SPECIAL ISSUE
Music, drama, dance movement and art therapy: Interdisciplinary dialogues

Article

Examining arts psychotherapies practice elements: Early findings from the Horizons Project

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ABSTRACT

Background: Arts Psychotherapies (art, music, drama and dance/movement) have been integral to mental health care services for several decades, however consensus and transparency about the clinical process is still being established. This study investigates practice with a team of six arts psychotherapists working with severe mental illnesses in London, inpatient and community services. The study examines what in-session practice elements are used, whether there is consensus about what the practice elements are and why the arts therapists use them.

Method: The methods employed in the first phase of the project are interview-based with thematic analysis; repertory grid technique and nominal group techniques are used to analyse the data with the aim of triangulating results to establish greater validity.

Results: The results showed that there is scope for developing a shared language about in-session practice elements within a mental health context. However the research examining the timing and reasons for employing those practice elements is still being undertaken. In this study the first results from an extract of the interviews illustrates a complex relationship between theory and practice.

Conclusion: From the findings so far it would appear that within this specific context it is possible to see that there are ways of categorising the therapist's actions that become comparable across the arts psychotherapies. From the therapist's personal descriptions of his or her own practice, there also appears to be a close correlation between arts psychotherapies in a mental health community and inpatient context. Additionally, evidence-based practice models such as mentalisation-based therapies appear to have a close correlation.

KEYWORDS

arts therapies, mental health, repertory grid, nominal group technique, consensus, evidence, mentalising

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BACKGROUND

This paper describes the early findings of the Horizons Project (HP), a small research team set up within the NHS to support inquiry into arts psychotherapies practice in mental health services in community and inpatient services. The Horizons Project was established in 2013 by arts psychotherapists and honorary researchers in collaboration with the Art Therapy Department at the University of Hertfordshire to further our understanding of arts psychotherapies and their relation to verbal models of evidence-based practice. In 2013 the process began with the team examining a range of structured psychodynamic interventions. When the HP team set out to study the practice elements of arts psychotherapists, the team was aware that arts therapists were informed by a wide range of theoretical models about how and why arts therapies help the patient (see Karkou & Sanderson 2006). Patterson et al. (2011: 72) believed that for art therapists, theory was not integrated into practice and went as far to suggest, "…with theory developing alongside practice there is no consensus about the process of therapy and mechanisms of action or for whom it is most effective". Therefore there was not an expectation that there would be consensus about *why* arts psychotherapies are effective, which is why the HP team started out with *what* arts therapists do. Clinicians involved in the study received extra clinical trainings in the five chosen evidence-based verbal models to broaden their understanding of the clinical process. We set out to compare arts psychotherapies practice with existing evidence-based practice that was being recommended by NICE guidelines or the department of health. We explored five evidence-based verbal models: Mentalisation Based Therapy (MBT), Mentalisation Based Therapy for Families (MBT-F), Interpersonal Psychotherapy (IPT), Dynamic Interpersonal Therapy (DIT) and Psychodynamic Interpersonal Therapy (PIT). This involved team discussions examining theoretical and practice similarities of the EBP models with arts psychotherapies. Through exploration within a group context the clinicians found that there were two types of intervention that appeared to have a close fit with arts psychotherapists practice within a London locality. The models chosen focused on enabling mentalising as a core feature of the interventions. Those models were MBT and DIT. A team of six arts psychotherapists were selected according to the criteria that their work was related to helping the patient to focus on affect and differentiating self and other perceptions, these being fundamental to a mentalising process. These were the only criteria for inclusion and the selection included two art psychotherapists, two music therapists, one dramatherapist and one dance movement psychotherapist. The first two studies were designed to investigate:

1. What in the therapist's words is the therapist doing in terms of their therapeutic observable action during the session? The researchers called these actions 'practice elements'.
2. What are the key factors that the therapist considers implicitly or explicitly when doing something intended to be therapeutic?
3. Are there commonalities between the practice elements described by the therapists?
4. Are there commonalities between the reasons why they used specific practice elements?

When the researchers finished the first phase of defining themes for the interventions, the findings were taken back to the group of therapists that had been interviewed to further examine them to ensure that the results were accurate. The process took several months and the results went back and forth

between the researcher group and the arts psychotherapists before producing a categorical list of practice elements.

The focus of the interviewing process was about *examining the role of the therapist* rather than change for the patient, the patient's perceptions or the aesthetics and content of the art form itself. In this study it was also notable that the action of the therapist was sometimes using a musical instrument or making an image and this was examined in detail by the honorary researcher during the interview process. The therapist was asked to describe their own actions in terms of their therapeutic value rather than the aesthetic qualities of the arts making. What became apparent was that often the arts were used in a similar way to how talking can be used and therefore many of the final clinical practice elements could be conducted through the arts or through verbal means. For example, one of the practice elements, '*mirror affect'* was considered to happen both verbally and through the arts.

THE SEARCH FOR COMMON FACTORS: MENTALISATION

This study set out to examine the hypothesis that there are likely to be common practice elements between arts psychotherapies and that those practice elements are also evident in some evidence-based treatments. Before the study began the arts psychotherapies team had engaged in looking at common factors of practice of arts psychotherapies and forms of verbal evidence-based practice (EBP). In his search for the common factors of psychotherapy Jerome Frank (1993a) referred to the capacity of arts therapists to arouse the emotions of the patient within the interpersonal creative encounter. Whilst each form of psychotherapy might facilitate the use of emotional expression and reflection on emotional states in a range of different ways as one of many contextual factors that seems central to efficacy, arousing and regulating emotions has been identified as a core feature of psychotherapy more generally (Allen, Fonagy & Bateman 2008; Fonagy, Gergely, Jurist & Target 2005; Fonagy & Target 2005; Frank 1993b; Frank 2012). Along with the affect focus an interpersonal, interactional therapeutic approach is central to arts psychotherapies as much as other mentalisation-based models. Implicitly, or explicitly the arts offer a method of exploring and reflecting on the experience of self and other within an interpersonal context and therefore developing a vehicle for emotional non-verbal communication to another. For example, Havsteen-Franklin and Altamirano (2015: 6) state,

> "The embodied image is often felt to be closer to the emotional world of the patient, the primary affects and therefore assumptions about the intentions of the other.
>
> However, when the image is brought into the dialogue, the interpersonal context and the scope for establishing mentalising processes can be made more explicit and therefore the potential for examining assumptions about the other increases."

Mentalising is about exploring what underpins a person's behaviour, for example, feelings, desires and beliefs. This is essential to the art psychotherapy process on many levels; from mirroring the affective state of the patient to the exploration of the image. This is a powerful process, where the non-verbal and verbal domains of experience are brought together.

It is possible to see the affect-focused mindful interventions as arts-based dialogue, where the patient develops a way of responding to the therapist that relates to how they conceive plausible communication to another where they have previously struggled. Nowell Hall (1987: 171) states,

> "[…] making an image can create a bridge and a way of 'speaking' out of states that might be described as the depth of despair".

Communicating to another requires a change in the anticipation of the other being neglectful or abusive. When the patient begins to conceive of the opacity of mental states of the other, there is scope for imagining something different from what is expected. It is commonly the case that the work becomes more affect-focused and that the patient engages with the other through the artistic medium of music, art, drama or dance.

DO ARTS PSYCHOTHERAPISTS HELP PATIENTS TO MENTALISE?

Mentalising is another way of describing the process of interpersonal relatedness and can be measured and observed. Whilst the concept of mentalising was first described within psychodynamic practice during the 1950s (Bennitt 1954) contemporary mentalisation-based therapeutic models have emerged working across many clinical areas, including couples therapy (Velotti & Zavattini 2008) and working with psychosis (Brent 2009). One of the central pioneers

in this area of inquiry is Professor Peter Fonagy who developed the conceptual basis of mentalising (Choi-Kain & Gunderson 2008). In all of the applications of mentalisation there appears to be a common focus; put simply, mentalising is being able to have a realistic notion that mental states exist that motivate behaviours and that these states of mind are implicitly inferred but require further exploration to understand inevitable mis-inferences. The concept of mentalising includes a number of psychological mechanisms, including mindfulness, psychological mindedness, empathy and affect consciousness (Choi-Kain & Gunderson 2008). The relationship between these domains of relating is embedded in the history of how arts psychotherapists practice. There is not scope to go into detail about these concepts here but there are a number of authors who have focused specifically on these concepts in clinical practice; *empathy* (Bohart, Elliott, Greenberg & Watson 2002; Bohart & Greenberg 1997; Schaverien 1999), *psychological mindedness,* (Ferrara 1999; Gordon 2010), *mindfulness* (Franklin 2010) and *affect consciousness* (Nowell Hall 1987; Schaverien 1999).

During the interviews, conducted by the Horizons Project team, arts therapists described a therapeutic stance that appeared to parallel the mother being contingently attuned, mirroring the affective state, validating the patient's experience but also tentatively exploring what is being experienced behind the expression; modelling being curious about themselves and the world. Essentially, helping the patient to build a trusting bond that facilitates the capacity to be curious and engage with others in a meaningful way. Given that the caregiver's behaviour can cause long-term damage to the infant's capacity to relate to another, this is also a parallel that rings true for therapists. Inadequate mentalising, for example the therapist being rigid, unattuned, non-validating and even building a close attachment can lead to iatrogenic results. Therefore, by beginning to describe therapist in-session actions, the aim is to begin to understand when in-session interventions are being applied, in what context and ultimately to have a better understanding of good practice.

There are philosophical and theoretical overlaps between mentalisation-based treatment and arts therapies orientations. For example, there is a general emphasis on the phenomenology of exploration through the arts. For psychodynamic practitioners, the focus on interpersonal communication, attachment patterns and more generally a psychological formulation of clinical presentation is familiar (Austin 1999; Case & Dalley 2013; Cattanach 1994; Krantz 1999; Pallaro 1996; Rubin 2001; Sobey & Woodcock 1999). Other schools of arts therapists, for example Nordoff-Robbins music therapists, also find a lot of common sentiment here; not only the emphasis on the phenomenology of engagement, but also an active and interventionist therapist who is collaborative, inquisitive and challenging of the patient (Aigen 1998; Simpson 2007).

In psychiatry many arts therapists adapt their qualifying training to be more informed by an interactional model based on a number of factors, including the explicit aims of the organisation, supervisory contact, evidence-based practice and the culture within which they work (Odell-Miller 2013; Payne 1993; Waller 1993). This process of developing practice within psychiatry has led some arts therapists to consider the premise of mentalising as a first stage intervention (Allen & Fonagy 2006; Odell-Miller 2013; Or 2010; Springham, Findlay, Woods & Harris 2012; Taylor Buck & Havsteen-Franklin 2013). The pragmatic, supportive and collaborative forms of treatment that mentalisation-based approaches often demonstrate were also identified as being common to arts therapists in the interviews conducted by the HP team.

Our initial explorations were focusing on how arts psychotherapies fit within existing evidence-based models of practice. However, it is also likely that arts psychotherapists have a significant contribution to offer to the range of evidence-based mentalisation-focused therapies; arts therapists work with patients who would not normally engage well with a purely verbal approach. Arts therapists are experts in helping a highly aroused patient regulate their affect through co-improvised activity, which can then make a verbal exchange possible (Bragge & Fenner 2009; Bruscia 1987; Forrester 2000; Panhofer & Payne 2011).

EXAMINING GOOD PRACTICE: THE REPERTORY GRID TECHNIQUE

The investigations conducted by the honorary researchers associated with the Horizons Project began by examining current practice with six arts psychotherapists (art, music, drama and dance-movement) practising in community and inpatient settings, working within a similar locality in London. The results of the first study suggested that the interview material showed significant overlap in terms of practice elements across the arts

therapies. Many of the practice elements compared to a mentalisation-based process in a similar way to recent mentalising models such as MBT or DIT. The findings suggest that the arts modality within the arts therapies enables practitioners to engage patients on an affective implicit level. As with other mentalisation-based therapies the model is accessible, however there is increased scope for communication and greater possibility for titration of interpersonal contact when required. In other words, by using a non-verbal medium, the first step of the mentalising process is more easily accessed, building a sense of trust in the therapeutic encounter.

The next step in our investigation was to examine what good mentalising practice looked like in the arts therapies. The researchers considered the methods by which practice elements had been delineated within evidence-based models for the purposes of training and research. The first stage of the investigation employed a repertory grid method (Winter 2003). This entailed interviewing the therapist about what they would do in contrasting clinical situations, for example *"When one of your patients was in a clinically high affect state what did you do that was similar or different to another patient that you treated that was in a psychotic state of mind?"* This process was employed to elicit conscious and preconscious material from the therapist about their clinical repertoire based on their memories of recent clinical interactions with patients diagnosed with severe mental illnesses. When they had talked about what they did and what practice elements they used, the therapist was also asked what the therapeutic opposites of their practice elements were. In other words, how would they describe another therapeutic intervention that they might use, but is the opposite of the intervention that they have described? Each interview lasted approximately two hours. The aim was to make the arts therapies clinical process more transparent, so that what was often thought of as being intuitive responses that made up a fluid continuum in the arts therapies context could be examined more closely for the discrete elements that made up a range of interactions.

Following a standard repertory grid method as outlined by Fransella Bell and Bannister (2004), the researchers met as a group and looked for overarching themes for 302 statements taken from the interviews. The opposite themes were also included in the pool of statements. Three honorary researchers, one repertory grid expert researcher, one senior lecturer and the consultant in arts psychotherapies used a theme-based model of categorisation (Figure 1). The researchers familiarised themselves with the interview material, considered the intended meaning of specific phrases in context and discussed types of material that they might find. Transcript statements were grouped and then given a code, e.g. 'mirroring'. On closer examination of the particular code a theme was developed that summarised the material, e.g. mirroring, became 'mirror affect'. All themes were reviewed with the clinicians and two special meetings were held with clinicians to explore further the themes 'Communicate the embodied emotional situation' and 'Empathically attuned'.

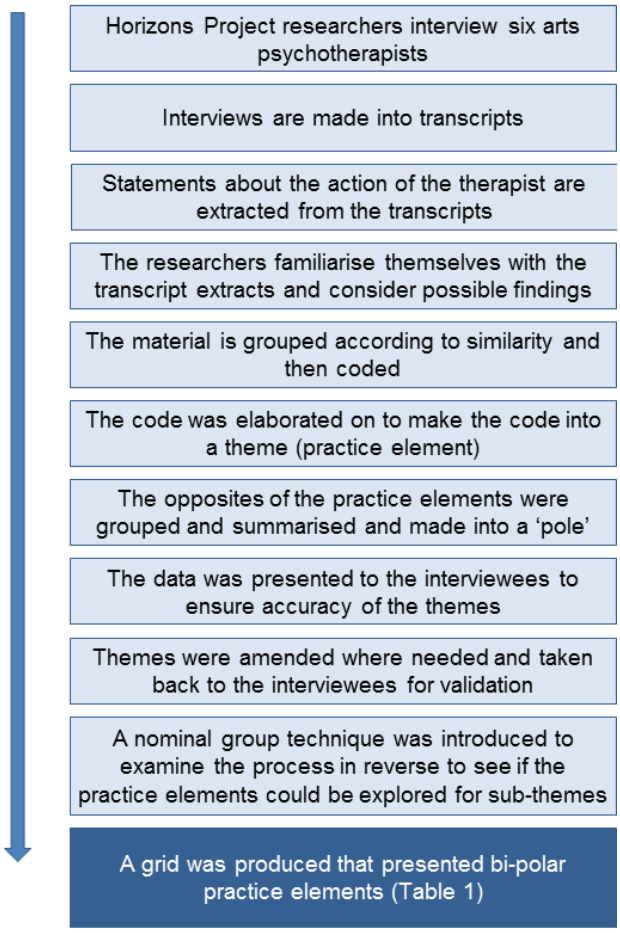

Figure 1: 'Examining practice elements' research design

RESULTS OF THE REPERTORY GRID PROCESS

Once the practice elements had been amended the themes were then taken back to the clinicians for review. In response to the clinicians' suggestions the themes were slightly altered to allow for clearer themes that represented the therapist's practice elements before the themes were taken back to the clinicians for final validation. The final tabulation was as follows:

Practice elements (themes)	
Pole 1	*Pole 2*
Empathically attune	Explore perspectives
Adapt personal boundaries	Establish / maintain personal boundaries
Adapt time/ space boundaries	Establish/ maintain time / space boundaries
Regulate affect	Take a neutral position / non-action / witness / observe
Be challenging	Mirror affect
Be non-directive / collaborative	Be directive
Ask direct questions	Be openly curious / explorative
Focus on working within the therapeutic / group relationship	Focus on working with external relationships
Use arts media to make contact	Use verbalisation to make contact
Work in the here and now	Explore relational patterns
Use a structured exercise / game	Use arts-based improvisation
Not exploring self-other states of mind	Explore self-other states of mind
Work with meaning in the implicit	Make implicit meaning explicit
Communicate the embodied emotional situation	Reconstruct narrative / story

Table 1: Results of the thematic analysis

VALIDATING THE REPERTORY GRID FINDINGS: EXAMINING SUB-THEMES

Our initial interest was focused on what the observable practice elements of the therapist were and whether these essentially represented a shared language that could span the arts therapies in an NHS mental health context amongst colleagues. From the findings there appeared to be 14 bi-polar practice elements that demonstrated an overlap in actions between the arts therapies (Table 1). One of the review sessions employed a nominal group technique (NGT) that focused on 'empathically attune'. The method uses an individualised response to a question and in this instance video extracts of role-play and then used group discussion to narrow down the themes and finally the themes are ranked. (See Havsteen-Franklin 2014 for how the NGT can applied in this context). The application of this method helped to build consensus about the defining features of the practice element 'empathically attune'. The aim was to revisit how differentiated the themes were and to see if there were any underlying constructs that were closely associated with each of the practice elements. A group of six clinicians (art therapy, music therapy and dramatherapy) observed a piece of art therapy role-play and music therapy role-play and took notes about how they describe the moments of affect attunement in the clinical scenarios. It was evident that there were some more closely associated codes that had not been included before, however, it was suggested that through further investigation there could be a range of 'sub-codes' that could be themed. The codes were then ranked according to their importance, validity and relevance in relation to defining affect attunement. The final result of the ranking process suggested that shared attention, *the use of open body language*, *enabling expression* and *encouraging shared attention* were perceived by the group as underpinning empathic attunement. This was helpful in considering a range of practice elements that were implicit to the broad themes already established. Further work could be conducted to examine where the overlaps are between sub-themes in order to consider a more complex modelling of the practice elements.

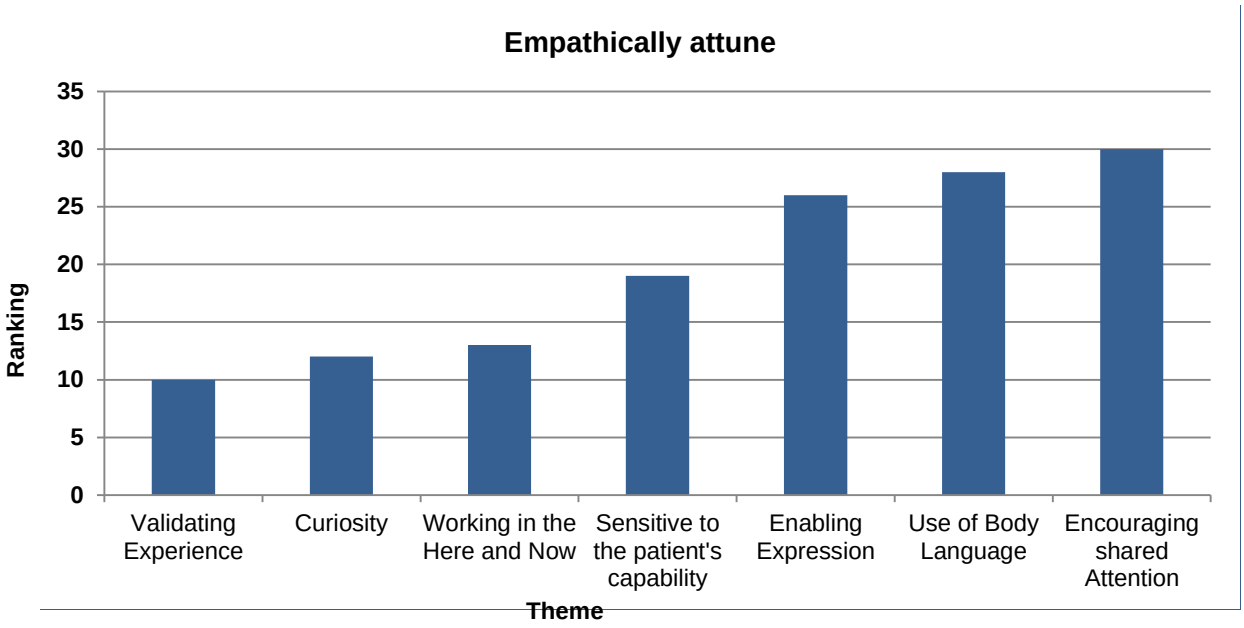

Figure 2: Nominal group technique results for ranking sub constructs relating to 'empathically attune'

RESULTS OF THE NOMINAL GROUP

What was of interest is that only one of the major practice elements (curiosity) was identified as being an important part of affect attunement, however this theme was not considered by the nominal group (NG) as very important to defining affect attunement. By reversing the process of thematic analysis, the NG found that there were similar results to the original data grouped in the repertory grid thematic analysis. The practice elements relating to affect can be mapped according to the perceived conceptual distance of the related practice elements (Figure 3). In this example the NG felt that the therapist could be observed to be empathically attuned. This was based on observations of '*validating experience'*, followed by the '*curiosity'* and the '*working in the here and now'*. These findings were based on the NG observing the verbal content and the musical/art content in extracts taken from filmed arts therapies role-play sessions.

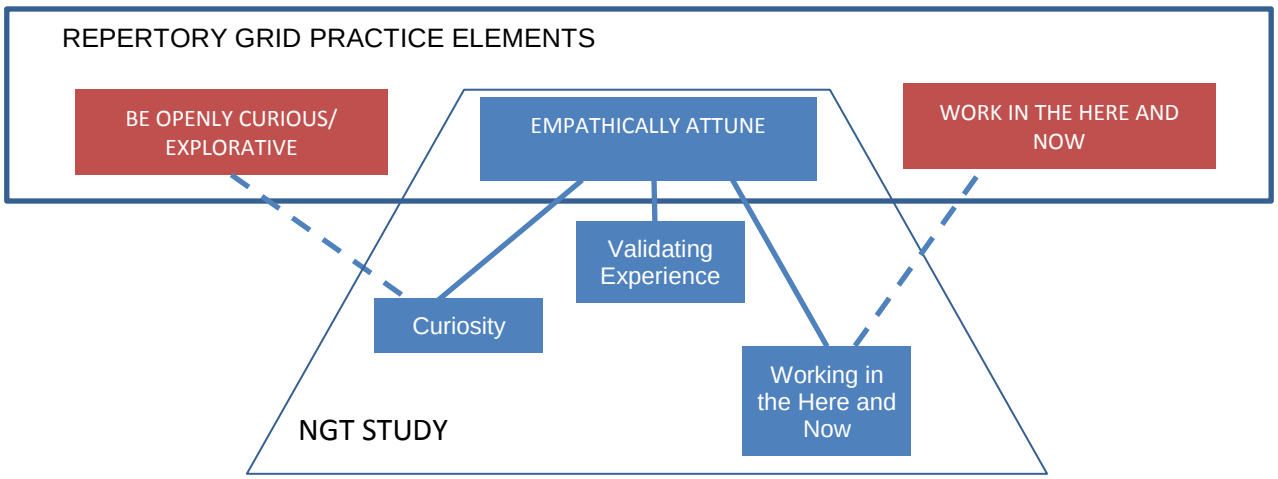

Figure 3: NGT conceptual mapping of 'empathically attune'

VALIDATING THE REPERTORY GRID FINDINGS: WHY DO ARTS THERAPISTS USE THESE PRACTICE ELEMENTS?

Defining themes for the therapist's practice elements only describes what the therapist does, rather than whether it is applied at a time that is helpful or not. The question of why the practice elements are considered by the therapist to be helpful or not required a further study examining firstly why the therapist chooses to respond in a particular way. A semi-structured interview model (Gugiu & Rodriguez-Campos 2007; Louise Barriball & While 1994) was designed that would draw out decision-making processes.

The researchers examined recent literature regarding decision-making processes in clinical healthcare and in particular nursing. The literature resulted in two models of decision-making that are relevant to arts therapies, firstly the 'intuitive-humanist' model (Denkena, Charlin, Gillen & Bode no date; Pelaccia et al. 2014; Pelaccia, Tardif, Triby & Charlin 2011) which assumes that decision-making comes from first-hand experience (Buckingham & Adams 2000) and is based on creative pattern recognition (Cioffi & Markham 1997). In the most part, decision-making using an 'intuitive-humanist' method is not taught, but is understood to be related to emotional awareness and physical experiences such as gut feeling (Smith, Thurkettle & De la Cruz 2004). This has received criticisms on the basis that people are acting on a 'hunch' rather than making decisions that are grounded in a more systematic approach of assessing the problem and thereby producing a response that will be part of the solution (McCain 1965; Smoyak 1982). The second approach to making decisions is more linear and called the 'hypothetico-deductive model', (Lubarsky, Dory, Duggan, Gagnon & Charlin 2013; Pelaccia et al. 2014, 2011; Thompson, Prowse Turner & Pennycook 2011) referring to building a hypothesis about why the patient is presenting in a particular way and acting upon the hypothesis to produce a desired outcome (Elstein & Schwarz 2002). The problem of this more cognitive approach is that the hypothesis needs to allow considerable uncertainty, particularly in mental health where there is still not consensus on how much of the causation of severe mental illness is to do with the early environment and how much is socio-biological (Bradley, Jenei & Westen 2005; Cohen 1984; Tandon, Keshavan & Nasrallah 2008; Willick 1990). From examining these two methods of decision-making, the research team anticipated a higher degree of intuitive responses. However, it seemed pertinent that the more cognitive explorations were not seen as an alternative to intuitive responses but instead as a method of mapping practice. As Junge and Linesch (Junge & Linesch 1993: 66) put it,

> "[The art therapist's] natural tendencies as clinicians to work intuitively and metaphorically do not have to be sacrificed in the interests of rigor."

To examine the in-session decision-making process more closely, we took a case scenario, explaining behaviours of a patient entering an arts therapy session looking preoccupied and disengaged and explored with the therapist how they would respond to the patient and why they would respond in that way. We then took the material about why the arts therapist responded in a particular way and analysed it in terms of how they formulated a hypothesis about what is happening for the patient and the type of response that the therapist felt was required and had used to produce a specific result. During the interview the therapist referred back to patients that they had worked with.

SEMI-STRUCTURED THERAPIST INTERVIEW STEPS

The following diagram (Figure 3) shows the focus areas for the researcher during semi-structured interviews. Each clinician was asked the same questions, which aimed to link an assessment of the situation with the arts therapies response, based on the therapist's desired effect of the response.

The interview focus and categorisation was based on various components of the decision-making process behind the therapeutic interaction (Figure 3). The question that resulted needed to include the perceived effect of the intervention. Whilst this project has only recently begun, the first findings are of interest. In Figure 3 each part of the decision-making process is delineated according to a sequence of events assuming that the patient is presenting a difficulty with mentalising. The sections (Figure 4) A (Therapist Subjectivity), C (Description of Action) and E (Outcomes) of the decision-making process were based on the thematic analysis of elements as described in Table 1. The other two areas of exploration during the interview were based on the perceived impact of the treatment, which formed the patient presentation (B) and the believed impact of the intervention (E).

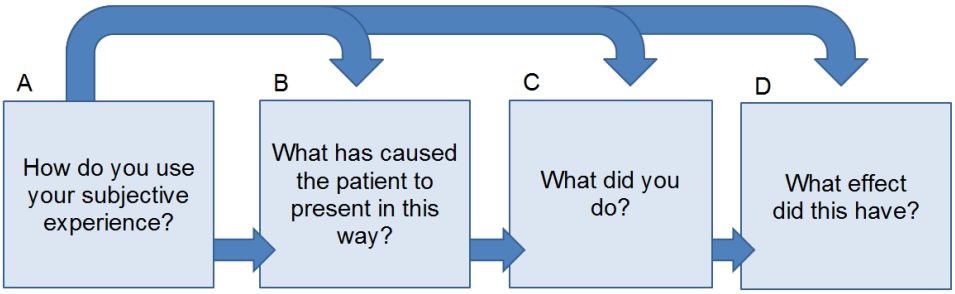

Figure 4: Framework for decision making

Extract from interview between the researcher and a music therapist

The following transcript was taken from video footage of an experienced music therapist (Mario Eugster) being interviewed about his clinical work. The interviewer (Emma Kinani) elicits and explores the decision-making process which is then mapped out according to the main questions in Figure 4.

Scenario

The interview focuses questions on the following scenario:

> The therapist is in the early phase of working with a male patient that appears to avoid contact with the therapist and the arts medium. The patient appears distracted and sometimes appears to speak to themselves in a way that appears persecuted. The patient moves to the other side of the room, with no eye contact.

Transcript of video material

Researcher: Ok and as a music therapist at this stage, can you describe what you would be doing? Because you've talked about trying to build a relationship with baby steps doing minimal interventions at this stage but what would it look like? Can you describe what you would be doing?

Music Therapist: So what I'd be doing, the first thing that I would, what is very common with this client group is when they go into music they tend to go very quickly into music, there's not a lot of encouragement there as soon as you have instruments people are quite naturally drawn to play. So there would be, when we go into musical expression you find the musical parameters have certain characteristics seem to be very typical of people with psychotic states. The rhythmic structure tends to be very repetitive, has a lack of form, and tends to be often minimal or no contact in the music. So whereas the patient can establish some kind of relationship with the music and are beginning to be engaged in the musical process, the music has a certain degree of rigidity and inflexibility and also in terms of the timing and the time parameters a lack of a sense of beginning and end and usually a lack of form in terms if melodic. So my response would be to attune to the music parameters so rhythmically attune, in terms of intensity, in terms or timbre attunement. Building a musical structure around, that has quite clear direction so I wouldn't leave it too open-ended, for example I wouldn't leave it atonal because patients at this stage tend to be disoriented to time and place.

Researcher: Ok.

Music Therapist: So within the improvisation I would use quite clear directions and then the music that I would provide would have quite a lot of structure to give the patient a sense of orientation in time in the music.

Researcher: So what would be 'not working in a more structured way musically', given the parameters you know, you've talked about the different paces of music, its rigidity and how people may or may not get into it and the pace, you know, they build up to that stage but how would working differently affect the patient's can I say mood, given that you know the scenario that we have created?

Music Therapist: Yeah I mean, it's quite clear I mean. What we find is that if people are psychotic disoriented, as a therapist, you offer a response which has a lack of structure, a lack of direction, um that the patient tends to become more disoriented. They also tend to, they're probably more likely to stop or to withdraw or anxiety levels might go up and the kind of disengagement. You would probably move towards a kind of musical disengagement, at that stage.

Researcher: And what would, what effect would, um what would inform how you're working, can I say to alter their, the opposite of, can I say being more engaged? Because if they're disengaged, if you work in a less structured way, what would the reverse of that be? For example, you're working in a more structured way, how would it affect them?

Music Therapist: I see that sometimes it. This is not the very acute end because it's in the community but sometimes if you're very acutely psychotic and have high arousal as well it will channel arousal. When they have an experience of being in a structure, that tends to bring

down the arousal and tends to help patients to stay, even if there is not a lot of actual immediate contact, they, there's a tendency, I see the patients can actually maintain, for example, a presence in or engagement in a group for longer and in other contexts sometimes. I see that, you know the patients, you know they can't, for example, hold a conversation for too long or they can't tolerate any interaction for very long. For just a few seconds or a few minutes on the ward. But what we sometimes see, certainly in a context where there is this structure, is there's a musical architecture to orient themselves whilst not be asked to directly to interact that they can engage and stay much longer

This section of the interview focused on areas B, C and D (see Figure 5) rather than the subjective experience of the therapist. This small section of the overall data reveals that the therapist's understanding of the patient's presentation is based on a general notion of the presenting features of schizophrenia particularly in relation to the immediacy of the patient's engagement with the instruments and a range of boundary distortions to do with musical sequences and time and space. The resulting action of the therapist in this instance means that they are more likely to structure the work through being directive and providing boundaries, which the therapist felt produced an improvement to the patient's relationship to music, reduced affect arousal, increased attention span and engagement with others.

This first part of the sequential analysis described will be compared with transcript data from other arts therapists that have also been interviewed looking at the same clinical scenario to examine whether there are similar reasons for introducing a particular practice element or whether there are significant differences between the therapist's decision-making process.

RESULTS: ANALYSIS OF INTERVIEW DATA

The following diagram illustrates this process for the categorisation of a five-minute section of a one-hour interview which focused on defining the practice elements and the impact of those practice elements (Figure 2) (Charlin et al. 2010; Dexter, Lee, Dow & Lubarsky 2007; Lubarsky et al. 2013).

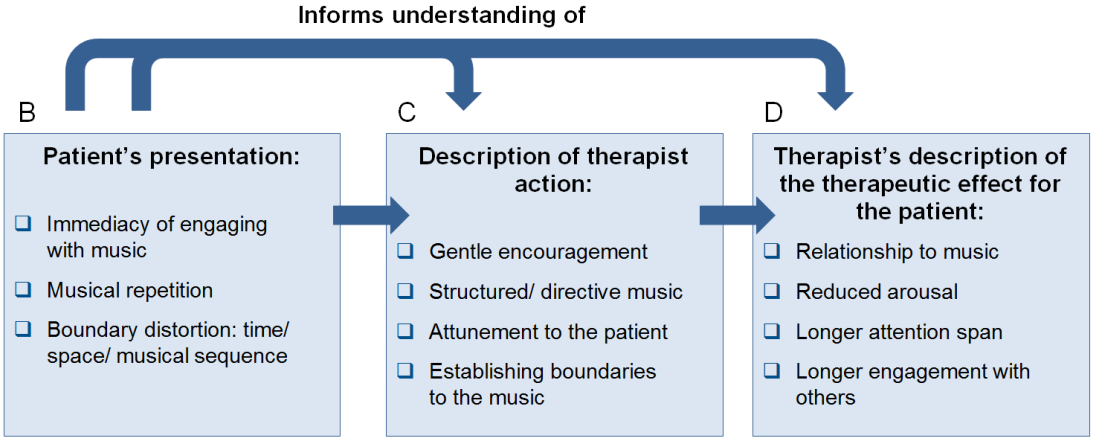

Figure 5: Thematic analysis of interview extract with a music therapist

CONCLUSION

The researchers believe that understanding the clinical process is not an exact science nor is it necessarily generalisable outside of the service setting. The limitations of these investigations are specifically in relation to six arts therapists that have worked in psychiatry for between one and ten years. The focus of their work was with patients diagnosed with severe mental illnesses in London mental health services. Whilst we realise that there is a strong influence on the clinicians chosen from recent developments in verbal evidence-based practice such as MBT, the researchers wanted to know about the personal beliefs of the clinicians and how they construct their model of practice. The findings suggested that there are significant overlaps in the ways that therapists described their practice according to a range of practice elements. In our current study exploring why arts therapists do what they do, this will help to elucidate similarities and differences in how and when in-session practice elements are implemented.

Whilst the investigation may frame the process in terms of a rational and cognitive framework, the authors acknowledge the importance of intuitive, creative responses in the therapeutic process.

There are numerous models of practice, and this research has begun to systematically investigate whether there are core methods of treatment in terms of in-session practice elements. Perhaps unsurprisingly, many of the practice elements also fit evidence-based verbal models of intervention, strengthening the proposition that it is not what is different about psychotherapies that make them work, but what is common to them. In this study, we focused on personal accounts of what therapists do rather than the theory or schools of thought that might support the therapist's actions. The themes are broad and further studies could help us to build a more complex and nuanced model of in-session practice elements.

The authors hope that the work of the Horizons Project of reflecting on how we collectively understand the clinical process will continue to gather support over the coming years. Additionally, we hope that service evaluation and research projects will find fruition through increasingly effective and responsive practice where arts therapies find a stronger place within the psychological therapies being provided in mental health services. The more that the researchers examined the practice elements; the more was revealed about the process; that in most areas of arts therapies practice there is an interpersonal and affective focus that is supported by creative and intuitive responses.

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