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Elsevier are grateful to Dr Raymond MacDonald for kindly allowing us to use a selection of his art for the book cover. The front cover image is 'Station Map' and the back cover images are (top to bottom) 'Thelonious', 'Bird on Verve' and 'Scottish Sky No. 1'.

Preface

When we first thought about looking at the field of arts therapies as a whole we were aware that our task was ambitious. We knew that the field is complex, as any field involving social interaction is likely to be, but it is even more so because arts therapies involve multilayered therapeutic endeavours. The use of the arts and associated creativity and imagination also suggest limitless applications. Moreover, there are different traditions within the field deriving from subdivisions into music, art, drama and dance therapy fields, each with its own huge variety of practices. Therefore, attempting to describe such a complex and diverse field was not always easy. Attempting to do so while both of us were in full-time employment was an additional challenge.

However, a major aid to this task has been the fact that a substantial part of this book was based on our empirical research work completed over a number of years at the School of Education at The University of Manchester. This study was supported financially by the Economic and Social Research Council (ESRC) as part of the PhD work completed by one of the authors and supervised by the other. A large number of arts therapists offered their time and expertise as participants in the study through interviews and/or through responding to the survey questionnaire. Key participants in the first interview stage were, amongst others: Laurence Higgens, Steve Mitchell, Dr Helen Payne and Susan Scarth. The 580 arts therapists practising in the UK who responded to the survey also need to be acknowledged.

In a follow-up research project, financial support and time was offered by the Department of Art and Arts Therapies at the University of Hertfordshire. During this second research period, leading figures in the field made additional contributions in the form of case vignette material and explanations about their own practice; many of these contributions have been included in the book. For their input, we need to thank: Madeline Andersen-Warren, Dr Gary Ansdell, Professor Leslie Bunt, Sue Curtis, Dr Alida Gersie, Dr Sue Jennings, Dr Alison Levinge, Helen Odell-Miller, Nina Papadopoulos, Kay Sobey and Derryn Thomas.

We are also thankful to: Alex Chew, Katrina Hyvonen, Dr Raymond MacDonald, Pauline McGee and Patti Parfitt who, during the revision process of the manuscript, commented on certain specialised chapters (especially those in Section 2) from a discipline-specific perspective. Given our consistent attempts to include the voices of practitioners from within the field during all the stages of our research work, it has been vital to check whether practitioners' voices were indeed recognised by their colleagues from the same discipline in the final delivery of this work, i.e. this book. Ultimately, we hope that the arts therapists reading this book will offer additional comments, perspectives and ideas and will engage in fruitful discussions about its content.

Finally, we need to thank: Mark Elliott, Dr Colin Lees, Themis Kokolakakis, Professor Frank Sanderson and Dr Dimitris Sirakos who read substantial sec-

tions of the book, identified areas of ambiguity, asked questions about the content and commented on the overall style of our writing. We found that their input contributed towards making this book accessible to a much wider audience than the arts therapies field. We will be glad if this will indeed prove to be the case.

Vicky Karkou and Patricia Sanderson, 2005

Introduction

Both authors have experienced the blank looks on the faces of people when they first hear about arts therapies:

'Arts what?'

'Therapy for whom . . .?'

Or on a more positive note:

'Oh, yes, I understand. When I listen to my favourite music, I find it so relaxing.'

'It's about self-expression.'

'It's when you use people's drawings to find out what sort of problems they have.'

Nevertheless, the message is clear: the field is new and largely unknown to the general public. Thus, we often find ourselves in the position of having to introduce, explain or correct:

'It's not about relaxation only.'

'It's not just about self-expression . . .'

'It's not just a diagnostic tool (although it may be used as one).'

Undoubtedly, such misconceptions suggest that arts therapies are not sufficiently known and understood by the public. Although arts therapies (otherwise known as creative arts therapies) are becoming increasingly recognised within health services, schools and social or voluntary organisations, we believe that even amongst colleagues in these settings there is limited understanding of what the field stands for. Similarly, although there is a growth in availability of postgraduate training courses within established higher education structures and an increasing number of publications and research studies in the area, we are aware that these developments have not been as extensive or as rapid, as we, along with many members of the profession, would wish.

A major aim of this book is therefore to offer explicit descriptions and explanations of arts therapies practices that make the field accessible to lay readers and other professionals. Indeed, not to do this will perpetuate misconceptions, will inevitably limit the progress of the profession, and will lead to questioning of the quality of the service provided to the public.

Another important aim of this book is to inform arts therapists themselves about the field as a whole and/or other practices that exist alongside their own. The arts therapies field consists of four professions: art therapy (AT), music therapy (MT), dramatherapy (DT) and dance movement therapy (DMT). Despite the common threads amongst these four professions, each of them has a separate history and training, separate professional organisations and indeed different theoretical and methodological preferences. Although these days there are a number of arts therapies teams consisting of DT, MT, AT and/or DMT, the majority of arts therapists still find themselves working in isolation with limited connections with professionals from other arts therapies disciplines. This book aims to bring these isolated practices together, outline similarities and differences and offer a broad picture within which

practitioners can make connections between their own work and the work of their colleagues.

In order to achieve the above aims, this book is based extensively on our research work in the field. Our research perspective is different from those frequently adopted in the relevant published literature. For example, this book does not limit itself to case study material from one practitioner with one client, one client group and/or in one setting. It does not limit itself to one arts therapies discipline either. Instead, it offers general demographic information, overall trends and a collection of case vignettes that are found across a variety of arts therapies practices. The voices of as many practising arts therapists in the UK as possible are incorporated in the book, either as analysed findings from contributions from a large number of research participants, or as direct quotes and summaries from a selected few. Grounded theory has offered philosophical justification for our research design (the study was 'grounded' in the field – Glaser & Strauss 1967), while creativity, an important aspect for arts therapies practice and research (Meekums 1993), has been a characteristic of our methodological choices (see Appendix 1 for further details on research methodology).

With empirical research work to back up our writing, this book claims to offer a first broad picture of the field in the UK. Although references to arts therapies in the USA are also made (there is substantial literature originating from there), our emphasis remains on arts therapies in the UK. With few exceptions, British arts therapies literature is primarily used to discuss relevant concepts and findings from our study. We are aware that locating arts therapies in the context of the whole of the UK is an ambitious undertaking, especially as the individualistic nature of practice is characteristic of the work in the UK; Woddis (1986) for example, acknowledges this culture within British *art* therapy; we find this to be true for the field as a whole. At the same time, we believe that, despite this diversity, there are a number of commonalities across arts therapies practices. As the American dramatherapist Landy (1995) claims: 'The . . . differences among our modalities of treatment are ultimately insignificant for, as professionals, we are more alike than different' (p. 84). A number of voices from within the field (the majority of them are American) call for developing closer links between different arts therapies (e.g. Johnson 1994, 1999, Levine 1997, McNiff 1986). In Europe, the ECArTE (European Consortium for Arts Therapies Education) plays an important role in promoting such links across arts therapies and across nations. In the UK, all four modalities fall under one group for professional registration with the Health Professions Council (HPC), while work across disciplines is currently undertaken in a number of areas (e.g. standards of practice, benchmarking, research and education). Waller, leading the way for arts therapies towards HPC registration, has argued that the four arts therapies share enough in common to be regarded 'as a single professional body for regulatory purposes' (cited in ADMT UK 1997, p. 15). However, there have been no substantial attempts, as yet, to delineate common ground between disciplines in terms of theory and practice in a manner that goes beyond anecdotal testimonies or short scale projects.

In an attempt to foster close links amongst arts therapies in the UK, this book offers an overall description of professional groupings and identifies

common areas of clinical practice. At the same time it refers to arts therapies as separate disciplines. We can see these different arts therapies as different 'cultures' or better 'subcultures'. With such associations, our work can be seen as holding a cross-cultural perspective. One of the major discussions within cross-cultural studies is the preference for either an absolute or relative position, otherwise known as the etic-emic debate (Shiraev & Levy 2001). With the first perspective, commonalities are highlighted. With the second, differences are valued. Both of these approaches have their limitations as well as their strengths. Strict absolutism bears the danger of making comparisons between things that are different, e.g. comparing an apple to an orange. Strict relativism has the disadvantage of prohibiting any comparisons between fields assuming that everything is context-specific. Our position is that arts therapies share between them a number of common features that can be studied and presented through the search for common beliefs and practices (absolutism). We also see each of the arts therapies disciplines as having their own idiosyncrasies and unique character that make sense within a specific context (relativism). In this book we will be shifting from one position to the other. According to Shiraev & Levy (2001, p 5) 'there are not two cultures that are either entirely similar or entirely different'. This statement is even truer for arts therapies within which separate disciplines are perceived as subcultures of a greater whole. Looking at arts therapies as one whole and arts therapies as separate disciplines is reflected in Sections 1 and 2 of the book, respectively.

In particular, in Section 1, we place the field in the wider western context from which it mainly originates and make a brief review of the development of arts therapies in the UK. We present and discuss common issues surrounding arts therapies professional associations, training courses, professional developments and important working environments. We also refer briefly to the range of client groups currently working with arts therapies. We argue that arts therapies is a field that is different from therapeutic arts, arts education or 'talking therapies' (i.e. psychotherapy and counselling), areas incidentally, which often overlap with arts therapies.

By examining a number of definitions associated with each of the arts therapies subfields, which are discussed in the literature, we endeavour to redefine the field and highlight common aspects across all arts therapies. Some of the common topics we discuss are: principles and assumptions about the use of the arts, the emphasis on creativity, the role of imagery and imagination, symbolism and metaphors, non-verbal communication, the significance of the client–therapist relationship and the type of therapeutic aims relevant to arts therapies. There are a number of other aspects that are not covered in our list of essential common features of arts therapies. For example, all arts therapists are engaged in routine assessment/evaluation practices. This aspect of arts therapies work deserves specialised attention and research. Readers interested in this topic can consult sections/chapters within discipline-specific books or arts therapies publications such as Feder & Feder (1998) and Wigram (2000).

Section 1 also deals with the need to locate arts therapies work within therapeutic frameworks that support, explain and guide practice. The role of theory and those therapeutic frameworks most frequently drawn upon by

arts therapists are given close attention. We discuss the humanistic, psychoanalytic/psychodynamic, developmental, artistic/creative, active/directive and eclectic/integrative trends in relation to major principles, models and/or methodological relevance to arts therapies practice. Throughout Section 1 we consider the field as a whole.

In Section 2, we address arts therapies as separate modalities and focus on the uniqueness of each discipline in terms of both their separate professional developments and current practices. Some important approaches to MT, AT, DT and DMT are presented, compared and contrasted. Case examples illustrate these different approaches and present opportunities for some understanding of practices in each modality.

Although it is not our intention to offer in-depth accounts of each of the different disciplines (key texts in each separate discipline are more appropriate readings for this), the interplay between closeness (distinctive practices – Section 2) and distance from the subject (field as one whole – Section 1) will offer the lay reader of this book the possibility of a first, comprehensive understanding of the field. Comparisons between practices and between disciplines will give an opportunity to the more informed reader to think about what is common and what is unique in the field and, if the reader is an arts therapies practitioner, to locate his or her own practices within the wider picture. We believe that mapping the field in this way will provide a sound basis from which information can be acquired, discussion can be triggered and further development can proceed.

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Section 1

Arts Therapies as One Field

Chapter 1: Professional Development of Arts Therapies

Chapter 2: Defining Arts Therapies

Chapter 3: Important Features of Arts Therapies

Chapter 4: Therapeutic Trends across Arts Therapies

For this section of the book we will discuss arts therapies as one field in order to identify patterns of practice that are shared amongst different disciplines of art therapy (AT), music therapy (MT), dramatherapy (DT) and dance movement therapy (DMT). The main reason for our 'global' approach to the field is our belief that arts therapies have a lot of things in common that are hardly ever discussed in any depth within existing arts therapies literature. The silence on the topic is even more curious given the fact that arts therapies disciplines currently come under the same umbrella insofar as professional registration with the Health Professions Council (HPC) is concerned. Although they retain separate professional identities, they manage to represent the field with one voice when faced with governmental negotiations. We find that the fact that arts therapies are collaborating closely in relation to professional issues is not just the result of a strategic decision for professional recognition, although, as McNiff (1986) argues, this can also play an important role. Over the years, members of the different arts therapies disciplines have felt strong affiliations with each other. We think that this tendency reflects the common ground shared across arts therapies, for example in terms of theoretical principles and ethos of practice. Section 1 looks at exactly this, i.e. the areas of overlap across the four disciplines.

What Section 1 does not attempt to do is to make a case for all four disciplines to become one. Initiatives to bring arts therapies together in one professional body that emerged during the early days of professional development were finally abandoned as theoretically unsound and professionally dangerous. It was believed that the depth of knowledge and understanding of the art form would be jeopardized, and consequently clinical practice would become superficial and thus questionable. Such initiatives were also seen as putting already limited resources into further danger. Policy makers could easily settle for cheap solutions in relation to anything to do with the arts, and as a consequence, also anything to do with arts therapies. Similar debates had already taken place in arts education. Movements that supported an arts education system in which all arts were taught as one subject were subsequently dropped with a similar rationale.

Instead, Section 1 attempts to look at similarities amongst arts therapies in order to foster closer links between practices, contribute to further development of collaborative work amongst practitioners and strengthen the theoretical and practical positions of each of the four disciplines. While differences may offer richness and depth in the field, common features may create a clearer and thus stronger basis for further developments.

From a cross-cultural perspective, Section 1 is closely aligned with absolutism (an etic view) in that it steps back from each of the separate disciplines and attempts to describe the bigger picture of the field as a whole. While it throws light on what is common amongst the disciplines, with few exceptions, it leaves in the shadow what is different and unique about each of them separately. Section 2 will focus more on the 'different' and 'unique' in each discipline.

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Chapter 1

Professional Development of Arts Therapies

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Key issues:

- The idea of the arts for healing has been in and out of favour throughout western history. This view was highly regarded in classical Greece, but lost favour during the Middle Ages. During the Renaissance and the Age of Enlightenment the healing purpose was reinstated, but again was suppressed during the Victorian era.
- Modern psychology/psychotherapy, artistic movements at the beginning of the 20th century, and movements within social psychiatry and education during and after the Second World War, opened the way for the development of arts therapies.
- Official recognition of the professional status of arts therapies began in the second half of the 20th century as a result of political action initiated by artists, teachers and other health professionals.
- Arts therapies are organised according to each art form into separate professional associations. The aims of all these associations are similar: to represent members' interests, to negotiate conditions of work, and jointly with the Health Professions Council to assure quality of practice.
- Training for qualified arts therapist status takes place at postgraduate level. Currently there are more than 15 universities offering or validating arts therapies training courses at a Master's level.
- Arts therapists work mainly in hospitals, in education or in community-based settings with a range of client groups; the most important areas of work are in mental health and learning disabilities.

Introduction

Arts therapies is a field that, in the west, has developed significantly during the 20th century. However, the use of the arts for healing purposes is much older. A brief overview is presented in order to locate some of the historical roots of arts therapies and provide a perspective on the use of the arts for healing and/or well-being. A background to the re-emergence and growth in popularity of arts therapies since the end of the 19th century will assist us in describing the immediate roots of the field, in the UK in particular. Current professional developments are described particularly in relation to British professional associations, training courses and main areas of work. With the exception of the broad sources of information utilised in the first sections of this chapter and some references to government documents later on, findings from our study are discussed in relation to relevant arts therapies literature.

The healing role of the arts: an historical perspective

The arts have been used as therapy and/or healing for centuries (see Fig. 1.1). For example, evidence from prehistoric times and anthropological studies of contemporary indigenous cultures suggests that the arts had functional purposes of a magico-religious nature (Fleshman & Fryrear 1981). The connection of the arts in rituals with the supernatural has served, and in some places continues to serve, as the predominant means of preventing or curing physical and mental illness, of not only the individual but also the community as a whole. In the west, and classical Greece in particular, there was a strong belief in the integrated nature of mind and body, and a strong connection between music and medicine. Apollo, the god of music, was also a physician to the other gods, with sons such as Aesculapius, the god of medicine, and Orpheus, the god of soothing and curative music. Similar emphasis was placed on the power of music by Pythagorean thinkers, who perceived specific types of music as contributing towards the promotion of individual and universal harmony. The belief in harmony and balance was extended to all the other arts and theatre enactment in particular. Aristotle (trans. 1961), for example, regarded drama as promoting catharsis through identification of the audience with the ordeals of the actors, emotional crescendo and eventual return to a more normal balance of emotions. Similarly dance, as part of ancient Greek theatre, ceremonies and rituals, was regarded as contributing to emotional balance and therefore mental health.

However, such confidence in the power of the arts for mental health was not retained during subsequent periods in Greek history, starting with Plato. The arts were banned from his ideal city (Plato, trans. 1957) because artistic engagement was regarded as enabling people to get in touch with feelings that would make them 'emotional and softer than they ought to be' (Plato, trans. 1957 p. 84). Furthermore, the 'world of ideas' attained a superior position and the mind–body division was introduced for the first time in the western world.

During the Middle Ages, Christianity, which spread rapidly throughout Europe, was a major influence, and it embraced this premise (Feder & Feder 1981). However, the Christian Church held an ambivalent attitude towards

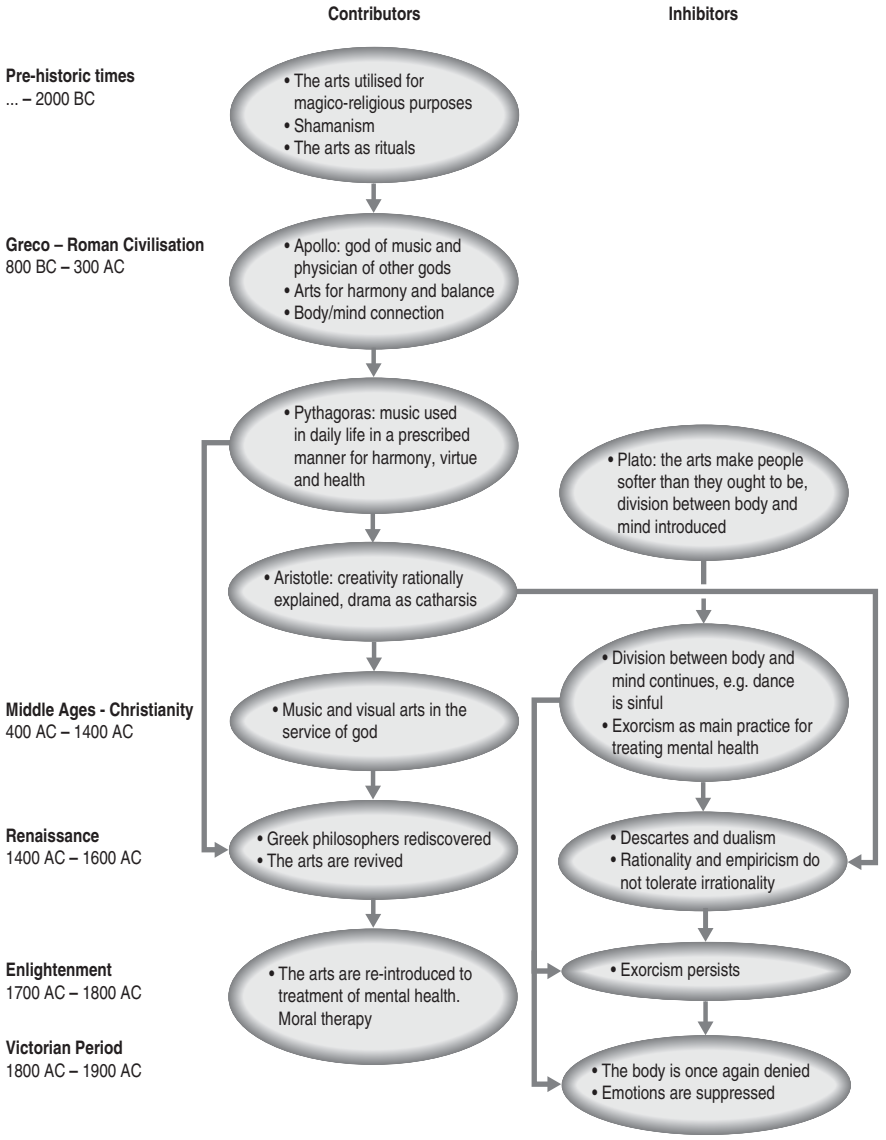

Figure 1.1: *The arts as healing in western Europe.*

the arts as a form of expression that involved both the body and the mind. On the one hand it regarded dance as sensual and therefore sinful, yet on the other, enlisted music and the visual arts in the service of God (Clark 1966). It is also likely that the Church, despite officially holding some anti-arts doctrines, integrated preChristian rituals and arts practices into its religious services. This ambiguous relationship between the Church and the arts continued for a long time.

Major shifts of thought occurred during periods such as the Renaissance and Enlightenment. The former for example, signified a shift towards rationality and empiricism through the revival of Greek philosophers and Aristotle in particular. With this revival, the status of the arts increased compared to that in the Middle Ages. However, this period also signified the re-establishment of

dualism initially introduced by Plato in classical Greece. Descartes (1947 [trans.]), the philosopher with whom dualism is most often connected, was searching for truth. According to him the truth could only be achieved through rational thought and the mind, a process that was distinct and superior to sensory experience and the body. Consequently, the arts that involved the senses and the body had nothing to do with the truth and were perceived as more closely aligned with mere amusement. Similarly, the treatment of mental illness did not improve. On the contrary, the belief in rationality led to a decreased tolerance towards irrationality and consequently towards mental illness. Exorcism remained the means of dealing with mental illness, often employing harsh methods of 'separating the devil from abnormally behaving victims' (Fleshman & Fryrear 1981, pp. 12–13). It was not until the Age of Enlightenment that the arts were re-introduced in the treatment of people with mental health problems, mainly through the moral reform movement, and as a form of occupational therapy (Fleshman & Fryrear 1981). The Victorian period of the 19th century signified yet another backlash: emotions were suppressed and there was only limited acceptance of the interdependence of body and mind.

The emergence of arts therapies in the 20th century

Arts therapies emerged as a result of changes in a number of related areas (see Fig. 1.2). For example, between the end of the 19th and beginning of the 20th centuries, a number of revolutionary changes occurred in the arts and their relationship to mental health. The 'Art of the Insane' and Cizek's 'Child Art' movements in visual arts (Waller 1991), the contribution of Isadora Duncan, Mary Wigman and most importantly, Laban to dance (Levy 1992), and Stanislavski's, Evreinov's and Artaud's approaches to the theatre (Jones 1996), are some examples of the roots of arts therapies found in the arts world during this period. Although most of these artists and movements were very different from each other in terms of emphasis, content and direction of their work, they shared common themes: they emphasised self-expression, placed value on emotions, attempted to connect the artists' artistic work with psychological states, made sociological and political references and interventions, and stressed new ways to relate to the audience or the spectators.

Simultaneous with revolutionary developments in the arts world, psychotherapy emerged with the writings of Freud and the founding of psychoanalysis. After centuries of Aristotelian thinking, Freud's writings signified a

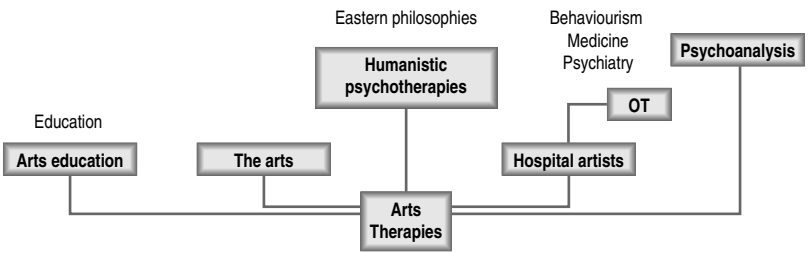

Figure.1.2: *Contributors to the emergence of arts therapies in the 20th century in the UK.*

challenge to rational materialism. The concept of the unconscious was introduced and intrapsychic forces were acknowledged. The belief in the presence of the unconscious opened up the way to make connections with the arts and provided starting points for the development of arts therapies. For example, the surrealist movement was particularly inspired by Freudian writings. Open expression, spontaneous play and acknowledgement of the irrational characterised this artistic movement and was closely connected with Freud's free association technique which had been introduced as a means of accessing the unconscious material of the individual (Chilvers et al 1988, Hogan 2001).

Other thinkers linked with the psychoanalytic tradition offered even further support for the development of arts therapies. For example, Jung (1990) regarded imagination and creativity as healing forces within his analytical psychology approach. Similarly to dreams, they were regarded as having potential to throw light onto the 'shadow' self (i.e. the primitive side of the self that is generally unacceptable to the individual concerned and hence is experienced as either inferior or uncontrollable). According to Jung (1990), the shadow self consists of the personal and the 'collective unconscious' (the collective unconscious refers to aspects of the psyche that are common to all humankind, transmitted genetically and that consist of universal images called 'archetypes'). The arts were therefore seen as allowing the individual to access personal as well as deeply located archetypal images and to contribute towards accepting and coming to terms with or integrating the shadow self. Having given such a valuable role to the arts, Jung inspired the work of many pioneers in the arts therapies, who not only incorporated his theoretical principles into their own practice but also adopted and adapted some of his techniques. For example, 'active imagination', a technique introduced and developed by Jung as a means of freeing personal and collective unconscious associations, has been in extensive use within the arts therapies field up until the present day.

Finally, deriving from the same psychoanalytic tradition there has been another important development in psychotherapy that has had an impact upon the emergence of arts therapies: object relations theory, with Melanie Klein and Winnicott as the main representatives. Object relations theory introduced a major shift from the primacy of instinctual drives within classical psychoanalysis to relational bonds between the self and the 'object' (i.e. inner representations of a real or phantasised person or aspects of a person that either satisfies or frustrates individual needs). It highlighted symbolic play as a means of understanding the inner world of children (Klein 1975) and the creative process as an important indicator of healthy psychological development (Winnicott 1971).

As a result of development in psychoanalytic thinking, psychoanalytically-trained psychiatrists began to pay attention to the value of visual art, drama and music as adjunctive tools to their work (Hogan 2001, Jones 1996, Waller 1991) and boosted therapeutic activity that involved the arts. For example, Hogan (2001) describes how drawings and paintings created outside the therapy sessions were analysed by a number of psychoanalytically trained psychiatrists such as Pickford, Kris and Pailthorpe.

Humanistic psychology, another major school of thought that evolved in parallel and as a reaction to psychoanalysis, offered even stronger support for the emergence of arts therapies. Moreno, the person often regarded as the

founder of humanistic psychotherapy, was a contemporary of Freud in Vienna at the beginning of the 20th century. His work diverged from Freudian thinking in that he introduced group psychotherapeutic work, in the form of psychodrama (an early precursor of dramatherapy [DT]) and gave theoretical 'permission' for the development of action therapies. During the 1960s and 1970s, humanistic psychotherapies became increasingly popular in various ways and with a number of different names, for example client-centred therapy (Rogers 1951), Gestalt therapy (Perls et al 1969) and transactional therapy (Berne 1961). Common elements of all of them are: (i) a rejection of psychoanalytic determinism over the development of human potential, (ii) an emphasis on the here-and-now of the therapy rather an exploration of the past, and (iii) a belief in a close relationship between the client and therapist, a relationship in which both client and therapist are regarded as equal partners in their therapeutic journey. Humanistic psychotherapists have also regarded self-expression and creativity as important aspects of their therapeutic work. The active nature of these therapies, taken in conjunction with their emphases on self-expression and creativity, has had a direct impact on the development of arts therapies.

In contrast to psychoanalytic thinking and the numerous humanistic traditions, behaviourism, the third important school of thought within modern psychology, has had much less contribution to the emergence of arts therapies. Behaviourism, rooted in the physiological tradition of the 19th century, focuses on observable behaviour that may be explained as a response to a stimulus. Underlying causes for such responses are not explored, the idea of the unconscious is rejected, while laws of learning theory are utilised to explain, predict and control behaviour. The more esoteric and holistic claims made by arts therapists have neither found very fertile ground within this tradition nor within the numerous types of therapies that derived from this major school of thought (e.g. behaviour modification, rational-emotive, cognitive, cognitive behaviour therapy).

Nevertheless, there have been many physicians who have shown an interest in the effects of the arts upon human physiology and/or on psychology. For example, there have been a number of experimental studies that have attempted to establish direct links between certain types of movement, music or art with either physiological or psychological health and its opposite, pathology. Systematic reviews of such studies made by people like Biley (2000), Cambrera & Lee (2000), Hacking & Foreman (2001), Kneafsey (1997) and Thomas & Jolly (1998) offer, in some cases, strong evidence that some such links are present (e.g. regarding movement and physiological changes, music and alleviation of chronic pain). In other cases, despite extensive research literature completed on such topics, the results remain inconclusive. Overall, arts therapists in the UK have been particularly sceptical towards such work. Edwards (2004) for example, argues that in most cases, the value of these findings for either the arts therapists or their clients has been questionable. This can be due to the fact that such studies often presented a limited understanding of the nature of the arts. There have also been some inherent difficulties in the translation of results from the controlled environment of a laboratory into the complexity of daily practice. Despite these criticisms, the interest shown by the medical profession towards the

arts meant that some physicians have been particularly open towards encouraging the use of the arts with their patients. For example, as early as the 1920s and 1930s they invited musicians to play 'sedative' music for large numbers of patients (Bunt 1994) or artists to draw pictures for hospital walls (Waller 1991).

In the UK however, it was primarily during and particularly after the Second World War that active use of the arts by patients was encouraged. It was also during this period that such usage was considered for purposes other than mere entertainment and/or aesthetic cultivation. This shift of perspectives was closely linked with a growing awareness of the psychological needs of war veterans, the development of therapeutic communities and the growth of the social psychiatry movement. During this climate of change, the profession of occupational therapy emerged; it was the first health profession that openly acknowledged the potential contribution of the arts towards well-being. Bunt (1994) records that initial state recognition of arts therapies in the UK was achieved in 1982 under the remit of occupational therapy. Distinctions between occupational therapy and arts therapies are still not clearly understood by people outside the two professions; a discussion of some of these differences is included in Chapter 2.

Movements such as 'the arts for all' and 'the arts for health' also grew at that time and artists became regularly employed in hospitals, therapeutic communities and community settings. Although the early work of artists was very exploratory and their theoretical frameworks often ill-defined, their work constituted the first serious attempt, in modern times and in the western world, to involve the arts directly in improving health within the wider community (Bunt 1994, Waller 1991). 'Community' and 'hospital' artists contributed to the development of arts therapies but then continued as distinctive practices from arts therapies. Clear differences between 'therapeutic arts' (a generic term referring to all the practices that use the arts therapeutically) and arts therapies were outlined for the first time in 1985 with the Attenborough Report; this will be further discussed in Chapter 2.

In the post-war era, changes in attitudes also took place within education. The contribution of the American educator Dewey had a significant effect upon existing practices (Waller 1991). Child-centred education, with its emphasis on personal, emotional and social development, became the preferred theoretical framework for many arts teachers (Bunt 1994, Waller 1991) and contributed to the development of arts therapies in the UK. Jennings (1987), Payne (1992) and Waller (1991), for example, testify to the educational background of many of the pioneers of arts therapies. Moreover, Waller (1992) claims that, during the early days of the profession, arts therapies were often regarded as sensitive forms of arts teaching. This trend persisted until the end of the 1980s. The introduction of the National Curriculum of England and Wales in 1988 signified the end of child-centred education and created obvious differences between arts education and arts therapies. Within the current arts education climate, increasing emphasis is placed upon specific artistic/aesthetic learning outcomes, which are different from the emotional and social objectives of the previous period and different from the therapeutic aims of current arts therapies practice (see Ch. 2 for further discussion of differences between the two fields).

Professional associations

Formal organisation of practitioners working with the arts in a therapeutic way began during the 1950s and 1960s. In 1958 the pioneer Julliette Alvin founded the first organisation for practitioners working with the arts and special needs populations; it was called the Society for Music Therapy and Remedial Music. Jones (1996) and Waller (1991) describe how individuals, with a special interest in the therapeutic use of visual arts and drama/theatre, also formed their own groups in order to exchange experiences and promote existing work to potential employers.

Developing a common body of knowledge amongst the members of these first groups was particularly difficult. Individuals involved in these groupings were used to working on their own in a variety of different settings and with various factors supporting or inhibiting their work; this was particularly apparent for example, in the development of the dramatherapy profession. The diverse and often disconnected approaches adopted by practitioners created a number of inter-professional battles (Waller 1991), but gradually a less individual character began to emerge, common characteristics were agreed and a number of common practices developed. However, the choice of the artistic medium (visual art, music, drama/theatre or dance and movement) remained an important distinguishing factor for subgroupings. A vigorous debate started between the supporters of the maintenance of separate identities for each of the arts therapies, and those believing in the existence of substantial common ground shared by all the arts therapies types. The supporters of a common ground for arts therapies initiated the movement of the study of arts therapies as a whole in 1977; the latter was connected with the Sesame Institute and was chaired by Antony Storr (Jones 1996). A parallel debate was taking place in the USA, with arguments that arts therapies share a clear, definite and common identity. McNiff (1986) for example, considered the existence of separate professional identities as a characteristic of the 1980s and 1990s based on an unjustifiable and unsound 'media-related' division of creativity. He explained this division as being the result of political rather than philosophical or theoretical choices. Those supporting separate identities argued that merging the arts therapies together into one professional association bore the danger of developing practices with questionable depth in the understanding of the art form, and thus questionable therapeutic value (Waller 1991). They also warned of the danger of minimising opportunities for funding within a context where there were already limited budgets for anything relating to the arts.

As a result of such arguments, separate developments in the arts therapies remained the rule. Some exceptions to this rule have been: the 'expressive arts therapies' movement in the USA and the Institute for the Arts in Therapy and Education in the UK. The latter has pursued an integrative arts route and is currently affiliated with the UKCP (UK Chartered Psychotherapists: the regulatory organisation for psychotherapists that holds a voluntary register for practitioners as opposed to the obligatory registration required for arts therapies practitioners). For most arts therapists in the UK however, the main forums for political action were separate professional associations, namely the BAAT (British Association of Art Therapists), APMT

(Association of Professional Music Therapists), BADth (British Association of Dramatherapists) and ADMT UK (Association for Dance Movement Therapy UK) (see Appendix 3 for contact details). BAAT, one of the first associations to be formed (1964), is currently the professional body with the longest list of registered practitioners (more than 1000 members; BAAT 2004). ADMT UK is the most recent professional body to be established. It was founded in 1982 by Crane, Garvie and Payne (Payne 1992), and since then it has expanded to currently more than 140 qualified members (ADMT UK 2004/2005). Current sizes of each of these associations are reflected in Figure 1.3.

Despite their separate developments, all arts therapies associations have similar aims and responsibilities and often cooperate in representing the professional interests of their members, such as negotiating conditions of work. For example, they have pursued, and in 1982, partly succeeded in gaining recognition as professionals working within the National Health Service (NHS), with initial state recognition under the remit of OT (DHSS 1982). Since then, arts therapists have become recognised allied health professionals within the NHS with a similar status to occupational therapists, physiotherapists and speech and language therapists, and have continued expanding and establishing practices in a number of other areas as we will see later in this chapter. Arts therapies professional associations have been instrumental to these changes. Current alliance with AMICUS, a very active trade union, is expected to strengthen associations' ongoing attempts to improve conditions of work and payment and contribute towards further professional recognition and status.

In return, arts therapies associations have realised the need to ensure high quality of practice for all their members. For example, all arts therapists are obliged to follow explicit codes of ethics, attend ongoing clinical supervision and show commitment to continuing professional development (CPD). Evidence of CPD work is currently becoming increasingly formalised for all arts therapists and it is expected that it will eventually become mandatory especially insofar as re-registration is concerned. Arts therapies professional

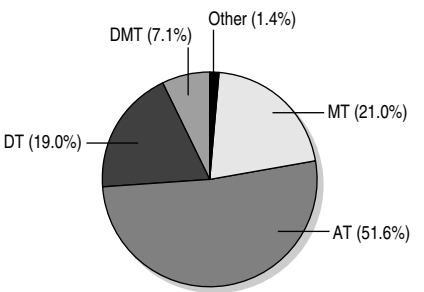

Figure 1.3: *Indicative sizes of arts therapies professional associations. The questionnaire for our study was fully completed by 580 arts therapists, around 40% of all arts therapists registered with arts therapies professional associations at the time of the study. The make-up of the final sample of the study in terms of representation of different arts therapies is shown. More than half of the respondents were registered art therapists, with the music therapists and dramatherapists making up around 20% each. Dance movement therapists constituted only 7% of the total sample.*

associations have also pursued and achieved independent regulation for their members through the Health Professions Council (HPC). The HPC is an independent regulatory body that assures high quality of training and high standards of service provision for most health professions in the country (HPC 2003). Arts therapists are now, and have been since 1999, represented in the HPC as a separate health profession through an umbrella arts therapies board that represents the different arts therapies disciplines. Title protection is an additional assurance of quality, since only HPC-registered, and consequently sufficiently-monitored practitioners, are allowed to practice as arts therapists.

During the recent history of the profession there have been a number of interdisciplinary arts therapies groups that work on areas of common interest. Committees for arts therapies in education and in prisons, the Joint Quality Assurance Committee, National Arts Therapies Research Committee, and the Research Forum for Allied Health Professions and the National (Scottish) Network for Clinical Effectiveness and Practice Development are some examples. Representatives from each of the different arts therapies associations are members of these groups.

Training courses

The first training course in the arts therapies was set up by Alvin in 1968 at the Guildhall School of Music and Drama in London, followed soon after by two courses in art therapy (AT) in at the Birmingham School of Art (as part of the Diploma and later the MA in Art Education) and at the St Albans School of Art (a Certificate in Remedial Art course). According to Waller (1991), between 1965 and 1972, discussions were taking place about the possibility of offering an Advanced Diploma incorporating art, music and movement at the Institute of Education, University of London; however, Waller (1991) claims that the plan for such training was possibly overly ambitious at the time.

During the following period a number of training courses were developed in various forms. For example, much of the initial training schemes for dramatherapy (DT) comprised short courses or weekend and summer schools. Training of a similar short duration and format was also developed for the first dance movement therapy (DMT) courses established in the UK. Very soon however, these courses adopted a more formal structure and, following the example of the courses in music therapy (MT) and AT, entry requirements, curricula and recognition were established. Today, programmes that lead to a licence to practise are at a Master's level and are approved by higher education (HE) institutions, their respective arts therapies associations and the HPC. Information about the length of these courses, the degrees awarded and the specific university they are validated by is included in Appendix 2.

Arts therapies training courses are currently validated by more than 15 HE institutions. Some of these courses are based within arts, health, social sciences, humanities or education faculties, while others are run independently (e.g. as charities) and receive academic validation without using university premises. In some cases there is more than one arts therapies programme; the same institution may be offering training for professionals in more than one discipline. When this is the case, often although separate programmes are followed, some common aspects of these programmes are

shared (e.g. modules on psychotherapy or research methods). For instance, Goldsmiths College has recently developed a new DMT course alongside its much older AT training programmes. At the University of Roehampton, programmes incorporating all four arts therapies are available. Derby University has developed postgraduate training courses (Diploma/Master) alongside an undergraduate course. (Note: A licence to practise is granted only to graduates from Diploma/Master courses. This is a characteristic of British training; in the Netherlands, for example, arts therapies training is primarily offered at an undergraduate level.) Also available in the UK are foundation courses that prepare applicants to reach appropriate entry requirements for professional qualification training, as well as opportunities for post-qualification studies at an MPhil/PhD level. Such programmes can be followed in most universities that offer arts therapies postgraduate training (see Appendix 2).

After lengthy debates within and between professional associations, there is currently consensus across disciplines and courses on some of the important 'ingredients' of arts therapies training programmes. In most cases, both Diploma and the more recent Master courses attempt to combine experiential knowledge and academic studies. According to the handbook of the Joint Quality Assurance Committee (JQAC 2002), the practical/experiential part often comprises:

- a number of supervised placements
- training in relevant skills and the art form central to the specific arts therapies
- experience in individual and group work as participants and facilitators
- some experience in other arts and arts therapies
- experience of writing clinical reports and keeping records.

Recent studies of experiential groups within training and placement learning (Karkou et al 2002, Payne 2001) highlight the value of this type of work for personal and professional development. The academic/theoretical part of the work usually covers areas such as:

- the theory of the modality and the art form central to it
- relevant psychological, psychiatric, sociological, psychotherapeutic and medical aspects
- theories of group and individual work
- a deep understanding of the therapeutic relationship and the management of the process
- issues related to equal opportunities, culture, age, gender, disability and ethics
- assessment and evaluation.

Introduction to the code of ethics, regulations and relevant legislations is also included in the theoretical aspects of these courses. (JQAC 2002). Requirements for training reflect expected standards of practice once trainees are qualified, and have been taken into account in the formulation of government documents such as the *Standards of Proficiency* (HPC 2003) and the *Benchmark Statement* (QAA 2004).