvia: a new perspective with important profession group in health care

Music therapists in Europe work at the highest level of music competences, medical and psychological knowledge, acquirements and research skills. The profession requires a secondary postgraduate higher education, mostly based on the graduation as musician, psychologist, rehabilitation scientist and other health care professional. Many of the music therapists working in paediatric hospitals have a doctoral degree and are able to fill out the scientific side of their work through clinical studies. They are involved in supervision to get an optimal balance in their own inner psychodynamic processes being challenged by the daily work. The great number of training courses in the EU is mostly linked to faculties of Music Psychology or even medicine at many European Universities and is connected in the European Music therapy Confederation, Brussels. Under http://emtc-eu.com/courses all training courses in Europe are listed; recent number is about 60 higher education courses. The European Music Therapy Confederation was founded in 1990 as a forum for exchange between music therapists in Europe. The EMTC is a confederation of professional music therapy associations working actively to promote the further development of professional practice in Europe, and to foster exchange and collaboration between member countries. The overall purpose of the EMTC is to nurture mutual respect, understanding and exchange between music therapists in Europe.

An example for academic training in music therapy of highest quality is the Master program music therapy at Liepaja University, Latvia, which can be seen as the model for the professional standard of music therapy training courses in Europe in common. It was founded in 1998 and chaired by the author (2002–2006) and has included many of the most important clinicians and researchers in Europe, quoted in this article, as guest lecturers (Erkillä J., Hoffmann P., Neuhäusel R., Nöcker-Ribaupierre M., Wigram T.). Linked to this study program, the author has implemented a sustained network of music therapy supply in paediatric hospitals, outpatient clinics, rehabilitations centres and institutions for special education in Latvia, which got numerous grants for academic staff mobility projects from the EU-ERASMUS programs as well as from the EU paediatric network EUROPET (38).

Expert recommendations

Children have natural interest in music; this can be utilized by the fact that they experience the stimulating motor and auditory activities in music more associated with play or fun than work or therapy. The careful and repetitious combination of music activity with multisensory experiences in the context of a creative self-expression and nurturing relationship has a remarkable range of clinical benefits. In most paediatric fields, numerous clinical studies have given answer to the question whether there is evidence in the obvious improvement of so many conditions of disease or disorders when music therapy is offered. The answer is affirmative. Moreover, one can not only measure it with the highest standard of clinical studies, the concepts of methods and the theories of science standing behind the efficacy of music therapy are as coherent as medical science itself. This rationale can convince that music therapy is an important part of the paediatric service in general and can be without any doubt considered as an crucial factor in the healing process of diseases in many paediatric fields as in health care in general.

The remaining question, where the answer still is to be found and to be developed is why the dimension of music therapy supply in paediatric hospitals, outpatient service and rehabilitation institutions is so far away from the clinical requirement. Looking at the music therapy service supply in paediatric facilities in Europe in general, we do not see a homogenous picture at all. In the UK, Austria and the Netherlands the reimbursement of costs for music therapy has its legal framework, since in these countries it is a State recognized health care profession. In Scandinavian countries the costs for music therapy in the paediatric area are partly covered by either insurance or social care system. In many other countries in Europe music therapy service in paediatric hospitals can get its financing only through charities or fundraising. On the other hand, outpatient service is sometimes covered by health insurance when it is linked to the reimbursement context of psychotherapy. If music therapy claims to offer a new perspective for e health care system, one has to find an answer to the question what is necessary to achieve a sustained framework of those complementary factors like academic training, music therapy supply and research. The Republic of Latvia is a good example that one should not wait too long for the government's generosity in times after the world wide financial collapse, where the budgets of health care systems in many European countries had to face heavy cuts.

Over the 10-years time, it has been possible to establish a Master study program with 59 graduates in total up-to-day in Latvia. Moreover, a music therapy network in health care institutions in all regional centres has been implemented only through fundraising and donations of German charities. This project of the largest German Children Hospital, the Vestische Child and Youth Hospital in Datteln, University Witten-Herdecke (www.kinderklinik-datteln.de) was awarded as "best practice model" for Eastern Europe from the German Charity for People with Disabilities

in 2008 (www.aktion-mensch.de) and offers music therapy service to hundreds of children in Latvia every day. The research work done in this field in health care system in Latvia underlines the necessity but also the practicability of this new health care approach.

To provide this new perspective for the entire country, it is undeniably not only a question of academic specialisation or only a matter of money. Professional concept of strategies is needed including all levels involved, i.e. profile of academic training with international academic staff mobility programs for continuing education, development of therapy service accessible for everyone in every region regardless of the financial situation of clients, and sustained finance and communication structures for research work. This strategy work was not possible without professional help from outside. In the case of Latvia, a highly recommendable European wide working consulting agency (www.xpand.eu) was invited with the reference from the German Embassy in Riga to support this process. This consulting agency XPAND has an extensive experience in co-operating with ministries of several other countries in Eastern and South-Eastern Europe and is very open to support similar projects in health care area in this region.

In the case of Latvia, their work proved to be very effective, especially if the dimension of music therapy service in hospitals, rehabilitation centres and outpatient facilities are observed (www.muzikasterapija.lv).

Conclusions

There is a rationale for music therapy in predictive, preventive and personalised medicine based on evidence proved research.

There is an obvious need to implement music therapy services more in paediatric care.

New perspectives in health care, like music therapy, can become substantial if there is a long term strategy concept which includes academic, infrastructure, finance and research development as it has been developed for the country of Latvia.

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CASE STUDY: AN EVALUATION OF TIME-LIMITED MUSIC THERAPY GROUP WORK WITH CHILDREN

Abstract

The format of this presentation given at the art therapies summer school in Riga, Latvia, July 2012, was a case study of time-limited group work projects that took place with children in mainstream primary schools and specialist provisions. In this article the music therapy approach will be outlined and examples of work described as an aid for clinicians, students and educators working in this area. The methods and outcomes of an evaluation of the work are described, and the article outlines some of the benefits of music therapy group work in schools including increased participation in play, increased awareness of others and a decrease in anxiety and frustration. Robertson and Pethybridge (2010) identified ways in which this group work approach can be considered within the theoretical foundations of educational music therapy, some of which are included in the article.

Keywords: music therapy, group work, participation, anxiety.

Introduction

This case study provides an example of time-limited music therapy group work and the evaluation process that was designed as part of the project in the context in which it originated in 2005. The work was funded by Youth Music Initiative (YMI) in partnership with the NHS and Local Educational Authority who were already providing a small service to children with additional support needs attending one of the four core provisions in the region. The aims of YMI are to provide access to the widest range music tuition for all young people in Scotland through schools-based and community-based music making. Music therapy was identified to develop new and innovative time-limited projects to meet some of the needs of youngsters with less severe additional support needs and to integrate music therapy with what other music practitioners were offering in new and imaginative ways. The evaluation was, therefore, to be focused on both the effectiveness of music therapy intervention and the integration or increased awareness of professional approaches between music therapy and music education.

This article will be separated into two sections. The first will outline the music therapy approach taken toward developing time-limited music therapy group work with children. It will include a brief discussion of the ways in which aims were set and

targeted within tailored improvisational and structured musical activities. The second will look at the evaluation of the project and will highlight the ways in which connections between the aims and outcomes of the work were seen to be demonstrable.

An approach towards music therapy group work with children

Music therapy is a client-led intervention based on the understanding that everyone has a natural responsiveness to music. The music that a child plays and the way in which he or she interacts with the therapist and/or peers may give a broader, holistic view of a child's emotional life or ways of relating to other people. In this way, the child's responses indicate the direction of work. In this project YMI, whose main merit was to provide access to music, was interested in including music therapy group work for children with additional support needs. Ansdell (2002) suggests that "music therapists have built up a body of experience and expertise working with pathology and its manifestations in the service of giving people access to musicing." The main aims of each project from the outset were, therefore, to provide access to "musicing" and active participation in music therapy groups. Children were selected by school staff in groups of four to six children who, it was thought, would benefit from group work aiming to facilitate positive change in the areas of communication and language skills, social/personal development and emotional wellbeing. The groups took place on a weekly basis for between thirty and forty minutes for approximately twenty weeks. They adhered to a philosophy of child-led creative music making whilst including some directed activities facilitating turn-taking, joint play and dialoguing to encourage participation and self-expression within a small group environment.

It was agreed that teachers would participate throughout the project as part of each group, which might enable experiential learning to take place (Leite, 2002), and, therefore, increase integration. It also provided support for the music therapist in the form of a co-therapist at times to assist with the presentation of instruments or modeling (Wigram, 2004).

The four stages of group work process: assessment, agreeing aims, treatment or intervention and discharge will be discussed in more detail below. It is interesting that in order to integrate the project alongside other music provisions, there was a keenness to consider how this was presented and whether words such as *therapy* or *referral* should be used in discussions with parents.

Assessment

The first four to six weeks were designed to be an assessment period in which observations and experiences with the children in music-making provided information about the individuals in each group as well as the group dynamics. The sessions began mostly child-led following the Nordoff-Robbins creative music therapy approach. Each group began with a structured song for "hello" and "goodbye". Within this a mixture of pre-composed play songs and individual and group improvisation opportunities were introduced and adapted as appropriate. Weekly notes recorded the r*aw response* (Robertson, 2000; Robertson & Pethybridge, 2010) of each child to different activities. Particular attention was given to what each child was able to do in terms of interaction and relationship with adults and peers, communication, movement, musical responses, attention, sense of self and managing feelings.

Agreeing therapeutic aims

Following initial observations within the group, the music therapist and education staff met to agree a treatment plan or *personal profile* (Robertson, 2000; Robertson & Pethybridge, 2010) including therapeutic aims for each child. The aims were based on what each child was able to do and what music therapy strategies, as it was felt, might support further development for each individual within the group. At this point we began to think more concretely about the "purpose" of music-making. For example, aims might include:

- to explore a musical relationship with the therapist and/or peers;
- to encourage confidence to play an instrument as the focus of attention in front of the group;
- to increase listening, concentration and ability to wait for or anticipate a turn.

Treatment or intervention

Activities were then adapted to encourage each of the individuals to *contribute* (Robertson, 2000; Robertson & Pethybridge, 2010) to the group. Activities were tailored to the abilities observed and the aims agreed for each group and its different members. The section below illustrates examples of activities and aims:

"Welcome to Music": Greeting Songs:

Every group work session began with a "hello" song and ended with a "goodbye" song. This had a number of functions:

- to provide "safe" and familiar boundaries;
- to provide a vocal and/or instrumental warm up;
- to acknowledge everyone in the group individually and as part of the group.

Supporting individuals to express themselves and to communicate in relation to others in the group:

Instruments might be offered to each child and opportunities provided as part of the "hello" song structure to enable each child to play to the group in turn. This can:

- signify who the group is greeting in each verse or repetition of the song;
- provide an opportunity for each child to express how he or she is feeling in the musical treatment of the instrument. Here the therapist often observed and considered which instrument each child chose, how they chose to play, how the instrument is used to participate in relation to the therapist or peers and what kind of mood was created.

The therapist used the piano to interact musically with every child in a short improvisation before returning to the familiar "hello" chorus. Depending on each individual relationship, she either chose to support or enhance what the child was doing hoping to provide a sense of being listened to and valued, match or reflect (Wigram, 2004), or mismatch (Pavlicevic, 1997). As described by Wigram (2004) "improvisation applied in clinical practice can be understood as a spontaneously created "recipe" where the therapist will utilize "ingredients" from these different criteria to either respond to, or create a musical improvisation that would be relevant and therapeutically meaningful for the client".

Example 1:

An example from the DVD (East Lothian Council, NHS Lothian and Scottish Arts Council Youth Music Initiative (eds), 2007) outlined a progression observed in the relationship between a child and therapist. In the first clip he plays fast and loud. He is watching but mainly drowns out the therapist. In the next two clips he shows an increased sense of awareness of the therapist in the music adapting his beat to a 3/4 tempo and creating clear endings for the therapist to follow.

This demonstrates the way in which, once individual aims have been decided, the therapist can begin to support and at times challenge each child's instrumental playing as appropriate. In the example above a musical structure was provided by the therapist with a *basic beat* (Nordoff and Robbins, 1985) to contain what was recognized as *disordered beating.* The response from the child was an increased awareness of relationship with the music and, to some extent the therapist. He began to acknowledge that he could lead the musical relationship and express himself in partnership with another. His selfconfidence appeared to increase.

Example 2:

A further clip exemplified the same boy directing the group. The therapist provided a musical framework and "safe" boundaries within which the children were able to explore different ways of playing. She asked the by what he would do and he clearly

communicated what he would play, what she would play, what the group would play and how it would end. "Start" and "stop" are simple directions expressed by the children vocally and through gesture. The chart below shows the development within this group.

Group 2:	
Activity:	**Group Aims:** *Exploring dialogues and relationships in music*
"Drum Talk" (Adaptation of a Nordoff-Robbins play-song.)	*Example:* Two children play the drums start very loudly. They are beginning to show awareness of the trio (piano and drums) and follow a change to playing quietly and then a crescendo led by the piano.
Improvised drum dialogues.	*Example:* Two children take turns and create a dialogue on the drums. The structured play song and therapist are no longer necessary. The children are now regulating the dialogue between themselves.
Directing the group.	*Example:* Using words and gestures to direct the group the therapist provides a musical framework and "safe" boundaries within which the children can explore playing. "Start" and "stop" are simple directions expressed by the children vocally and through gesture.

The following tables illustrate some other methods and techniques employed in accordance with identified group aims and developments.

Group 1:	
Activity:	**Group Aims:** *Exploring ownership – leading and following.*
Chorus and solo.	*Example:* Structured musical framework within which the group is able to explore a choice of instruments together. The song, *"Let's Make Some Music"* (Schnur, Ritholz, Michele, 1999) indicates individual solos on each instrument. The therapist's playing on the piano is adapted according to the use of the instrument and individual aims for each child.
Pop goes the weasel (Nordoff and Robbins, 1977) Arrangement used with tone chimes.	This is based on an arrangement of the popular song, which offers familiarity. The children are directed by the therapist in taking turns by following eye contact or a small nod of the head. This promotes awareness of others, following a leader, taking turns and waiting.
Leading the group in free improvisation with a solo instrument.	Individual in front of the group with a cymbal. The other group members follow with a chorus instrument. Stopping and starting with the group leader encourages confidence, increased self-esteem and a sense of group play. The group is also beginning to develop a sense of group identity in which they think for themselves.
Conducting the group.	Directing other children in the group and creating a sound-scape encourages a sense of group cohesion in which everyone is actively participating, showing awareness of one another and leading or following.

Group 3:	
Activity:	**Group Aims:** *Increasing group participation and awareness of self and others.*
Sharing an instrument.	Following the beat to play the drum together and in turn demands a great sense of group cohesion and awareness of others. The teacher in the group is able to model playing as well as provide some prompts whilst participating and learning as part of the group.
"How Many People in the Room?" (Turry, 1999)	A simple counting song promoting taking turns on the drum and awareness of the group. As the weeks progress and the children become familiar with the song, taking turns becomes more natural and confidence and attention levels appear to increase. This is a technique that can be transferred to the classroom.

Group 4:	
Activity:	**Group Aims:** *Participation. Decreasing anxiety, resistance or passivity within the group.*
Passing an instrument.	The quick turn-taking in time with the music creates motivation to be part of the group. An example is provided with one boy at the back of the group. At first, he does not want to be part of the group but begins to reach out for the tambourine. He then explores changing the tambourine into a hat, an idea that is incorporated in the group. The repetitive musical framework creates "safe" environment in which to explore the group interaction. Here the tambourine is the main protagonist and the children are not exposed as the focus of attention. The music changes and grows with the children.

"Goodbye": Greeting Songs:

Each session ended with a greeting song. Everyone was thanked for his or her participation individually and the song acknowledged when the next meeting would be. This was also another opportunity to promote turn-taking or singing as a group.

Discharge

The therapist constantly monitored each child's relationship to the instrument, the therapist and peers and recorded observations in weekly case notes. Outcomes were recorded in an end of project report for each child.

Evaluation

The necessity of evaluation has been clearly defined by Ansdell, Pavlicevic, Proctor (2004):

- to identify the main aims/benefits of one's work with their particular client group and its relationship to their particular needs;
- to find ways of making the connections between the aims and outcomes of one's work demonstrable.

a) The aims for this project were to evaluate:

b) The effectiveness of the music therapy intervention, and

The integration or increased awareness of professional approaches between therapy and education.

Thinking about what information it was important to identify from the evaluation, the following tools were selected to make the connections between the aims and outcomes of the work demonstrable:

- direct Observation (participant observation),
- observations in other contexts,
- behaviour checklists completed by parents/carers/teachers,
- video recordings (East Lothian Council, NHS Lothian and Scottish Arts Council Youth Music Initiative (eds), 2007),
- interviews of educational staff directly involved in the groups (film crew),
- questionnaires completed by music specialists and instrumental instructors in response to the DVD.

The following descriptions outline some of the outcomes noted from each method of evaluation in turn followed by an overall conclusion.

Observations, direct and in other contexts:

Direct observations were made by the music therapist within the sessions and in the reviewing of video recordings. Regular discussion with educational staff and occasional observations in the playground and the classrooms contributed to an awareness of how this compared to what was happening in other contexts. Clinical notes were written at the end of each group work session and reports for each child linked the main benefits of the work to each client need. Criticisms towards this type of evaluation are the high levels of subjectivity.

Examples:

One boy described passing the tambourine in group four and then beginning to play and explore using it as a hat was able to participate for an increased length of time in group activities moving from a high level of resistance to increased participation. As described above, another boy demonstrated an increased sense of awareness of the therapist in the music adapting his beat to a 3/4 tempo and creating clear endings for the therapist to follow. Building further on this, he was able to lead his peers stopping and starting in an improvised group activity. These observations are based on the clinical knowledge of the therapist and assessing, monitoring and evaluating in this way often forms a standard part of therapeutic practice.

Behaviour checklists:

These were devised by the music therapy department with support from the clinical governance team. They were completed before and after the project by teachers and parents/carers and provided a form of triangulation. Unfortunately, the return rate was low for families and it was only possible to review the effectiveness of the music therapy intervention on individual basis. The outcomes noted here for Catherine[18]have also been recorded elsewhere (Robertson and Pethybridge, 2010) and show some of the perceived benefits for one girl involved in the groups.

The therapeutic aims agreed for Catherine were to increase ability to lead when the focus of attention, increase self-confidence at the beginnings and endings and to participate in group beginnings and endings. From the different responses to the checklists before and after increases were noted in playing appropriately with peers, making decisions/choices, involving herself in adult-led activities, using appropriate gestures and/or actions to get the attention of others, awareness of how others might be feeling, co-ordination of left and right, initiating new behaviours, joining in games led by peers and dominating group activities. Decreases were noted in anxiety and frustration, expressing her thoughts and emotions (always reduced to often), becoming over-excited, showing aggressiveness, becoming sulky when asked to do things she did not enjoy, appearing confused, having difficulty making friends her own age and deliberately breaking rules.

Video recordings:

Consent was gained from parents of all of the children involved before the project began to use clips from the music therapy group work in a training DVD. Clips were edited and the final draft was viewed by parents and children before reaching a finished product. This has been used throughout the region to exemplify the observed changes as described in an approach towards music therapy group work with children section of this article.

Interviews of educational staff directly involved in the groups:

The film crew interviewed the staff involved in the groups. These were all classroom teachers and auxiliary staff with a range of different musical backgrounds. None of the staff described themselves as practicing musicians. Whilst the interview process provided some objectivity given the absence of the therapist, the presence of a camera may have influenced what was said. Responses were very positive from all of the staff involved. Some mentioned that they were able to use some of the ideas or adaptations of the ideas that they had experienced in the classroom. Transferable skills such as turn-taking, waiting and listening were thought to have been experienced in

[1] The name has been changed to respect confidentiality and promote anonymity.

fun and playful atmosphere, which could be built on in other contexts (Robertson and Pethybridge, 2010). Other benefits for the children included realizing that "they have to think for themselves" (East Lothian Council et al., 2007).

Philosophical differences: Music Education and Music Therapy

The questionnaires completed by music specialists and instrumental instructors in response to the DVD highlighted the perspective from music education that educational objectives are usually closely linked to curriculum targets in mainstream education and in larger groups (Robertson and Pethybridge, 2010). Provision of an increased music therapy service could, therefore, be seen to have offered children, who found participation difficult in some of these activities, a sense of ownership encouraged within a safe, small group environment in which therapeutic objectives were usually child-led. However, it was also noted that the professional perspective of the group facilitator, whether from education or therapy influenced the boundaries between therapeutic and educational musical objectives.

Conclusion

The evaluation highlighted:

- Connections between aims and outcomes for individuals in group music therapy including observable changes in musical relationships with the therapist and/or peers, increased confidence to play an instrument as the focus of attention and increases noted by teachers in listening, concentration and ability to wait for or anticipate a turn.
- Perceived transferable benefits of music therapy in observations outside the music therapy room and behaviour checklists completed before and after the music therapy group work such as decreased anxiety and frustration and increased appropriate play with peers
- Learning outcomes for teachers directly involved in the groups
- Some perceived differences between music education and therapy amongst practitioners in the region.

Central to these examples of music therapy group work with children was the philosophy of group boundaries creating a "safe" place for self-expression. Activities built upon observations of child-led music-making were shown to lead to increased participation and produce a range of therapeutic benefits observed both within and external to the group work context. The therapist and educational staff noted the benefits of children being encouraged to play in music. As described by Winnicott (1991; 54), "it is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self".

Activities could be seen to have encouraged children who may not have engaged immediately in musical tuition to benefit from participation in active music-making in with others in a group context. Robertson and Pethybridge (2010) argue that this participation might enable children to go on to participate more fully in opportunities offered by music education practitioners. In this project professionals working together with YMI were able to explore and discover similarities and differences between music therapy and music education through active dialogue and sharing of experiences.

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THE DEVELOPMENT OF COMMUNICATIVE BASIC SKILLS IN MUSIC THERAPY FOR CHILDREN WITH SEVERE PSYCHOPHYSIOLOGICAL DISORDERS

Abstract

The article highlights methods used in music therapy and their efficacy in the context of integration in practice, according to patient's individual needs. The author of the Paper has offered an understanding of conception of severe physical and psychological development disorders. Music therapy, as an important intervention for children with ASD, has been discussed in the article. The author's reliance is based on International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) by World Health Organization, to concretize diagnosis. The practical application of theories studies have been based on such asssessment technologies as primary assessment process; assessment of patient's difficulties and the analysis of the situation, obtaining additional information from health care institutions; questionnaires; objective evaluation tests; music-based music therapy assessment – Paul Nordoff and Clive Robbins' musical profile – "Non-Verbal Communication".

In praxis, the author fundamentally used an active/creative musical improvisation and "built" an integration of variety of music therapy techniques on them. To gain the goals of therapy, the author used improvisational techniques. The result of author's work was a successful integration of music test into improvisation; music test was necessary to check the level of sound perception in children with cochlear implants.

In empirical part of an article, the author shares her conclusions on efficacy of various MT techniques working with patients with lowly developed communication.

Keywords: basic communication, improvisation of musical techniques, low behaviour level, music therapy, and severe physical and psychological development disorders.

Introduction

Based on literature studies, the author of this article concludes that children with severe physical and psychological development disorders have been researched very insufficiently in a statistical perspective. The author's 8-year long experience in dealing with patients with different diagnoses and with different client groups shows there are a lot of children with disabilities. According to the trials performed by the experienced practitioners – special psychologists, those children represent an average of 40% of special education students (Жигорева, 2009; 27).

Success in dealing with such patients/clients depends on the professional level of different specialists. Assessment tools, both quantitative and qualitative, have been developed for the analysis and interpretation of musical material in creative improvisation. Evaluation or assessment scales developed to date have focused on a variety of aspects of music therapy process, including musical interaction (Pavlicevic, 1995; 167–180), responsiveness, engagement and musical communicativeness (Nordoff & Robbins, 1977; 21), diagnosis (Raijmaekers, 1993; 126–136), cognitive, perceptual, motor and visual skills (Grant, 1995; 273), sound-musical profiles (Franco, 1999; 93), elements that contribute to the structure of music (Grocke, 1999), the predictability of music (Wigram, 2002; 152) and the analysis of improvised music (Bruscia, 1987).

Music therapist must be competent in the use of assessment tools. The level of specialist's knowledge and versatility is determined by his ability to be competent enough in various medical disciplines. Learning of these skills becomes a possible and successful base for integrative approach, by building an individual program of corrections and variable models of program for children with complex disabilities.

As an aim of the article the author puts forward the discussion about the different methods, their efficacy and integration in practice, according to every patient's individual needs.

The Term of Severe Physical and Psychological Development Disorder

Studying literature of special education, one can conclude that the term "serious physical and psychological development disorders" has relatively very wide interpretation. The term should be understood as a complex syndrome, which includes intellectual disabilities combined with vision, hearing, physical disabilities and difficulties of raising children. It refers mainly to the fact that these are serious disorders, and it does not specify which disorder has a specific important meaning (Жигорева, 2009; 19).

According to the ICD-10 (World Health Organization (WHO), Geneva, 1996), mental disorders can be divided into:

- **mild (F70)** – Mildly retarded people acquire language with some delay but most achieve the ability to use speech for everyday purposes, to hold conversations, and to engage in the clinical interview. Most of them also achieve full independence in self-care;
- **moderate (F71)** – Individuals in this category are slow in developing comprehension and use of language, and their eventual achievement in this area is limited. Achievement of self-care and motor skills is also retarded, and some need supervision throughout life;
- **severe (F72)** – Most people in this category suffer from a marked degree of motor impairment or other associated deficits, indicating the presence of clinically significant damage to or maldevelopment of the central nervous system;

- and **profound forms (F73)** – The IQ in this category is estimated to be under 20, which means in practice that affected individuals are severely limited in their ability to understand or comply with requests or instructions. They possess little or no ability to care for their own basic needs, and require constant help and supervision.

Severe physical and psychological development disorders are two or more disorders caused by the body's multi-functional system combined with a simultaneous loss of brain structure damage. Each of them in this complex exists with the secondary characteristic of the disorders, which extremely complicates the overall structure of the defect, makes its compensation difficult, respectively, disorders reflect in the mental development of children and cause difficulties in social adjustment (Жигорева, 2009; 21).

Communication Concept

The term "communication" is used in many disciplines. There are sources where any reaction of the organism is indicated as communication. The author supports Bruscia's (1989) opinion, who defined communication in music therapy as "a systematic process of intervention wherein the therapist helps the client to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change" (Bruscia, 1998, 47). Musical experiences can include singing or vocalizing, playing various percussion and melodic instruments, and listening to music. Although children can passively listen to music, they are more often actively engaged in making music. The various types of music therapy activities typically consist of either playing structured songs or improvisational music (i.e., spontaneous music making). The music therapist is often involved in playing music and can interact with the client through the elements in music.In understanding music therapy as a specialized field, it is helpful to distinguish music therapy and music education.

The "systematic process of intervention" refers in part to the rationale behind the use of music as therapy. A basic assumption is that musical behaviours, such as the way a client makes music, reflect and parallel underlying psychological functions. Systematic interventions in music therapy may lead to changes in a client's musical behavior that are indications that a psychological change has also occurred.

The Importance of Music Therapy as an Intervention for children with ASD

Children with autistic spectrum disorder (ASD) presenting with significant limitations in conventional forms of verbal and non-verbal communication are found to respond positively to music therapy intervention involving both active, improvisational methods and receptive music therapy approaches. Improvisational musical activity with therapeutic objectives and outcomes has been found to facilitate motiva-

tion, communication skills and social interaction, as well as sustaining and developing attention. The structure and predictability found in music assist in reciprocal interaction, from which tolerance, flexibility and social engagement to build relationships emerge, relying on a systematic approach to promote appropriate and meaningful interpersonal responses (Wigram, 2005; 535).

Music therapy has been recommended as an effective treatment in facilitating communication, as music is a medium that involves a complex range of expressive qualities, dynamic form and dialogue, and offers a means by which some form of alternative communication can be established to help achieve engagement, interaction and relationships (Wigram, 2002; 152).

Music is processed by a different area of the brain than speech and language; hence, a child may be able to more easily absorb information and skills presented with music. Therefore, one of the purposes of music therapy for persons with special needs is to provide the student with an initial assistance using melodic and rhythmic strategies, followed by fading of musical cues to aid in generalization and transfer to other learning environments (American Music Therapy Association, 2010).

Music therapy as Medical Technology

As psychological intervention, music therapy uses the expressive elements of music as the primary means of interaction between therapist and client. Attentive listening on the part of the therapist is combined with shared musical improvisation using instruments and voices so that people can communicate in their own musical language, whatever their level of ability.

Music therapists work with individuals and groups and the methods vary according to the setting and the theoretical approach of the music therapist.

Assessment technologies include:

1. primary assessment process (contact formation with the patient);
2. assessment of patient's difficulties and the analysis of the situation, obtaining additional information from health care institutions;
3. questionnaires;
4. objective evaluation tests;
5. music-based music therapy assessment – for instance Nordoff & Robbins' musical profile – "Non-Verbal Communication", which is based on improvisation.

Improvisation is a key for the so called "non-verbal communication" after Nordoff and Robbins' method in music therapy. The music therapist's duty is to observe patient's psychological reaction to music, to estimate instant musical reactions and activities (Nordoff & Robbins, 1983; 80).

During the individual therapy both instrumental and vocal improvisation can be used. It stimulates the interpersonal communication and interaction between the therapist and the patient.

Therapeutic process largely becomes individualised, the control of video equipment, assistance and assessment of each session by audio and video recordings is important to maintain continuity of MT and increase its effectiveness (Paipare, 2011; 354).

Improvisation reflects the process of the subconscious: something a child does by accident, but something intentionally; for example, he repeats the sound, which he liked. Thus, during the musical improvisation a child has been unobtrusively taught to interact with the surrounding world through interactions with instruments (Alvin, 2004; 38).

The Guidelines of Author's praxes

At the beginning of therapeutic process with a patient, a therapist must assess patient's psycho-social, emotional, physical and psychological needs. For example: in the case of autistic spectrum disorder, referral criteria will relate specifically to the disorder. They are closely connected to pathological indicators, and contain all aspects of autism, which form the working goals of music therapy (Wigram, 2002; 152).

Criteria for referral and needs that have been met by music therapy:

- difficulties with social interaction at verbal and non-verbal level;
- lack of understanding or motivation for communication;
- rigid and repetitive patterns of activity and play;
- hypersensitivity to sounds;
- lack of ability or interest in sharing experiences;
- significant difficulties in coping with change;
- apparent lack of ability to learn from experiences;
- lack of emotional reciprocity and empathy;
- poor sense of self (Wigram, 2002; 152).

According to the International Clasificator of Functioning (ICF, 2001), the author created a questionaire for parents, kindergarten teachers and specialists (speech therapists, psychologists, physiotherapists) to investigate and identify the patient's/client's development of communicative behaviour. A reduced form of questionnaire was used for children with severe psychological and physical disabilities in the development of communicative behaviour to determine the level of a child's development; the author of this article finds this questionnaire as an objective way to identify patient's/client's development of communicative behaviour. And the author led a number of interviews as well.

The author is convinced that patient/client communication behaviour directly affects the choice of methods, techniques and models of musical improvisation. For example, it was frequently necessary to prepare a few patients with low level of com-

municative behaviour and uncontrolled aggression for interaction with musical instrument (for example, piano). The author has observed in her praxes that patients who do not suffer from uncontrolled aggression immediately begin to play various instruments in music therapy sessions.

To develop communicative skills for children with severe physical and psychological development disorders, the author of the article bases on the principles of Paul Nordoff and Clive Robbins' active in creative music therapy – on the concept of innate musicianship (music child), meeting the child's personality, personal representation of musical expression (Nordoff & Robbins, 1983; 73).

Children's communicative basic assessment and evaluation of the dynamics were regularly fixed by Nordoff & Robbins' musical communication test, which allows to define the patient's and therapist's communicative musical interaction after a 10-point scale. The lowest is the 1st degree, it is scored as 1 point, which means that there is no communicative response and patient's participation is not visible. The highest assessment is 10 points, when a patient actively eggages in musical tasks with excitement and becomes self-sufficient in group (Paipare, 2011; 354).

To develop a child with severe disabilities and with low level of development of communicative behaviour, a therapist must define the aim of therapy for the basic communicative development. In this case, the author in her own praxes uses International Classification of Functioning (ICF, 2001) and focuses on goals of music therapy:

Primary aim is to improve communication skills;

Secondary aims are as follow:

1. promote vocalisation for communication purposes (d330, d 335, d 331 – prespeech vocalisation);
2. development of general psychosocial functioning, leading to interpersonal and relationship-building skills (b122), including emphasis on the function of integration (auditory perception b1560, b1561 visual perception, tactile perception b1564, visual spatial perception 1565);
3. reduction of stereotypes and ritual behaviour (b147 psychomotor functions);
4. development of attention stability (b1400).

There are many therapeutic improvisation techniques used in MT classes. Dealing with patients, these techniques can be used intuitively or can be chosen after careful analysis – research of patient behaviour within free improvisation and behavioural analysis.

The author's most frequently used methods are vocal and instrumental improvisations (Wigram 2004; 82–97):

a) **empathic improvisation** – the therapist must reflect the patient's mood at the moment. If a patient comes in excited or sad, this sentiment can be easily incorporated in the emphatic improvisation. The therapist does not try to reduce the patient's feelings, but just plays to support them;

b) **matching and conformity** is an improvisation, which matches the patient's type of play. It maintains the patient's/client's playing tempo, dynamics, musical component quality and complexity;

c) **mirroring and copying** – Imitation technique is accurate for all patient activities (movements) – both music and repetition of body movements. Here in mirroring improvisation the identities of contestants appear more clearly. In this way the patients/clients can observe their own behaviour;

d) **dialogue making technique** – a process in which the therapist and the patient communicate through music;

For patients, who do not understand the dialogue process, the modeling technique has been used.

e) **modeling techniques** – demonstration of some elements is provided to the patient to let him imitate (Wigram, 2004; 98).

Her own praxes, makes the author conclude that:

a) **empathic improvisation** creates secure and confidence atmosphere suitable for destructive behaviour and destructive sense of management;

b) **matching and conformity improvisation** is suitable for contact creation between the patient and the therapist;

c) **mirroring (imitation, copying) technique** suitable for the diagnosis for patient's communicative skills. Develops the ability to listen and respond, prepares for dialogue;

d) **dialogue technique**, suitable for the development of continuity skills, for communication skills and for development of literacy.

The modeling technique (needs participation of assistant) (Wigram, 2004; 98) contributes a number of abilities:

- respond to a referral;
- imitation;
- focusing;
- interaction with others.

The author concludes that the most effective technique for the development of child's communicative skills is the modeling technique, with which a child, with a help of therapist and an assistant, develops basic communicative skills. The nature of techniques is that the visual, audial and sensory perception of information promotes awareness.

The test is based on the mirroring principle, which has been initially demonstrated to the client/patient by music therapist and assistant. The music therapist's task is to wait patiently until the client/patient consciously responds to the given musical themes, which includes a variety of musical expression (dynamics, rhythm, tempo). The music therapist's offered motives can be sung, played or performed by body movements. In addition, the task bases on test, to check sound perception in children with cochlear implants (Haus, 2007).

The integration of modeling techniques into the music promotes rapid learning of basic communication elements. At each session, the music therapist and the patient's level of participation and interaction by Paul Nordoff and Clive Robins' scale rapidly increased by one unit.

The author has been using the modeling techniques in her praxes for several years and it has proved its effectiveness.

Risks in work with target group of patients

The complexity of some sessions appears within unpredictable behaviour of a child and it often requires from a therapist unprepared methods and techniques. For example, the method of vestibular stimulation has been used intuitively, which is described in literature of special psychology, and the author of this article integrated it into the work with children with severe physical and psychological development disorders.

Synchronization of vestibular stimulation by vocal or instrumental improvisation Vestibular stimulation is the first vestibular experience the child receives even before his birth, still in the mother's womb. Vestibular stimulation includes changes of body position in space. In vestibular stimulation process the simplest irritants have been used: touch, rocking, hugging, etc. Communication of children with severe physical and psychological development disorders has been "organised" in interaction with the body and voice timbre that are the basic elements of the communication and interaction development (Froehlich, 1984; 2–15).

The synchronisation method of vestibular stimulation, according to the author's observations, is suitable for destructive behaviour and destructive sense of overcoming emotional development and strengthening of relations between the patient and the music therapist.

The method of vestibular stimulation many times became the "key" factor for emotional connection between the therapist and the patient/client and also became a future "bridge" in mutual relationship.

Resources of working with target group of patients

During a child's development communicative skills it is essentially important to train parents and involve them in the course of therapy before and after music therapy sessions. After each session, the author writes in detail about the screening process and the techniques, makes recommendations for their use in everyday situations. Nevertheless, before each session, parents share details with therapists of their observations about a child's dynamics of development between the sessions, they estimate themselves either they have succeeded or failed in using the play with their child. This approach provides an opportunity not to only strengthen the results achieved in the sessions, but also to contribute further development of the patient. The results of the questionnaire showed a rapid and dynamic improvement of child's communicative behaviour.

The assessment of results

The author of this article made a qualitative research with two preschool-age children with severe physical and psychological development disorders, including low level of communicative behaviour:

- a 4-year-old boy with multiple psycho-physiological development disorders, including childhood autism F84.0 (ICD–10);
- a 6-year-old boy with trisomy of the 21st chromosome (Down's syndrome) Q90.9 (ICD-10–CM, 2012); severe mental development disorder, F48.9 (ICD–10).

Assessing the results of music therapy for the youngest patient, the author finds that there is a positive evolution in communication, vocalisation, and reduction of stereotypies, perception and attention functions. Communication: more frequent, more aware eye contact, tactile contact, distance reduction, ability to respond to music therapist play/vocalisation, to follow the changes in the playing, simulating, building alternate play – to listen, to wait for their turn himself in giving a response, the expression of emotion in communication, revealing the joy of shared actions.

The research was conducted on the basis of Music School. The hypothesis of the author's research – "Systematic work applying optimally chosen music therapy methods rapidly promotes basic communicative development for children with multiple psycho-physiological disabilities" – has been confirmed and the treatment process of children with low communicative level of development achieved significant results in the development of communication. After just 10 sessions in two months, the children were able to use the transmission of information and began to communicate at a very basic level.

It should be noted that on the basis of successful work lies the trust between both sides. It should be remembered that this work with a number of patients/clients will require a lot of patience before the results will be visible.

Conclusions

Children with multiple and severe psychological and physical disabilities have disturbed functions of the psyche: perception, attention, memory, speech, thinking, and emotional sphere of the will that also affects the formation of the communicative skills.

The author finds the modeling technique of improvisation as the most effective one for developing the basic communicative skills in work with children who have multiple, severe physical and psychological development disorders, and also low level of communicative behaviour. The modeling technique can be considered as an innovation in music technology, within which the child receives music tehrapy and improves his focusing skills, responding, imitation skills and ability to respect continuity.

The integration of various methods and techniques in work with patients/clients, who have a number of psychophysiological disorders contributes to the rapid development of a child's basic communicative skills. This conforms to Latvian integrative eclective approach in music therapy.

Music therapy plays a vital role in promoting communication capabilities, where music is a tool of communication that contributes to an individual's communicative skills development and improvement.

It is important to work with people who have severe physical and psychological development disorders, because they have, on the one hand, the major difficulties with communication with other members of society, but, on the other, communication is the only way of self-realisation and exploration of the world. Music in this case becomes as an important support of life and way of communication, it also helps a child a lot to express them on an accessible level, which contributes to a significant improvement of quality of life for children with severe disabilities.

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USING MUSIC THERAPY FOR PRESCHOOL CHILDREN WITH SPECIFIC DEVELOPMENTAL DISORDERS OF SPEECH AND LANGUAGE

Abstract

In this article the most typical disorders of mental and behavioural development, which hinder children's adaptation to real life, have been studied. A music therapy study case has been analyzed in a more profound way about a pre-school child with specific developmental disorders of speech and language: the types of music therapy and chosen techniques have been described; the outcome of the case study has been summarized in tables and diagrams.

Keywords: music therapy, musical communication, specific developmental disorders of speech and language, case study.

During the last decade the number of children with various developmental disorders have increased significantly. According to the World Health Organisation, only 20% of newborns can be considered relatively healthy. The other 80% can be assessed as being on the borderline between health and illness. Thus, these children have been diagnosed with developmental disorders. (Promoting Mental Health Concepts. World Health Organization, 2005).

Children with special needs or children with restricted abilities; this is how children with physical and/or mental development disorders are related to in the world. These disorders can be expressed in various ways, but they can have similar causes, and above all, influence further mental development. Any disorder hinders a child's adaptation to real life.

To characterize the frequency of mental and behavioural disorders in Latvia the data of Health Economics Centre were chosen. The data is a summary from the register "The patients' register of particular illnesses about the patients with mental or behavioural disorders." This register is the only formal tool in Latvia wich provides such statistics. However, the rules meant for the provision of the statistics overview do not identify the inpatients' group with minor mental disorders (which are not included in the group of particular illnesses). Moreover, some patients seek help from specialists who do not provide their data to the register.

Diagnosis	The number of patients in absolute numbers on 100,000 inhabitants
Organic disorder of non-psychotic type – ICD 10-F06.6-F06.71	244
Neurotic, stress-related and somatoform disorders – ICD 10-F40-F48	141
Disorder of psychic development – ICD-F80 -F83	491
Behavioural and emotional disorder with onset usually occurring in childhood and adolescence – ICD 10-F90-F98	385

Table 1. *The number of patients diagnosed for the first time in their life, 2009*[19]

Music is an ideal medium to work with the many different problems of handicapped children, because children have always incorporated and integrated music as a part of their everyday life. They sing while they play, sing and "call" each other. As children grow, music becomes more externalized. For example, something one can listen to on the radio or CD, or something which one can be skilled at. Evereyone can express themselves through the use of basic elements of musical communication: intonation, rhythm, timing and tone-colour. We have all used these elements in our earliest communication with the extern world (Wigram, Pedersen, Bonde, 2002; Wigram, Bruscia, 2004).

Music therapy with children with specific developmental disorders focuses on resources more than problems. "In the treatment the children most often have nice and positive experiences of themselves and of the resources they have. Music therapy offers a frame for these children, where they can express themselves on their own premises and thus can be seen, heard and valued through something they create themselves from inside, and not only from something they perform and imitate by learning from outer structures and schemas. Most children react spontaneously and with interest to music" (Wigram, Pedersen, Bonde, 2002; 181).

Case study

Further on the article will discuss the procedure of individual music therapy and practical experience of the methods and techniques used in the case of the specific developmental disorder of speech and language (ICD 10-F80).

Upon a neurologist's suggestion and an appointment, 10 music therapy sessions were organized for a 4-year-old girl who attends a rehabilitation group of a pre-

[1] Rokasgrāmata skolotājiem, strādājošiem specializētajās iestādēs bērniem ar psihiskās veselības traucējumiem (metodiskais materiāls) (Eng. Handbook for teachers working in specialised educational establishments with children with mental and health disorders), 2009, www.rezeknesnovads.lv/res/content2/33/33542113092431020.pdf

school educational institution for children with special needs. She has been diagnosed with an inborn hip dislocation and specific developmental disorders of speech and language. Music therapy sessions were filmed and analysed; parents' written consent was received.

The music therapy sessions were carried out on the premises of the pre-school educational establishment rehabilitation group once a week for one hour. It was a room where all children, who attend the group daily, stay/work. During the music therapy sessions for the 4-year-old girl the other children went out to do some sports activities. In my opinion, the choice of music therapy placement was successful as the child, who has got special needs and who had just recently adapted to the pre-school establishment with difficulty, did not have to adapt to a new environment for the music therapy session.

Upon starting the therapeutic sessions, the author of the article got acquainted with the neurologist, physical therapist, special needs teacher and speech therapist's descriptions of the child. The special needs teacher assessed the child's development, including 21 functions. These include: social contact, play-game, music, big motorics, fine motorics, form distinction, language.

Quality category/Type of activity	Pace	Dynamics (loud, quiet, a lot, little)	Response reaction
Verbal communication (speech, singing)	Slow, irregular, changeable	Both quiet and loud when doing *crescendo, accelerando,* variety of tone	- Mamma, mamma will be, - no, daddy, - don't need, - no shoes
Instrumental play (drums, tone, piano, etc.)	Slow, sometimes aggressive	Play of irregular motives (2–6 beats)	Responds to the drums, piano, sometimes unwillingly, only to get to know the sound of the instrument, unsustainable attention
Non-verbal communication (gestures, body movements)	Longing, observation, uncertainty, sometimes rejection	Body language unconfident, insecure, leaves the piano twice, shows with movements that does not want to cooperate	Frequent eye contact, indicative gestures, changeable mood – the will to work interchanges with rejection

Table 2. *Development Assessment after the First Music Therapy Session (Engele L., 2009)*

According to the special purpose teacher's observations, the child to be studied asks for attention, participates in separate common play-games, tries to sing, arranges

simple forms without any help, utters separate words, communicates with gestures, whereas does not reach the highest assessment.

After the first music therapy session, I assessed how the girl played one of the offered musical instruments, what the pace and dynamics of the verbal and non-verbal communication were, whether the patient showed a reaction to one of the activities offered by the music therapist. The obtained results are summarised in Table 2.

After summarizing all the specialists' observations about the patient, observations of the first music session and taking into account the patient's level of development, the stated diagnosis and the possible potential development, the goals of the music therapy were set, as well as the music therapy improvisation method and techniques were chosen.

The goals of music therapy were determined in accordance with the *International Classification* of *Functioning*, *Disability and Health* (ICF).

The primary goal of music therapy: to promote the activity of musical communication (SFK–d3359).

Secondary goals:

- to acquire new motor skills through singing and playing (SFK-b7600-b7602),
- to acquire new behavioural forms – listen, not interrupt, make a dialogue (SFK-b1400-1401; b16710),
- to improve social skills and communication skills (SFK-d330, d7200-7201),
- to promote the expression of emotions using musical communication SFK-7202).

In work with the patient Nordoff/Robbins's music therapy was used (Etkin, 2002; 155–165; Wigram, Pedersen, Bonde, 2004; Wigram, Bruscia, 2004) which has been directed towards the promotion of musical communication activity:

- Integration technique of sensory-motor skills and sound;
- "Takeover" of the patient's vocalised sounds and tunes;
- Support of the patient's vocal or instrumental activity expression with the music therapist's voice;
- "Transmission" of the patient's motor abilities – instrumental play elements to the piano improvisation or voice;
- Creation and development of simple song forms.

In the analysis Nordoff/Robbins's "Musical Communication Scale of 10 Levels" was used as a measurement (Nordoff and Robbins, 1971, cited in Paipare Mākslu terapija (Eng. Arts therapies), 2011: 340–371), where the 1st level is the lowest and it is assessed with 1 point which means there is no communication reaction. Maintenance of managed response impulses is the 5th level of communication – the middle stage when it is possible to observe the formation of musical communication, assessment – 5 points. However, the 10th level, the highest, when it is possible to observe

the patient's enthusiasm performing musical tasks in group activities, assessment – 10 points.

Nordoff/Robbins's "Musical Communication Scale of 10 Levels":

1. No communicative reaction
2. Provoked reactions I: fragmented
3. Provoked reactions II: created in a musically comprehensive way
4. Musical temporary perception
5. Maintenance of managed response impulses, formation of musical communication
6. Developed communicative reaction with an interest, intensity of individually formed actions increases
7. Careful, flexible reaction, musical self-reliance
8. Joy about the musical creativity.
9. Free manifestation of musical intelligence and skills in communication
10. Enthusiasm performing musical tasks in groups (Nordoff and Robbins , 1971, cited in Paipare Mākslu terapija (Eng. Arts therapies), 2011: 340–371).

After 10 music sessions the patient's musical communication level assessment in 3 areas was carried out: play of musical instruments, vocal activities and body movements. The results were summed up in 3 diagrams.

Analysing **the musical communication: play of musical instruments** (see Figure 1) one can conclude that during the initial stage of the music therapy process (up to the 4th session) the child plays in a slow pace, sometimes aggressively, mostly uneven motives (2–6 beats), and inconsistent attention can be observed. Thus, the highest assessment of the stage is 5 points – formation of managed response impulses, formation of musical communication. However, starting from the 6th session the patient's initiative choosing the musical instruments and rhythmical play of the instruments can be observed. The patient harmonizes her play with the music therapist and manifests successfully the coordination of the right/left hand. At the end of the music therapy (8th–10th session) the patient's highest assessment is 8 points – joy about the musical creativity – the girl demonstrates her creative abilities several times making up the play with the drums, bells and tones. As this was the process of individual music therapy, the highest assessment 10 points for the enthusiasm of musical activities performance in a group was not possible.

Figure 2 **Musical Communication: Vocalisation** lets one conclude that even up to 5th–6th session the communication can be assessed with 6 points – increasing intensity of individually performed activities. The patient utters a few words, mixing Latvian and Russian (the girl is from a bilingual family); it is possible to notice variety in the voice both in tones and dynamics. In the sessions 8–10 the girl makes a narrative in

"her" language, deliberately speaks or sings loudly and quietly, expresses varied emotions, repeats precisely in tune 2–3 syllable words sung by the music therapist, thus receiving the highest assessment – 8 points.

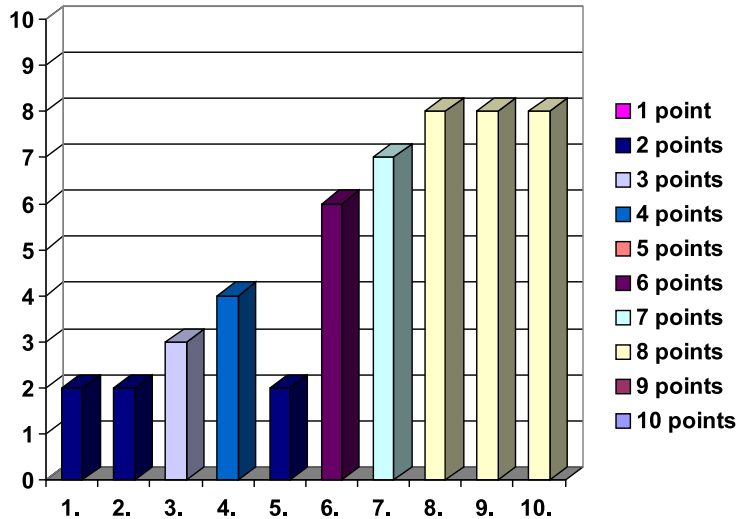

Figure 1. *Musical Communication: Play of Musical Instruments*

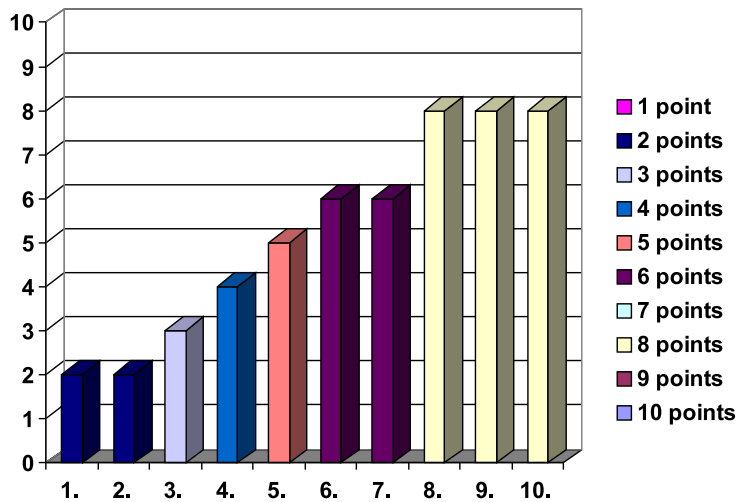

Figure 2. *Musical Communication: Vocalisation*

Figure 3: **Musical Communication: Movements** allows us to conclude that at the beginning of the therapy the patient's uncertainty, longing, sometimes rejection can be noticed. However, there is a frequent eye contact. Gestures are uncertain,

insecure; the girl leaves the musical instrument several times during the music therapy process showing with her movements that she does not want to cooperate. The assessment of this stage is 3–4 points – temporary musical perception. However, starting from the 4th session the girl becomes more confient, trusts the music therapist manifesting it with touches and hugs. Varied facial expressions, confident body language can be observed, the child does not leave the premises of music therapy before the end of the session. Frequent eye contact, peaceful gestures, the wish to cooperate dominates, various joy expressions can be noticed – laughter, waving hands, swinging by the piano to adapt the music character and pace. At the end of the music therapy the patient is assessed with 9 points, for she demonstrates musical intelligence and the necessary skills for musical communication.

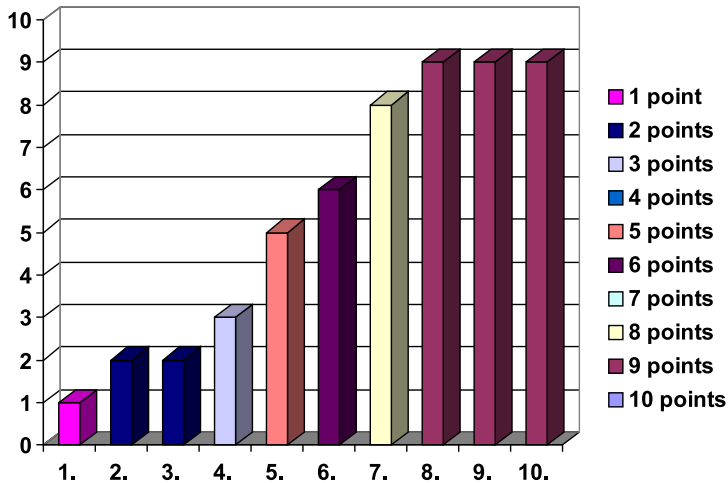

Figure 3. *Musical Communication: Movements*

After 10 music therapy sessions one can notice positive dynamics in all 3 musical communication areas: play of musical instruments, movements, and vocalisation. The most significant changes can be noticed in the areas of musical communication – play of musical instruments and movements. When playing various musical instruments, the child to be studied manifested a new acquisition of motor skills, a successful development of the right/left hand coordination. The girl was able to adapt to the music therapist's pace, demonstrating an even, rhythmical play, as well as comprehension of the terms "loud", "quiet," "fast", "slow." The smallest changes were noticed in the musical communication area – vocalisation. The diapason of the verbal communication means in the child did not change in a qualitative way during the music therapy process.

The changes which happened during the music therapy have been summarized in Table 3 (Development Assessment after Music Therapy), using the observation criteria

of the 1st session: how the girl played the instruments, what the pace and dynamics of verbal and non-verbal communication were, whether she showed any response to an activity offered by the music therapist.

Quality categories/Type of activity	Pace	Dynamics (loudly, quietly, a lot, little)	Response reaction
Verbal communication (speech, signing)	Adapts to the music therapist's pace or creates her own rules of the "game"	Deliberatlely sings or speaks both quietly and loudly, understands the terms "loudly," "quietly," expresses varied emotions – joy and sorrow	Makes questions and narratives in her "own language", does not use the word "no", repeats precisely in tune 2–3 syllable words sung by the music therapist: "lalala", "bye", "drums", "piano", "bells", makes up 1 syllable words for a familiar motive – "čiv"
Play of musical instruments (drums, tone, piano etc.)	Harmonizes her play with the music therapist, shows initiative when choosing the musical instrument	Even rhythmical play of musical instruments, successful coordination of the right/left hand	Responds deliberately to the drums, piano, observing the limits created by the music therapist or creates her own, distinguishes the pitches, plays "loudly" or "quietly", cooperation with the music therapist, demonstrates creative abilities – makes up a play with both the drums, bells and tones
Non-verbal communication (gestures, body movements)	Sense of safety, support, trust, touches, hugs, pats	Confident body language, varies facial expressions, does not leave the music therapy place before the end of the session	Frequent eye contact, peaceful gestures, the wish to cooperate dominates, various expression of joy-laughter, waving hands, falling on the floor, body movements at the piano adapting to the music character and pace

Table 3. *Development Assessment after the Music Therapy (Engele , 2009)*

After the 10 music sessions the special needs teacher assessed the child's development repeatedly using the "Development Assessment Criteria." According to the special purpose teacher's observations, the girl's social abilities have improved, she is more willing to cooperate with other children, while she is playing, she sings and uses musical instruments, makes short sentences. The assessment results confirm that positive changes have taken place in each of the areas looked upon.

Conclusions

1. By implementing a complex approach to the problem and cooperating with several specialists, it is possible to determine goals and correction methods for a child with specific developmental disorders of speech and language more successfully.
2. Nordoff-Robbins's music therapy method can be used successfully if a child has got difficulties on verbal and non-verbal level of social communication, lack of motivation, lack of skills and interests to share the experience, disorders in emotional communication.
3. The observations partly confirm the hypothesis that cooperation with several specialists and purposeful choice of music therapy methods and sessions can help to overcome development disorders.
4. The analysis of the particular case revealed that during the music therapy session a child could have a negative attitude towards the music therapy which makes the therapist think over the improvement of the therapeutic communication to make music therapy more efficient.
5. Further studies are necessary in order to discover the efficiency of music therapy with a bigger number of children who suffer from the specific developmental disorders of speech and language.

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