Ειδικό τεύχος

Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία:
Διεπιστημονικοί διάλογοι | **Προσκεκλημένη συντάκτρια:** Βίκυ Κάρκου

Special issue

Music, drama, dance movement and art therapy:
Interdisciplinary dialogues | **Guest editor:** Vicky Karkou

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ΕΙΔΙΚΟ ΤΕΥΧΟΣ
Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία: Διεπιστημονικοί διάλογοι

Σημείωμα σύνταξης

Διεπιστημονικοί διάλογοι

Βίκυ Κάρκου

Edge Hill University, Ηνωμένο Βασίλειο

Είχα την τύχη να προσκληθώ ως συντάκτρια αυτού του ειδικού τεύχους που σχετίζεται με ένα θέμα που έχει τόσο προσωπικό όσο και επαγγελματικό νοήμα για μένα. Σε προσωπικό επίπεδο, η συνεργατική δουλειά, όσες προκλήσεις κι αν παρουσιάζει ορισμένες φορές, είναι ο τρόπος που έχω επιλέξει και με τον οποίο προτιμώ να εργάζομαι. Η συνεργασία με συναδέλφους από τους διάφορους τομείς των θεραπειών μέσω τεχνών μού έχει προσφέρει ευκαιρίες να μάθω και να αναστοχαστώ σχετικά με την πρακτική μου, με έχει ενθαρρύνει να αρθρώσω με ακρίβεια αυτό που κάνω και μου έχει προσφέρει το αίσθημα του ανήκειν σε μια κοινότητα. Αν και έχω εκπαιδευτεί ως χοροκινητική ψυχοθεραπεύτρια, συχνά αντιλαμβάνομαι τον εαυτό μου να ανήκει στην ευρύτερη κοινότητα των ψυχοθεραπευτών μέσω τεχνών, μια αίσθηση του «ανήκειν» που αντηχεί την έννοια της «κοινωνίας» όπως αυτή εισήχθη στις μεγάλες ομάδες από τον de Mare (de Mare, Piper & Thompson 1991).

Όσον αφορά την επαγγελματική μου εμπειρία, η εξέταση παρόμοιων και κοινών, καθώς και μοναδικών και διαφορετικών στοιχείων ανάμεσα στις ψυχοθεραπείες μέσω τεχνών έχει αδιαμφισβήτητα καταλάβει μεγάλο μέρος του ερευνητικού μου χρόνου, συμπεριλαμβανομένης και της δουλειάς που πραγματοποίησα κατά τη διάρκεια των διδακτορικών μου σπουδών (η οποία δημοσιεύτηκε στο πρώτο μου βιβλίο: Karkou & Sanderson 2006). Εντυπωσιάστηκα από την διαπίστωση ότι όντως υπάρχουν κοινά σημεία μεταξύ των ψυχοθεραπευτών μέσω τεχνών. Ορίζουμε τις τέχνες με τον ίδιο δημοκρατικό, συμμετοχικό και μη-ελιτίστικο τρόπο. Αναγνωρίζουμε τη δημιουργικότητα ως μια βασική έννοια που επιτρέπει τη συμμετοχή και υποστηρίζει τα θεραπευτικά αποτελέσματα. Αντιλαμβανόμαστε τη φαντασία, τον συμβολισμό και τη χρήση της μεταφοράς ως επιπρόσθετα εργαλεία τα οποία υπερβαίνουν τον συγκεκριμένο χαρακτήρα του μέσου και της καλλιτεχνικής μορφής και καθιστούν ικανή την εσωτερική, επικοινωνιακή, έμμεση και, ως εκ τούτου, ασφαλή εμπλοκή με δύσκολα θέματα. Τείνουμε να εκτιμούμε τις μη-λεκτικές πτυχές της δουλειάς μας πιστεύοντας ότι η αλλαγή συμβαίνει μέσα από τον συνδυασμό της καλλιτεχνικής εμπλοκής και της θεραπευτικής σχέσης. Συμφωνούμε όλοι πως οτιδήποτε συμβαίνει στις συνεδρίες εμπεριέχει μια σκόπιμη χρήση της τέχνης η οποία επηρεάζει τους πελάτες με διαφορετικούς τρόπους· γι' αυτόν τον λόγο είναι κοινή πρακτική να αξιολογούμε τις ανάγκες και να εκτιμούμε τη διαδικασία και τα αποτελέσματα της θεραπείας. Εν τέλει, αντί να λειτουργούμε βάσει των δικών μας αισθητικών προκαταλήψεων, στηρίζουμε τη δουλειά μας εντός ξεκάθαρα καθορισμένων θεραπευτικών πλαισίων έτσι ώστε να υπηρετούμε καλύτερα τις ανάγκες των πελατών με τους οποίους και για τους οποίους δουλεύουμε. Στην έρευνα σχετικά με τις ψυχοθεραπείες μέσω τεχνών που πραγματοποιήθηκε το 1998 (και δημοσιεύθηκε από τους Karkou και Sanderson το 2006), εντοπίστηκαν, παρουσιάστηκαν και συζητήθηκαν έξι θεραπευτικά πλαίσια: το ανθρωπιστικό/υπαρξιακό, το ψυχαναλυτικό/ψυχοδυναμικό, το αναπτυξιακό, το καλλιτεχνικό/δημιουργικό, το ενεργό/κατευθυντικό και το εκλεκτικό/ενοποιητικό. Οι ψυχοθεραπείες μέσω τεχνών στο Ηνωμένο Βασίλειο – σε διαφορετικούς βαθμούς και συνδυασμούς και με πολλαπλές παραλλαγές – φαίνεται κατά κάποιον τρόπο να χρησιμοποιούν ένα ή περισσότερα από αυτά τα θεωρητικά και βασισμένα στην πρακτική πλαίσια, τα οποία καθοδηγούν την εργασία με τους πελάτες και

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κατευθύνουν και προσφέρουν ψυχολογικό νόημα στη θεραπευτική διαδικασία. Το βιβλίο (Karkou & Sanderson 2006) παρουσιάζει επίσης διακριτές, μοναδικές πρακτικές οι οποίες εμπλουτίζοντάς το δημιουργούν μια ενδιαφέρουσα ποικιλομορφία και πολλές φορές παράγουν δημιουργικές εντάσεις. Μέσα από αυτές τις εντάσεις συχνά προκύπτει ένας διάλογος που προσφέρει τη δυνατότητα καινούριων τρόπων σκέψης και πράξης.

Αυτό το ειδικό τεύχος σχετικά με τους διεπιστημονικούς διαλόγους αποτελεί ως εκ τούτου μια ακόμη πρωτοβουλία διευκόλυνσης των επαγγελματιών του χώρου να συνομιλήσουν, να έχουν δημόσιο διάλογο, να συμφωνήσουν, να βρουν κοινά σημεία και να προχωρήσουν – συνεργατικά και ενωμένοι – μπροστά. Η ανάπτυξη μιας ξεκάθαρης επαγγελματικής ταυτότητας μπορεί να λειτουργήσει ως μια έννοια που διευκολύνει τόσο έναν εσωτερικό ορισμό, όσο και τη διεξαγωγή χρήσιμων διαλόγων.

Το πρώτο άρθρο αυτού του τεύχους επικεντρώνεται στην Ευρώπη και πιο συγκεκριμένα στη Λετονία, με το κείμενο των Akmane και Martinsone στο οποίο βλέπουμε πώς υλοποιήθηκε η επαγγελματική ανάπτυξη από τους ψυχοθεραπευτές μέσω τεχνών σε αυτήν τη χώρα. Πιο συγκεκριμένα, δίνεται έμφαση στην ανάπτυξη της επαγγελματικής ταυτότητας τόσο των επαγγελματιών όσο και των φοιτητών στις ψυχοθεραπείες μέσω τεχνών. Όντας ένα καινούριο επάγγελμα στη Λετονία (το οποίο έχει προκύψει μόλις τα τελευταία δέκα χρόνια) οι ψυχοθεραπείες μέσω τεχνών έχουν μια εντυπωσιακή ανάπτυξη με εκπαιδευτικά προγράμματα σε ιδρύματα ανώτατης εκπαίδευσης, νομική αναγνώριση του επαγγέλματος και θεσμοθετημένες θέσεις εργασίας στον τομέα υγείας. Το άρθρο ερευνά τον ορισμό και τα στάδια ανάπτυξης της επαγγελματικής ταυτότητας που προτείνει ο Berliner (1994) και τα οποία αναπτύχθηκαν στον τομέα της εκπαίδευσης. Ο ορισμός και τα στάδια αυτά υιοθετούνται ως ένα θεωρητικό πλαίσιο για την αναζήτηση της πολύπλοκης έννοιας της επαγγελματικής ταυτότητας ανάμεσα σε φοιτητές και επαγγελματίες. Τα σημεία καμπής στην επαγγελματική ταυτότητα κάποιου – όπως η αλλαγή από τον πρώτο στον δεύτερο χρόνο σπουδών – συζητιούνται σε συνάρτηση με τους παράγοντες που στηρίζουν (π.χ. η παρουσία συναδέλφων, το νομικό πλαίσιο του επαγγέλματος) ή εμποδίζουν (π.χ. περιορισμένοι οικονομικοί πόροι, γενικότεροι στρεσογόνοι παράγοντες και προβλήματα υγείας, η αβεβαιότητα του μέλλοντος) την ανάπτυξη μιας τέτοιας ταυτότητας. Κατά τη διαδικασία απόκτησης της επαγγελματικής ταυτότητας, εξωτερικοί παράγοντες, όπως η εποπτεία και η διά βίου εκπαίδευση, φαίνεται να παίζουν σημαντικό ρόλο στην περαιτέρω ανάπτυξή της. Ωστόσο, η ανάπτυξη μιας εσωτερικής αίσθησης αυτής της ταυτότητας, ακόμα κι αν είναι μια διαδικασία που παίρνει χρόνο, υποδεικνύει ότι έχει όντως επιτευχθεί. Αξιοσημείωτο είναι το γεγονός ότι η ταχεία ανάπτυξη όχι μόνο του επαγγέλματος αλλά και της επαγγελματικής ταυτότητας των επαγγελματιών στη Λετονία φαίνεται να οφείλεται εν μέρει στον συνεργατικό χαρακτήρα αυτής της ανάπτυξης. Σε αντίθεση με πολλές άλλες χώρες, όπου οι θεραπείες μέσω τεχνών έχουν επιχειρήσει να αναπτυχθούν ανεξάρτητα η μία από την άλλη, η συνεργατική και συντονισμένη δράση στη Λετονία επιτάχυνε την ανάπτυξη του επαγγέλματος αξιοποιώντας την κοινή υποστήριξη και τη γονιμοποίηση των διαφόρων επιστημονικών πεδίων.

Στην άλλη πλευρά της Ευρώπης, στο Ηνωμένο Βασίλειο, όπου η παράδοση των θεραπειών μέσω τεχνών είναι μακροβιότερη, μπορούμε να βρούμε παραδείγματα τέτοιων συνεργασιών τόσο εντός όσο και εκτός της εκπαίδευσης των ψυχοθεραπειών μέσω τεχνών. Στην ανώτατη εκπαίδευση – όπου η εκπαίδευση των ψυχοθεραπειών μέσω τεχνών στο Ηνωμένο Βασίλειο λαμβάνει μέρος – οι Laahs και Derrington πλαισιώνουν το άρθρο τους εντός της ευρέως συζητημένης αρχής της «διεπιστημονικής εκπαίδευσης» η οποία έχει αναπτυχθεί σημαντικά στα πλαίσια υγείας. Παρουσιάζονται και συζητιούνται διεπιστημονικές θεραπευτικές συνεδρίες που πραγματοποιήθηκαν σε ένα πλαίσιο στη Σκωτία, και στις οποίες συμμετείχαν δύο φοιτητές από τον χώρο της μουσικοθεραπείας και της χοροκινητικής ψυχοθεραπείας αντίστοιχα. Οι συγγραφείς καταλήγουν ότι η συγκεκριμένη εργασία εμπλούτισε την εμπειρία των φοιτητών όσον αφορά την αμοιβαία υποστήριξη, βοηθώντας τους να διευρύνουν την κατανόησή τους σχετικά με την πρακτική συγγενικών πεδίων και ενδυνάμωσε τις δεξιότητες των φοιτητών να επικοινωνούν σε διαφορετικούς κλάδους τις ιδέες και τις σκέψεις τους σχετικά με την κλινική τους δουλειά.

Σε αυτό το ειδικό τεύχος συμπεριλαμβάνονται δύο ακόμη παραδείγματα τέτοιων συνεργασιών από τη Μεγάλη Βρετανία οι οποίες βασίζονται στο Εθνικό Σύστημα Υγείας (NHS). Στο πρώτο άρθρο ο Hackett παρουσιάζει δουλειά που έλαβε μέρος στη βόρεια Αγγλία, ενώ στο δεύτερο οι συγγραφείς (Havsteen-Franklin, Maratos, Usiskin και Heagney) αναφέρονται σε πρακτικές από τη νότια Αγγλία. Το πρώτο άρθρο εστιάζει στη συνεργατική δουλειά ψυχοθεραπευτών μέσω τεχνών οι οποίοι εργάζονται κυρίως με άτομα με μαθησιακές

δυσκολίες και αυτισμό, ενώ το δεύτερο εστιάζει στην ψυχική υγεία προτείνοντας ξεκάθαρα ότι οι συνεργασίες δεν περιορίζονται σε συγκεκριμένες πελατειακές ομάδες, αλλά μπορούν να πραγματοποιηθούν προς όφελος ποκίλων ομάδων και αναγκών. Παρόμοια, το πρώτο άρθρο συζητά παραδείγματα συνεργασιών ανάμεσα σε ψυχοθεραπευτές μέσω τεχνών σε διάφορα επίπεδα. Δανειζόμενο ορολογία από τις οδηγίες του NICE (National Institute for Health and Care Excellence) εκλαμβάνει τις ψυχοθεραπείες μέσω τεχνών ως πολύπλοκες θεραπευτικές παρεμβάσεις οι οποίες έχουν κοινούς θεραπευτικούς σκοπούς, κλινικές παρατηρήσεις και αξιολογήσεις, τεχνικές και θεραπευτικό έργο. Το κείμενο μελετά την πρακτική μιας ομάδας η οποία αποτελείται από επαγγελματίες που προέρχονται και από τις τέσσερις ψυχοθεραπείες μέσω τεχνών. Τα μέλη της ομάδας συζητούν μελέτες περίπτωσης, μοιράζονται σκέψεις σχετικά με την πρακτική τους και συντονίζουν κοινές θεραπευτικές ομάδες, ενώ παράλληλα συμμετέχουν σε ερευνητικές πρωτοβουλίες και συνεργάζονται με πολλαπλά εργασιακά περιβάλλοντα συμπεριλαμβανομένων και των οργανισμών ανώτατης εκπαίδευσης.

Στον νότο, το δεύτερο άρθρο περιγράφει μια συνεργατική δουλειά η οποία συνδέεται με θεραπευτικές παρεμβάσεις που βασίζονται σε ερευνητικά δεδομένα όπως η θεραπεία που στηρίζεται στην εν-νόηση (mentalisation therapy) και η δυναμική διαπροσωπική θεραπεία (dynamic interpersonal therapy). Πιο συγκεκριμένα, συζητούνται πτυχές της έννοιας της εν-νόησης οι οποίες είναι παρούσες στις ψυχοθεραπείες μέσω τεχνών, καθώς και πτυχές από το έργο των ψυχοθερεπειών μέσω τεχνών οι οποίες έχουν δυνητική αξία για τις λεκτικές θεραπείες. Αυτή η συζήτηση γίνεται παράλληλα με μια εις βάθος διερεύνηση σχετικά με το πώς δρούμε ως ψυχοθερεπευτές μέσω τεχνών. Μέσα από μια αναλυτική μελέτη του έργου των θεραπειών μέσω τεχνών εντός ενός συγκεκριμένου πλαισίου, οι συγγραφείς παρουσιάζουν και συζητούν τι έχουν ανακαλύψει κατά τη διάρκεια της κοινής τους θεραπευτικής πρακτικής. Μελετούν συγκεκριμένες έννοιες σε μεγαλύτερο βάθος μέσα από τη χρήση βιντεοσκοπημένων σκηνών με παιχνίδια ρόλων. Μελετάται, για παράδειγμα, ο τρόπος που ένας μουσικοθεραπευτής χρησιμοποιεί την έννοια του συναισθηματικού συντονισμού (affect attunement) έτσι ώστε οι διάφοροι ψυχοθεραπευτές μέσω τεχνών να εξερευνήσουν πώς αυτή η έννοια μπορεί να χρησιμοποιηθεί με πελάτες με ψύχωση. Οι συγγραφείς καταλήγουν στο ότι υπάρχει αδιαμφισβήτητος λόγος για περαιτέρω εξερεύνηση σχετικά με το τι γίνεται στις συνεδρίες ψυχοθεραπείας μέσω τεχνών και επιχειρούν να εντοπίσουν μια κοινή γλώσσα, ενώ εξερευνούν περαιτέρω το *πώς* δρούμε ως επαγγελματίες και *γιατί*. Προτείνεται μια πολύπλοκη σχέση μεταξύ θεωρίας και πράξης, κάτι το οποίο συνδέεται με την ιδέα που συζητείται από τον Hackett στο προηγούμενο άρθρο αναφορικά με τις ψυχοθεραπείες μέσω τεχνών ως πολύπλοκες παρεμβάσεις. Συγκεκριμένες πτυχές μπορούν να περιγραφούν λεκτικά, μερικές δράσεις εντός των συνεδριών μπορούν να εξηγηθούν και να αιτιολογηθούν, αλλά το πεδίο αφήνει – και πολλοί θα συμφωνούσαν ότι οφείλει να αφήνει – χώρο για το απροσδόκητο, το δημιουργικό και το διαισθητικό.

Μεταφερόμενοι από τη Μεγάλη Βρετανία στη Γερμανία, η συνεργασία μεταξύ των ψυχοθεραπειών μέσω τεχνών εξερευνάται από την Αρώνη στον χώρο της ογκολογίας. Το άρθρο συζητά πώς ένα πρόγραμμα συνεχόμενης επαγγελματικής ανάπτυξης στην ογκολογία, το οποίο σχεδιάστηκε αρχικά για χοροκινητικούς θεραπευτές, προσαρμόστηκε ώστε να συμπεριλάβει όλους τους θεραπευτές μέσω τεχνών. Το άρθρο αναδεικνύει τη χρησιμότητα της συγκέντρωσης των διαφορετικών τύπων ψυχοθεραπειών μέσω τεχνών προσφέροντας έναν πλούσιο διάλογο μεταξύ αυτών των χώρων, ο οποίος έχει επιτρέψει την ανάδειξη και ενδεχομένως την ανάπτυξη νέων τύπων εκπαιδευτικής πρακτικής.

Μια λιγότερο επίσημη συνεργασία περιγράφεται στο άρθρο που διερευνά τη ζωή της ομάδας KATI (από τους Αθανασιάδου, Καγιάφα, Κάρκου, Λυκοπούλου, Μπάμπαλης, Μπιτζαράκη, Μπουζιώτη, Σαμπαθιανάκη και Τσίρης). Η ομάδα αποτελείται από περισσότερους από 15 θεραπευτές απ' όλα τα διαφορετικά πεδία των θεραπειών μέσω τεχνών, οι οποίοι ζουν κυρίως στην Ελλάδα και το Ηνωμένο Βασίλειο και ήρθαν σε επαφή για τη διεξαγωγή σεμιναρίων, εργαστηρίων και δρώμενων. Το άρθρο αναφέρεται στους αναστοχασμούς των συγγραφέων σχετικά με την εμπειρία τους ως μελών της ομάδας. Οι αναστοχασμοί αυτοί αναδύθηκαν μέσα μια διαδικασία καλλιτεχνικής αναζήτησης (artistic inquiry) (Hervey 2000) που αποτελεί μια μεθοδολογική προσέγγιση η οποία γίνεται ολοένα και πιο δημοφιλής στην εικαστική και στην χοροκινητική θεραπεία. Έξι από τα μέλη της ομάδας ενεπλάκησαν σε καλλιτεχνικές διαδικασίες ανταποκρινόμενοι δημιουργικά στην ερώτηση: *«Ποιο είναι το νόημα της ομάδας KATI για εμάς;»* Μέσα από ένα στάδιο «διαλόγου» με εικόνες, κινήσεις και μουσική που δημιουργήθηκαν κατά τη διαδικασία συλλογής δεδομένων, αναδύθηκε μια

σειρά σημαντικών θεμάτων τα οποία είχαν νόημα για τα μέλη της ομάδας. Τα θέματα ήταν τα εξής: (i) καινούριες προοπτικές, (ii) προσωπική και συλλογική εξέλιξη, (iii) εξερεύνηση ταυτότητας, (iv) δέσμευση, απαιτήσεις και δυσκολίες, (v) προσωπική εμπλοκή, (vi) θεωρητικές οπτικές, (vii) συλλογικές διαδικασίες της ομάδας, και (viii) συνεργασία. Οι συγγραφείς καταλήγουν στο ότι η ομάδα έχει λειτουργήσει ως μια πλατφόρμα για κοινές εξερευνήσεις, ένας χώρος συζήτησης όπου επαγγελματίες με κοινά ενδιαφέροντα μπορούν να ανταλλάξουν ιδέες, να συνεργαστούν και να εξελιχθούν. Τέτοιες πρωτοβουλίες μπορούν να εμπνεύσουν περαιτέρω δράση, δίνοντας έμφαση στο τι είναι κοινό και σημαντικό μεταξύ των διαφορετικών πεδίων, καθώς προσπαθούν να γεφυρώσουν θεωρητικές και μεθοδολογικές διαφορές.

Αυτό το ειδικό τεύχος συνεχίζει με ένα θέμα με ιδιαίτερη ευαισθησία: τη συμβολή της δημιουργικότητας, των τεχνών και των θεραπειών μέσω τεχνών στη φροντίδα στο τέλος της ζωής (end of life care). Στη συνέντευξη που δίνει στον Ridley, ο Hartley μοιράζεται την εμπειρία 25 χρόνων εργασίας σ' αυτόν τον χώρο και υποστηρίζει την ανάγκη για ευελιξία και ανταπόκριση τόσο στις προσωπικές όσο και στις κοινωνικές ανάγκες των ασθενών. Η συμβολή των τεχνών και των θεραπειών μέσω τεχνών στη φροντίδα ασθενών στο τέλος της ζωής είναι επίσης το αντικείμενο του βιβλίου που επιμελήθηκε ο Hartley και το οποίο παρουσιάζεται από την Πέττα. Το βιβλίο μάς ενημερώνει για τους τρόπους εργασίας και μας υπενθυμίζει τη μοναδική και πολλαπλή συμβολή που μπορεί να φέρουν αυτές οι παρεμβάσεις στη φροντίδα ατόμων που αντιμετωπίζουν το θάνατο. Σε όλες τις περιπτώσεις δίνεται έμφαση στην συνεργατική εργασία.

Αυτό το ειδικό τεύχος κλείνει με δυο επιπλέον βιβλιοκριτικές. Παρουσιαζόμενο από την Derrington, το πρώτο είναι ένα άκρως κατατοπιστικό και περιεκτικό βιβλίο από τους Τσίρης, Pavlicevic και Farrant σχετικά με τον ρόλο της αξιολόγησης στις θεραπείες μέσω τεχνών. Η Derrington το προτείνει ως έναν ευκολόχρηστο οδηγό για την εκτίμηση της θεραπευτικής δουλειάς που μπορεί να χρησιμοποιηθεί τόσο από επαγγελματίες θεραπευτές μέσω τεχνών, όσο και από φοιτητές. Το δεύτερο βιβλίο, το οποίο παρουσιάζει η Αθανασιάδου, αναφέρεται στην έννοια της συνειδητότητας (mindfulness) στις θεραπείες μέσω τεχνών. Επιμελούμενο από την Rappaport, πρόκειται για ένα πρωτοπορειακό βιβλίο στις θεραπείες μέσω τεχνών το οποίο καταφέρνει να φέρει μαζί και να ισορροπήσει την εσωτερική ακρόαση με τη δημιουργικότητα, ενώ εγκαθιδρύει συνδέσμους μεταξύ όχι μόνο των θεραπειών μέσω τεχνών, αλλά και με το χώρο του διαλογισμού, της νευροεπιστήμης, καθώς και των διάφορων δημιουργικών και σωματικών πρακτικών και ψυχοθεραπειών.

Σε μια εποχή που βρισκόμαστε αντιμέτωποι με την παγκόσμια ύφεση και που γίνονται περικοπές σε όλες τις υπηρεσίες, η στενή συνεργασία, η εύρεση κοινής γλώσσας και η αλληλοϋποστήριξη είναι ζωτικής σημασίας για την επαγγελματική επιβίωση. Τα δυνατά σημεία ενός χώρου μπορούν να προστεθούν σε αυτά ενός άλλου δημιουργώντας έτσι ένα επαγγελματικό μέτωπο το οποίο λειτουργεί στη βάση ενός αμοιβαίου σεβασμού για τη μοναδική πρακτική, εμπειρία και πιθανή συμβολή του καθενός. Τα άρθρα που συμπεριλαμβάνονται σε αυτό το ειδικό τεύχος σίγουρα επιδεικνύουν ότι τέτοιες συνεργασίες δεν θέτουν υπό αμφισβήτηση τις επαγγελματικές ταυτότητες, αλλά προσθέτουν αξία, προσφέρουν καλύτερες υπηρεσίες στους πελάτες, προστατεύουν τους επαγγελματίες από πιθανή απομόνωση και – όπως και στην περίπτωση της ομάδας KATI, της οποίας είμαι μέλος – δίνουν τεράστια χαρά και ενθουσιασμό. Επιπρόσθετα, αυτό το τεύχος δίνει έμφαση στην ανάγκη εμπλοκής σε έναν διάλογο με άλλες σημαντικές πρωτοβουλίες έξω από τον χώρο των θεραπειών μέσω τεχνών, όπως είναι η ιατρική (π.χ. ογκολογία), ο τομέας υγείας (π.χ. διεπιστημονική εκπαίδευση, πολύπλοκες παρεμβάσεις, συνειδητότητα), οι πρωτοβουλίες σε άλλες ψυχοθεραπείες (π.χ. θεραπεία βασισμένη στην ενόηση, τη δυναμική διαπροσωπική θεραπεία και τις σωματικές ψυχοθεραπείες), οι τέχνες (π.χ. διεπιστημονικά σχέδια εργασίας και αυτοσχεδιαστικά πειράματα) και η έρευνα (π.χ. καλλιτεχνική αναζήτηση, μοντέλα βασισμένα σε ερευνητικά αποτελέσματα και νευροεπιστήμη). Φαίνεται ότι αυτή είναι μια πολύ καλή στιγμή για όλους μας να εμπλακούμε σε τέτοιου είδους συζητήσεις.

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

Guest editorial

Interdisciplinary dialogues

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I was fortunate to be invited as the editor for this special issue on a topic that speaks to me both personally and professionally. On a personal note, I find that working collaboratively, challenging as this may be at different times, has been my default and preferred way of working. Engaging with colleagues from different arts therapy disciplines has offered me opportunities to learn and reflect upon my practice, encouraged me to articulate what I am doing and offered the sense of belonging to a community. Although a trained dance movement psychotherapist, I often perceive myself to be located within the wider community of arts psychotherapies, a sense of belonging that echoes the concept of *'koinonia'* (community) introduced by de Mare in large groups (de Mare, Piper & Thompson 1991).

In terms of my prior professional experiences, looking at what is similar and common across arts psychotherapies and what is unique and different has certainly taken a lot of my research time including the work I undertook for my PhD studies (published in my first book: Karkou & Sanderson 2006). I was fascinated to discover that there are indeed things that arts psychotherapists do have in common. We define the arts in the same democratic, participatory and non-elitist way. We see creativity as a key concept that enables engagement and supports therapeutic outcomes. We see imagery, symbolism and metaphors as additional tools which go beyond the particular characteristic of the modality and the art form, and enable internal, communicative, implicit, and thus safe engagement with difficult issues. We tend to value the non-verbal aspects of our work, believing that change takes place through a combination of artistic engagement and the therapeutic relationship. We all agree that what is happening within sessions involves an intentional use of the arts affecting clients in different ways; for this reason we assess needs and evaluate process and outcomes as a routine task. Finally, instead of operating with our own artistic biases, we anchor our work within clearly defined therapeutic frameworks in order to better serve the needs of the clients we work with and work for. In the 1998 survey of arts psychotherapies (published by Karkou and Sanderson in 2006), six frameworks were identified, presented and discussed: the humanistic/existential, psychoanalytic/psychodynamic, the developmental, the artistic/creative, the active/directive, and the eclectic/integrative. Arts psychotherapies in the UK – in different degrees, combinations and with multiple variations – appear to somehow make use of one or more of these theoretical and practice-based frameworks that guide the work with clients and offer direction and psychological meaning to the therapeutic process. The book (Karkou & Sanderson 2006) also covers distinctive practices, practices that are unique, adding richness and creating interesting variety, if not at times also generating creative tensions. A dialogue often comes from these tensions opening up possibilities for new ways of thinking and working.

This special issue on interdisciplinary dialogues is therefore one more attempt to enable the professionals in this field to talk, debate, agree, find connections and move – collaboratively and jointly – forward. Having a clear professional identity may act as a holding concept that enables both an internal definition as well as useful

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dialogues to take place.

In the first paper of this issue we turn to Europe, and Latvia in particular, to see, in a paper written by Akmane and Martinsone, how professional development has been facilitated amongst arts therapists in this country. In particular, attention is paid to the development of the professional identity of both qualified and student arts therapists. Arts therapies, being a new profession in Latvia (one that has arisen within only the last ten years) has seen an impressive growth, with training programmes in place within higher education institutions, legal recognition of the profession and established posts in healthcare. The article explores Berliner's (1994) definition and stages of development of professional identity which was developed within education. This definition and stages are adopted as a theoretical frame to research the complex concept of professional identity amongst students and qualified professionals. Turning points in one's professional identity – such as the shift from the first to the second year of one's training – are discussed next to factors that support (e.g. the presence of colleagues, the legal framework of the profession) or hinder (e.g. limited finances, overall stress and health problems, uncertainty about the future) the development of such an identity. When the acquisition of this identity is taking place, external factors such as supervision and continuing education appear to play a more important role in its development. However, the development of an internal sense of this identity, even if it may take place over time, suggests that such an identity has been achieved. Interestingly, the rapid development of not only the profession, but also of the professional identity of practitioners in Latvia, can be partly located in the collaborative character of this development. Unlike several other countries where different arts therapies have attempted to grow independently, collaborative and coordinated action has enabled the profession in Latvia to grow fast while taking advantage of joint support and cross-discipline fertilisation.

On the other side of Europe, in the UK, where the tradition of arts therapies is longer, we can find examples of such collaborative ideas both within and beyond the education of arts psychotherapists. In higher education – where the education of arts psychotherapists takes place in the UK – Laahs and Derrington contextualise their paper within the widely discussed principle of 'interdisciplinary education', which is extensively discussed in healthcare contexts. Interdisciplinary sessions in a Scottish setting involving a music therapy student and a dance movement psychotherapy student are presented and discussed. The authors conclude that this work added to the experience of the students in terms of peer support, enabling each of them to widen their understanding of neighbouring fields, and strengthening their skills to communicate ideas and thoughts relating to their clinical work across disciplines.

In this special issue, two additional UK-based examples of such collaborations are included which are located within the National Health Service (NHS). The first paper by Hackett presents work that takes place in the north of England, while the second by Havsteen-Franklin, Maratos, Usiskin and Heagney refers to practices in the south of the country. The former focuses on collaborative work amongst arts psychotherapists who work primarily with people with learning disabilities and autism, while the latter has a mental health focus, making clear suggestions that collaborations are not limited to a particular client population but can take place for the benefit of diverse client needs. Along similar lines, the first paper discusses collaborations amongst arts psychotherapists on a number of levels. Borrowing terminology from the NICE (National Institute for Health and Care Excellence) guidelines, it conceptualises arts psychotherapies as complex interventions that share therapeutic aims, clinical observations and evaluation, techniques and therapeutic work. The paper investigates the practice of a team which consists of practitioners from all four arts psychotherapies. Team members meet monthly for case study discussions, share practice in away days and facilitate joint therapy groups next to their engagement in ongoing research and collaboration with multiple work environments including higher education establishments.

In the south, the second paper describes collaborative work that connects with evidence-based interventions such as mentalisation-based therapy and dynamic interpersonal therapy. More specifically, areas discussed involve the concept of mentalisation that are present in arts psycho-therapies, and aspects of the arts psychotherapies work that can be potentially of value to verbal-based therapies. This takes place next to a very thorough exploration of what we do as arts psychotherapists. Through a thorough investigation of arts psychotherapies practice within a particular Trust and the engagement of practising arts psychotherapists, the authors present and discuss their discoveries of a number of aspects of shared practice. They study particular concepts in greater depth through the use of video-recorded role-

playing scenes. The way a music therapist is using affect attunement, for example, is studied as a way for different arts psychotherapists to explore how this concept can be used with clients with psychosis. The authors conclude that there is certainly scope to investigate further what happens in arts psychotherapy sessions and attempt to identify a common language, while exploring further *what* we are doing as practitioners and *why*. A complex relationship between theory and practice is suggested which links back to the idea discussed by Hackett about arts psychotherapies being complex interventions. Certain aspects may be articulated, some of our actions within sessions can be explained and justified, but the field retains – and many would argue should retain – space for the unpredictable, for the creative and the intuitive.

Moving from the UK to Germany, collaboration amongst arts therapies is explored by Aroni in the area of oncology. The paper discusses how a continuing professional development programme on oncology originally designed for dance movement therapists was adapted to include all arts therapists. The paper highlights the usefulness of bringing together the different types of arts psychotherapies, offering a rich dialogue between disciplines that has allowed new types of educational practice to emerge and potentially grow.

A less formal collaboration has been followed in the paper that explores the life of the group 'CATI' (by Athanasiadou, Kagiafa, Karkou, Lykopoulou, Mpampalis, Mpitzaraki, Mpouzioti, Sampathanaki and Tsiris). The group consists of over 15 therapists from each of the different arts therapies disciplines, who are based mainly in Greece and the UK, and came together to deliver collaborative seminars, workshops and events. The paper reports on the authors' reflections regarding their experience of being part of this group. These reflections emerged through a process of artistic inquiry (Hervey 2000); a methodological approach which becomes increasingly popular within art and dance movement therapy. Six of the members of the group immersed themselves in arts-making processes, responding creatively to the question: "*What is the meaning of the group CATI for us?"* After 'dialoguing' with images, movement and music created during the data generation process, a number of important themes emerged that appeared to be meaningful to the group members. The themes were: (i) new perspectives, (ii) personal and collective growth, (iii) exploring identities, (iv) commitment, demands and difficulties, (v) personal engagement, (vi) theoretical perspectives, (vii) collective processes of the team, and (viii) collaboration. The authors conclude that the group has operated as a platform for mutual explorations, a forum where professionals with common interests can exchange ideas, co-operate and develop. Initiatives like the one taken up from the group CATI can inspire further actions, highlighting what is common and of value across disciplines, while attempting to bridge theoretical or methodological differences.

This special issue continues with an area with increased sensitivity, that is the contribution of creativity, the arts and arts therapies to the end of life care. In the interview Hartley gives to Ridley, he shares his 25 years experience of working in this area arguing for the need of flexibility and responsiveness to both the private and social needs of patients. The contribution of the arts and arts therapies to patients' end of life care is also captured in the book edited by Hartley and reviewed by Petta. The book informs us of ways of working and reminds us of the unique and diverse contributions these interventions can make to people faced with death. In all cases, collaborative work is highlighted.

This special issue closes with two additional book reviews. The first book, reviewed by Derrington, is a highly informative and comprehensive book on the role of evaluation in arts therapies by Tsiris, Pavlicevic and Farrant. Derrington recommends it as a user-friendly guide to evaluation that can be used by practising arts therapists as well as students. The second book, reviewed by Athanasiadou, refers to mindfulness in the arts therapies. Edited by Rappaport, this is a pioneering book that manages to bring together and balance inner listening with creativity, while forging links not only amongst arts therapists but also with the fields of meditation, neuroscience as well as different creative and body-based practices and psychotherapies.

At a time when we are faced with a global recession and cuts being implemented in all services, working closely together, finding a common language and offering support for each other become vital for professional survival. The strengths of the one discipline can be added to the strengths of the other, creating a professional front that operates on the basis of mutual respect for one's unique practice, experience and potential contribution. The papers included in this special issue certainly demonstrate that such collaborations do not challenge professional identities but add value, offer better services to clients, safeguard professionals from potential isolation, and – as was

certainly the case with the CATI group that I was part of – add an enormous amount of enjoyment and excitement. Furthermore, this issue highlights the need to engage in a dialogue with other important initiatives outside the field of arts therapies, such as medicine (e.g. oncology), healthcare (e.g. interdisciplinary education, complex interventions, mindfulness), initiatives in other psychotherapies (e.g. mentalisation-based therapy, dynamic interpersonal therapy, body psychotherapy), the arts (e.g. interdisciplinary projects and improvisatory experimentations) and research (e.g. artistic inquiry, evidence-based models, and neuroscience). For all of us, this certainly seems a good time to engage in these discussions.

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

Article

The initial stage of the professional identity development of an arts therapist: The example of Latvia

Elīna Akmane & Kristīne Mārtinsone

ABSTRACT

This article explores the issue of professional identity development of an arts therapist within the context of Latvia. One hundred and eighty-five participants were invited to take part in the research and to fill in the questionnaire electronically – 118 certified arts therapists and 67 arts therapies students of all four specialisations. The questionnaire was completed by 101 participants (51 certified arts therapists, 50 arts therapies students). In addition, five focus groups were arranged including certified arts therapists and arts therapies students. As a theoretical basis this research uses the professional identity development model by Berliner (1994) which distinguishes five stages and levels according to duration of the professional activity and the accumulated work experience. The objective of the study was to find out which factors are forming the professional identity of an arts therapist, and also explore factors influencing the professional identity development of an arts therapist. This study explores what helps and what hinders the arts therapist's professional identity development process. This research and the acquired results can be used to form or improve the training of arts therapists. These conclusions could be used for better supporting trainees' personal and professional development and in reviewing approaches to supervision by foreseeing possible difficulties while creating the support systems.

KEYWORDS

art therapist, professional identity, development, Latvia

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INTRODUCTION

The profession of an art therapist – as an independent healthcare profession – is relatively new in Latvia, therefore, professionally educated art therapists[1] still have to demonstrate their abilities in the labour market, as well as maintain the image of the profession and strengthen their professional identity (Karkou & Mārtinsone 2010; Mārtinsone 2010; Paiča, Mārtinsone & Karkou 2013). According to information provided by the Latvia Music Therapy Association (Paipare, personal communication, 16th June 2013), Rīga Stradiņš University (Mārtinsone, personal communication, 14th June 2013) and the Latvia Art Therapy Association (Mihailova, personal communication, 14th June 2013) there are 118 certified arts therapists[2] in Latvia at the moment – graduates of Riga Stradiņš University (73), Liepāja University (44) and Goldsmiths University in London (1) who work in healthcare, social care and education spheres, as well as in the private and state sectors in four specialisations – visual plastic art therapy (VPAT), dance and movement therapy (DMT), music therapy (MT) or drama therapy (DT).

The formal arts therapies[3] education in Latvia started in the academic year 2003/04 with the professional study programme "Music Therapy" in the Liepaja Pedagogical Academy (now Liepaja University). In the academic year 2006/207 Riga Stradiņš University (RSU) launched the professional Master's programme "Arts Therapies". Within its framework the future arts therapists began their studies in three specialisations – VPAT, DMT, MT and starting from the academic year 2007/08, DT.

According to the enrolment requirements of the RSU (enrolment requirements of the RSU professional Master's programme "Arts Therapies") people with different academic and personal experience choose to study arts therapies (in specialisation) – those who have a medical, healthcare, social care, pedagogics or arts degree. After completing their arts therapies studies the graduates receive the professional Master's degree in healthcare and arts therapist's qualification with specialisation in one of the types of arts (visual plastic art, dance and movement, drama or music (The Medical Treatment Law; The Professional Standard of Arts Therapists 2010).

In the last decade it has been topical to investigate the professional identity development among medical students (Wilson, Cowin, Johnson & Young 2013; Wear & Castellani 2000). It has been pointed out that the professional identity development – the way a healthcare professional thinks of oneself as a professional, feels oneself working in this profession – is as important as developing skills and acquiring knowledge in the study process. An intentional understanding of oneself in context of the professional identity is also connected to a successful career in the chosen profession.

There are several models from which to view the professional identity development. This research uses the professional identity development model by Berliner (1994) which distinguishes five stages and levels according to duration of the professional activity and the accumulated work experience. This model was initially designed to view the professional identity development of students (Dreyfus & Dreyfus 1980); later it was used to view the professional identity development of nurses (Benner 1984, 2004). Despite Berliner's model being designed for describing the professional identity development of those working in the field of pedagogics, it can be adapted to understand the professional identity development of other professions; as the above mentioned model shows the identity development process as a continuous and gradual process that begins with educating an inexperienced beginner until one reaches the highest level of development.

Berliner (1994) begins his model with the 1st stage – *the novice stage of development* that includes acquisition of the profession and the initial period of professional activity. The 2nd stage – *the advanced beginner stage of development* characterises professionals with a one to three-year work experience. Beginners who reach the 3rd stage – *the competent stage of development* – become competent in their field in the third or fourth year of working. The 4th stage – *the proficient stage of development* is reached in the fifth year of

[1] In Latvia an art therapist regardless of any of the four specialisations one represents (visual plastic art therapy, dance and movement therapy, music therapy or drama therapy) works under a single job title – *art therapist* (The Professional Standard of Art Therapists 2010). The term "art therapist" used in the research comprises art therapists of all four specialisations (visual plastic art therapy, dance and movement therapy, music therapy and drama therapy).

[2] Information as at the research writing period. In 2014, 12 art therapists graduated from the RSU.

[3] The term "arts therapies" used in the research comprises all four arts therapies' specialisations (visual plastic art therapy, dance and movement therapy, music therapy and drama therapy).

working and professionals who have reached the 5th stage – *the expert stage of development* – are free in their performance and act without an obvious effort.

This model was chosen as a basis to distinguish between the professional identity development stages of an arts therapist. In addition to the five levels and stages set forth by the author the *0 level* should also be mentioned. It includes the process of profession choice that is also a significant factor of professional identity formation. While examining the scientific literature on the professional identity development of healthcare professionals, it is obvious that the professional identity begins to form itself a while before commencing studies when one's future profession is just considered (Kroger 2007; Skorikov & Vondracek 2011). Studies indicate that medical students laid foundations to the choice of their future profession before they commenced their studies by deciding whether to study in a particular study programme (Wilson et al. 2013). So the *0 level* includes the stage before starting studies, in this case the time when an individual decides to study arts therapies (in specialisation).

The novice stage of development. When attributing this model to the professional identity development of an arts therapist it should be mentioned that the *novice stage of development* is represented by arts therapies students during their studies while they are acquiring knowledge and getting to know new professional spheres. The professional identity development is significantly influenced by acquiring the particular profession's studies and learning process (Mann, cited in Wilson et al. 2013: 370). Other authors agree (Mārtinsone et al. 2008; Moon 2003). This level is also represented by arts therapists who have just finished their arts therapies studies and started their professional activity in the field of arts therapies.

2nd stage*: The advanced beginner stage of development*. One to three-year experience. This level includes those arts therapists who have received the medical practitioner certificate (Certification procedure of medical practitioners 2012).

3rd stage: *The competent stage of development*. Arts therapists with a four-year work experience who have reached the competent stage of development can start their supervisor training that is co-ordinated with the ANSE standards for national organisations (Association of National Organisations for Supervision in Europe).

4th stage: *The proficient stage of development*; and 5th stage: *The expert stage of development*. These levels are mainly characterised by intuition and free performance resulting from the accumulated experience; these levels are represented by arts therapists and supervisors who have worked in their profession for more than five years.

These development stages show the professional identity development as a gradual process that is based on the duration of the professional activity and accumulated work experience. They show how the understanding of situations and the ability to foresee changes in the course of development occur by acquiring knowledge and expanding professional expertise.

The research objective was to investigate what are the affecting factors of an arts therapist's professional identity development and to determine what promotes and what hinders the professional identity development process of an arts therapist.

In order to reach the goal, research questions were defined: 1. What are the influencing factors of the professional identity development of an arts therapist? 2. What promotes and what hinders the professional identity development factors of an arts therapist?

RESEARCH METHOD

Instruments

1) An individual electronic external questionnaire for arts therapists and arts therapies students that included various questions related to their professional activity and development (e.g. Have you acquired further continuing professional education after graduating as an arts therapist? How long after you graduated from the "Arts Therapies" programme did you began to work as an arts therapist? What workload do you have as an arts therapist? In what environment do you currently work as an arts therapist? etc.). This article analyses only questions 29-31:
   - ❑ 29. What factors influence your professional identity development as an arts therapist?
   - ❑ 30. What helps you in your professional development while becoming an arts therapist/developing as an arts therapist?
   - ❑ 31. What hinders you in your professional development while becoming an arts therapist/developing as an arts therapist?

2) Five focus groups including certified arts therapists and arts therapies students.

Participants

One hundred and eighty-five participants were invited to take part in the research and to fill in the questionnaire electronically – 118 certified arts therapists and 67 arts therapies students comprising the four specialisations. The questionnaire was completed by 101 participants (51 certified arts therapists, 50 arts therapies students who studied arts therapies in either RSU or Liepaja University, including six arts therapies students who are currently on sabbatical leave). 13 certified arts therapists and 19 arts therapies students participated in the focus group discussions. All focus group participants were divided into subgroups based on the gradualness of their professional identity development, according to the duration of their arts therapies studies and accumulated professional experience.

Procedure

One hundred and eighty-five electronic mail messages with an invitation to take part in the questionnaire and a brief information sheet on the research were sent out. The participants filled in the questionnaire online (www.visidati.lv) between 1st and 31st of October 2013. The questionnaire was designed in a way that participants had to answer to all questions without leaving any out.

Five focus groups were arranged (I, II, III, IV and V). Nine 1st, six 2nd and four 3rd year students of the RSU programme "Arts Therapies" were invited to participate in focus groups I, II and III on a principle of voluntary participation. While in focus groups IV and V, 13 certified arts therapists were involved – participants of the RSU continuing education course "Supervision". Discussions of all five focus groups (with the consent of all participants) were filmed.

Data analysis and results

To answer the first research question the focus group discussions were analysed as well as data acquired from the 29th question of the questionnaire ("What factors influence your professional identity development as an arts therapist?").

The content analysis strategy – grounded theory that sets several consecutive steps – was used for data analysis (Cropley 2002; Strauss & Corbin 1998). First, a transcription of the focus group discussions was carried out while performing the formal data coding by assigning each of the participants a code comprising of the number of the focus group and participant's serial number in the course of discussion (for example, F1-4). Then, using the building-block approach (Cropley 2002), a content analysis on factors affecting the professional identity development indicated by the focus groups' respondents was performed and they were grouped in more general categories. When giving the categories general titles the most typical categories of the particular sphere were used that included factors of similar significance; for instance, *previous education, previous background, past experience, one's own basis, life experience, one's own experience, professional experience, etc.* and these were combined in one category and generalised as "Previous experience". Twenty-three categories were formed as a result of the content analysis. A list of general factors influencing the professional identity development was obtained which, in turn, was used for further classification of factors by analysing the qualitative data from the 29th question of "The Questionnaire for Arts Therapists and Arts Therapies Students".

When performing the content analysis of the 23 categories, general category spheres were acquired. Firstly, when creating general titles for different spheres, arts therapists' professional identity development affecting factors' spheres were considered; for instance, "Arts therapies studies, acquired knowledge", "Practical professional activity", "Relationship" (with colleagues, teachers etc.), "Previous experience", "Individual development and continuing education" and "Profession of an arts therapist". Secondly, after taking into consideration results obtained during the content analysis, new spheres were created, for example, "Inner factors" and "External factors".

While performing the content analysis of the qualitative data acquired from the 29th question of the questionnaire, the professional identity affecting factors were grouped in the previously created factor categories. As the respondents more than once have indicated the answer *hard to tell* or have not answered the question, two more categories appeared – “Hard to tell” and “No answer” as well as one new category sphere – “Hard to tell/No answer”.

The content analysis and questionnaire results combined to create 25 categories and 9 category spheres (Table 1).

When examining the answers' analysis results (Table 1) of the 29th question of the questionnaire it

is obvious that the most frequently mentioned factors that influence the professional identity development of an arts therapist are related to the category "Practical professional activity" (13.88%) .

No.	Category spheres	Category No.	Factor categories	Frequency of the category appearance (%) in the questionnaire (n=101)	Frequency of the category appearance (%) in focus groups				Frequency of the category appearance (%) in total (n>101)
					Focus groups IV and V (certified arts therapists) (n=13)	Focus group I (1st year students) (n=9)	Focus group II (2nd year students) (n=6)	Focus group III (3rd year students) (n=4)	
I	Arts therapies studies	1	Studies, acquired knowledge	11	10.79	**19.15**	11.11	14.29	**12.41**
		2	Higher education institution	0.95	1.96	-	11.11	-	1.42
II	Practical professional activity	3	Practical activity	**13.88**	9.81	-	-	**19.06**	9.57
		4	Participation in supervisions	6.22	5.88	-	-	**19.05**	4.26
		5	Certification	0.48	0.98	-	-	-	0.35
III	Relationship	6	Colleagues	5.74	5.88	10.64	7.41	9.52	5.32
		7	Teachers	6.22	3.92	14.89	**18.52**	9.52	5.67
		8	Supervisor as a personality	0.48	2.94	-	-	4.76	2.13
		9	Participation in an association	1.44	4.9	2.12	7.41	4.76	3.19
		10	Guest lecturers	0.96	4.9	-	-	-	1.77
		11	Other authorities	0.48	-	-	-	-	1.06
IV	Previous experience	12	Previous experience	6.22	9.81	**19.15**	**18.52**	4.76	8.87
V	Personal growth and continuing education	13	Continuing education	11	8.82	6.38	-	-	8.87
		14	Individual therapy	7.66	1.96	4.26	7.41	-	5.32
		15	Creative activity	2.39	-	4.26	-	-	2.13
VI	Profession	16	Profession's situation in LV	1.44	-	12.77	3.7	-	2.13
		17	Explaining the profession to others	0.48	4.9	-	3.7	-	2.13
VII	Internal factors	18	Personality characteristics, emotions	11.96	0.98	-	-	-	8.51
		19	Feeling oneself	-	**15.69**	-	7.41	4.76	6.74
		20	Goal, vision	-	5.88	-	3.7	9.52	3.19
		21	Enthusiasm of the 1st year student	-	-	6.38	-	-	1.06
		22	Moral satisfaction	0.95	-	-	-	-	0.71
VIII	External factors	23	Family, environment	4.78	-	-	-	-	3.19
IX	Hard to tell/no answer	24	Hard to tell	4.31	-	-	-	-	3.22
		25	No answer	0.96	-	-	-	-	0.72
			Total	100.00	100.00	100.00	100.00	100.00	100.00

Table 1: Categories of factors forming the professional identity of an arts therapist

This includes any practical activity within the profession, including both the study praxis during studies and further professional work with clients/patients while working in the profession. The next most frequently mentioned factors were a range of psychic conditions and personality characteristics – for example determination, interest, urge to help, willpower, patience, persistence, dutifulness, diligence etc. – that were all summarised in the category "Personality characteristics, emotions" (11.96%). An equally high number of participants also considered factors in the categories "Studies, acquired knowledge" (11%) and "Continuing education" (11%) as important. Studies and the study process include all answers related to the acquisition of knowledge, including individual reading of literature. The continuing education includes participation in master classes, workshops, courses, professional and personality growth groups

Figure 1 shows only those factor categories where frequency of the mentioned factors is more than 4%. All factors mentioned in the questionnaire are summarised in Table 1.

When analysing data of focus group I it was concluded that the 1st year students' enthusiasm helps them (willingness to acquire new knowledge, huge interest about the process and urge to participate) and that this was also reflected in their responsiveness when they were invited to participate in the focus group. The most important factors mentioned by this focus group can be included in the following categories – "Studies, acquired knowledge" (19.15%), "Previous experience" (19.15%), "Teachers" (14.89%) as well as "Profession's situation in Latvia" (12.77%). These factors point to the actual situation of the 1st year students as they are related to the initial phase of studies and their topicalities – adapting to the higher education institution and getting used to the study process, becoming acquainted with teachers as well as with authorities related to the profession, their recent past experience and the legal situation of the profession in Latvia.

Participants of focus group II mentioned several times during the discussion that they felt a certain confusion, indicating that at the moment they do not feel any professional identity or have a student identity. The most important factors that currently influence the professional identity development indicated by the named focus group can be attributed to the following categories – "Teachers" (18.52%), "Previous experience" (18.52%), "Studies, acquired knowledge" (11.11%), as well as "Higher education institution" (11.11%).

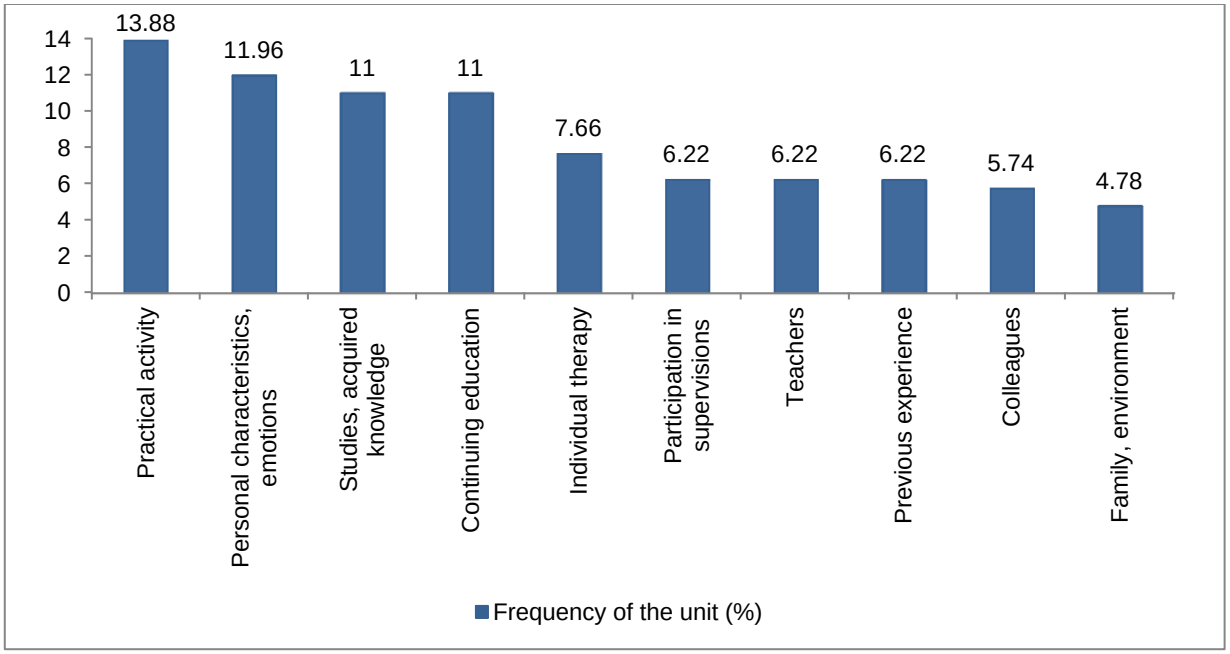

Figure 1: Factors influencing the professional identity development of art therapists (n=101)

These factors points to the actual situation of the 2nd year students as they are related to the intense study process. In this phase of studies, students mostly communicate with their teachers and get support from them; therefore, one of the most frequently mentioned factors influencing the professional identity development is teachers. It can be concluded that in the second study year the professional identity crisis forms – the 2nd year students feel confused in their sense of

professional identity. It would appear that some part of the previous identity is lost and a new professional identity is created. This is at a time when students also gain an intensive placement experience.

The 3rd year students of arts therapies study programmes were the participants of focus group III. This focus group faced resistance to participate in the research. The number of participants was low and answers to the questions were short. It may be that this was influenced by the fact that the discussion moderator and research author was a student of this course and students were actively involved in writing their Master's thesis. Although the discussion was not extended it can be concluded from the received answers that the most important factors influencing the professional identity development go under the category "Practical professional activity" – "Practical activity" (19.06%) that includes practical activity both during the study praxis and within the framework of research done for the Master's thesis, as well as "Participation in supervisions" (19.06%). Both of these important factors point to the actual situation of the 3rd year students as in this semester they undertake research related to their Master's thesis through carrying out professional activities with clients/patients. During this time students also visit supervisions where they get significant support for carrying out their research.

Data of focus groups VI and V were analysed together after transcription as they were organised according to the aquarium principle and participants of the same level took part in these focus groups, namely, certified arts therapists with a work experience in the arts therapy professions. When analysing these materials it is obvious that arts therapists during the discussion and when discussing factors that influence their professional identity development often mentioned concepts related to their *inner feelings,* for instance, *getting to know oneself; filling one's inner world; feeling of being liked; inner process; strengthening the inner feeling.* Along with other more frequently mentioned factors that influence the professional identity development of an arts therapist, such as: "Studies, acquired knowledge" (10.79%), "Practical professional activity" (9.81%), "Previous experience" (9.81%), factors related particularly to the category "Inner feeling" were mentioned the most (15.69%). The participants indicated several times that their professional identity development is an *inner process* and "the house of professional identity" *is built internally.*

While interpreting results of this focus group, it can be concluded that certified arts therapists who during their professional development have graduated from their arts therapy studies, and by a professional activity have gained work experience in an arts therapy profession, have most frequently named those factors which, during the content analysis, were placed under the category's "Personal growth and continuing education" sphere "Feeling oneself". This points to the actual situation of participants from this focus group, namely, that studies are finished, experience is gained by working in the profession and now it is the time and opportunity to think of one's inner feeling – "this profession is "my profession"", "this is what I want to do". This makes these arts therapists think of how they feel themselves as arts therapists, how they integrate the arts therapist within themselves.

Arts therapies students named several external factors as the ones influencing their professional identity development – *studies, acquired knowledge, teachers, participation in supervisions,* etc. While certified arts therapists mentioned the inner factor as the main one influencing their professional identity development – *the inner feeling*. From the above it can be concluded that during the process of acquiring a profession several external professional identity factors are important, while the *inner feeling* indicated by certified arts therapists shows that arts therapists, along with gaining experience from professional activity, also gained a feeling of professional identity.

In order to answer the second research question, focus group discussions were analysed, data acquired from answers to questions 30 (What helps you in your professional development while becoming an arts therapist/developing as an arts therapist?) and 31 (What hinders you in your professional development while becoming an arts therapist/developing as an arts therapist?) were gathered and analysed.

First, taking the building-block approach as a basis, the content analysis on factors that arts therapists mentioned as helping their professional identity development was performed; factors were grouped in categories and category spheres of factors influencing the professional identity development of arts therapists designed in the first steps of the data analysis. Five previously created category spheres were retained; however, some categories were slightly changed. For instance, the categories "Certification", "Other authorities" and "Feeling oneself" were taken out as they were not topical in relation to the helping factors. The categories "Individual reading of literature", "Availability of the professional literature" and

"Work in a multidisciplinary team" were added to the list. The new categories were assigned general titles and these included factors of various importance, for instance, *reading of literature, profound theory acquisition, literature, reading of the professional literature, literature studies, literature sources, information, professional literature and periodicals, self-education, etc.* that were all combined under one category and generalised as "Individual reading of literature". In total, nine category spheres and 25 factor categories were retained (Table 2).

As the end of focus groups' VI and V video material was "lost" due to technical problems. Response data on the second question (What helps and hinders you in your professional development while developing as an art therapist?) are valid only partially, namely, only the first part of this question is recorded that includes answers on factors that help arts therapists in their professional identity development process. Data on factors that hinder arts therapists in their professional identity development process is incomplete; therefore, it is not included in the research analysis.

When viewing analysis results of the 30th question (Figure 2) it is obvious that the most frequently mentioned factors that help arts therapists in their professional identity development process are from the category "Continuing education" (17.05%). In addition, category "Practical activity" (12.79%) including any practical professional activity is mentioned as an important factor for the professional development; and "Colleagues" (12.02%) including co-operation with colleagues, their support as well as sharing experience with other colleagues.

Figure 2 shows only those factor categories where frequency of the mentioned factors is more than 4%. All factors mentioned in the questionnaire are summarised in Table 2.

When viewing the helping factors for each focus group (Figure 3) it can be concluded that for the 1st year students the most important factor in their professional identity development process is "Colleagues" (28.58%). For the 2nd year students the legal situation of the arts therapist profession in Latvia is important (42.86%). For the 3rd year students, however, participation in supervisions is the most frequently mentioned (45.45%) as the helping factor. Certified arts therapists named "Continuing education" (22.22%) as the most important factor in their professional identity development process.

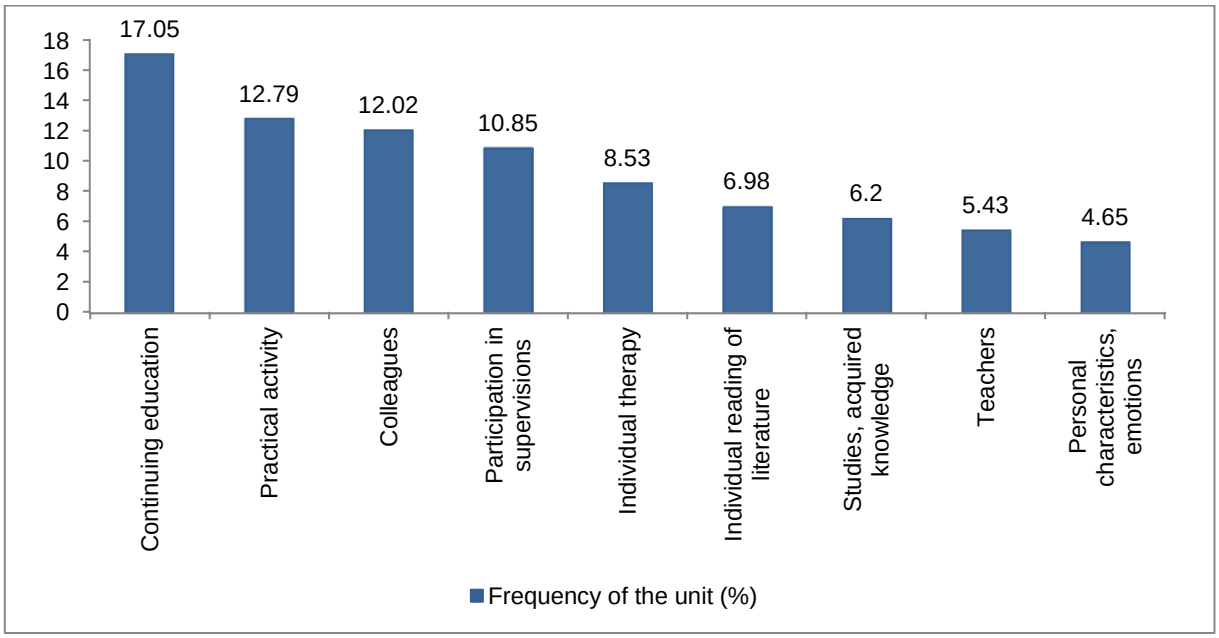

Figure 2: Factors that help in arts therapist's professional identity development process (n=101)

No.	Category spheres	Category No.	Factor categories	Frequency of the category appearance (%) in the questionnaire (n=101)	Frequency of the category appearance (%) in focus groups			Frequency of the category appearance (%) in total (n>101)
					Focus group I (1st year students) (n=9)	Focus group II (2nd year students) (n=6)	Focus group III (3rd year students) (n=4)	
I	Arts therapies studies	1	Studies, acquired knowledge	6.2	-	-	-	5.39
		2	Availability of literature	1.55	4.76	-	-	1.68
		3	Individual studying of literature	6.98	14.29	-	-	7.07
		4	Higher education institution	0.78	-	-	-	0.67
II	Practical professional activity	5	Practical activity	12.79	-	-	9.09	11.45
		6	Participation in supervisions	10.85	-	-	**45.45**	11.11
III	Relationship	7	Colleagues	12.02	**28.58**	-	27.27	13.47
		8	Teachers	5.43	9.52	14.29	18.19	6.4
		9	Supervisor as a personality	0.39	-	-	-	0.34
		10	Participation in an association	1.16	-	-	-	1.01
		11	Work in multidisciplinary team	0.78	-	-	-	0.67
		12	Guest lecturers	1.55	-	-	-	1.35
IV	Previous experience	13	Previous experience	1.52	-	-	-	1.35
V	Personal growth and continuing education	14	Continuing education	**17.05**	-	-	-	**14.81**
		15	Individual therapy	8.53	4.76	14.29	-	8.08
		16	Creative activity	2.71	-	28.56	-	3.03
VI	Profession	17	Situation of the profession in LV	-	9.52	**42.86**	-	1.68
		18	Explaining the profession to others	0.39	-	-	-	0.34
VII	Inner factors	19	Personal characteristics, emotions	4.65	9.52	-	-	4.71
		20	Goal, vision	0.78	-	-	-	0.67
		21	Enthusiasm of a 1st year student	-	14.29	-	-	1.01
		22	Moral satisfaction	0.39	-	-	-	0.34
VIII	External factors	23	Family environment	2.33	4.76	-	-	2.36
IX	Hard to tell/ NA	24	Hard to tell	0.39	-	-	-	0.34
		25	No answer	0.78	-	-	-	0.67
			Total	100.00	100.00	100.00	100.00	100.00

Table 2: Categories of the helping factors in the professional identity development of an arts therapist

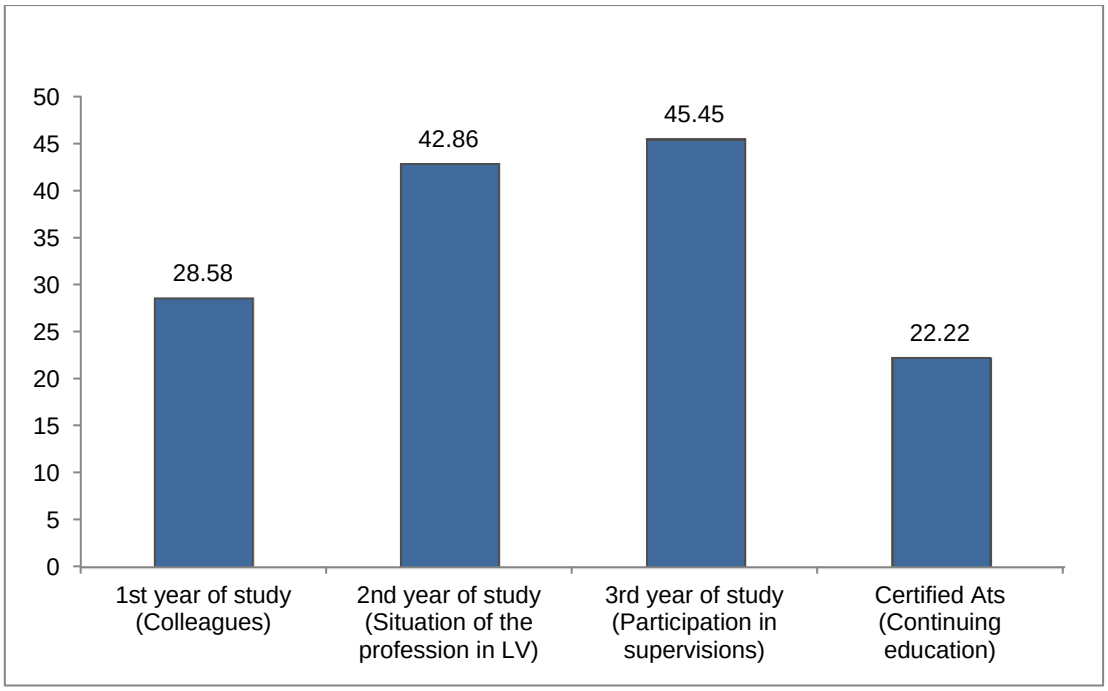

Figure 3: The most frequently mentioned factors that help during the professional development process of an arts therapist (unit frequency % in each focus group), data of focus groups I, II, III, IV and V (n=32)

To answer the second part of the second question (what hinders an arts therapist in his/her professional development process) a content analysis on focus group respondents mentioned troublesome factors were performed and they were grouped in general categories. When creating general category titles the most typical categories of the particular sphere including factors of similar importance were used, for instance: *family circumstances, living in a province, large workload simultaneously working and studying, lack of time, combining work and family lives, unarranged and deranged work environment, etc.* that were all combined under one category and generalised as "External conditions". Category 21 was created as a result of the content analysis and a general list of hindering factors was developed (Table 3).

When viewing the analysis results of the 31st question (Figure 4) it is obvious that the most frequently mentioned factors that hinder the professional identity development process of an arts therapist are under the category "Lack of finance" (23.08%). The category "Lack of awareness in society" (12.31%) was also mentioned as an important factor; it includes a sometimes negative attitude towards the arts therapies profession, lack of understanding, prejudice and resistance; and "External conditions" (11.54%) that include such hindering factors as living in a province, large workload, simultaneously working and studying, lack of time, combining work and family lives, unarranged and deranged work environment, etc.

Figure 4 shows only those factor categories where frequency of the mentioned factors is more than 5%. All factors mentioned in the questionnaire are summarised in Table 3. When examining the hindering factors for each focus group (see Figure 5) it can be concluded that for the 1st year students the most hindering factor in their professional development process is "Lack of finance" (31.58%), for the 2nd year students an important hindering factor is "Stress and health problems" (50.00%). This data highlights the professional identity crisis of 2nd year students showing that students often experience stress and health problems during their second year of study. While the 3rd year students mentioned "Uncertainty about future" (18.18%), "External factors" (18.18%) and "The short period of study" (18.18%).

No.	Category spheres	Category No.	Factor categories	Frequency of the category appearance (%) in the questionnaire (n=101)	Frequency of the category appearance (%) in focus groups			Frequency of the category appearance (%) in total (n>101)
					Focus group I (1st year students) (n=9)	Focus group II (2nd year students) (n=6)	Focus group III (3rd year students) (n=4)	
I	Arts therapies studies	1	Lack of knowledge	0.77	-	-	9.09	1.16
		2	Unavailability of literature	0.77	-	-	-	0.58
		3	Complaints about the study programme, teachers	7.69	-	16.67	9.09	7.56
		4	Study difficulties	1.54	-	-	-	1.16
		5	Short study period (2.5 years)		10.53	8.33	18.18	2.91
II	Practical professional activity	6	Little practical activity	3.07	-	16.67	-	3.49
			Low-quality/inaccessible supervisions	3.07	-	-	-	2.33
		7	Unemployment	3.07	-	-	-	2.33
III	Relationship	8	Lack of communication with colleagues	0.77	-	-	-	0.58
IV	Previous experience	9	Previous experience as a hindrance	-	10.53	-	-	1.16
V	Personal growth and continuing education	10	Lack of individual therapy alternatives	1.54	26.32	8.33	-	4.65
VI	Profession	11	Disarray of the profession in LV	1.54	-	-	-	1.16
		12	Lack of authority in profession	-	-	-	9.09	0.58
VII	Inner factors	13	Individual characteristics, emotions (e.g. anxiety, disbelief in oneself)	7.69	-	-	-	5.81
VIII	External factors	14	External conditions (family, lack of time)	12.31	-	-	18.18	10.47
		15	Lack of finance	**23.08**	**31.58**	-	9.1	**21.51**
		16	Uncertainty about future	3.85	5.26	-	18.18	4.65
		17	Lack of foreign language knowledge	3.85	-	-	-	2.91
		18	Uninformed society	11.54	15.78	-	-	10.47
		19	Stress, health problems	2.31	-	**50.00**	9.09	5.81
IX	Nothing / NA	20	Nothing hinders	7.69	-	-	-	5.81
		21	No answer	3.85	-	-	-	2.91
			Total	100.00	100.00	100.00	100.00	100.00

Table 3: Categories that hinder the professional identity development of an arts therapist

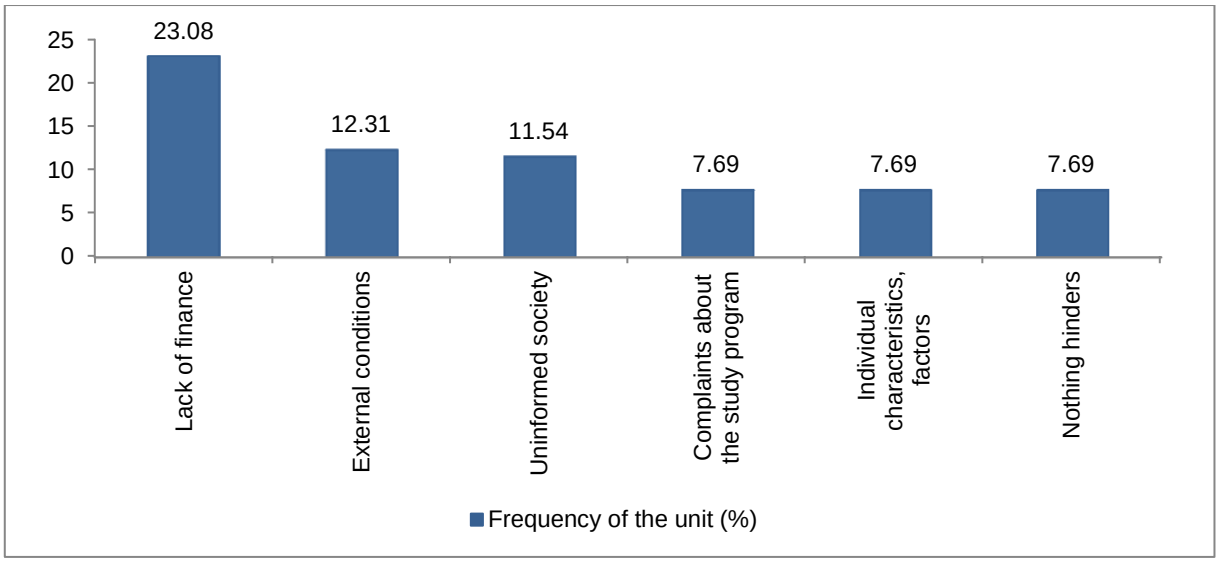

Figure 4: Factors that hinder the professional identity development process of an arts therapist (n=101)

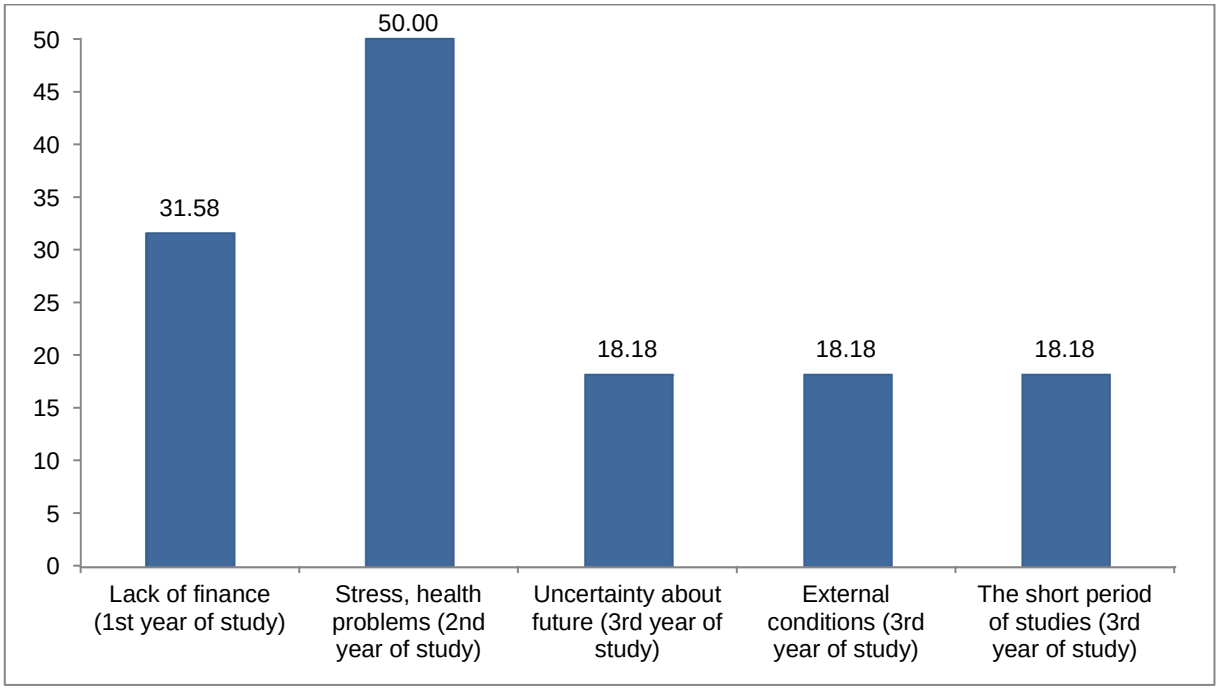

Figure 5: The most frequently mentioned factors that hinder the professional identity development process of an arts therapist (unit frequency in %), data of focus groups I, II and III (n=19)

CONCLUSIONS

1. The research results on the professional identity development of an arts therapist show that the professional identity development process of an arts therapist proceeds gradually beginning with studies, start of the professional activity by acquiring experience during the professional activity and during the time changing from external factors that influence professional identity to inner factors.
2. Factors influencing the professional identity development of an arts therapist vary among arts therapists of different professional development levels, at the same time they reflect the current professional situation of each represented level.
3. The breaking point in the professional identity development process of an arts therapist can be observed in the 2nd year of study when a professional identity crisis and health problems appear. This aspect would require further investigation by performing, for example, a phenomenological analysis, which would also

deepen our understanding of the required support system for students.

4. During the process of acquiring the profession of an arts therapist the external professional identity influencing factors are more important; however, the inner factor – *inner feeling* – mentioned by certified arts therapists indicates that arts therapists along with their professional activity experience have reached a sense of professional identity as an arts therapist.

Research limitations

Arts Therapies and the profession of an arts therapist in Latvia are relatively new in comparison to the USA and United Kingdom where several arts therapists' generations have already developed their professional identity. In contrast, in Latvia those arts therapists who have been first to acquire this profession have a relatively small experience in arts therapies. As a result, a view into the development of the professional identity of an arts therapist through a perspective of experience gained in Latvia can be relatively narrow and limited. It would be useful to repeat this research in a more developed arts therapy context to discover whether similar or different 'conclusions' would be found using the same methodology, or perhaps its replication in Latvia in about three years' time.

Perhaps the insight into the professional identity development of an arts therapist would be more profound and extensive if the research included opinions of clients/patients on the impact of arts therapists on their lives! This could also be a significant aspect of identifying professional identities. This can be measured either through direct comments or by comments made to members of care teams, their referrals of other clients/patients to work with arts therapists, or even by indirect data such as attendance and punctuality.

Research significance

This research and the acquired results can be used to form or improve the training of arts therapists. These conclusions could be used for better supporting trainees' personal and professional development or in reviewing approaches to supervision by foreseeing possible difficulties while creating the support systems.

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

Article

Learning together: An investigation into the potential of interprofessional education within music therapy

Jenny Laahs & Philippa Derrington

ABSTRACT

The literature acknowledges the benefits of collaboration between music therapists and other professionals for the individual therapist who collaborates, for our clients and for the music therapy profession itself. However, there has been little discussion regarding how therapists acquire the skills required for collaboration. In a wider healthcare context, the principle of interprofessional education is utilised to facilitate such collaboration in practice. This study considers peer clinical work review sessions as a potential interdisciplinary training tool within a UK arts therapy training context, from a music therapy perspective. Using a phenomenological paradigm, the experience of participating in interdisciplinary peer review sessions between a music therapy student and a dance movement psychotherapy student was modelled and evaluated.

The study found that interdisciplinary peer review was experienced as beneficial to the training experience in several ways, including developing peer support, widening perspectives of other professions and developing cross-discipline communication skills. These results could provide a framework upon which to base development of interdisciplinary inputs within the UK training context.

KEYWORDS

music therapy, arts therapies, collaboration, interdisciplinary education, training, peer review

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INTRODUCTION

Music therapists as collaborators

Compared to other Allied Health Professions, the music therapy profession is relatively new to working collaboratively (Twyford & Watson 2007). Despite this, collaboration with other professionals in clinical work does not seem to be rare in current music therapy practice, perhaps most commonly through involvement in a treatment team containing different professions for a particular client or client

group (Twyford & Watson 2008b), and during clinical supervision (Odell-Miller 2009).

The benefits for music therapists working collaboratively outside the profession appear to fall into three generic categories – benefits to the music therapy profession, to the individual therapist and to the clients. The identity of the music therapy profession can be consolidated through collaboration with other disciplines; by extension, new referrals to music therapy could then be promoted, and thus new roles potentially created (Twyford & Watson 2007; 2008a). The individual music therapist who collaborates may benefit from understanding the different perspectives and skills of other professions, the provision of a source of professional emotional support and the stimulation of professional discussion (Watson 2002; Twyford & Watson 2008b). Pavlicevic (1999) emphasises this last point, stating that discourse with other professionals is necessary to develop meaning within music therapy. Finally, music therapy clients may also benefit from professional collaboration, in that by sharing their insights, each professional gains a greater understanding of the client (Durham 2002).

This phenomenon is not unique to music therapy. Twyford and Watson (2008a) describe how the same benefits of collaboration are applicable to other arts therapists. Best (2000), speaking from a dance movement psychotherapy perspective, exemplifies the knowledge she gained from each individual in a multidisciplinary team, and describes how this experience created an "inner collaborator" (p. 210) that could be referred back to in future clinical experience, suggesting lasting benefits. In a wider healthcare context, collaboration is also a prominent concept. Effective professional treatment teams in healthcare are recognised as essential in providing optimal patient/client care (Barwell et al. 2013), and interdisciplinary supervision in healthcare has also been described as "beneficial and rewarding" (Chipchase et al. 2012: 465).

The literature also acknowledges that collaborations involving music therapists "can be compounded by a myriad of challenges" (Register 2002: 307). Furthermore, several authors suggest that the individual music therapist must develop team working skills before successful collaboration with another profession can occur (Register 2002; Twyford & Watson 2008b; Zallik 1992). Many factors may hinder effective team working, including "personality factors, poor communication skills, individual dominance, status, hierarchy, and gender effects" (Twyford & Watson 2008b: 19). Furthermore, the benefits of collaboration described previously can only be reaped if music therapy has been "valued, understood and proven effective" (Twyford & Watson 2008b: 21), suggesting that the communication skills of the music therapist are paramount.

Much like the benefits of collaborative working, these barriers to collaboration do not seem to be unique to music therapy. Xyrichis and Lowton's (2008) extensive literature review of multidisciplinary teams in both primary and community care settings identified several barriers to effective team working, including large team sizes hindering effective communication, a lack of clear goals, and a lack of understanding within the team of the roles of the other professionals. These barriers could also apply to music therapy collaborations. Indeed, both Odell-Miller (1993) and Priestley (1993) echo this preference for smaller teams within music therapy collaborations. Of particular relevance to music therapy is Xyrichis and Lowton's (2008) observation that a team member with a separate base to the multidisciplinary team may be "less integrated […] which may limit team functioning and effectiveness" (p. 143). Hills et al. (2000) observe how many music therapists may work in a peripatetic nature and as a result are members of more than one professional team at once; this could be a prominent barrier to effective collaboration. Despite acknowledgement of these barriers to collaboration in the literature, there has been little discussion of the process by which music therapists acquire the skills to overcome them.

The concept of interprofessional education

Castle Purvis (2010) suggests that interprofessional education could be an appropriate method by which to introduce music therapy trainees to the values and skills required for effective team working. The World Health Organisation defines interprofessional education (IPE) as "when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (World Health Organisation 2010: 7). Many healthcare professions have adopted this concept, including medicine, nursing, midwifery, occupational therapy, physiotherapy, and speech and language therapy (Barwell et al. 2013). These inputs are primarily delivered during training; while IPE inputs in the workplace also occur, these tend to be more setting-specific and less widely considered in the literature.

The World Health Organisation states that "there is sufficient evidence to indicate that effective IPE enables effective collaborative practice" (2010: 7). The majority of this evidence consists of subjectively perceived benefits by individuals who have participated in IPE inputs. For example, Chan et al. (2013), Ruebling et al. (2014), Miller et al. (2013) and Gilligan et al. (2014) unanimously reported overall positive attitudes from students towards the value of IPE. Chan et al. (2013) summarise these benefits as role clarification and an increased understanding of both the importance of communication and the meaning of teamwork. Bridges et al. (2011) summarise the common theme for success of these inputs: that the chosen training tool should help students to understand their own professional identity while gaining an understanding of the roles of other professionals. Perhaps this could be considered an overall aim for any interdisciplinary training tool.

The formats of IPE interventions found across healthcare disciplines are varied, both in the combinations of professions involved and in the format and frequency of the training tool itself. Each learning situation is unique, and so Barr and Low (2013) recommend that each input strategy be devised according to the learners' needs and practicalities of the specific setting. They also specify that regardless of format, the learning should be "active, interactive, reflective and patient centred" (p. 19). IPE inputs could occur regularly throughout a training programme (Barwell et al. 2013), or during a concentrated week-long interprofessional programme, followed by occasional inputs throughout the remainder of the year (Barr & Low 2013). One-off inputs seem particularly common (Abu-Rish et al. 2012).

The potential of IPE within music therapy training

Inclusion of IPE inputs within healthcare training courses is recommended by the General Medical Council, the Nursing and Midwifery Council, the General Social Care Council and the Health and Care Professions Council (Barr & Norrie 2010). Such inputs are not mandatory under the HCPC guidelines under which the Allied Health Professions are validated, since IPE may not be possible at every institution (HCPC 2012). However, the HCPC does recommend and support interprofessional working and is looking to introduce a requirement for IPE in approved education and training programmes. Its role is currently being reviewed by a team from Keele University, led by Professor Steven Shardlow.

Several professions validated by the HCPC already have incorporated elements of IPE into at least some of their training courses (Barwell et al. 2013; Ruebling et al. 2014; Ruiz et al. 2013), including the arts therapies. However, IPE is not as evident in the music therapy literature, or indeed in the wider arts therapies' literature. This could be due to the relatively young age of the arts therapies compared to other healthcare professions.

At the time of writing, only one example of collaboration between music therapy trainees and students of another course was reported in the literature. A study by Ballantyne and Baker (2013) utilised a transdisciplinary model of collaboration, with students working together on placement to deliver a songwriting project with the same clients. The students reported the value of the experience in terms of the transferable skills obtained: developing an understanding of the roles of the other profession and developing interdisciplinary communication skills. While the collaboration format in this study is not representative of a common means of collaboration in practice, the results are encouraging nonetheless, suggesting that even if a collaborative training tool does not exactly model professional collaboration, benefits can still be reaped.

While no other specific discussions of IPE were found in the current music therapy literature, its existence in UK music therapy training is not necessarily negated. From the websites of the UK music therapy training courses, the precedence and format of interdisciplinary inputs seem varied. Some institutions offer shared modules between the arts therapy training courses (e.g. Anglia Ruskin University (2014); others mention occasional inputs from professionals of another arts therapy discipline (e.g. University of Roehampton (2014); but some do not mention it at all.

Despite this, my own experience at Queen Margaret University contained several cross-disciplinary inputs between the arts therapies: primarily teaching inputs from another arts therapy professional, or inputs delivered jointly to my cohort of students alongside a cohort from another training course. While I personally found these inputs valuable in increasing my knowledge of other arts therapies, I feel their value in providing practical preparation for collaboration in practice was minimal. Unlike the IPE methods described previously, these inputs did not provide opportunity for meaningful discourse with students of another profession, and bore little similarity to the cross-disciplinary liaisons I experienced during my clinical placements.

Several authors have voiced opinions that provide an argument for the development of IPE within music therapy. For example, Barrington (2008) observes that establishing understanding of the role and potential of music therapy to interdisciplinary collaborators has proven challenging. IPE could be a potential solution: the World Health Organisation (2010) guidelines identify a major aim of IPE as facilitating an understanding of the roles and responsibilities of both other professions and the student's own profession. Additionally, Twyford and Watson (2008b) question "how confident newly qualified therapists are in working with colleagues and in utilising the knowledge and expertise of other professionals" (p.11), and suggest how this "may be easier if the knowledge, values and skills required for collaboration are developed in initial professional training before attitudes and stereotypes become established" (p.19). Odell-Miller and Krueckeberg (2009) describe particular challenges of collaboration to inexperienced therapists as the need to convince other professionals of the role of music therapy, and to have the necessary interpersonal skills to build rapport with non-music therapy professionals. Finally, Castle Purvis (2010) identifies a need for increased awareness of music therapy among other health professions, and also a need for increased awareness of these other professions within music therapy, proposing IPE as a potential solution.

Noting these views alongside the contrast between the established concept of IPE in wider health professions and my own experience of interdisciplinary inputs during training, there could be scope for strategic development of structured interdisciplinary inputs to music therapy training to be more closely modelled on practice and with greater focus on promoting interaction between disciplines.

Considerations in implementing interdisciplinary training inputs

Upon introduction of IPE to a music therapy training context, two primary parameters should be considered: the professions collaborated with and the format of the input. Barr and Low (2013), in their guide for introducing IPE to new contexts, suggest "the best practicable mix of professional groups" (p. 7) be prioritised. As described previously, it seems the majority of currently documented interdisciplinary inputs within UK music therapy training involve other arts therapies. This could be due to closer similarities in course structure compared to other Allied Health courses. It seems prudent that these existing collaborations be developed rather than attempting to establish a new collaboration within training. Of the seven accredited music therapy training courses in the UK, six are either run by institutions also offering training in another arts therapy, or are at least in the same city as another arts therapy training course (ADMP UK 2013; BAAT 2013; BADth 2011; BAMT 2013); thus for the majority of trainees, it would not be geographically impossible to develop IPE inputs with other arts therapy students. Additionally, as collaborative working seems similarly valued throughout the arts therapies (Twyford & Watson 2008b), establishing such inputs could extend mutual benefits to the students of these other arts therapies.

A possible counter-argument for further collaborations between the arts therapies during training could be concern in maintaining distinctions between the disciplines. Relevant here is Karkou's (2012) description of how early attempts to unite the arts therapies raised concerns that "the depth of knowledge and understanding of the art form would be jeopardized, and consequently clinical practice would become superficial and thus questionable" (p. 7). Bearing this in mind, perhaps the introduction of other therapeutic art forms during training could be detrimental. This concern is not unique to arts therapies; the HCPC (2012) general training guidelines recommend that inclusion of IPE inputs must not negate acquisition of profession-specific skills. However, Landy (1995), speaking from a dramatherapy perspective, suggests a balance must be struck: while borders between professions must be maintained, working in complete isolation would also be detrimental. Perhaps the borders in a training context should be ensuring prominence of profession-specific inputs, and that arts therapy collaborations are introduced in the later stages of training, once an initial understanding of the profession has developed.

Regarding the selection of a practical and beneficial IPE format for arts therapies training collaborations, while inspiration can be taken from IPE methods utilised in other disciplines, each context requires individual consideration to determine an appropriate method (Barr & Low 2013). As described previously, an element of successful IPE is that the training tool be modelled on how collaboration might occur in practice to facilitate meaningful discourse between professions. Barr and Low (2013: 8) suggest a preferred format as "interactive learning in small groups dealing in differences". Bearing these

factors in mind, the current study proposes interdisciplinary peer review sessions as a potential strategy to introduce more active collaboration between different arts therapies training courses. This suggestion is modelled on aspects of two major methods of collaboration in practice identified previously – interdisciplinary supervision and multidisciplinary team working. A common feature of these collaborations is discussion of a case of clinical work undertaken by one or more of the professionals involved, albeit with differing foci.

In contrast to hearing a lecture, peer review sessions may provide opportunity for active, interpersonal discussion of clinical work undertaken by the trainees, thus providing potential for the development of practical collaborative skills. Peer groups are considered effective for encouraging active involvement in IPE training inputs: for example, Barwell et al. (2013) describe the benefits of interprofessional peer groups from a student viewpoint, describing how "as the student team had lacked the normal hierarchy, they were able to question, share knowledge and learn together without professional and defensive boundaries" (p. 15). Ruiz et al. (2013), although speaking about student-driven rather than true peer groups, suggest that student-led formats for IPE should be encouraged over facilitated IPE, as this format encourages more active responsibility from students for their learning.

The focus of the proposed peer input is suggested as the review of clinical work, to facilitate the reflectiveness and client-centred nature of the interdisciplinary input. Although true peer supervision is not possible in this context due to the non-qualified status of the students, it could be that peer review of clinical work could hold similar learning potential to that identified in the literature as occurring during peer supervision (Austin & Dvorkin 2001). It should be noted that when interdisciplinary supervision has been modelled as an IPE input in other healthcare contexts, it has been emphasised that profession-specific supervision remains necessary during training (Chipchase et al. 2012). It is not suggested that these interdisciplinary review sessions replace normal supervision, but that they may be a potentially valuable addition.

As a final justification for the peer review model, several studies have reported the success of similar IPE inputs in other contexts (Brandt et al., 1991; Lindqvist et al. 2005; Phelan et al. 2006). Perhaps most relevant is the comprehensive review by Thomasgard and Collins (2003) of an interdisciplinary peer supervision group within a family care profession context. This group differs from the model proposed in this study in that it was held in a continuing professional development context, and also on a much longer-term basis. Regardless, the group's aim remains relevant: to improve communication between the professions. Several benefits of this peer supervision model for IPE purposes are described, such as strengthening clinical skills as a result of the presence of multiple perspectives within the case-based discussions, and also development of professional support between group members. The peer model is acknowledged as facilitating these benefits. Barriers to the group are also described, particularly regarding discipline-specific language and the value placed on particular pieces of information. Regardless, the authors recommend this model as an effective method of interprofessional development.

SUMMARY OF METHODS

This study was granted ethical approval by the Queen Margaret University Research Ethics board prior to data collection. Since the study aimed to describe lived experiences, a qualitative, phenomenological approach was utilised.

As the proposed interdisciplinary training format of peer review sessions does not seem to have previously occurred in a music therapy training context, it would not have been appropriate to use common qualitative data collection methods, such as interviewing or focus groups. Instead, the proposed input style was modelled to explore the potential of this experience. Despite the potential ethical dilemma inherent in my dual role as both researcher and student, the dual role also provided an advantage: permitting full immersion in modelling the process of interdisciplinary peer review, thus providing a rich representation of this experience as a music therapy trainee. As the peer review format differed from any other inputs delivered on my training course, it seemed necessary to carry out the same format of peer review sessions with a music therapy peer as well as a student on another arts therapy course. This experience of peer review within my own profession could then act as a control against which to compare the experience of interdisciplinary peer review, and thus discern what the process of interdisciplinary collaboration had added to my experience.

To carry out these interdisciplinary and intradisciplinary peer review sessions, it was necessary to carry out a concurrent course of clinical music therapy to share with the peer

reviewers. Sharing current clinical work rather than clinical work previously completed by the researcher provided opportunities for the collaboration to influence my thinking about the work, and also more closely modelled the way in which aspects of current clinical work might be shared in both multidisciplinary teamwork and cross-discipline supervision in practice.

A course of six sessions was carried out with a 6-year old boy with autism in a primary school for children with additional support needs in Edinburgh, Scotland. These sessions were video recorded, with consent to share acquired from the client's parent. A music therapy (MT) student and a dance movement psychotherapy (DMP) student were recruited as peer reviewers for the study, both via an email advert to the Level 2 student cohorts of these subjects. Four review sessions were held with each peer reviewer separately during this time frame, after sessions 1 2, 4 and 6. In each peer review session, three clips selected from the most recent music therapy sessions were shared. In the final review session, a short discussion reviewing the experience of peer review was included. Each review session lasted 30 minutes and was audio recorded. Each review session was transcribed and a thematic coding analysis (Creswell, 1994) carried out on the transcriptions. Alongside this process, I kept a researcher's diary to log my reflections on the process of participating in the review sessions.

RESULTS

Summary of codes and themes

The thematic analysis revealed seven emergent themes from the peer review sessions. Figure 1 summarises the precedence of each of these themes with each student across the course of review sessions. To further discuss these results, it is important to compare the spread of the individual codes within each theme with each peer reviewer.

Comparison of themes with each peer reviewer

The therapeutic relationship

> "How, so how do you feel when you're in there? Like, in relationship to him?" (DMP student, review session 3)

The therapeutic relationship was a prominent theme with both peer reviewers throughout. As displayed in Figure 2, the spread across the codes within this theme differed substantially for the two peer reviewers. This difference could be due to the different training experiences of the two students, resulting in different perspectives when reviewing the clinical work.

Music and sound

> "…I was just thinking first about the tempo. . . 'cause that's not as slow as it has been, or as fast as it had been…" (MT student, review session 4)

It is perhaps not surprising that the theme of "music and sound" was more prominent overall in the review sessions with the music therapy student than the dance movement psychotherapy student. Figure 3 summarises the occurrences of each code within this theme for each peer reviewer. While the music therapy student frequently considered the music of both the therapist and client, the dance movement psychotherapy student's comments on musical aspects of the session were more prominently regarding the therapist's music. This often consisted of confirming her understanding of the therapist's musical approach by describing the music in non-musical therapeutic terms such as matching or mismatching, as if to translate the music into more familiar terminology. Perhaps the dance movement psychotherapy student felt less able to comment on the significance of the client's music, given that this was not a familiar modality to her.

The therapeutic frame

> "What's his reasons, for being referred to yourself?" (DMP student, review session 1)

The theme of the therapeutic frame was slightly less prominent overall in the peer review sessions with the dance movement psychotherapy student compared to the music therapy student. Figure 4 shows the precedence of each code within this theme with each student. The music therapy student was particularly focussed on aspects of the therapy room set-up, whereas the dance movement psychotherapy student considered the setting itself in more detail. As with the theme of the therapeutic relationship, these differing foci are likely due to the different training experiences promoting certain aspects of the therapeutic frame with each peer reviewer.

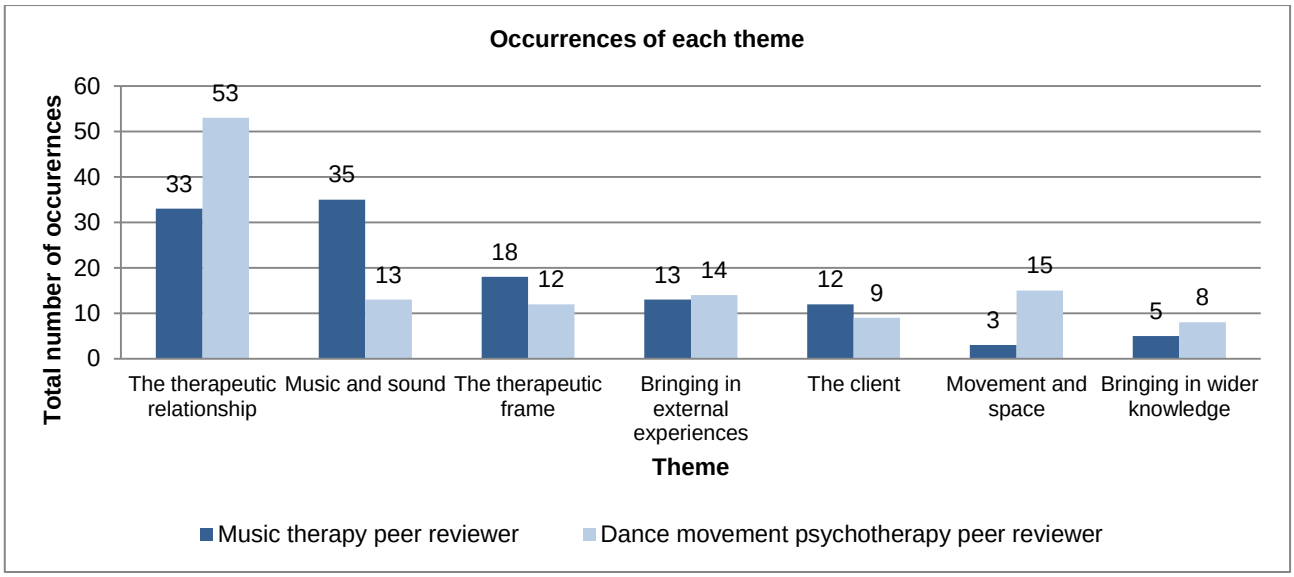

Figure 1: Precedence of each theme with each student peer reviewer

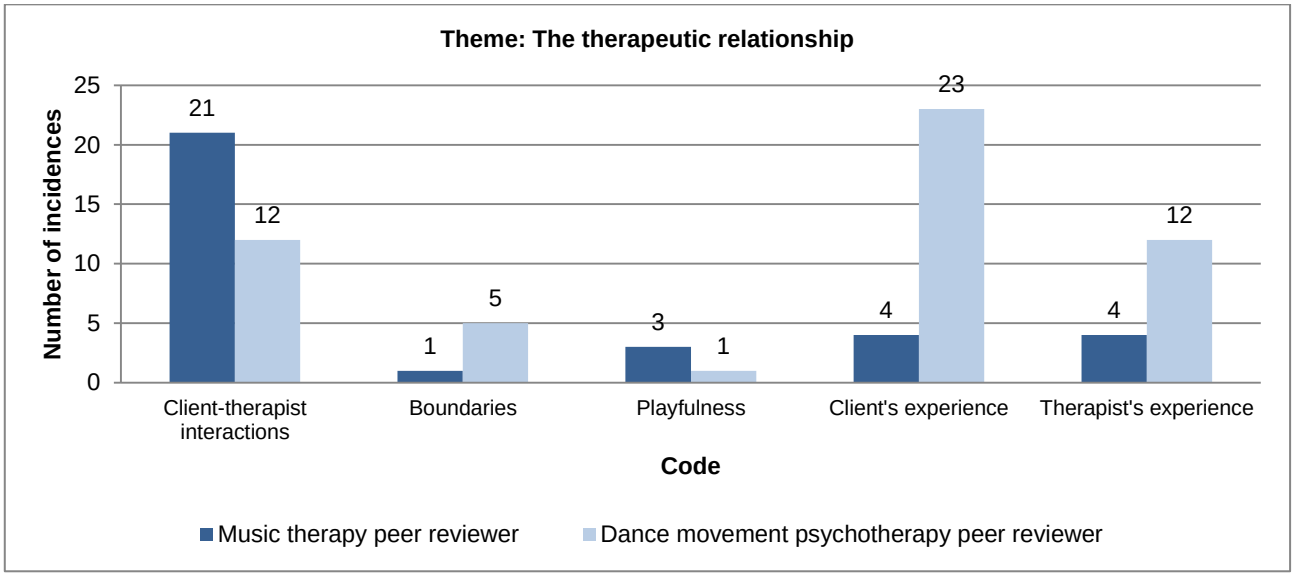

Figure 2: Occurrences of each code within the theme 'the therapeutic relationship' with each peer reviewer

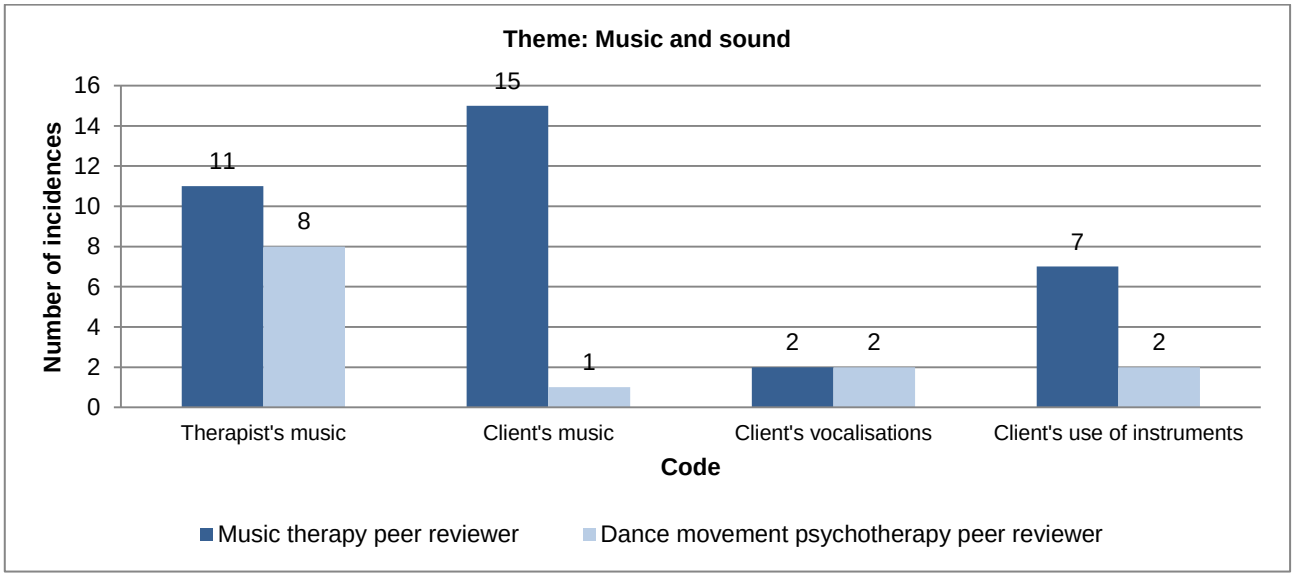

Figure 3: Occurrences of each code within the theme 'music and sound' with each peer reviewer

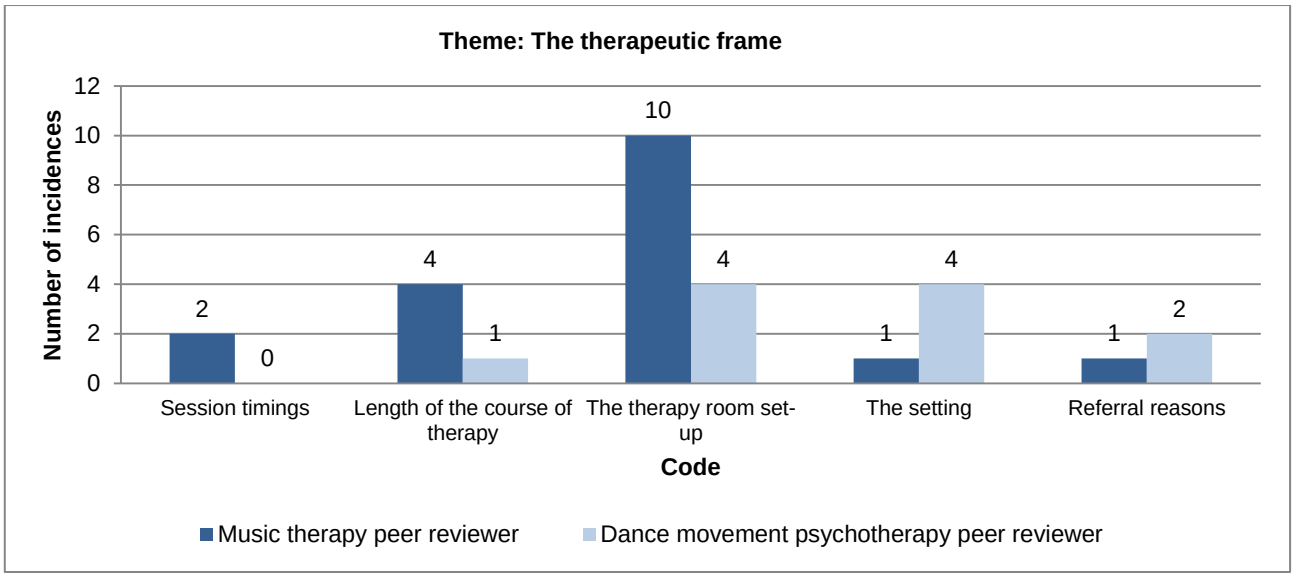

Figure 4: Occurrences of each code within the theme 'the therapeutic frame' with each peer reviewer

Bringing in external experiences

> "…when I first started shadowing a music therapist, years and years ago, and she was in this room with all of these toys, and she would just put sheets over them…" (MT student, review session 1)

Figure 5 summarises the occurrences of each code within the theme of "bringing in external experiences". The codes within this theme were similarly prominent with both students, with the exception of the code "experience as an arts therapy student". The foci of the discussions within this code were also contrasting with the two students. The two instances of this code with the music therapy student emerged from relevance of the clinical work to an aspect of our shared training experience. With the dance movement psychotherapy student, this code emerged upon comparison of the similarities and differences between our training experiences.

The client

> "Oh, 'cause he seems very calm, in comparison to other weeks" (Music therapy student, review session 3)

Figure 6 summarises the prominence of the codes within the theme of the client. The comments from both students were similar within this theme. The dance movement psychotherapy student referred slightly less frequently to the client's general presentation, with more prominent focus on the inner experience of the client, as indicated previously under the theme of the therapeutic relationship in Figure 2. Again, this could be due to general differences in perspective between the two students.

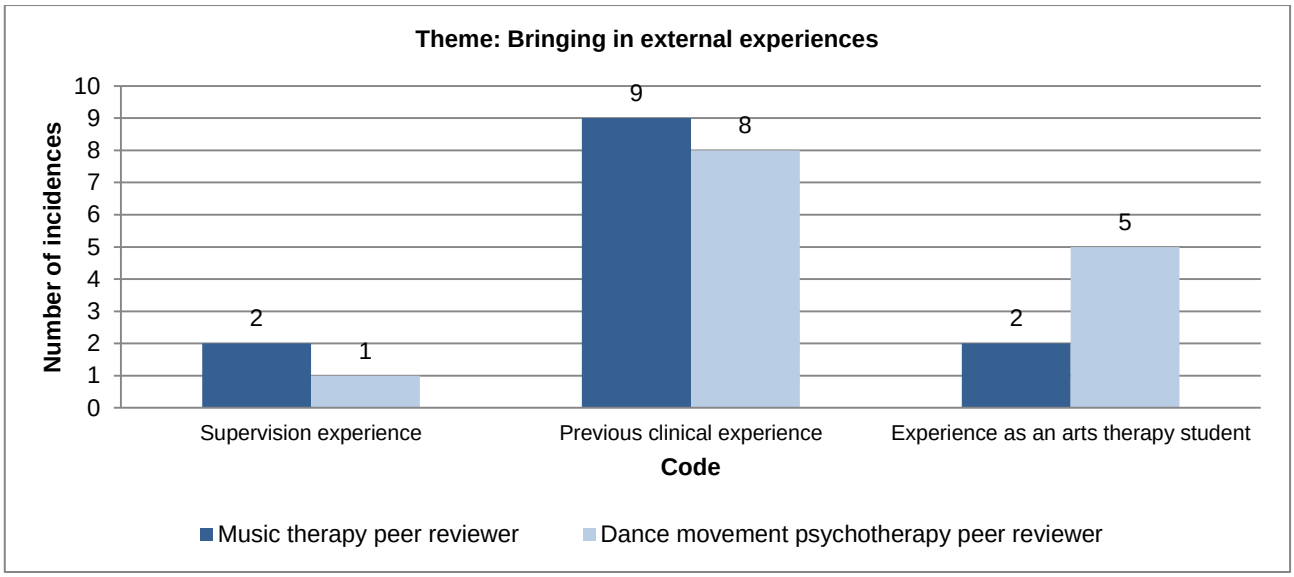

Figure 5: Occurrences of each code within the theme 'bringing in external experiences' with each peer reviewer

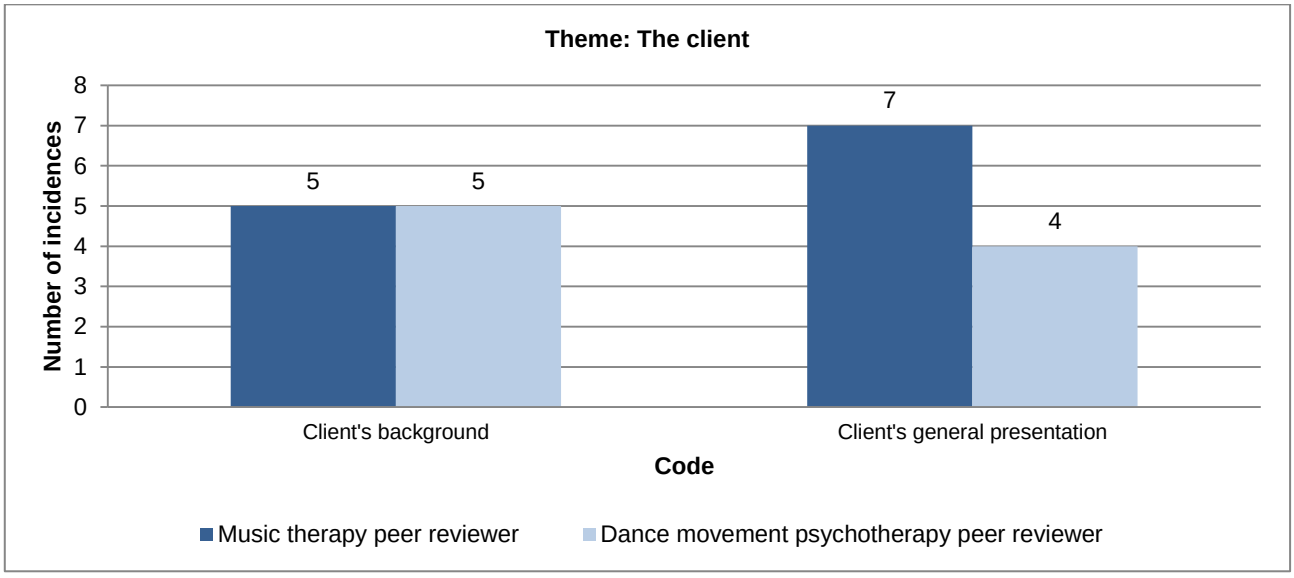

Figure 6: Occurrences of each code within the theme 'the client' with each peer reviewer

Movement and space

> "He's taking control, ownership of the space really quickly, marking his territory" (DMP student, review session 2)

Perhaps unsurprisingly, the theme of movement and space was significantly more prominent during the dance movement psychotherapy student's review sessions. Figure 7 summarises the precedence of each code under this theme with each peer reviewer. The dance movement psychotherapy student discussed the client's movements, use of the space, and the potential communicative meanings behind these features in more depth than the music therapy student.

Bringing in wider knowledge

> "…so is that something that you would do, y'know a Hello song, is that quite common that you would do that for children more so then, than adults?" (DMP student, review session 1)

Figure 8 summarises the occurrences of each code within the theme of bringing in wider knowledge with each peer reviewer. Interestingly, the spread of individual codes is polarised between the reviewers, with the consideration of general music therapy and dance movement psychotherapy concepts limited to the dance movement psychotherapy peer review sessions, and discussion of autism in general limited to the music

therapy peer review sessions. The prominence of the code of autism with the music therapy student is likely due to this student's past experiences working with this client. On several occasions with the dance movement psychotherapy student, the discussion considered the explanation of a general concept from either of the two professions, e.g. clarifying the purpose of using a Hello song in music therapy, or discussing the range of movement of a dance movement psychotherapist within a session.

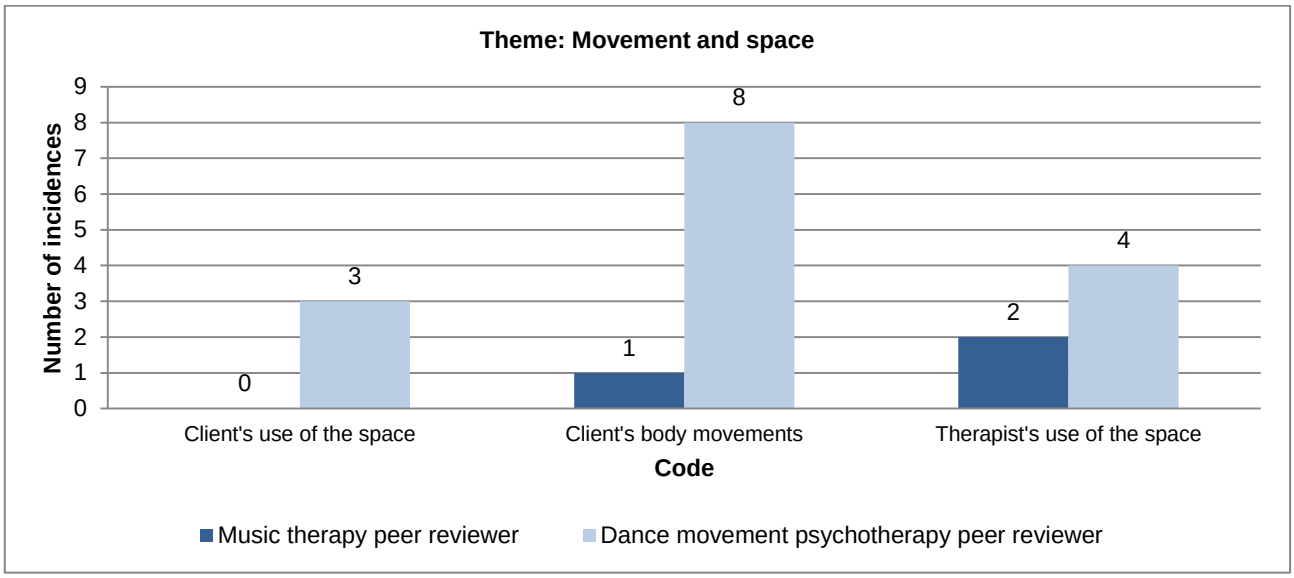

Figure 7: Occurrences of each code within the theme 'movement and space' with each peer reviewer

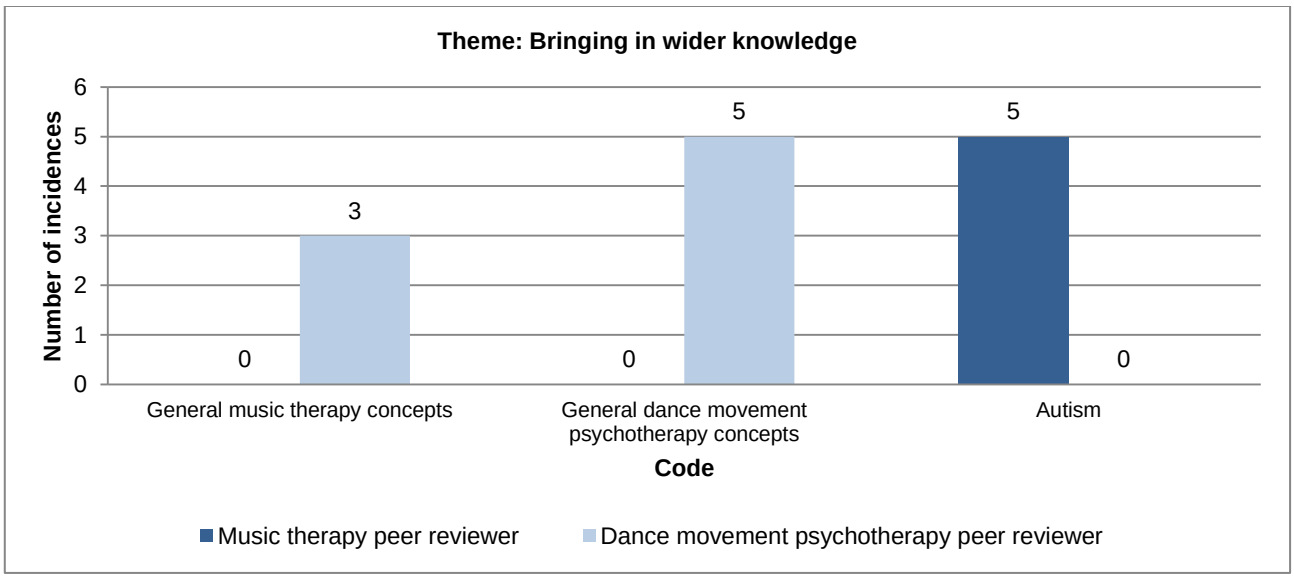

Figure 8: Occurrences of each code within the theme 'bringing in wider knowledge' with each peer reviewer

Themes from reflections on the experience of peer review

Reflections on intradisciplinary peer review

From the discussion with the music therapy peer reviewer, the major theme arising was the difference between intradisciplinary peer review sessions compared to group supervision as part of the training course. We discussed how there was little input to our course carried out in a peer format without a facilitator. The student stated that she felt freer to say her reflections of the clinical work in the peer review format than in group supervision, without the pressure of a facilitator's presence.

The music therapy peer reviewer also expressed on several occasions throughout the sessions her enjoyment and interest in the work. In our discussion, we jointly noted the value of an additional opportunity to share and discuss clinical work during our training experience.

Reflections on interdisciplinary peer review

The two major themes arising from the final discussion with the dance movement psychotherapy student were developing effective cross-discipline communication, and drawing parallels between music therapy and dance movement psychotherapy. The student expressed how she felt her communication skills had developed through having to express ideas from a dance movement psychotherapy perspective to someone outside the profession.

Our discussion of the parallels between music therapy and dance movement psychotherapy covered many features. She spoke of her difficulty at times as a non-musician in understanding musical features of the work, but spoke of the common features she identified which aided her understanding. Rhythm and the use of the voice were identified as common modalities within both therapies.

Like the music therapy student, the dance movement psychotherapy student also expressed on several occasions her interest in and enjoyment of the peer review sessions, and her appreciation of the opportunity to see the clinical work. She also valued the opportunity to learn more about another arts therapy discipline, and noted she perceived her understanding of music therapy to have increased as a result of the review sessions. I also noted my reciprocation of this aspect of the experience, reflecting on my own increased understanding of dance movement psychotherapy.

Reflections from the researcher

Informed by the researcher's diary, my reflections on the experience of interdisciplinary compared to intradisciplinary peer review identified four additional themes.

The roles of the peer reviewers and the clinical supervisor

Following each clinical supervision session, I noted the importance of receiving supervision from a qualified music therapist. The supervisor offered specific suggestions for undertaking an interactive approach which significantly influenced the direction of the work. The peer review sessions did not replace supervision, but neither were they superfluous; I reported feeling that I gained new insight and perspectives each time the work was reviewed.

Awareness of movement

A prominent theme in my reflections was my increasing awareness of my own movements throughout the course of therapy. I noted following sessions how I had been conscious of my positioning in the therapy room, and also how I found myself giving more thought to reflecting on the movements of myself and the client upon reviewing the session recordings regardless of the presence of the dance movement psychotherapy student.

Clarification of communication

In my researcher's diary, I echoed the opinions of the dance movement psychotherapy student in how the process of sharing work with someone outside my discipline had encouraged me to consolidate my reasoning and ability to explain my decisions within the sessions to a greater extent than my past experiences of sharing clinical work, which had been limited to within the music therapy profession. I also noted the novel experiences of explaining general music therapy concepts within the interdisciplinary review sessions. While I had expected to note differences between the content of the interdisciplinary and intradisciplinary peer review sessions, I had not anticipated the emergence of these reciprocal learning opportunities in the interdisciplinary peer review sessions.

Peer support

I noted in my researcher's diary the comfort I found in my discussions with the dance movement psychotherapy student regarding parallels between our training experiences. I also noted how this opportunity for discourse with the dance movement psychotherapy student facilitated opportunities for further collaborations and also social meetings between the two wider student cohorts, which may not otherwise have occurred.

DISCUSSION

Key findings

The content comparison of the inter- and intra-disciplinary review sessions showed that while the interdisciplinary peer review sessions were less focussed on musical aspects of the clinical work, an opportunity for additional discourse was provided, regarding the similarities and differences between not only our respective professions but also our respective experiences as students of those professions. The key themes emerging from the experience of participation in interdisciplinary peer review sessions were that the peer review sessions were provision of an engaging, enjoyable experience, promoting the clarification of interprofessional communication skills, an experience of cross-discipline peer support, and exposure to wider perspectives.

Limitations

Prior to relating these findings to existing literature, the limitations of the peer review session model must be acknowledged. Several aspects of the study may have affected the content or experience of the peer review sessions. Firstly, while objectivity was striven for during data analysis, the subjectivity of this particular experience of interdisciplinary peer review to the students involved must be noted. The dance movement psychotherapy student expressed an existing interest in the voice within dance movement psychotherapy, and my own interest in arts therapies collaboration must also be recognised. Perhaps these innate interests resulted in an amplification of our engagement in the interdisciplinary peer review sessions. However, the extent of this influence on the results cannot be established without repeating the study with different students.

This experience of interdisciplinary peer review may also be subjective towards the particular training courses involved. At the time of this study, the music therapy course at Queen Margaret University followed a music-centred Nordoff Robbins approach, and thus would possibly hold fewer crossovers with other arts therapy courses. Perhaps a more psychodynamically-oriented music therapy course would find greater similarities with other arts therapy courses. To explore this, repetition of the study at another institution would be necessary.

The inclusion of intradisciplinary peer review sessions for comparison was a useful aspect of the study design. However, this resulted in the sharing of the clinical work in three individual settings – with each peer reviewer and also in clinical supervision. If the interdisciplinary peer review model were applied to training courses, the comparative review sessions would not exist, and so it is important to acknowledge that this additional opportunity to reflect on the clinical work may have emphasised aspects of my experience of the peer review sessions.

A final aspect of the study design which may have affected the content and experience of the peer review sessions is the effects of the multiple roles held by the participants. I held three roles in this project - therapist, researcher and student – of which I was often concurrently aware. Likewise, the peer reviewers were also aware of their role as research participants during the review sessions; both students commented on the clarity of their speech in the recordings, aware that I would later be transcribing the sessions. This awareness of our multiple roles may have affected both the content and experience of the peer review sessions; however, this is not easily predicted.

Implications of the results

Effectiveness of interdisciplinary peer review as an IPE input

Despite the study limitations, the experience of interdisciplinary peer review features some themes of successful collaboration. As described in the literature review, benefits of music therapy collaboration may occur at three levels – for the profession, the client and the therapist. Despite difficulties in measuring these benefits for the profession and the client in particular, relevant outcomes have still emerged. The dance movement psychotherapy student reported increased knowledge and understanding of the music therapy profession. Perhaps if this type of IPE input were introduced on a larger scale, this benefit to the profession of promoting increased

understanding of music therapy within other professions would be augmented. Furthermore, having reflected on this piece of clinical work more widely as a result of the collaboration, my understanding of my client improved, potentially resulting in an improved therapeutic experience. This reflects Durham's (2002) description of how sharing insights between professions can facilitate greater understanding of our clients. However, the most prominent benefits of this collaboration seem to be for the individual therapist. My experiences of peer support, widening awareness of another expressive modality and the opportunity for discourse with another profession reflect many of the benefits of collaboration described in the arts therapy literature (Best 2000; Karkou 2012; Twyford & Watson 2008b).

Despite these benefits of the collaboration itself, there are restrictions in determining how effective the peer review sessions were as an IPE input. This can be highlighted by referral to the definition of IPE provided by WHO: "when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (World Health Organisation 2010: 7). While the results suggest that the dance movement psychotherapy student and I learnt "about, from and with each other", it is beyond the scope of this study to establish whether our ability to effectively collaborate in practice was indeed enabled and client outcomes thus improved. However, as noted in the literature review, this aspect of IPE is inherently difficult to measure; there seems to be an existing assumption in the healthcare literature that if students fulfil the first part of this definition – learning "about, from and with each other" - then collaboration in practice will be enabled, at least to some extent. Therefore, a similar assumption can be applied to these results; this interdisciplinary input may have a positive incidental effect on our ability to participate in teamwork in future clinical practice.

One feature of successful IPE described in the literature is increased understanding of the identity of both the student's profession and other disciplines as a result of the input (Bridges et al. 2011). Bearing this in mind, it seems notable that discussion of the general principles of both music therapy and dance movement psychotherapy emerged only in the interdisciplinary peer review sessions and not the intradisciplinary peer review session. Therefore, by this measure at least, the interdisciplinary peer review method seems to have been an effective means of IPE.

Another feature of successful IPE described in the literature is the aim of IPE inputs to deal "in differences" between the professions involved (Barr & Low 2013: 8). Discussion of the similarities and differences between the disciplines and our experiences as trainees of those professions emerged within the interdisciplinary peer review sessions. This further suggests suitability of the peer review model as an opportunity for stimulating meaningful discourse between trainees.

Barriers to interdisciplinary peer review as an IPE format

While interdisciplinary peer review does seem to be an effective means of IPE, several barriers must be recognised. The most notable barrier during this IPE input was timetabling the interdisciplinary peer review sessions, although this was overcome by advance scheduling of the peer review sessions. The review by Abu-Rish et al. (2012) identifies timetabling as a prominent barrier to IPE inputs, so this was not unexpected. Due to the small scale of the project, many of the other barriers identified by Abu-Rish et al. were not experienced, such as funding, administrative support and preparation time. If interdisciplinary peer review sessions were established on a larger scale, these barriers may present a greater issue.

Thomasgard and Collins (2003), in their study reviewing an interdisciplinary peer supervision group identify a significant barrier in the differences in communication between the professions, particularly in terms of the information valued by each profession and the language used. A similar experience occurred in this study, from both my own perspective and that of the dance movement psychotherapy student. In our final discussion the dance movement psychotherapy student noted her lack of understanding of some of the musical terminology used in description of the clinical work; furthermore, the content analysis of the peer review sessions revealed that the dance movement psychotherapy and music therapy students each prioritised different aspects of the work. Pavlicevic (1999) notes how the challenge of asynchronous discourse is necessary for the development of meaning within music therapy. This suggests that this particular barrier may not necessarily be disadvantageous, instead promoting reflection on the assumptions of one's own discipline.

Implications for music therapy training courses

While these results hold useful information regarding the experience of interdisciplinary peer review, certain parameters were necessarily placed on the IPE framework due to the restrictions of the research project. It is thus important to consider how the experience of interdisciplinary peer review could translate to a training context without these constraints. Firstly, this study takes a UK focus, due to my perspective as a student on a UK training course at the time of data collection. While the potential learning opportunity in interdisciplinary peer review explored in this study may be applicable in other countries, each country's training context will differ, particularly in terms of the level of the qualification, the length of the training, and the similarity in structure of other training courses in that country. As such, careful adaptation of the results must be considered if applied to a non-UK context.

The peer review sessions were held within the six-week data collection period of the study; however if applied in practice, the input length could vary. For example, the literature acknowledges the value of isolated interdisciplinary inputs (Abu-Rish et al. 2012; Miller et al. 2013). Indeed, following the first interdisciplinary peer review session, I noted in my researcher's log that I perceived the experience as valuable. Furthermore, it may be that single inputs are preferable from a practical point of view. However, I would suggest a course of peer review sessions as in this study be prioritised; it was only as the sessions continued that the rapport between the dance movement psychotherapy student and I developed, which strengthened our ability to communicate with one another and also the theme of peer support.

The restriction to two arts therapy professions within the collaboration in this study seemed effective. It would be interesting to repeat the study with a student of another arts therapy discipline as the interdisciplinary peer reviewer and compare the results. While the aspects of the peer review sessions pertaining to the therapeutic use of movement are likely specific to collaboration with a dance movement psychotherapist, it would be interesting to note if the other emerging themes were consistent with another arts therapy discipline. This would be valuable information, as collaboration between music therapy and dance movement psychotherapy may not be possible at every institution. Furthermore, collaboration with other healthcare training courses could be trialled and compared in the same way. It is recommended, however, that each IPE input explored in future studies focus on collaboration with only one other profession; the simultaneous collaboration of three or more professions during training seems likely to feature additional timetabling issues and have implications on the dynamics between the student peers.

If interdisciplinary peer review sessions were integrated into training curricula, it would be necessary for students of both professions involved to share their clinical work, instead of only one as in this study. Perhaps a practical suggestion for implementing aspects of the interdisciplinary peer review could be in monthly peer review meetings of small groups, where each student could present aspects of their clinical work for discussion. This would be in addition to more regular subject-specific supervision; both the literature (Chipchase et al. 2012) and my experience of the different roles of the peer reviewers compared to the supervisor within this study emphasise the importance of this. Ensuring the prominence of this subject-specific supervision in comparison to the IPE input would also meet the HCPC criteria (2012): inclusion of an IPE input must not restrict subject-specific learning. However, further study would be required before this suggestion could be implemented, particularly considering the effects of moving from a peer dyad to a peer group dynamic.

CONCLUSION

The key findings of this study were that a number of differences in both the content and the experience of participation were evident in comparison of the course of interdisciplinary and intradisciplinary peer review sessions. The interdisciplinary peer review input in particular was experienced as a beneficial addition to the training experience in a number of ways, including developing peer support, widening perspectives and understanding of other professions and providing an opportunity to develop cross-discipline communication skills.

This study suggests scope for developing IPE inputs within music therapy training contexts. The study results provide a framework upon which further development of such inputs could be based. Several possible variations to the interdisciplinary peer review sessions have been suggested in the discussion. However, a more action-orientated recommendation for future research could be to adapt the structure of Ballantyne and Baker's (2013) study. A course of interdisciplinary peer review sessions could be implemented with several student peer groups, and the students' experiences

explored via interviewing. In this format, the researcher would not partake in the peer review sessions, allowing for more objective representation of the student experience. Furthermore, the larger scale of such a study would more accurately reflect the realisation of such an experience if implemented into a training curriculum.

Further discussion and study of IPE is necessary to reveal its full potential in music therapy programmes. Programmes are continually reviewed and updated. For example, following an extensive review leading to programme revalidation, to which this study contributed, students on the MSc Music Therapy programme at Queen Margaret University now share two modules with students on the MSc Art Psychotherapy programme. Such integration of collaborative working and learning from other colleagues throughout a programme is useful and hugely important, as this study has shown.

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

Article

The combined arts therapies team: Sharing practice development in the National Health Service in England

Simon Hackett

ABSTRACT

The complex nature of many arts therapies interventions indicates a richness in practice development and the number of potential applications in the clinical, social and cultural sectors. There is greater opportunity to consider the overlap of shared models, skills, techniques and approaches in the arts therapies, and in a combined arts therapies team in the National Health Service (NHS) some early examples of interdisciplinary practice sharing have emerged. A number of practice-based examples are used to illustrate the work of a combined arts therapies team in the NHS in England. Combined practice developments are described, including shared therapeutic levels, shared observations, shared techniques and shared therapeutic work. It is hoped that these areas of shared development within a clinical context will lead to practice developments that support improved outcomes for clients.

KEYWORDS

arts therapies, practice development, practice sharing, intellectual disability, complex intervention

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ARTS THERAPIES AS COMPLEX INTERVENTIONS

Arts therapies are concerned with engaging people in creative processes and exploring the meaning of personal experience that bring about helpful psychotherapeutic changes for individuals or group members (Hackett 2012a). In January 2015 there were 3,574 arts therapists (art, music, drama) registered with the UK Health and Care Professions Council (HCPC) and 324 dance movement therapists registered with the Association for Dance Movement Psychotherapy UK (ADMPUK). Arts therapies are described by the National Institute for Health and Care Excellence (NICE) as "[…] complex interventions that combine psychotherapeutic techniques with activities aimed at promoting creative expression" (NICE 2014: 217). Arts therapies emphasise expression, communication, social connection and self-awareness through supportive and interactive experiences (NICE 2014).

Complex interventions are defined by the Medical Research Council (Craig et al. 2008) as interventions that have,

- several interacting components;
- practical and methodological difficulties for successful evaluation;

- difficulty standardising the design and delivery of the interventions;
- sensitivity to features of the local context;
- organisational and logistical difficulty of applying experimental methods to service or policy change;
- length and complexity of the causal chains linking intervention with outcome.

The complex nature of many arts therapies interventions indicates a richness in practice development and the number of potential applications in the clinical, social and cultural sectors. There is greater opportunity to consider the overlap of shared models, skills, techniques, and approaches in the arts therapies and in a combined arts therapies team in the National Health Service (NHS) some early examples of interdisciplinary practice development have emerged.

COMBINED ARTS THERAPIES TEAM

The combined arts therapies team is based in the North East of England within Northumberland, Tyne and Wear NHS Foundation Trust. Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totalling 2,200 square miles. The Trust has over 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland and provides a number of regional and national specialist services. Within the Trust arts therapies are based within psychological services. The combined arts therapies team model is one that includes all arts therapy modalities: art, music, drama, and dance movement psychotherapy. The team consists of four and a half full-time equivalent posts which are split between two full-time and five part-time staff. The team is made up of a Head Arts Therapist, an Arts Therapist Principal, four Arts Therapists (Art, Music, Drama, Dance Movement) and an Arts Therapies Assistant. Within this structure there are a number of benefits to the service delivery that are supported by shared practice and practice development. The combined arts therapies team allows for each therapy modality to be supported to deliver and develop their own practice for the benefit of clients but also encourages practice sharing that can strengthen and enrich each approach. Mechanisms for sharing and developing practice include monthly team meetings that incorporate clinical case discussion and occasional 'away days' for detailed practice sharing. Combined therapy programmes or projects, for example art and drama therapy group work or music and dance movement therapy group work, have been developed by the team. The team works primarily in hospital wards that provide assessment, treatment and rehabilitation services to adults and young people with intellectual disabilities and/or mental health difficulties or risky and challenging behaviour. The specialist service provision includes work with young people with complex needs or psychotic illness; adults with autistic spectrum disorder and challenging behaviour (Wadsworth & Hackett 2014); adult offenders with intellectual and developmental disabilities (Hackett 2012a); and adults with intellectual disabilities and mental health difficulties that include community pilot projects for people who are at risk of a hospital admission (Hackett & Critchley 2012) or following their discharge from hospital (Hackett & Bourne 2014).

In this paper I will draw from a number of practice-based examples that illustrate the combined arts therapies team work towards (1) shared therapeutic levels, (2) shared observations, (3) shared techniques, and (4) shared therapeutic work. It is hoped that these areas of shared development within a clinical context will lead to practice developments that support improved outcomes for clients.

ARTS THERAPIES SHARED PRACTICE

There are overlapping areas in all arts therapies that give a clear rationale for therapeutic work with a wide range of people with social and communication difficulties including those with psychosis and intellectual and/or developmental disabilities (Karkou & Sanderson 2006). Arts therapists working with these client groups can support (1) engagement in a therapy that has non-verbal capacity, (2) encourage communication and self-expression, and (3) help relational and/or social connection. There has been longstanding recognition of the role that creative arts can have in clinical and health settings "[…] the creative arts are uniquely suited to the task of preserving and maximising the sense of self in patients with mental disorders, mainly because they are non-verbal modalities which encourage self-expression and socialisation" (Johnson 1992 cited in Staricoff 2004: 26). Arts therapies have been identified as a helpful approach for people with intellectual disabilities

who may also have communication problems (Royal College of Psychiatrists 2004). There are wide ranging examples of how arts therapies can engage people at a non-verbal level and support engagement. Music therapy is well established in work with children with autistic spectrum disorder and there is evidence for specific benefits to communication (Gold & Wigram 2006). Music therapy research for adults with autistic spectrum disorder is an emerging area with clinical benefits being indicated in case studies and small trials (Kaplan & Steele 2005). Arts therapies have great relevance for individuals with autistic spectrum disorder due to the accessibility of the non-verbal medium. Music therapy also provides opportunities for relationship building and the sharing and expression of feelings and emotions (Watson 2007). Practice-based research in music therapy featuring a child with Rett Syndrome has also shown positive outcomes for functional skills such as turn-taking and holding an object (Hackett, Morison & Pullen 2013).

Dance movement therapy is a therapeutic intervention which combines verbal and non-verbal methods in its application (Payne 2006). Dance movement psychotherapy is described as "the psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration" (ADMP UK 2015). Improvisational movement and dance is used with the emphasis being placed on deeper expressiveness and self-exploration (Koch et al. 2015). A single-case study of dance movement therapy with an adult with autistic spectrum disorder gives an account of early practice-based observations (Wadsworth & Hackett 2014). Observational studies of this kind offer the potential to make progress towards developing specific research questions and lager scale studies.

Group drama activity has been seen to enable individuals with learning disabilities to express themselves with other group members and raise their current concerns. The use of drama activities has been observed to encourage cognitive, emotional and social skill development in groups (Price 1999). More specifically in groups of people with learning disabilities and mental health needs the use of psychodrama approaches has been seen to increase social competence (Tomasulo 2006). Drama and participatory arts are reported to provide enjoyment, active participation and self-development which may then contribute to personal benefits like confidence building, improved self-esteem, and skills development. Social benefits may include relationship building, conflict resolution and social inclusion (Stickley, Crosbie & Hui 2011). The Get Going Group (Hackett & Bourne 2014) has been developed within the combined arts therapies team. The Get Going Group runs once a week for 12 weeks with group members having the opportunity to continue as facilitators in subsequent groups. It takes place in a central (non-NHS) community venue that is accessible by public transport. The group is welcoming to paid support staff who often work with group members in the community and joint participation is encouraged. The two NHS facilitators are both inpatient therapy staff, a dramatherapist and a nurse psychological practitioner, who work alongside a service user with an interest in drama. The Get Going Group has incorporated 'mutual support' and 'peer support' within its approach and ethos. Mutual support is a model of peer support by and for people with learning disabilities with involvement of non-disabled people as allies. Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful (Keyes & Brandon 2012).

Art therapy studies have reported that people with learning disabilities increased pro-social behaviour during art psychotherapy sessions (Pounsett, Parker, Hawtin & Collins 2006). White, Bull and Beavis (2009) have also shown that a client became less reliant upon community learning disability team resources following art psychotherapy. Research conducted within Northumberland, Tyne, and Wear NHS Foundation Trust forensic services as part of a PhD programme has found art psychotherapy treatment effects in reducing self-rated anger and observed aggression in repeated single-case studies of offenders with intellectual and developmental disabilities (Hackett 2012a). Measures of process identified components of art psychotherapy that were influential upon participants' negative maladaptive schemas linked to repeated patterns of interpersonal conflict with others (Hackett 2012a; Hackett, Porter & Taylor 2013). Findings from these early studies showed that male participants found making drawings a useful and accessible means of processing various historic and interpersonal difficulties. Improvements in behavioural outcomes for aggression were measured by the Modified Overt Aggression Scale (Oliver et al. 2007).

Few published research papers evaluating combined arts therapies appear in the literature but one notable example describes dance/movement and music therapy with young adults diagnosed

with severe autism (Mateos-Moreno & Atencia-Dona 2013).

AUDIT OF COMBINED ARTS THERAPIES TEAM SERVICE DELIVERY

An audit of two years of combined arts therapies team activity from 2011 to 2013 showed that an annual average of 1030 direct therapy sessions were provided to patients (this figure does not include cancelled or unattended sessions). The delivery of therapy sessions is split between 50% group work, 46% individual therapy with 4% unattended. The percentage of unattended sessions reflects the complex nature of the services the arts therapies team work in, such as inpatient assessment and treatment units and nationally commissioned specialist services. Work with adults with intellectual disabilities and mental health problems amounts to 50% of the team's work with 30% provided to children and young people. The remaining 20% of provision is split equally between work with offenders with intellectual and developmental disabilities and work in a specialist hospital unit for people with autistic spectrum disorder and challenging behaviour. Equally important as direct therapeutic work with patients is close multidisciplinary team working and all members of the combined arts therapies team work within a full clinical team in their service area.

SHARED THERAPEUTIC LEVELS

By articulating therapeutic levels it is possible to deliver tailored interventions in a specific and targeted way that can be appropriate for different client groups and the aims of specialist health services. Examples of levels of therapy in arts therapies have been discussed by Wheeler (1987) and Chesner (1995) used the metaphor of the 'dramatherapy tree' to describe components of therapy that can be considered as therapeutic levels. Within the combined arts therapies team therapeutic levels have been developed in clinical practice so that they can be applied to single session interventions or to a full programme of group work with a targeted focus. This practice based approach to articulating therapeutic levels has primarily been developed with clients who have intellectual disabilities and/or autism but it has potential for wider application across client groups. The levels described below are flexible in that they consist of the basic building blocks of therapy and can be interchangeable. Whilst there is a 'person centred' bias in the components forming each level, the aims of this simple framework for practice-based arts therapies can be applied in a pan-theoretical and multimodal way.

Level 1: Building trust

Aim: To establish a positive working relationship.

Components: Be welcoming, provide basic information; give clarity about roles and responsibilities; actively support positive engagement; offer specific choices; identify and respond to individual needs; work collaboratively with the client; seek to reduce anxiety through giving direction and setting parameters such as a defined start and end or structuring the therapy session by providing source material/subject or theme or introducing an exercise or game for a group.

Level 2: Using and developing skills

Aim: Confidence building.

Components: Provide opportunities for skills to be used and encourage the development of skills; give constructive feedback in the session; skill development can be broad and client-focused and may encompass physical skills, social skills, or psychologically-based skills that reduce personal distress; appropriate to the client group some games and tasks for basic skills like turn-taking may be used to encourage interaction and communication.

Level 3: Engaging with creative work

Aim: To create and develop personal material.

Components: Be supportive; promote periods of self-directed work and/or use a collaborative approach; give praise and encouragement; support the use of imagination and how ideas can be flexible, changed, or adapted: support sensory work by offering opportunities to explore movement/ materials/instruments and asking questions about the 'here and now' and the clients' immediate experience.

Level 4: Self-development

Aim: To support positive change such as reduced distress/increased independence/improved ways of relating to others/developing resilience.

Components: Show empathy, provide opportunities to consider what can be learnt from

the creative work; support the client to make links or associations between their creative work and life or own experience; use a positive approach to explore how things can change/improve/be managed/be supported (Hackett 2012b).

It is important that all arts therapy modalities remain focused on building safe therapeutic relationships that support access to creative processes or art forms. One benefit of using the shared therapeutic levels within a team or service is in providing a common language regarding therapeutic work. The levels have also enabled some arts therapy interventions to be targeted at a specific level. For example, providing a 'drop-in' group for children and young people with acute psychotic illness in an inpatient setting which is focused primarily upon level 1 - 'building trust'. Other interventions may encompass all levels such as individual art psychotherapy which seeks to address negative interpersonal behaviours (Hackett 2012a). Identifying levels within therapy also allows for consideration to be given to the outcomes and observations that are expected as a result of the level of therapeutic work being carried out.

SHARED OBSERVATIONS

Due to the overlapping nature of therapeutic aims across many arts therapy modalities, devising and validating observational tools that allow practitioners to record the progression of their clients is an area for development. The 'Creative Arts Therapies Session-Rating-Scale' (CAT-SRS) is a therapist observational tool developed in clinical practice in the combined arts therapies team (see Appendix 1). It provides a range of descriptors for arts therapists to choose from based upon their observation of the client within each therapy session. The CAT-SRS is based upon goal attainment scales which have a long history of use in mental health services to assess a patient's individual goals and whether they have been achieved (Hart 1978; Kiresuk & Sherman 1968). As yet this tool has not been used in any formal research studies and requires further reliability testing. There is one published example of its use in an observational single-case study (Wadsworth & Hackett 2014). The CAT-SRS has been developed primarily for observation of work with children and adults with intellectual and developmental disabilities and provides observational descriptors within four areas, (a) '*Communication: Use of the person's primary method of communicating: i.e. verbal language, non-verbal signs/gestures and vocalisations'; (b) 'Social skills: Use of listening, turn-taking, eye contact, appropriate body language, tone of voice'; (c) 'Motivation/participation: Motivation to engage actively throughout the session'; (d) 'Linking: Ability to make links between personal experience and material that arises in therapy'.* For example, descriptors in the communication component are (1) responds to verbal and non-verbal communication initiated by the therapist only; (2) expresses basic wants and needs; (3) uses basic communicative function to gain and hold attention, to request items of information, to reject/protest, to express basic feelings; (4) uses advanced communicative function which include giving instructions, negotiating, speculation, describing own or others' feelings/ reactions/opinions; (5) uses higher level communication to develop ideas, plan, predict, reason, evaluate, explain, argue/debate. With further testing the CAT-SRS has potential to be broadly used in arts therapies evaluation and offers an unobtrusive means of recording therapy observations and monitoring areas of therapeutic development.

SHARED TECHNIQUES

Across all modalities in the arts therapies there are a wide range of techniques and approaches that are utilised routinely in clinical practice. Some of the approaches are driven by a particular theoretical model or modality and others can be generally applied to support engagement or for a specific therapeutic purpose. Within the combined arts therapies team we routinely hold practice sharing meetings where a therapist will present their clinical work to the team. This has led to a number of therapeutic approaches and techniques being adopted and included in the arts therapy 'toolbox' for all modalities in the team. One such example is a creative narrative approach called the 'six part story' (Lahad, Shacham & Ayalon 2013). The origin of the six-part story is rooted in work supporting positive coping strategies and resilience in people experiencing ongoing stress (Lahad, Shacham & Ayalon 2013). This structured approach requires the client to generate narratives about a situation where a character faces an obstacle and requires some help. Each story includes (1) a character, (2) a place or land, (3) a task, (4) an obstacle, (5) some help (to overcome the obstacle), and (6) an outcome or ending (Lahad, Shacham & Ayalon 2013). The six-part story method is very accessible to the majority of the clients the team works with and can be adapted

for groups and individual work. We have introduced the six-part story in therapeutic work across a range of client groups including people with autistic spectrum disorder (Wadsworth & Hackett 2014) and people with learning disabilities and mental health problems (Hackett & Bourne 2014). It has been successfully used in an adapted manner in clinical practice with children and young people and in work with adult offenders with intellectual and developmental disabilities. The six-part story approach can also be used alongside the therapeutic levels described earlier leading to work in levels 3 (engaging with creative work) and level 4 (self-development). Potentially, the therapist observations of the client can also be recorded and monitored using the CAT-SRS in areas like 'item 4 - linking' when the client makes 'links or associations between' their six-part story and 'their own experiences'.

There are many techniques and approaches that are specific to the different arts therapy modalities requiring a trained and competent clinical practitioner. Outside the scope of this practice there are also areas that can be adopted and adapted across the arts therapies with broad appeal to clients and potential for generalised therapeutic benefit. Such areas require further investigation. This could initially take place through practice-based sharing and evaluation that progresses towards well-designed clinical research. The 'causal chains linking intervention with outcome' (Craig et al. 2008) in arts therapies are a rich source of research and evaluation which have not as yet been fully explored.

SHARED THERAPEUTIC WORK

Shared therapeutic work is possible in a combined arts therapies team and we routinely offer programmes of group work that draw from collaborative approaches. This has included an art and dramatherapy group programme for patients admitted to an assessment and treatment unit for adults with intellectual disabilities and mental health problems. The 12-week programme explores six themes including, turn taking, trust and friendships, noticing and sharing feelings, personal space, communicating, and celebrating achievements. A combination of dramatherapy and art therapy approaches is used to introduce and explore the themes within each group. For example, art therapy techniques used to explore the theme of 'trust and friendship' include asking clients to draw a safe place and then talking about why it is safe, drawing a supportive person and talking about how they make the client feel good. The group members are then led to discuss 'the importance of placing themselves in a safe situation within different places and with different people'. The dramatherapy techniques used to help explore the theme of 'trust and friendship' include asking clients to walk around the room and nod and smile at different group members as they pass, then shaking hands and saying hello in different ways. This is followed by playing trust games and other games such as 'counting 1, 2, 3 and looking at a person; if their eyes meet, they swap seats with that person'. The games then lead on to sharing and discussion regarding a story about trust (Critchley & Bourne 2014).

CONCLUSION

Within this paper I have attempted to set out and illustrate some examples of shared practice development within a combined arts therapies team working in the NHS in England. The combined arts therapies team model is not unique but it is still rare within many areas of service delivery. This shared approach also retains the important and unique skills found in the training and competencies of the separate arts therapies. Without compromising the unique skills of each modality, finding some shared ground in practice such as shared therapeutic levels, shared observations, shared techniques, and shared therapeutic work is a positive interdisciplinary approach. It is my personal view that arts therapies have a great deal more to offer and demonstrate therapeutically within diverse clinical, social and cultural sectors. Whilst it has been important for the arts therapy professions to incorporate and adapt various therapeutic models and areas of evidence-based practice, there is further work that can be done to demonstrate the specific arts therapy techniques that are being utilised and developed in practice. Developing the evidence base around component parts of arts therapy approaches will offer further insights into the 'active ingredients' of our interventions. Ultimately this will enable interventions to be delivered in a more sophisticated and targeted way for the maximum benefit of our clients. Arts therapies have had diverse applications in the UK NHS and remain available on a limited basis. The value of arts therapies in supporting positive therapeutic gains for some client groups warrants further investigation and research. In many ways arts therapies research in clinical practice is an 'open field'. There is space for in-depth study of 'process' within all of the arts therapies that can

lead to rigorous investigation of the causal chains linking intervention with outcome. The areas of shared practice reported in this paper are still within early stages of development with greater potential for testing and validation. The combined arts therapies team can support arts therapy practitioners to deliver and develop their work whilst contributing towards important collaborative practice development.

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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'.

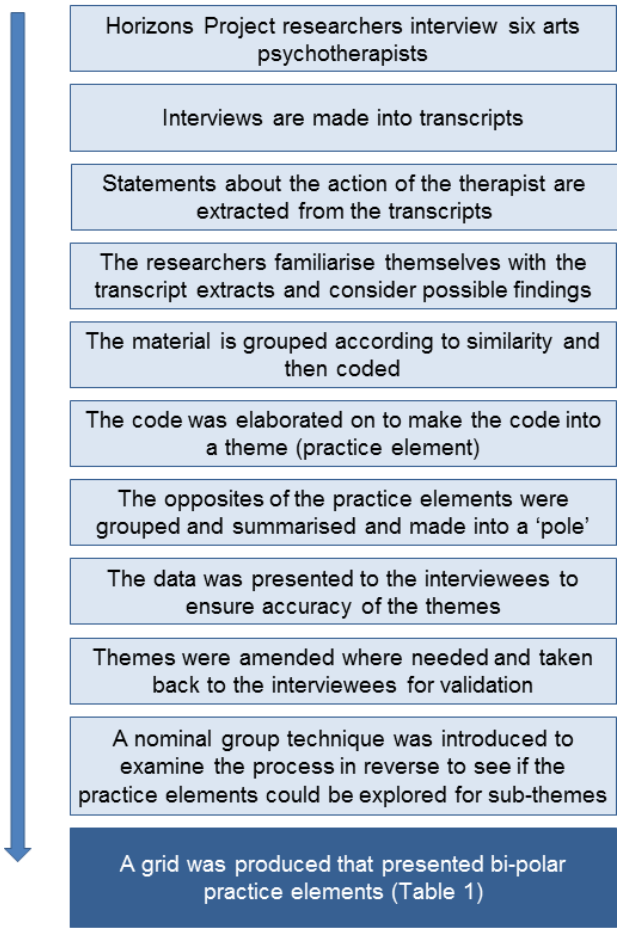

Figure 1: 'Examining practice elements' research design

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.

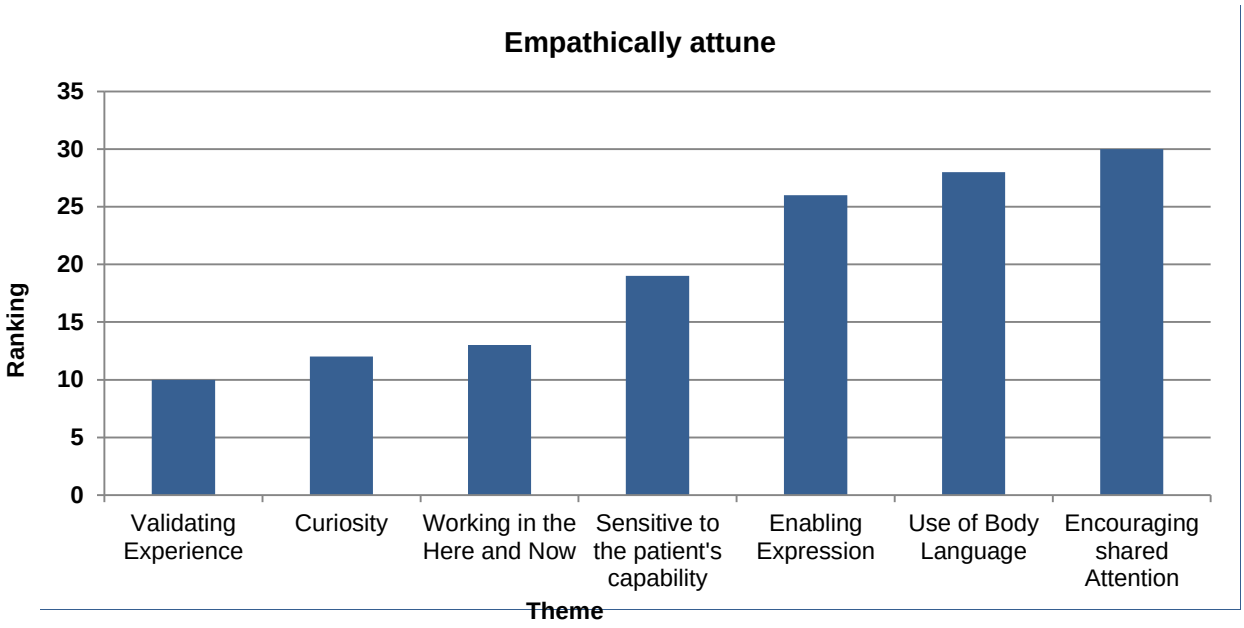

Figure 2: Nominal group technique results for ranking sub constructs relating to 'empathically attune'

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.

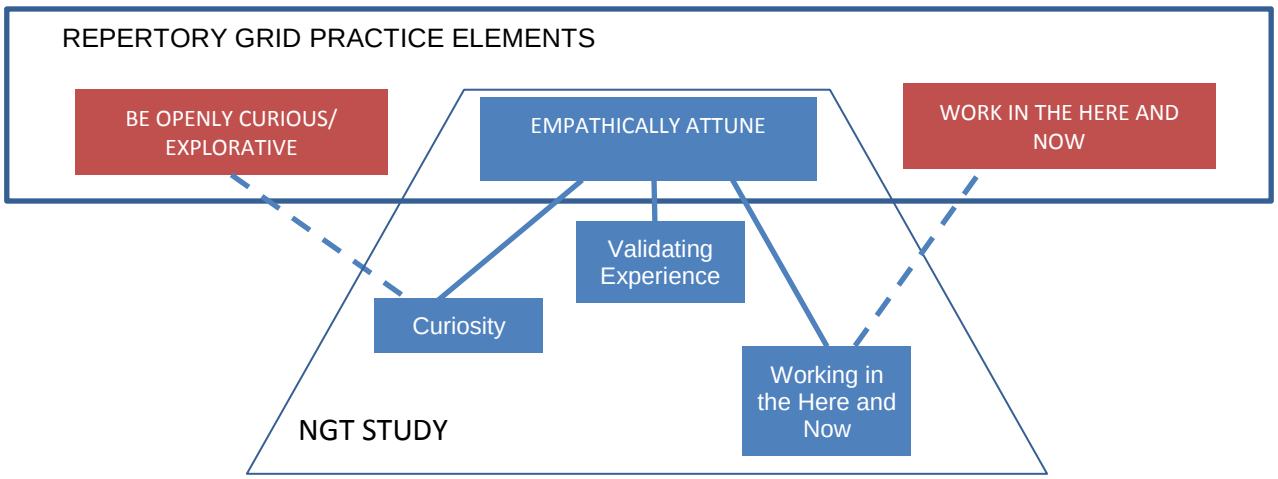

Figure 3: NGT conceptual mapping of 'empathically attune'

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).

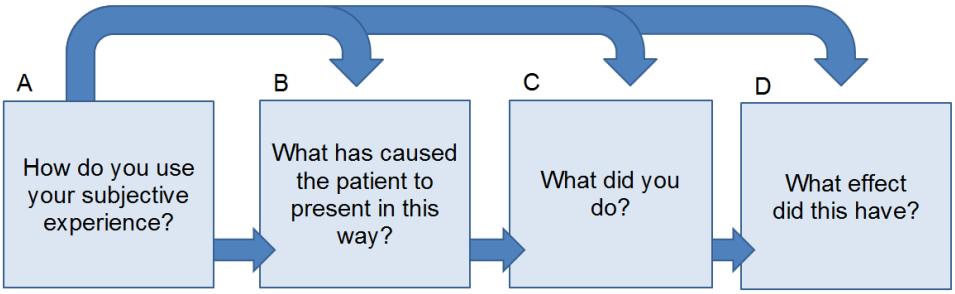

Figure 4: Framework for decision making

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).

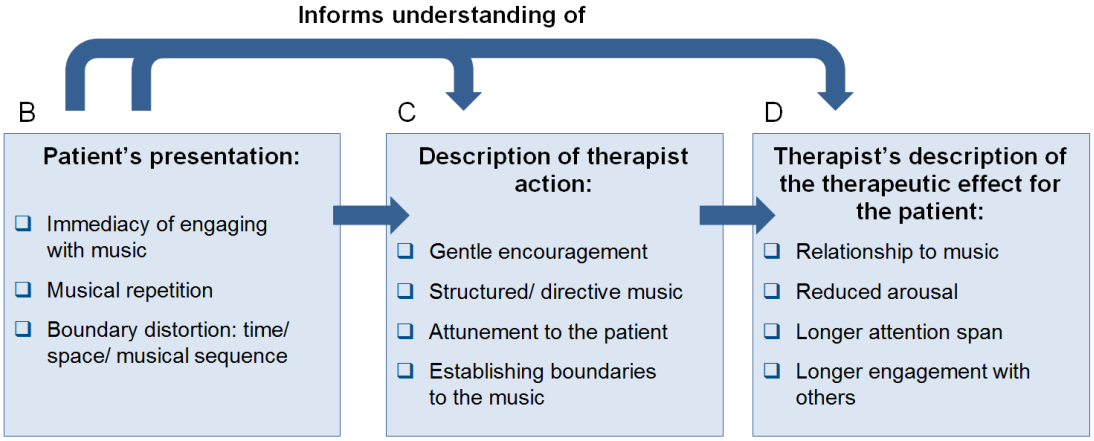

Figure 5: Thematic analysis of interview extract with a music therapist

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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ΕΙΔΙΚΟ ΤΕΥΧΟΣ
Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία: Διεπιστημονικοί διάλογοι

Άρθρο

Ένα μοντέλο συνεχιζόμενης εκπαίδευσης για τις θεραπείες μέσω τεχνών στην ογκολογία

Γεωργία Αρώνη

ΠΕΡΙΛΗΨΗ

Η παρούσα περιγραφή αναφέρεται στην εμπειρία του προγράμματος συνεχιζόμενης εκπαίδευσης «*Οι Θεραπείες μέσω Τεχνών στην Ογκολογία*», στο Πανεπιστήμιο Alanus Hochschule für Kunst und Gesellschaft στη Βόννη της Γερμανίας. Εστιάζει στην αλληλεπίδραση και στη συσχέτιση των πεδίων της Μουσικοθεραπείας, της Εικαστικής Θεραπείας και της Χοροθεραπείας όπως αυτά απαντώνται στο πρόγραμμα, με σκοπό να επιμορφωθούν οι θεραπευτές μέσω τέχνης ως προς τις βασικές αρχές της ογκολογίας καθώς και της ψυχο-ογκολογίας. Ειδικότερα αναφέρεται στο σχεδιασμό, στην οργάνωση και στο περιεχόμενο της συγκεκριμένης εκπαίδευσης.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ογκολογία, ψυχο-ογκολογία, καρκίνος, θεραπείες μέσω τέχνης, συνεχιζόμενη εκπαίδευση, Γερμανία

Η **Γεωργία Αρώνη** είναι κλινική χοροθεραπεύτρια BTD- GDTR Sr, με παράλληλες σπουδές στα Παιδαγωγικά και τον Ελληνικό Πολιτισμό. Είναι μέλος του Berufsverband der TanztherapeutInnen Deutschlands (BTD) καθώς και της Ένωσης Χοροθεραπευτών Ελλάδας (ΕΧΑ). Τα τελευταία χρόνια ζεί στη Γερμανία και εργάζεται σε κλινική αποκατάστασης στο τμήμα Ψυχοσωματικής και Ψυχοθεραπείας, με ασθενείς οι οποίοι παρουσιάζουν ένα ευρύ φάσμα διαταραχών. Έχει εργαστεί σε διάφορα κλινικά πλαίσια με χρόνιους ψυχικά ασθενείς, με χρήστες ουσιών και έχει σχεδιάσει και οργανώσει καινοτόμα εκπαιδευτικά προγράμματα για εφήβους και παιδιά. Εστιάζοντας στην αντιμετώπιση του ψυχικού και συναισθηματικού τραύματος μελετά, ασκεί και διδάσκει την πρακτική της Αυθεντικής Κίνησης. Παράλληλα συντονίζει σεμινάρια και εργαστήρια για επαγγελματίες ψυχικής υγείας καθώς και για το ευρύ κοινό.

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ΨΥΧΟ-ΟΓΚΟΛΟΓΙΑ

Η διάγνωση της νόσου του καρκίνου δημιουργεί στον ασθενή μια τεράστια ψυχική δυσφορία με τραυματικές συνέπειες όπου ενδοπροσωπικοί, διαπροσωπικοί και κοινωνικοοικονομικοί παράγοντες διαμορφώνουν την προσαρμογή σε αυτήν τη νόσο (Breitbart & Alici 2009). Η Ψυχο-Ογκολογία (psycho-oncology) είναι

> «ένα πεδίο το οποίο ασχολείται με την ψυχολογική απάντηση στον καρκίνο των ασθενών, των οικογενειών τους και των κλινικών γιατρών, καθώς επίσης και με τους ψυχολογικούς, συμπεριφορικούς και κοινωνικούς παράγοντες που επηρεάζουν τον κίνδυνο για καρκίνο, την ανίχνευση του καρκίνου και την επιβίωση από αυτόν» (Breitbart & Alici 2009: 21).

Εμφανίστηκε ως υποειδικότητα στο πλαίσιο της ογκολογίας περίπου το 1970 από τον Ελβετό γιατρό Fritz Meerwein καθώς και στα πλαίσια της ψυχιατρικής και της ψυχοσωματικής ιατρικής (Schwartz 2007).

Οι στόχοι της ψυχολογικά προσανατολισμένης αντικαρκινικής φροντίδας αφορούν: α) την υποστήριξη των ασθενών στην επεξεργασία και

διαχείριση της νόσου και της ψυχικής δυσφορίας που νιώθουν, β) τη βελτίωση της ποιότητας ζωής των ασθενών και των οικογενειών τους, και γ) την αναγνώριση και θεραπεία των ψυχιατρικών διαταραχών που επιπλέκουν την πορεία και τη θεραπεία της νόσου (Gruber & Weis 2009).

Με σκοπό την ανταπόκριση των ειδικών αναγκών αυτού του πληθυσμού, σχεδιάζονται εκπαιδευτικά προγράμματα, ώστε οι επαγγελματίες υγείας να είναι σε θέση να υποστηρίζουν την ψυχιατρική φροντίδα των ασθενών αλλά και των οικογενειών τους σε όλα τα στάδια της νόσου, συμπεριλαμβανομένης και της επιβίωσης από τον καρκίνο.

Μέσα στο πλαίσιο των θεραπευτικών παρεμβάσεων, οι Θεραπείες μέσω Τεχνών Künstlerishe Therapien) εφαρμόζονται στη Γερμανία και διευρύνονται συνεχώς σε κλινικές αποκατάστασης, εξωτερικά ιατρεία, ξενώνες, ογκολογικές κλινικές, αλλά και μονάδες παρηγορητικής φροντίδας. Οι έρευνες των τελευταίων ετών στον τομέα της Ογκολογίας αναδεικνύουν ενδιαφέροντα αποτελέσματα. Συγκεκριμένα στο πεδίο της χοροθεραπείας, πραγματοποιούνται και αξιολογούνται ερευνητικές εργασίες οι οποίες αφορούν τη βελτίωση της ποιότητας ζωής των ασθενών, την αύξηση της ζωτικότητας, τη μείωση της κατάθλιψης (Bradt, Goodill & Dileo 2011). Ταυτόχρονα στο πεδίο της μουσικοθεραπείας βρίσκουμε μελέτες οι οποίες αναδεικνύουν θετικά συμπεράσματα αναφορικά με την μείωση του πόνου, την αλλαγή της διάθεσης καθώς και τη μείωση του άγχους σε καρκινοπαθείς ασθενείς (Bradt, Dileo, Grocke and Magill 2011). Πολλες μελέτες αναδεικνύουν πως με την εφαρμογή της εικαστικής θεραπείας, παρατηρείται μείωση του πόνου καθώς και μια γενικότερη βελτίωση στην ψυχολογική και φυσική υγεία του ασθενούς (Monti et al. 2006· Nainis et al. 2002). Τα τρία συγκεκριμένα επιστημονικά πεδία αναφέρονται και αποτελούν μέρος των ψυχο-ογκολογικών μέτρων στις κατευθυντήριες οδηγίες της Γερμανικής Ογκολογικής Εταιρείας (DKG-Deutsche Krebsgesellschaft) στη θεραπεία του καρκίνου του μαστού (Kreienberg et al. 2008).

Μέσα από αυτό το πρίσμα, μπορούν να προσφέρουν ένα συμβολικό *δοχείο* (container) ώστε να υποστηρίζουν τον ασθενή κατά τη διάρκεια της νόσου και να του παρέχουν: α) τη δυνατότητα έκφρασης των συναισθημάτων του β) τη δημιουργία ενός σωματικού και συναισθηματικού στηρίγματος που αφορά την έννοια της ταυτότητας γ) την αναζήτηση και χρήση πηγών στήριξης κατά τη διαδικασία προσαρμογής της νόσου δ) τη μείωση ορισμένων συμπτωμάτων που συνοδεύουν την νόσο ε) τη βελτίωση του αισθήματος της αυτοεκτίμησης και στ) τη βελτίωση της ποιότητας ζωής του (Mannheim 2014).

Κατά συνέπεια, διαμέσου των Θεραπειών μέσω Τεχνών, οι ασθενείς αναπτύσσουν την ψυχική τους αντοχή ενεργοποιώντας τις κοινωνικές, σωματικές και ψυχικές τους πηγές, οι οποίες λόγω της νόσου είχαν στερέψει (Gruber & Weis 2009).

ΔΙΑΡΘΡΩΣΗ ΕΚΠΑΙΔΕΥΣΗΣ

Πρώτο τριήμερο

Το συγκεκριμένο πρόγραμμα πραγματοποιήθηκε στη Βόννη της Γερμανίας στο ιδιωτικό πανεπιστήμιο Alanus Hochschule für Kunst und Gesellschaft, το οποίο προσφέρει τμήματα σπουδών στις Καλές Τέχνες, στο Θέατρο, στην Εικαστική Θεραπεία, στα Παιδαγωγικά Waldorf και στην Ευρυθμία. Η επιμόρφωση απευθύνεται σε θεραπευτές μέσω τέχνης, ειδικότερα σε εκείνους που εφαρμόζουν τη Μουσικοθεραπεία, τη Χοροθεραπεία και την Εικαστική Θεραπεία. Σημαντική ωστόσο προϋπόθεση για τη συμμετοχή στο πρόγραμμα, αποτελεί η ολοκλήρωση ενός εκπαιδευτικού προγράμματος σε ένα από τα αντίστοιχα πεδία, το οποίο να είναι αναγνωρισμένο από την Ομοσπονδιακή Ενωση των Θεραπειών μέσω Τεχνών (Bundesarbeitsgemeinschaft Künstlerischer Therapien – BAGKT). Το πρόγραμμα πραγματοποιείται σε σύνολο 48 ωρών και είναι διαρθρωμένο σε δύο τριήμερα. Στο πρόγραμμα διδάσκουν: η Jutta Beckerle, ειδικευμένη γιατρός στον τομέα της ψυχοσωματικής ιατρικής και ψυχοθεραπείας, η Elana Mannheim, χοροθεραπεύτρια και ψυχο-ογκολόγος, ο μουσικοθεραπευτής Jens-Peter Rose και η εικαστική θεραπεύτρια Alexandra Hopf.

Το πρώτο τριήμερο έλαβε χώρα κατά τη χρονική περίοδο 7-9 Φεβρουαρίου 2014. Η ομάδα των συμμετεχόντων αποτελούνταν από τέσσερις χοροθεραπεύτριες, πέντε εικαστικούς θεραπευτές και τέσσερις μουσικοθεραπευτές Την πρώτη ημέρα της συνάντησης, η υπεύθυνη γιατρός εστίασε στις βασικές αρχές της ογκολογίας, όπως για παράδειγμα στους κύριους τύπους του καρκίνου, ενώ παράλληλα δόθηκαν στοιχεία σχετικά με τη διεθνή ταξινόμηση των ογκολογικών νοσημάτων (ICD,0-3). Ακολούθησαν παρουσιάσεις οι οποίες επικεντρώθηκαν σε θέματα ογκογένεσης, κληρονομικότητας, διατροφής καθώς και σε θέματα σχετικά με τις τεχνικές χειρουργικής, ακτινοθεραπείας,χημειοθεραπείας,μεταμοσχεύσεων μυελού κλπ.

Μετά από μια γεμάτη ημέρα πλούσια σε υλικό και πληροφορίες, η συνάντηση έκλεισε με ένα βίντεο με αποσπάσματα από μια τριήμερη συνάντηση γυναικών οι οποίες πάσχουν από καρκίνο και χρησιμοποιώντας τη χοροθεραπεία μοιράζονται με τις έφηβες κόρες τους τις σκέψεις και τα συναισθήματά τους. Κάποια από τα ενδιαφέροντα θέματα που μας απασχόλησαν αφορούσαν τον καρκίνο του μαστού και ιδιαίτερα τον γυναικολογικό καρκίνο, την αλλαγή της εικόνας σώματος και εαυτού, τα πιθανά αισθήματα απώλειας θηλυκότητας και σεξουαλικότητας καθώς και την αλλαγή στις διαπροσωπικές σχέσεις. Ακολούθησε μια σύντομη αναφορά στην εφαρμογή των Θεραπειών μέσω Τεχνών στα μέλη των οικογενειών των καρκινοπαθών ασθενών και στη γενικότερη ψυχοκοινωνική φροντίδα τους.

Τη δεύτερη ημέρα, η υπεύθυνη σχεδιασμού του προγράμματος Elana Mannheim πρωτοπόρος στη Γερμανία σχετικά με την οργάνωση, σχεδίαση και εφαρμογή προγραμμάτων χοροθεραπείας σε ογκολογικές κλινικές τα τελευταία 20 χρόνια, επικεντρώθηκε στις βασικές αρχές της ψυχο-ογκολογίας. Από τις μεταφορές και τους μύθους αναφορικά με την ετυμολογία της λέξης « καρκίνος» χαρακτηριστική ήταν η περιγραφή μιας ασθενούς, η οποία περιγράφει τον καρκίνο ως ένα ζώο που κυνηγά το θύμα του και το δαγκώνει κατατρώγοντάς το. Μετά απο την εισαγωγή πραγματοποιήθηκε η πρώτη συνάντηση μέσα απο την κίνηση με τους υπόλοιπους θεραπευτές και ακολούθησαν βιωματικές ασκήσεις

Στο σημείο αυτό αναδύθηκαν διάφορες ερωτήσεις: *Τι οδηγεί έναν θεραπευτή μέσω τέχνης σε αυτήν την επιμόρφωση; Ποια είναι τα πιθανά θέματα ζωής που επεξεργάζεται ο κάθε εκπαιδευόμενος και τα οποία συνδέονται με την εκπαίδευση; Πόσο έτοιμος είναι να δουλέψει με έναν τέτοιο πληθυσμό; Ποια είναι τα πιθανά αρχετυπικά θέματα που ζουν μέσα του και αντηχούν σε σχέση με τη νόσο του καρκίνου;*

Όπως αναφέρει η Goodill, ο θεραπευτής ο οποίος προσεγγίζει και ενσωματώνει στην κλινική του πρακτική, θέματα όπως αυτά της απώλειας, του θανάτου, του πένθους, του πόνου, της ασθένειας, οφείλει να ανιχνεύσει και να διεργαστεί τις δικές του συνδέσεις αναφορικά με τα συγκεκριμένα θέματα ζωής, τα οποία θα αποτελέσουν πηγές γνώσης και ενσυναίσθησης για τη θεραπευτική σχέση (Goodill 2005).

Στην απογευματινή συνάντηση κάποια από τα θέματα που αναπτύχθηκαν, αφορούσαν την εμφάνιση και αντιμετώπιση της ψυχιατρικής συννοσηρότητας σε καρκινοπαθείς ενήλικες ασθενείς όπως για παράδειγμα οι αγχώδεις διαταραχές (και ειδικότερα οι διαταραχές μετατραυματικού στρές), οι καταθλιπτικές διαταραχές, οι πιθανές απόπειρες αυτοκτονίας, η κατάχρηση ουσιών, οι νοητικές αλλαγές που συνδέονται με τη χημειοθεραπεία. Η μελέτη των ψυχοκοινωνικών, σωματικών, ψυχικών προβλημάτων που συνοδεύουν τη νόσο, αλλά και κάποια θέματα πνευματικότητας και θρησκείας που απασχολούν τους ασθενείς, ήταν το αντικείμενο των ομάδων εργασίας οι οποίες σχηματίστηκαν την επόμενη ημέρα.

Οι ομάδες εργασίας από θεραπευτές διαφορετικών προσεγγίσεων έδωσαν τη δυνατότητα αλληλοεπίδρασης γεφυρώνοντας διαφορετικά επιστημονικά πεδία. Οι ομάδες είχαν ως στόχο να εξερευνήσουν και να προτείνουν τρόπους παρέμβασης με ασθενείς σε ατομικό ή ομαδικό επίπεδο, αναφορικά με συγκεριμένα θέματα όπως για παράδειγμα η διαταραχή γενικευμένου άγχους. *Πώς προσεγγίζει το θέμα ένας μουσικοθεραπευτής σε μια ομάδα; Πώς παρεμβαίνει ένας εικαστικός θεραπευτής και τι υλικά προτείνει; Πώς υποστηρίζει ένας χοροθεραπευτής τον ασθενή που κατακλύζεται από το άγχος που αναπτύχθηκε μετά τη διάγνωση του καρκίνου;*

Μετά τη δημιουργική ανταλλαγή πληροφοριών των ομάδων εργασίας, ακολούθησε μια αναφορά σχετικά με τον τρόπο ταξινόμησης των θεραπευτικών παροχών στις Θεραπείες μέσω Τεχνών (Klassifikation Therapeutischer Leistungen – KTL) ειδικότερα σε χώρους ιατρικής αποκατάστασης και νοσοκομειακές κλινικές. Η συνάντηση έκλεισε με έναν γόνιμο διάλογο μεταξύ των θεραπευτών, δίνοντας έμφαση στην επιστημονική καταγραφή και αξιολόγηση των δεδομένων των Θεραπειών μέσω Τεχνών, τα οποία στη Γερμανία περιλαμβάνονται στον φάκελο του ασθενή.

Δεύτερο τριήμερο

Στη δεύτερη συνάντησή μας (7-9 Μαρτίου 2014), ο στόχος των ομάδων επικεντρώθηκε στην ανάπτυξη συγκεκριμένων παρεμβάσεων με καρκινοπαθείς ασθενείς στα πεδία της Χοροθεραπείας, της Μουσικοθεραπείας και της Εικαστικής Θεραπείας. Χωριστήκαμε σε ομάδες ανάλογα με το επιστημονικό μας πεδίο και η καθεμία εστίασε σε μελέτες περίπτωσης και βιωματικές ασκήσεις αναφορικά με τους πιθανούς τρόπους προσέγγισης των ασθενών σε κλινικά πλαίσια, όπως μονάδες παρηγορητικής φροντίδας, εξωτερικά ιατρεία, κλινικές αποκατάστασης κλπ.

Η ομάδα της Χοροθεραπείας για παράδειγμα ανέπτυξε τους στόχους της θεραπευτικής

προσέγγισης της συγκεκριμένης πληθυσμιακής ομάδας σε ατομικό και ομαδικό επίπεδο και μελέτησε βιωματικά ένα ήδη εφηρμοσμένο μοντέλο Χοροθεραπείας σύμφωνα με τις τελευταίες έρευνες στη Γερμανία (Mannheim, Helmes & Weis 2013). Μέρος αυτού του μοντέλου εκπαίδευσης αφορούσε την εποπτεία των θεραπευτών και τα πιθανά συμπτώματα εργασιακής εξουθένωσης (burn-out) που παρατηρούνται.

Ακολούθησαν διάφορες βιωματικές ασκήσεις και ασκήσεις διαλογισμού οι οποίες δύναται να χρησιμοποιηθούν με ασθενείς. Ωστόσο και εδώ αναδύθηκαν καινούριες ερωτήσεις: *Πόσο αληθινά παρών μπορεί να είναι ο θεραπευτής στη διαδικασία βάθους του ασθενή; Πόσο διαθέσιμο εσωτερικό χώρο έχει για να προσφέρει το συμβολικό γιατρικό*; *Είναι πρόθυμος να κρατά και να υποφέρει το υλικό της αντιμεταβίβασής του; Πόσο χώρο και ενέργεια του παίρνει ο θεραπευόμενος; Πώς μπορεί να ξεχωρίσει την ανάγκη του για παύση και ανάσα προκειμένου να στηρίξει τον ασθενή;*

Στο σημείο αυτό έγινε μια αναφορά στην αναγκαιότητητα της ατομικής και ομαδικής εποπτείας αλλά και της προσωπικής φροντίδας των θεραπευτών που εργάζονται με τον συγκεκριμένο πληθυσμό. Στόχος είναι η καλλιέργεια της ικανότητάς τους για αναστοχασμό της θεραπευτικής τους πρακτικής αλλά και η καλλιέργεια της αυθεντικότητάς τους, εμβαθύνοντας στη συνειδητότητα (mindfulness). Οπως αναφέρει η Rappaport (2014), η συνειδητότητα αποτελεί μια πρακτική η οποία εστιάζει την προσοχή μας στην παρούσα στιγμή μέσα από μια στάση αποδοχής και μη- κριτικής. Ο Franklin (2014) επισημαίνοντας τον ρόλο της συνειδητότητας στην εκπαίδευση των θεραπευτών μέσω Τεχνών αναφέρει χαρακτηριστικά:

> «Πριν σταθούμε απέναντι στους άλλους ως θεραπευτές, χρειάζεται να ανακαλύψουμε τον τρόπο με τον οποίο στεκόμαστε απέναντι στους εαυτούς μας, ειδικότερα όταν ο νούς μας είναι ανήσυχος και υπό πίεση. Πριν προσφέρουμε ένα άνευ όρων θετικό βλέμμα στους ασθενείς μας, είναι σημαντικό να είμαστε άνευ όρων ολοκληρωτικά εστιασμένοι εκεί» (Franklin 2014: 264).

Αργότερα, η κάθε ομάδα είχε τη δυνατότητα εξερεύνησης των άλλων πρακτικών μέσω ενός βιωματικού εργαστηρίου. Με αυτόν τον τρόπο η χοροθεραπευτική ομάδα βίωσε μια σύντομη συνεδρία δεκτικής μουσικοθεραπείας και πειραματίστηκε με υλικά στην εικαστική θεραπεία. Ακολούθως, και οι υπόλοιπες ομάδες πειραματίστηκαν με τις διαφορετικές θεραπευτικές προσεγγίσεις, και με αφορμή ένα θέμα παρουσιάστηκαν βιωματικές ασκήσεις προσαρμοσμένες στον συγκεκριμένο πληθυσμό. Οι θεραπευτές μπορούσαν να υποβάλλουν μια δική τους μελέτη περίπτωσης στην ψυχο-ογκολογία, αφού προηγουμένως δόθηκαν πληροφορίες σχετικά με τον τρόπο καταγραφής αυτής.Ακολούθησε μια παρουσίαση από τον υπεύθυνο μουσικοθεραπευτή Jens Peter Rose, η οποία εστίαζε στην εφαρμογή των Θεραπειών μέσω Τεχνών σε μονάδες παρηγορητικής φροντίδας καθώς και σε θέματα πνευματικότητας και θρησκείας που απασχολούν τον ασθενή.

Η συνάντηση έκλεισε με μια σύντομη αξιολόγηση του προγράμματος, με μια θετική ανατροφοδότηση και με έναν εποικοδομητικό, δημιουργικό διάλογο μεταξύ των θεραπευτών.

ΕΠΙΛΟΓΟΣ

Το συγκεκριμένο μοντέλο συνεχιζόμενης εκπαίδευσης που ακολουθήθηκε, είχε σχεδιαστεί αρχικά από την προαναφερόμενη Elana Mannheim με προσανατολισμό στην εφαρμογή της χοροθεραπείας σε καρκινοπαθείς. Στη συνέχεια προσαρμόστηκε στο πεδίο των Θεραπειών μέσω Τεχνών δίνοντας τη δυνατότητα στους θεραπευτές να αποκτήσουν βασικές γνώσεις στις αρχές της Ογκολογίας και της Ψυχο-Ογκολογίας σε συνδυασμό με τη βιωματική εμπειρία. Ενδιαφέρον θα παρουσίαζε μια μακρότερης διάρκειας εμβάθυνση στα τρία συγκεκριμένα επιστημονικά πεδία που αναφέρθηκαν, καθώς και μια αναφορά στην εφαρμογή των Θεραπειών μέσω Τεχνών σε άλλες πληθυσμιακές ομάδες, όπως για παράδειγμα στα παιδιά. Επίσης, το πρόγραμμα θα μπορούσε να εμπλουτισθεί ακόμη περισσότερο με τα νέα ερευνητικά δεδομένα στις Θεραπείες μέσω Τεχνών στην Ογκολογία.

Ανεξάρτητα από τη μελλοντική πορεία τού συγκεκριμένου προγράμματος συνεχιζόμενης εκπαίδευσης, επιχειρήθηκε μια νέα συνομιλία. Μέσα από την ετερότητα αλλά και τον διαφορετικό θεωρητικό πυρήνα των παραπάνω προσεγγίσεων, επιχειρήθηκε μια αλληλεπίδραση των Θεραπειών μέσω Τεχνών. Μέσα απο την συνεργασία και την συσχέτιση των επιστημονικών πεδίων, διατηρήθηκε ανοιχτή η δυνατότητα μιας νέας ζύμωσης, η οποία ανέδειξε νέα σχήματα εκπαίδευσης.

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ΕΙΔΙΚΟ ΤΕΥΧΟΣ
Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία: Διεπιστημονικοί διάλογοι

Άρθρο

Η ομάδα KATI: Βιώματα και αναστοχασμοί σχετικά με τη σύμπραξη των θεραπειών μέσω τεχνών

Φωτεινή Αθανασιάδου, Ντιάνα Καγιάφα, Βίκυ Κάρκου, Μυρτώ Λυκοπούλου, Τάσος Μπάμπαλης, Αγγελική Μπιτζαράκη, Κάνδια Μπουζιώτη, Εργίνα Σαμπαθιανάκη & Γιώργος Τσίρης

ΠΕΡΙΛΗΨΗ

Το παρόν άρθρο περιγράφει την πορεία της ομάδας KATI – μιας ομάδας Ελλήνων θεραπευτών μέσω τεχνών οι οποίοι εργάζονται στην Ελλάδα και το Ηνωμένο Βασίλειο. Πέρα από μια ιστορική καταγραφή του έργου της ομάδας από το 2011 μέχρι σήμερα, περιγράφονται προσωπικά βιώματα και αναστοχασμοί μελών της ομάδας, όπως αυτά αναδύθηκαν μέσα από μια διαδικασία καλλιτεχνικής αναζήτησης (artistic inquiry). Αντλώντας από το έργο και τα βιώματα της ομάδας KATI, οι συγγραφείς θέτουν ερωτήματα και προσφέρουν προτάσεις σχετικά με τη διεπιστημονική συνεργασία λαμβάνοντας υπόψιν το ευρύτερο πεδίο των θεραπειών μέσω τεχνών τόσο στην Ελλάδα όσο και στο εξωτερικό.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

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ΕΙΣΑΓΩΓΗ

Η μουσικοθεραπεία, η εικαστική θεραπεία, η δραματοθεραπεία και η χοροθεραπεία αποτελούν τις λεγόμενες «θεραπείες μέσω τεχνών»[1]. Η κάθε θεραπεία έχει τα δικά της χαρακτηριστικά τα οποία πηγάζουν πρωταρχικά από την ιδιαιτερότητα του εκάστοτε καλλιτεχνικού-θεραπευτικού μέσου: μουσική, εικαστική τέχνη, δράμα και χορός αντίστοιχα. Ως αποτέλεσμα έχουν εδραιωθεί σήμερα εξειδικευμένα προγράμματα σπουδών για την κάθε θεραπεία μέσω τέχνης, ενώ εντός της κάθε θεραπείας έχουν αναπτυχθεί διάφορες προσεγγίσεις. Αυτές οι προσεγγίσεις ποικίλουν ανάλογα με το θεωρητικό τους υπόβαθρο (π.χ. ψυχοδυναμική, ανθρωπιστική προσέγγιση κλπ.) ή/και το πρωταρχικό πεδίο εφαρμογής τους (Karkou & Sanderson 2006).

Παρόλες τις διαφοροποιήσεις βέβαια, παρατηρούνται πολλά κοινά στοιχεία μεταξύ των θεραπειών μέσω τεχνών τόσο σε επίπεδο ορισμένων γενικών αρχών όσο και σε επίπεδο πρακτικής εφαρμογής. Για παράδειγμα, η θεραπευτική αξία της συμμετοχής στην καλλιτεχνική πράξη φαίνεται να αποτελεί κοινή αρχή σε όλες τις θεραπείες μέσω τεχνών (Karkou & Sanderson 2006).

Με γνώμονα τις ομοιότητες και τη σύγκλιση, καθώς και την αλληλοσυμπληρωματικότητα μεταξύ των θεραπειών μέσω τεχνών έχουν πραγματοποιηθεί μέχρι σήμερα πολλές συνεργατικές πρωτοβουλίες μεταξύ αυτών σε διάφορα επίπεδα.

Παρόλο που σε ορισμένες χώρες οι θεραπείες μέσω τεχνών έχουν χαράξει διαφορετικές επαγγελματικές πορείες, η συνεργασία ανάμεσά

[1] Σε ορισμένες χώρες οι θεραπείες μέσω τεχνών συμπεριλαμβάνουν και άλλες θεραπείες όπως η παιγνιοθεραπεία (Κάρκου, Τσίρης & Καγιάφα, υπό δημοσίευση). Στο παρόν άρθρο ωστόσο εστιάζουμε μόνο στις τέσσερις πρώτες.

τους έχει παίξει καταλυτικό ρόλο σε κοινές επαγγελματικές διεκδικήσεις και συλλογικές δράσεις[2]. Βασιζόμενοι στην σύγκλιση των στόχων και των ευθυνών των επαγγελματικών τους ενώσεων, οι θεραπευτές μέσω τεχνών συχνά συνεργάζονται για συγκεκριμένα ζητήματα, όπως για τη διαπραγμάτευση συνθηκών εργασίας των μελών τους. Ένα ενδιαφέρον παράδειγμα από το Ηνωμένο Βασίλειο αποτελεί η διεκδίκηση και εν μέρει αναγνώριση των επαγγελματιών οι οποίοι εργάζονται στο Εθνικό Σύστημα Υγείας (National Health Service) αρχικά υπό την αιγίδα του κλάδου της εργοθεραπείας (DHSS 1982) που χάραξε την πορεία για τη μετέπειτα αναγνώριση των θεραπειών μέσω τεχνών ως ανεξάρτητος επαγγελματικός κλάδος υγείας. Η Waller (1992), πρωτοπόρος σε θεματα επαγγελματικής αναγνώρισης των θεραπειών μέσω τεχνών στη Βρετανία, υποστηρίζει ότι ο χώρος έχει αρκετές ομοιότητες για να διεκδικεί κοινά επαγγελματικά δικαιώματα.

Οριμένοι επαγγελματίες έχουν εστιάσει στη μελέτη και προώθηση του συνδυασμού των θεραπειών μέσω τεχνών γεγονός που οδήγησε σταδιακά στη δημιουργία του κινήματος των «εκφραστικών θεραπειών μέσω τεχνών» (expressive arts therapies) (Jones 1996· Malchiodi 2005; McNiff 1986). Όπως αναφέρουν και οι Κάρκου, Τσίρης και Καγιάφα (υπό δημοσίευση):

> «Μερικές από τις αρχικές προσπάθειες για συνεργασία μεταξύ των τεσσάρων θεραπειών μέσω τεχνών εξελίχθηκαν σε μια συνένωσή τους σε επαγγελματικό ή/και εκπαιδευτικό επίπεδο. Αυτή η συνένωση, η οποία αντηχεί με το κίνημα των εκφραστικών θεραπειών μέσω τεχνών (expressive arts therapies) που ξεκίνησε στις ΗΠΑ, δεν αποτελεί το επικρατόν πρότυπο σε πολλές ευρωπαϊκές χώρες.»

Αυτό και άλλα παρόμοια κινήματα έχουν οδηγήσει σε προσπάθειες συλλογικής δράσης. Ως αποτέλεσμα της προσπάθειας για επίτευξη μιας κοινής πλατφόρμας για την εκπαίδευση και επαγγελματική αναγνώριση στις θεραπείες μέσω τεχνών στην Ευρώπη, το 1991 ιδρύθηκε το European Consortium of Arts Therapies in Education (ECArTE). Το ECArTE καταμετρά σήμερα 32 εκπαιδευτικούς οργανισμούς-μέλη από 14 ευρωπαϊκές χώρες (μέχρι σήμερα, καμία ελληνική εκπαιδευτική πρωτοβουλία δεν πληρεί τα κριτήρια του ECArTE).

Σε εκπαιδευτικό επίπεδο, υπάρχουν ορισμένα προγράμματα σπουδών όπου οι φοιτητές διδάσκονται όλα τα διαφορετικά καλλιτεχνικά μέσα και τη συνδυαστική ενσωμάτωση αυτών στη θεραπευτική διαδικασία. Το Institute of the Arts in Therapy and Education στο Ηνωμένο Βασίλειο, για παράδειγμα, προσφέρει κοινή εκπαίδευση στις θεραπείες μέσω τεχνών: οι φοιτητές παρακολουθούν κοινές διδακτικές ενότητες σχετικά με όλες τις μορφές τέχνης και με την ολοκλήρωση των σπουδών τους λαμβάνουν τον τίτλο «Integrative Arts Psychotherapy». Παρόμοιο είναι το προγραμμα του Βελγίου (Artevelde University College), όπου οι θεραπείες μέσω τεχνών διδάσκονται σε προπτυχιακό επίπεδο (Bachelor in Arts Therapies). Σε άλλα μέρη της Ευρώπης, όπως για παράδειγμα στη Λετονία (Riga Stradins University), παρόλο που οι φοιτητές παρακολουθούν κοινές διδακτικές ενότητες σχετικά με όλες τις μορφές τέχνης, κατά την ολοκλήρωση των σπουδών τους αποφοιτούν με μεταπτυχιακό τίτλο σε μια από τις τέσσερις θεραπείες μέσω τεχνών (για λεπτομέρειες, βλ. Κάρκου, Τσίρης & Καγιάφα, υπό δημοσίευση).

Πέρα από τον συντονισμό δράσεων μεταξύ συλλογικών οργάνων/επαγγελματικών ενώσεων με σκοπό την επίτευξη κοινών επαγγελματικών δικαιωμάτων και την προώθηση των αντίστοιχων επαγγελματικών και επιστημονικών πεδίων, παρατηρούνται διάφορες άλλες συνεργατικές πρωτοβουλίες, όπως η διοργάνωση εκπαιδευτικών σεμιναρίων και εργαστηρίων για την προώθηση των θεραπειών μέσω τεχνών. Το International Centre for Arts Psychotherapies Training (ICAPT) του Ηνωμένου Βασιλείου αποτελεί ένα χαρακτηριστικό παράδειγμα συνεργασίας των θεραπειών μέσω τεχνών.

Παρόμοιες πρωτοβουλίες παρατηρούνται και στην Ελλάδα.[3] Οι αντίστοιχοι επαγγελματικοί σύλλογοι έχουν συνεργαστεί στο παρελθόν με σκοπό την προώθηση, την κρατική αναγνώριση και την ανάπτυξη των επαγγελμάτων όπως έγινε στη συνάντηση «Μαζί» (Αθήνα, Δεκέμβριος 2013). Άλλες πρωτοβουλίες συμπεριλαμβάνουν

[2] Για παραδείγματα διαφόρων χωρών, βλέπε τις αναφορές χωρών στο ειδικό τεύχος του Approaches σχετικά με τη μουσικοθεραπεία στην Ευρώπη (Ridder & Tsiris 2015).

[3] Σήμερα στην Ελλάδα υπάρχουν οι εξής επαγγελματικές ενώσεις για τις θεραπείες μέσω τεχνών: Έλληνες Εικαστικοί Θεραπευτές (ΕΕΘ), Σύλλογος Εικαστικών Θεραπευτών Ελλάδος (ΣΕΘΕ), Ελληνικός Σύλλογος Πτυχιούχων Επαγγελματιών Μουσικοθεραπευτών (ΕΣΠΕΜ), Ένωση Δραματοθεραπευτών και Παιγνιοθεραπευτών Ελλάδος (ΕΔΠΕ), Πανελλήνια Επαγγελματική Ένωση Δραματοθεραπευτών και Παιγνιοθεραπευτών (ΠΕΕΔΠ), και Ένωση Χοροθεραπευτών Ελλάδος (ΕΧΕ).

διοργανώσεις σεμιναρίων όπως το διεθνές φοιτητικό σεμινάριο «4ArTS» που πραγματοποιήθηκε στην Αθήνα το 2009, αλλά και τοπικών σεμιναρίων και εργαστηρίων.

Πέρα από τα παραπάνω παραδείγματα από το διεθνές και ελληνικό προσκήνιο, παρατηρούνται συνεργασίες σε τοπικό επίπεδο εντός κάθε χώρας. Τέτοιου τύπου συνεργασίες συμπεριλαμβάνουν περιπτώσεις όπου θεραπευτές μοιράζονται κοινούς εργασιακούς χώρους, συντονίζουν θεραπευτικές ομάδες από κοινού ή/και συμμετέχουν σε μεικτές ομάδες εποπτείας ή καλλιτεχνικού αυτοσχεδιασμού με στόχο την αυτο-ανάπτυξη (όπως η ομάδα Artsjam στο Λονδίνο).

Τα προαναφερόμενα παραδείγματα συνεργασιών μεταξύ των θεραπειών μέσω τεχνών θα μπορούσαν να οργανωθούν σε τρία επίπεδα: το μακρο-, το μεσο- και το μικρο-επίπεδο (Σχήμα 1).

Σχήμα 1: Επίπεδα συνεργασίας μεταξύ των θεραπειών μέσω τεχνών

Θεωρούμε αυτές τις συνεργασίες και πρωτοβουλίες – ανεξαρτήτως επιπέδου – ιδιαίτερης σημασίας για την περαιτέρω εξέλιξη των θεραπειών μέσω τεχνών σε επίπεδο επαγγελματικής και επιστημονικής εξέλιξης, αλλά και υποστήριξης των επαγγελματιών του χώρου και των πελατών τους.

Αντλώντας από την εμπειρία και το έργο μας στην ομάδα «KATI» (η οποία εντάσσεται στο μεσο-επίπεδο), το παρόν άρθρο αποσκοπεί σε μια συστηματική και αναστοχαστική καταγραφή της πορείας της ομάδας μέχρι σήμερα. Πέρα από τις δράσεις της ομάδας, περιγράφονται οι δυσκολίες αλλά και οι προοπτικές της ομάδας όπως αυτές αναδύθηκαν μέσα από μια διαδικασία καλλιτεχνικής αναζήτησης (artistic inquiry). Ελπίζουμε ότι μέσα από το παρόν άρθρο μπορούν να προκύψουν ιδέες και προτάσεις που ίσως φανούν χρήσιμες σε άλλες παρόμοιες πρωτοβουλίες στο χώρο.

Η ΟΜΑΔΑ «KATI»

Η ανάδυση, η πορεία και η σύνθεση της ομάδας

Η ομάδα KATI, αν και δεν έχει ιδρυθεί επισήμως, έχει αναδυθεί οργανικά μέσα από τις δημιουργικές δράσεις και συναντήσεις των μελών της. Η μη νομική, επίσημη ύπαρξή της έχει αφήσει περιθώρια δημιουργικής δράσης και πρωτότυπης σκέψης δίχως την ανάγκη να ακολουθείται μια διαδικασία θεσμοθετημένων και τυποποιημένων όρων συνεργασίας. Οι δράσεις της στηρίζονται στην πρωτοβουλία και αφοσίωση των μελών της – μαζί με τα πλεονεκτήματα, αλλά και τις προκλήσεις και τους πιθανούς περιορισμούς που φέρνει μια τέτοια συνεργασία.

Η ομάδα KATI αποτελεί μια δυναμική ομάδα η σύνθεση της οποίας αλλάζει ανάλογα με τις εκάστοτε ανάγκες, προτεραιότητες και συνθήκες. Μέχρι σήμερα έχουν συνεισφέρει στην ομάδα 17 θεραπευτές (Πίνακας 1). Έχοντας ποικίλα εκπαιδευτικά και επαγγελματικά υπόβαθρα σε Ηνωμένο Βασίλειο, Ελλάδα, Ισπανία και ΗΠΑ, τα μέλη της ομάδας μέχρι σήμερα έχουν συντελέσει στη δημιουργία ενός πολυσύνθετου συνόλου που εστερνίζεται διαφορετικές θεραπευτικές προσεγγίσεις και πρακτικές.

Όντας μια δημιουργική, δυναμική και πολυφωνική ομάδα, βασικό της χαρακτηριστικό είναι η διαρκής διαδικασία αυτο-προσδιορισμού της. Η ομάδα παραμένει ανοιχτή σε νέους συνεργάτες –ανεξαρτήτως θεωρητικής προσέγγισης– καθώς και σε νέες πρωτοβουλίες και δράσεις. Αυτή η ανοικτή στάση, ο εσκεμμένος μη-(καθ)ορισμός καθώς και η διάθεση για παιχνίδι της ομάδας αντανακλάται και στο όνομά της, το οποίο προέκυψε αυθόρμητα μέσα από τις συναντήσεις μας. Καθώς η ανάγκη για ονομασία της ομάδας γινόταν εντονότερη με τη συνέχιση και διεύρυνση της δράσης της, η έννοια του ότι είμαστε «κάτι» το οποίο είναι συγκεκριμένο, αλλά ταυτόχρονα και ασαφές, φάνηκε να αρμόζει στην ταυτότητα της ομάδας. Μια άλλη όψη της ονομασίας KATI ήταν η αγγλική της ερμηνεία ως CATI (Creative Arts Therapies International) η οποία αντανακλά τη σύνθεση της ομάδας από Έλληνες θεραπευτές με εθνική και διεθνή δράση, και τη διάθεση της ομάδας να συμμετέχει σε διεθνείς συνεργασίες.

Το ξεκίνημα και η πορεία της ομάδας χαρακτηρίζονται από ένα κοινό όραμα: την πραγματοποίηση δράσεων με σκοπό την προώθηση των θεραπειών μέσω τεχνών μέσα από την ενημέρωση άλλων επαγγελματιών καθώς και του ευρύτερου κοινού. Μέχρι σήμερα οι δράσεις της ομάδας έχουν πάρει τη μορφή φεστιβάλ και εκπαιδευτικών σεμιναρίων όπως περιγράφεται συνοπτικά παρακάτω.

Δραματοθεραπεία

Αιμιλία Καπερνέκα (Πήλιο, Αθήνα, Αίγιο)
Εμμανουέλα Κρασανάκη (Πήλιο)
Τάσος Μπάμπαλης (Πήλιο*, Αθήνα*, Αίγιο*)

Εικαστική θεραπεία

Πωλίνα Αναγνωστοπούλου (Αθήνα)
Κατερίνα Ζερβού (Πήλιο)
Ντιάνα Καγιάφα (Πήλιο*, Αθήνα*)
Δάφνη Καλαφάτη (Αθήνα)
Μυρτώ Λυκοπούλου (Πήλιο, Αίγιο*)
Νιόβη Σταυροπούλου (Αθήνα, Αίγιο)

Μουσικοθεραπεία

Ευαγγελία Αραχωβίτη (Πήλιο, Αθήνα, Αίγιο*)
Κάνδια Μπουζιώτη (Αίγιο)
Εργίνα Σαμπαθιανάκη (Αίγιο)
Γιώργος Τσίρης (Πήλιο*, Αθήνα*)

Χοροθεραπεία

Φωτεινή Αθανασιάδου (Πήλιο, Αθήνα, Αίγιο)
Βίκυ Κάρκου (Πήλιο*, Αθήνα*, Αίγιο*)
Στέλλα Κολυβοπούλου (Αθήνα, Αίγιο)
Αγγελική Μπιτζαράκη (Πήλιο, Αθήνα, Αίγιο)

Πίνακας 1: Μέλη της ομάδας ΚΑΤΙ (2011-2014) (Το σύμβολο * υποδεικνύει τους υπευθύνους της κάθε υπο-ομάδας στην εκάστοτε δράση)

1ο φεστιβάλ θεραπειών μέσω τεχνών της ομάδας ΚΑΤΙ (Ανήλιο Πηλίου, 2011)

Πρωτεργάτρια του ξεκινήματος της ομάδας ήταν η χοροθεραπεύτρια Βίκυ Κάρκου. Στις αρχές του 2011 –και ύστερα από πολυετή εργασία στο Ηνωμένο Βασίλειο και διεθνείς συνεργασίες, και μέσα από την επιθυμία προώθησης των θεραπειών μέσω τεχνών στην Ελλάδα– η Βίκυ αναζήτησε Έλληνες συναδέλφους με σκοπό την συνδιοργάνωση ενός φεστιβάλ για τις θεραπείες μέσω τεχνών.

Μέσα από επαφές με το Κέντρο Τέχνης και Ψυχολογίας (Θεσσαλονίκη), το Queen Margaret University (Edinburgh) και το Ινστιτούτο Δραματοθεραπείας ΑΙΩΝ (Αθήνα), η Βίκυ γνώρισε την εικαστική θεραπεύτρια Ντιάνα Καγιάφα, τον μουσικοθεραπευτή Γιώργο Τσίρη και τον δραματοθεραπευτή Τάσο Μπάμπαλη. Οι τέσσερίς τους αποτέλεσαν τον διοργανωτικό πυρήνα του φεστιβάλ για το οποίο σταδιακά συντέθηκε μια ευρύτερη ομάδα 11 θεραπευτών (Πίνακας 1).

Το φεστιβάλ έλαβε μέρος στις 22-29 Ιουλίου 2011 στο μη-κερδοσκοπικό Κέντρο Ολιστικής Εκπαίδευσης «Το Σπίτι των Κενταύρων» στο Ανήλιο Πηλίου (Εικόνα 1). Το φεστιβάλ είχε χαρακτήρα εισαγωγικού σεμιναρίου που συμπεριέλαβε ομιλίες, δημιουργικά εργαστήρια καθώς και καλλιτεχνικές δράσεις δίνοντας ισάξια έμφαση τόσο στη θεραπευτική όσο και στην καλλιτεχνική διάσταση των τεχνών (Εικόνα 2).

Εικόνα 1: Το Σπίτι των Κενταύρων, Ανήλιο Πηλίου

Εικόνα 2: Χώρος διεξαγωγής εργαστηρίων

Η ομορφιά του φυσικού τοπίου στο «Σπίτι των Κενταύρων», καθώς και η εμπειρία εφταήμερης συμβίωσης των εμψυχωτών εντός της κοινότητας του Κέντρου, πλαισίωσαν ιδανικά και έθεσαν τις βάσεις για τη δημιουργία της ομάδας (Εικόνα 3). Όπως περιγράφει ο Τάσος Μπάμπαλης:

> «[...] μέσα σε ένα περιβάλλον που από μόνο του συνθέτει ήχο, χρώμα, κίνηση και ιστορία συναντώ ανθρώπους που όλοι μαζί ανάγουμε αυτή τη σύνθεση σε επίπεδο ανθρώπων, τεχνών, επιστημών. Συνθέτουμε με κέφι, συνυπάρχουμε δημιουργικά, αναπνέουμε συντονισμένα, μαθαίνουμε και 'ξεμαθαίνουμε' πως οι θεραπείες μέσω τέχνης συνεργάζονται και αλληλεπιδρούν μα και πώς οι εκπρόσωποί τους συνδιαλέγονται αρμονικά».

Εικόνα 3: Μέλη της ομάδας στο Πήλιο (από αριστερά προς τα δεξιά: Φωτεινή Αθανασιάδου, Ευαγγελία Αραχωβίτη, Βίκυ Κάρκου, Μυρτώ Λυκοπούλου, Τάσος Μπάμπαλης, Αιμιλία Καπερνέκα, Γιώργος Τσίρης, Ντιάνα Καγιάφα και Εμμανουέλα Κρασανάκη)

Διήμερο εκπαιδευτικό σεμινάριο (Αθήνα, 2012)

Ύστερα από τη διοργάνωση του φεστιβάλ και ανταποκρινόμενοι στη θετική ανατροφοδότηση των συμμετεχόντων και το αίτημά τους για τη διοργάνωση άλλων παρόμοιων δράσεων, η ομάδα προγραμμάτισε ένα διήμερο εκπαιδευτικό σεμινάριο. Με τίτλο «Οι Τέχνες ως Θεραπεία: Θεωρία – Πράξη – Έρευνα» το σεμινάριο αυτό πραγματοποιήθηκε στις 19-20 Μαΐου 2012 στον Πολυχώρο Πολιτισμού «Διέλευσις» στην Αθήνα.

Με βασικό διοργανωτή τον Γιώργο Τσίρη και με ορισμένους νέους θεραπευτές στο δυναμικό της ομάδας, το σεμινάριο προσέλκυσε 60 συμμετέχοντες από διάφορα μέρη της Ελλάδας. Την πρώτη ημέρα παρουσιάστηκαν θεωρητικές προσεγγίσεις, ερευνητικά δεδομένα και παραδείγματα από τη θεραπευτική πράξη των θεραπειών μέσω τεχνών. Η δεύτερη ημέρα του σεμιναρίου ήταν αφιερωμένη σε βιωματικά εργαστήρια για την κάθε θεραπεία μέσω τεχνών χωριστά (Εικόνα 4).

Το σεμινάριο πραγματοποιήθηκε με την υποστήριξη του περιοδικού *Approaches: Μουσικοθεραπεία & Ειδική Μουσική Παιδαγωγική* (από το 2015 γνωστό ως *Approaches: Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας*) και της Ένωσης Εκπαιδευτικών Μουσικής Αγωγής Πρωτοβάθμιας Εκπαίδευσης (ΕΕΜΑΠΕ), ενώ προσκλήθηκαν εκπρόσωποι από όλες τις επαγγελματικές ενώσεις του χώρου στην Ελλάδα.

Αυτή η δεύτερη δράση της ομάδας έπαιξε καθοριστικό ρόλο στην εδραίωσή της: επιβεβαιώθηκε η λειτουργία της ομάδας, το κοινό της όραμα, και ορισμένες από τις βασικές της αξίες όπως ο σεβασμός μεταξύ των διαφορετικών θεραπευτικών προσεγγίσεων, ο συνδυασμός πράξης, θεωρίας και έρευνας, το κοινό ενδιαφέρον για συνεργασία και σύμπραξη των θεραπειών μέσω τεχνών σε επαγγελματικό, ερευνητικό και πρακτικό επίπεδο. Το Μάιο του 2012, επίσης, η ομάδα απέκτησε λογότυπο (Εικόνα 5), και σε μια προσπάθεια αυτοπροσδιορισμού της προέκυψε η ονομασία «ΚΑΤΙ».

Εικόνα 4: Δημιουργική ανατροφοδότηση-αποτύπωμα των συμμετεχόντων (Αθήνα, 2012)

Εικόνα 5: Λογότυπο της ομάδας KATI[4]

2ο φεστιβάλ θεραπειών μέσω τεχνών της ομάδας KATI (Αίγιο, 2014)

Η τρίτη δράση της ομάδας έλαβε τη μορφή ενός διήμερου φεστιβάλ το οποίο πραγματοποιήθηκε στις 18-20 Ιουλίου 2014 στο «Αλυκών Φως» στην Αλυκή Αιγίου. Όπως περιγράφει ο βασικός διοργανωτής του φεστιβάλ, Τάσος Μπάμπαλης:

> «Η ομάδα για τέσσερα χρόνια τώρα έχει γεννήσει ιδέες, αισθήματα και δράσεις. Πήλιο, Αθήνα, Αίγιο [...] ένα γαϊτανάκι που ξεδιπλώνεται συνεχώς και εμπνέει.»

Με ανανεωμένη σύνθεση της ομάδας, το φεστιβάλ αυτό είχε κοινά χαρακτηριστικά με το πρώτο του Πηλίου, συμπεριλαμβανομένης της ομορφιάς του φυσικού χώρου, καθώς και της εμπειρίας συμβίωσης συμμετεχόντων και εμψυχωτών.

ΚΑΛΛΙΤΕΧΝΙΚΉ ΑΝΑΖΉΤΗΣΗ

Αντλώντας από τις τρεις προαναφερόμενες δράσεις και ορμώμενοι από τις εμπειρίες μας στα πλαίσια συνεργασίας της ομάδας KATI, παρακάτω εξερευνούμε τα νοήματα που προσδίδουμε ως μέλη της ομάδας στην ύπαρξη αυτής. Ελπίζουμε πως μέσα από αυτή τη διαδικασία εξερεύνησης μπορούν να προκύψουν ιδέες και προτάσεις καθώς και ερωτήματα σχετικά με την ανάπτυξη άλλων παρόμοιων πρωτοβουλιών.

Για την εξερεύνηση και καταγραφή των εμπειρίων και των νοημάτων που βρίσκουμε στην ομάδα επιλέξαμε να ακολουθήσουμε μια δημιουργική διαδικασία, αξιοποιώντας καλλιτεχνικούς και μη λεκτικούς τρόπους επικοινωνίας, έκφρασης και σκέψης – στοιχεία που ούτως ή άλλως χρησιμοποιούμε στη θεραπευτική μας εργασία αλλά και στην καθημερινή μας ζωή εν γένει. Δανειστήκαμε στοιχεία και προσαρμόσαμε διαδικασίες εμπνευσμένες από την έρευνα βασισμένη στις τέχνες (arts-based research, βλ. Leavy 2015· McNiff 1998) και συγκεκριμένα από την ερευνητική μεθοδολογία της καλλιτεχνικής αναζήτησης (artistic inquiry) (Finley 2005· Hervey 2000).

Εντασσόμενη στα πλαίσια της μεταμοντέρνας ποιοτικής έρευνας, η καλλιτεχνική αναζήτηση ως μεθοδολογία βρίσκει ιδιαίτερη εφαρμογή στην εξερεύνηση και περιγραφή κοινωνικών φαινομένων και προσωπικών εμπειριών αφήνοντας περιθώριο για πολλαπλές και δημιουργικές ερμηνείες (Finley 2005· Hervey 2000). Αυτά τα χαρακτηριστικά συμβαδίζουν με τη φιλοσοφία και τον τρόπο λειτουργίας της ομάδας KATI, ως μια πολυάριθμη ομάδα εντός της οποίας συνυπάρχουν πολλαπλά και ποικιλόμορφα νοήματα.

Μέθοδος

Αυτή η δημιουργική αναζήτηση πραγματοποιήθηκε κατά τη διάρκεια δύο τρίωρων συναντήσεων οι οποίες έλαβαν μέρος στο Liverpool του Ηνωμένου Βασιλείου. Συμμετέχοντες ήταν έξι μέλη της ομάδας (Φωτεινή Αθανασιάδου, Ντιάνα Καγιάφα, Βίκυ Κάρκου, Μυρτώ Λυκοπούλου, Εργίνα Σαμπαθιανάκη και Γιώργος Τσίρης) τα οποία μπορούσαν να παρευρεθούν στις συγκεκριμένες συναντήσεις.

Καθόλη τη διαδικασία είχαμε κατά νου τα γνωρίσματα της καλλιτεχνικής αναζήτησης. Η συλλογή και επεξεργασία του υλικού έγινε με καλλιτεχνικές διαδικασίες στις οποίες συμμετείχαμε και οι ίδιοι. Η ανάλυση του υλικού με αισθητικά κριτήρια (McNiff 1998) οδήγησε σε κάποιες θεματικές ενότητες .

Πιο συγκεκριμένα, ακολουθήσαμε τα στάδια της καλλιτεχνικής αναζήτησης που προτείνει η Hervey (2000): έναρξη (inception), αντίληψη (perception), εσωτερικός διάλογος (inner dialogue), φώτιση (illumination), έκφραση / διαμόρφωση (expression / formation) και εξωτερικός διάλογος (outer dialogue), χρησιμοποιώντας αισθητικές αξίες που χαρακτηρίζουν την ομάδα εν γένει, όπως ο αυτοσχεδιασμός, η εμπιστοσύνη στο άγνωστο και στη διαίσθηση, καθώς και η εκτίμηση της τέχνης ως μέσο έκφρασης και γνώσης.

Αρχικά (στάδιο: έναρξη) ορίσαμε ως βασικό

[4] Θερμές ευχαριστίες στον γραφίστα Δημήτρη Αναστασιάδη για τη δημιουργία του λογότυπου.

θέμα αναζήτησης το εξής ερώτημα *«Τι νόημα έχει για εμάς η ομάδα ΚΑΤΙ;»* αφήνοντας παράλληλα περιθώρια για την αυθόρμητη ανάδυση του θέματος κατά τη δημιουργική διαδικασία που ακολούθησε.

Στη συνέχεια (στάδιο: αντίληψη) χρησιμοποιήσαμε ποικίλες πηγές και συλλέξαμε όσον το δυνατόν περισσότερο υλικό, όπως οπτικο-ακουστικές ηχογραφήσεις από τις τρεις δράσεις της ομάδας, καθώς και ηλεκτρονικό και οπτικό υλικό που έστειλαν μέλη της ομάδας τα οποία δεν μπορούσαν να παρευρεθούν στις συναντήσεις.[5] Κατά τη διάρκεια της παρακολούθησης του οπτικο-ακουστικού υλικού ανταποκρινόμασταν κινητικά, ηχητικά και με εικαστικά μέσα σε ότι ακούγαμε ή/και βλέπαμε καθώς και στις ανάλογες συναισθηματικές αντιδράσεις και σκέψεις που αναδύονταν. Αυτή η διαδικασία μαγνητοσκοπήθηκε, με την κάμερα να παίζει το ρόλο εξωτερικού παρατηρητή (Lowell 2010) που μας συνόδευε και παράλληλα πρόσφερε περαιτέρω οπτικό υλικό. Σε αυτό το στάδιο δημιουργήθηκαν έργα τέχνης (ζωγραφιές και γλυπτά) ενώ επίσης δημιουργήσαμε κινητικά μοτίβα, στάσεις σώματος, ήχους και μουσική. Η καλλιτεχνική έκφραση ήταν κυρίως ατομική σε αυτό το στάδιο ενώ σε αρκετές στιγμές υπήρχε συντονισμός μεταξύ μας ως προς το ρυθμό (π.χ. συντονισμός κινητικού και ηχητικού ρυθμού), το καλλιτεχνικό μέσο έκφρασης και το περιεχόμενο των εικαστικών έργων (π.χ. παρόμοια σχήματα και φόρμες στα έργα τέχνης).

Μετά την ολοκλήρωση της δημιουργικής ανταπόκρισης στο υλικό που είχαμε συλλέξει, προβήκαμε σε δημιουργικές συνθέσεις (στάδιο: εσωτερικός διάλογος) των «δεδομένων» που δημιουργήσαμε στο προηγούμενο στάδιο (δηλ. τα έργα τέχνης, τα κινητικά και ηχητικά μοτίβα κλπ.). Με κριτήρια κατά βάσει αισθητικά (όπως κοινή φόρμα, ρυθμός και χρώματα), εξερευνήσαμε τα δεδομένα (τα έργα τέχνης, κινητικά και ηχητικά μοτίβα) και αναδύθηκαν ορισμένες αρχικές θεματικές ενότητες. Παραμένοντας συντονισμένοι με το τι αντιλαμβανόμασταν ως αληθινό, ολοκληρωμένο και σημαντικό τη συγκεκριμένη χρονική στιγμή (στάδιο: φώτιση) και πάντα αναφορικά με το θέμα της εξερεύνησής μας, εμβαθύναμε περισσότερο, εδραιώσαμε και αποκρυσταλλώσαμε εκείνες τις θεματικές ενότητες που θεωρούσαμε ότι απαντούν στο αρχικό μας ερώτημα: *«Τι νόημα έχει για εμάς η ομάδα ΚΑΤΙ;»*

Σταδιακά αρχίσαμε να σκιαγραφούμε ορισμένα συμπεράσματα και να τα διατυπώνουμε με τρόπο που να μπορούν να μεταδώσουν το νόημα της διαδικασίας όσο πιο πιστά γίνεται (στάδιο: έκφρασης / διαμόρφωσης). Στο τελικό στάδιο (εξωτερικός διάλογος) καταγράψαμε τα συμπεράσματά μας με σκοπό την επικοινωνία τους στο ευρύτερο κοινό στη μορφή του παρόντος άρθρου. Οι αναδυόμενες θεματικές ενότητες παρουσιάζονται παρακάτω, μαζί με οπτικά παραδείγματα από τα δεδομένα που δημιουργήθηκαν και κατανεμήθηκαν σε υπο-ομάδες ή «συνθέσεις» σύμφωνα την παραπάνω διαδικασία.

ΑΝΑΔΥΟΜΕΝΑ ΘΕΜΑΤΑ

Θέμα 1: Καινούργιες προοπτικές

Η συμμετοχή μας στην ομάδα ξεκινάει από τις έννοιες του άδειου χώρου και του ανοιχτού ορίζοντα, όπως αποτυπώνονται στην Σύνθεση 1 που τιτλοφορείται «αέρας». Η κοινή επιθυμία των μελών της ομάδας να συνεργαστούν με θεραπευτές

Σύνθεση 1: Αέρας

[5] Το γνήσιο οπτικο-ακουστικό υλικό που στάλθηκε από την χοροθεραπεύτρια Αγγελική Μπιτζαράκη είναι διαθέσιμο ηλεκτρονικά στον ιστοχώρο του Approaches (www.approaches.gr, βλ. το παράρτημα του παρόντος άρθρου).

από όλες τις θεραπείες μέσω τεχνών συνδέεται με τη δυνατότητα συνύπαρξης σε έναν καινούργιο για όλους μας χώρο. Αυτός ο χώρος έχει διττή σημασία: την οριοθετημένη γεωγραφικά, όπως αρχικά το Πήλιο, και τη μεταφορικά προσδιορισμένη έννοια του χώρου που χρειάζεται η ομάδα προκειμένου τα μέλη να εμπλακούν στις διαδικασίες που είναι απαραίτητες πριν, κατά τη διάρκεια και μετά από κάθε δράση αυτής.

Θέμα 2: Προσωπική και συλλογική εξέλιξη

Κοινό βίωμα ανάμεσα στα μέλη της ομάδας ήταν η επιθυμία μας να μοιραστούμε και να προσφέρουμε προσωπικές ιδέες, εμπειρίες και γνώσεις – γεγονός που οδήγησε σε έναν πλούτο υλικού. Η Σύνθεση 2 (Γη) –όπου η μεγάλη ποσότητα πράσινου χρώματος παίρνει σταδιακά μια πιο οργανωμένη μορφή και εξελίσσεται σε ένα φυτό που αναπτύσσεται– νιώθουμε ότι αντανακλά την πορεία της ομάδας. Κατά τη διάρκεια αυτής της πορείας έχουμε προσπαθήσει να ξεκαθαρίσουμε και να οργανώσουμε το υλικό που διαθέτουμε και να του δώσουμε συγκεκριμένη μορφή ανάλογα με το πλαίσιο της εκόστοτε δράσης της ομάδας. Στο διήμερο σεμινάριο της Αθήνας, για παράδειγμα, εστιάσαμε περισσότερο σε θεωρητικές και ερευνητικές διαστάσεις των θεραπειών μέσω τεχνών, ενώ στο φεστιβάλ στην Αλυκή Αιγίου δόθηκε μεγαλύτερη έμφαση στην καλλιτεχνική έκφραση.

Σύνθεση 2: Γη

Θέμα 3: Εξερεύνηση ταυτότητας

Καθώς η ομάδα μας εξελισσόταν αρχίσαμε να αναζητάμε την ταυτότητά της. Κύριο στοιχείο της ομάδας είναι το παιχνίδι μέσα από το οποίο γνωριστήκαμε και συνεχίζουμε να γνωριζόμαστε. Το στοιχείο του ρευστού (όπως το διακρίναμε στη Σύνθεση 3 που τιτλοφορείται «Νερό») αποτυπώνει ένα κομμάτι της ταυτότητας το οποίο δεν είναι παγιωμένο. Η ομάδα παραμένει δυναμική και ενεργητική συνεχίζοντας τη διηνεκή διαδικασία προσδιορισμού της, κάτι που αναγνωρίζουμε στο κεντρικό σημείο της Σύνθεσης 3.

Σύνθεση 3: Νερό

Θέμα 4: Δέσμευση, απαιτήσεις και δυσκολίες

Μια θεματική στην οποία αφιερώσαμε πολύ χρόνο είναι η ανασκόπηση των απαιτήσεων και των δυσκολιών που φέρει η συμμετοχή μας στην ομάδα. Καταρχάς, μια δυσκολία που έχει

αντιμετωπίσει η ομάδα είναι η διαχείριση πρακτικών ζητημάτων όπως, για παράδειγμα, η επιλογή και η οργάνωση του χώρου διεξαγωγής των δράσεών της, καθώς και οι εκάστοτε οικονομικές απαιτήσεις.

Επίσης, συζητήθηκε η διαχείριση των δυναμικών που δημιουργούνται εντός της ομάδας και των συμμετεχόντων στις δράσεις της. Η συμμετοχή στα βιωματικά εργαστήρια καθώς και η εμπειρία συμβίωσης της ομάδας μας μαζί με τους συμμετέχοντες στα δύο φεστιβάλ (Πήλιο και Αλυκή Αιγίου) γεννούν έντονες συναισθηματικές εμπειρίες και –παρόλο που τα φεστιβάλ και τα σεμινάρια δεν λειτουργούν ως θεραπευτικές ομάδες– οι συμμετέχοντες συχνά εξερευνούν και εκφράζουν σημαντικές και ευαίσθητες όψεις του εαυτού τους. Το γεγονός αυτό επιφέρει την ευθύνη στην ομάδα μας για τη δημιουργία ενός ασφαλούς περιβάλλοντος κατά τη διάρκεια των ημερών που λαμβάνει μέρος η εκάστοτε δράση.

Οι ευθύνες και οι δυσκολίες που προκύπτουν αποτυπώνονται στη Σύνθεση 4 με το μαύρο χρώμα και τις μαύρες κλωστές. Η επιτυχής πλαισίωση αυτών των δυσκολιών από τα μέλη της ομάδας μας, φαίνεται να συνδέεται με τη διάθεση της ομάδας να συνεχίσει να δημιουργεί – μια διάθεση που εκφράζεται και ως «πάθος», όπως αυτό αποτυπώνεται στο «χορό της φωτιάς» της Σύνθεσης 4.

Σύνθεση 4: Φωτιά

Θέμα 5: Προσωπική εμπλοκή

Η θεματική αυτή έχει δύο όψεις. Η πρώτη αφορά την έκταση της προσωπικής εμπλοκής του κάθε μέλους της ομάδας: την επένδυση χρόνου, εργασίας, ενέργειας, συναισθηματικής διαθεσιμότητας και ευελιξίας. Η δεύτερη όψη αφορά το πώς η εμπλοκή του κάθε μέλους της ομάδας αποτυπώνεται στο σύνολο αυτής. Εδώ προέκυψαν ερωτήματα σχετικά με την ύπαρξη (η μη) ενός πυρήνα της ομάδας, καθώς και με τον τρόπο διαμόρφωσης του πυρήνα και της σημασίας αυτού. Για παράδειγμα, αναρωτηθήκαμε εάν τα μέλη που έχουν συμμετάσχει σε όλες τις δράσεις της ομάδας μέχρι σήμερα, έχουν παγιωθεί ως ο πυρήνας της ομάδας. Τι συμβαίνει όταν κάποιο μέλος δεν μπορεί να πάρει ενεργό μέρος σε μια δράση και ποιος είναι ο εν δυνάμει ρόλος του;

Αναζητώντας αυτά και άλλα παρόμοια ερωτήματα, αισθανθήκαμε ότι ο πυρήνας δεν στηρίζεται στα άτομα, αλλά στην ιδέα και το όραμα της ομάδας. Αυτό αναγνωρίσαμε και στη Σύνθεση 5 όπου φαίνονται σχέδια με ανοιχτούς και κλειστούς κύκλους που άλλοτε έχουν πυρήνα κι άλλοτε όχι, ή

Σύνθεση 5: Κύκλοι

άλλοτε ο πυρήνας φαίνεται να αποκτά διάφορες μορφές.

Θέμα 6: Θεωρητικές οπτικές

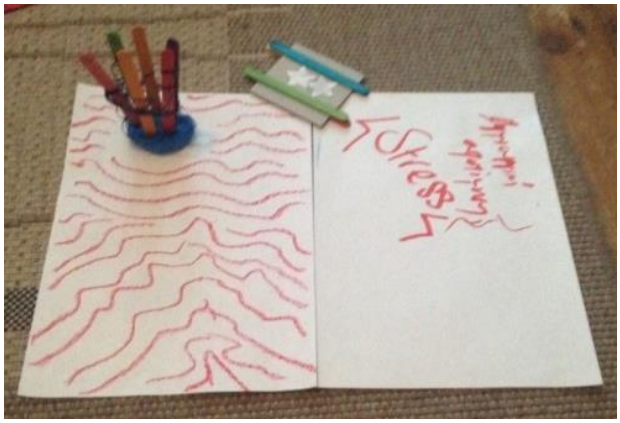
Εδώ γίνεται αναφορά στο πώς η ομάδα ΚΑΤΙ επικοινωνεί τις διάφορες θεωρητικές πτυχές των θεραπειών μέσω τεχνών ή τα διαφορετικά «μοντέλα». Έχοντας ως βίωμα το διήμερο σεμινάριο της Αθήνας –όπου δόθηκε ιδιαίτερη έμφαση σε θεωρητικές και ερευνητικές διαστάσεις των θεραπειών μέσω τεχνών– αναρωτηθήκαμε πώς θα μπορούσαμε να ισορροπήσουμε τη βιωματική με τη θεωρητική γνώση (αριστερή εικόνα στο τρίπτυχο της Σύνθεσης 6). Επίσης, γίνεται αναφορά στην ενσωμάτωση διαφορετικών θεωρητικών και θεραπευτικών προσεγγίσεων τις οποίες πρεσβεύουν τα μέλη της ομάδας (μεσαία εικόνα στο τρίπτυχο της Σύνθεσης 6. Χαρακτηριστική είναι η μορφή των πολλαπλών προσώπων (δεξιά εικόνα στο τρίπτυχο της Σύνθεσης 6) που μπορεί να διακρίνει ο παρατηρητής από διαφορετικές πλευρές.

Σύνθεση 6: Μοντέλα

Θέμα 7: Συλλογικές διαδικασίες της ομάδας

Στη θεματική αυτή αναδύθηκαν προβληματισμοί γύρω από το «δεσμό» τόσο ανάμεσα στις θεραπείες μέσω τεχνών όσο και ανάμεσα στα μέλη της ομάδας ΚΑΤΙ. Τί είναι αυτό που μας κρατάει μαζί; Πώς η ομάδα μας συνεχίζει να δρα χωρίς σταθερές αναφορές (π.χ. έλλειψη συγκεκριμένου χώρου, ατόμων ή μορφής δράσης); Είναι το νησί της Σύνθεσης 7 μια διάθεση να δημιουργήσουμε αυτόν το συγκεκριμένο χώρο; Ποια είναι η κυριολεκτική έννοια της της «κλωστής-δεσμού» που συγκρατεί τα ξυλάκια ως ενότητα πάνω στη βάση σε αυτή τη σύνθεση; Πώς ο καθένας μας φροντίζει να διατηρεί τον προσωπικό του χώρο και χρόνο για αναστοχασμό και επαναπροσδιορισμό του ρόλου του μέσα στο σύνολο της ομάδας;

Οι παραπάνω προβληματισμοί προκάλεσαν κατά καιρούς στα μέλη της ομάδας άγχος το οποίο συχνά διαχειριστήκαμε μέσα από μια διαδικασία δημιουργικής αποτίμησης. Όπως φαίνεται και στη Σύνθεση 7, οι λέξεις «stress» (άγχος) και «δημιουργική αποτίμηση» βρίσκονται η μία δίπλα στην άλλη και φαίνεται να αλληλεπιδρούν εξισορροπητικά.



Σύνθεση 7: Νησί

Θέμα 8: Συνεργασία

Ο πλούτος ιδεών, εμπειριών και γνώσεων που φέρουμε ως άτομα και που αποκτήσαμε μέσα από τη συνεργασία μας, αρχίζει κι αποκτά πιο συγκεκριμένη μορφή (Σύνθεση 8) σε σύγκριση με την πιο άμορφη παράσταση του πλούσιου υλικού στην κάτω εικόνα της Σύνθεσης 2.

Κοινή επιθυμία της ομάδας είναι η πιο στενή συνεργασία των διάφορων θεραπειών μέσω τεχνών τόσο στο σχεδιασμό όσο και στην υλοποίηση παρουσιάσεων και βιωματικών εργαστηρίων. Μια ιδέα, για παράδειγμα, αφορά την υλοποίηση ενός συνεργατικού εργαστηρίου μουσικοθεραπείας και χοροθεραπείας το οποίο να εστιάζει στην έκφραση και το ρυθμό.

Επιπλέον, αυτός ο πλούτος ιδεών, εμπειριών και γνώσεων που αποτυπώνεται στη Σύνθεση 8, φαίνεται να συνδέεται με την εμπειρία των ίδιων των συμμετεχόντων όπως αυτή διατυπώνεται στην καλλιτεχνική ανατροφοδότηση-αποτύπωμα (βλ. Εικόνα 4), καθώς και στην προφορική ή γραπτή τους ανατροφοδότηση:

> «Ο χώρος [διεξαγωγής του σεμιναρίου] μετατράπηκε σε χώρο έμπνευσης και δημιουργίας.»

«Ευχαριστώ για την ευκαιρία που μου δώσατε να δω τη ζωή από μία άλλη οπτική γωνία και να ανακαλύψω περισσότερο τον εαυτό μου. Είμαι ευγνώμων.»[6]

Σύνθεση 8: Πολλαπλότητα

ΣΥΖΗΤΗΣΗ

Η συνεργασία μεταξύ των θεραπειών μέσω τεχνών είναι καθοριστικής σημασίας και, όπως συζητήσαμε συνοπτικά στην αρχή αυτού του άρθρου, μπορεί να λειτουργήσει σε διαφορετικά επίπεδα: από το μακρο-επίπεδο (π.χ. διεκδίκηση επαγγελματικών δικαιωμάτων, ίδρυση πανεπιστημιακών προγραμμάτων), στο μεσο-επίπεδο (π.χ. προσφορά υπηρεσιών και σεμιναρίων ή εργαστηρίων) και στο μικρο-επίπεδο (π.χ. μεικτές ομάδες εποπτείας ή/και αυτοσχεδιασμού για συνεχή επαγγελματική εξέλιξη των θεραπευτών).

Ανεξαρτήτως επιπέδου, θεωρούμε πως η αναστοχαστική καταγραφή συνεργατικών πρωτοβουλιών (όπως το παρόν άρθρο) μπορεί να συμβάλει στη βελτίωση και στην περαιτέρω ανάπτυξη της συνεργασίας μεταξύ των θεραπειών μέσω τεχνών. Μπορεί να συμβάλει στην κατανόηση των διαδικασιών συνεργασίας, καθώς και των δυσκολιών και των προοπτικών της.

Σε αυτό το πλαίσιο το παρόν άρθρο περιγράφει την πορεία της ομάδας ΚΑΤΙ, η οποία έχει αποτελέσει μέχρι σήμερα έναν «χώρο» ανάπτυξης, ανταλλαγής ιδεών και δυναμικής δράσης. Πέρα από μια ιστορική καταγραφή του έργου της ομάδας από το 2011 μέχρι σήμερα, περιγράψαμε παραπάνω προσωπικά μας βιώματα και αναστοχασμούς ως μέλη της ομάδας, όπως αυτά αναδύθηκαν μέσα από μια διαδικασία καλλιτεχνικής αναζήτησης.

Θέματα όπως οι διαφορετικοί ρόλοι, η εξισορρόπηση της ανάγκης για έναν πυρήνα αλλά και για ρευστότητα, η αλληλοεξάρτηση, η ταυτότητα της ομάδας καθώς και η ταυτότητα του ατόμου μέσα στην ομάδα, αναδύθηκαν κατά την καλλιτεχνική αναζήτηση που περιγράφεται παραπάνω. Αυτές οι θεματικές αντικατοπτρίζουν όψεις της ευρύτερης εμπειρίας μας στην ομάδα.

Έχοντας ως κοινό όραμα τη δημιουργική συνύπαρξη και σύμπραξη όλων των θεραπειών μέσω τεχνών στην Ελλαδα αλλά και το εξωτερικό, η ομάδα ΚΑΤΙ έχει λειτουργήσει ως τόπος δημιουργικής συνεύρεσης ατόμων με κοινό όραμα, αλλά και ως χώρος ζύμωσης ιδεών και γέννησης δημιουργικών πρωτοβουλιών.

Το έργο και τα βιώματα της ομάδας ΚΑΤΙ ελπίζουμε πως συμβάλουν στη (δι)επιστημονική συνεργασία λαμβάνοντας υπόψιν το ευρύτερο πεδίο των θεραπειών μέσω τεχνών τόσο στην Ελλάδα όσο και στο εξωτερικό. Ήδη στους κόλπους της ομάδας έχουν διαμορφωθεί πρωτοβουλίες οι οποίες έχουν πάρει αυτόνομη μορφή και πορεία. Το καλοκαίρι του 2015, για παράδειγμα, πραγματοποιήθηκε μια δεύτερη συνάντηση των θεραπειών μέσω τεχνών στην Αλυκή Αιγίου (με συντονιστή τον Τάσο Μπάμπαλη). Επίσης, μέσα από τη δράση της ομάδας ΚΑΤΙ γεννήθηκαν διάφορες συγγραφικές δραστηριότητες αναφορικά με τη συνεργασία των θεραπειών μέσω τεχνών (βλ. Κάρκου, Τσίρης & Καγιάφα, υπό δημοσίευση) συμπεριλαμβανομένου του παρόντος ειδικού τεύχους του *Approaches* με προσκεκλημένη αρχισυντάκτρια την πρωτεργάτρια του ξεκινήματος της ομάδας ΚΑΤΙ, Βίκυ Κάρκου.

[6] Μερικά επιπρόσθετα σχόλια σχετικά με την εμπειρία των συμμετεχόντων συγκεκριμένα στα εργαστήρια χοροθεραπείας είναι διαθέσιμα ηλεκτρονικά: http://www.gadt.gr/article06.htm

Η λειτουργία της ομάδας ΚΑΤΙ ως μια κοινότητα κοινής αναζήτησης, ως ένας χώρος όπου επαγγελματίες με κοινά ενδιαφέροντα συναντιούνται, ανταλλάζουν ιδέες, συμπράττουν και εξελίσσονται, φαίνεται να είναι ιδιαίτερης αξίας ιδιαίτερα στον ελληνικό χώρο όπου τα αντίστοιχα επαγγελματικά πεδία βρίσκονται σε διαμορφωτικά στάδια της εξέλιξής τους. Ο σχετικά μικρός αριθμός επαγγελματιών στον ελληνικό χώρο καθιστά ακόμη πιο επιτακτική την ανάγκη για γόνιμο διάλογο, εύρεση κοινού οράματος και δημιουργικής σύμπραξης των θεραπευτών μέσω τεχνών. Η ομάδα ΚΑΤΙ και οι εμπειρίες μας σε αυτήν μπορούν να προσφέρουν ορισμένες ιδέες για παρόμοιες δράσεις. Τα κοινά βιώματα και η εμπειρία συλλογικής δράσης σε δημιουργικό επίπεδο μπορούν να λειτουργήσουν ως καταλύτες για τη γεφύρωση πιθανών διαφορών σε θεωρητικό επίπεδο μεταξύ θεραπευτικών προσεγγίσεων. Ομάδες αυτοσχεδιασμού για θεραπευτές μέσω τεχνών, για παράδειγμα, μπορούν να συμβάλουν προς αυτήν την κατεύθυνση. Μέσα από τέτοιες δημιουργικές δραστηριότητες κτίζεται μια αίσθηση συλλογικότητας και ενδυναμώνεται το αίσθημα του ανήκειν. Αναδεικνύονται επίσης καινούργιες προοπτικές τόσο για την προσωπική όσο και τη συλλογική εξέλιξη των συμμετεχόντων, και διευκολύνεται η εξερεύνηση της ταυτότητας του καθενός αλλά και του συνόλου.

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

Interview

Creativity, discipline and the arts at the end of life: An interview with Nigel Hartley

Nigel Hartley
interviewed by Andy Ridley

ABSTRACT

In this interview Nigel Hartley discusses the importance of the arts and arts therapy in end of life care and the therapeutic benefits of a shared, public experience of music and art making, performance and exhibition. He contests that arts therapies work best in this setting when the artists and arts therapists are disciplined, flexible and responsive to the both social and private experience of the patients.

KEYWORDS

creativity, arts, end of life care

Nigel Hartley currently holds the post of Director of Supportive Care at the St Christopher's Group, London. He has worked in end of life care for 25 years, the last 11 years at the St Christopher's Group, where he has been responsible for transforming day and outpatient services, developing volunteers and also leading on Community Engagement. He has an international reputation as a teacher and lecturer and is also an experienced published writer. In April 2015 Nigel will take up a new position of Chief Executive Officer at Earl Mountbatten Hospice on the Isle of Wight in the South of England.

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Note: This interview took place in February 2015 at St Christopher's Hospice, London, UK. The interview was recorded, transcribed verbatim and then edited.

Andy: Today, we're going to talk around how the arts and arts therapy become an integrated practice with different models, different ways of working and different kinds of therapy. That's something you practise and encourage here at St Christopher's Hospice. Why?

Nigel: I suppose for me it's probably important to understand that where we are now has been part of a process – both a process here at St Christopher's over the last 12 years or so but also a personal process over the past 25 years in terms of how I've developed and rearticulated my own understanding and knowledge of what the arts can bring to organisations.

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One of the things I've found confusing, I suppose, about arts therapies particularly, is that the therapist always has a tendency to think of their work as being very private. I understand that people have complex and very challenging issues they need to work through, but certainly working in end of life care the focus has always been for me to strive for a normality, to say that actually dying is okay and that people's reactions, responses, fears and anxieties around it are quite normal. If that is the case, therefore, I think the expression of all those things for the individuals living with death, dying and bereavement could be held a lot more publicly and a lot more openly in order to affect and challenge the environments, the communities if you like, that the people are dying in. So the drive here for myself at St Christopher's over the years, has been to challenge the very nature of the unfounded fact that dying should be private and therefore hidden. And really try to enable people, us, me, to reclaim some kind of public, open, community type expression of it.

Andy: And does that come from your experience as a therapist and now your experience as a manager of the arts and the arts therapies and other things? Or is it something that you've come to through your understanding of communities and how communities work?

Nigel: It's a mixture of both, of course, and I think as life goes on and I mature and hopefully get a more established view of things, it's been more about an integration of all the different aspects of my own experience. So, for instance, now being able to understand the impact and importance of the fact that I was brought up in a Welsh village in a pub where being together and coming together with others was the natural way that people worked through their problems and issues. When mines closed down, when people were out of work, people gravitated towards the pub and the church and actually did it together. So that is a very strong influence, I think, on where I've come to. You know, I also think the fact that my grandfather was very much involved and influenced by the socialist movement in Wales was a strong influence and that's what I was brought up with. Rather than being victims, people need to be celebrated and respected, whoever they are and however they have lived their lives and that needs to be done as openly and publicly as possible. So that has been very influential and I think probably it is only in the last four to five years that I realise the impact of that as being an important factor in how I've come to manage people and systems creatively.

I think also having begun my own work as a therapist at the time of HIV and AIDS pandemic, when where there was a big public drive to make sure that people were accepting this and forcing them, rather brutally in many ways, to accept that there was nothing to be afraid of and that it was okay. How releasing and refreshing for communities to work together and realise that all of the physical destruction didn't have to always be terrifying and no-one was to blame. That sort of real movement and drive towards pushing people to their limit in terms of what was acceptable and what was possible I found really inspiring and engaging. So having begun as a therapist in the midst of all of that attention, although incredibly challenging, both personally and professionally, it gave me a glimpse of what is possible – the importance of always working towards potential. We all found it challenging and devastating, but the fact that we were in it together was the important thing that gave it meaning and drive.

Andy: Do you think that has got easier or harder? I'm thinking particularly now in the age of austerity and closing ranks, which often lead to people defending their specialism. Has that influenced you or have you to some extent railed against this?

Nigel: I think what the arts in health or whatever we call it and however we format it (and there are many different formations of it, different ways of practising it), really must be careful not to become defensive and stuck and narrow as many healthcare professions have become. We need to watch and learn from the main healthcare professions such as nursing and medicine who are being governed by the assessment of risk, by the fear of getting things wrong, and please let's do something different together. I think the success of healthcare professions in the future will be about how flexible and real we can be, and of course, how cost effective. We also have to prove that what we bring to the table really works and really helps people live and die within the current culture and climate – all of that. I always pushed myself to find a language to talk about the work of the arts. People need to understand what the arts are, what they do, how they work, and of course, their limitations. When I hear many artists or arts therapists talk about their work, it makes no sense to me. There is no excuse for lazy language as it plays right into the hands of the critics. I think it has got easier for myself because I think now, after all of these years, I begin to trust the language I have honed to talk about the arts. I have always been really conscious of artists finding a way of talking

about what they believe and realising that *talking* about what we do is not the same as *doing* it. I think many arts therapists use really lazy language to talk about what they do, and that gives the impression that their work is also lazy. Using the arts with people who are vulnerable is a discipline which has to be practised and perfected and we also need to practise and perfect the language we use to talk about it. We need to understand our craft, the stuff which we work with in the most detailed way.

Andy: Lazy in the sense of formulaic?

Nigel: I think formulaic, yes, but I also see that people just think those that they talk to about what they do should just understand what they are talking about as if by magic. So I do not think people really try, really work on the discipline of how to articulate it and work through finding words and phrases and language where people can really understand the benefit and potential of what it is that can be offered. You know for me the tension that exists within the arts in therapy not being witnessed, not being seen or heard, not being public as opposed to the normal process of music and art being exhibited and performed is really very important. So this tension in the arts therapies which has gone on for years now, and I am actually so bored with it by the way, of people saying that this work has to be private because it is about expression and pain which must remain confidential, is very low level and it goes right to the heart of being afraid, of taking risks, of what we were talking about earlier. In terms of the real impact and power that the arts can really have, it is much bigger than allowing a person to let off steam behind closed doors. There's something about the structures and discipline that the arts have and the fact that they offer people different ways of being together. They offer a place to question and to formulate concrete solutions, if you like, to come to terms with problems; and the part of exhibiting and performing what has been created and other people seeing it and hearing it to me is part of the process. That is what artists do. You know, it's very rare that artists, musicians create work which they never want to be witnessed. There are examples of this, of course, but on the whole the intention is for their work to be public, and for most artists and musicians it's a vital part of the process that things must be witnessed. After all, most creativity is about wanting to change the world and to bring order out of chaos.

Andy: There has always been a link, a tension between a private space or private place and a public space - perhaps exaggerated now because the age of the internet and what it means to have both simultaneously. With the internet we have both a shared social space but also a space which might be exposing and threatening. So by bringing these two experiences together through the arts and arts therapy at St. Christopher's, what does it offer to the patient?

Nigel: I think what it does, it pulls the 'patient', if that's what you want to call them because this is about many different kinds of people, isn't it? It pulls the person out of isolation, sometimes actually quite brutally, quite surprisingly, quite shockingly. It pulls them out of themselves into a world where they have to relate, or can't help but relate, to other people around them, and life must be better for all of us when that happens. I mean that's what we all believe we're here for isn't it? The social death, if you like, of people dying and this way that people are isolated from their family and friends when they don't have a language to talk about what is happening, suddenly their world shrinks and what the arts do is give people the possibility of actually 'bigging up' their world again and creating relationships with other people – how absolutely vital – what an amazing thing to be able to offer each other – helping us realise that even when our world is falling apart, we really do still matter. That's the kind of realisation that takes my breath away and helps me to understand that even in the depths of despair and destruction, there is the potential for beauty, for truth and for love.

Andy: So, in fact, is this really based on the socialist principle, that we are primarily social beings and it's in isolation that we can become ill?

Nigel: Yes that's it! Even when dying, people can be healthy and I think there is something so right about that - if that makes sense. And actually just engaging with people, being pulled back into a social world through the play and creativity of the arts maybe gives us the health that we need in order to die, to die well, if that's the phrase we want to use.

Andy: You have introduced things at St Christopher's which offer connections to other traditions from other parts of the world. I am thinking of Mexico; Mexican death festivals, the kind of Irish spaces for a wake, celebration - different things come to mind. How has that come to play?

Nigel: I think all of the stuff that's happened here, the arts included, but broader stuff in terms of real community engagement, there was never a real plan, but it has evolved naturally through listening and responding. We have really watched and learned together and then we have responded by doing the next thing. The hospice building being open to the public, for instance, was never part of the plan, but it was just the right thing to do at a certain moment in time – to create a community arts venue, a community café, a place where people really want to come to. How challenging - a hospice being a place where people actually want to come to! That is an example of thinking and acting creatively – doing the next thing, but doing it seriously, with discipline, with real thought.

Andy: You have spoken in different parts of the world, haven't you, particularly Europe?

Nigel: Yes. It goes back to striving to find a language to talk about this work, and being driven to talk to a broad range of people with different experiences and from different cultures helps that, of course. And you know, on the whole, people get it. I think that's the thing about it: people understand the benefits of how the arts can be used as containers, as buckets, as structures, as places where people can come together and actually articulate, experience, create, if you like, a world that they can live in on their terms. I think people understand that. People understand that moving from being isolated, into a community and probably engaging with it in a way that most people have never done even before they were dying, is a good thing and can be life changing. Artists working in health must really strive to not make their work mystical and secretive. It does no-one any good – either themselves, or more importantly those they are offering support to. I do sometimes wonder if most people use the dubious need for things to be confidential in order to hide the inefficiency of their own work. It might be that what they are doing is creating bad music or bad art and that is really not okay. You need to be at the height of your skills, both as a human being, emotionally and psychologically, of course, but also as an artist or musician. I have learned that we have to be the best artist, the best musician we can possibly be in order to do this work.

Andy: You're moving on from St Christopher's in a couple of months…

Nigel: Yes indeed – but it's the right time. I mentioned earlier about 'doing the next thing'. I always trust my instinct, but also realise that with all decisions we have a 50% chance of getting it right. I have always loved a challenge – fingers crossed!

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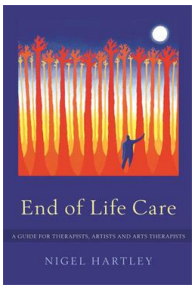
ΕΙΔΙΚΟ ΤΕΥΧΟΣ
Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία: Διεπιστημονικοί διάλογοι

Βιβλιοκριτική

End of Life Care: A Guide for Therapists, Artists and Arts Therapists (Nigel Hartley, Επιμ.)



Από την Ευρυδίκη Πέττα

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Η **Ευρυδίκη Πέττα** αποφοίτησε απ' το Τμήμα Ιατρικής του Πανεπιστημίου Πατρών, έλαβε τον τίτλο της ειδικότητας της Γενικής Ιατρικής και ολοκλήρωσε τη διδακτορική της διατριβή στο εργαστήριο Παθολογικής Ανατομικής του Τμήματος Ιατρικής του Πανεπιστημίου Πατρών. Έχει εργαστεί ως επιμελήτρια στο ΕΣΥ, και από τον Μάρτιο του 2010 εργάζεται ως ιατρός στην Μονάδα Ανακουφιστικής Φροντίδας "ΓΑΛΙΛΑΙΑ". Διατηρεί ιδιωτικό ιατρείο στην Αθήνα.

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Η ενασχόληση με ασθενείς στο τελευταίο στάδιο της ζωής είναι δημιουργική και πολύ ενδιαφέρουσα, αλλά μπορεί επίσης να είναι περίπλοκη.

Το νέο βιβλίο του Nigel Hartley, *End of Life Care: A Guide for Therapists, Artists and Arts Therapists*, έχει ως στοχο να αποσαφηνίσει παρεξηγήσεις, να καταρρίψει μύθους και τελικά να χαρτογραφήσει τις ιδιαίτερες συνθήκες που επικρατούν στο χώρο της φροντίδας τελικού σταδίου. Απευθύνεται κυρίως σε καλλιτέχνες και θεραπευτές μέσω τεχνών που ήδη δουλεύουν ή πρόκειται να δουλέψουν στον συγκεκριμένο χώρο, αλλά καταφέρνει να αποτυπώνει με τόση διαύγεια τις τρέχουσες προκλήσεις της ανακουφιστικής φροντίδας, ώστε τελικά αποτελεί χρήσιμο βοήθημα για οποιονδήποτε απασχολούμενο σε αυτήν.

Ο επιμελητής ως κύριο λόγο συγγραφής του συγκεκριμένου βιβλίου αναγνωρίζει τις επιπτώσεις των οικονομικών και ανθρωπιστικών μεταβολών στα συστήματα παροχής κοινωνικών υπηρεσιών και υπηρεσιών υγείας σε παγκόσμιο επίπεδο. Έχοντας ο ίδιος δουλέψει για τα τελευταία 25 έτη στον χώρο της φροντίδας τελικού σταδίου, αρχικά ως μουσικοθεραπευτής και στη συνέχεια ως διευθυντής της υποστηρικτικής φροντίδας του St Christopher's Hospice, θεωρεί την παρούσα συγκυρία ως την πλέον κρίσιμη για την επαναξιολόγηση και αναμόρφωση τόσο των δομών όσο και των ομάδων επαγγελματιών παροχής υπηρεσιών υγείας.

Στο πρώτο μέρος του βιβλίου γίνεται αναδρομή στην ιστορία και τη φιλοσοφία της ανακουφιστικής φροντίδας με αναφορά σε βασικές έννοιες όπως αύτη του "ολικού πόνου", της διεπιστημονικής ομάδας, του τρίπτυχου "φροντίδα, εκπαίδευση, έρευνα" το οποίο διέπει τη λειτουργία των μονάδων ανακουφιστικής φροντίδας από την εποχή της Cicely Saunders έως και σήμερα, τη σχέση της ανακουφιστικής με την προσέλκυση χορηγών-δωρητών, το βασικό δόγμα της δικαιοσύνης στην παροχή φροντίδας και τη σημασία των δεξιοτήτων επικοινωνίας.

Αναλύεται ο λόγος για τον οποίο είναι ιδιαίτερα χρήσιμο να γνωρίζει ο επαγγελματίας το στρατηγικό σχέδιο της μονάδας στην οποία απασχολείται, όπως και να είναι σε θέση να αντιλαμβάνεται τις διαφορετικές προσδοκίες, κίνητρα και ανάγκες που έχουν οι διαφορετικές ομάδες ανθρώπων που εμπλέκονται σε κάποιο κοινό σκοπό.

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Στο δεύτερο και τρίτο μέρος, με τη συμβολή θεραπευτών από το St Christopher's Hospice, ο επιμελητής πραγματεύεται μια σειρά θεμάτων που αφορούν στη λειτουργία της διεπιστημονικής ομάδας, στην επικοινωνία και στην εργασία σε ποικίλα περιβάλλοντα (π.χ. στην κοινότητα, στο εξωτερικό ιατρείο, στους εσωτερικούς ασθενείς). Αναλύονται επίσης πρακτικά ζητήματα, όπως η αίτηση και η συνέντευξη για διεκδίκηση μιας θέσης εργασίας στην φροντίδα τελικού σταδίου, η αυτοφροντίδα, η έρευνα και η αξιολόγηση.

Όλα τα κεφάλαια αρχίζουν με μια μικρή λίστα των θεμάτων που αναπτύσσονται, ώστε ο αναγνώστης να μπορεί να ανατρέξει σύντομα στο σημείο που τον ενδιαφέρει. Με εύληπτο τρόπο αναδεικνύονται οι ιδιαιτερότητες της επαγγελματικής ομάδας των θεραπευτών μέσω των τεχνών στον χώρο της φροντίδας τελικού σταδίου, όπου, παρόλο που συμμετέχουν ήδη εδώ και πολλά χρόνια, αυτοί οι θεραπευτές εύκολα περιθωριοποιούνται σε σχέση με τους υπόλοιπους επαγγελματίες.

Μέσα από παραδείγματα από την καθημερινή κλινική πράξη, αναδεικνύεται η πολλαπλή προσφορά της θεραπευτικής μέσω των τεχνών όσον αφορά στους ασθενείς, στους επαγγελματίες αλλά και στους οργανισμούς που παρέχουν ανακουφιστική φροντίδα. Αναδεικνύονται επίσης κάποιες περιοριστικές παράμετροι που χρειάζεται να έχει υπ' όψιν του όποιος επιθυμεί να ασχοληθεί με τον συγκεκριμένο τομέα.

Μία σημαντική παράμετρος είναι η σχέση εργασίας των επαγγελματιών, η οποία συνήθως αφορά συμβάσεις ορισμένου χρόνου. Αυτό συνήθως στερεί τον επαγγελματία από τη δυνατότητα να συμμετέχει σε όλες τις συναντήσεις της ευρύτερης διεπιστημονικής ομάδας και άρα να παίρνει την υποστήριξη και τη θετική ανάδραση από τα υπόλοιπα μέλη της.

Σημαντικό επίσης θέμα είναι η έλλειψη μιας κοινής γλώσσας μεταξύ των επαγγελματιών οι οποίοι προέρχονται από πολύ διαφορετικούς επιστημονικούς χώρους. Προτείνεται στην περίπτωση αυτή να χρησιμοποιείται το ίδιο το προϊόν της συνεδρίας (π.χ. ηχογραφημένη μουσική, εικαστικό έργο, κ.λπ.) ώστε οι θεραπευτές μέσω των τεχνών να περιγράψουν τη δουλειά που κάνουν με τον ασθενή και την οικογένεια στην υπόλοιπη διεπιστημονική ομάδα ή σε πιθανούς χορηγούς, χωρίς να είναι απαραίτητη η λεκτική περιγραφή.

Γίνεται επίσης εκτενής αναφορά στην πολύ σημαντική παράμετρο της χρηματοδότησης. Με βάση τις διεθνείς τάσεις προτείνεται να αναζητηθούν εναλλακτικές πηγές εφόσον οι επίσημοι φορείς (π.χ. ασφαλιστικά ταμεία) δεν προθυμοποιούνται να καλύψουν τα έξοδα πλην των παραδοσιακών ειδικοτήτων (ιατρική, νοσηλευτική, φυσικοθεραπεία).

Αναθέτοντας σε συναδέλφους του να μοιραστούν την προσωπική τους κλινική εμπειρία, ο επιμελητής επιδεικνύει την εξοικείωση των επαγγελματιών της ανακουφιστικής φροντίδας με την πολυφωνία και την ομαδική συνεργασία, συντηρώντας παράλληλα αμείωτο το ενδιαφέρον των αναγνωστών. Το βιβλίο αυτό εστιάζει στη ρεαλιστική απόδοση των ιδιαίτερων συνθηκών στην παροχή ανακουφιστικής φροντίδας, ειδικά όσον αφορά στο τελικό στάδιο της ζωής.Εκτός από την επιστημονική επάρκεια των επαγγελματιών, δίνει έμφαση στη δημιουργική ικανότητά τους να χρησιμοποιήσουν τις δεξιότητες και τη γνώση τους με ευελιξία, ώστε να ανταποκριθούν στις σύγχρονες προκλήσεις μετατρέποντάς τες ταυτόχρονα σε ευκαιρίες συνεργασίας.

Πολύ χαρακτηριστικό της διάθεσης του επιμελητή να παράσχει έναν χρηστικό οδηγό, ιδίως στους συναδέλφους που τώρα ξεκινούν την ενασχόλησή τους με τη φροντίδα του τελικού σταδίου, είναι το τελευταίο κεφάλαιο, όπου υπογραμμίζει εκ νέου τα σημαντικά θέματα τα οποία διεξήλθε στα προηγούμενα μέρη του βιβλίου και επιπλέον προσθέτει δέκα συμβουλές που προκύπτουν από τα κλινικά παραδείγματα που έχουν προηγουμένως παρατεθεί.

Προερχόμενη από διαφορετικό επαγγελματικό χώρο από αυτόν των συγγραφέων αλλά ασχολούμενη τα τελευταία χρόνια με την ανακουφιστική φροντίδα, διαπίστωσα ότι το παρόν βιβλίο αναδεικνύει θέματα κοινού ενδιαφέροντος και ευρύτατης εμβέλειας για όποιον δραστηριοποιείται στον συγκεκριμένο χώρο. Μπορεί να συμβάλλει στην καλύτερη κατανόηση και επικοινωνία των μελών της διεπιστημονικής ομάδας, καθώς συνειδητοποιούν τις δυσκολίες αλλά και τις δυνατότητες που δημιουργεί η συνύπαρξη διαφορετικών επαγγελματιών με κοινό στόχο. Ταυτόχρονα, πρόκειται για ένα πολύ ζωντανό κείμενο, το οποίο χωρίς καμία αίσθηση διδακτισμού μεταδίδει έμπνευση για συνεχή βελτίωση και πίστη στη δυνατότητα των αφοσιωμένων στον στόχο τους θεραπευτών να πλαισιώνουν εξατομικευμένα τους ασθενείς και τις οικογένειές τους προσφέροντας φροντίδα και ανακούφιση.

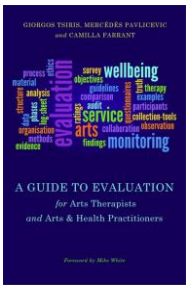
Προτεινόμενη παραπομπή:

Πέττα, Ε. (2016). Βιβλιοκριτική: “End of Life Care: A Guide for Therapists, Artists and Arts Therapists” (Nigel Hartley, Επιμ.). *Approaches: Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας, Ειδικό Τεύχος 8*(1), 85-87.

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

Book review

A Guide to Evaluation for Arts Therapists and Arts and Health Practitioners (Giorgos Tsiris, Mercédès Pavlicevic & Camilla Farrant)



Reviewed by Philippa Derrington

Title: A Guide to Evaluation for Arts Therapists and Arts and Health Practitioners | **Authors:** Giorgos Tsiris, Mercédès Pavlicevic & Camilla Farrant | **Year:** 2014 | **Publisher:** Jessica Kingsley | **Pages:** 176 | **ISBN:** 978-1-84905-418-8

Philippa Derrington, PhD, is Programme Leader of the MSc Music Therapy at Queen Margaret University, Edinburgh. She has worked as a music therapist in various settings with children, adults and older people. She developed music therapy provision for young people with emotional and behavioural difficulties at a secondary school in Cambridge and established a full-time post there. Her international research activities focus on music therapy for adolescents at risk of marginalisation and exclusion.

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This book provides a comprehensive overview of evaluation in the arts therapies and offers clear and practical steps in evaluating clinical practice. The authors, Giorgos Tsiris, Mercédès Pavlicevic and Camilla Farrant (from the Nordoff Robbins Research Department at the Nordoff Robbins Centre in London, UK) have successfully created a user-friendly guide that is suitable for students and practitioners from the arts therapies, wherever they are working.

Based on their own considerable experience, the authors take the reader through the evaluation process in clearly constructed and logically explained phases, beginning with how to plan and develop appropriate data collection tools and going on to cover how best to manage this data and present the evidence meaningfully.

After setting out the reasons for evaluating clinical work in the arts therapies, the first phase is given over to planning evaluation. This 'Phase 1' is explicated fully with relevant practical information to guide the reader. The following Phases, 2 and 3, detail the how and why of data collection. The authors present a useful introduction to statistics in Phase 4. Some references for further reading would have been helpful, particularly for those who want to pursue the use of specific quantitative evaluation tools. The final Phases 5 and 6 explain clearly how data can be drawn together and, importantly, disseminated.

The extremely informative, clear and engaging style makes this book easily accessible to those who have no experience of evaluation. The way that the authors have presented the chapters makes it easy to navigate and locate specific issues. Although the length of the book is attractive for such a guide, more illustrative examples added to each chapter and to each phase, such as case studies, would have been welcomed. These would have added colour and further helped the novice researcher grasp key concepts.

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The authors focus on relevant details and, whilst there is some repetition, the key points are made very clearly and the reiteration helps to remind the evaluator of each important step.

In some instances, the print within some figures and tables is very small and therefore unclear (for example, figures 1 and 14). As a result, some examples are impossible to read (for example, figures 8, 12, 23 and 24) and therefore do not add to the text as they could.

Ethics is not covered fully in this guide, although the authors clearly emphasise the importance for research ethics board approval for any project. It is therefore worth highlighting to the reader that *A Guide to Research Ethics for Arts Therapists and Arts and Health Practitioners*, also published by Jessica Kingsley in the same year and by the same authors, is a companion text.

On its own, *A Guide to Evaluation for Arts Therapists and Arts and Health Practitioners* answers many questions and will be helpful to all arts therapists across contexts and client groups. Masters' level students in the UK, in particular, will find this an invaluable guide as they are expected to evaluate work and understand evidence-based practice during an HCPC arts therapists' pre-registration programme, and it should be highly recommended as required reading.

I also expect this book to generate further interest in the practice of evaluation amongst arts therapists working in many different clinical contexts. I look forward to hearing of its constructive impact on the expansion of clinical practice across the arts therapies.

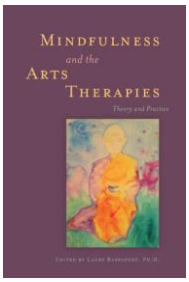
Suggested citation:

Derrington, P. (2016). Book review: "A Guide to Evaluation for Arts Therapists and Arts and Health Practitioners" (Giorgos Tsiris, Mercédès Pavlicevic & Camilla Farrant). *Approaches: An Interdisciplinary Journal of Music Therapy, Special Issue 8*(1), 88-89.

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

Book review

Mindfulness and the Arts Therapies: Theory and Practice (Laury Rappaport, Editor)



Reviewed by Foteini Athanasiadou

Title: Mindfulness and the Arts Therapies: Theory and Practice | **Editor:** Laury Rappaport | **Year:** 2014 | **Publisher:** Jessica Kingsley | **Pages:** 343 | **ISBN:** 978-1-84905-909-1

Foteini Athanasiadou has obtained an MSc in Dance/Movement Psychotherapy from Queen Margaret University, Scotland and is a registered member of the Association of Dance and Movement Psychotherapy (ADMP) UK. Her clinical experience includes work with children and adults in various settings, such as special and mainstream schools, an NHS dementia ward, and a day service for autism spectrum disorders. In addition, she holds experience in facilitating movement-based personal development workshops for adults, and she had been implementing well-being promotion programmes at Anatolia Elementary and Kindergarten in Thessaloniki, Greece. She lives and works in Brighton, UK.

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Mindfulness can be traced back to Buddhism 2,500 years ago and since then it has taken various forms both within and external to religious contexts. Nowadays, mindful practices and techniques have been successfully incorporated into modern western culture and lifestyles within educational, mental health and community contexts. Mindfulness which is underpinned by awareness and acceptance of the present moment, compassion and a non-judgmental way of being suggests the state of the quiet mind that affects overall wellbeing. In addition, there is clinical evidence and research regarding the positive outcomes of mindfulness in people's physical and emotional resilience, social and cognitive skills and spiritual enhancement (Caldwell 2014; Kabat-Zinn 2003). At the same time, arts therapies have been developed substantially as a creative approach to psychotherapy offering - through evidence-based practices - therapeutic change, integration of the emotional, social, mental, physical and spiritual aspects of one's self and a better sense of wellbeing (Karkou, Oliver & Lycouris in preparation; Karkou & Sanderson 2006; Payne 2006).

What happens when these two fields meet each other? How can the expressive aspects of arts therapies be combined with the more esoteric aspects of mindfulness? *Mindfulness and the Arts Therapies: Theory and Practice* is a book that thoroughly describes how mindful practices and creative therapies are integrated creating a continuum of psychotherapeutic methods. Laury Rappaport, originator of the FOAT (Focusing-Oriented Expressive Arts) method and editor of this multiple-authors book, invited international clinicians to contribute to the book proposing new ways of establishing a therapeutic relationship and achieving transformation and healing within the therapeutic space.

The book is comprised of six parts:

- Part I: an overview of mindfulness; how mindfulness has been practised in various religions and how it has influenced psychotherapy;
- Part II: discussion of the concepts of witnessing and intention in the therapeutic space and their role to promote self-reflection and awareness,

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artistic expression and internal peace;

- Part III: theoretical reviews and clinical applications of creative psychotherapeutic approaches combined with mindful practices; the chapters explore the use of drawing, voice, embodiment, poetry, music and dramatic enactment in combination with meditative silence, mindful breath and awareness of the present moment to achieve pain relief, meaning-making, mental and emotional wellbeing and spiritual growth;
- Part IV: accounts of mindful-based therapies that use creative mediums, such as movement and drawing. Clinical applications describe the implementation and effectiveness of Authentic Movement, Focusing-Oriented Arts Therapy, Hakomi & Art Therapy and Mindful-based Expressive Arts Therapy to heal people coping with diverse physical and emotional issues. In all cases, there are references to the principles underlying these mindful-based therapeutic approaches;
- Part V: the use of mindfulness within a training framework for art therapy and dance movement therapy students; and
- Part VI: input from a clinical neuroscience perspective; an extensive and comprehensive description of the "polyvagal theory" (Porges 2001) and its link to different ways of coping with stress; moreover, the chapter includes a discussion regarding the therapeutic use of arts and mindfulness and its link to evidence coming from the neuroscience field.

In addition, the book includes coloured illustrations which support case studies, a resource section containing a selection of mindfulness exercises and pieces of music and a section with the authors' brief biographies. Both the subject and author index in the end of the book are helpful.

This is a pioneering book in the field of psychotherapy that successfully achieves to convey the value of inner listening, compassion, awareness of the here-and-now moment and creativity in psychotherapeutic practice. All chapters include theoretical frameworks supported by updated theory and research as well as enlightening clinical applications. A broad spectrum of professionals, students and researchers would benefit from the proposed therapeutic methods developed by therapists who have being developing and applying them throughout their professional careers.

From a personal perspective, I believe that what gives additional value to the book is the fact that the authors disclose their personal experience with mindfulness and the artistic media, and they explain how their experience shaped their approach to psychotherapy. Additionally, there is diversity in the case studies regarding the clinical populations and settings. Overall, the book has effectively achieved to convey new thinking and possibilities regarding the psychotherapeutic process. Quoting from the book's foreword:

> "Mindfulness creatively joined with the new therapies offers a stream of helping and compassionate services for something very old. If the newness of this is taken beyond these words and disciplines, that very stream will become the ocean" (Rappaport 2014, p.13).

Having read the book, I once again confirmed to myself the significance of non-intrusiveness in both the therapeutic and self-relationship, as well as the inspiring and limitless potency of the creative therapies.

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Μεταφρασμένες περιλήψεις

Translated abstracts

Το αρχικό στάδιο ανάπτυξης της επαγγελματικής ταυτότητας του θεραπευτή μέσω τεχνών: Το παράδειγμα της Λετονίας

Elīna Akmane & Kristīne Mārtinsone

ΠΕΡΙΛΗΨΗ

Το άρθρο αυτό διερευνά το ζήτημα της ανάπτυξης της επαγγελματικής ταυτότητας του θεραπευτή μέσω τεχνών στη Λετονία. Εκατόν ογδόντα πέντε συμμετέχοντες κλήθηκαν να λάβουν μέρος στην έρευνα και να συμπληρώσουν ένα ερωτηματολόγιο σε ηλεκτρονική μορφή – 118 πιστοποιημένοι θεραπευτές μέσω τεχνών και 67 φοιτητές θεραπευτές μέσω τεχνών από όλες τις τέσσερις ειδικότητες. Το ερωτηματολόγιο συμπληρώθηκε από 101 συμμετέχοντες (51 πιστοποιημένους θεραπευτές μέσω τεχνών, 50 φοιτητές θεραπευτές μέσω τεχνών). Επιπλέον, πραγματοποιήθηκαν πέντε ομαδικές συνεντεύξεις οι οποίες συμπεριλάμβαναν πιστοποιημένους θεραπευτές και φοιτητές. Ως θεωρητική βάση, αυτή η έρευνα χρησιμοποιεί το μοντέλο του Berliner (1994) σχετικά με την ανάπτυξη της επαγγελματικής ταυτότητας το οποίο διακρίνει πέντε στάδια και επίπεδα ανάλογα με τη διάρκεια της επαγγελματικής δραστηριότητας και τη συσσωρευμένη εργασιακή εμπειρία. Ο στόχος της μελέτης ήταν να εντοπίσει τους παράγοντες που διαμορφώνουν την επαγγελματική ταυτότητα ενός θεραπευτή μέσω τεχνών, αλλά και να διερευνήσει τους παράγοντες που επηρεάζουν την εξέλιξη της επαγγελματικής ταυτότητας. Αυτή η μελέτη διερευνά τι βοηθάει και τι εμποδίζει τη διαδικασία ανάπτυξης της επαγγελματικής ταυτότητας του θεραπευτή μέσω τεχνών. Η έρευνα και τα κεκτημένα αποτελέσματα μπορούν να χρησιμοποιηθούν για το σχηματισμό ή τη βελτίωση της εκπαίδευσης των θεραπευτών μέσω τεχνών. Τα συμπεράσματα αυτά θα μπορούσαν να χρησιμοποιηθούν για την καλύτερη υποστήριξη της προσωπικής και επαγγελματικής ανάπτυξης των φοιτητών και στην αναθεώρηση των προσεγγίσεων εποπτείας, προβλέποντας πιθανές δυσκολίες κατά τη δημιουργία των συστημάτων υποστήριξης.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

θεραπευτής μέσω τεχνών, επαγγελματική ταυτότητα, ανάπτυξη, Λετονία

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Μαθαίνοντας μαζί: Μια έρευνα σχετικά με τις δυνατότητες της διεπαγγελματικής εκπαίδευσης στη μουσικοθεραπεία

Jenny Laahs & Philippa Derrington

ΠΕΡΙΛΗΨΗ

Η βιβλιογραφία αναγνωρίζει τα οφέλη που επιφέρει η συνεργασία μεταξύ μουσικοθεραπευτών και άλλων επαγγελματιών για τον θεραπευτή ο οποίος συνεργάζεται, για τους πελάτες και για το ίδιο το επάγγελμα της μουσικοθεραπείας. Ωστόσο, η συζήτηση σχετικά με το πώς οι θεραπευτές αποκτούν τις δεξιότητες που απαιτούνται για τη συνεργασία είναι περιορισμένη. Σε ένα ευρύτερο πλαίσιο φροντίδας υγείας, η αρχή της διεπαγγελματικής εκπαίδευσης αξιοποιείται για τη διευκόλυνση μιας τέτοιας συνεργασίας επί της πράξης. Αυτή η μελέτη μελετά συνεδρίες ομότιμης επανεξέτασης κλινικής εργασίας ως δυνητικό εργαλείο διεπιστημονικής εκπαίδευσης στο πλαίσιο ενός προγράμματος εκπαίδευσης στις θεραπείες μέσω τεχνών στο Ηνωμένο Βασίλειο, μέσα από μια μουσικοθεραπευτική σκοπιά. Μέσα από τη χρήση ενός φαινομενολογικού παραδείγματος, διαμορφώθηκε και αξιολογήθκε η εμπειρία της συμμετοχής σε διεπιστημονικές συνεδρίες ομότιμης επανεξέτασης μεταξύ μιας φοιτήτριας μουσικοθεραπείας και μιας φοιτήτριας χοροκινητικής ψυχοθεραπείας.

Η μελέτη διαπίστωσε ότι η διεπιστημονική ομότιμη επανεξέταση βιώθηκε ως ωφέλιμη εκπαιδευτική εμπειρία με διάφορους τρόπους, συμπεριλαμβανομένης της ανάπτυξης αμοιβαίας υποστήριξης, της διεύρυνσης των προοπτικών άλλων επαγγελμάτων και της ανάπτυξης δεξιοτήτων επικοινωνίας μεταξύ διαφορετικών πεδίων. Τα αποτελέσματα προσφέρουν ένα δυνάμει πλαίσιο στο οποίο μπορεί να στηριχθεί η ανάπτυξη διεπιστημονικών δράσεων εντός του εκπαιδευτικού πλαισίου του Ηνωμένου Βασιλείου.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, θεραπείες μέσω τεχνών, συνεργασία, διεπιστημονική εκπαίδευση, κατάρτιση, ομότιμη επανεξέταση

Η **Jenny Laahs** ολοκλήρωσε τις μεταπτυχιακές της σπουδές στη μουσικοθεραπεία (Nordoff Robbins) στο Queen Margaret University στο Εδιμβούργο το 2014. Αυτό το άρθρο έχει προσαρμοστεί από την τελική της διατριβή. Η πρώτη της μουσικοθεραπευτική εργασία μετά την αποφοίτησή της ήταν σε ένα πρόγραμμα ανάπτυξης δεξιοτήτων διάρκειας έξι εβδομάδων στο Tbilisi της Γεωργίας, με τον οργανισμό Music as Therapy International. Η Jenny τώρα εργάζεται για το Nordoff Robbins Music Therapy στη Σκωτία με ένα εύρος πελατειακών ομάδων.

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Η ενοποιημένη ομάδα θεραπειών μέσω τεχνών: Κοινή ανάπτυξη πρακτικών στην Εθνική Υπηρεσία Υγείας της Αγγλίας

Simon Hackett

ΠΕΡΙΛΗΨΗ

Η σύνθετη φύση πολλών θεραπευτικών παρεμβάσεων μέσω τεχνών υποδηλώνει έναν πλούτο στην ανάπτυξη πρακτικών καθώς και στον αριθμό των πιθανών εφαρμογών τους στον κλινικό, κοινωνικό και πολιτιστικό τομέα. Σήμερα υπάρχει μεγαλύτερη ευκαιρία για μελέτη της αλληλοεπικάλυψης των κοινών μοντέλων, δεξιοτήτων, τεχνικών και προσεγγίσεων στις θεραπείες μέσω τεχνών, και σε μια ενοποιημένη ομάδα θεραπειών μέσω τεχνών στην Εθνική Υπηρεσία Υγείας (NHS) έχουν προκύψει μερικά πρώτα παραδείγματα κοινών διεπιστημονικών πρακτικών. Μια σειρά παραδειγμάτων βασισμένων στην πράξη χρησιμοποιούνται για να απεικονίσουν το έργο μιας ενοποιημένης ομάδας θεραπειών μέσω τεχνών στο NHS της Αγγλίας. Περιγράφονται εξελίξεις κοινών πρακτικών συμπεριλαμβανομένων κοινών θεραπευτικών επιπέδων, κοινών παρατηρήσεων, κοινών τεχνικών και κοινού θεραπευτικού έργου. Ευελπιστώ ότι αυτές οι περιοχές κοινής ανάπτυξης εντός ενός κλινικού πλαισίου θα οδηγήσουν στην ανάπτυξη πρακτικών που υποστηρίζουν βελτιωμένα αποτελέσματα για τους πελάτες.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

θεραπείες μέσω τεχνών, ανάπτυξη πρακτικών, ανταλλαγή πρακτικών, νοητική καθυστέρηση, σύνθετη παρέμβαση

Ο **Δρ Simon Hackett** είναι ένας κλινικός ακαδημαϊκός εικαστικός ψυχοθεραπευτής ο οποίος εργάζεται σε μια ενοποιημένη ομάδα θεραπειών μέσω τεχνών στο NHS της Αγγλίας. Το έργο και η έρευνά του επικεντρώνονται κυρίως στις θεραπευτικές παρεμβάσεις μέσω τεχνών με ενήλικες και παιδιά με νοητική καθυστέρηση και αναπτυξιακές αναπηρίες.

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Εξετάζοντας τα στοιχεία πρακτικής των ψυχοθεραπειών μέσω τεχνών: Πρώτα ευρήματα από το Πρόγραμμα Ορίζοντες (Horizons Project)

Dominik Havsteen-Franklin, Anna Maratos, Miriam Usiskin & Mary Heagney

ΠΕΡΙΛΗΨΗ

Υπόβαθρο: Οι Ψυχοθεραπείες μέσω Τεχνών (εικαστική τέχνη, μουσική, δράμα και χορός/κίνηση) αποτελούν αναπόσπαστο μέρος των υπηρεσιών ψυχικής υγείας για αρκετές δεκαετίες, όμως η συναίνεση και η διαφάνεια σχετικά με την κλινική διαδικασία εξακολουθεί να είναι υπό διερεύνηση. Αυτή η μελέτη ερευνά την πρακτική μιας ομάδας έξι ψυχοθεραπευτών μέσω τεχνών που εργάζονται με σοβαρές ψυχικές ασθένειες στο Λονδίνο, σε ενδονοσοκομειακές και κοινοτικές υπηρεσίες. Η μελέτη εξετάζει τι στοιχεία πρακτικής χρησιμοποιούνται εντός των συνεδριών, αν υπάρχει συναίνεση σχετικά με το ποια είναι αυτά τα στοιχεία και το γιατί οι θεραπευτές μέσω τεχνών τα χρησιμοποιούν.

Μέθοδος: Οι μέθοδοι που χρησιμοποιήθηκαν στην πρώτη φάση του προγράμματος βασίζονταν σε συνεντεύξεις με θεματική ανάλυση, ενώ οι τεχνικές του πλέγματος ρεπερτορίων (repertory grid) και της ονομαστικής ομαδικής γένεσης ιδεών (nominal group technique) χρησιμοποιήθηκαν για την ανάλυση των δεδομένων με σκοπό την τριγωνοποίηση των αποτελεσμάτων και την εξασφάλιση μεγαλύτερης ισχύος.

Αποτελέσματα: Τα αποτελέσματα έδειξαν ότι υπάρχει περιθώριο για την ανάπτυξη μιας κοινής γλώσσας σχετικά με τα ενδο-συνεδριακά στοιχεία πρακτικής μέσα σε ένα πλαίσιο ψυχικής υγείας. Ωστόσο, η έρευνα που εξετάζει την επιλογή του χρόνου και τους λόγους για τη χρήση αυτών των στοιχείων πρακτικής είναι υπό εξέλιξη. Σε αυτή τη μελέτη, τα πρώτα αποτελέσματα από ένα απόσπασμα από τις συνεντεύξεις απεικονίζουν μια σύνθετη σχέση μεταξύ θεωρίας και πράξης.

Συμπέρασμα: Από τα ευρήματα μέχρι στιγμής φαίνεται ότι μέσα στο συγκεκριμένο πλαίσιο είναι εφικτό να δούμε ότι υπάρχουν τρόποι κατηγοριοποίησης των ενεργειών του θεραπευτή οι οποίοι γίνονται συγκρίσιμοι μεταξύ των διαφορετικών ψυχοθεραπειών μέσω τεχνών. Από προσωπικές περιγραφές της πρακτικής του/της θεραπευτή/τριας φαίνεται επίσης να υπάρχει μια στενή συσχέτιση μεταξύ των ψυχοθεραπειών μέσω τεχνών σε ένα πλαίσιο κοινοτικής και νοσηλευτικής ψυχικής υγείας. Επιπλέον, τα μοντέλα τεκμηριωμένης πρακτικής, όπως οι θεραπείες βασισμένες στην εν-νόηση (mentalisation-based therapies) φαίνεται να έχουν μια στενή συσχέτιση.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

θεραπείες μέσω τεχνών, ψυχική υγεία, πλέγμα ρεπερτορίων (repertory grid), ονομαστική ομαδική τεχνική γένεσης ιδεών (nominal group technique), συναίνεση, τεκμήρια, εν-νόηση

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A continuing professional development model for the arts therapies in oncology

Georgia Aroni

ABSTRACT

This paper refers to the experience of the continuing education programme 'The Arts Therapies in Oncology' which took place at the Alanus University of Arts and Social Sciences in Bonn, Germany. It focuses on the exchange and correlation of the fields of Music Therapy, Art Therapy and Dance Therapy as these occur in the programme, with the aim to train arts therapists in the basic principles of oncology and psycho-oncology. In particular, it refers to the design, organisation and content of this programme.

KEY WORDS

oncology, psycho-oncology, cancer, arts therapies, continuing professional development, Germany

Georgia Aroni is a clinical dance movement psychotherapist BTD- GDTR Sr, with parallel studies in Education and in Hellenic Culture. She is a member of Berufsverband der TanztherapeutInnen Deutschlands (BTD) as well as of the Greek Association of Dance Therapists (GADT). In recent years she has been living in Germany and currently works in a rehabilitation clinic at the Psychosomatic and Psychotherapy department with patients who present a wide spectrum of disorders. She has worked in various clinical contexts with chronic mental health patients, with substance users and she has designed and organised innovative training programmes for adolescents and children. Focusing on the treatment of mental and emotional trauma, she investigates, practises and teaches the practice of Authentic Movement. In addition she runs seminars and workshops for mental health professionals and the general public.

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The CATI team: Experiences and reflections regarding the co-action of arts therapies

Foteini Athanasiadou, Diana Kagiafa, Vicky Karkou, Mytro Lykopoulou, Tasos Babalis, Aggeliki Bitzaraki, Candia Bouzioti, Ergina Sampathianaki & Giorgos Tsiris

ABSTRACT

This article describes the trajectory of the CATI team – a team of Greek arts therapists who work in Greece and the UK. In addition to a historic documentation of the team's work since 2011, personal experiences and reflections of the team members are described, as these emerged through an artistic inquiry process. Drawing from the work and experiences of the CATI team, the authors set questions and offer suggestions regarding interdisciplinary collaboration while considering the broader field of arts therapies not only in Greece but also internationally.

KEY WORDS

arts therapies, CATI team, interdisciplinary collaboration, artistic inquiry

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