

ARTICLE

What are the factors of effective therapy? Encouraging a positive experience for families in music therapy

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ABSTRACT

This article discusses the impact of trauma on cognitive development, linking this to a review of some of the literature available on the factors that enhance the therapeutic experience. Although the literature reviewed concerns general psychotherapy, further discussion is offered on the impact of the findings on music therapy. In response to the findings and the author's continuing clinical music therapy work in the field of the impact of trauma, a pilot project is proposed using the Swanick-Chroma Assessment of Supportive Factors (S-CAF) questionnaire, which is based on Lambert's four main factors of effective therapy: relationship/alliance, client characteristics, model of therapy, and expectancy. The S-CAF questionnaire can provide opportunities for professionals and the referred family to reflect on the levels of emotional and practical support available to them before and after the therapeutic process. It is proposed that the more the family feels emotionally supported, the greater the chance of success during and after therapy. A pilot research scheme is proposed to test the effectiveness of the S-CAF, with the creative arts therapists associated with Chroma (a creative arts therapies agency in the UK) undertaking the questionnaire as part of the therapeutic process (during assessment and evaluation). The results from the questionnaire will be used to inform the goals of the therapy, providing support to the family where needed.

KEYWORDS

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INTRODUCTION

I have worked for Chroma, a UK arts therapies agency, since 2016. Chroma employs nearly 100 creative arts therapists who work as either music, art or drama therapists across the country. During a management meeting at Chroma HQ, the leadership team asked, "What is it that makes our therapy effective?". Although we could talk about success stories and the benefits of our different modalities, we could not identify anything specific. What were the qualities that helped us have a positive impact

on our referred families? I decided to look into the qualities of successful therapy and feed back to the team. I have a professional interest in assessment, having written an assessment training manual on the Assessment of Parent Child Interaction (APCI) (Swanick & Jacobsen, 2019) and built the foundations for the Chroma model of multi-disciplinary assessments, which incorporates the APCI and Fagus questionnaire (Beech Lodge School, 2016). The APCI is an objective musical assessment which measures the attachment style and parenting skills of the family, whilst the Fagus monitors the educational and social development of the child, from the point of view of school. I started to reflect on how we could develop an assessment tool that measures the qualities of successful therapy and how this impacts upon the family, to help families have the best possible experience of therapy. In my music therapy work with adopted children, I have often shared my thoughts with other professionals on the powerful impact that the wider family has on the child and the therapy space. A child is often referred to Chroma at a time when the family are in crisis. There can be a reduction in emotional resilience, and the family feel they cannot cope with the behaviours of the child. If a family accesses the support offered by the therapist and professionals there seems to be, in my experience, a higher chance of a positive therapeutic outcome. All these thoughts, reflections, research and experience have informed the development of S-CAF in the hope that we, as therapists, can provide consistent, individual and useful care for the families that we work with. The aim of this paper is to describe the process of development which led to creating S-CAF. Firstly, there is a review of findings on how trauma affects the brain, followed by a discussion on the factors that contribute to effective therapy. The paper concludes with a proposal for a pilot scheme to test the effectiveness of S-CAF on measuring resilience and effective therapy with families.

TRAUMA AND THE BRAIN

Research has shown that children who are exposed to trauma often experience challenges with cognitive abilities, and experience changes to their brain structure (Enlow et al., 2012). Children may present with a reduction in executive functioning, and their brain structure can show a reduction in volume in the cerebral cortex and hippocampus. They can also experience challenges in cognitive domains, indicated by IQ levels and reading and maths ability.

Enlow et al. (2012) found that interpersonal trauma in infancy had a negative and enduring impact on children's cognitive development (past the age of five), even when adjusting the data for environmental contexts. Some physically traumatic events have a direct impact on the brain, i.e., a head injury caused by physical abuse or severe malnutrition. When the trauma is psychological, the damage is caused by overloading the stress pathways in the brain. Extreme stress causes changes in the chemical and hormonal balance in the brain, as well as damaging the neurotransmitters that connect the different areas. Enlow et al. (2012, p. 1005) state that "because early brain organisation frames later neurological development, changes in early development may have lifelong consequences".

Bremnar (2006) discussed the long-term effects of the child experiencing high levels of stress. After trauma, the brain shows long term changes in neurochemical systems and specific brain regions. The production of cortisol increases dramatically, and the hippocampus, amygdala and prefrontal cortex are affected. As the brain is flooded with cortisol, neural pathways change, causing dysfunction

in cognitive processes. The hippocampus, amygdala and prefrontal cortex all play a part in verbal and actual (visual) memory and emotional regulation, meaning that the child will struggle in times of stress into his adult life.

Winnicott (1971) proposed that the child's relationship with their caregiver (specifically their mother) is the biggest indication of future mental wellbeing. If a child does not feel safe or is not psychologically/physically safe, their levels of cortisol (a stress hormone) rise. When this increase is long term, the neural pathways in the brain are permanently changed.

Richard Anderson (1978) developed the idea of humans arranging cognitive information in schemas (or schemata). A schema is the 'mental framework' in which we remember and organise information. As we mature, our schemata help us by providing a social and emotional anchor for our behaviours. With our schemata as a cognitive base, two further skills of emotional understanding are employed in our reactions to others – reflective functioning (how we understand feelings) and then mentalisation (seeing things from another perspective) (Goulding, 2007).

In children who have experienced trauma, the schemata are dysfunctional. For example, in a good enough environment, a child will learn that if they cry or ask for help, their caregiver will respond by soothing and listening to them. The consistent caregiver will meet the emotional and physical needs of the child more often than not, giving the child a functional emotional schema to refer to. When caregivers are in crisis, they may not have the capacity to meet the needs of the child. If the child cries, the parent does not respond in a thoughtful way. The child either feels catastrophically overwhelmed or dissociates from the situation. As the child matures, this dysfunctional schema becomes their reference point in times of stress, and the child will react by behaving in a similar way.

To understand further the impact of stress on brain function, it is important to look at working memory. A healthy prefrontal cortex is essential to working memory. As noted above, this is also a key area that is affected by trauma. Extreme stress can cause structural damage which lessens the capacity of working memory (Luethi et al., 2008)

Working memory holds temporary information and is responsible for reasoning, behaviour and decision making. Theorists have argued that working memory is directly related to the development of cognitive processes in humans. Cognitive abilities in childhood are reliant on a successful working memory; in fact, the capacity of working memory is a predictor for these abilities (Case, 1985; Jarrold & Bayliss, 2007). Kail (2007) led a longitudinal study on working memory in children from one year old until later life and found that this area of brain development was the strongest indicator of reasoning ability in maturity. Working memory is affected physiologically by acute and chronic stress (Arnsten, 1998). The effects of stress on the physiology of the brain – both functionally and structurally – can help explain how stress impacts mental ill health. When we are stressed, working memory capacity is reduced, and therefore so is our ability to think reasonably and make decisions, possibly adding more stress to our daily lives. Mood states, whether positive or negative, influence the chemical structure of the brain, which can also affect problem solving (Revlin, 2007).

As well as having implications for the young person, the impact of trauma on the brain has implications during therapy. For information to be stored in long-term memory (and remembered as a changing experience), it needs to have meaning and association with previously acquired knowledge, i.e., it needs to be relevant to our lives. One way to ensure relevance is with mental repetition, which improves memory storage. A further key element of relevance is motivation. If a person is fully

engaged in a task or moment, they will remember it as a sensory experience. In therapy, there must be time to build positive experiences, with links to the client's subconscious, in order for the therapy to be truly effective. Regular and consistent therapy sessions become imperative to positive change (Thomas, 2006).

Having established working memory capacity and repetition of behaviours as key elements in the learning processes of humans, we can now start to think about how this relates to change through the therapeutic process.

FACTORS FOR EFFECTIVE THERAPY

Many therapists will experience positive outcomes in their work with clients. This success may be measured using a questionnaire, or standardized tool. It may be that the client feels more resilient and ends the treatment when they are ready. An important part of the therapist's role is to reflect on the journey that opened up with the client – "Why did it go so well? What did we do together that helped?" In the following section, I will discuss research around what makes an effective therapeutic experience.

According to Lambert (1992), there are four main factors in a therapeutic relationship, which can be divided into 'therapist issues' and 'client issues'. Lambert weighted each of the four factors with a percentage, relating to how much they affected the therapeutic experience. The two factors that the therapist has control over are 'relationship' and 'model'. *Relationship*, which accounts for 30% of the overall therapy experience, is associated with the character of the therapist; namely, warmth, empathy and acceptance. The *model* used by the therapist accounts for 15% of the therapy experience. Then, there are two factors which are 'client issues'. Firstly, the client's *hope* and expectancy for the outcome of therapy (whether hoping for a positive or negative outcome). This accounts for 15% of the overall experience. Secondly, the client also brings *extra factors* – or characteristics – which make up 40% of the experience and include the client's inner strength, support system and the influence of their environment. If the weighting for the therapist factors and client factors are added, the therapist carries 45% of the responsibility for a positive outcome in therapy, whilst the client carries 55% of the responsibility (Lambert, 1992).

Thomas (2006) tested Lambert's theory in a family counselling context. In this study, therapists reported a higher emphasis on the therapeutic relationship, followed by the client's expectancy of the therapy. When surveyed, clients emphasised the importance of their expectancy for the therapy. However, the majority of the factors for effective therapy from a client point of view were associated with the therapist. Using Lambert's proposed factors for effective therapy, the following section will draw on literature to highlight the important aspects set out in the original study (Lambert, 1992).

Therapeutic relationship/alliance

Horvath and Greenberg (1989) suggest that the therapeutic alliance can be broken in to three areas:

- Bond: The relationship between the therapist and client.
- Goals: The aim of the therapy that the therapist and client work upon.
- Task: The methods used to work on the goals.

Sharpley et al. (2006) state that in order for the goals and task to be completed, there needs to be a solid and meaningful therapeutic bond. This emphasis on the therapeutic relationship, with the therapist at the heart of it, has certainly been found in many literature reviews over the past 20 years. Lantz (2004) found that 'relationship factors' including empathy and listening skills suggested more positive outcomes than, say, techniques or theories. The therapeutic relationship, or alliance, is a space where client and therapist work together to create goals for positive change – and this is common to all modalities of therapy. Teyber and McClure (2011) state that the relationship is built on trust, acceptance and empathy. Empathy is a key element in forming any human relationship. As social creatures, we respond to body language, tone of voice and eye contact, and can sense when the other is listening acutely to us. Therapists can enhance the relationship by understanding the client's experiences and intentions; showing interest and engaging with them on their journey (Sharpley et al., 2006).

The point in the treatment at which the alliance is made will have a direct impact on the outcomes of the therapy. McCoy-Lynch (2012) ran a study with psychotherapists, using questionnaires to capture their experiences on the factors of effective therapy. Over 50% of the therapists interviewed stated that the first two to four sessions were the most important when building bonds, with some therapists reporting a sense of the relationship within the first ten minutes of a session (Littauer, Sexton & Wynn 2005). Factors such as how long the client has waited for therapy, the efficiency of the organisation or therapist at responding to enquiries, and the initial contact for the first appointment will add to the foundations of the therapy alliance.

Empowering the client in the therapy process is important when considering the balance of power in the therapeutic alliance. Sullivan, Skovholt and Jennings (2005) found that therapists who were struggling to start positive change in their clients had new success when they discussed this barrier with their client. This action seemed to lead to the finding of a joint solution to the problem and reaffirmed the mutual alliance. In parallel to this, Littauer et al. (2005, p. 30) surveyed 36 clients after their second psychotherapy session and found the following qualities to be most important: "be warm, calm, responsive, be prepared and have a plan, listen attentively, be understanding, and balance specific questions with comments and conscientious listening".

Black et al. (2005) discuss the influence of attachment styles and behaviours on the ability to make and sustain relationships. This seems particularly relevant when discussing trauma and work with children. When a client is feeling unsafe, they will revert to their original behaviour patterns. In the therapy space, these behaviours can become heightened in the transference of the therapeutic alliance. If the client has experienced trauma through parental abuse or neglect, they may subconsciously revert to this as they feel vulnerable in the therapy space. This can harm the relationship, and therefore the outcomes of the therapy. Attachment styles in clients cross two elements of the factors of effective therapy: the therapeutic alliance and the 'extra factors', or client characteristics.

Client characteristics

Bachelor et al. (2007) found a high correlation between the client's motivation, symptomology and relationship skill in positive outcomes in therapy, echoing Lambert's (1992) findings stated earlier.

When the client is invested in the process of therapy, it will help to create a safe space where difficult feelings can be explored (Sullivan, Skovholt & Jennings, 2005). This is the crux of therapy: trying to understand why the client is in turmoil and how that relates to their life – past, present and future.

As the client's personality affects the progress of therapy, so does the therapist's. The therapist needs to be reflective and flexible, working in partnership with the client. They need to feel positive about the outcomes of the therapy and communicate this to the client (Whitbourne, 2011). Interestingly, evidence shows that the amount of experience, training or professional skills a therapist has do not have a significant effect on the therapy experience (Hersoug et al., 2001). Hoglend (1999) found that variables such as therapist personality, training, years of experience and even amount of supervision had inconclusive results with regard to the outcomes of therapy. However, Hoglend did find that unplanned or early endings with clients were more highly associated with inexperienced therapists, which could be related to the building of the therapeutic alliance.

Model

If we return to Horvath and Greenberg's (1989) three areas of the therapy relationship, the model used by the therapist would be the 'task'. In creative arts therapies, the task is the modality of the therapy – whether that be one of the specific disciplines of art therapy, dramatherapy or music therapy. When a referral is made, it is usually with a modality in mind. Sullivan, Skovholt and Jennings (2005) detailed numerous studies showing that the modality of the therapy was unimportant as most approaches will offer positive change. This again suggests the force of the therapeutic alliance is key to the change process. The modalities that Sullivan, Skovholt and Jennings referred to were associated with traditional psychotherapeutic thought, and there was no evidence available at the time of writing on arts therapies models.

Hoglend (1999) suggests that the therapist must find a balance between clinical judgement, creativity and flexibility in order to bring about change. The therapist must use a range of therapeutic tools to meet the needs of the client. When clients are asked about their experiences in therapy, they do not always speak of the modality, but of the relationship and characteristics of the therapist (Carr, 2011).

McCoy-Lynch (2012) found that from the interviews in the study there were several themes for successful therapy. Therapists suggested that being open to new ideas and receiving regular supervision was important to them when informing their practice. One interviewee shared that "not being complacent, going to training, reading books, expanding your skills and thinking and recognising your own countertransference" (McCoy-Lynch, 2012, p. 26) are all ways to develop and support clients. All therapists agreed that high numbers of sessions, consistency of the therapist and frequent (weekly, for example) sessions all contribute to successful outcomes in therapy.

Expectancy

When a client seeks out therapy, a self-referral, they are more likely to succeed in the therapeutic process (Hoglend, 1999). Summers and Barber (2003) shared this view in that the client's pre-treatment expectations, added to the alliance created between the therapist and client, will have a

positive impact. In Lambert's (1992) original study, the expectancy of a positive outcome by the client contributed to up to 15% of the therapeutic outcome. Sprenkle and Blow (2004) also found this therapeutic variable important and suggested that this factor was not specific to a particular model of therapy. In Thomas's (2006) replica study of Lambert's work (discussed above; Lambert, 1992), both therapists and clients felt that hope for positive work being done was of higher significance than was expressed in Lambert's study. Therapists felt that hope represented 27% of the emphasis in the therapeutic experience (ranked second), whilst clients believed this to be the most important factor (30%).

Winger (2010) suggests that although there are myriad of reasons why people seek therapy, the one common factor is hope; it is the "essential therapeutic factor" (Winger, 2010, p.6). Hope for the possibility of change is open to all people from all cultures, experiencing all challenges. When feeling hopeful, clients are more likely to believe in their future and value, and this is then linked to self-esteem, positive personal relationships and overall wellbeing (Basset, Llody & Tse, 2008). With 80% of clients receiving therapy experiencing enhanced general wellbeing (Synder, Michael & Cheavens, 2006), Synder proposed 'The Psychology of Hope' model (Synder, 1994). This is a two-component theory: *Pathways Thinking*, which is associated with a client's ability to "produce one or more workable routes to their goal," and *Agency Thinking*, which regards the client's ability to move along these routes to their goals (Winger, 2010, p. 11). For hope to be present, both components need to be available to the client. Synder (1994) proposed several blockages to The Psychology of Hope – stress, negative emotions and difficulties with coping. Clients who are experiencing high levels of difficulties will struggle to engage in the often painful and challenging journey of therapy. They seek therapy in despair, without hope. As discussed earlier, the lack of hope could be due to the extreme impact of their presenting problems, leading to a reduction in the capacity of working memory and therefore a reduced ability to think reflectively about their issues.

REFLECTIONS ON LITERATURE

The research reviewed here suggests that, although there are many factors that create an effective therapeutic space, the therapeutic alliance and the motivation of the client are the most important factors. Meeting the client where they are emotionally will enable the therapy process to have positive outcomes as the therapist works flexibly and empathetically with the client. As professionals, we may even have a duty to ensure that the client is in the 'right place' for therapy to start. This could include having a safe base, resources to call upon (time, money and people), reduced symptomology and a motivation for change to happen. To ensure this, there needs to be more emphasis on assessment before therapy, and funding in place to ensure therapy can take place regularly to allow the therapeutic alliance to take hold and grow.

What are the implications for music therapy?

The four main areas described above – therapeutic relationship/alliance, client characteristics, model and expectancy – can be used in a variety of therapy settings. How do these factors relate specifically to music therapy with children and families, and how can therapists use them to enhance their work?

The factors reaffirm the therapist's responsibilities to give the family the 'benefit of the doubt' (Swanick & Jacobsen, 2018). This means that even though the family are accessing therapy to relieve their difficulties, the therapist has an obligation to shine a light on the positive aspects of the family. Often a referral for music therapy will be specifically for the child. However, by understanding the dynamics and emotional landscape which surrounds the child, the therapist can have a more positive effect, and therefore a greater chance of enabling sustainable change after therapy. In this supportive way of working, the child not only gains positive attachment experiences and tools for coping and understanding through therapy, the family does, too. This, in turn, can foster stronger bonds between parent and child and an enhanced sense of resilience for the future.

Music therapy has an evidence base on the power of creating attachment and alliance through its emphasis on nonverbal communication (Cropper & Godsall, 2016; Saotome, 2010; Swanick & Jacobsen, 2019; Van der Kolk & Saporta, 1991). For the child who has experienced trauma in the levels needed for therapy, using spoken language may not be possible (and they may not be 'in touch' with their experiences in this way). Music provides an accessible way for the child and therapist to meet each other and create a safe and meaningful bond without words. With this bond comes the therapeutic relationship needed to explore, understand and nurture the child's inner world. Furthermore, music therapy can bring solace to a child as well as give them a method for managing intense emotional experiences (Saarikallio & Erkillä, 2007).

In the UK, the role of the music therapist has commonly been part of a wider, multi-disciplinary team, typically in schools and NHS settings. In recent years, the source of funding has changed and now the families and professionals referring children to music therapy have a bigger impact on the goals being set for the work (Thomas & Abad, 2018). With this in mind, 'extra factors' and the expectancy of the family may also have an increased impact on the subsequent outcome of the therapeutic contract. In the music therapy work that is undertaken with traumatised and/or adopted children, extra factors such as the stability of the family and their ability for reflective functioning will affect the child's experience of therapy; the child may start to change and realign themselves in the therapy room, but without the ripple effect of change in the home environment, it may end there. The music therapist can bring something of themselves to support the family – offering regular time for the family to reflect on the process they are going through, and being available to encourage in times of difficulty or celebrate small successes which will create a further bond within the family. They can learn coping techniques and resilience (along with the child) by being heard by the therapist and therefore feeling more supported in the journey. Having a positive experience with an empathetic professional will increase the sense of hope and expectancy for the future.

THE SWANICK-CHROMA ASSESSMENT OF SUPPORTIVE FACTORS (S-CAF) QUESTIONNAIRE: A PROPOSED PILOT STUDY

In order to address the themes offered by the literature review and discussion, a pilot study of a questionnaire has been proposed. The pilot study will use data collected by the associate therapist of Chroma, using the Swanick-Chroma Assessment of Support Factors (S-CAF) questionnaire. The questionnaire is divided into sections which reflect the highlighted factors of effective therapy: relationship between parent and child, client and therapist factors, model and expectancy. Each

section has questions that are used to ascertain key qualities for the major factors. For example, the question “How easy is it to be affectionate with your child?”, helps the assessor to understand the relationship between parent and child and their perceived attachment experiences (see Figure 1). The questionnaire uses a Likert scale, which typically uses numbers to rate an experience/issue, along with some qualitative questions. The aim of adding qualitative questions to the number rating scale is to encourage reflective thought and therefore add to the expectancy predictions of the family.

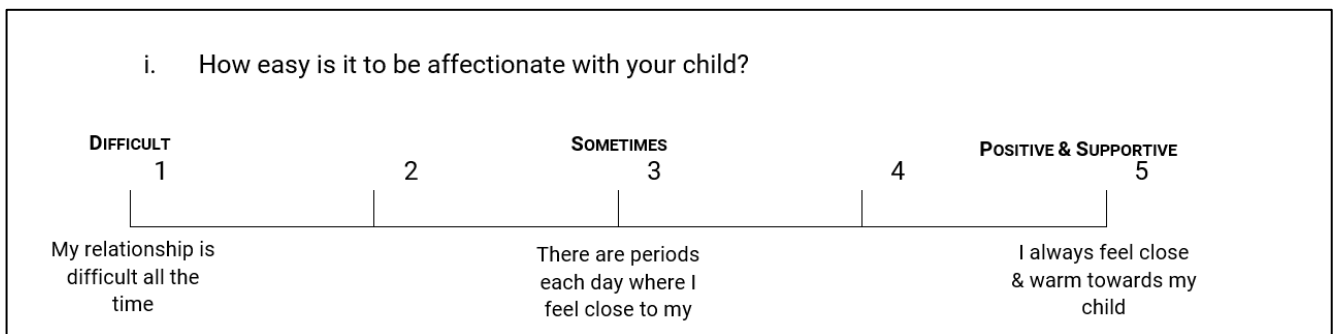


Figure 1: An example question from S-CAF

The proposed pilot study is based on the hypothesis that by assessing the emotional and practical resources available to the family at the time of referral, and subsequently meeting needs where appropriate, the family will experience a positive experience of therapy and increased hope for the future. A positive outcome will take into account an increased attachment and/or increased understanding between parent and child, increased hope for the future, a stronger sense of emotional resilience and coping skills in the client and family.

Proposed method and participants

To test the validity of the S-CAF, a pilot scheme will be run through Chroma Therapies Ltd (www.wearechroma.com). Chroma is the UK's largest arts therapies organisation and specialises in working with attachment and trauma, as well as neurological issues. The funding for much of the work is provided by the Adoption Support Fund (ASF) and commissioned by local and regional authorities for social services. The ASF provides funds for essential therapies for families who have adopted children or who have Special Guardianship of children who have been removed from their birth family. The associate creative arts therapists who undertake the contract work for Chroma will use the S-CAF as part of their initial assessments and final evaluations on each case.

At the point of referral, the questionnaire will be used by the lead therapist to assess the current situation of the family and their alignment to the factors. The information from the questionnaire will be used to collect data and to inform the professional team of the family's supportive factors. The professionals involved may or may not use the outcome data to implement further support for the family (information on this will be collected at the evaluation stage).

Therapy will unfold as planned. At the end of the therapy, the lead therapist will contact the family and evaluate the therapeutic process using the S-CAF. The pilot scheme will run for six months, with the average length of therapy through the ASF being 22 weeks.

Participants for the S-CAF will be adoptive families referred for arts therapies through social services (in the UK) and entitled to funding from the ASF. Children aged between three and 16 are eligible for the S-CAF.

DISCUSSION

The S-CAF questionnaire has been shared with social workers in London and the South West of England (through two regional training days provided by Chroma), with positive feedback. Several associate therapists from Chroma have also used the questionnaire, and the S-CAF has been moulded with the need of the users in mind with the aim of gathering useful information on the family.

The S-CAF questionnaire is an evaluation tool with an emotive underpinning. It asks the family to reflect on their current experiences and identify what is difficult and what is working well. For some families, this level of self-reflection can be hard as they may feel trapped in managing challenging behaviours or in denial about anything but the positive aspects of their relationships. As Lambert (1992) and Thomas (2006) found, the 'extra factors' or the client characteristics play a large part in the outcome of the therapeutic experience. When working with children, those extra factors are not only in the child client, they are heavily influenced by the family making the referral, as the child is still dependent upon them. The S-CAF questionnaire hopes to encourage a sense of responsibility in the family through their reflection on and understanding of the relationships with the child. Furthermore, the professionals working with the family are able to see the holes in the safety net around the child and help to fill them by providing resources individually tailored to the family needs, so that the child and the family have the best possible chance of experiencing positive change. The resources needed may not require additional funding; it could be an extra phone call or meeting each week to help the family feel heard.

Ideas for further research using the S-CAF questionnaire are still in early development. The questionnaire will be used both pre- and post-therapy with families, and a full data set collected. It is hoped that supporting the wider family will have the predicted positive impact, and that the S-CAF questionnaire will be a useful addition to the evaluation tools used by music therapists. The S-CAF may also be appropriate to use with other therapeutic mediums, such as art or drama therapy, or even outside the creative arts field in social work and NHS settings.

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Ελληνική περίληψη | Greek abstract

Ποιοι είναι οι παράγοντες της αποτελεσματικής θεραπείας; Ενθαρρύνοντας μια θετική εμπειρία για τις οικογένειες στη μουσικοθεραπεία

Rachel Swanick

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο εξετάζει την επίδραση του τραύματος στη γνωστική ανάπτυξη, συνδέοντας τις πληροφορίες με μια ανασκόπηση ενός μέρους της διαθέσιμης βιβλιογραφίας η οποία αναφέρεται στους παράγοντες που

ενισχύουν τη θεραπευτική εμπειρία. Παρ' όλο που οι πληροφορίες που επανεξετάζονται εδώ αφορούν τη γενική ψυχοθεραπεία, προβάλλεται μια γενικότερη συζήτηση σε σχέση με τον αντίκτυπο που έχουν τα ευρήματα αυτά στη μουσικοθεραπεία. Ως απάντηση στα ευρήματα και στη συνεχή κλινική μουσικοθεραπευτική εργασία μου στον τομέα των επιπτώσεων του τραύματος, προτείνεται ένα πιλοτικό πρόγραμμα που χρησιμοποιεί το ερωτηματολόγιο Swanick-Chroma Assessment of Supporting Factors (S-CAF) το οποίο βασίζεται στους τέσσερις βασικούς παράγοντες αποτελεσματικής θεραπείας του Lambert: τη σχέση/συμμαχία, τα χαρακτηριστικά του πελάτη, το μοντέλο θεραπείας και την προσδοκία. Το ερωτηματολόγιο S-CAF μπορεί να προσφέρει ευκαιρίες στους επαγγελματίες και στην οικογένεια που παραπέμπεται για θεραπεία να αναστοχαστούν πάνω στα επίπεδα συναισθηματικής και πρακτικής στήριξης που διατίθενται πριν και μετά τη θεραπευτική διαδικασία. Προτείνεται ότι όσο περισσότερο η οικογένεια αισθάνεται ότι υποστηρίζεται συναισθηματικά, τόσο μεγαλύτερη είναι η πιθανότητα επιτυχίας τόσο κατά τη διάρκεια όσο και μετά τη θεραπεία. Προτείνεται λοιπόν ένα πιλοτικό ερευνητικό πρόγραμμα για τον έλεγχο της εγκυρότητας που έχει το S-CAF, με τους δημιουργικούς θεραπευτές μέσω τεχνών που σχετίζονται με την Chroma –έναν οργανισμό για τις δημιουργικές θεραπείες μέσω τεχνών στο Ηνωμένο Βασίλειο– να εντάξουν το ερωτηματολόγιο ως μέρος της θεραπευτικής τους διαδικασίας (κατά την αποτίμηση και την αξιολόγηση). Τα αποτελέσματα από το ερωτηματολόγιο θα χρησιμοποιηθούν για την ενημέρωση των στόχων της θεραπείας παρέχοντας στήριξη στην οικογένεια, όπου απαιτείται.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

τραύμα, θεραπευτική συμμαχία [therapeutic alliance], αξιολόγηση